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	165329	A. BUILDING _____ B. WING _____	C 09/12/2017

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F 000	INITIAL COMMENTS Correction date: 9-13-17 The following deficiency was identified during the investigation of facility self reported incident #70391-I and & #70726-I completed September 5-12, 2017. Self Report 70391-I was not substantiated. Self Report 70726-I was substantiated. (See code of federal regulations (42CFR) Part 483, Subpart B-C)	F 000		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure that the resident environment remained as free from accident hazards as possible; and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 4 residents reviewed. Resident #12 used a merry walker and fell. The resident sustained injury including fractures. The resident expired 3 days later. A death certificate identified the cause of death as blunt force trauma due to the fall and the manner of death was "accident". Facility census was twenty-nine (29) residents. Findings include: 1. A Minimum Data Set (MDS) with assessment reference date of 4/11/17, revealed Resident #12 admitted to the facility on 3/31/17 from a community setting and the resident discharged on 4/11/17 to an acute hospital. The resident had impaired short and long term memory problems and moderately impaired decision making skills. The resident had the following indicators of delirium: inattention and disorganized thinking. The resident had wandering behaviors that occurred daily. The resident required extensive staff assistance with bed mobility, transfers, ambulation in room and corridor, dressing, toileting, eating, personal hygiene and bathing. The resident was frequently incontinent of bowel and bladder. The resident had diagnoses that included: dementia and anxiety. The MDS identified the resident with falls since admission to the facility, one with injury and one with major	F 323		

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F 323	Continued From page 2 injury. The resident was 65 inches tall and weighed 121 pounds. A fall risk assessment dated 3/31/17 identified the resident with a score of "20". A total score of 10 or above represented high risk. A resident assessment/data collection form dated 3/31/17 revealed the resident had a diagnoses of frequent falls. The initial care plan identified the resident transferred with one person assist and ambulated with 2 person assist. The care plan did not identify the use of a merry walker. The care plan did not address how they would monitor the wandering resident to ensure safety. On 9/11/17 at 10:16 a.m. the director of nursing (DON) identified the resident assessment/data collection form as the resident's care plan. A merry walker ambulation device assessment dated 3/31/17 and completed by the physical therapist (PT) identified the resident's primary diagnosis as dementia and the secondary diagnosis as repeated falls. At the conclusion of the assessment, the PT revealed the use of the merry walker was justified and the resident would benefit from walking independently with the merry walker. A treatment encounter note dated 3/31/17 identified PT performed trained the resident with the sit to stand transfers from the merry walker seat to ensure the resident could safely transfer independently. The resident could transfer safely. PT instructed the resident with walking using the merry walker. The resident could safely ambulate using the merry walker independently with periodic supervision of staff. The resident could turn corners and change directions with	F 323		

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instruction. PT performed a merry walker assessment indicating the need for the merry walker.

A treatment encounter note dated 4/4/17 revealed PT adjusted the resident's merry walker to improve the resident's ability to sit down. PT instructed the resident with sit to/from stand transfers from the merry walker seat. The resident ambulated using the merry walker with supervision.

A treatment encounter note dated 4/10/17 revealed the resident fell over the weekend. The resident was in the merry walker when he/she got stuck between 2 wheelchairs and tipped the merry walker over. PT fit the resident with a new merry walker that had a seat to allow the resident to sit when he/she got fatigued. PT adjusted the merry walker to the resident's size. PT instructed the resident with the new merry walker. The resident could ambulate with the walker in the facility. PT provided cues to improve the resident's ability to avoid hitting objects.

On 3/31/17 a restraint advisement form revealed the resident's responsible party signed the form giving consent for merry walker use.

1st Incident:

Nurses notes dated 4/9/17 at 10:30 a.m. and documented by Staff A RN (registered nurse) revealed staff found the resident tipped over in the merry walker on hands and knees in the day room next to 2 other residents in wheelchairs. The resident did not call for help. The resident denied pain and there was no evidence of injury. Staff assisted the resident back up to his/her feet.

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F 323	Continued From page 4 The entry identified the resident as agitated. The resident pushed his/her way through people and objects in merry walker and drank other resident's beverages at empty seats in the dining room. Staff administered Ativan (antianxiety) to help the resident relax. Staff also proved 1 to 1 attention to the resident for the rest of the shift after the fall. On 9/12/17 at 9:47 a.m. Staff A RN stated when the 4/9/17 fall occurred, it appeared that the resident tried to push his/her way through two wheelchairs. The resident was on his/her hands and knees still in the merry walker with the top of the merry walker forward in between the 2 parked wheelchairs. Staff A stated the resident must have gotten "hung up". Staff A felt the merry walker was appropriate for the resident because the resident never sat still. A fall investigation for nurses dated 4/9/17 and completed by Staff A revealed when the form asked if there were any observable problems related to the way the resident used the equipment (merry walker), Staff A wrote the resident "leans forward and rams into things". In the area of what contributed to the fall, Staff A wrote the resident tried to "push their way through objects". The fall investigation contained a statement from Staff B CNA (certified nurse aide), dated 4/9/17 that revealed the resident needed more one on one in response to the question "what factors could have contributed to the fall?" and under the question "what new interventions would you suggest to prevent the fall from happening, Staff B wrote that the facility needed "more staff to accommodate the resident's higher level of care".	F 323		

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F 323	Continued From page 5 On 9/11/17 at 11:44 a.m. Staff B stated when the 4/9/17 fall occurred the resident tried to squeeze between 2 wheelchairs. Staff B stated the resident needed more attention from staff because he/she would get into things and rearrange things. Staff B thought the resident got around well in the merry walker and that the resident seemed safe in it. On 9/11/17 at 10:50 a.m. the PT stated he felt the resident was safe to use the merry walker independently. The resident did a good job of avoiding obstacles and residents. After the 4/9/17 incident, they gave the resident a different merry walker. On 9/12/17 at 12 p.m. PT stated the different merry walker was wider and more stable. 2nd Incident: Nurses notes dated 4/11/17 at 7:55 a.m. and documented by Staff A RN revealed staff found the resident lying on his/ her left side still in the merry walker on the floor of the beauty shop. The left side of the resident's face was on the floor with a moderate amount of blood and a visible tooth lying in the blood. Upon evaluation, staff notes a 3 centimeter (cm.) laceration to the chin with 7 cm. swelling to the cheek and bleeding from the upper lip and oral cavity. Bilateral eyes were equal and reactive to light. Range of motion was intact and staff found no other injuries. Staff applied steri strips to the chin laceration which the resident later took off. The resident still wanted up and to move around per usual. Staff applied ice to the resident's face and administered acetaminophen (analgesic) and Ativan to help with restlessness. The resident's spouse arrived and staff informed the spouse of the incident. Staff notified the clinic and the resident	F 323		

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F 323	Continued From page 6 transported to the clinic for evaluation of the injuries. Nurses notes on the same date at 11:45 a.m. revealed the resident received 7 stitches to the chin at the clinic and then the resident transported to ER (emergency room) for x-rays of facial injuries as the clinic does not do those types of x-rays. At 1:30 p.m. ER phoned and said the resident had a broken mandible/jaw on CT (computerized tomography). On 4/16/17 at 6:30 p.m. (late entry for 6:30 p.m.) the resident's son called to say the resident expired at the hospital. The fall investigation for nurses dated 4/11/17 and completed by Staff A RN revealed when asked if there were any observable problems related to the way the resident used the equipment (merry walker) that could have contributed to the fall, Staff A wrote that the resident "tried to force their way through objects when the walker gets caught". When asked if any environmental factors contributed to the fall, Staff A wrote that the resident went into the beauty shop and likely caught the merry walker on scale. The nurse identified Resident #12 was confused at all times, and had internal risk factors (decline in functioning and decline in cognition) as factors that contributed to the incident. The immediate action to prevent another event was "one to one". Staff C CNA documented she would suggest one to one supervision as an intervention to prevent another fall. An ER report dated 4/11/17 at 11:37 a.m. identified the impression as "fracture right mandible condyle with displacement", "fractured front portion of the maxilla extending into the left maxillary sinus", "2 front incisors on the right are lifted forward", "fluid in the left maxillary sinus and significant soft tissue swelling over the upper lip	F 323		

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F 323	Continued From page 7 on the left cheek with small amount of blood within the subcutaneous tissue left cheek". On the same date at 2:22 p.m. the ED physician discussed the case with the hospital and they accepted the resident for admission. A hospital history and physical (H&P) dated 4/11/17 at 6:52 p.m. revealed the resident was walking with the walker when the wheel of the walker stuck and the resident fell forward and hit his/her face to a handle in the nursing home. The resident was found to have a fracture of the mandible and maxilla and the case was discussed with a plastic surgeon who agreed to evaluate and probably take the resident to the operation theater when the swelling went down. A hospital discharge summary dated 4/14/17 identified the physician informed the resident's family that the resident was high risk for surgery given the resident's dementia and how the resident looked. The resident went for surgery on 4/13/17 and open reduction and internal fixation of the mandible fracture was performed. After surgery, the resident later that night became unresponsive with problems breathing. A chest x-ray showed right lung atelectasis versus infiltrate. The resident deteriorated over the next few hours and expired on 4/14/17 at 4:21 p.m. Staff Working When the 4/11/17 Incident Occurred: On 9/12/17 at 9:47 a.m. Staff A RN stated she had just seen the resident in the hallway in his/her merry walker 3 minutes tops before the incident. Staff C CNA called for Staff A and Staff A observed the resident in the doorway of the beauty shop on his/her stomach with left side of	F 323		

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F 323	Continued From page 8 the face on the floor. There was blood on the floor with a tooth in it. Staff A described the resident as still in the merry walker just as if you turned the merry walker from upright to its side-as if you just tipped it over. She stated the resident did not lose consciousness. The resident could move everything and his/her vitals were OK. The resident had a good sized laceration in the chin that hung open and was deep. Staff A steri stripped the laceration. There was swelling to the gums and lip right away and one tooth was out and the 2 front teeth appeared pushed up into the gum. The left cheek was swollen and puffy. Staff A thought the incident occurred around 8 a.m. Staff A called the clinic and the resident went per facility van. Staff A thought the merry walker got caught on something. During the resident's 4/9/17 fall, the bottom of the merry walker got stuck and the resident kept trying to push it and the top tipped forward. Staff A stated she thought if the merry walker bottom got stuck then the top must be tipable. Staff A stated she had not seen the resident hung up before, just maybe with the 4/9/17 fall. Staff A stated she had not seen the resident in the beauty shop before. She stated the weigh scale was by the doorway of the beauty shop when the incident occurred and Staff A wondered if the resident wandered and caught the merry walker wheel in it. She identified a ramped area on the scale where the wheel could catch. It appeared that was what occurred based on where the resident landed. The bottom of the walker was right by the scale and the resident extended from there to the doorway. Staff A tried to shut the beauty shop door the weekend of 4/9/17 and it would not latch and would slowly open back up. On 9/12/17 at 10:38 a.m., interview with Staff A and the Administrator revealed, Staff A stated she	F 323		

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informed the Administrator of the beauty shop door not latching. The Administrator stated he did not recall but after the incident the facility put a lock on the door.

On 9/11/17 at 9:30 a.m. observation showed the beauty shop door shut and locked with a sign on the door to keep the door closed when not in use. On 9/11/16 at 3:46 p.m. observation of the weight scale showed a sloping area on the left side of the scale adjacent to the doorway of the beauty shop and an opening under the ramp area where a merry walker wheel could get caught (see photos).

On 9/11/17 at 10:05 a.m. Staff C CNA stated she worked on the day of the incident. Staff C stated the resident was hard to reason with. When staff got him/her up that morning, one staff needed to guide the resident while another staff talked to the resident. After they got the resident in the merry walker, the resident roamed around. Staff C took a resident to breakfast and when she came out, the resident was on the floor in the doorway of the beauty shop. At the time, Staff C stated they kept the beauty shop door open. Staff C stated the merry walker must have tipped. Staff C didn't see or hear anything. The resident received injuries from the fall. Staff C stayed with the resident while Staff A checked him/her. The resident hit their head and knocked out a tooth. Staff C stated there was a lot of blood coming from the resident's oral cavity. Staff C didn't notice the resident having any issues while using the merry walker before.

On 9/11/17 at 11:39 a.m. Staff D CNA stated she worked on the day of the incident. Staff D stated

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the resident did have a problem with the merry walker. The resident would tip and run into staff. Staff D reported the beauty shop was [door] was never shut.

On 9/11/17 at 12:01 p.m. Staff E CNA she worked another hall on the day of the incident. She went to the beauty shop after the incident to see if she could help but there was a nurse and 1 or 2 staff assisting so she went back to her hall. Staff E stated she saw the resident earlier before the incident going up and down the hall in the merry walker and was OK at that time. Staff E stated staff tried to keep an eye on the resident and when they didn't see him/her then they would go find the resident. The resident would occasionally bump into something with the merry walker otherwise no concerns.

On 9/11/17 at 1:35 p.m. Staff F CNA stated she worked the other hall on the day of the incident. The resident would get caught on things occasionally. Staff F felt the resident needed one to one. Staff F stated the resident would not sit still. The resident would get up and down constantly. The resident would go in rooms and get into things.

On 9/11/17 at 10:16 a.m. the Director of Nursing (DON) stated the resident admitted to the facility on 3/31/17 from a private pay memory care unit. The family stated the resident was nonambulatory. After the resident arrived on 3/31/17, the resident was in a wheelchair and staff was one to one with the resident because of restlessness. Therapy evaluated the resident that day and said the resident could safely use a merry walker. The resident tipped the merry walker forward on 4/9/17 after getting between 2

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wheelchairs. Therapy again evaluated the resident after that fall and gave the resident a different merry walker because of the seating system. Therapy felt the merry walker was safe. `When asked about the merry walker not included on the initial plan of care, the DON stated she educated staff on the merry walker and a half hour restraint record. She stated it was a verbal face to face education. On 4/11/17 Staff A saw the resident go up and down the hall while she passed pills. At one point the resident went in the beauty shop and the merry walker tipped over and the resident hit the floor and hit their head on the doorway. No one witnessed the incident. The DON stated she thought the resident went in the beauty shop and turned and rolled onto the weight scale ramp or caught the merry walker wheel on the ramp and lost his/her balance. After the incident they lock the beauty shop door and moved the scale.

On 9/12/17 at 2:58 p.m. Staff F CNA stated she didn't remember a face to face education regarding the merry walker.

On 9/12/17 at 3:04 p.m. Staff G CNA stated she did not remember a face to face education regarding the merry walker.

Other staff:

On 9/12/17 at 2:22 p.m. Staff H LPN (licensed practical nurse) stated she had concerns regarding the resident and the merry walker. The resident would get close to things and get in a room and not know how to get out.

On 9/11/17 at 5:14 p.m. Staff I CNA stated she thought the resident was safe in the merry walker

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F 323	Continued From page 12 but the resident needed a dementia unit. On 9/11/17 at 2:10 p.m. Staff J CNA stated the resident could get stuck while using the merry walker and staff would assist the resident from the situation. Death Certificate A death certificate revealed the resident expired on 4/14/17 at 4:21 p.m. The immediate cause of death was "complications of blunt force trauma" due to or as a consequence of: "fall". Manner of death was listed as "accident". The description of the injury was "fell against door frame, struck face/head" with the date of the fall listed as 4/11/17.	F 323		

Kingsley Specialty Care

F 000

Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law.

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It continues to be the policy of Kingsley Specialty Care that a resident environment will remain as free from hazards as possible. Resident #12 no longer resides at the facility. A safe environment will be maintained for all other residents at the facility. On 4/13/17, the facility reorganized the beauty shop to ensure the scale was not near the doorway. The facility ensured the beauty shop door was able to close and latch appropriately and installed a door knob with a keypad entry system. The facility also posted a sign on the door to notify staff to keep the door closed when not in use. A 5-minute meeting was written to all staff to educate keeping the beauty shop door closed at all times when not in use.

If a resident is noted with increased restlessness and needing to move about the facility, an evaluation will be completed to determine the appropriate intervention for the resident at that time, and staff education will be provided so all are aware of the interventions that have been implemented in order to provide adequate supervision.

The facility QA team will monitor daily to ensure compliance. Compliance date is 9/13/17.

Matt Rotert, Administrator

September 28, 2017