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F 000	INITIAL COMMENTS Correction date _____ Investigation of facility-reported incident # 72492-I resulted in the following deficiency. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 700 SS=J	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(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. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, record review and physician and staff interviews, the facility failed to	F 700	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/27/2017

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implement appropriate precautions and interventions after the facility added an air mattress to a bed frame with side rails which caused an entrapment hazard that resulted in death of Resident #1. This created an immediate jeopardy situation for the health and safety of a resident. The sample consisted of 3 residents and the facility identified a census of 44 residents.

Findings include:

Resident #1 had a MDS (Minimum Data Set) assessment with a reference date of 9/29/17. The MDS identified the resident had diagnosis including anemia, atrial fibrillation (irregular heart rhythm), heart failure, orthostatic hypotension (significant decrease in blood pressure with position changes), muscle weakness, unsteadiness on feet and age related physical debility. The MDS identified the resident as unsteady, could only stabilize with staff assistance and required extensive assistance of 1 staff person for all ADLs (activities of daily living). According to the MDS, the resident displayed delusional behaviors and had a BIMS (brief interview for mental status) score of 3 out of 15. A score of 3 identified the resident had a severe cognitive impairment.

According to the Care Plan, the following interventions pertained to Resident #1:
The resident's needs should be anticipated as of 8/3/16.

Nonskid strips had been applied in front of the toilet on 2/3/17.

Ensure the resident wore gripper socks at night

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as of 2/23/17.

The accordion door removed from the bathroom on 5/25/17.

The resident requested not to be toileted or repositioned at bed time as of 6/28/17.

Staff should check on the resident frequently for safety as of 7/3/17.

Non-ambulatory as of 8/16/17.

Assist the resident with toileting before meals, after meals, at bedtime and as needed. The Care Plan also noted the resident's tendency to refuse help.

The floor mat should be next to the bed when he lays down in it as of 9/24/17.

Required extensive assistance of one person for transfers as of 9/29/17.

Hospice provided an air mattress on 9/29/17.

Relied on staff to propel his wheelchair as of 10/12/17.

Wheelchair pedals (foot rests) should be removed "when staff not assisting" as of 11/6/17.

The wheelchair should be folded and stored in the bathroom while in bed as of 11/6/17.

A list of ten incidences noted Resident #1 either fell in the bathroom or self-transferred from his bed or the toilet between 2/2/17 and 9/24/17. The Care Plan did not contain interventions for

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precautions, interventions, potential risks or hazards related to the use of the air mattress and side rail combination.

The document titled "Fall Scale-Morse" and dated 9/20/17 indicated the resident at a high risk for falling.

The document titled "Safety Device Audit Assessment Tool" dated 9/20/17 noted Resident #1 would benefit from an enabler/assistive device for repositioning.

The documents titled Physician's Orders/Plan of Care dated from 9/20/17 to 12/18/17 ordered DME durable medical equipment/Supplies: Tilt and space wheel chair, low loss air mattress, Roho cushion, oxygen concentrator 5 liter/minute and oxygen cylinders. The physician also ordered safety measures: call bell/light in reach, bed low position, and oxygen safety precautions.

The Medication Review Report dated on or after 11/8/17 noted Resident #1's physician ordered him to be admitted to Hospice Care at Oakland Manor on 9/22/17.

The document titled, Hospice/Long Term Care Checklist for Reporting Death, dated 11/19/17, noted Resident #1 died as a result of accidental asphyxiation by bed rail. The document titled Preliminary Report of Investigation by Medical Examiner and dated 11/22/17 indicated Resident #1 was pronounced dead on 11/19/17 at 6:17 a.m. by Staff C, RN. The author indicated asphyxiation due to compression of the head and neck by the bed rails had been identified as the probable cause of Resident #1's death. The narrative summary of circumstances surrounding

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the death indicated Resident #1 was checked on and seen sleeping comfortably at about 5:00 a.m. on 11/19/17. According to the document, the staff found the resident about an hour later, partially on the floor and pinned on the side of the bed by the bed rail. The reported identified the resident did not have a pulse, was not breathing and the nurse pronounced him dead at that time. After review of the history, circumstances and photographs, the medical examiner believed Resident #1 died accidentally while trying to get out of bed and became pinned between the mattress and bedrail which caused a "compressive force" on the right side of his face and neck.

On 12/5/17 at 12:00 p.m. the Administrator was interviewed and stated the door to the resident's room was locked and the facility left everything the way they found it, except stripping the bed of soiled linen. The Administrator stated the CNAs (certified nursing assistants) chart by exception. According to the Administrator, their rounding [of each resident assigned] only got documented if they found something out of the ordinary. When asked about the frequency in which they reposition residents, the Administrator stated the DON (Director of Nursing) told her turning and repositioning are standards of practice that are done frequently and as needed. When asked to clearly define "frequently", the Administrator said they do not "quantify by hours" on the care plans. According to the Administrator, she has personally observed the CNAs reposition residents if they are found in awkward positions. The Administrator stated the staff offered to intervene if they see residents with grimaces on their faces or if they voice a desire to be repositioned. The Administrator stated a Care

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Plan that specified a numerical value, like every two hours; may be an infringement on their right to stay in the same position to watch TV or whatever else they might prefer to do.

On 12/5/17 at 1:00 p.m. Staff C, registered nurse, was interviewed and stated she went down Resident #1's hallway about 5:00 a.m. when she started her medication administration pass. Staff C stated the resident usually liked his door closed, but she kept it half way open because of the resident being 101 years old. Staff C stated she went into his room but did not disturb him because she visually saw him sleeping. Staff C stated she tried to visualize each resident every two hours, but two hour rounding was the CNAs responsibility. Staff C stated as she sat at the nurse's station with 3 other nurses at about 6:15 a.m. during shift change. According to Staff C, Staff A, CNA and Staff B, CNA approached them and reported they found Resident #1 on the floor next to his bed with his head caught between the mattress and the bed rail. Staff C stated she, Staff D, LPN (licensed practical nurse), Staff E, RN and Staff F, LPN went to the resident's room. Staff C stated they found him in a kneeling position on the floor mat beside the bed with his head between the mattress and the bed rail. According to Staff C, they found him with the left side of his face against the mattress and the other side against the bed rail. Staff C stated his head was stuck and they removed it easily. Staff C stated she recalled the call light being attached to the sheet that partially covered him. Staff C stated he had not been tangled in the sheet. According to Staff C, one of the resident's hands gripped the bed rail as if he tried to stand himself up. Staff C said he had a history of self-transferring and explained they had his bed

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in the low position with the floor mat next to it. The RN described Resident #1 as being physically incapable of standing himself up. Staff C said the facility had a policy of not using bed alarms.

On 12/5/17 at 1:37 p.m. Staff B (certified nursing assistant) was interviewed and stated she received a shift report from Staff A about 6:15 a.m. According to Staff B, Resident #1's door was partially closed so they opened it and found him kneeling/leaning against the side of the bed with his head between the mattress and the bed rail. The CNA stated his left shoulder and upper back were against the bed and he faced forward with the left side of his face against the mattress and the right side against the bed rail. Staff B stated he did not have any color and did not appear to be breathing. The CNA stated she stayed with the resident and Staff A went to get the nurses. Staff B stated Resident #1 still needed the side rail for repositioning. Staff B stated she had not seen Resident #1 stand on his own for weeks because of a recent decline. According to the CNA, Resident #1 had a history of trying to get up on his own when he needed to use the bathroom but he had a catheter at the time of the incident. Staff B stated she remembered the call light being within reach, but did not remember its exact location. Staff B stated she heard the CNAs talking about Resident #1 needing a low bed because she thought he slid his feet out of bed. When asked, Staff B stated she did not know if that resulted from him moving around in bed or attempting to get up on his own. The CNA stated Resident #1 did not like to be positioned in the center of the bed. According to Staff B, Resident #1 frequently self-transferred to the bathroom before a recent hospitalization. Staff B stated the

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resident was unsteady and should have used his call light, but would not. Staff B stated the resident was readmitted from the hospital with a catheter. Staff B stated within the first day or two after being readmitted, she found him on the floor of his bathroom doorway. According to Staff B, he must have forgotten he had a catheter. The CNA stated the drainage bag was still attached to the bed frame. She said the catheter had not gotten pulled out, but the tubing had gotten stretched tightly. Staff B stated she wondered why they had not issued a low bed for Resident #1 after his return; especially since he had fallen again after being readmitted from the hospital. Staff B stated she thought all cognitively impaired residents with balance issues should have low beds that go all the way to the floor. The CNA stated she overheard Staff G talking to someone else about Resident #1 needing a low bed.

On 12/5/17 at 3:05 p.m. Staff E (registered nurse) was interviewed and stated she received shift report from Staff C when Staff A approached them and said it looked like Resident #1 was caught in the bed rail and it appeared he passed away. According to Staff E, when they arrived at Resident #1's room they found him on the floor mat next to the bed. Staff E stated he was in a kneeling position, but almost appeared as if he were sitting on his legs. Staff E stated the resident's upper body leaned forward with his head between the mattress and the bed rail facing forward and his right hand grasped the hand rail. Staff E stated Resident #1 wore a brief and a night gown. According to Staff E, she could not remember the location of the call light. Staff E stated Resident #1 had a history of trying to get up on his own, but lost the ability due to a recent decline in his health. Staff E stated the

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resident had the ability to use his call light, but whether or not he did varied from day to day. Staff E stated Resident #1's head was lodged between the mattress and the side rail and they had to push against the mattress to relieve some of the pressure to remove his body. Staff E stated it was difficult to get him out of the position they found him in.

On 12/5/17 at 3:30 p.m. Staff A, CNA, was interviewed and stated she last saw Resident #1 asleep in bed about 3:30 a.m. Staff A stated she found the resident with his head caught between the mattress and bed rail at 6:15 a.m. According to the CNA, she did rounds every two hours, and her last rounds were at 4:00 a.m. Staff A stated she started the rounds a little early to ensure she got them all done. Staff A stated she and the oncoming CNA stopped at Resident #1's room during shift report about 6:15 a.m. According to Staff A, she found the door slightly open and when she pushed it open all the way, she and the oncoming CNA found Resident #1 kind of "slumped over to the side" kneeling on the floor mat next to the bed with his body at kind of an angle. The CNA stated his left hand gripped the bed rail and his other hand had "just kind of fallen along his side". The CNA stated the resident's head was lodged in between the mattress and the bed rail, facing forward with the left side of his head against the mattress and the right side against the rail. According to Staff A, she had to push the rail outward to relieve enough pressure to get his head out. Staff A said it looked like he had moved the call light because the cord stretched across the side rail and the stuffed animal attached to the end of it dangled above the floor. Staff A stated Resident #1 typically did not use his call light; he just screamed if he

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needed something. Staff A stated Resident #1 had a history of trying to get up on his own. Staff A stated the resident did not have a real "high low" bed. According to her, Resident #1's bed would only lower to about mid-thigh or knee level, but not all the way to the floor. The CNA said she suggested getting an actual high low bed to a couple nurses on separate occasions when she caught him trying to get up on his own. Staff A stated they would look into it, but nothing had ever been done about it. Staff A recalled the 1st time she suggested the high low bed was a couple months before the incident. The CNA said she suggested it again a couple weeks before his death. According to the CNA, she happened to be passing by Resident #1's room when she saw him trying to get up on his own and then suggested it again. Staff A stated she doubted if the incident would have happened if his bed had been lowered all the way to the floor. According to her logic, Resident #1 would have been in a much better position to help him because his whole body would have been on the floor. The CNA stated it looked like he had been gripping the rail trying to pull him out. According to Staff A, she was so upset she mentioned to Staff C "if he had a high low bed it wouldn't have happened." Staff A stated the facility had not conducted an in-service or provide individual education related to the situation. Staff A stated the only thing the Administrator did was take our statements. Staff A stated the Administrator didn't ask how it could have been avoided or anything else. Staff A stated she believed any resident with the inability to self-transfer, but has a history of doing so should have a bed that goes all the way to the floor. Staff A stated despite having a fall mat next to the bed, the resident could have fallen and broken a hip from that

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height. Staff A stated it appeared as if he had been hanged.

On 12/6/17 at 8:30 a.m. with the ME (Medical Examiner) identified that although an autopsy had not been performed on Resident #1, it seemed apparent that significant pressure had been applied after getting his head caught between the mattress and the bed rail. According to the ME, Resident #1 had an indentation on the side of his face and ecchymosis (bruise; primarily formed when blood vessels near the surface of the skin are damaged, usually by impact from an injury) across the maxillary (jawbone) facial area and the right neck. According to the ME, providing appropriate interventions to keep someone with a history of self-transferring safe would be the prudent thing to do.

A subsequent interview on 12/6/17 at 9:40 a.m. with Staff C (Registered Nurse) revealed Staff G spoke to her about Resident #1's need for a low bed and they both agreed. Staff C stated she found it difficult to speak to the maintenance department because she worked the overnight shift; therefore she never relayed that information. According to Staff C, they tried to keep Resident #1 near the nurse's station during his waking hours because inevitably he would try to self-transfer if they were not monitoring him. Staff C stated Staff G, LPN told her she had previously spoken to the ADON (assistant director of nursing) about arranging for Resident #1 to have a low bed, but unfortunately it never happened. Staff C stated she believed Resident #1 would have been sitting on the mat instead of the position they found him in if he had a bed that went all the way to the floor. Staff C stated other residents that cannot stand are found on the floor

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when they are equipped with a low bed.

On 12/6/17 at 10:35 a.m. Staff G (licensed practical nurse) was interviewed and stated she no longer worked at the facility and unaware of the side rail incident with Resident #1. Staff G said she worked the day shift and always tried to keep Resident #1 at the nurse's station, the lobby or in activities; somewhere he could be supervised. According to Staff G, staff would shut his door when he was in his room because he wanted it shut and would yell if they left it open. Staff G stated he was not safe in his room with the door shut because of being a fall risk. Staff said Resident #1 did not always use the call light. Staff G stated if he did activate the call light and someone did not respond in a few minutes; he would transfer himself.

On 12/6/17 at 11:25 a.m. with Staff F, LPN revealed that was the first night she trained on Resident #1's hall. According to Staff F, she walked to the end of his hall at 5:20 a.m. to remote start her car. According to Staff F, she had not heard anyone calling for help. When asked, the LPN could not recall if Resident #1's door was opened or closed. Staff F said they were at the nurses' station reporting off to the day shift when Staff A came to the desk and told them Resident #1 appeared to have died because of getting his head caught between the bed rail and mattress. Staff F said she, Staff C and Staff E went down to his room. The LPN said he appeared to be on his knees with the left side of his body against the bed. Staff F said she could not tell if his buttocks touched the floor mat or just his knees because he had been wearing a gown. Staff F said the side rail was in the up position and Resident #1 faced downward with the left

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side of his head against the mattress and the right side against the side rail. Staff F said she saw the rounded corner of the side rail under his jawbone. The LPN said the resident's head had been lodged. According to the LPN, indentations had been left due to the pressure from the bars of the side rail and his right hand gripped the bottom of the bar. Staff F also said she saw the call light directly under the bed on the floor about 8" (inches) just to the left of him. Staff F said she helped physically lift the resident and reposition him so Staff C could assess his pulse. According to Staff F, she assumed Resident #1 choked because of his head being compressed between the bed rail and mattress.

On 12/6/17 at 2:40 p.m. the Nurse Consultant was interviewed and stated the facility did not have a side rail policy; they considered the use of side rails as a standard of practice.

On 12/7/17 at 8:15 a.m. the MDS Coordinator was interviewed and stated she agreed; there should have been something on the Care Plan about precautions related to the use of side rails and an air mattress. The MDS Coordinator stated the Maintenance Supervisor periodically checked beds. The MDS Coordinator stated that is "his thing" The MDS Coordinator stated she did not know what the Maintenance Supervisor specifically looked for. The MDS Coordinator confirmed and agreed a collaborative approach with the Maintenance Supervisor may be more effective in developing specific precautions and interventions related to the use of side rails and air mattresses to ensure resident safety.

On 12/7/17 8:25 a.m. the Maintenance Supervisor was interviewed and stated Hospice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165230	A. BUILDING _____ B. WING _____	C 12/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKLAND MANOR	737 NORTH HIGHWAY OAKLAND, IA 51560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 13	F 700		

provided the air mattress for the resident's bed. The Maintenance Supervisor stated he checks the condition of all mattresses and beds once a month at which time he also measures to ensure they have the appropriate distance between the mattress and bed rails.

On 12/11/17 at 10:00 a.m. the DON (Interim Director of Nursing) was interviewed and stated Resident #1's bed had already been equipped with an air mattress and side rail before she started working for the facility on 10/2/17. When asked to explain the process that leads to the decision to equip a resident's bed with bed rails and/or an air mattress, the DON stated each resident's comorbidities and ability to "move around "are factors. According to the DON, they use the values generated by the skin assessment tool and then reference online resources (not one in particular) to determine their risks and whether an air mattress and/or bed rails should be used. The DON stated if residents don't need bed rails to reposition themselves, then the rails should not be put on the bed. According to the DON, the Maintenance Supervisor determined if the side rails were safe after the installation of the bed rails.

A subsequent interview on 12/7/17 at 11:00 a.m. with the Administrator identified they stopped using that specific bed frame and mattress immediately after Resident #1's death on 11/19/17. According to the Administrator, she locked the door as soon as the funeral home took the resident's body. The Administrator stated the facility had no other bed frames/rails or mattresses like the one Resident #1 had in his room.

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Per an interview with the Administrator on 12/5/17 at 12:00 p.m., the Administrator stated there was an air mattress on the bed (not tethered) which was still functioning when she was in the room on the day of the resident's death. Observation of facility beds during the investigation identified no other beds posing a hazard.

The document titled Guidance for Industry and FDA staff and Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 3/10/06, directed the following: Additonal caution should be taken when using these products to ensure a tight fit of the mattress to the bed system. If a powered air mattress is replacing a mattress on a bed system that meets the recommendations in the guidance with the original mattress, the resulting bed system with the new air mattress may still pose a risk of entrapment. When these products are used, we recommend that steps are taken to ensure that the therapeutic benefit outweighs the risk of entrapment.

NOTE:

At the time of the complaint investigation, the complaint was coded at a "J", immediate and serious jeopardy. The facility self corrected the immediate and serious jeopardy on 11/19/17 by securing and removal of bed/side rails in order to prevent further usage. The facility investigated the other beds in the facility and found none after removal of the bed/side rails that Resident #1 used.