| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235715 | A. BUILDING _____ B. WING _____ | 03/12/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| WELLBRIDGE OF FENTON | 901 PINE CREEK DRIVE FENTON, MI 48430 |

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| F 0550<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>This Citation pertains to MI 779, MI 246, and MI 526. Based on interview and record review, the facility failed to ensure that residents were treated with respect and dignity by answering call lights timely and scheduling treatments during waking hours for three residents (Resident #202, Resident #203, and Resident #204) out of eight residents reviewed for treatment with dignity and respect, resulting in long call light wait times for care and being awakened for wound care with feelings of frustration, anger, and worthlessness. Findings include: Resident #202: According to the Admission Record, printed on 3/12/2020, Resident #202 was a [AGE] year old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During a telephone interview with Resident #202 on 3/9/2020 at 9:42 AM, Resident #202 reported that she had arrived at the facility at about 12:10 PM on 1/31/2020. Resident #202 stated that she had waited for over an hour for staff to respond to her call light after she had activated the call system around 1:30 PM to request medication for pain.<br>Resident #202 stated she had left the facility later that night with her son. A review of the call light log for 1/31/2020 for the room assigned to Resident #202 revealed three times that the call light had been on for over an hour on 1/31/2020. From 1:05:34 PM until 2:13:31 PM, from 3:50:31 PM until 4:57:30 PM, and from 8:11:18 PM until 9:25:04 PM. Resident #203: According to the Admission Record, printed on 3/11/2020, Resident #203 was an [AGE] year old female admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #203 was discharged to her home on 2/14/2020. During a telephone interview with Resident #203 on 3/10/2020 at 2:45 PM, Resident #203 reported that she had waited at times for staff to answer her call light for over an hour; one of those hour long waits was when she was left on a bed pan. During an interview on 3/11/2020 at 3:30 PM, the Social Worker, Staff J was asked if she had any complaints about long wait times for a call light. Staff J said that sometimes new residents complained about having to wait for 10 minutes. Staff J was asked about how long she thought was too long for a resident to wait for a call light response. Staff J thought that call lights should be answered in less than 15 minutes. A review of the call light log for 1/16/2020 through 2/14/2020 for the room assigned to Resident #203 during her stay at the facility revealed the following wait times for the call light that were over 20 minutes: 1/17/2020 at 5:52 AM until 6:33 AM - 41 minutes 1/19/2020 at 8:31 PM until 9:08 PM - 37 minutes 1/20/2020 at 7:03 AM until 7:44 AM - 40 minutes 1/21/2020 at 11:00 PM until 11:49 PM - 49 minutes 1/23/2020 at 100:15 AM until 10:39 AM - 23 minutes 1/23/2020 at 10:27 PM until 11:20 PM - 53 minutes 1/24/2020 at 2:11 PM until 2:34 PM - 23 minutes 1/25/2020 at 8:33 AM until 8:59 AM - 25 minutes 1/25/2020 at 9:00 AM until 9:25 PM - 25 minutes 1/27/2020 at 9:34 AM until 10:27 AM 53 minutes 1/27/2020 at 8:08 PM until 8:29 PM - 21 minutes 1/28/2020 at 11:25 AM until 12:27 PM - 1 hour and 1 minute 1/28/2020 at 12:47 PM until 1:15 PM - 28 minutes 1/29/2020 at 5:44 PM until 6:08 PM - 23 minutes 1/30/2020 at 10:44 AM until 11:11 AM - 26 minutes 1/31/2020 at 12:17 AM until 12:44 AM - 26 minutes 1/31/2020 at 6:03 AM until 7:32 AM - 1 hour and 29 minutes 1/31/2020 at 7:34 AM until 7:57 AM - 23 minutes 1/31/2020 at 6:47 PM until 7:33 PM - 46 minutes 2/1/2020 at 6:59 AM until 7:21 AM - 22 minutes 2/1/2020 at 7:03 AM until 7:26 AM - 22 minutes 2/2/2020 at 2:46 PM until 3:16 PM - 30 minutes 2/2/2020 at 8:48 PM until 10:14 PM - 1 hour and 25 minutes 2/3/2020 at 3:54 AM until 4:20 AM - 26 minutes 2/4/2020 at 1:41 PM until 2:12 PM - 31 minutes 2/4/2020 at 8:51 PM until 9:16 PM - 25 minutes 2/5/2020 at 6:28 AM until 6:55 AM - 26 minutes 2/5/2020 at 2:03 PM until 2:29 PM - 26 minutes 2/5/2020 at 5:29 PM until 6:05 PM - 36 minutes 2/7/2020 at 11:06 AM until 11:38 AM - 32 minutes 2/7/2020 at 9:10 PM until 9:32 PM - 22 minutes 2/7/2020 at 12:06 PM until 12:43 PM - 37 minutes 2/8/2020 at 10:00 PM until 10:21 PM - 21 minutes 2/10/2020 at 9:25 PM until 9:47 PM - 21 minutes 2/11/2020 at 8:15 AM until 8:56 AM - 41 minutes 2/11/2020 at 9:00 AM until 9:32 AM - 32 minutes 2/11/2020 at 3:14 PM until 3:41 PM - 27 minutes 2/11/2020 at 5:45 PM until 6:32 PM - 46 minutes 2/12/2020 at 8:16 PM until 9:20 PM - 1 hour and 3 minutes 2/14/2020 at 5:49 AM until 6:40 AM - 50 minutes 2/14/2020 at 7:00 AM until 8:12 AM - 1 hour and 11 minutes On 3/12/2020 at 9:09 AM, during an interview with Registered Nurse (RN) L, when she was asked about call lights, she stated that she believes call lights should be answered in less than 10 minutes and that one hour was too long. On 3/12/2020 at 11:25 AM, the RN unit manager M stated that some staff members leave the call light active after they have responded and while they are giving care. RN M stated she did not know what the scenario was for Resident #203. RN M explained that the call system was progressive, the first notification goes to the aides and the phones that the hall nurses carry. After a call light has been active for five minutes it rings on her phone, and after 10 minutes, the Director of Nurses and the Administrator are alerted. On 3/11/2020 at 10:50 AM, the Regional Interim Director of Nurses was asked about the possibility of wound care observations, her response was we do them (dressing changes/treatments) all on night shift. The floor nursing staff were scheduled for 12 hour shifts, 7 AM to 7 PM and 7 PM to 7 AM. Resident #203 had been asked about her usual, routine hours of sleep on her admission assessment, Section J, on 1/16/2020. Resident #203 had reported that her usual bedtime, varies, 10 pm and that she usually slept for nine to ten hours, arising around 7 or 8 in the morning. The treatment for [REDACTED].#203's sacrum was scheduled for bedtime. According to the Treatment Administration Record for January 2020 and February 2020 identified that the treatment for [REDACTED].#203's sacrum was scheduled for liberalized bed time. On 3/12/2020 at 11:25 AM RN M stated that bedtime was anywhere from 8:00 PM to 10:00 PM, although she wasn't sure what the liberalized times were. The Medication Admin Audit Report for Treatment Administration Record for Resident #203 was requested, and provided for 1/1/2020 through 2/29/2020. The first time recorded on the report was on 1/20/2020 at 8:44 PM, the next time recorded was 1/21/2020 at 8:17 PM, then 1/22/2020 at 7:51 PM, then 1/23/2020 at 10:17 PM, then 1/24/2020 at 8:25 PM, then 1/25/2020 at 9:9:59 PM, then 1/26/2020 at 10:54 PM, then 1/27/2020 at 11:55 PM, then 1/28/2020 at 10:42 PM, next was 1/29/2020 at 10:20 PM, next was 1/30/2020 at 10:55 PM, then 1/31/2020 at 11:55 PM, then 2/1/2020 at 9:25 PM, next was 2/2/2020 at 10:41 PM, then 2/3/2020 at 11:23 PM, then 2/4/2020 at 10:04 PM, then 2/6/2020 at 6:28 AM, then 2/6/2020 at 9:50 PM, next was 2/8/2020 at 12:33 AM, next 2/8/2020 at 9:21 PM, then 2/9/2020 at 10:39 PM, then 2/10/2020 at 10:17 PM, then 2/13/2020 at 10:38 AM, and lastly 2/14/2020 at 2:41 AM. Some of these times were clearly during the hours of Resident #203's preferred sleeping time.<br><br>Resident #204: According to admission face sheet, Resident #204 was [AGE] year old female admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. According to Brief Interview for Mental Status assessment dated [DATE], Resident #204 scored 15 on the Cognition Assessment, indicating no Cognition Impairment. According to Discharge Minimum Data Set ((MDS) dated [DATE], Resident #204 required Extensive assistance with Activities of Daily (ADL) care to include bed mobility, transfers, and toileting. During an interview conducted on 3/9/20 @ 9:47 AM, Resident #204's family member indicated they were upset at how Resident #204 was cared for while residing in the facility from a time frame of 2/12/20 through 2/20/20. Family member indicated Resident #204 had called on the phone several occasions indicating staff did not respond to her call light needs timely, and Resident #204 had to wait from 30 minutes to an hour to get staff in to help her to the |

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

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| F 0550<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>bathroom, or respond when she needed assistance. Family member verbalized that Resident #204 indicated she had falls and had self transferred to the bathroom early on 2/19/20, to keep from soiling herself. Review of Alarm Event log, dated 3/11/20, documented: On 2/14/2020 call light activated at 9:42:18 PM, and cleared in room [ROOM NUMBER], after 40:57 (40 minutes and 57 seconds). On 2/15/20 Call light activated at 1:09:35 AM for room [ROOM NUMBER], cleared 20:14 (twenty minutes and 14 seconds). On 2/16/20, room [ROOM NUMBER], call light activated 3:54:41 PM, and cleared from bathroom [ROOM NUMBER]:51 (twenty nine minutes and 51 seconds). On 2/16/20, room [ROOM NUMBER] at 4:55:46 PM and cleared 22:52 (twenty two minutes and 52 seconds). On 2/16/20, room [ROOM NUMBER], at 11:06:31 PM, call light cleared 20:56 (twenty minutes and 56 seconds). On 2/18/20, room [ROOM NUMBER], at 5:46:43 AM, call light cleared 35:52 (thirty five minutes and 52 seconds). On 2/18/20, room [ROOM NUMBER], at 2:35:04 PM, call light cleared 40:50 (forty minutes and fifty seconds). On 2/20/20, at 8:49:12 AM, bath call light cleared 58:25 (fifty eight minutes and 25 seconds). An interview was conducted in the facility with a Confidential Family member 3/11/20 @ 10:20 AM, for a Resident residing on the 200 hall. The Confidential Family member verbalized they came quite frequently to visit and knew the facility was having problems getting staff to respond to call lights timely. The family member indicated they had to go out of town on the previous week of 3/4/20, and was able not visit for several days. Family member verbalized that the Resident residing on the 200 hall indicated through phone calls and face to face conversation, upon return to the facility to visit, that call lights were not being responded to anywhere from 30 to 40 minutes, and up to an hour, and that the facility knows that it takes longer to get help during meal time and on 2nd and 3rd shifts. They indicated it had been a problem before and apparently still is a problem based on recent conversation with their loved one. |
| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>This Citation pertains to Intake Number MI 526. Based on interview, and record review, the facility failed to ensure that the Safety Care Plan/Kardex was implemented and ensure that safety interventions were followed for one resident (Resident #204) out of three residents reviewed for safety, resulting in rolling out of bed, left alone post-fall, pain, injuries, and lack of communication and interventions to meet safety needs. Findings include: Resident #204: According to admission face sheet, Resident #204 was [AGE] year old female admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. According to Brief Interview for Mental Status assessment dated [DATE], Resident #204 scored 15 on the Cognition Assessment, indicating no Cognition Impairment. According to Discharge Minimum Data Set ((MDS) dated [DATE], Resident #204 required Extensive assistance with Activities of Daily (ADL) care to include bed mobility, transfers, and toileting. Review of hospital discharge notes, dated [DATE], documented under History and Physical Problem 1: [MEDICAL CONDITION] (passing out), secondary to [MEDICAL CONDITION] (iron deficient). Under 'Chief Complaint' documented [AGE] year old African-American with PMH (past medical history) significant for A-Fib, chronic [MEDICAL CONDITION], hypertension (high blood pressure), chronic debility (weakness) and other complications, who is known to our service. According to patient while at a rehab facility, she was having light headedness during positional changes, and was also feeling weak. According to son, resident was feeling light headed and passed out, [MEDICATION NAME] 5 to 10 minutes, and then able to regain consciousness. Son had brought her to the ER for evaluation. Resident #204 discharged to the facility on [DATE]. Review of Base Line care plans, dated [DATE], for Resident #204, documented several problems with interventions for management of: [MEDICAL CONDITION], Diabetes, Excess fluid volume, Hiatal Hernia, incontinence, Falls r/t Cardiovascular Diagnosis: [REDACTED]. Care plans for ADL/mobility: (assist and praise participation in care, assist pt with showers, assist with dressing/hygiene, explain all procedures). Under Diuretic Therapy, [MEDICAL CONDITION] and hypertension documented: (May cause dizziness, postural [MEDICAL CONDITION], fatigue, and increased risk for falls). The Care plan for [MEDICAL CONDITION] interventions: (Encourage intake of foods high in iron, Vitamin C, give med's as ordered, obtain and monitor labs). Under the Care Plan for [MEDICAL CONDITION]: (Assist with activities, diet consult, med's as ordered, oxygen as ordered, monitor [MEDICAL CONDITION], monitor lungs, obtain vital and weight, report to physician any signs and symptoms of CAD/[MEDICAL CONDITION]) There was not a Care Plan specifying the Cardiac [DIAGNOSES REDACTED]. Resident #204 also had skin, pain, nutrition, musculoskeletal, anticoagulant, renal, mood, constipation, activities and respiratory care plans. Under the respiratory care plan: ([MEDICAL CONDITION] at night, factory settings). Review of Nursing Assistant Care guide (Kardex) for Resident #204, dated [DATE], printed [DATE], documented under 'Safety' offer guest pillows to be tucked under sides at night that are easily removed to maintain bed positioning. Provide safety razor/electric shaver for shaving. Reinforce need to call for assistance. Under 'Mobility' to ambulate with therapy, Non-pharmacological intervention, exercise-encourage to prevent muscle stiffness, ROM (range of motion) with care daily. (Nothing was documented for one or two person assist with bed mobility or any mobility status for positioning in bed). For transferring, was documented as 'Resident transfers via 1 PA (person assist). Review of Policy for Baseline Care Plans, dated [DATE], documented under Policy The facility must develop and implement a baseline care plan for each resident that includes instructions needed to provide effective and person-centered care of the resident that will meet the professional standards of quality of care, and include the minimum healthcare information necessary to properly care for a resident. Review of 'Care Plans-Comprehensive', dated October, 2010, documented under Policy Statement: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs, is developed for each resident. Under Purpose of Care Plan: Each resident's comprehensive care plan is designed to: Incorporate identified problems areas; incorporate risk factors associated with identified problems, Build on resident's strengths, reflect residents wishes, reflect treatment goals .The Policy also reflects that Care Plan interventions are designed after careful consideration of the relationship between resident's problems and causes. Whenever possible, interventions address the underlying source of the problem areas rather than only addressing symptoms or triggers .The Care Plan Team is responsible for the review and updating the Care Plans. Review of additional facility care plans dated [DATE], with revision dates of [DATE], after surveyor requested to see, did not address or specify the Cardiac condition of [MEDICAL CONDITION] or [MEDICAL CONDITION] episodes, or for loss of consciousness with positional changes or the possibility of [MEDICAL CONDITION]/passing or with postural changes. On [DATE], Regional Interim Director of Nursing was asked for Incident/Accident reports for any falls Resident #204 had during her 8 day stay at the facility, and provided 2 incident reports dated [DATE], and [DATE]. Review of Incident/Accident Report dated [DATE] @ 6:50 AM, documented 'Fall in Resident #204's room' and described the incident Upon entering Guest's room, to administer [MEDICATION NAME], guest's feet were seen at the end of the bed on the floor. Guest observed to be laying on stomach with head lifted up and wearing [MEDICAL CONDITION] (Bilevel Positive Airway Pressure). Guest was noted to be resting on elbows. Guest stated she rolled out of bed and doesn't remember doing it until she was jolted awake on the floor. Guest denies hitting head and states increased pain in left ankle. Guest states SOB (shortness of breath) with [MEDICAL CONDITION] off. Under Immediate Action: Guest assessed while on the floor and assisted to seating position to help breathing ability. Guest assisted onto Hoyer pad and lifted with Hoyer machine back to bed by staff. Guest educated on importance of having bed in low position during H.S. (at bedtime). Guest re-assessed on ability to use bed control, demonstration was appropriate and successful. Under injuries: No injuries observed at the time of incident. Under 'other info' documented 'Guest rolled during sleep and rolled off the bed.' An interview was conducted with Regional Interim Director of Nursing related to safety interventions put in place for the roll out of bed on [DATE]. RIDON verbalized that pillows were to be placed in bed for positioning and mobility to prevent Resident #204 from rolling out of bed. Review of Incident/Accident report dated [DATE] @ 1945 (7:45 PM), with a revision date of [DATE] @ 8:07 AM, listed as prepared by the Regional Interim Director of Nursing documented a Fall. Location of Incident was Residents' room. Under Nursing description At 1942 (7:42 PM), this writer was called by nurse on the 300 hall that guest had rolled off the edge of the bed during a check and change. CENA (Certified Nursing Assistant) ensured that guest was ok, guest observed alert and responsive and left the room to get the nurse. Nurse and CENA entered guest's room less than 3 minutes after incident and observed guest unresponsive in Cardiac and respiratory assessed (SIC). Resident unable to give a description. Under the heading of 'Description': CPR (Cardiopulmonary Resuscitation) initiated at 1945 (7:45 PM), EMS/911 called at 1945, AED (automated external defibrillator) applied, no shock was advised, but advised to continue CPR. CPR continued. Nurses rotated CPR until EMS arrived and took over at 1951. [MEDICAL CONDITION] (continuous positive airway pressure) and O 2 (oxygen) had been on patient. Patient has BIMS ,[DATE] and applies [MEDICAL CONDITION]/[MEDICAL CONDITION] mask herself with supervision of nursing. EMS obtained pulse and guest |

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| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 2)<br>left the facility via emergency stretcher at 2015 (8:15 PM), per nursing documentation. Nurse attempted to get a hold of son and left voicemail. Son returned call and instructed to go to ER. This writer notified medical director and NP (Nurse Practitioner). Under the listing of 'Resident taken to the hospital' was documented an 'N' indicating No. Under injuries documented no injuries observed. Under 'Predisposing Physiological Factors' documented as 'Weakness/Fainted'. Under the heading of 'Witnesses' documented No witnesses's found. An interview was conducted on [DATE] @ 1:27 PM, with Registered Nurse D. RN D was asked if she was in care of Resident #204 on the evening of [DATE], and indicated she was the nurse working the hall 100 and 300 called a wrap. She indicated she had residents to care for on both halls. RN D indicated she was working down on the 300 hall around rooms ,[DATE], when CNA B came and said We had a fall in room [ROOM NUMBER]. RN D<br>verbalized get another aid as resident is a large woman. She went and got CNA C to assist. I was right behind them. I entered the room with the CNA's and observed Resident #204 on her back next to the bed. They (2 CNA's) said that resident had gone unresponsive. When I got in there, resident was unresponsive. I checked for a pulse. I initiated CPR. CNA C and another nurse came to help. I yelled to another nurse to call 911. CNA B was standing back in the corner pretty upset. One nurse was using the Ambu bag, another nurse brought the crash cart, and we hooked up the AED. We took turns with CPR. EMS came and took over, and got Resident out. The EMS and Sheriff started asking questions as to what happened. I heard CNA B verbalized she had got Resident #204's right leg up over the left leg, and the next thing Resident #204 rolled out of bed onto the floor. During the code, I called the RIDON and explained what had happened. This event occurred at shift change 7 to 7:30 PM. The next nurse came onto shift in the middle of the code. RN D was asked if she documented an Incident/Accident report and Progress notes and verbalized she did not. I don't know why I didn't. I just did not. I wrote out a statement of what happened.(That statement was not provided to surveyor by end of the survey). RN D was asked if she was aware of the roll out of bed on [DATE], and what interventions were supposed to be in place to prevent another roll out of bed and verbalized she did not know. RN D was asked if she was aware of [MEDICAL CONDITION] or [MEDICAL CONDITION] episodes with positional changes and indicated she was not aware. I knew she had Cardiac issues, but I did not exactly know. I only cared for this resident a couple of times. No one shared that information with me. RN D was asked if CNA C initiated CPR and said No, us nurses performed CPR. RN D was asked if CNA C helped at all during the code and said No. An interview was conducted on [DATE] @ 11:56 AM, with CNA B related to the event on [DATE]. CNA B indicated she had worked with Resident #204 only one day, and was not familiar with her. CNA B was asked if she had received report that day from nurse or off going CNA and indicated she did from the CNA, but not the nurse. CNA B was asked what information was relayed to her, and verbalized that it was just about the emotional state of Resident #204, and if she had a good or bad day, and that Resident #204 transferred with one person assist, and could move in the bed with help. CNA B was asked if she looked at the Kardex and said yes. CNA B was asked if she was aware of the roll out of bed on [DATE], and said No, I was not told about that. CNA B was asked if she was informed that Resident #204 had a recent history of passing out/[MEDICAL CONDITION] with positional changes and said, No, no one told me that. I had no idea. That would be important to know. CNA B indicated that she responded to call light around 7 to 7:30 PM, and the first shift nurse was getting ready to leave. She indicated that Resident #204 said she was wet, and needed a dry brief. CNA B was asked if there were any pillows placed on either side of Resident #204, or on the floor, chair, or near by, and said, No, there was only one pillow and her head was on it. CNA B indicated she gathered all her supplies for a brief change. She said Resident #204 was laying in the middle of the bed. CNA B was asked if she tried to move or position Resident #204 toward her in bed before rolling her over, and said, No, she was a large lady almost 400 lbs. I did not move her toward me before rolling her. CNA B was asked if she rolled Resident #204 toward her body or away from her body and said away from her body. CNA B went on to say that she crossed Resident #204's right leg over the left leg and rolled her onto her left side, and started care, cleaning her bottom. CNA B indicated her and Resident #204 was having general conversation, and then Resident #204 got quiet. CNA B was asked if Resident #204 was wearing her [MEDICAL CONDITION]/[MEDICAL CONDITION] mask and said No, she had oxygen on with the plastic things in her nose, not the [MEDICAL CONDITION]/[MEDICAL CONDITION]. CNA B said she felt Resident #204 start to roll and by the time she noticed the movement, Resident #204 rolled off the edge of the bed onto the floor landing face down. CNA B said Resident #204 was on the floor down on her stomach, face down, not on her back. CNA B was asked if Resident #204 was talking to her after being down on the floor and indicated she could not remember Resident #204 talking to her. CNA B verbalized she could not remember if Resident #204 was alert and responsive at that time. CNA B was asked if Resident #204 ever became responsive from the time of rolling out of bed and the time she left Resident #204 alone and said she could not remember Resident #204 ever talking to her again. CNA B said she tried to roll Resident #204 over by herself while she was down on the floor, but could not because of her size. CNA B was asked if Resident #204 was responsive enough to help roll over and indicated she could not remember. CNA B verbalized she pulled on Resident #204's gown to try and move her onto her right side, but was unsuccessful. CNA B was asked if she activated the call light or staff assist button and said, No, I left the room and went to find a nurse. I went to the 300 hall from the 100 hall to find a nurse. I was the only aid on the 100 hall. CNA B indicated she found RN D in a sitting area on the 300 hall, and said, 'we had a fall in room [ROOM NUMBER], can you help'. RN D said 'Yes', I am on my way, go get another aid because Resident #204 is large lady. So I walked further down the 300 hall, and found another aid coming out of a room. I asked her if she could help me. We went to the 100 hall linen closet and got a Hoyer sling pad to lift her up off the floor first, before going to room [ROOM NUMBER]. When we (Me and other aid) entered the room, Resident #204 was not talking or responding, and still face down on the floor. The other aid was near her feet. I was near her head. We rolled her toward the right side. Resident was still not responding. RN D came in after we rolled her over. RN D checked for a pulse and respirations. There were none. Another nurse came with the crash cart and CPR was started. I was panicking at first and had my back to what was going on and not watching, but could hear everything. I called 911 from my personal cell phone in my pocket. I heard them taking turns doing CPR until EMS arrived. The nurses put an AED on Resident, and then the EMS took over and got Resident #204 out of the building. A Cop took my statement. I answered questions. RIDON instructed staff to get my statement. I wrote out a statement and gave it to a nurse. CNA B was asked again if she activated the call light, and said No, I thought it would be faster to go get help. So I left the room. CNA B was asked how long it took her to go to another hall, talk to the nurse, get another aid, get a sling and go back to the room, and said maybe ,[DATE] minutes maybe 5 minutes. I don't really know for sure. CNA B was asked if she was running thru the halls and first replied 'Yes', then said 'No, I was walking fast or brisk. I was freaked out. This was my first experience with anything like this. CNA B was asked if she typically leaves a resident alone after a fall, while face down on the floor, and indicated that she thought it was faster to go get help. CNA B was asked again if Resident #204 ever became responsive enough to say she was ok, and said, I don't remember. According to 'Basic Nursing' 7th edition Potter-Perry, 2011, chapter 8, page 126, Process in Nursing Care. A nursing care plan reduces the risk for incomplete, incorrect, or inaccurate care. The plan is a guideline for coordinating nursing care, promoting continuity of care, and listing outcome criteria for the evaluation of care. The care plan communicates nursing priorities to other health care professionals and identifies and coordinates resources for delivering nursing care .The nursing care plan enhances the continuity of nursing care by listing specific nursing actions necessary to achieve goals of care. |
| F 0686<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate pressure ulcer care and prevent new ulcers from developing.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>This Citation pertains to MI 046. Based on interview and record review the facility failed to assess a pressure ulcer upon admission for one resident (Resident #203) out of two residents reviewed for pressure ulcer care, resulting in the potential for being unaware of the progression or healing of a wound. Findings include: According to the Admission Record, printed on 3/11/2020, Resident #203 was an [AGE] year old female admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #203 was discharged to her home on 2/14/2020. During an interview with the Registered Nurse (RN) Unit Manager of the 100 hall, where Resident #203 had been residing while in the facility, on 3/12/2020 at 11:25 AM, she stated that on the day of Resident #203's admission to the facility, 1/16/2020, Resident #203 had preferred not to have the stage 3 pressure ulcer on her sacrum measured and her request was honored. The first noted measurements and description of the pressure ulcer was located in the medical record by RN M on 1/21/2020, five days after admission. RN M stated that the dressing change for the pressure ulcer had been performed 1/16/2020 according to the progress notes. However, no pictures were taken and no measurements or description of the wound were found in the progress notes according to RN M. The dressing change of the pressure ulcer on the sacrum had been performed on 1/17/2020, 1/18/2020, 1/19/2020, and 1/20/2020 with no documentation of the wound measurements or an assessment of the wound itself. According to the facility policy Pressure Ulcers/Skin Breakdown - Clinical Protocol, revised October 2010, the nurse was to assess and document the full assessment of a pressure sore, including the location, stage, length, width and depth, and the presence of drainage and appearance of |

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| F 0686<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 3)<br>the tissue. According to the Prevention and Management of Pressure Ulcers in Primary and Secondary Care, published by the National Institute for Health and Care Excellence in April 2014, The measurement of pressure ulcer size can be used by healthcare professionals for recording and monitoring the progression and healing of a pressure ulcer. Recording this accurately can allow an assessment to be made as to whether a treatment is effective in promoting healing, by reducing the size of the pressure ulcer. |
| F 0689<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>This Citation pertains to intake MI 526. Based on interview, and record review, the facility failed to maintain the safety of one Resident (#204) resulting in two falls with injury, failed to maintain safety by following safety care planned interventions, failed to perform an assessment timely post fall, failed to follow standards of practice for positioning and bed mobility, failed to thoroughly and accurately complete and investigate Incident/Accident for one Resident (#204) out of three reviewed for safety/accidents, resulting in Resident #204 rolling out of bed and sustaining serious injuries.<br>Findings include: According to admission face sheet dated [DATE], Resident #204 was [AGE] year old female admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. According to Brief Interview for Mental Status assessment dated [DATE], Resident #204 scored 15 on the Cognition Assessment, indicating no Cognition Impairment. According to Discharge Minimum Data Set ((MDS) dated [DATE], Resident #204 required Extensive assistance with Activities of Daily (ADL) care to include bed mobility, transfers, and toileting. Review of hospital discharge notes, dated [DATE], documented under History and Physical Problem 1: [MEDICAL CONDITION] (Passing out) secondary to [MEDICAL CONDITION] (iron deficient). Under 'Chief Complaint' documented [AGE] year old African-American with PMH (past medical history) significant for A-Fib (cardiac abnormality), chronic [MEDICAL CONDITION], hypertension (high blood pressure), chronic debility (weak) and other complications, who is known to our service. According to patient while at a rehab facility, she was having light headedness during positional changes, and was also feeling weak. According to son, resident was feeling light headed and passed out, [MEDICATION NAME] 5 to 10 minutes, and then able to regain consciousness. Son had brought her to the emergency room (ER) for evaluation. Resident #204 discharged to facility on [DATE]. During an interview conducted on [DATE] at 9:47 AM, Resident #204's family member indicated they were upset at how Resident #204 was cared for while residing in the facility from a time frame of [DATE] through [DATE]. Family member indicated Resident #204 had called on several occasions indicating staff did not respond to her call light needs, and Resident #204 had to wait from 30 minutes to over an hour to get staff in to help her to the bathroom, or respond when she needed assistance. Family member verbalized that Resident #204 indicated she had falls and had self transferred to the bathroom early on [DATE], to keep from soiling herself. Family member also verbalized she had contacted the facility and was informed that Resident #204 had a fall on [DATE], and [DATE], but indicated she was not sure what events took place and no one would give her any answers to events that occurred in the facility. Resident #204's family member indicated that after a fall on [DATE], Resident #204 called indicated her leg was hurt and required medication for pain relief. Family member verbalized Emergency Contact person, listed in the medical record, was in touch with her and informed her that Resident #204 had another fall on [DATE], which resulted in Resident #204 being sent to the emergency room . The family member indicated that a nurse from the facility contacted the family indicating Resident #204 was sent to the ER and the family needed to go to ER due to a change in Resident #204's Level of Consciousness, and that Resident #204 had been down (on the floor) for at least 20 minutes. Family member verbalized that Resident #204 came to the facility as a fall risk and that the facility should have kept a closer eye and better supervision for Resident #204. Family member also indicated the family had some difficulty obtaining Resident #204's belongings and could not get any answers from the facility timely. Family member indicated the hospital physican indicated to her that in order to have [DIAGNOSES REDACTED]. Review of Progress notes dated [DATE], by physician documented: Pt (patient) seen today for follow up on fall. Found early this morning lying on her stomach at the side of her bed. She states she rolled out of bed. Pt notes left ankle pain following her fall, x-ray was ordered and negative for acute fracture or dislocations. Resident did also sustain an abrasion on her right upper arm. Will order 50 milligrams of [MEDICATION NAME] every 8 hours for pain management for 5 days. Review of Progress notes dated [DATE] through [DATE], documented on [DATE] at 09:36 AM that a fall occurred on [DATE], indicating CNA alerted nurse of guest fall at 1942. Guest was on floor next to bed, supine (on back) unresponsive. No apical pulse was noted and no respirations were noted. CPR (cardio-pulmonary resuscitation) was then started at 1945 (7:45 PM). 911 was called at 1946. AED (automatic external defibrillator) applied, no shocks were required. CPR continued till EMS (emergency medical services) arrived and took over at 1951. Family notified at 2000. DON notified at 1949. Stat EMS left building with guest at 2015. Guest son called the facility at 2025, and was instructed to follow up with Emergency Department for further updates, documented by a Licensed Practical Nurse. (There were no additional progress notes documented by the Registered Nurse who was in care of Resident #204 for the occurrence on [DATE]. There was no incident report documentation entry made for the occurrence on [DATE]). On [DATE], Regional Interim Director of Nursing was asked for Incident/Accident reports for any falls Resident #204 had during her eight day stay at the facility, and provided two incident reports dated [DATE], and [DATE]. Review of Incident/Accident Report dated [DATE] at 6:50 AM, documented 'Fall in Resident #204's room' and described the incident Upon entering Guest's room, to administer [MEDICATION NAME], guest's feet were seen at the end of the bed on the floor. Guest observed to be laying on stomach with head lifted up and wearing [MEDICAL CONDITION] (Bilevel Positive Airway Pressure). Guest was noted to be resting on elbows. Guest stated she rolled out of bed and doesn't remember doing it until she was jolted awake on the floor. Guest denies hitting head and states increased pain in left ankle. Guest states SOB (shortness of breath) with [MEDICAL CONDITION] off. Under Immediate Action: Guest assessed while on the floor and assisted to seating position to help breathing ability. Guest assisted onto hoyer pad and lifted with hoyer machine back to bed by staff. Guest educated on importance of having bed in low position during H.S. (at bedtime). Guest re-assessed on ability to use bed control, demonstration was appropriate and successful. Under injuries: No injuries observed at the time of incident. Under 'other info' documented 'Guest rolled during sleep and rolled off the bed. (physician progress notes [REDACTED]. Resident #204 used [MEDICAL CONDITION] not [MEDICAL CONDITION]. ([MEDICAL CONDITION] is continuous positive airway pressure. [MEDICAL<br>CONDITION] is Bilevel positive airway pressure and has 2 pressure settings. One for inhalation and one for exhalation). Review of Incident/Accident report dated [DATE] at 7:45 PM, with a revision date of [DATE] at 8:07 AM, listed as prepared by the Regional Interim Director of Nursing documented a Fall. Location of Incident was Residents' room. Under Nursing description At 1942 (7:42 PM), this writer was called by nurse on the hall that guest had rolled off the edge of the bed during a check and change. CENA (Certified Nursing Assistant) ensured that guest was ok. Guest observed alert and responsive and left the room to get the nurse. Nurse and CENA entered guest's room less than 3 minutes after incident and observed guest unresponsive in Cardiac and respiratory assessed (SIC). Resident unable to give a description. Under the heading of 'Description' CPR (Cardiopulmonary Resuscitation) initiated at 1945 (7:45 PM), EMS/911 called at 1945, AED (automated external defibrillator) applied, no shock was advised, but advised to continue CPR. CPR continued. Nurses rotated CPR until EMS arrived and took over at 1951. [MEDICAL CONDITION] (continuous positive airway pressure) and O2 (oxygen) had been on patient. Patient has BIMS ,[DATE] and applies [MEDICAL CONDITION] or [MEDICAL CONDITION] mask herself<br>with supervision of nursing. EMS obtained pulse and guest left the facility via emergency stretcher at 2015 (8:15 PM), per nursing documentation. Nurse attempted to get a hold of son and left voicemail. Son returned call and instructed to go to ER. This writer notified medical director and NP (Nurse Practitioner). Under the listing of 'Resident taken to the hospital' was documented an 'N' indicating No. Under injuries documented no injuries observed. Under 'Predisposing Physiological Factors' documented as 'Weakness/Fainted'. Under the heading of 'Witnesses' documented No witnesses's found. This entry was in contradiction to the above documentation from the same incident report that described the incident as having happened while she was under care from the CNA. During an interview on [DATE], with Regional Interim DON (RIDON), related to the two incidents that occurred for Resident #204, The RIDON indicated she had completed an investigation related to the two falls for Resident #204. RIDON was asked what interventions were implemented for the roll out of bed on [DATE], and verbalized pillows were to be put in place to prevent Resident #204 from rolling out of bed. Review of the report provided by the RIDON, documented an investigation completed dated [DATE]. The RIDON was asked why she completed an<br>investigation for Resident #204, and verbalized because Resident #204 had left the facility unresponsive. Review of the report documented that Resident #204 was admitted to the facility on [DATE], after she was admitted to the hospital after |

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| F 0689<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 4)<br>multiple episodes of vasovagal like [MEDICAL CONDITION] episodes ([MEDICAL CONDITION] or passing out) at home and [MEDICAL CONDITION] (slow heart rate). Guest had recent stay at another SNF (skilled nursing facility) and reported having multiple episodes of light headedness during positional changes, and was discharged from SNF and went home to have [MEDICAL CONDITION] episodes and then returned to the hospital. Patient has an extensive cardiovascular history including [MEDICAL CONDITION] with acute exacerbation, [MEDICAL CONDITIONS] hypertension and [MEDICAL CONDITION]. Guest also has extensive respiratory history including [MEDICAL CONDITIONS], sleep apnea, acute and chronic [MEDICAL CONDITION] with [MEDICAL CONDITION] (insufficient oxygen in the body). Patient also morbidly obese. The report revealed on [DATE], This writer was called by floor nurse, (name listed), that guest was observed in cardiac and respiratory arrest and that CPR had been initiated. Time line as follows: 1940 (approximation) CENA (name listed) entered room to complete a check and change on guest due to incontinence. CENA gathered supplies and entered room. Guest observed with [MEDICAL CONDITION]/oxygen on. Guest transferred 1 person assist and had been previously been easily check and changed in bed without incident. CENA had turned guest onto her side, guest had been positioned in the middle of the bed. CENA reported that all of the sudden it appeared that guest had a slight change in consciousness and rolled off the edge of the bed per her statement. CENA attempted to correct the movement, guest is morbidly obese with a weight of 371.8 lbs and CENA unable to correct move independently. CENA immediately went to check on guest who was alert and responsive after rolling off the edge of the bed. Guest reported that she was ok, and CENA left the room to notify nurse. 1942 Nurse was notified that guest had fallen off the edge of the bed. Nurse and 2 CENA's re-entered room. Guest observed in a Supine position (on her back), guest unresponsive and in cardiac and respiratory arrest. 1945 CPR initiated by nurse, other nurses in facility notified that guest was undergoing a code blue. At 1946, 911/EMS called. AED applied, no shock advised, but AED advised to continue CPR. Nurses continued CPR and ventilation via ambu bag in rotation until EMS arrived. 1951 EMS arrived and took over CPR. 200 nurse attempted to call guest's son and left voicemail to call facility as soon as possible. 2005 (8:05 PM), this writer notified the Medical Director, Nurse Practitioner and updated on guest's status. 2005, after obtaining a pulse, EMS took guest from facility via stretcher. 2025, Guest's son called facility and was updated and directed to ER. Review of Physical Therapy evaluation completed by Physical Therapist (PT) F who provided an evaluation for Resident #204 dated [DATE]. Under current illness documented pt is being evaluated s/p (status [REDACTED]. Currently she presents with functional regression in terms of bed mobility, transfer, and functional ambulation. She exhibits decrease in muscle strength, of B/L (bilateral) LE (lower extremity), decrease in dynamic standing balance and increased risk of falls. Under bed mobility 'Roll left and right' was documented as 'Partial/moderate assistance.' An interview was conducted on [DATE] at 2:31 PM, with Certified Nursing Assistant C related to what happened on [DATE]. CNA C verbalized she had been working on the back of 300 hallway and remembered very well what happened that night. CNA C indicated CNA B was working on the 100 hall where Resident #204 was residing in room [ROOM NUMBER]. CNA C indicated CNA B came to get some help from her, and indicated she needed help getting Resident #204 off the floor from a fall that occurred when she was changing Resident #204's brief, and that she had Resident #204 rolled over on her left side facing the window, and then Resident #204 rolled off the bed onto the floor. She verbalized that the nurse in care of Resident #204 was working a wrap assignment, working the 100 hall and 300 hall that night, and was down on the 300 hall. CNA C indicated she made sure that Registered Nurse D was informed that Resident #204 was on the floor and in need of assistance. CNA C indicated that she found RN D down passing medications on the 300 hall and RN D verbalized I'm coming. CNA C indicated her and CNA B left and went down to room [ROOM NUMBER], after stopping on the 100 hallway linen closet, to get a hoyer lift pad. Upon entering the room, Resident #204 was observed on the floor next to the bed, laying on her stomach, face down, not talking, and not responsive. We rolled her over before the nurse got there, onto her back. CNA C said that Resident #204 was unresponsive and not breathing, and she tried to wake her up. CNA C indicated that she did a sternal rub with no response, and the RN still had not come. CNA C verbalized at least 5 minutes had passed maybe longer, and she wanted to start CPR and was CPR certified. CNA C indicated RN D showed up and said Resident was a Full Code and to go ahead with CPR. CNA C indicated she started CPR on Resident #204 with 3 other nurses who had arrived, taking turns for about 10 to 15 minutes until EMS arrived. CNA C was asked if she observed the call light or staff assist button on and activated upon entering the room, and verbalized it had not been activated by CNA B. CNA C verbalized that RN D got there and other nurses showed up as well. One nurse brought the crash cart, and ambu bag that was used to deliver breaths. An AED was applied, with no shocks delivered. CNA C indicated they took turns rotating with compressions and ventilation device until EMS arrived. CNA C indicated she stayed and helped with CPR the whole time until the EMS's took over, and then left and went back to her rooms with other nurses. CNA C verbalized that RN D had her write a statement, and provided one. CNA C was asked if Resident #204 had a [MEDICAL CONDITION] mask on and indicated it was not observed on Resident #204 or lying any where near her. I was at her feet area and covered her bottom with a gown, and the other CNA was at her head area and it was very difficult to roll Resident #204 over due to her size. I was asked to provide my CPR card to the DON after the incident, and I did. (The investigation completed after the event documented [MEDICAL CONDITION] on). On [DATE] at 10:18 AM, an interview was conducted with PT F inquiring about the bed mobility status for Resident #204. PT F indicated he was aware that Resident #204 could pass out during positional changes, but she had not had any episodes while he was working with her. PT F was asked if he was aware of Resident #204's weight up near 400 lbs and verbalized he was. PT F was asked what moderate assist was for bed mobility and indicated it was one person assist, as Resident #204 was able to roll with assist from side to side. PT F was asked if he should have made Resident #204 a two person assist due to her weight. PT F indicated again 'No' as Resident is able to help staff with movement in bed. PT F was asked if he let the nurses and CNA's know that with positional changes, Resident #204 could pass out. PT F indicated he did not share that with nursing, that it was nursing's responsibility to get that information from the medical record and documents and share it with the CNA's. Review of Nursing Assistant Care guide (Kardex) for Resident #204, dated [DATE], printed [DATE], documented under 'Safety' to offer guest pillows to be tucked under sides at night that are easily removed to maintain bed positioning. Provide safety razor/electric shaver for shaving. Reinforce need to call for assistance. Under 'Mobility' to ambulate with therapy, Non-pharmacological intervention, exercise-encourage to prevent muscle stiffness, ROM (range of motion) with care daily. (Nothing was documented for one person assist with bed mobility or any mobility status for positioning in bed). For transferring, was documented as 'Resident transfers via 1 PA (person assist). After the interview with CNA C that occurred on [DATE], Regional Vice President of Nursing A and Regional Interim Director of Nursing asked to speak to Surveyor on [DATE], at 2:58 PM, to clarify 'minor misunderstandings' related to the investigation that was completed for Resident #204. The RIDON indicated she was under the impression thru her investigation that RN D, CNA B, and CNA C all entered the room at the same time. She verbalized that she was unaware that the two CNA's entered the room before the nurse and rolled her over. RIDON verbalized that Resident #204 has no [MEDICAL CONDITION] episodes since being in the hospital or [MEDICAL CONDITION], and assumed that Resident #204 was stable, and the condition of [MEDICAL CONDITION] was related to the [DIAGNOSES REDACTED].#204 was on her back (supine), not face down, and was alert and responding when the aid left the resident alone. RIDON was asked if CNA B pushed the call light or assist button to summons help, and indicated she did not. CNA B thought it would be faster to go get help and left Resident #204 alone in her room. CNA B came back to find Resident #204 unresponsive and in [MEDICAL CONDITION]. RIDON was asked why the RN in care of Resident #204 did not complete any progress notes or an Incident/Accident report. RIDON verbalized the RN involved with care for Resident #204 was leaving and did not document the event or fill out the Incident/Accident report. The next oncoming nurse who had come to help documented some notes at the end of her shift the next day. RIDON indicated she, herself, completed the Incident/Accident report for [DATE] on [DATE]. The RIDON was asked if she thought it was ok to leave Resident #204 alone in her room, and indicated it was probably faster to leave the resident alone and go get help. I don't think we could have done or would have done anything different. RIDON was asked if she obtained written statements from the Nurse and CNA's involved and provided two hand written statements, one from CNA B and one from CNA C. RIDON did not provide any written statements from RN D who was in care of Resident #204 on the night of [DATE], by the end of the survey. RIDON was asked to provide a hospital transfer sheet, and all documents that were given to EMS and hospital. RIDON did not provide the documents by the end of the survey. Review of written statement from CNA C dated [DATE], documented On [DATE], I was asked by CNA B to come assist with a guest in room [ROOM NUMBER]. We needed a hoyer sling first, so we went and retrieved the sling first in the linen closet. Upon opening the door to room [ROOM NUMBER], I walked into guest lying face down on the floor, on the right side of her bed and her [MEDICAL CONDITION] mask was to the left of her face. As I approached Resident, I asked CNA B what happened. I was notified she (Resident #204) rolled off the side of the bed while being changed. I cleaned the guests back end and covered her, tried to get her to respond. CNA B and I rolled her over onto her back, and I instructed CNA B to check for pulse. I was going to get a nurse. I informed a 200 hall nurse (this was at shift change), |

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| F 0689<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Few | (continued... from page 5)<br>that we needed help. We arrived back in the room, and as they assessed her. RN D said go ahead on CPR and we started CPR. EMS was in route. Once EMS arrived, we stepped out, after I made sure I was clear to go. I returned back to 300 hall. At the top of the form listed a phone number for any questions. (According to this written statement, Resident #204 was left alone again for 2nd time by both CNA's to go get help, as CNA B originally left resident to get CNA C and nurse). CNA B was attempted to be contacted several times from [DATE], and [DATE], and RIDON indicated CNA B worked another job and was hard to contact. Review of hand written statement provided to RIDON by CNA B dated [DATE], documented I went into change 112, (not 100% of what time). I gathered all supplies I would need then proceeded with patient care. I rolled 112 on her side and began cleaning her bottom. She was facing the window. Resident was secure in the middle of the bed. While cleaning resident, I felt and noticed her body start to roll. I tried to prevent the fall but was unable to. I immediately went to notify the nurse and a 2nd aid for help. Resident was alert and talking when I left to retrieve help, but was not when we returned. I would say I was gone for 30 sec to a minute. Myself and second aid noticed resident not responding to verbal prompts, noticed she was unconscious. Went to alert the other staff and nurses. All nurses came. CPR & AED was performed. Emergency Services had to be started. The statement was signed and dated [DATE], by CNA B An interview was conducted on [DATE] at 1:27 PM, with RN D. RN D was asked if she was in care of Resident #204 on the evening of [DATE], and indicated she was the nurse working the hall 100 and 300 called a wrap from 7 AM to 7 PM. She indicated she had residents to care for on both halls. RN D indicated she was working down on the 300 hall around rooms ,[DATE], when CNA B came and said We had a fall in room [ROOM NUMBER]. RN D verbalized to get another aid as resident is a large woman and got CNA C to assist. I was right behind them. I entered the room with the CNA's and observed Resident #204 on her back next to the bed. They (two CNA's) said that resident had gone unresponsive. When I got in there, resident was unresponsive. I checked for a pulse. I initiated CPR. CNA C and another nurse came to help. I yelled to another nurse to call 911. CNA B was standing back in the corner pretty upset. One nurse was using the Ambu bag, another nurse brought the crash cart, and we hooked up the AED. We took turns with CPR. EMS came and took over, and got Resident #204 out. The EMS and Sheriff started asking questions as to what happened. I heard CNA B verbalized she had got Resident #204's right leg up over the left leg, and the next thing was Resident #204 rolled out of bed onto the floor. During the code, I called the RIDON and explained what had happened. This event occurred at shift change 7 to 7:30 PM. The next nurse came onto shift in the middle of the code. RN D was asked if she documented an Incident/Accident report and Progress notes and verbalized she did not. I don't know why I didn't. I just did not. I wrote out a statement of what happened (which was not received). RN D was asked if she was aware of the roll out of bed on [DATE], and verbalized she did not know. RN D was asked if she was aware of [MEDICAL CONDITION] episodes with positional changes and indicated she was not aware. I knew she had Cardiac issues, but I did not exactly know what it involved. I only cared for this resident a couple of times. No one shared that information with me. RN D was asked if CNA C initiated CPR and said No, us nurses performed CPR. RN D was asked if CNA C helped at all during the code and said No. (CNA C indicated she initiated CPR). A telephone interview was conducted on [DATE] at 11:56 AM, with CNA B related to the event on [DATE]. CNA B indicated she had worked with Resident #204 only one day, and was not familiar with her. CNA B was asked if she had received report that day from nurse or off going CNA and indicated she did from the CNA, but not the nurse. CNA B was asked what information was relayed to her, and verbalized that it was just about the emotional state of Resident #204, and if she had a good or bad day, and that Resident #204 transferred with one person assist, and could move in the bed with help. CNA B was asked if she looked at the Kardex and said yes. CNA B was asked if she was aware of the roll out of bed on [DATE], and said No, I was not told about that. CNA B was asked if she was informed that Resident #204 had a recent history of passing out/[MEDICAL CONDITION] with positional changes and said, No. No one told me that. I had no idea. That would be important to know. CNA B indicated that she responded to call light around 7 to 7:30 PM, and the first shift nurse was getting ready to leave. She indicated that Resident #204 said she was wet, and needed a dry brief. CNA B was asked if there were any pillows placed on either side of Resident #204, or on the floor, chair, or near by, and said, No, there was only one pillow and her head was on it. CNA B indicated she gathered all her supplies for a brief change. She said Resident #204 was laying in the middle of the bed. CNA B was asked if she tried to move or position Resident #204 toward her in bed before rolling her over, and said, No, she was a large lady almost 400 lbs. I did not move her toward me before rolling her. CNA B was asked if she rolled Resident #204 toward her body or away from her body and said away from her body. CNA B went on to say that she crossed Resident #204's right leg over the left leg and rolled her onto her left side, and started care, cleaning her bottom. CNA B indicated her and Resident #204 was having general conversation, and then Resident #204 got quiet. CNA B was asked if Resident #204 was wearing her [MEDICAL CONDITION] or [MEDICAL CONDITION]<br>mask and said No, she had oxygen on with the plastic things in her nose, not the [MEDICAL CONDITION] or [MEDICAL CONDITION]. CNA B said she felt Resident #204 start to roll and by the time she noticed the movement, Resident #204 rolled off the edge of the bed onto the floor landing face down. CNA B said Resident #204 was on the floor down on her stomach, face down, not on her back. CNA B was asked if Resident #204 was talking to her after being down on the floor and indicated she could not remember Resident #204 talking to her. CNA B verbalized she could not remember if Resident #204 was alert and responsive at that time. CNA B was asked if Resident #204 ever became responsive from the time of rolling out of bed and the time she left Resident #204 alone and said she could not remember Resident #204 ever talking to her again. CNA B said she tried to roll Resident #204 over by herself while she was down on the floor, but could not because of her size. CNA B was asked if Resident #204 was responsive enough to help roll over and indicated she could not remember. CNA B verbalized she pulled on Resident #204's gown to try and move her onto her right side, but was unsuccessful. CNA B was asked if she activated the call light or staff assist button and said, No, I left the room and went to find a nurse. I went to the 300 hall from the 100 hall to find a nurse. I was the only aid on the 100 hall. CNA B indicated she found RN D in a sitting area on the 300 hall, and said, 'we had a fall in room [ROOM NUMBER], can you help'. RN D said 'Yes', I am on my way, go get another aid because Resident #204 is large lady. So I walked further down the 300 hall, and found another aid coming out of a room. I asked her if she could help me. We went to the 100 hall linen closet and got a hoyer sling pad to lift her up off the floor first, before going to room [ROOM NUMBER]. When we (Me and other aid) entered the room, Resident #204 was not talking or responding, and still face down on the floor. The other aid was near her feet. I was near her head. We rolled her toward the right side. Resident was still not responding. RN D came in after we rolled her over. RN D checked for a pulse and respirations. There were none. Another nurse came with the crash cart and CPR was started. I was panicking at first and had my back to what was going on and not watching, but could hear everything. I called 911 from my personal cell phone in my pocket. I heard them taking turns doing CPR until EMS arrived. The nurses put an AED on Resident, and then the EMS took over and got Resident #204 out of the building. A Cop took my statement. I answered questions. RIDON instructed staff to get my statement. I wrote out a statement and gave it to a nurse. CNA B was asked again if she activated the call light, and said No, I thought it would be faster to go get help. So I left the room. CNA B was asked how long it took her to go to another hall, talk to the nurse, get another aid, get a sling and go back to the room, and said maybe ,[DATE] minutes maybe 5 minutes. I don't really know for sure. CNA B was asked if she was running thru the halls and first replied 'Yes', then said 'No, I was walking fast or brisk. I was freaked out. This was my first experience with anything like this. CNA B was asked if she typically leaves a resident alone after a fall, while face down on the floor, and indicated that she thought it was faster to go get help. CNA B was asked again if Resident #204 ever became responsive enough to say she was ok, and said, I don't remember. Certified Nursing Assistant (CNA) B, hired on [DATE] according to the undated Employee List, had a CNA Orientation/Annual Competency form dated [DATE] where the column designated for the Reviewers Initial had been initialed by herself. The skills listed were vital signs & weight, transfers, ambulation, documentation, activities of daily living, positioning, dining room, skin care, equipment, bowel and bladder, communication, supplies, oxygen, shower, and abuse. When the scheduler, Staff K was asked about why CNA B may have initialed all of the entries on [DATE] at 9:45 AM, she stated that CNA B had probably done that to indicate she was familiar with the procedures listed. The signature line at the bottom on the back of the form for the Reviewer Signature, was signed illegibly, although the last two letters, RN, were legible. According to the employee list, undated, CNA B was hired on [DATE]. According to the Course Results Report of the computer training for CNA B, dated [DATE], the lessons under the sections of Activities of Daily Living and Fall and Restraint Reduction had not been attempted or completed by CNA B. The CNA Orientation/Annual Competency checklist for CNA B did not include a section for the CNA role/responsibility when a resident fell . Review of hospital notes, Neurology Consult, dated [DATE], documented by Consulting Physician, under Physician Assessment: Severe [MEDICAL CONDITIONS]. Exam with no [DIAGNOSES REDACTED] reflexes. CT |
| F 0726<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235715 | A. BUILDING _____ B. WING _____ | 03/12/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| WELLBRIDGE OF FENTON | 901 PINE CREEK DRIVE FENTON, MI 48430 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0726<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 6)<br><br>This citation pertains to MI 526. Based on interview and record review, the facility failed to assure competent nurse aide staff by allowing nursing assistants to evaluate competency of other nursing assistants resulting in the unevaluated competence of nursing assistants by Registered Nurses who are required to perform assessments of the needs of the 85 residents in the facility and delegate responsibility of that care to nursing assistants resulting in the delegation of responsibilities to staff who may not be competent. Findings include: According to the 3rd Edition of "'Professional & Legal Regulation of Nursing Practice in Michigan", published in 2010 by the Michigan Nurses Association, delegating appropriately is critical to enhance the nurse's ability to provide complete, competent care efficiently and within nursing standards. Licensed Practical Nurses (LPN) are not able to delegate acts, tasks, or functions. A Registered Nurse (RN) may delegate to RN's, LPN's, and unlicensed assistive personnel. For those tasks that may be appropriate to delegate, RN's should validate the competencies of the unlicensed assistive personnel and develop a plan for unlicensed assistive personnel continuing education and competency revalidation. Certified Nursing Assistant (CNA) B, hired on 1/16/2020 according to the undated Employee List, had a CNA Orientation/Annual Competency form dated 2/15/2020 where the column designated for the Reviewers Initial had been initialed by herself. The skills listed were vital signs & weight, transfers, ambulation, documentation, activities of daily living, positioning, dining room, skin care, equipment, bowel and bladder, communication, supplies, oxygen, shower, and abuse. When the scheduler, Staff K was asked about why CNA B may have initialed all of the entries on 3/12/2020 at 9:45 AM, she stated that CNA B had probably done that to indicate she was familiar with the procedures listed. The signature line at the bottom on the back of the form for the Reviewer Signature, was signed illegibly, although the last two letters, RN, were legible. During an interview with the facility educator, RN L on 3/12/2020 beginning at 9:00 AM, she stated that she had started as the educator in the end of November or beginning of December 2019 and that she had done about 10 orientation classes since then. She said that the classroom takes about 1 1/2 days and that includes about 1/2 day of orientation with each of the department heads and the administrator. There was also training to be done on the computer. RN L stated that she did not sign the competency forms, did not watch the CNAs performance of any skill, that training is done by other CNAs and nursing staff. RN L stated that she leaves it up to the scheduler to assign which CNA the orientees work beside for training on the floor. The annual competencies of CNAs she stated was a collaborative effort. The completed competency forms RN L stated were turned in to human resources or myself. During an interview with the scheduler K on 3/12/2020 beginning at 9:45 AM, Staff K stated that she had been in her current position about six months. Staff K stated that she had been employed here at the facility for about a year and before becoming the scheduler, she worked on the floor as a CNA. Staff K stated that she gives the orientee CNAs three to five days of training, dependent on their previous experience. Staff K stated that she chooses who to put the new CNAs with based on seniority and work ethic. She checks with the educator or human resources to make sure the competency form is complete before the new CNAs are put on the schedule. If she sees that the form is not completed, she goes over it with them and initials it. CNA C, hired on 12/29/2019 according to the undated Employee List, had a CNA Orientation/Annual Competency form dated 1/3/2020. In the column designated for the Reviewers Initial, were the initials of CNA Q. The Reviewer Signature line was signed by CNA Q. CNA N, hired on 11/22/2019 according to the undated Employee List, had a CNA Orientation/Annual Competency form dated 12/10/2019. In the column designated for the Reviewers Initial, were the initials of CNA R. The Reviewer Signature line was signed by CNA R. CNA O, hired on 1/29/2020 according to the undated Employee List, had a CNA Orientation/Annual Competency form dated 2/17/2020. In the column designated for the Reviewers Initial, were the initials of herself and CNA/scheduler K. The Reviewer Signature line was signed by CNA/Scheduler K. CNA P, hired on 1/29/2020 according to the undated Employee List, had a CNA Orientation/Annual Competency form dated 2/7/2020. In the column designated for the Reviewers Initial, were the initials of CNA/scheduler K. The Reviewer Signature line was signed by CNA/Scheduler K. |
| F 0732<br><br>**Level of harm -** Potential for minimal harm<br><br>**Residents Affected -** Many | **Post nurse staffing information every day.**<br><br>This citation pertains to MI 779 and MI 46. Based on interview and record review, the facility failed to identify the categories of nursing staff on the daily posted Nurse Staffing Information resulting in the potential for all residents and visitors to be unaware of the availability of Registered Nurses and Licensed Practical Nurses. Findings include: The Staffing Report & Concern Contact form, dated 3/12/2020 was located, with help from the receptionist, in a binder in the front lobby. At the top was the date and the Current Census. The section at the bottom contained the Staffing Report. The Staffing Report contained a column for Category of Staff which was broken down by shift for Certified Nursing Assistant and Registered Nurse. There was no category listing for Licensed Practical Nurse. On 3/12/2020 at 2:30 PM, the scheduler, Staff K, stated that she was responsible for completing the Staffing Report. When asked why there was no information for the Licensed Practical Nurses, she replied that their numbers were included with the Registered Nurses, that there was no category for the Licensed Practical Nurses. Scheduler K stated that was the way it was done when I got here. |
| F 0842<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>This citation pertains to intakes MI 779, and MI 46 Based on interview, and record review, the facility failed to maintain an accurate and complete medical record by not accurately documenting Narcotic administration for Resident (#202), and failing to accurately document a Cardiac Event as evidenced by no Incident/Accident report timely, no progress notes or documentation by RN in charge, and inaccurate investigation for Resident (#204) out of 8 Resident's medical record reviewed, resulting in inaccurate and incomplete medical record. Findings include: Resident #204 According to admission face sheet, Resident #204 was [AGE] year old female admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. According to Brief Interview for Mental Status assessment dated [DATE], Resident #204 scored 15 on the Cognition Assessment, indicating no Cognition Impairment. According to Discharge Minimum Data Set ((MDS) dated [DATE], Resident #204 required Extensive assistance with Activities of Daily (ADL) care to include bed mobility, transfers, and toileting. On [DATE], Regional Interim Director of Nursing was asked for Incident/Accident reports for any falls Resident #204 had during her 8 day stay at the facility, and provided 2 incident reports dated [DATE], and [DATE]. Review of Incident/Accident report dated [DATE] @ 1945 (7:45 PM), with a revision date of [DATE] @ 8:07 AM, listed as prepared by the Regional Interim Director of Nursing documented a Fall. Location of Incident was Residents' room. Under Nursing description At 1942 (7:42 PM), this writer was called by nurse on the hall that guest had rolled off the edge of the bed during a check and change. CENA (Certified Nursing Assistant) ensured that guest was ok, guest observed alert and responsive and left the room to get the nurse. Nurse and CENA entered guest's room less than 3 minutes after incident and observed guest unresponsive in Cardiac and respiratory assessed (SIC). Resident unable to give a description. Under the heading of 'Description': CPR (Cardiopulmonary Resuscitation) initiated at 1945 (7:45 PM), EMS/911 called at 1945, AED (automated external defibrillator) applied, no shock was advised, but advised to continue CPR. CPR continued. Nurses rotated CPR until EMS arrived and took over at 1951. [MEDICAL CONDITION] (continuous positive airway pressure) and O2 (oxygen) had been on patient. Patient has BIMS ,[DATE] and applies [MEDICAL CONDITION] mask herself with supervision of nursing. EMS obtained pulse and guest left the facility via emergency stretcher at 2015 (8:15 PM), per nursing documentation. Nurse attempted to get a hold of son and left voicemail. Son returned call and instructed to go to ER. This writer notified medical director and NP (Nurse Practitioner). Under the listing of 'Resident taken to the hospital' was documented an 'N' indicating No. Under injuries documented no injuries observed. Under 'Predisposing Physiological Factors' documented as 'Weakness/Fainted'. Under the heading of 'Witnesses' documented No witnesses's found. (Resident #204 was transfer to the Emergency Department for a Cardiac event, and being found unresponsive. The incident report was completed as revised on [DATE], by the RIDON, no documentation of an incident by the Registered Nurse in care of Resident #204). Review of Progress notes dated [DATE] through [DATE], documented on [DATE] @ 09:36 (9: 36 AM), that a fall occurred on [DATE] at 7:42 PM, indicating CNA alerted nurse of guest fall at 1942 (7:42 PM). Guest was on floor next to bed, supine unresponsive. No apical pulse was noted and respirations were noted. CPR was then started at 1945. 911 was called at 1946. AED applied, no shocks were required. CPR continued till EMS arrived and took over at 1951. Family notified at 2000. DON notified at 1949. Stat EMS left building with guest at 2015. Guest son called the facility at 2025, and was instructed to follow up with Emergency Department for |

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| F 0842<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 7)<br>further updates. (There were no additional progress notes documented in the medical record by the Registered Nurse who was in care of Resident #204 for the occurrence on [DATE]. There was no incident report or a documentation entry made for the occurrence on [DATE]. The documentation was completed by a Licensed Practical Nurse, who was not the nurse in care of Resident #204 at the time of the Cardiac event [DATE], until after the event occurred. The offgoing RN's shift ended, who had been the charge nurse for Resident #204). During an interview on [DATE], with Regional Interim DON (RIDON), related to the two incidents that occurred for Resident #204, The RIDON indicated she had completed an investigation related to the two falls for Resident #204. RIDON was asked what interventions were implemented for the roll out of bed on [DATE], and verbalized pillows were to be put in place to prevent Resident #204 from rolling out of bed. Review of a report was provided by the RIDON that documented an investigation completed dated [DATE]. The RIDON was asked why she completed an investigation for Resident #204, and verbalized because Resident #204 had left the facility unresponsive. Review of the report documented that Resident #204 was admitted to the facility on [DATE], after she was admitted to the hospital s/p (status [REDACTED]. Guest had recent stay at another SNF (skilled nursing facility) and reported having multiple episodes of light headedness during positional changes, and was discharged from SNF and went home to have [MEDICAL CONDITION] episodes and then returned to the hospital. Patient has an extensive cardiovascular history including [MEDICAL CONDITION] with acute exacerbation, [MEDICAL CONDITIONS] hypertension and [MEDICAL CONDITION]. Guest also has extensive respiratory<br>history including [MEDICAL CONDITION], sleep apnea, acute and chronic [MEDICAL CONDITION] with [MEDICAL CONDITION]. Patient also morbidly obese. The report revealed on [DATE], this writer was called by floor nurse, (name listed), that guest was<br>observed in cardiac and respiratory arrest and that CPR had been initiated. Time line as follows: 1940 (approximation) CENA (name listed) entered room to complete a check and change on guest due to incontinence. CENA gathered supplies and entered room. Guest observed with [MEDICAL CONDITION]/oxygen on. Guest transferred 1 person assist and had been previously been easily check and changed in bed without incident. CENA had turned guest onto her side, guest had been positioned in the middle of the bed. CENA reported that all of the sudden it appeared that guest had a slight change in consciousness and rolled off the edge of the bed per her statement. CENA attempted to correct the movement, guest is morbidly obese with a weight of 371.8 lbs and CENA unable to correct move independently. CENA immediately went to check on guest who was alert and responsive after rolling off the edge of the bed. Guest reported that she was ok, and CENA left the room to notify nurse. 1942 Nurse was notified that guest had fallen off the edge of the bed. Nurse and 2 CENA's re-entered room. Guest observed in a Supine position (on her back), guest unresponsive and in cardiac and respiratory arrest. 1945 CPR initiated by nurse, other nurses in facility notified that guest was undergoing a code blue. At 1946, 911/EMS called. AED applied, no shock advised, but AED advised to continue CPR. Nurses continued CPR and ventilation via ambu bag in rotation until EMS arrived. 1951 EMS arrived and took over CPR. 200 nurse attempted to call guest's son and left voicemail to call facility as soon as possible. 2005 (8:05 PM), this writer notified the Medical Director, Nurse Practitioner and updated on guest's status. 2005, after obtaining a pulse, EMS took guest from facility via stretcher. 2025, Guest's son called facility and was updated and directed to ER. An interview was conducted on [DATE] @ 2:31 PM., with Certified Nursing Assistant C related to what happened on [DATE]. CENA C verbalized she had been working on the back of 300 hallway and remembered what happened that night. CENA C indicated CENA B was working on the 100 hall where Resident #204 was residing in room [ROOM NUMBER]. CENA C indicated CENA B came to get some help from her, and indicated she needed help getting Resident #204 off the floor from a fall that occurred when she was changing Resident #204's brief, and had Resident #204 on her left side facing the window, and then rolled off the bed onto the floor. She verbalized that the nurse in care of Resident #204 was working a wrap assignment working the 100 hall and 300 hall that night and was down on the 300 hall. CENA C indicated she made sure that Registered Nurse D was informed that Resident #204 was on the floor and in need of assistance. CENA C indicated that RN D was down passing medications on the 300 hall and verbalized I'm coming. CENA C indicated her and CENA B left and went down to room [ROOM NUMBER], after stopping on the 100 hallway linen closet to get a hoyer lift pad. Upon entering the room, Resident #204 was observed on the floor next to the bed, laying on her stomach, face down, not talking, and not responsive. We rolled her over before the nurse got there, onto her back. CENA C said that Resident #204 was unresponsive and not breathing, and she tried to wake her up. CENA C indicated that she did a sternal rub with no response, and the nurse still had not come. CENA C verbalized at least 5 minutes had passed and she wanted to start CPR and was CPR certified. CENA C indicated RN D showed up and said Resident was a Full Code and to go ahead with CPR. CENA C indicated she started CPR on Resident #204 with 3 other nurses who arrived, taking turns for about 10 to 15 minutes until EMS arrived. CENA C was asked if she observed the call light or staff assist button on and activated upon entering the room, and verbalized it had not been activated by CENA B. CENA C verbalized that RN D got there and other nurses showed up as well. One nurse brought the crash cart, and ambu bag that was used to deliver breaths. An AED was applied, with no shocks delivered. CENA C indicated they took turns rotating with compressions and ventilation device until EMS arrived. CENA C indicated she stayed and helped with CPR the whole time until the EMS's took over, and then left and went back to her rooms with other nurses. CENA C verbalized that RN D had her write a statement, and provided one. CENA C was asked if Resident #204 had a [MEDICAL CONDITION] mask on and indicated it was not observed on Resident #204 or lying any where near her. I was at her feet area and covered her bottom with a gown, and the other CENA was at her head area and it was very difficult to roll Resident #204 over due to her size. I was asked to provide my CPR card to the DON after the incident, and I did. RIDON was asked if staff provided any written statements of the Cardiac Event, and provided 2 hand written statements from CENA B and C. There was no written statement provided to this Surveyor for RN D by the end of survey. Review of written statement from CENA C dated [DATE], documented On [DATE], I was asked by CENA B to come assist with a guest in room [ROOM NUMBER]. We needed a hoyer<br>sling first, so we went and retrieved the sling first in the linen closet. Upon opening the door to room [ROOM NUMBER], I walked into guest lying face down on the floor, on the right side of her bed and her [MEDICAL CONDITION] mask was to the left of her face. As I approached Resident, I asked CENA B what happened. I was notified she (Resident #204) rolled off the side of the bed while being changed. I cleaned the guests back end and covered her, tried to get her to respond. CENA B and I rolled her over onto her back, and I instructed CENA B to check for pulse. I was going to get a nurse. I informed a 200<br>hall nurse (this was at shift change), that we needed help. We arrived back in the room, and as they assessed her, RN D said go ahead on CPR and we started CPR. EMS was in route. Once EMS arrived, we stepped out, after I made sure I was clear to go. I returned back to 300 hall. At the top of the form listed a phone number for any questions. After the interview with CENA C that occurred on [DATE], Regional Vice President of Nursing, and Regional Interim Director of Nursing asked to speak to Surveyor on [DATE], at 2:58 PM, to clarify 'minor misunderstandings' related to the investigation that was completed for Resident #204. The RIDON indicated she was under the impression through her investigation that RN D and CENA B and CENA C all entered the room at the same time. She verbalized that she was unaware that the 2 CENA's entered the room before the nurse and rolled her over. RIDON verbalized that Resident #204 has no [MEDICAL CONDITION] episodes since being in the hospital or [MEDICAL CONDITION], and assumed that Resident #204 was stable, and was related to the [DIAGNOSES REDACTED].#204 was on her back (supine), not face down, and was alert and responding when the aid left the resident alone. RIDON was asked if CENA B pushed the call light or assist button to summons help, and indicated she did not. The CENA thought it would be faster to go get help and left Resident #204 alone in her room. The CENA came back to find Resident #204 unresponsive and in [MEDICAL CONDITION]. RIDON was asked why the RN in care of Resident #204 did not complete any progress notes or an Incident/Accident report. RIDON verbalized the RN involved with care for Resident #204 was leaving and did not document the event or fill out the Incident/Accident report. The next oncoming nurse who had come to help documented some notes at the end of her shift the next day. RIDON indicated she, herself, completed the Incident/Accident report for [DATE] on [DATE]. The RIDON was asked if she thought it was ok to leave Resident #204 alone in her room, and indicated it was probably faster to leave the resident alone and go get help. I don't think we could have done anything different. Review of hand written statement provided to RIDON by CENA B dated [DATE], documented 'I went into change 112, (not 100% of the time). I gathered all supplies I would need then proceeded with patient care. I rolled 112 on her side and began cleaning her bottom. She was facing the window. Resident was secure in the middle of the bed. While cleaning resident, I felt and noticed her body start to roll. I tried to prevent the fall but was unable to. I immediately went to notify the nurse and a 2nd aid for help. Resident was alert and talking when I left to retrieve help, but was not when we returned. I would say I was gone for 30 sec to a minute. Myself and second aid noticed resident not responding to verbal prompts, noticed she was unconscious. Went to alert the other staff and nurses. All nurses came. CPR & AED was performed. Emergency Services had to be started.' The statement was signed and dated [DATE], by CENA B An interview was conducted on [DATE] @ 1:27 PM, with RN D. RN D was asked if she was in care of Resident #204 on the evening of [DATE], and indicated she was the nurse working the hall 100 and 300 called a wrap. She indicated she had residents to care for on both halls. RN D |

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| F 0842<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 8)<br>indicated she was working down on the 300 hall around rooms ,[DATE], when CENA B came and said We had a fall in room [ROOM NUMBER]. RN D verbalized get another aid as resident is a large woman. She got CENA C to assist. I was right behind them. I entered the room with the CENA's and observed Resident on her back next to the bed. They (2 CENA's) said that resident had gone unresponsive. When I got in there, resident was unresponsive. I checked for a pulse. I initiated CPR. CENA C and another nurse came to help. I yelled to another nurse to call 911. CENA B was standing back in the corner pretty upset. One nurse was using the Ambu bag, another nurse brought the crash cart, and we hooked up the AED. We took turns with CPR. EMS's came and took over, and got Resident out. The EMS's and Sheriff started asking questions as to what happened. I heard CENA B verbalized she had got Resident #204's right leg up over the left leg, and the next thing was Resident rolled out of bed onto the floor. During the code, I called the RIDON and explained what had happened. This event occurred at shift change 7 to 7:30 PM. The next nurse came onto shift in the middle of the code. RN D was asked if she documented an Incident/Accident report and Progress notes and verbalized she did not. I don't know why I didn't. I just did not. I wrote out a statement of what happened. RN D was asked if she was aware of the roll out of bed on [DATE], and verbalized she did not know. RN D was asked if she was aware of [MEDICAL CONDITION] episodes with positional changes and indicated she was not aware. I knew she had Cardiac issues, but I did not exactly know. I only cared for this resident a couple of times. No one shared that information with me. RN D was asked if CENA C initiated CPR and said No, us nurses performed CPR. RN D was asked if CENA C helped at all during the code and said No. An interview was conducted on [DATE] @ 11:56 AM, with CENA B related to the event on [DATE]. CENA B indicated she had worked with Resident #204 only one day, and was not familiar with her. CENA B was asked if she had received report that day from nurse or off going CENA and indicated she did from the CENA, but not the nurse. CENA B was asked what information was relayed to her, and verbalized that it was just about the emotional state of Resident #204, and if she had a good or bad day, and that Resident #204 transferred with one person assist, and could move in the bed with help. CENA B was asked if she looked at the Kardex and said yes. CENA B was asked if she was aware of the roll out of bed on [DATE], and said No, I was not told about that. CENA B was asked if she was informed that Resident #204 had a recent history of passing out/[MEDICAL CONDITION] with positional changes and said, No, no one told me that. I had no idea. That would be important to know. CENA B indicated that she responded to call light around 7 to 7:30 PM, and the first shift nurse was getting ready to leave. She indicated that Resident #204 said she was wet, and needed a dry brief. CENA B was asked if there were any pillows placed on either side of Resident #204, or on the floor, chair, or near by, and said, No, there was only one pillow and her head was on it. CENA B indicated she gathered all her supplies for a brief change. She said Resident #204 was laying in the middle of the bed. CENA B was asked if she tried to move or position Resident #204 toward her in bed before rolling her over, and said, No, she was a large lady almost 400 lbs. I did not move her toward me before rolling her. CENA B was asked if she rolled Resident #204 toward her body or away from her body and said away from her body. CENA B went on to say that she crossed Resident #204's right leg over the left leg and rolled her onto her left side, and started care, cleaning her bottom. CENA B indicated her and Resident #204 was having general conversation, and then Resident #204 got quiet. CENA B was asked if Resident #204 was wearing her [MEDICAL CONDITION] mask and said No, she had oxygen on with the plastic things in her nose, not the [MEDICAL CONDITION]. CENA B said she felt Resident #204 start to roll and by the time she noticed the movement, Resident #204 rolled off the edge of the bed onto the floor landing face down. CENA B said Resident #204 was on the floor down on her stomach, face down, not on her back. CENA B was asked if Resident #204 was talking to her after being down on the floor and indicated she could not remember Resident #204 talking to her. CENA B verbalized she could not remember if Resident #204 was alert and responsive at that time. CENA B was asked if Resident #204 ever became responsive from the time of rolling out of bed and the time she left Resident #204 alone and said she could not remember Resident #204 ever talking to her again. CENA B said she tried to roll Resident #204 over by herself while she was down on the floor, but could not because of her size. CENA B was asked if Resident #204 was responsive enough to help roll over and indicated she could not remember. CENA B verbalized she pulled on Resident #204's gown to try and move her onto her right side, but was unsuccessful. CENA B was asked if she activated the call light or staff assist button and said, No, I left the room and went to find a nurse. I went to the 300 hall from the 100 hall to find a nurse. I was the only aid on the 100 hall. CENA B indicated she found RN D in a sitting area on the 300 hall, and said, 'we had a fall in room [ROOM NUMBER], can you help'. RN D said 'Yes', I am on my way, go get another aid because Resident #204 is large lady. So I walked further down the 300 hall, and found another aid coming out of a room. I asked her if she could help me. We went to the 100 hall linen closet and got a hoyer sling pad to lift her up off the floor first, before going to room [ROOM NUMBER]. When we (Me and other aid) entered the room, Resident #204 was not talking or responding, and still face down on the floor. The other aid was near her feet. I was near her head. We rolled her toward the right side. Resident was still not responding. RN D came in after we rolled her over. RN D checked for a pulse and respirations. There were none. Another nurse came with the crash cart and CPR was started. I was panicking at first and had my back to what was going on and not watching, but could hear everything. I called 911 from my personal cell phone in my pocket. I heard them taking turns doing CPR until EMS arrived. The nurses put an AED on Resident, and then the EMS took over and got Resident #204 out of the building. A Cop took my statement. I answered questions. RIDON instructed staff to get my statement. I wrote out a statement and gave it to a nurse. CENA B was asked again if she activated the call light, and said No, I thought it would be faster to go get help. So I left the room. CENA B was asked how long it took her to go to another hall, talk to the nurse, get another aid, get a sling and go back to the room, and said maybe ,[DATE] minutes maybe 5 minutes. I don't really know for sure. CENA B was asked if she was running thru the halls and first replied 'Yes', then said 'No, I was walking fast or brisk. I was freaked out. This was my first experience with anything like this. CENA B was asked if she typically leaves a resident alone after a fall, while face down on the floor, and indicated that she thought it was faster to go get help. CENA B was asked again if Resident #204 ever became responsive enough to say she was ok, and said, I don't remember. Review of 'Falls Reduction Program' Policy dated [DATE], documented under Purpose: To provide a safe environment for residents, modify risk factors, and reduce risk of fall related injury. Procedure: Identify/analyze risk for fall. Implement and indicate individualized interventions on Care Plan/Kardex. If fall occurs Charge Nurse to complete the following: Physical assessment of resident and observation of environment. Immediate interventions as identified by physical assessment and environmental observation. Incident report . The facility failed to accurately document and complete an investigation related to a fall and cardiac event, failed to ensure an Incident/Accident report was completed by the RN who was in Charge at the time of the Cardiac event, Failed to ensure that the RN documented progress notes in the medical record related to Cardiac event, and failed to ensure accuracy on Incident/Accident report of the events that occurred during an Incident for Resident #204 on [DATE].<br><br>Resident #202 According to the Admission Record, printed on [DATE], Resident #202 was a [AGE] year old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During a telephone interview with Resident #202 on [DATE] at 9:42 AM, Resident #202 reported that she had arrived at the facility at about 12:10 PM on [DATE]. Resident #202 stated that she had waited for over an hour for staff to respond to her call light after she had activated the call system around 1:30 PM to request medication for pain. The [DATE] Medication Record was reviewed, no entry for the medication [MEDICATION NAME]/[MEDICATION NAME] ([MEDICATION NAME]) ,[DATE] milligrams, a controlled substance, had been recorded. There was a progress note dated [DATE] at 2:20 PM that stated Resident #202 had received [MEDICATION NAME] shortly after arriving to facility with ,[DATE] pain. On [DATE] at 1:57 PM, according to the log for the back-up medications, one tablet of [MEDICATION NAME]/[MEDICATION NAME] had been removed from the back-up pharmacy supply by Licensed Practical Nurse (LPN) G for Resident #202. On [DATE] at 1:26 PM, LPN G was contacted by phone. LPN G recalled getting the medication from the back-up supply after being told by an aide that Resident #202 had requested something for pain. When asked why she had not recorded the medication on the Medication Administration Record [REDACTED]. The facility policy for Administering Medications, dated as revised [DATE], directed that The individual administering the medication must initial the resident's MAR indicated [REDACTED]. |