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	345389	A. BUILDING _____ B. WING _____	C 06/26/2024

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F 000	INITIAL COMMENTS A complaint investigation was conducted onsite from 6/19/24 through 6/20/24. Additional information was obtained offsite through 6/26/24 and onsite validation of the immediate jeopardy removal plans was conducted on 6/26/24. Therefore, the exit date was changed to 6/26/24. The following intake was investigated: NC00218345. Two (2) of the 2 allegations resulted in a deficiency. Intake NC00218345 resulted in immediate jeopardy. Immediate jeopardy was identified at: CFR 483.12 at tag F 604 at a scope and severity of (J) CFR 483.25 at tag F689 at a scope and severity of (J) CFR 483.35 at tag F726 at a scope and severity of (J) Tags F604 and F689 constituted Substandard Quality of Care Immediate Jeopardy began on 6/12/24 and was removed on 6/22/24. A partial extended survey was conducted.	F 000		
F 604 SS=J	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F 604		7/22/24

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

Electronically Signed | 07/22/2024

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F 604	Continued From page 1 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations and staff, Responsible Party (RP), Medical Director (MD), Nurse Practitioner #1 (NP) and Paramedic #1 interviews and record review, when the facility moved the resident's bed against the wall to prevent her from getting out of the bed, they failed to identify this as a restraint, failed to complete a restraint assessment, failed to obtain a physician order and failed to obtain the RP's consent for the use of a restraint. When the resident fell out of the bed she was wedged between the bed and the wall. Resident #1 was assessed by facility staff and found to not have a pulse or respirations. Cardiopulmonary Resuscitation (CPR) was started by the facility staff and assumed by paramedics. Resident #1 expired on 6/12/24.	F 604	Resident #1 expired on 6/12/24. The Director of Nursing (DON) or Assistant Director of Nursing (ADON) completed an audit of residents with their bed against the wall for a physician order, physical device evaluation, current signed consent and care plan on 6/20/24. All items identified in the audit were corrected. In the event a similar situation is identified, corrective actions as stated above will be completed to secure and maintain compliance. The DON completed an audit of residents with behaviors of attempting to get out of bed, to identify residents that have the	

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F 604	Continued From page 2 This was for 1 of 3 residents reviewed for restraints (Resident #1). Immediate Jeopardy began on 6/12/24 when Resident #1 was found wedged between the bed and the wall after being restrained. Immediate Jeopardy was removed on 6/22/24 when the facility implemented a credible allegation for immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective. The findings included: Resident #1 was admitted on 10/11/23 with diagnoses including congestive heart failure, chronic obstructive pulmonary disease, anxiety, unspecified psychosis and dementia. The quarterly Minimum Data Set dated 5/31/24 indicated Resident #1 was assessed for severe cognitive impairment, she exhibited no behaviors, required partial staff assistance rolling from side to side, no impairments to bilateral upper and lower extremities, a weight of 275 pounds, and no use of restraints. Resident #1 was care planned on 10/12/23 as a risk for falls related to her decreased range of motion and pain. The care plan included the intervention of assist bars (narrow type of side rail attached to the side of a resident's bed approximately at shoulder level that is used to assist a resident with getting out of the bed or repositioning more easily. Assist bars are made to also swing outward to assist with a transfer	F 604	bed placed against the wall as a behavior management intervention and none were observed on 6/21/2024. The facility implemented the immediate actions to ensure that policies and systems were in place to investigate, implement effective interventions, document, ensure training and competencies for all nursing staff, Registered Nurse (RN), Licensed Practical Nurse (LPN) and Medication Aides (MA) and Certified Nursing Assistants (CNA) who would place a residents' bed against the wall to prevent future accidents and or injuries. No revisions to the restraint management policy were required. The Licensed Nursing Home Administrator (LNHA) and the DON received education from the Regional Clinical Coordinator (RCC) on 6/20/24 regarding the restraint management policy, incidents and accidents policy and the abuse policy to include injuries of unknown origin. The education was provided, in person, verbally with opportunity for discussion and /or clarification, and contained the definition of a restraint, the required evaluation prior to application of a restraint, identification of the risks of using the restraint, physician order for the bed against the wall prior to initiation of the restraint and that a bed placed against the wall as a behavior management intervention is considered a restraint with alternative behavior management interventions. The facility nursing staff currently working	

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F 604	Continued From page 3 from the bed to another surface as well but are not full weight bearing. They are not capable of movement up or down and are stationary). The care plan did not include the new intervention of pushing her bed against the wall to prevent her from getting out of bed. Review of Resident #1's June 2024 Physician orders included an order dated 5/27/24 for Oxygen at 2 liters per minute as needed for shortness of breath, Risperdal (antipsychotic) 0.25 milligrams (mg) at bedtime for psychosis and an order dated 5/28/24 for bilateral assist bars up on both sides of the bed to increase bed mobility. There was also an order dated 5/29/24 for Hydroxyzine (antihistamine) 25 mg every 8 hours as needed for restlessness/anxiety. Review of a progress note written by Nurse #1 dated 6/10/24 at 2:41 AM, read Resident #1 was yelling, wanting to get out of bed, calling out to her roommate for help. This behavior went on for about 2 to 3 hours. When asked what she needed help for, she replied, "I don't know," will continue to monitor. A telephone Interview was completed on 6/19/24 at 1:25 PM with Nurse #1. Nurse #1 stated he worked with Resident #1 from 7:00 PM on 6/9/24 through 7:00 AM on 6/10/24 when she was experiencing behaviors during the 6/9/24 night shift around 2:40 AM. He stated her behaviors were yelling out, calling her roommate's name keeping her awake, repeatedly trying to get up out of the bed and asking for her son. Nurse #1 stated the staff could not sit the rest of the 11:00 PM-7:00 AM shift with her so he decided to move Resident #1's bed from its regular position in the center of the room to having the right side of the	F 604	in the facility received education from the DON or the ADON verbally, in person, with opportunity for discussion and /or clarification, regarding the restraint management policy, incidents and accidents policy and the abuse policy, to include injuries of unknown origin, on 6/20/2024 and contained the definition of a restraint, the required evaluation prior to application of a restraint, identification of the risks of using the restraint, physician order for the bed against the wall to be completed prior to initiation of the restraint, that a bed placed against the wall, as a behavior management intervention, is considered a restraint and alternative behavior management interventions that is not a restraint. The remaining facility nursing staff will receive this education from the DON prior to returning to work at the facility. This education will also be provided to new nursing staff during orientation. All staff currently working in the facility received education from the DON or the Assistant Director of Nursing verbally, in person, with opportunity for discussion and /or clarification, abuse policy, to include injuries of unknown origin, on 6/20/2024. The remaining facility staff will receive this education from the DON prior to returning to work at the facility. This education will also be provided to new facility staff during orientation. The DON or Assistant Director of Nursing (ADON) will complete and audit new admissions/readmissions for the bed being placed against the wall, for a	

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F 604	Continued From page 4 bed up against the wall. He stated he did this to keep Resident #1 from getting out of the bed. Nurse #1 stated he did not obtain a physician order, complete a restraint assessment or get a consent from her RP. Nurse #1 stated he did not do the things associated with implementing a restraint because a bed against the wall was not a restraint. Nurse #1 confirmed that according to the June 2024 Medication Administration Record (MAR), on 6/9/24 second shift starting from when he came in at 7:00 PM and third shift on 6/10/24, he did not administer Resident #1's prescribed as needed Hydroxyzine (antihistamine) for anxiety and restlessness. He was unable to recall if the bed had bilateral assist bars, why he didn't administer her prescribed Hydroxyzine or call the Physician for an antianxiety medication. Nurse #1's only explanation was that he did not think of it. A telephone interview was completed on 6/20/24 at 3:10 PM with Nursing Assistant (NA) #8. He confirmed working on 6/9/24 and 6/10/24 on third shift with Resident #1 and Nurse #1. NA #8 stated in the middle of the night of the 11-7 shift of 6/9/24, Resident #1 was yelling, bothering her roommate, keeping other residents awake and repeatedly attempting to get out of her bed. He stated Nurse #1 decided to move Resident #1's bed from the center of her room up against the wall so the right side of her bed was blocked by the wall. NA #8 stated this was done to keep Resident #1 from trying to get up out of her bed because she tended to throw her legs off the bed to the right side in an effort to get up. He stated he was not aware that in doing that, Nurse #1 had restrained Resident #1 because he thought that it was ok to do that because the facility did it for other residents. NA #8 stated he thought	F 604	restraint evaluation, physician order, RP consent and appropriate care plan intervention daily for five days, then weekly for three weeks and then monthly for three months to validate continued compliance. The DON or Assistant Director of Nursing (ADON) will complete an audit of residents with a new behavior of attempting to get out of bed, for the bed being placed against the wall as a behavior management intervention daily for five days, then weekly for three weeks and then monthly for three months to validate continued compliance. Audits will presented to the QAPI Meeting monthly by the DON and or ADON for review of Audit Findings to assess if additional actions need to be implemented to maintain compliance.	

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Resident #1's bed did have bilateral assist bars that made her bed not flush against the wall but rather it "stuck out maybe an inch."

A telephone interview was completed on 6/20/24 at 3:02 PM with Nurse #4. She stated she worked 7:00 AM to 7:00 PM on 6/10/24 with Resident #1. Nurse #4 stated Nurse #1 reported to her that morning that Resident #1 was up most of the night, yelling out and trying to get out of the bed. She stated Nurse #1 reported he moved Resident #1's bed against the wall during his shift to keep her from falling out of the bed. Nurse #4 stated she was aware that for the use of a restraint, there had to be permission from the Director of Nursing (DON) and the RP and the care planned had to be revised. She stated she didn't think of Resident #1 bed position change as restraint at the time. Nurse #4 stated Medication Aide (MA) #1 worked with Resident #1 on first shift on 6/10/24.

An interview was completed on 6/19/24 at 244 PM with MA #1. He stated he was assigned Resident #1 on 6/10/24 and 6/11/24 on first shift. MA #1 stated Resident #1 was known to have anxiety, agitation and restlessness that was difficult to redirect and that her providers were aware. MA #1 stated Resident #1 would disrobe, attempt to get out of her bed unassisted and had fallen at the facility before. He stated Nurse #4 reported to him on 6/10/24 that her bed was moved on night shift to prevent her from trying to get up out of the bed and falling. He stated at other facilities he worked at, that would have been a restraint but he did not think it was considered a restraint at this facility.

A telephone interview was completed on 6/21/24

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at 1:57 PM with NA #9. She stated she worked 6/10/24 7:00 AM to 7:00 PM with Resident #1. She stated she noticed Resident #1's bed had been moved up against the wall and that MA #1 told her that the weekend staff did it to keep her from getting out of the bed. NA #9 stated Resident #1 was anxious and she removed her oxygen on multiple occasions but this was not unusual. MA #1 recommended getting her up to the reclining chair which settled her down. NA #9 stated Resident #1 stayed up in her reclining chair from lunch time till right after dinner then she assisted her to bed. She stated at this time Resident #1 began yelling, screaming, swinging at her and her bed was still up against the wall. She stated the MA #1 gave her a Hydroxyzine at 4:45 PM and that he could not give her anything else because it was too early. NA #9 stated Resident #1 eventually settled down enough that she felt it was safe to leave the room.

A telephone interview was completed on 6/20/24 at 7:25 PM with NA #10 who worked with Resident #1 on 6/10/24 from 7:00 PM to 11:00 PM. She stated she immediately noticed that her bed had been moved up against the wall and assumed it was because of her attempts to get up out of the bed. She recalled Resident #1 as being emotional and confused on her shift. NA #10 stated she was not aware that Resident #1's bed against the wall was considered a restraint since she could exit the other side of her bed if she wanted to.

A telephone interview was completed on 6/19/24 at 2:14 PM with Nurse #3. She confirmed working with Resident #1 on 6/10/24 from 3:00 PM to 7:00 PM and on 6/11/24 from 7:00 AM to 7:00 PM. She stated MA #1 reported to her the Resident #1

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had been experiencing anxiety of late and there were two occasions the week before when her RP was contacted and came to sit with her. Nurse #3 stated there had been communication left in the psychiatric providers notebook and in the Physician's notebook regarding her increased anxiety but so far only Hydroxyzine had been ordered as needed. She stated Resident #1 received psychiatric services and talk therapy but there had been no significant changes and that her confusion and behaviors seemed to worsen later in the afternoons. Nurse #3 stated she noticed that Resident #1's bed had been moved but it never occurred to her that it could be considered a restraint until Resident #1 fell in between the bed and the wall and ended up dying. Nurse #3 stated the bed against the wall created a dangerous situation for Resident #1 given her cognitive status with her increased anxiety and behaviors.

A telephone interview was completed on 6/20/24 at 7:55 AM with NA #12. She stated she worked 11:00 PM on 6/10/24 to 7:00 AM on 6/11/24. She stated she noticed Resident #1's bed had been moved. She stated Resident #1 was known to try to get out of the get, crawl out of the bed, disrobe, yell and strike at staff. NA #12 stated she was not aware that having her bed pushed up against the wall was considered a restraint. She confirmed restraint training but could not recall when she last received that training.

A telephone interview was completed on 6/20/24 at 7:30 PM with NA #11. She stated she worked on 6/11/24 from 7:00 AM to 3:00 PM with Resident #1 and noticed that her bed had been moved up against the wall. She stated Resident #1 seemed to experience increased anxiety while

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in the bed and rested better in the reclining chair. NA #9 stated that was where she typically let Resident #1 nap on the days she was assigned to her. She stated that moving the bed against the wall was not considered a restraint as far as she knew.

Review of psychiatric NP note dated 6/11/24 read the reason for her visit was due to staff request regarding anxiety, insomnia and psychosis. Staff reported the Resident #1 had been confused and yelling out to be put to bed or taken out of the bed. The note read Hydroxyzine was prescribed by the MD on 5/29/24.

A telephone interview was completed on 6/24/24 at 10:37 AM with the psychiatric NP. She stated when she saw Resident #1 on 6/11/24 it was because it was at the request of the staff. They documented the reason as anxiety and restlessness. She stated when she reviewed Resident #1's medical record, she noted that that the MD had already prescribed a medication for her anxiety (Hydroxyzine). The psychiatric NP stated she reviewed Resident #1's nursing notes and read that after the Hydroxyzine was administered, the nurses documented that it was effective. She stated this was why she did not to prescribe anything else for her anxiety or restlessness. When questioned if she interviewed any of the floor staff about Resident #1's anxiety or recent behaviors, she stated she only reviewed the electronic medical record.

A telephone interview was completed on 6/20/24 at 7:00 PM with Nurse #5. She stated she worked on 6/11/24 from 7:00 PM to 7:00 AM with Resident #1. She recalled Resident #1 often yelling out "help me' and she was difficult to

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redirect. Resident #1 would want to get up out of the bed then she would want to get back in the bed. She stated she assumed the bed was positioned against the wall because she often tried to get out of the bed unassisted. Nurse #5 stated Resident #1's bed was a bariatric bed that also had bilateral assist bars to help with bed mobility.

A telephone interview was completed on 6/11/24 at 12:41 PM with NA #13. She confirmed she worked 6/11/24 from 3:00 PM to 11:00 PM with Resident #1. She stated Resident #1 seemed to rest better sitting up in her reclining chair and when she was placed in the bed, she would attempt to get out of the bed and exhibit more behaviors. NA #13 stated when she left at 11:00 PM, Resident #1 was sleeping in her reclining chair. She stated she noticed that Resident #1's bed had been moved against the wall with maybe one to two inches in between the wall and the bed due to assist bars. NA #13 stated the assist bars on her bed did not move up or down but were affixed to the bed frame.

An interview was completed on 6/19/24 at 1:00 with NA #1. She recalled working first shift on 6/12/24 with Resident #1. NA #1 stated she asked NA #2 to assist her to put Resident #1 back to bed using the mechanical lift and assist with giving her a bath. She stated after the bath, Resident #1 was tired and stated she wanted to take a nap.

An interview was completed on 6/19/24 at 1:16 PM with NA #2. She stated she helped NA #1 transfer Resident #1 using the mechanical lift into the bed on 6/12/24 at approximately 1:30 PM and they gave her a bath and completed her personal

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care. NA #2 stated Resident #1 was known to try to get out of the bed and she was unsafe to do so. She also said Resident #1 was known to display agitation and anxiety at times and was extremely difficult to redirect. NA #2 stated that also was the first day she had observed Resident #1's bed pushed up against the wall. She stated she did not consider that a restraint because Resident #1 could still get out of her bed on the other side. NA #2 stated Resident #1 was known to try to get out of the bed and she was unsafe to do so. She also said Resident #1 was known to display agitation and anxiety at times and was extremely difficult to redirect. NA #2 stated that also was the first day she had observed Resident #1's bed pushed up against the wall. She stated there were bilateral assist bars on Resident #1's bed that left about one to two inches of room between her bed and the wall.

A review of an incident report dated 6/12/24 at 4:38 PM read Resident #1's RP opened her door and called out for assistance. An aide screamed out for additional staff assistance. Resident #1 was seen lying on her right side face down next to the right side of her bed on the floor. Resident #1 was turned over while her RP moved the bed and furniture out of the way. Resident #1's vital signs and blood sugar were requested along with a request for someone to call Emergency Medical Services (EMS) and to announce a "code blue" (full code for presumed cardiac arrest). CPR was started and taken over by EMS while the RP was present in the room.

A telephone interview was completed on 6/21/24 at 2:11 PM with NA #3. She stated she was scheduled to work from 3:00 PM to 11:00 PM with Resident #1 on 6/12/24 but she was late for work

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and walked by her room around 3:20 PM and saw her sleeping in her bed. NA #3 stated she then gave another resident a shower and returned to check on Resident #1 sometime between 3:30 PM and 3:45 PM. It was at this time she observed Resident #1's door to her room closed so she assumed her RP was in the room visiting. NA #3 stated she was aware that Resident #1's bed had been pushed up against the wall so she could not get out of the bed on the right side because she tended to throw her legs over to the right side of the bed when trying to get up. NA #3 stated she would not have considered Resident #1's bed against the wall an accident hazard.

A telephone interview was completed on 6/19/24 at 2:51 PM with MA #2. She stated she was working on 6/12/24 from 7:00 AM to 7:00 PM with Resident #1. She stated she heard NA #4 calling out for help saying Resident #1 was on the floor. She stated she responded to the room and saw her face down in between the bed and the wall. MA #2 stated the bed had been moved and UM #1 and Nurse #2 were working on her. She stated she had not questioned Resident #1's bed being up against the wall because she assumed the interdisciplinary team (IDT) team had put it in place as a fall intervention.

A telephone interview was completed on 6/19/24 at 1:30 PM with Resident #1's RP. He stated he arrived on 6/12/24 at 4:03 PM and stopped at the nurses station to talk to UM #1 then proceeded down the hall to Resident #1's room. The RP stated when he observed the door to her room closed, he assumed staff were inside providing care and would be coming out shortly. He stated within a few minutes of standing in the hallway outside Resident #1's door, he thought heard her

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call out his name but he didn't think much of it since he assumed staff were in the room with her. He said he was chatting with a few other residents in the hallway when he decided he had waited too long for staff to be in the room assisting Resident #1.The RP stated it was around 4:15 PM when he decided to knock on the door and gently open the door to peek inside. He stated that was when he saw the bottom of Resident #1's right foot on top of her mattress and could not see the rest of her body. He stated he knew something was wrong so he stuck his head outside her room and asked staff to get help. He stated he then attempted to pull the bed away from the wall to see Resident #1. He said the bed must have been locked because it was difficult to move but he got the end of the bed pulled out and the head of the bed out slightly enough to see that Resident #1 was not responsive and her color didn't look right. The RP stated he called for help and then staff entered the room and took over. He stated they turned her over and started CPR until EMS arrived but they were unable to revive her. When asked approximately how much space did he think was between the bed and the wall when he found her, he stated just a few inches. The RP stated Resident #1's bed had never seen her bed up against the wall before and Resident #1 had bilateral assist bars on her bed.

An interview was completed on 6/19/24 at 9:45 AM with UM #1. She stated Resident #1 had a history of throwing her feet over the side of the bed trying to get up unassisted. UM #1 stated it was reported to her Monday (6/10/24) by Nurse #2 that Resident #1 had experienced increased anxiety and behaviors over the weekend. Resident #1 was yelling, calling out for her

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roommate to assist her and trying to get up out of the bed unassisted. Nurse #2 stated that Nurse #1 reported to her that he moved her bed from the center of her room to be flush against the wall with the headboard against the wall near the hallway door. UM #1 stated she did not question the bed being moved nor did she consider the bed against the wall as a restraint. When questioned regarding the rationale for the bed being moved up against the wall, UM #1 stated it was to keep her from getting out of the bed and falling. When asked if that could be the definition of a restraint, UM #1 stated "yes". UM #1 stated on 6/12/24 at approximately 4:15 PM, she heard NA #4 calling for help needed in Resident #1's room. NA #4 stated the RP found Resident #1 on the floor between the bed and the wall. She summoned Nurse #2 to assist and asked staff to retrieve the crash cart (a cart that contains all the supplies and equipment need in the event of a cardiopulmonary arrest) requiring CPR and call 911. UM #1 stated upon entry to the room, the RP was standing at the foot of the bed and had pulled to foot of the bed away from the wall to allow them to get between the bed and the wall and turn her over to assess. UM #1 stated Resident #1 was blue, warm to the touch, absent of any pulses or respirations so CPR was initiated.

A telephone interview was completed on 6/26/24 at 1:10 PM with NA #4. She stated she was walking down the hallway when Resident #1's RP opened her door and stated he needed help because Resident #1 was on the floor. She stated she could not see Resident #1 from the doorway. She stated once she entered the room and walked over to the end of the bed, she could see Resident #1 lying on the floor in between the bed

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and the wall. She stated the RP had already pulled out the foot of the bed some but stated she assisted him in pulling out the bed more to allow for staff to roll her and perform CPR. NA #4 stated she did not know how much space was between the bed and the wall prior to her fall. She stated once CPR was initiated, she exited the room.

An interview was completed on 6/19/24 at 2:30 PM with NA #6. She confirmed she was working second shift on 6/12/24 but was not assigned Resident #1. She stated Resident #1 was known to display agitation, disrobe and continuously trying to get out of her bed. NA #6 recalled Resident #1's door being closed thinking her RP was in the room for a visit. She stated she was not aware that he wasn't in the room until he found her on the floor between the bed and the wall. NA #6 stated since this incident with Resident #1, she understood better how putting a bed against a wall could be a restraint. She also confirmed that Resident#1's bed had bilateral assist bars.

A telephone interview was completed on 6/19/24 at 3:00 with Nurse #2. She stated she worked 6/12/24 7:00 AM to 7:00 PM on another cart but she responded to Resident #1's room with UM #1. Nurse #2 stated when she arrived in the room, Resident #1 was lying on the floor in between her bed and the wall. She stated the bed had already been pulled out enough so that she and UM #1 could roll her over and begin CPR. Nurse #2 stated Resident #1 was known to try to get out of the bed unassisted but she did not have the cognition nor the ability to walk and would end up falling. She stated she did not think she had assist bars on her bed at the time of the

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fall.

A telephone interview was completed on 6/21/24 at 4:07 PM with NA #5. She stated she was working second shift on 6/12/24 and she was in another residents room when she heard the RP say outside Resident #1's door that she was on the floor. She stated she entered the room to see Resident #1 on the floor in between the right side of her bed and the wall and the RP was pulling the bed out some to allow for the staff to help Resident #1. That's when UM #1 and Nurse #2 entered and rolled Resident #1 over and we saw she was not breathing and blue so they began CPR then she exited the room.

A telephone interview was completed on 6/20/24 at 12:59 PM with NP #1. She stated she was not notified that Resident #1's bed was being used as a restraint and would have not ordered it due to the risk associated with Resident #1's known behaviors of attempting get out of her bed unassisted and the risk of injuries and possible entrapment.

On 6/20/24 at 3:40 PM, in the presence of the DON, ADON and the Regional Clinical Coordinator, UM #1 provided a description of what occurred on 6/12/24 involving Resident #1's fall. This description was done in an empty room with a non-bariatric bed that was placed against the wall in the same position as Resident #1's bed would have been in on 6/12/24. UM #1 described entering the room and noting the foot of the bed had been pulled away from the wall approximately 18 to 20 inches at the foot and approximately 8 inches at the head when she observed Resident #1 with the right side of her body lying on the floor while the left side of her

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body lying against the base board of the floor slightly leaning into the wall. She described her as nonresponsive. UM #1 stated somebody moved the bed out of the way further and they rolled Resident #1 onto her back and noted she was not breathing and had no pulse.

An interview was completed on 6/19/24 at 10:48 AM with the ADON. She stated she was not aware that Resident #1's bed had been repositioned against the wall on the 11:00 PM to 7:00 AM shift 6/10/24.

A telephone interview was completed on 6/25/24 at 2:12 PM with Paramedic #1 who responded to the code at the facility on Resident #1 on 6/12/24. He recalled that when he arrived at Resident #1's room, the facility staff were in the process of performing CPR. He stated staff reported that Resident #1 was found on the right side of the bed near the wall but that she had not fallen off of the bed. He stated Resident #1 never regained a pulse and only a brief rhythm change was seen before asystole (no heart beat) again. He said the code was called at 5:00 PM.

An interview was completed on 6/19/24 at 9:30 AM with the DON. She stated at approximately 4:05 PM on 6/10/24, the RP came to the facility for a visit but stopped at the nurses station to talk to Unit Manager (UM) #1 then he walked down the hall to Resident #1's room and noted the door closed. He stated he assumed staff were in the room providing personal care. The DON stated he was waiting in the hallway chatting with other residents until he eventually knocked on the door and stuck his head in. The DON stated that was when the RP reported seeing Resident #1 on the floor in between in the bed and the wall with her

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right foot still propped up on the bed. The DON stated he stuck his head out of the room and yelled for help. NA #4 was walking down the hallway and ran to get the nurses and NA #5 was in another room but responded to the room. The DON stated next UM #1 and Nurse #2 arrived in the room where the RP had pulled the foot end of the bed out to allow the nurses to roll Resident #1 over to assess her and initiate CPR. The DON stated EMS and the police were notified. She stated when EMS arrived, they assumed care of Resident #1 and pronounced her deceased at 5:00 PM. The DON stated she was not aware that Resident #1's bed had been moved up against the wall until 6/12/244. The DON stated her investigation included staff statements at the time of the incident and review of the incident report. She stated at no time did the facility consider moving Resident #1's bed up against the wall as a restraint. The DON stated prior to any device being used to prevent a resident's movement in any manner, it had to be assessed for safety, a Physician order had to be obtained and a written consent obtained from the RP.

A telephone interview was completed on 6/25/24 at 11:07 AM with the MD. He stated Resident #1 being found on the floor in between her bed and the wall, it would not mean that it caused her death. He stated she could have had a pulmonary embolism (a sudden blockage in the pulmonary arteries) or died due to her poor cardiac status. The MD stated her death was not likely the result of suffocation or strangulation in conjunction with her weight of 280 pounds. He stated Resident #1's bed being placed against the wall and subsequent fall did not result in her death because she could have easily gotten out of the bed on the left side as well.

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The Administrator was notified of Immediate Jeopardy on 6/20/24 at 11:55 AM.

The facility provided the following credible allegation of immediate jeopardy removal with a competition date of 6/22/24:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

The deficient practice resulted when the facility failed to have licensed nurses and nurse aides that were able to demonstrate competency in skills and techniques to address Resident # 1's behavior and attempts to get out of bed. Staff restrained Resident #1's movement by pushing the bed against the wall on 6/10/24. This staff nor other staff who subsequently provided care for Resident #1 recognized the restraint of the resident's movements could create a life-threatening hazard. Resident #1 was found unconscious and wedged between the wall and the bed. Resident #1 expired on 6/12/24.

Based on the investigation and the root cause analysis completed by the Licensed Nursing Home Administrator (LNHA), DON, Regional Clinical Coordinator (RCC) for Laurel Health Care Company on 6/20/24, it was noted that the lack of staff education related to the restraint management policy, incidents and accidents policy and the abuse policy to include injuries of unknown origin is what led to the incident forementioned.

Specify the action the entity will take to alter the process or system failure to prevent a serious

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adverse outcome from occurring or recurring, and when the action will be complete.

The facility implemented the immediate actions to ensure that policies and systems were in place to investigate, implement effective interventions, document, ensure training and competencies for all nursing staff who would place a resident's bed against the wall to prevent future accidents and or injuries. No revisions to the restraint management policy were required.

On 6/20/2024 the LNHA, DON and the RCC for Laurel Health Care completed a root cause analysis of the incident related to Resident #1.

The resulting interventions from the root cause analysis were:

The LNHA and the DON received education from the RCC on 6/20/24 regarding the restraint management policy, incidents and accidents policy and the abuse policy to include injuries of unknown origin. The education was provided, in person, verbally with opportunity for discussion and /or clarification, and contained the definition of a restraint, the required evaluation prior to application of a restraint, identification of the risks of using the restraint, physician order for the bed against the wall prior to initiation of the restraint and that a bed placed against the wall as a behavior management intervention is considered a restraint with alternative behavior management interventions.

The facility nursing staff (to include LPN, RN, Med Aides, and CNAs) currently working in the facility received education from the DON or the Assistant Director of Nursing verbally, in person,

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with opportunity for discussion and /or clarification, regarding the restraint management policy, incidents and accidents policy and the abuse policy, to include injuries of unknown origin, on 6/20/2024 and contained the definition of a restraint, the required evaluation prior to application of a restraint, identification of the risks of using the restraint, physician order for the bed against the wall to be completed prior to initiation of the restraint, that a bed placed against the wall, as a behavior management intervention, is considered a restraint and alternative behavior management interventions that is not a restraint. The remaining facility nursing staff will receive this education from the DON prior to returning to work at the facility. This education will also be provided to new nursing staff during orientation.

All staff currently working in the facility received education from the DON or the Assistant Director of Nursing verbally, in person, with opportunity for discussion and /or clarification, abuse policy, to include injuries of unknown origin, on 6/20/2024. The remaining facility staff will receive this education from the DON prior to returning to work at the facility. This education will also be provided to new facility staff during orientation.

The DON or Assistant Director of Nursing (ADON) completed an audit of residents with their bed against the wall for a physician order, physical device evaluation, current signed consent and care plan on 6/20/24.

The DON completed an audit of residents with behaviors of attempting to get out of bed, to identify residents that have the bed placed against the wall as a behavior management intervention and none were observed on

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F 604	Continued From page 21 6/21/2024. The facility alleges the immediate jeopardy was removed on 6/22/2024. An onsite validation of the immediate jeopardy removal plan was completed on 6/26/24. Staff were interviewed to validate in-services were completed on the restraint management policy, incidents and accidents and the abuse policy to include injuries of unknow origin and included the definition of a restraint. A review of the audits completed by the DON or ADON of residents with their bed against the wall for a physician order were confirmed to be completed. A review of the audits completed by the DON of residents with behaviors of attempting to get out of bed were confirmed to be completed. A review of the education completed by the LNHA and DON regarding the restraint management policy, incident and accidents policy and the abuse policy that included injuries of unknow origin were confirmed to be completed. The IJ removal date of 6/22/24 was validated.	F 604		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations and	F 689	Resident #1 expired on 6/12/24.	7/22/24

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F 689	Continued From page 22 interviews with staff, Responsible Party (RP), Bed Supplier Manager, Medical Director (MD), Nurse Practitioner #1 (NP), Police Officer #1, Paramedic #1 and Medical Examiner (ME) #1 the facility failed to keep Resident #1 free from accident hazards by placing her bed against the wall and trying to restrict her from getting out of bed and implement fall interventions ensuring Resident #1's bed remained in the lowest position. Resident #1 fell out of the right side of her bed in between her bed and the wall where there was approximately two to three inches of space. Resident #1 was discovered by her RP in between the wall and the bed lying face down with the left side of her body slightly leaning against the base board on the wall keeping her from being completely flat on the floor. Resident #1 was assessed by facility staff and found not to have a pulse or respirations so cardiopulmonary resuscitation (CPR) was started by the facility staff and assumed by paramedics. Resident #1 expired on 6/12/24. This deficient practice was for 1 of 3 residents reviewed for accidents (Resident #1). Immediate jeopardy began on 6/12/24 when Resident #1 was discovered wedged between the wall and the bed face down without pulse and respiration. Immediate jeopardy was removed on 6/22/24 when the facility implemented an acceptable credible allegation for immediate jeopardy removal. The facility will remain out of compliance at a scope and severity level grid of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective and all staff have been in-serviced. The findings included:	F 689	Other residents that may be at risk for the same deficient practice include those residents with behaviors identified with attempts to get out of bed unsafely. The Director of Nursing (DON) and nurse managers evaluated like residents on 6.21.24, residents that are fall risk and attempting to get out of bed unassisted, to ensure no other beds were pushed against the wall, creating a safety hazard. There were no other residents with these behaviors that had beds pushed against the wall. The Director of Nursing and Nurse Managers implemented education to licensed nurses and certified nurses assistants on the fall management , restraint management, and behavior management policies, with a focus on the potential creation of safety hazard of pushing a bed against the wall, and the potential of the bed against the wall being a restraint on 6.21.24. Additionally, there is a focus on Behavioral Interventions to utilize for residents displaying behaviors of attempts to self exit beds unsafely. Any nursing staff not educated will receive this education prior to their next scheduled shift and will be included in the orientation of new nursing staff. The Director of Nursing (DON) or Assistant Director of Nursing (ADON) will complete an audit of incident and accident reports for falls with a new intervention of placing the residents with their bed against the wall daily for five days, then	

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F 689	Continued From page 23 Resident #1 was admitted on 10/11/23 with diagnoses including congestive heart failure, chronic obstructive pulmonary disease, psychosis and dementia. Resident #1 was care planned on 10/12/23 as a full code and for a risk for falls related to her decreased range of motion and pain. The care plan included the intervention of assist bars to her bed as of 11/15/23 and the intervention to keep her bed in the lowest position was added on 5/13/24. Resident #1's June 2024 Physician orders included an order dated 5/27/24 for Oxygen at 2 liters per minute as needed for shortness of breath. Risperdal (antipsychotic medication) 0.25 milligrams (mg) at bedtime for psychosis and an order dated 5/28/24 for bilateral assist bars up on both sides of the bed to increase bed mobility. A Physical Device Assessment dated 5/28/24 read Resident #1 was re-evaluated and approved for bilateral assist bars to increase her bed mobility on readmission. The quarterly Minimum Data Set dated 5/31/24 indicated Resident #1 had severe cognitive impairment, required partial staff assistance rolling from side to side, a weight of 275 pounds, no restraints and coded. A progress note written by Nurse #1 dated 6/10/24 at 2:41 AM read, Resident #1 was yelling, wanting to get out of bed, calling out to her roommate for help. This behavior went on for about 2 to 3 hours. When asked what she needed help for, she replied, "I don't know," will	F 689	weekly for three weeks and then monthly for three months, starting on 6/21/24, to validate continued compliance. The Audits will be submitted monthly to QAPI Committee by the DON and or ADON for review and further actions as indicated to sustain compliance.	

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continue to monitor.

A telephone Interview was completed on 6/19/24 at 1:25 PM with Nurse #1. Nurse #1 stated he was assigned Resident #1 on 6/9/24 from 7:00 PM to 7:00 AM on 7/10/24 when she was experiencing extreme behaviors that night. He stated her behaviors were yelling out, calling her roommate's name, keeping her awake, repeatedly trying to get up out of the bed and asking for her son. Nurse #1 stated the staff could not sit with her for the rest of the shift, so he decided to move Resident #1's bed from its regular position in the center of the room to the right side of the bed up against the wall. He stated he did this to keep Resident #1 from getting out of bed and he did not consider it as a potential accident hazard. Nurse #1 stated he could not recall if Resident #1 had an assist bar to the right side of her bed against the wall but recalled one assist bar to the left side of her bed.

A telephone interview was completed on 6/20/24 at 3:10 PM with NA #8. He confirmed working on 6/9/24 and 6/10/24 on third shift with Resident #1. NA #8 stated on 6/9/24 night shift, Resident #1 was yelling, bothering her roommate, keeping other residents awake and repeatedly attempting to get out of her bed. He stated Nurse #1 decided to move Resident #1's bed from the center of her room to up against the wall so the right side of her bed was blocked by the wall. NA #8 stated this was done to keep Resident #1 from trying to get up out of her bed because she tended to throw her legs over the bed to the right side to get up. He stated he thought it was okay to do because the facility does it for other residents. NA #8 stated Resident #1 had bilateral assist bars to her bed.

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A telephone interview was completed on 6/20/24 at 3:02 PM with Nurse #4. She stated she worked 7:00 AM to 7:00 PM on 6/10/24 with Resident #1. Nurse #4 stated Nurse #1 reported to her that morning that Resident #1 was up most of the night, yelling out and trying to get out of the bed. She stated Nurse #1 reported he moved Resident #1's bed up against the wall during his shift to keep her from falling out of the bed and she did not consider it unusual since there were other residents with their beds against the wall.

An interview was completed on 6/19/24 at 1:00 with NA #1. She recalled working first shift on 6/12/24 with Resident #1. She stated after lunch, Resident #1 was sitting up in her reclining chair in the hallway around 1:30 PM. NA #1 stated Resident #1 seemed to rest better in her reclining chair. NA #1 stated things were slow so she asked NA #2 to assist her to put Resident #1 back to bed using the mechanical lift and assist with giving her a bath. She stated after the bath, Resident #1 was tired and stated she wanted to take a nap. NA #1 stated she did not recall if she left the bed in the lowest position or not but did recall Resident #1's bed having bilateral assist bars attached to her bed.

An interview was completed on 6/19/24 at 1:16 PM with NA #2. She stated she helped NA #1 transfer Resident #1 using the mechanical lift into the bed on 6/12/24 at approximately around 1:30 PM. NA #2 stated the head of her bed (HOB) was raised to approximately 30 degrees and Resident #1 was going to take a nap. NA #2 stated Resident #1 was known to try to get out of the bed and she was unsafe to do so. She also said Resident #1 was known to display agitation and

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anxiety at times and was extremely difficult to redirect. NA #2 stated that this was the first day she had observed Resident #1's bed pushed up against the wall. She stated Resident #1's bed was not left in the lowest position based on her recollection since it was raised to provide care and moved away from the wall while care was provided. NA #2 did recall placing the bed back against the wall and locking the brakes prior to leaving the room. She stated there were bilateral assist bars on Resident #1's bed that left about 1-2 inches of room between her bed and the wall and she did not consider the bed against the wall an accident hazard.

A telephone interview was completed on 6/19/24 at 2:51 PM with MA #2. She stated she was working on 6/12/24 from 7:00 AM to 7:00 PM with Resident #1. She stated she heard NA #4 calling out for help saying Resident #1 was on the floor. She stated she responded to the room and saw her face down in between the bed and the wall. MA #2 stated UM #1 and Nurse #2 were working on her. MA #2 stated the bed was not in a low position when she was in the room earlier. She stated she did not question Resident #1's bed being up against the wall because she assumed the interdisciplinary team (IDT) team had put it in place as a fall intervention.

A telephone interview was completed on 6/21/24 at 2:11 PM with NA #3. She stated she was scheduled to work from 3:00 PM to 11:00 PM with Resident #1 on 6/12/24 but she was late for work and walked by her room around 3:20 PM and saw her sleeping in her bed. She stated she did not think Resident #1's bed was in the lowest position. NA #3 stated she then gave another resident a shower and returned to check on

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Resident #1 sometime between 3:30 PM and 3:45 PM. It was at this time she observed Resident #1's door to her room closed so she assumed her RP was in the room visiting. NA #3 stated she was aware that Resident #1's bed had been pushed up against the wall so she could not get out of the bed on the right side because she tended to throw her legs over to the right side of the bed when trying to get up. NA #3 stated she would not have considered Resident #1's bed against the wall an accident hazard.

A telephone interview was completed on 6/19/24 at 1:30 PM with Resident #1's RP. He stated he arrived on 6/12/24 at 4:03 PM and stopped at the nurse station to talk to UM #1 then proceeded down the hall to Resident #1's room. The RP stated when he observed the door to her room closed, he assumed staff were inside providing care and would be coming out shortly. He stated within a few minutes of standing in the hallway outside Resident #1's door, he thought he heard her call out his name, but he didn't think much of it since he assumed staff were in the room with her. He said he leaned against the handrail opposite Resident #1's door chatting with a few other residents when he decided he had waited too long for staff to be in the room assisting Resident #1. The RP stated it was around 4:15 PM when he decided to knock on the door and gently open the door to peek inside. He stated that when he saw the bottom of Resident #1's right foot on top of her mattress and could not see the rest of her body. He stated he knew something was wrong, so he stuck his head outside her room and asked staff to get help. He stated he then attempted to pull the bed away from the wall to see Resident #1. He said the wheels must have been locked because it was

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difficult to move but he got the end of the bed pulled out and the head of the bed out slightly enough to see that Resident #1 was not responsive and her color didn't look right. The RP stated staff entered the room and took over. He stated they turned her over and started CPR until EMS arrived, but they were unable to revive her. When asked approximately how much space did he think was between the bed and the wall when he found her, he stated just a few inches. The RP stated Resident #1's bed was not in the lowest position when he found her and that he had never seen her bed up against the wall before. He stated Resident #1 had bilateral assist bars on her bed.

A telephone interview was completed on 6/26/24 at 1:10 PM with NA #4. She stated she was walking down the hallway when Resident #1's RP opened her door and stated he needed help because Resident #1 was on the floor. She stated she could not see Resident #1 from the doorway. She stated once she entered the room and walked over to the end of the bed, she could see Resident #1 lying on the floor in between the bed and the wall. She stated the RP had already pulled out the foot of the bed some, but she assisted him in pulling out the bed more to allow for staff to roll her and perform CPR. NA #4 stated she did not know how much space was between the bed and the wall prior to her fall but there was maybe three to four inches between the wall and the foot of the bed when she saw Resident #1 on the floor. She also recalled the bed was not in its lowest position.

An interview was completed on 6/19/24 at 2:30 PM with NA #6. She confirmed she was working from 3:00 PM to 11:00 PM on 6/12/24 but was not

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assigned Resident #1. She stated Resident #1 was known to display agitation, disrobe and continuously tried to get out of her bed. She said her bed was supposed to be in the lowest position when she was in it. NA #6 recalled Resident #1's door being closed thinking her RP was in the room for a visit. She stated she was not aware that he wasn't in her room until he found her on the floor between the bed and the wall.

An interview was completed on 6/19/24 at 9:45 AM with UM #1. She stated Resident #1 had a history of throwing her feet over the side of the bed trying to get up unassisted. UM #1 stated it was reported to her on 6/10/24 by Nurse #4 that Resident #1 had experienced increased anxiety on the previous night shift on 6/10/24 and that Resident #1 was yelling, calling out for her roommate to assist her and trying to get up out of the bed unassisted. Nurse #4 stated that Nurse #1 reported to her that he moved her bed from the center of her room to be flush against the wall with the headboard against the wall near the hallway door. UM #1 stated she did not question the bed being moved nor did she consider the bed against the wall as an accident hazard. When questioned as to the rationale for the bed being moved up against the wall, UM #1 stated it was to keep her from trying to get out of the bed and falling. UM #1 stated on 6/12/24 at approximately 4:15 PM, she heard NA #4 calling for help to Resident #1's room. NA #4 stated the RP found Resident #1 on the floor between the bed and the wall. She summoned Nurse #2 to retrieve the crash cart (a cart that contains all the supplies and equipment needed in the event of a cardiopulmonary arrest). UM #1 stated upon entry to the room, the RP was standing at the foot of the bed and had pulled the foot of the bed away

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from the wall to allow them to get between the bed and the wall and turn her over to assess Resident #1. She stated the bed was not in the lowest position at the time she entered the room, and she could not recall if there was an assist bar on the side of the bed (right) that was against the wall. UM #1 stated Resident #1 was blue, warm to the touch, absent of any pulses or respirations so CPR was initiated.

A telephone interview was completed on 6/19/24 at 3:00 with Nurse #2. She stated she worked 6/12/24 from 7:00 AM to 7:00 PM on another cart but she responded to Resident #1's room with UM #1. Nurse #2 stated when she arrived in the room, Resident #1 was lying on the floor in between her bed and the wall. She stated the bed had already been pulled out enough so that she and UM #1 could roll her over and begin CPR. She stated the staff kept her bed in the lowest position, but it was the regular position at the time of this fall.

A review of an incident report dated 6/12/24 at 4:38 PM read, Resident #1's Responsible Party (RP) opened her door and called out for assistance. An aide screamed out for additional staff assistance. Resident #1 was seen lying on her right-side face down next to the right side of her bed on the floor. Resident #1 was turned over while her RP moved the bed and furniture out of the way. Resident #1's vital signs and blood sugar were requested along with a request for someone to call emergency medical services (EMS) and to announce a "code blue" (full code for presumed cardiac arrest). Cardiopulmonary Resuscitation (CPR) started and taken over by EMS while the RP was present in the room the entire time.

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A telephone interview was completed on 6/21/24 at 2:23 PM with the Maintenance Director. He stated Resident #1's bariatric bed was a rental so he could not make any alterations or repairs to the bed and when it was picked up on 6/13/24, it had bilateral assist bars in place.

A telephone interview was completed on 6/25/24 at 3:18 PM with the Bed Supplier Manager. He stated when Resident #1's bariatric bed was picked up on 6/13/24, the bed was received in good condition and returned with assist bars attached to the bed.

On 6/20/24 at 3:40 PM, in the presence of the DON, ADON and the Regional Clinical Coordinator, UM #1 provided a description of what occurred on 6/12/24 involving Resident #1's fall. This description was done in an empty room with a non-bariatric bed that was placed against the wall in the same position as Resident #1's bed would have been in on 6/12/24. UM #1 described entering the room and noting the foot of the bed had been pulled away from the wall approximately 18 to 20 inches at the foot and approximately 8 inches at the head when she observed Resident #1 with the right side of her body lying on the floor while the left side of her body lying against the base board of the floor slightly leaning into the wall. She described her as nonresponsive. UM #1 stated somebody moved the bed out of the way further and they rolled Resident #1 onto her back and noted she was not breathing and had no pulse.

An interview was completed on 6/19/24 at 9:30 AM with the Director of Nursing (DON). She stated that NA #3 reported that after she completed the other resident's shower she went

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back to Resident #1's room and noticed her door was closed. NA #3 stated this was between 3:30 PM or 3:45 PM. The DON stated NA #3 assumed Resident #1's RP was in the room for a visit. The DON stated at approximately 4:05 PM, the RP came to the facility for a visit but stopped at the nurse's station to talk to Unit Manager (UM) #1 first. She stated he then walked down the hall to Resident #1's room and noted the door closed assuming staff were in the room providing personal care. The DON stated he was waiting in the hallway chatting with other residents until he eventually knocked on the door and stuck his head in. The DON stated that was when the RP reported seeing Resident #1 on the floor in between the bed and the wall with her right foot still propped up on the bed. The DON stated he stuck his head out of the room and yelled for help. NA #4 was walking down the hallway to get the nurses and NA #5 was in another room but responded to the room. The DON stated next UM #1 and Nurse #2 arrived in the room with the crash cart. The RP pulled the foot end of the bed out to allow the nurses to roll Resident #1 over to assess her and initiate CPR. The DON stated Emergency Medical Services (EMS) and the police were all notified. She stated when EMS arrived, they assumed care of Resident #1 and pronounced her deceased at 5:00 PM. She stated when Police Officer #1 arrived, he never entered the room but rather, once the code was over, Police Officer #1 spoke with the RP at that time. The DON stated she was not aware that Resident #1's bed had been moved up against the wall. The DON stated her investigation included staff statements at the time of the incident and review of the incident report. She stated that was the extent of the facility's investigation and at no time did the facility consider moving Resident #1's bed

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up against the wall as an accident hazard. The DON stated she did not investigate whether her assist bars were involved in the events surrounding Resident #1's fall and subsequent outcome.

An interview was completed on 6/19/24 at 5:00 PM with Police Officer #1. He stated when he arrived at the facility, staff reported to him that Resident #1's RP discovered her on the floor face down with the right leg still partially on the mattress. Police Officer #1 stated after he spoke with the RP in the hallway after the code ended, he contacted Medical Examiner #1 and reported that there were no suspicious circumstances involved in Resident #1's death and he did not feel an autopsy was warranted.

A telephone interview was completed on 6/21/24 at 2:35 PM with Medical Examiner #1. She recalled Police Officer #1 contacting her on 6/12/24 regarding Resident #1. She read from her report that Police Officer #1 stated to her that Resident #1 was found unresponsive in her bed and not on the floor. She read he reported there was nothing suspicious and her death appeared to be from natural causes. The Medical Examiner stated had she known about the actual details of how Resident #1 was found, it would have been up to the RP if he would have wanted an autopsy.

A telephone interview was completed on 6/25/24 at 2:12 PM with Paramedic #1 who responded to the code at the facility on Resident #1 on 6/12/24. He recalled that when he arrived at Resident #1's room, the facility staff were in the process of performing CPR. He stated staff reported that Resident #1 was found on the right side of the bed near the wall, but the facility staff did not

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report that she had fallen. He stated Resident #1 never regained a pulse and only a brief rhythm change was seen before asystole (no heart beats) again. He stated the code was called at 5:00 PM.

A telephone interview was completed on 6/20/24 at 12:59 PM with NP #1. She stated she not aware that Resident #1's bed had been moved to up against the wall and likely would not have approved it because of fears of her known behaviors of attempting to get out of her bed unassisted along with the risk of injuries and possible entrapment.

A telephone interview was completed on 6/25/24 at 11:07 AM with the MD. He stated Resident #1 being found on the floor in between her bed and the wall, it would not mean that it caused her death. He stated she could have had a pulmonary embolism (a sudden blockage in the pulmonary arteries) or due to her poor cardiac status. The MD stated her death was not likely the result of suffocation or strangulation. He stated Resident #1's bed being placed against the wall and subsequent fall did not result in her death because she could have easily gotten out of the bed on the left side as well.

The Administrator was notified of the immediate jeopardy on 6/20/2024 at 11:55 AM.

The facility provided the following credible allegation of immediate jeopardy removal with a competition date of 6/22/24:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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The deficient practice resulted when the facility failed to have licensed nurses and nurse aides that were able to demonstrate competency in skills and techniques to address Resident # 1's behavior and attempts to get out of bed. Staff restrained Resident #1's movement by pushing the bed against the wall on 6/10/24. This staff nor other staff who subsequently provided care for Resident #1 recognized the restraint of the resident's movements could create a life-threatening hazard. Resident #1 was found unconscious and wedged between the wall and the bed. Resident #1 expired on 6/12/24.

An incident and accident report form was completed by the licensed nurse at the time of the incident. An investigation of the incident was initiated by the Director of Nursing on 6/13/24 Other residents that may be at risk for the same deficient practice include those residents with behaviors identified with attempts to get out of bed unsafely. The Director of Nursing (DON) and nurse managers evaluated like residents on 6.21.24, residents that are fall risk and attempting to get out of bed unassisted, to ensure no other beds were pushed against the wall, creating a safety hazard. There were no other residents with these behaviors that had beds pushed against the wall.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

Based on the investigation and the root cause analysis completed by the Licensed Nursing Home Administrator (LNHA), DON, Regional

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	345389	A. BUILDING _____ B. WING _____	C 06/26/2024

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Clinical Coordinator (RCC) on 6/20/24, it was determined that the lack of staff knowledge related to the potential safety hazard contributed to the deficient practice, as well as the licensed nurse not using alternative methods of addressing the residents behavior of self exiting the bed unsafely.

The Director of Nursing and Nurse Managers implemented education to licensed nurses and certified nurses assistants on the fall management, restraint management, and behavior management policies, with a focus on the potential creation of safety hazard of pushing a bed against the wall, and the potential of the bed against the wall being a restraint on 6.21.24. Additionally, there is a focus on Behavioral Interventions to utilize for residents displaying behaviors of attempts to self exit beds unsafely. Any nursing staff not educated will receive this education prior to their next scheduled shift and will be included in the orientation of new nursing staff.

The LNHA and the DON received education from the RCC on 6/21/24. The education was provided, in person, verbally with opportunity for discussion and /or clarification regarding the incident and accident management policy and procedure, general investigation guidelines for incident investigations, how to develop a root cause analysis, and the implementation of effective interventions for incidents. Additionally, the DON and LNHA received education from the RCC on the behavioral management policy with an emphasis on behavioral interventions at that time.

The facility alleges the immediate jeopardy was

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F 689	Continued From page 37 removed on 6/22/24. Onsite validation of the immediate jeopardy removal plan was completed on 6/26/24. Staff were interviewed to validate in-services were completed on the fall management, restraint management and behavior management to include the potential safety hazard of pushing a bed against the wall. The in-service included a focus on behavioral interventions for residents displaying behaviors of attempting to self-exit the bed unsafely was confirmed to be completed. A review of the education completed by the Licensed Nursing Home Administrator (LNHA) and DON regarding the incident and accident management policy, general investigations and behavioral management policy were confirmed to be completed. The immediate jeopardy removal date of 6/22/24 was validated.	F 689		
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents'	F 726		7/22/24

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F 726	Continued From page 38 needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with staff, Responsible Party (RP), Medical Director (MD), Nurse Practitioner #1 (NP), Police Officer #1, Paramedic #1 and Medical Examiner (ME) #1, psychiatric NP and the Bed Supplier Manager, the facility failed to demonstrate competency by not recognizing that putting the bed against the wall for a severely cognitively impaired resident with anxiety, agitation and restlessness was a restraint and an accident hazard. Nurse #1 positioned Resident #1's right side of her bed up against a wall to prevent her from getting out of the bed. Resident #1 fell out of the right side of her bed in between the bed and the wall where she was discovered by her RP on the floor with the left side of her body slightly leaning against the base board keeping her from being completely flat on the floor. She was found to not have a pulse or respirations. Cardiopulmonary Resuscitation (CPR) was started by the facility staff and assumed by paramedics. Resident #1 expired on 6/12/24. This was for 1 (Resident #1) of 3	F 726	Resident #1 expired on 6/12/24. Other residents that may be at risk for the same deficient practice include those residents with behaviors identified with attempts to get out of bed unsafely. The Director of Nursing (DON) and nurse managers evaluated like residents on 6.21.24, residents that are fall risk and attempting to get out of bed unassisted, to ensure no other beds were pushed against the wall, creating a safety hazard. There were no other residents with these behaviors that had beds pushed against the wall. Nurse # 1 received 1:1 education on 6/19/24 by Director of Nursing (DON) on the restraint and abuse policy and procedure with a focus on a bed against the wall needing to be evaluated as well as options to address residents that are attempting to get out bed.	

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F 726	Continued From page 39 residents reviewed for restraints. Immediate Jeopardy began 6/12/24 when Resident # 1 was found on the floor wedged between the bed and the wall after being restrained and staff did not identify the position of the bed as a restraint or accident hazard. Immediate Jeopardy was removed on 6/22/24 when the facility implemented a credible allegation for immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective. The findings included: This tag is cross referenced to: F604: Based on observations, staff, Responsible Party (RP), Medical Director (MD), Nurse Practitioner #1 (NP) and Paramedic #1 interviews and record review, when the facility moved the resident's bed against the wall to prevent her from getting out of the bed, they failed to identify this as a restraint, failed to complete a restraint assessment, failed to obtain a physician order and failed to obtain the RP's consent for the use of a restraint. When the resident fell out of the bed she was wedged between the bed and the wall Resident #1 was assessed by facility staff and found to not have a pulse or respirations. Cardiopulmonary Resuscitation (CPR) was started by the facility staff and assumed by paramedics. Resident #1 expired on 6/12/24. This was for 1 of 3 residents reviewed for restraints (Resident #1).	F 726	On 6/21/24, the Director of Nursing was provided education on the restraint and abuse policy with a focus on a bed against the wall potentially being a restraint, as well as addressing residents' attempting to get out of bed and options to address this behavior, by the Regional Clinical Coordinatorn(RCC). The education was provided, in person, verbally with opportunity for discussion and/or clarification. On 6/20/24, the Director of Nursing and the Nurse Managers initiated education on the restraint, abuse, and behavioral policy for licensed nurses and aides with an emphasis on the potential of pushing a bed against the wall being a restraint. The education was provided, in person, verbally with opportunity for discussion and/or clarification. Licensed nurses and nursing assistants will continue to receive this education prior to their next scheduled shift until all have been educated. This education will also be provided to new nursing staff during orientation. The Director of Nursing, Assistant Director of Nursing and Nurse Managers have conducted observational audits of residents in bed, with a focus on whether the bed is pushed against the wall. This was completed on 6/21/24. The Director of Nursing (DON) or Assistant Director of Nursing (ADON) will complete an audit nursing staff ability to recognize that the bed being placed against the wall as a behavior management intervention can be a restraint and an accident hazard. This will	

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F 726	Continued From page 40 F689: Based on record review, observations and interviews with staff, Responsible Party (RP), Bed Supplier Manager, Medical Director (MD), Nurse Practitioner #1 (NP), Police Officer #1, Paramedic #1 and Medical Examiner (ME) #1 the facility failed to keep Resident #1 free from accident hazards by placing her bed against the wall and trying to restrict her from getting out of bed and implement fall interventions ensuring Resident #1's bed remained in the lowest position. Resident #1 fell out of the right side of her bed in between her bed and the wall where there was approximately two to three inches of space. Resident #1 was discovered by her RP in between the wall and the bed lying face down with the left side of her body slightly leaning against the base board on the wall keeping her from being completely flat on the floor. Resident #1 was assessed by facility staff and found not to have a pulse or respirations so cardiopulmonary resuscitation (CPR) was started by the facility staff and assumed by paramedics. Resident #1 expired on 6/12/24. This deficient practice was for 1 of 3 residents reviewed for accidents (Resident #1). Review of the facility's electronic training records indicated the most recent restraint training was on 2/5/24 for the following staff: Nurse #1, Nursing Assistant (NA) #8, Nurse #4, Medication Aide (MA) #1, NA #9, NA #10, Nurse #3, NA #12, Nurse #5, NA #13, NA #2, NA #3, MA #2, UM #1 and Nurse #2. NA #11 received her training on 4/3/24 and review of NA #1's New Employee Facility General Orientation Checklist dated 5/29/24 did not include any specific training on restraints. An interview was completed on 6/20/24 at 1:12	F 726	be completed by nursing staff interviews daily for five days, interviews will be completed for three nursing staff daily for five days, then three nursing staff weekly for three weeks and then nursing staff monthly for three monthly for three months to validate continued compliance. The Audits will be submitted monthly to the QAPI Committee by the DON and or ADON for review and additional actions as needed to sustain compliance.	

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PM with the Director of Nursing (DON). She stated the facility did not currently have a Staff Development Coordinator (SDC) so she had been filling in with general orientation and ensuring certifications were not expired. She stated the facility utilized an electronic education system that was programmed for different training subjects to be due for the staff at certain times of the year and the previous restraint training was 2/5/24. The DON stated the training included a review of the risk associated with implementing a restraint, the different types of restraints, the facility's effort to create a restraint free environment, alternatives to restraints and the risk associated with the use of side rails. She stated it was not up to the floor nurses to initiate restraints but rather to the nursing management team after an assessment, obtaining a Physician order and written consent from the resident's RP. She stated the annual training for 2024 was already set up. She stated it was clear that the staff needed re-education and clarification on the definition of restraints and accident hazards. She stated she had all the staff completed retraining on again on 6/19/24 but clearly, there was still work to be done. She stated NA #1 was a new hire on 5/29/24 and apparently the New Employee Facility General Orientation Checklist that was completed with NA #1 didn't have anything on it regarding restraints and she was unable to find any kind of orientation competency checklist.

The Administrator was notified of Immediate Jeopardy on 6/20/24 at 11:55 AM.

The facility provided the following credible allegation of immediate jeopardy removal with a date of 6/22/24:

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F 726	Continued From page 42 Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: The deficient practice resulted when the facility failed to have licensed nurses and nurse aides that were able to demonstrate competency in skills and techniques to address Resident # 1's behavior and attempts to get out of bed. Staff restrained Resident #1's movement by pushing the bed against the wall on 6/10/24. This staff nor other staff who subsequently provided care for Resident #1 recognized the restraint of the resident's movements could create a life-threatening hazard. Resident #1 was found unconscious and wedged between the wall and the bed. Resident #1 expired on 6/12/24. Other residents in the facility that have a behavior of trying to get out of bed were reviewed and there were no other residents noted that the staff had pushed the bed against the wall to keep the residents in bed. This was completed on 6/21/24 by the Director of Nursing. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. Nurse # 1 received 1:1 education on 6/19/24 by Director of Nursing on the restraint and abuse policy and procedure with a focus on a bed against the wall needing to be evaluated as well as options to address residents that are attempting to get out bed. On 6/21/24, the Director of Nursing was provided education on the restraint and abuse policy with a focus on a bed against the wall potentially being a	F 726		

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F 726	Continued From page 43	F 726		

restraint, as well as addressing resident's attempting to get out of bed and options to address this behavior, by the Regional Clinical Coordinator. The education was provided, in person, verbally with opportunity for discussion and/or clarification.

On 6/20/24, the Director of Nursing and the Nurse Managers initiated education on the restraint, abuse, and behavioral policy for licensed nurses and aides with an emphasis on the potential of pushing a bed against the wall being a restraint. The education was provided, in person, verbally with opportunity for discussion and/or clarification. Licensed nurses and nursing assistants will continue to receive this education prior to their next scheduled shift until all have been educated. This education will also be provided to new nursing staff during orientation.

The Director of Nursing, Assistant Director of Nursing and Nurse Managers have conducted observational audits of residents in bed, with a focus on whether the bed is pushed against the wall. This was completed on 6/21/24.

The Director of Nursing, Assistant Director of Nursing and Nurse Managers have conducted staff interviews of five current nursing employees for validation of ability to identify that placing the bed against the wall as a behavior management intervention is a restraint and the required actions to complete prior to initiation of placing a bed against the wall. This was completed on 6/21/24.

The facility alleges credible allegation of immediate jeopardy removal June 22, 2024. The LNHA is responsible to implement the plan.

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F 726	Continued From page 44 An onsite validation of the immediate jeopardy removal plan was completed on 6/26/24. A review of Nurse #1's education on the restraint and abuse policy was confirmed to be completed. A review of the DON's education on the restraint and abuse policy and addressing resident's attempts to get out of bed was confirmed as completed. Staff were interviewed to validate in-services were completed on restraint, abuse and behavioral policy to include pushing a bed against the wall was a restraint. This education will also be provided to new nursing staff during orientation. A review of the audits of residents in bed with a bed against the wall were confirmed to be completed. The Immediate Jeopardy removal was validated as removed on 6/22/24.	F 726		