**F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES**

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

**Intakes:** TNO0032765

Based on review of the facility's investigation of the incident, medical record review and interview, it was determined the facility failed to provide two person assistance for transfer and bed mobility to prevent accidents for 1 of 5 (Resident #1) sampled residents. The failure to provide two person assistance for Resident #1 resulted in actual harm when resident fell from the bed and sustained a displaced oblique fracture through the left proximal fibula and a suspected nondisplaced chip fracture through the posterior lateral tibia.

The findings included:

Review of the facility's investigation revealed an "Employee Statement of Incident" completed by Certified Nursing Assistant (CNA) #1, dated 9/5/13 documented, "...I was turning the patient [Resident #1] towards me (right side) to pull her gown down a little after I had transferred her to the bed. When I turned her over towards me all of her weight shifted on to me. I was unable to get the patient back into the bed with it moving. The mattress overlay on Resident #1's bed was removed on September 05, 2013. The nursing staff continued to provide supervision and bed mobility assistance consistent with Resident #1’s needs, goals, and plan of care, and the current standards of practice, until discharge on September 20, 2013.

We promptly determined that no other resident had a mattress overlay. Overseen by the Director of Nursing, we have determined that no similar mattress overlay will be utilized in the facility. Overseen by the DON, in-service training will be conducted for all Certified Nursing Assistants and Licensed Nurses regarding their role in providing adequate supervision and bed mobility assistance, consistent with the residents' needs, goals, and plans of care, and the current standards of practice. This will be completed by December 14, 2013.

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**LABORATORY DIRECTORS OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE**

**DATE**
patient fell onto me and slipped past me onto the floor in between the night stand and the bed... A statement by Nurse #1 documented, "Incident 9/5/13... CNA [#1] interviewed following pt [patient] incident. CNA [#1] stated as she was turning pt and repositioning gown and removing sling [Hoyer lift sling] the pt started to slide with the mattress overlay. Siderail was in the down position on the side CNA [#1] was working. CNA [#1] attempted to reposition pt back onto bed, but was unable. CNA [#1] stated the bed was locked, but the bed gaveway. I [Nurse #1] also checked bed following incident and lock was engaged..."


Review of a hospital emergency room "Final Report" dated 9/5/13 documented, "...Fall... Associated Diagnoses... Head injury... Hematoma of scalp... Contusion of the upper arm... Contusion of the knee... Closed fracture of the..."
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fibula... History of Present Illness: The patient presents following fell during transfer to bed at nursing home... Radiology results... 1. Displaced oblique fracture through the LEFT proximal fibula. 2. Suspected additional nondisplaced chip fracture through the posterior lateral tibia..."

During a telephone interview in the Social Service's office on 11/20/13 at 11:35 AM, CNA #1 stated, "...I don’t want to speak about this. I gave my statement [CNA #1’s statement of the incident] and that’s what happened. I’m not answering any questions." Then CNA #1 hung up on the surveyor.

During a telephone interview in the Social Service's office on 11/20/13 at 12:00 PM, Nurse #8 stated, "...I heard [CNA #1's name] yelling for me and [CNA #2's name] yelling down the hall for me. I saw [Resident #1's name] in [on] the floor... [CNA #1] told me when she went to adjust her the mattress slid and patient ended in the floor..."

During a telephone interview in the state office on 11/21/13 at 11:20 AM, CNA #2 stated, "...I was in the hall taking linens when she [CNA #1] called me into the room. The patient was facedown in [on] the floor. She [CNA #1] had just put the patient [Resident #1] to bed. The lift was in the room... She [Resident #1] was a two person assist, two CNAs or a CNA and nurse to transfer, change or reposision the patient.

The failure of the facility to provide two person assistance for Resident #1 resulted in actual harm when resident fell from the bed and sustained a displaced oblique fracture through the left proximal fibula and a suspected nondisplaced chip fracture through the posterior..."
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