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	045390	A. BUILDING _____ B. WING _____	C 04/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VALLEY NURSING & REHABILITATION	12111 HINSON RD LITTLE ROCK, AR 72212

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F 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. Complaint #20903 (AR 00019153) was substantiated, all or in part, with a deficiency cited at F323.	F 000		
F 323 SS=K	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: Complaint #20903 (AR 00019153) was substantiated, all or in part, in these findings. Based on observation, record review, and	F 323		

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

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interview, the facility failed to ensure the environment was free of accident hazards as evidenced by the facility's failure to thoroughly assess entrapment risks when side rails were placed on beds with low air loss mattresses and adequate supervision was provided in monitoring for gaps between side rails and mattresses for 3 of 3 (Resident #1, 2 and 5) case mix residents who used a low air loss mattress and side rails. This failed practice resulted in Immediate Jeopardy which caused or could have caused harm, injury or death to Resident #1 who was found with her head lodged between the side rails and low air mattress and did not have any vital signs, and placed Resident #2 and #5 at risk for entrapment due to gaps between the side rails and low air mattress. This failed practice had the potential to affect 5 residents who had side rails/assist bars according to the Nurse Consultant on 4/12/16. The Administrator was informed of the Immediate Jeopardy on 4/12/16 at 12:20 p.m. The findings are:

1. The Invacare Manufacturer's Operating Instructions for the Half Bed Rails were received from the Administrator on 4/12/16 at 8:25 a..m. The Operating Instructions documented, "...Replacement mattresses and bed rails with dimensions different than the original equipment supplied or specified by the bed manufacturer may not be interchangeable. Variations in bed side rail design, thickness, size or density of the mattress could cause entrapment. Use only authorized Invacare replacement parts...."

The Liberty Series Section B: Assist Devices Optional Assist Bar Installation - Head End Only (received from the Administrator) documented, "...Warning when assessing the Risk of

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Entrapment, consider the bed, mattress, headboard, footboard, assist devices (i.e. rails and assist bars) and other accessories as an entire system. All bed systems are evaluated for full compliance to the FDA/CDRH 'Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment' guidelines..."

The User's Manual for the Supra CXC Low Air Loss and Alternating Pressure Release Mattress Replacement System did not address the use of side rails in conjunction with the air loss mattress.

The Bed Entrapment Zones received from the Administrator on 4/12/16 documented, "...Zone 4 Under the Rail at the Ends of the Rail. The gap between the mattress and the lowermost portion of the rail presents risk of neck entrapment. *Recommended space: less than 2 3/8 inch...."

2. Resident #1 had diagnoses of Hailey/Hailey Skin Disorder, Dementia with Behaviors, and Cerebrovascular Disease. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/22/16 documented the resident scored 6 (0-7 indicates cognitively impaired) on the Brief Interview for Mental Status, required extensive assistance of two or more people for bed mobility, and bed rails were not used as a restraint.

a. The Care Plan documented, "Problem Onset: 8/31/15 - I utilize 1/2 rails to aid with turning and repositioning to help define boundaries and help me feel secure and comfortable with bed environment. Approaches: Check 1/2 rails as needed to ensure good working order. Evaluate quarterly and as needed for appropriateness and need. Educate me/family as needed on potential

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injuries r/t [relate to] usage. Notify maintenance as needed of any loose fitting or malfunctioning rails for repair."

b. The April 2016 Physician's Orders documented, "9/23/15 - Low Air Loss Mattress, 11/24/15 - Floor Mat, 11/5/14 - S/R [Side rail] to bed to facilitate with positioning and bed mobility."

c. The I/A [Incident and Accident] Report dated 11/24/15 at 7:00 a.m. documented, "This nurse called to resident room, observed resident sitting on floor w [with]/back to bed w/right arm on bed rail asked resident what happened? Resident stated, I fell out of bed, assessed resident from head to toe no injury found at this time, this nurse and CNA [Certified Nursing Assistant] assisted resident back into bed resident denies pain at this time."

d. The Side Rail Assessment dated 1/18/16 documented the question, "Does the resident have a history of falls?" The Evaluation sheet documented no.

e. The DMS (Division of Medical Services)-762, Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property & (and) Exploitation of Residents in Long Term Care Facilities, dated 3/25/16 at 5:00 a.m. documented, "[Resident #1] was found unresponsive in room at approximately 5 a.m. by CNA staff members [CNA #1 and CNA #2] who immediately notified charge nurse [LPN #1]. [LPN #1] initiated CPR [Cardiopulmonary Resuscitation]. EMS [Emergency Medical Services] contacted [Ambulance Services], Police and Fire/Rescue responded. EMS, discontinued CPR and Coroner was contacted by Police.

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[Resident #1] body was released to funeral home. Incident reported to Administrator/DON [Director of Nursing] resident was found positioned with knees on floor mat and head resting against mattress and chin pointed toward rail. Full investigation was conducted and completed on 3/28/16. CNA and LPN stated reenactment of incident. Incident reenactment was conducted by DON, Administrator and Staff. Charge Nurse [LPN #1] reports that [Resident #1] was not wedged and they simply moved her to a supine position to perform CPR. Charge Nurse [LPN #1] reported there were no visible markings on resident to indicate there was entrapment. Resident had low air loss mattress on bed and padded rail and fall mat beside bed with bed in low position. Findings indicate resident may have pulled herself to side of bed due to possible distress and collapsed, slid to knees with head resting against mattress and chin pointed toward side rail. Facility was notified by Coroner on 4/5/16 that private autopsy was requested by family for questionable cause of death. Facility is reporting incident at this time due to preliminary autopsy reading postural asphyxiation. Coroner will return on 4/12/16 to conduct investigation with staff to help determine cause of death."

1) A witness statement dated 3/25/16 at 5:00 a.m. written by CNA #2 documented, "At 5 am went into resident's room with another CNA and saw Bed "B" [Resident #1's] head caught between the upper bed rail and mattress. Resident was half on floor mat from waist down, and head caught in rail."

On 4/12/16 at 9:26 a.m., CNA #2 stated, "[Resident #1] could not move her right arm. She required two people to assist her with care

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because she can be combative at times. She could not roll herself over in bed, it took two people to turn her. She used a wedge for repositioning. If you didn't have the bed up just right she would move when she scratched if the head of the bed was too high. She would lean to the left toward the wall. She was total care with bed mobility, confused, and a mat was on floor. ...at that time of the incident, [CNA #1] called me in the room. I was shocked how her head and neck was between the rail and the mattress. Her body was limp. That night I was on another hall. I'm usually down there but that night [CNA #1] was down there. When I work with [Resident #1], I've not noticed any problem with the side rail or the air mattress. I had never noticed gaps or side rails being loose." CNA #2 was asked if she had attended or had been trained on monitoring for gaps in the side rails or entrapment zones between the side rail and the air mattress and CNA #2 stated, "No,"

2) A witness statement dated 3/25/16 at 5:00 a.m. written by CNA #1 documented, "At the start of my shift I did rounds to check on everybody about 11:15 residents were fine and sleeping. At 1:30 a.m., I changed [Resident #1] she went back to sleep after. Every time I went pass I looked in on her. I did another round at 3:30 a.m. When I went back at 5 a.m. I found her on the floor with her head on the side rail with rest of her body on the mat. I called for the nurse to come."

On 4/12/16 at 10:15 a.m., CNA #1 stated, "We did everything for her. She would move around a little bit in bed. Some times she would tilt over if the head of the bed was elevated to high. She would wiggle down, we would have to pull her back up. We have never caught her with her leg

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off of the bed. But I'm sure if she had time to wiggle that much I'm sure she could." CNA #1 stated that the staff did the majority of the turning and repositioning. CNA #1 stated, "I had been up and down the hall all night. Between 3:15 a.m. and 3:20 a.m., I had checked on the hall and [Resident #1] had been asleep all night. At 5:00 a.m., I went down to get her up, she was on the floor. She wasn't moving. I called [LPN #1], he came immediately. [LPN #1] told me to call 911. I left." CNA #1 was asked if she could remember whether or not there was anything wrong with the side rail such as being too loose, gaps between the side rail and air mattress and CNA #1 stated, "It never crossed my mind. But now I would be more conscious of that." She was asked if she had attended or had been trained on monitoring for gaps in the side rails or entrapment zones between the side rail and the air mattress and CNA #1 stated, "No,"

f. The nurse's notes dated 3/25/16 at 7:53 a.m. and written by LPN #1 documented, "at 5:00 am on 3/25/16 [CNA #1] requested this [LPN #1] to assess resident. As I entered the room, [Resident #1] was off her knees on her fall mat and head resting on the side of bed, chin resting on side rail. Resident was non responsive, slight blue colored skin around the lips, slightly cool to touch, Repositioned resident to her back, assessed for pulse and tried a sternal rub with no response. Around this time [CNA #2] and [LPN #2] entered the room. I called out to call 911, [LPN #2] repeated order and [LPN #2] called for the crash cart. I started chest compressions, when the cart arrived the ambu bag and oxygen were hooked up. CPR continued between the three of us, still not getting pulse. When EMS, Fire, and Police arrived, I briefly explained

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situation, working with responders the residents chart was checked and identified resident as a DNR [do not resuscitate]. At this point, emergency response stopped..."

On 4/12/16 at 10:42 a.m., LPN #1 stated, "When the CNAs notified me to come to [Resident #1's] room I didn't dislodge her [from between the mattress and side rail], there was no problem getting her on her back." LPN #1 also stated that he had worked twice since the incident on 3/25/16 and there had been no inservicing regarding identifying entrapment zones or gaps between the mattress and side rails.

g. On 4/11/16 at 6:20 a.m., CNA #3 stated Resident #1 could not reposition herself in the bed. "We always had two people with bed mobility." CNA #3 was asked if Resident #1 had side rails and CNA #3 stated, "Yes, we had written in the maintenance log they had been loose at one point." CNA #3 was asked if Resident #1 needed the side rails and she stated, "Yes and no. She would not use them herself to reposition. She would maybe grab to hold when we turned her." The morning the incident happened [3/25/16]afterward me and another CNA went back into the room. The bed was at it lowest position. You know the side rails are straight up and down. Well, her side rail was loose. It concerned me. You could just tell it, you could pull on it a little bit." The maintenance log was reviewed and no maintenance request were found for loose side rails.

h. On 4/11/16 at 10:16 a.m., the Maintenance Supervisor stated he looked at the side rail after the incident and stated it looked like a typical side rail. He also stated, "I don't think that anyone had

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messed with the bed or the side rail and no one had reported any issues with the side rail not working properly." The Maintenance Supervisor stated he had not been told to monitor the side rails on a routine basis for proper functioning or entrapment zones. He stated the mattress Resident #1 was using at the time was rented, so it did not come with the bed. The Maintenance Supervisor stated he only checked the rooms over when residents were moved out of the rooms. He stated, "I have a checklist I go by." The checklist did not specifically list side rail functioning, or monitoring gaps between mattresses with side rails.

i. On 4/11/16 at 6:56 a.m., Licensed Practical Nurse (LPN) #3 stated she was off that night (3/25/16). She stated, "[Resident #1] was total care. She had a bad rash that scratched to the point you could see blood under her fingernails. When she was in the bed she didn't move much. She leaned to the left side more. She has fallen out of the bed before. It's been about 2 months ago. [Resident #1] had side rails. The bed was up against the wall and had one side rail in use on the right side." LPN #3 was asked if Resident #1 could use the side rails and LPN #3 stated, "No, I never seen that. I am not sure she could grab the side rail. She would try to move to turn from side to side." LPN #3 stated she had not been inserviced on identifying and monitoring beds with siderails for entrapment zones.

j. On 4/11/16 at 8:32 a.m., CNA #4 stated he occasionally took care of Resident #1. CNA #4 stated, "[Resident #1] was confused at times, incontinent, and was total care. Staff had to reposition her in bed, help her roll over. She could not reposition herself. She wasn't aware of

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her movements. She had a real bad skin disease. She would scratch frequently. Her scratching a lot would cause her to wiggle and move about somewhat in bed. We would have to reposition her. She had small rails." He was asked if the resident used the rail at all and CNA #4 stated, "Sometimes she was able to use the rail, we would have to que her to hold it. I just know that when I have repositioned her. I would leave and come back and see that she is in a different position. I've had to reposition her because her legs were hanging on the side, looked like she was going to fall out of the bed." The CNA was asked, "Did you ever notice gaps between the mattress and side rail?" CNA #4 stated, "No." The CNA was asked, "Did she use the side rail as a restraint?" CNA #4 stated, "I don't think they were used as a restraint. I don't think the side rail was used to keep her in bed." He was asked why were the side rails in use and CNA #4 stated, "Well, I guess they were then [used as a restraint]. They were used to keep her safe."

k. On 4/11/16 at 8:51 a. m., CNA #5 stated, "[Resident #1] pulled onto the rail. She would help if she wasn't in her way like having anxiety, combative or calling names. But it was related to her pain from the skin disease she had. The side rails were not used as a restraint. I assume they were used to help her roll. To my knowledge there was no issue with the side rail. She would wiggle herself down lower than the side rail. She would wiggle herself down and lean toward the right side of bed. Her head would be leaning against the rail sometimes."

l. On 4/11/16 at 9:11 a.m., CNA #6 stated, "I helped assist with [Resident #1] from time to

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time. When it came to scratching she would scratch so bad. She would wiggle so much to get to the areas to scratch, she would not be aware she was scooting about in the bed. [Resident #1] would need two people to help reposition her in bed... We would reposition her and leave then come back 20 minutes later she had wiggled down in the bed. We had to reposition her again."

m. On 4/11/16 at 11:35 a.m., CNA #7 stated, "I took care of [Resident #1]. She was total care and scratched a lot. Because of her scratching, she would be agitated... she couldn't move really. She needed us to adjust her in bed. ...she did have side rails." CNA #7 was asked why she had side rails and he stated, "I don't know, maybe just in case to prevent her from falling. She only used her hand to scratch with that's about it." He stated that he had no idea why the side rail was up because she never used them to pull over with." CNA #7 was asked if he had attended any training or inservices since the incident [3/25/16] regarding monitoring gaps in side rails or identifying entrapment zones between the mattress and side rails and he stated, "No, the next day I came to work, there were no more side rails in the building."

n. On 4/12/16 at 11:05 a.m., the Coroner stated, "We initially weren't told of any of this, that there were any problems. If we had known there was any question or concern surrounding the death, we would have done an investigation right then, but then [physician who conducted the autopsy] called me. He said I need to turn this case back over to you. Apparently someone tipped the family off that the resident was found hanging and died. The family hired [Doctor] for a private

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autopsy and he told me he found something in the autopsy that would support this. His preliminary finding is Positional Asphyxia. Now, I will do my report and give it to him and he could change his findings, but right now he's leaning toward that because of what he found." The Coroner also stated that when interviewing [LPN #1, CNA #1 and CNA #3], "We got three totally different stories from the three employees."

o. On 4/12/16 at 2:43 p.m., the Administrator was asked, "Based on the staff interviews, staff indicated there was no inservice conducted after the incident occurred on 3/25/16. Has there not been a formal inservice to inform staff of the entrapment zones and monitoring gaps between the mattresses with side rails?" The Administrator stated, "It was not done. As far as entrapment zones, paperwork was not given out."

p. On 4/12/16 at 3:14 p.m., the Administrator provided the 2009 FDA [Food and Drug Administration] Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment documented, Zone 4 is defined as "This space is the gap that forms between the mattress compressed by the patient, and the lower most portion of the rail, at the end of the rail. Factors that may increase the gap size are: mattress compressibility, lateral shift of the mattress or rail, and degree of play from loosened rails. The space poses a risk for entrapment of a patient's neck. It may change with different rail height positions and as the head or foot sections of the bed are raised and lowered. The space may increase, decrease, become less accessible, or disappear entirely. Thus, in some positions, the potential for entrapment in this zone may still exist when the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VALLEY NURSING & REHABILITATION	12111 HINSON RD LITTLE ROCK, AR 72212

(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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deck is articulated."

q. The Coroner ' s Report prepared by the physician and faxed to the Office of Long Term Care on 4/19/16 documented, " This 68 year old white female died of positional asphyxia. Investigation of the circumstances of death revealed that the decedent was a patient at Pleasant Valley Nursing & Rehabilitation where, reportedly, she was wheelchair bound due to a remote cerebral aneurysm which resulted in a cerebral infarction. She was reportedly found with her head trapped between the upper bedrail and the mattress. ...Autopsy demonstrated petechial hemorrhage involving the face and left conjunctivae. Petechial hemorrhage were also present on the right hand and laryngeal mucosa. "

3. Resident #2 had diagnoses of Pain, Psychosis, and Dementia. The Quarterly MDS with an ARD of 4/1/16 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment of Mental Status, required extensive assistance from two or more staff for bed mobility, and side rails were not used as a physical restraint.

a. A Resident Incident Report dated 3/26/16 at 7:45 p.m. documented, "At 1945 [7:45 p.m.] CNA yelled out resident is on the floor, observed resident lying on the floor mat in fetal position on her left side beside her bed, alarm sounding..."

b. The Care Plan updated on 3/26/16 documented in the Problem section, "I am at risk for falls." The Approach section documented, "Fall mat... Low bed with assist rail... Bolsters added to air mattress 3/26/16."

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c. A Side Rail Evaluation dated 4/4/16 documented, "Evaluation Factors... Does the resident have fluctuations in levels of consciousness or a cognitive deficit? Yes... Is the resident able to get in/out of bed? Yes. Is the resident able to get out of bed safely? No. Does the resident have a history of falls? Yes. Is the resident having problems with balance or poor trunk control? Yes... Is there evidence (reason to believe) the resident has (or may have) a desire or reason to get out of bed? Yes... Is there a risk to the resident if side rails are used? No. Do the side rail alternative/interventions create more risks than side rail use? No.... Based off of Summary Findings: Side Rails - none. Half Rails - None."

d. On 4/11/16 at 10:40 a.m., the resident was in bed curled up in a fetal position. The resident was on a low air loss mattress with winged sides (bolster mattress) and a padded assist bar was on the right side of the bed. There was a gap between the air mattress and the assist bar.

e. On 4/12/16 at 9:30 a.m., the resident was in bed curled up in a fetal position. The resident was on a low air loss mattress with winged sides and a padded assist bar was on the right side of the bed. A gap was between the air mattress and assist bar. When the surveyor mashed down on the side of the mattress, the gap became much larger.

f. On 4/12/16 at 9:45 a.m., CNA #2 was asked if the resident could move about on her own in bed. She stated, "Yes. She can come out of the bed."

g. On 4/12/16 at 10:13 a.m., CNA #1 was asked

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if the resident could move about on her own in bed. She stated, "Yes. A lot."

h. On 4/12/16 at 2:00 p.m., the Maintenance Director measured the gap between the mattress and assist rail as approximately 1 1/2 inches. When pressure was put on the edge of the mattress, the gap size increased to 5 inches.

4. Resident #5 had diagnoses of Post Traumatic Seizures, Dementia, and Anxiety Disorder. The Quarterly MDS with an ARD of 2/15/16 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment of Mental Status, was totally dependent with two or more staff for bed mobility, and side rails were not used as a physical restraint.

a. A Side Rail Evaluation dated 3/29/16 documented, "Evaluation Factors... Does the resident have fluctuations in levels of consciousness or cognitive deficit? Yes... Do the side rail alternative/interventions create more risks than side rail use? No... Based off of Summary Findings: Side Rails - none. Half Rails - none."

b. On 4/11/16 at 8:41 a.m., 10:45 a.m., and on 4/12/16 at 8:35 a.m., there was a gap between the air mattress and assist rail.

c. On 4/12/16 at 9:45 a.m., CNA #2 was asked if the resident could move about on her own in bed. She stated, "Yes, she can scoot. We have to reposition her in bed all the time."

d. On 4/12/16 at 10:13 a.m., CNA #1 was asked if the resident could move about on her own in

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bed. She stated, "Oh yeah. She will surprise you."

e. On 4/12/16 at 11:35 a.m., the Maintenance Director measured the gap between the air mattress and assist rail as approximately 5 inches. When pressure was put on the edge of the mattress, the gap size increased to approximately 7 1/2 inches.

5. On 4/12/16 the Immediate Jeopardy was removed and the scope/severity reduced to "H" when the facility implemented the following plan of removal:

1) On 4/12/16 at 12:45 p.m. and ending at 1:45 p.m. on 4/12/16 - All residents with side rails will be identified by observation by Director of Nursing or Designee.

2) On 4/12/16 at 12:45 p.m. and ending at 1:45 p.m. on 4/12/16 - All residents with side rails were assessed for need of side rails and entrapment zones by Director of Nursing or Designee and any negative findings were corrected immediately.

3) On 4/12/16 at starting at 12:45 p.m. and ending at 1:45 p.m. - All beds in facility were assessed for entrapment for the seven entrapment zones and the proper dimensions for each any negative findings were corrected immediately.

4) On 4/12/16 at 12:45 p.m. and ending at 1:45 p.m. on 4/12/16 - An in-service was conducted for clinical department head staff, by Administrator on proper side rail assessments to include determining the need for rails and entrapment zones to include the 7 entrapment zones and

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F 323	Continued From page 16 proper dimensions to prevent entrapment. 5) On 4/12/16 starting at 1:50 p.m. an in-service was conducted by QA (Quality Assurance) Nurse or designee to all direct care staff on proper side rail assessments and the seven entrapment zones and proper dimensions for each to prevent possible entrapments. No direct care employee will be allowed to return to work until inservice is complete. 6) Starting on 4/12/16 monitoring will be conducted by DON or designee to ensure that all beds are free from entrapment zones and side rail assessments are completed to ensure need for side rail. Five beds a day will be assessed five times a week until compliance is determined by OLTC (Office of Long Term Care).	F 323		