

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/21/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045259</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/09/2006</b>
NAME OF PROVIDER OR SUPPLIER  <b>WOODLAND HILLS HEALTHCARE AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8701 RILEY DRIVE</b> <b>LITTLE ROCK, AR 72205</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 221 SS=E	<p>483.13(a) PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #11533 was substantiated (all or in part) with these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure assessments were completed with the involvement of the interdisciplinary team (IDT) to determine if restraint use was appropriate and to determine the least restrictive restraint device that should be implemented for 2 of 2 case mix residents with enclosed beds in use (Residents #1 and #5). The facility also failed to ensure the Plans of Care for Residents #1 and #5 included specific interventions for the safe utilization of the enclosed beds. The failed practices had the potential to affect 5 residents with enclosed beds in use, as documented on a restraint list provided by the Director of Nursing (DON) on 3/9/06. The findings are:</p> <p>1. Resident #1 had diagnoses of Liver Insufficiency, Cerebrovascular Accident, Insomnia and Depression. The Minimum Data Set (MDS)</p>	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1  dated 11/4/05 documented the resident was moderately impaired in cognitive skills for daily decision-making, had no behavioral problems, had reduced social interaction, was totally dependent on the assistance of two or more persons for physical assistance with transfers, had partial loss of range of motion in one arm, hand, leg and foot, had experienced a deterioration in her ability to perform the activities of daily living, had full side rails in use and fell and sustained a fracture in the past 31 to 180 days.  a. Physician's Telephone Orders dated 11/7/05 documented: "personal enclosure bed."  b. The Plan of Care dated 10/12/05 documented: "Physical Restraint Use/Gerichair... Approach: ...Side rails up when in bed for safety and mobility..." A handwritten revision to this care plan documented: "11/7/05 Personal Enclosure Bed. Approach: Personal Enclosure bed to increase safety..." There were no specific interventions regarding the proper assembly and safe use of the enclosure bed.  c. The Physical Restraint Consent dated 11/18/05 documented: "Restraint Type - Personal Enclosure Bed... Reason - Prevent falls & [and] Safety..." The sections of the form designated for documentation of whether a physician order was obtained, PT/OT and Interdisciplinary Team Documentation, Care Plan Documentation and other methods tried and documented had not been completed as of 3/8/06. This document had been signed by the resident's legal guardian on 11/18/05.  d. A Fall Risk Assessment dated 11/28/05	F 221		

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F 221	<p>Continued From page 2</p> <p>documented the resident's fall risk score as, "16," with a score of 10 or above representing a high risk for falls.</p> <p>e. The Occupational Therapy Consult Form dated 1/25/06 documented: "Impressions - OT recommends personal enclosure bed secondary to risk for crawling OOB..." This was a period of over 2 months after the physician ordered the enclosed bed for this resident.</p> <p>f. A Fall Risk Assessment dated 2/25/06 documented the resident's fall risk score as "15," with a score of 10 or above representing the resident was at high risk for falls.</p> <p>g. On 3/08/06 at 10:30 a.m., the resident was observed in an SNI enclosure bed. The right bottom tube frame assembly was on the floor, unattached from the other portions of the bed frame. The tubing portal to the bed enclosure was zipped in a closed position. The tube feeding tubing entered the enclosure through a care provision portal that was unzipped approximately 6 inches. At 10:38 a.m., the Assistant Director of Nursing (ADON) was asked if an interdisciplinary evaluation had been completed to determine Resident #1's need for an enclosed bed. The ADON stated there was no evaluation for the bed enclosure and no interdisciplinary meeting that included all disciplines.</p> <p>h. On 3/8/06 at 1:15 p.m., the Licensed Physical Therapy Assistant (LPTA) stated she screened the resident on the same date as the Occupational Therapist but did not recommend the enclosure bed because the Occupational Therapist already had. She stated she did feel that the resident needed the bed. When asked</p>	F 221			

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F 221	<p>Continued From page 3</p> <p>what interventions the LPTA and OT recommended as the least restrictive intervention prior to the enclosure bed, the LPTA stated, "A personal alarm on 8/19/05." The Occupational Therapist and the LPTA both agreed it was, "a big jump" to progress from the personal alarm to the use of an enclosed bed. When asked if he had evaluated the resident for the initiation of the enclosed bed, the Occupational Therapist stated, "...guess not. I can't find where I did a screen on her." He stated he had no documentation to indicate that he was involved in the initial decision to implement use of an enclosed bed for this resident.</p> <p>i. On 3/8/06 at 1:32 p.m., the Director of Nursing (DON) stated the facility obtained recommendations from the therapy disciplines or at times, the Nurses would do a pre-restraining assessment then inform therapy of which interventions were implemented. The DON stated the Pre-Restraining Assessment was completed on admission. When asked if the interdisciplinary team met to discuss evaluations for the use of restraints, the DON stated, "We don't." She stated she had never followed through on the assessment forms and did not remember filling one out. The DON stated Resident #1 had a tube feeding and low bed at the end of August 2005 and had rolled off of the low bed and onto the mat. She stated there was a concern that the resident would pull the tube feeding pump over on top of her. The DON stated there was no interdisciplinary team meeting related to Resident #1 being placed in an enclosed bed.</p> <p>2. Resident #5 had diagnoses of Dementia, Orthostatic Hypotension and Osteoarthritis. The</p>	F 221			

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F 221	<p>Continued From page 4</p> <p>Admission Minimum Data Set dated 2/13/06 documented the resident had modified independence in cognitive skills for daily decision-making, usually understood others and was understood by others, exhibited varying mental function over the course of the day, was totally dependent on 2 or more persons for physical assistance with transfers, had full bed rails in use daily, used bedrails for bed mobility and transfers, was incontinent of bowel and bladder and received antidepressant medications and Occupational and Physical Therapy.</p> <p>a. The Medicare Assessment Narrative Notes dated 2/15/06 at 1:40 a.m. documented: "Summoned to rm [room] via CNA [Certified Nursing Assistant], found pt. [patient] on floor by bedside by bedside commode. Denies injuries. Able to stand [without] probs. [problems]. Full ROM [range of motion] to extremities. Is up in w/c [wheelchair] at this time."</p> <p>b. The Communication Form dated 2/15/06 documented: " Recommendations - recommend pt to have bed alarm to alert staff of unassisted transfers from bed." The form was signed and dated by the Licensed Physical Therapy Assistant.</p> <p>c. The Medicare Assessment Narrative Notes dated 2/16/05 on the 11:00 p.m. to 7:00 a.m. shift documented: "In bed at start of shift, pt was trying to get out of bed &amp; [and] had legs already up on SR [side rail]. Put in w/c for now to keep from falling."</p> <p>d. The Medicare Assessment Narrative Notes dated 2/16/06 at 9:30 p.m. documented: "up in w/c over foot of bed. R [Resident] refused to</p>	F 221			

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F 221	Continued From page 5 allow staff to put him in bed or when put him to bed he gets up in chair."  e. The Medicare Assessment Narrative Notes dated 2/17/06 at 2:50 a.m. documented: "found pt on floor in room... Lifted into w/c by staff. No injuries noted. No comp. [complaints] voiced. [Physician] paged to report fall. Daughter... called to inform. Isn't wanting her Dad in low bed. Will advise DON [Director of Nursing]."  f. The Medicare Assessment Narrative Notes dated 2/17/06 on the 7:00 a.m. to 3:00 p.m. shift documented: "N.O. [New order] personal enclosure to decrease getting OOB [out of bed] [without] assist [assistance]... Consent personal enclosure signed by ...daughter, therapy today."  g. The Communication Form dated 2/17/06 documented: "Recommendations - recommends personal enclosure bed... Comments - Family does not want to have low bed per nursing." The form was signed and dated by the Licensed Physical Therapy Assistant.  h. A physician order dated 2/17/06 documented: "...personal enclosure bed to increase safety." The order did not document the medical symptom that necessitated the use of the personal enclosure bed. The March 2006 Standardized Physician Orders also documented the physician order for a personal enclosure bed, but did not document a medical symptom that necessitated the use of the bed.  i. The Physical Restraint Consent for the use of an enclosed bed restraint was signed and dated by the resident's daughter on 2/17/06. There was no documentation on the Physical Restraint	F 221			

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F 221	Continued From page 6  Consent, in the Nurses' Notes or elsewhere in the clinical record that the resident and his daughter were informed of the specific risks and benefits of using an enclosure bed restraint. The sections of the consent form designated for documentation of less restrictive alternatives that had been attempted and medical symptoms that necessitated the use of the bed enclosure had not been completed as of 3/9/06.  j. The Pre-Restraining Assessment in the resident's clinical record was not dated. The section of the Assessment form designated for documentation of Referrals and Recommendations, Interdisciplinary Team Evaluation, Psychology or Psychiatry Referrals and Occupational Therapy Evaluations had not been completed as of 3/8/06.  k. The Resident Plan of Care dated 2/17/06 documented: "...personal enclosure bed PT [Physical Therapy] screen." There were no specific interventions regarding the proper assembly and safe use of the enclosure bed.  l. On 3/8/06 at 3:20 p.m., the Director of Nursing (DON) accompanied the Surveyor to the resident's room. The resident was positioned on his left side inside the bed enclosure. The zippers on both sides of the bed were zipped from the top of the bed and met on the middle bottom of the bed. The DON stated the bed was zipped incorrectly and that the zippers should meet at the middle top of the bed.	F 221			
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS  The services provided or arranged by the facility	F 282			

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F 282	Continued From page 7  must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by:  Based on record review and interview, the facility failed to ensure the physician's plan of care was implemented for 1 of 1 case mix resident with a physician order for an Orthopedic Consultation (Resident #1), as evidenced by failure to ensure the Orthopedic Consultation was provided. The failed practice had the potential to affect 49 residents with physician orders, as documented on the Roster/Sample Matrix dated 3/8/06. The findings are:  Resident #1 had diagnoses of Cerebrovascular Accident, Dysphagia and Insomnia. The Minimum Data Set dated 11/4/05 documented the resident was moderately impaired in cognitive skills for daily decision-making, totally dependent on the assistance of two or more persons for physical assistance with transfers, had partial loss of range of motion in one arm, hand, leg and foot, had experienced a deterioration in the ability to perform activities of daily living and had fallen and sustained a fracture in the past 31 to 180 days.  a. Nurses' Notes dated 2/25/06 at 7:50 a.m. documented: "Noted resd [resident] right wrist to be swollen + [and] tender to touch... New orders to send to [Hospital] ER [emergency room] for right wrist x-ray..."  b. Nurses' Notes dated 2/25/06 at 9:30 a.m. documented: "[Ambulance Service] here to transport to [Hospital] ER for right wrist x-ray..."	F 282			

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F 282	Continued From page 8  c. Nurses' Notes dated 2/25/06 at 11:45 a.m. documented: "...ER called and stated resd is returning to facility [with] small displaced fx [fracture] to Rt [right] wrist and was splinted. May want to notify Dr [doctor] about getting a ortho consult next week."  d. A physician order dated 2/27/06 documented: "Be sure ortho [orthopedic] referral made [with] [Orthopedic Surgeon's name] or associate r/t [related to] R [right] wrist fx [fracture]."  e. A Geriatrics Progress Note documented by the resident's physician documented: "...recent fall & [and] ER [emergency room]visit [with]small displaced fx R [right] wrist that was splinted. Orders given for staff to consult orthopedist today..."  f. Nurses' Notes dated 2/27/06 at 2:50 p.m. documented: "...Call Ortho left message [with] [Orthopedic Surgeon's] nurse on voice mail. She states on machine it will be 24 hrs [hours] before she can get back [with] me..." No further Nurses' Notes regarding the physician-ordered Orthopedic Consultation were located in the resident's clinical record as of 3/9/06 at 8:00 a.m.  g. On 3/9/06 at 8:50 a.m., the Director of Nursing (DON) was asked about the physician order dated 2/27/06 for an Orthopedic Consultation. The DON stated the referral had not been made for the resident and that the resident had not been seen by an Orthopedic physician.	F 282			
F 323 SS=E	483.25(h)(1) ACCIDENTS  The facility must ensure that the resident	F 323			

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F 323	Continued From page 9 environment remains as free of accident hazards as is possible.  This REQUIREMENT is not met as evidenced by: Complaint #11533 was substantiated (all or in part) with these findings.  Based on observation, record review and interview, the facility failed to ensure the environment of 2 case mix residents was as free of potential accident hazards as possible, as evidenced by failure to obtain and follow the manufacturer's instructions for the safe installation and use of enclosed beds for 2 of 2 case mix residents with enclosed beds in use (Residents #1 and #5). The failed practice had the potential to affect 5 residents with enclosure beds in use, as documented on a restraint list provided by the Director of Nursing (DON) on 3/9/06. The findings are:  1. On 3/8/06, the Assistant Director of Nursing provided a copy of the Posey Bed Canopy Assembly Instructions. Page 10 of the instructions documented: "STEP 10: Make sure that all zippers are fully fastened and zipper handles are secured to the safety hooks... Note: putting safety hooks into the first hole of the zipper tab will prevent patients from opening the zipper from the inside." Page 13 documented: "Once a patient has been placed within the Posey Bed Canopy, make sure that... All zippers are fully closed and attached to their safety hooks."  2. The Instruction Manual for the SNI Acute Care Bed Enclosure Model #1100 documented: "Always Do - ...keep all four sides zipped... ask	F 323			

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F 323	Continued From page 10 for an inservice if not completely familiar with the device... Never... Leave patient in bed without complete closure and locking of the unit..."  3. Resident #1 had diagnoses of Liver Insufficiency, Cerebrovascular Accident and Insomnia. The Minimum Data Set (MDS) dated 11/4/05 documented the resident was moderately impaired in cognitive skills for daily decision-making, had no behavioral problems, was totally dependent on the assistance of two or more persons for physical assistance with transfers, had partial loss of range of motion in one arm, hand, leg and foot, had experienced a deterioration in the ability to perform activities of daily living, had full side rails in use daily and had fallen and sustained a fracture in the past 31 to 180 days.  a. Physician's Telephone Orders dated 11/7/05 documented: "Personal enclosure bed."  b. The Plan of Care dated 11/7/05 documented: "Physical Restraint Use... Personal Enclosure Bed to increase safety..."  c. An Incident/Accident Report dated 2/24/06 documented: "...found resident on floor next to wall beside Vail bed [with] peg [Percutaneous Endoscopic Gastrostomy] tube around her & [and] L [left] leg-calf & laying on R [right] arm & head - Foley cath [catheter] disconnected from Foley. ROM [range of motion] all extremities [without] grimacing - complete body audit - no lacerations, redness, bruising or nodules or hematomas found." The report also documented the physician was notified and the resident was transported to the Emergency Room for: "R [right] wrist eval [evaluation]."	F 323		

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F 323	Continued From page 11  d. Nurses' Notes dated 2/24/06 documented: "...found resident on floor next to wall side of bed with peg tube & foley bag tubing around her & left calf - her head on floor & leg in air & laying on R arm - Vail bed on that side was completely unzipped & SR [side rail] down R [resident] assessed on floor & then lifted to bed. ROM grimacing was done - complete audit - no broken areas bruising noted... able to move neck - no nodules or hematoma on head noted @ [at] this time-B/P [blood pressure] 149/84 - TPR [temperature, pulse, respirations] 99.6 90 - 20..."  e. A Witness Statement dated 2/24/06 at 11:50 p.m. and signed by Certified Nursing Assistant (CNA) #4 documented: "I witnessed [Resident #1] on the floor between the Vale bed and the wall. The Vale bed was unzipped and rail was down..."  f. A Witness Statement dated 2/24/06 at 12:00 a.m. and signed by Licensed Practical Nurse (LPN) #3 documented: "...found res [resident] on floor next to wall between Vail bed & wall - bed was unzipped on the bottom from F.O.B. [foot of bed] to H.O.B. [head of bed] but not the ends & SR [siderail] down..."  g. Nurses' Notes dated 2/25/06 at 11:45 a.m. documented: "...ER called and stated resd is returning to facility [with] small displaced fx [fracture] to Rt [right] wrist and was splinted..."  h. Geriatrics Progress Notes dated 2/27/06 and signed by the resident ' s physician documented: "...recent fall & ER [emergency room] visit [with] small displaced fx [fracture] R [right] wrist that was splinted. Orders given for staff to consult orthopedist today..."	F 323		

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F 323	Continued From page 12  i. On 3/8/06 at 10:30 a.m., the resident was in the enclosed bed with the right bottom tube frame assembly on the floor, unattached from the other portions of the bed frame. The tubing portal of the enclosure was zipped in a closed position. The tube feeding tubing entered the bed enclosure through the care provision portal which was unzipped approximately 6 inches.  j. On 3/8/06 at 12:51 p.m., the resident's bed was vacant. LPN #2 entered the bed enclosure and demonstrated that with a five-inch unzipped opening in the care provision portal, she could unzip the enclosure from inside by moving her hand in a back and forth motion. LPN #2 then exited the enclosure with the side rails in the down position at the lower third of the bed. She repeated the elopement process with the side rails in the up position, as they did not impede exiting from the lower third of the bed. This process was witnessed by the Assistant Director of Nursing and LPN #4.  k. On 3/8/06 at 1:00 p.m., LPN #4 stated she had administered medications to the resident via feeding tube that morning. She stated the enteral feeding tubing entered the bed enclosure through a six-inch opening in the care provision portal and that she left it that way when she exited the room. She stated, "I did not know that the bottom zippered area [tubing portal] was for tubing."  l. On 3/8/06 at 1:05 p.m., CNA #3, with the Director of Nursing and Assistant Director of Nursing in attendance, demonstrated how the resident's enteral feeding tubing was normally placed through the zippered area on the left side of the bed. This left a gap that was not zipped.	F 323			

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F 323	<p>Continued From page 13</p> <p>The CNA stated this was the first time she had noticed the bottom frame assembly bar on the floor, because she normally changed the resident and made the bed from the other side. Licensed Practical Nurse #2 entered the enclosure at this time and CNA #3 zipped the enclosure completely, leaving no gaps unzipped. LPN #2 attempted to unzip the enclosure from the inside and stated, "Nothing you can do - you can't get out if you're put in here right." Neither the Director of Nursing nor the Assistant Director of Nursing were aware that the short zippered area on the enclosure was for tubing.</p> <p>m. On 3/8/06 at 2:23 p.m., the Company Representative from the facility's Medical Equipment Vendor stated he had delivered the bed enclosure to the facility and assembled it. He stated he assembled the enclosure according to the assembly instructions, with the necessary pull pins to hold the bars in place. He stated intravenous (IV) tubing, enteral feeding tubing or urinary catheter extension tubing should be placed through the small zippered area below the care provision zippered enclosure area. He stated, "You don't unzip the other part because the patient can get out." He stated he inserviced approximately 3 aides when the bed was set up. He stated he did not leave an instruction manual because he had the technician's manual. He stated he was not called by the facility regarding the bar on the floor. He stated he did not leave any information about the bottom zipper being for tubing and was not asked before today.</p> <p>4. Resident #5 had diagnoses of Dementia, Orthostatic Hypotension and Osteoarthritis. The Admission Minimum Data Set dated 2/13/06 documented the resident had modified</p>	F 323			

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F 323	Continued From page 14  independence in cognitive skills for daily decision-making, usually understood others and was understood by others, had varying mental function over the course of the day, was totally dependent on 2 or more persons for physical assistance with transfers, had full bedrails in use daily and used the bed rails for bed mobility and transfers, was incontinent of bowel and bladder and received Occupational and Physical Therapy.  a. The Medicare Assessment Narrative Notes dated 2/15/06 at 1:40 a.m. documented: "Summoned to rm [room] via CNA [Certified Nursing Assistant], found pt. [patient] on floor by bedside by bedside commode. Denies injuries. Able to stand [without] probs. [problems]. Full ROM [range of motion] to extremities. Is up in w/c [wheelchair] at this time."  b. The Medicare Assessment Narrative Notes dated 2/17/06 at 2:50 a.m. documented: "found pt [patient] on floor in room... Lifted into w/c by staff. No injuries noted. No comp. [complaints] voiced. [Physician] paged to report fall. Daughter... called to inform. "  c. The Medicare Assessment Narrative Notes dated 2/17/06 on the 7:00 a.m. to 3:00 p.m. shift documented, "N.O. [New order] personal enclosure to decrease getting OOB [out of bed] [without] assist... Consent personal enclosure signed by... daughter, therapy today."  d. A physician order dated 2/17/06 documented: "personal enclosure bed to increase safety."  e. The Medicare Assessment Narrative Notes dated 2/21/06 on the 11:00 p.m. to 7:00 a.m. shift documented: "R [resident] opened personal	F 323			

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F 323	<p>Continued From page 15</p> <p>enclosure transferred to w/c [wheelchair] [without] assist [assistance], writer monitored activity standing in rm [room]. Attempt to redirect not to get up [without] calling. R then propelled self via w/c to BR [bathroom] transfer on &amp; [and] off commode. Will cont. [continue] to monitor. R remains up in w/c per his choice."</p> <p>f. The Medicare Assessment Narrative Notes dated 2/23/06 on the 3:00 p.m. to 11:00 p.m. shift documented: "noted R unzipping personal enclosure bed &amp; transferring self to w/c [without] assist, redirected &amp; explained why to call for assist prior to transferring to prevent falls."</p> <p>g. The Medicare Assessment Narrative Notes dated 2/25/06 on the 11:00 p.m. to 7:00 a.m. shift documented: "...in Vail bed but unzipped on 1 side d/t [due to] families request - no s/s [signs or symptoms] of problems - asleep."</p> <p>h. The Medicare Assessment Narrative Notes dated 2/26/06 on the 11:00 p.m. to 7:00 a.m. shift documented: "Recev'd [Received] in Vail bed asleep... no s/s of acute distress - Vail bed unzipped on 1 side - D/T [due to] family's request."</p> <p>i. On 3/8/06 at 3:20 p.m., the Director of Nursing accompanied the Surveyor to observe Resident #5 in the enclosure bed. The resident was lying on his left side. The zippers on both sides of the bed were zipped from the top of the bed (2 zippers started at the top of the bed) and met at the middle of the bottom of the bed. The Director of Nursing stated the bed was zipped incorrectly and should meet at the top of the middle of the bed. She rezipped the bed. The Assistant Director of Nursing entered the room and stated</p>	F 323			

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F 323	Continued From page 16 the staff had received an inservice on the beds.  j. On 3/9/06 at 8:04 a.m., the resident was sitting in a wheelchair with a self-releasing seat belt in place. The resident was asked about his bed. He stated the bed, " keeps me in. " The side of the enclosure closest to the resident was unzipped. The other side was zipped from the bottom up and the zippers met in the middle of the top of the bed. There were no fasteners engaged to prevent the bed from being opened from the inside.  k. On 3/9/06 at 8:08 a.m., CNA #1 demonstrated how to zip the bed enclosure. She zipped the bed from the top of the bed to the middle of the bottom and did not engage any of the fasteners to prevent the bed from being opened from the inside. The CNA stated she was inserviced the previous day on how to properly zip the bed enclosure.  l. On 3/9/06 at 8:13 a.m., LPN #1 stated she was inserviced by the bed company when the first Posey enclosure bed was brought to the facility. She zipped the open side of the resident's bed by pulling the bilateral zippers up to the middle top of the bed where they met. The LPN did not engage the fasteners to prevent the bed from being opened from the inside.  m. On 3/9/06 at 8:34 a.m., the Director of Nursing (DON) stated in May 2005, the facility had an inservice which included a video about different types of restraints. She stated the video did not include any specific details regarding the enclosure bed. She stated last year when the medical equipment supplier delivered the Posey enclosure bed to the facility, he inserviced the	F 323			

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F 323	Continued From page 17 staff. The DON stated the facility had not inserviced the staff regarding the enclosure beds. The DON stated the medical equipment supplier had demonstrated to her how the enclosure beds should be zipped. The DON and the Assistant DON (ADON) read pages 10 and 13 of the Posey Bed Canopy Assembly Instructions and both agreed they had never engaged the zippers in the safety fastener hooks as recommended in the instructions for use.  n. On 3/9/06 at 9:20 a.m., the DON stated she was going to inservice the staff on the instructions for the enclosure beds as soon as she obtained a copy from the Administrator. The facility did not have available for review a procedural manual for the utilization of the enclosure bed.	F 323			