STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185089	A. BUILDING _____ B. WING _____	C 10/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD HEALTH CARE CENTER	550 HIGH ST. BOWLING GREEN, KY 42101

(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 An abbreviated survey (KY #15419) was conducted on 10/06/10 through 10/08/10. The complaint was substantiated with deficiencies cited, with the highest Scope/Severity being a "G".	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT . ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225	F 225 N 110 Investigation of allegation of abuse for Resident #2 was completed by facility staff, OIG and DCBS. To identify other residents possibly affected, an audit of all grievances and event reports for the past 30 days was conducted to determine that appropriate agencies were notified of any allegations of abuse, mistreatment, including injuries of unknown origin. The procedure "responding to and investigating an abuse allegation" PRO 52002 states that the facility will report alleged abuse to the appropriate state agencies in accordance with state law. All staff has been in-serviced by Executive Director (ED), Director of Nursing (DNS), Weekend Supervisor (WS) and Unit Managers (UM), beginning 10-15-10, on requirements for reporting allegations of abuse, mistreatment, including injuries of unknown origin. After 10-15-10 staff will not be allowed to work until attending the	

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 225	Continued From page 1 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to ensure all alleged violations involving mistreatment, or abuse, including injuries of unknown source were reported immediately, for one resident (#2) in the selected sample of six, to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility failed to ensure the Abuse Policy had established procedures for the requirement to immediately report an abuse allegation. Furthermore, the facility failed to immediately report an abuse allegation made by Resident #2's spouse on 09/23/10 to the Department of Community Based Services (DCBS) and/the State survey and certification agency, OIG. The resident's spouse made the staff aware of the bruising on the front of Resident #2's upper left arm, left chest area and the outside of the left lower leg. The spouse also made staff aware that he/she thought the bruising to the chest area looked like a shoe print. On 09/26/10, the police entered the building to investigate the cause of the bruising, after receiving a report from the resident's spouse and on 09/26/10, the Department of Community Based Services (DCBS) entered the facility on 09/29/10 to investigate the cause of the bruising, after receiving a report from the police. However, the facility still failed to report the abuse allegation to	F 225	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* appropriate in-services. The Executive Director (ED) and Director of Nursing Services (DNS) were in-serviced on 10-15-10 by the Director of Operations on requirements for reporting allegations of abuse, mistreatment, including injuries of unknown origin. The ED and DNS will monitor all allegations of abuse and/or mistreatment, including injuries of unknown origin through review of the 24 hour report, discussion during morning meeting of events, any visits by any state agency or the police. The ED or DNS will notify the appropriate agencies in accordance with State law. ED reports related to notification of allegations of abuse, mistreatment, including injuries of unknown origin, will be monitored through the monthly Performance Improvement Committee (PIC) meeting.	10/16/10

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F 225	Continued From page 2 DCBS or the State survey and certification agency. Findings include: A review of the facility's Abuse policy and procedure, dated 10/31/09, revealed results of an alleged abuse investigation are reported to the Executive Director (Administrator) or their designee and to other officials in accordance with state law within five working days of the incident or in accordance with State law. Further review of the policy and procedure, revealed the facility's policy and procedure did not detail procedures to ensure that "all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property" are reported "immediately" to the Administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). A record review revealed Resident #2 was re-admitted to the facility on 05/03/10 with diagnoses to include Alzheimer's Dementia and Cerebral Vascular Accident (CVA). A review of Resident #2's quarterly Minimum Data Set (MDS) assessment, dated 08/02/10, revealed the facility assessed the resident's cognitive skills for daily decision making as moderately poor with poor decision making and cues and supervision required. A review of a nurse's progress note, dated 09/23/10 at 12:45 AM, revealed the resident was observed with purple bruising with yellow coloring around the bruise on the back of the left leg, a purple bruise with yellow coloring on the left upper chest to the armpit area and a purple bruise with yellow coloring on the left upper arm. The	F 225		

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F 225	Continued From page 3 resident was unable to tell staff the cause of the bruising. An interview with Resident #2's spouse, on 10/07/10 at 11:20 AM, revealed the spouse found the bruising on Resident #2 while visiting him/her on 09/23/10. The spouse informed the staff of the bruising and the spouse stated the Director of Nursing (DON) and other staff came in and assessed the resident. The spouse revealed they determined a Certified Nurse Aide (CNA) had seen the bruising the day before when he/she gave the resident a shower. The CNA stated she had reported it to the nurse, but the nurses denied the bruising was reported to them. The spouse told the DON the bruise on the resident's chest looked like a footprint. The spouse stated the more he/she thought about the bruising, the more upset he/she became so the spouse went to the police on 09/26/10. The police met the spouse at the facility, observed the bruising, talked to staff and the resident and told the spouse he would be reporting it to Social Services. A review of a Child Abuse, Adult Abuse, and Domestic Abuse Standard Report, dated 09/26/10 at 2:00 PM, revealed there was a physical abuse/neglect complaint made. The police report revealed the policeman went to the facility on 09/26/10. He observed and took pictures of the bruising on Resident #3. The report revealed he spoke with the Administrator and the Administrator advised him that the resident had fallen on one of the handrails in the bathroom. An observation conducted with Licensed Practical Nurse (LPN) #1 of Resident #2, on 10/07/10 at 12:55 PM, revealed there was no bruising on the	F 225		

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F 225	Continued From page 4	F 225		

resident's left arm. There was a small amount of fading purple bruising located on the resident's left chest area and two small fading purple bruises noted to the resident's left lower leg. An interview with the resident revealed he/she could not recall how he/she sustained the bruises or where it may have occurred.

An interview with the DON, on 10/07/10 at 10:20 AM, revealed she was made aware of Resident #2's bruising on 09/23/10. She stated Resident #2's spouse reported to her that he/she felt the bruising to the resident's chest looked like a shoe print, which made the spouse think it could be abuse. She stated they investigated the incident by interviewing the resident, the resident's roommate, other interviewable residents on the hall and staff, who had worked on that hall over the last week. Resident #2's roommate told them that Resident #2 had told him/her that he/she (Resident #2) had fallen in the bathroom. She stated they took Resident #2 in the bathroom and the resident was able to show them that he/she had fallen on the handrail by the toilet seat. The DON stated she did not report the allegation to the State agency. She said she was not sure if the allegation was reported by anyone at the facility.

An interview with the Administrator, on 10/07/10 at 10:25 AM, revealed she stated she did not report the abuse allegation to the appropriate state agencies because the facility had determined through its' investigation that the bruising was the result of a fall. A review of the facility's investigation revealed the facility determined Resident #2 fell in his/her bathroom and caused the bruising.

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F 225	Continued From page 5 An interview with the DCBS representative, on 10/08/10 at 8:35 AM, revealed she visited the facility on 09/29/10 to investigate the allegation of abuse that they received from the police department. She stated she interviewed staff and the resident.	F 225	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 279 SS=G	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interviews and record review it, was determined the facility failed to use the results of the assessment to develop the Comprehensive Care Plan, for one resident (#1) in the selected sample of six. The facility assessed Resident #1 to need extensive assistance of staff for bed	F 279	F 279 Resident # 1 no longer resides in the facility. To identify other residents possibly affected an audit of all current resident care plans, SRNA assignment sheets and assessments was conducted on 10-15-10 by the DNS, Unit Managers (UM), Case Manager (CM), Registered Nurses, Reflections Program Director, District Director of Case Management, and District Director of Clinical Operations to ensure care plans and State Registered Nursing Assistant (SRNA) assignment sheets were updated utilizing the resident's current assessment for bed mobility. The MDS Coordinators, Case Manager, Reflections Program Director and the DNS were in-serviced on 10-15-10 by the District Director of Case Management and District Director of Clinical Operations to	

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F 279	Continued From page 6 mobility and was knowledgeable of the resident's history and recent falls from the bed; however, review of the Comprehensive Care Plan revealed no interventions to address the need for the extensive assistance of two staff for bed mobility. The facility failed to ensure staff was knowledgeable of the number of staff required to assist Resident #1 with bed mobility to prevent accidents. On 09/29/10, Certified Nurse Aide (CNA) #1 assisted Resident #1 with bed mobility and hygiene needs, and after turning to retrieve a washcloth, the resident fell out of the bed and sustained a subdural hematoma. Findings include: The facility failed to provide adequate supervision and assistive devices to prevent accidents for Resident #2. Refer to F323 A record review revealed Resident #1 was readmitted to the facility on 02/19/10 with diagnoses to include Cerebral Vascular Accident (CVA), Dementia, Restless Leg Syndrome and a history of falls. Reviews of Post Fall Evaluations, dated 02/20/10 at 5:30 AM, 03/03/10 at 5:05 AM, 03/03/10 at 7:20 PM, revealed Resident #1 had falls from a low bed to a mat on the floor beside the bed. A review of the initial Minimum Data Set (MDS) assessment, dated 03/01/10, revealed the facility assessed Resident #1's cognitive skills as severely impaired and the resident required extensive assistance of two staff for bed mobility. A review of the Resident Assessment Protocol for falls and Activities of Daily Living (ADL) Functional/Rehab function, dated 03/01/10, revealed the resident had a history of falls and the	F 279	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* ensure utilization of the assessments during the development of the resident care plan and SRNA assignment sheets. After 10-15-10 no MDS staff will be allowed to work until attending the appropriate inservice. The Case Manager and the DNS will audit one new or revised care plan each week for 4 weeks to validate assessments were utilized in the development or revision of the care plan and SRNA assignment sheets. The DNS will report findings from the audits at the monthly PIC meeting with corrective action taken as needed.	10/16/10

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F 279	Continued From page 7 resident required the assistance of two staff for bed mobility. A review of the quarterly MDS assessment, dated 08/13/10, revealed the facility assessed the resident as needing the extensive assistance of two staff for bed mobility. A review of a bed safety evaluation and falls risk assessment, dated 08/14/10, revealed the facility assessed the resident as having no awareness of the proximity of the edge of the bed while moving or rolling in the bed and as a high risk for falls. In addition, reviews of Post Fall Evaluations, dated 09/10/10 at 2:30 PM and 09/10/10 at 4:30 PM, revealed Resident #1 had falls from a low bed to a mat on the floor beside the bed. Interviews with CNAs #2 and #3, on 10/08/10 at 12:15 PM and 12:25 PM respectively, revealed Resident #1 was able to throw his/her legs over the scoop/wing mattress and then pull him/herself over the scoop/wing mattress. They stated one staff was required to assist Resident #1 with bed mobility. A review of the Comprehensive Care Plan, dated 08/18/10, revealed the facility did not address the assessed need for the extensive assistance of two staff for bed mobility. A review of the CNA Care Plan, no date, revealed the facility developed an intervention for the resident to have the assistance of one staff for ADLs; even though, the facility's assessment had determined the resident required the extensive assistance of two staff for bed mobility. A review of the nursing progress notes, dated 09/29/10, and an interview with CNA #1, on 10/07/10 at 9:20 AM, revealed Resident #1 was in	F 279		

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bed and had vomited. CNA #1 stated she entered the room and obtained washcloths from the wheelchair. She stated she observed the resident had vomited on the sheet, so she rolled the resident toward the wall (resident's right side) to roll up the dirty sheet and place a clean sheet on the mattress. She then rolled the resident towards her (resident's left side) to remove the dirty sheet and pull the clean sheet around the rest of the mattress. She stated before she stretched the clean sheet over the mattress, she observed vomit on the mattress. The CNA stated she either rolled the resident to his/her back or the resident rolled on to his/her back when she let go of the resident. The CNA stated she told the resident "just a minute", turned her back and walked (three steps) over to the wheelchair to obtain another washcloth. She stated when she turned back around, the resident was falling from the bed. She stated she rushed to the resident and was able to grab the resident's leg, but the resident's head hit the floor. She stated when she bent down to check on the resident, she observed the resident was bleeding from his/her head and called for the nurse. The CNA stated she was aware Resident #1 would roll out of the bed. She stated she did not think to press the call light for assistance or place the bed back in the low position and put the mattress back in place before turning her back on the resident and taking the three steps to the wheelchair to obtain another washcloth. She stated one staff was needed to provide care to Resident #1 when in the bed.

An interview with Registered Nurse (RN) #1, on 10/06/10 at 4:40 PM, revealed he assessed the resident and noted a large hematoma on the left forehead with bleeding. He called for an ambulance to transfer the resident to the hospital.

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F 279	Continued From page 9 A review of the history and physical from the hospital, dated 09/29/10, revealed the resident was diagnosed with a subdural hematoma. An interview with the Director of Nursing, on 10/07/10 at 4:10 PM, revealed the CNA should have used the call light to call for assistance or she should have lowered the bed and put the mattress back in place before walking away from the resident.	F 279	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 323 SS=G	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: Based on interviews and record review, it was determined the facility failed to provide adequate supervision and assistive devices to prevent accidents for one resident (#1) in the selected sample of six. The facility failed to follow the Accident and Supervision to Prevent Accident policy and procedure. The facility failed to ensure staff was knowledgeable to the number of staff required to assist Resident #1 with bed mobility to prevent accidents. The facility assessed Resident #1 as requiring two staff to assist with bed mobility; however, the Comprehensive Care Plan failed to detail the number of staff necessary. Furthermore, the facility was knowledgeable of the resident's recent history of	F 323	F 323 Resident # 1 no longer resides in the facility. To identify other residents possibly affected an audit of all current resident care plans, SRNA assignment sheets and assessments was conducted on 10-15-10 by the DNS, Unit Managers (UM), Case Manager (CM), Registered Nurses, Reflections Program Director, District Director of Case Management, and District Director of Clinical Operations to ensure care plans and State Registered Nursing Assistant (SRNA) assignment sheets were updated utilizing the resident's current assessment for bed mobility. All nursing staff was in-serviced by DNS, WS and UM, on 10-15-10 on care plan implementation , including assistance by staff to meet requirements for resident's bed mobility. After 10-15-10 all other facility staff will be in-serviced prior to being allowed to work.	

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F 323	Continued From page 10 falls from the bed. On 09/29/10, Certified Nurse Aide (CNA) #1 assisted Resident #1 with bed mobility and hygiene needs, after turning to retrieve a washcloth, the resident fell out of the bed and sustained a subdural hematoma. Findings include: A review of the facility's Accidents and Supervision to Prevent Accident policy and procedure, dated 08/06/07, revealed the center should provide supervision and assistive devices for each resident to prevent avoidable accidents. The center should evaluate accident risk data, analyze potential causes of the accident risk and design interventions based on the immediacy of the risks. The center should communicate the interventions to relevant staff, assign responsibility to appropriately trained individuals, implement and document interventions. The center should implement interventions correctly and consistently, including adequate supervision. If the RAP for falls was triggered, the center should assess the need for assistive devices and care plan and implement preventive measures for the resident at risk for falls. A review of the facility's Accidents and Supervision to Prevent Accidents Definitions, dated 08/06/07, revealed Supervision/Adequate Supervision refers to an intervention and means of mitigating the risk of an accident. An avoidable accident means that a resident had an accident and the facility failed to implement interventions, including adequate supervision, consistent with the resident's needs, goals, plan of care, and recognized standards of practice in order to reduce the risk of an accident. A lack of supervision occurs when the center has determined supervision of the resident or resident's environment was necessary, but failed to provide it.	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The DNS, UMs, Weekend Supervisor will audit the care of 2 residents each week for 4 weeks to validate implementation of the care plan for bed mobility. Results of the audits will be reported to the PIC monthly by the DNS for corrective action as needed.	10/16/10

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	185089	A. BUILDING _____ B. WING _____	C 10/08/2010

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F 323	Continued From page 11 A record review revealed Resident #1 was readmitted to the facility on 02/19/10 with diagnoses to include Cerebral Vascular Accident (CVA), Dementia, Restless Leg Syndrome and a history of falls. A review of a Post Fall Evaluation, dated 02/20/10 at 5:30 AM, revealed the resident was found lying on the floor on his/her side beside the bed. The resident was in a low bed and had a sensor alarm on the bed. The facility investigated the incident and assessed the need for a landing strip beside the bed, therapy to evaluate the resident and the continued use of the sensor alarm and a low bed. A review of the initial Minimum Data Set (MDS) assessment, dated 03/01/10, revealed the facility assessed the resident as needing extensive assistance of two staff for bed mobility and the resident had a fall in the past 31-180 days. A review of the Resident Assessment Protocol (RAP) for falls and Activities of Daily Living (ADL) Functional/Rehab Potential, dated 03/01/10, revealed the resident had a history of falls. The resident was assessed as unable to maintain sitting balance or stand without staff assistance. The resident required total assistance of two staff for bed mobility. The facility had the resident in a low bed with a sensor pad alarm and a landing strip at the bedside for safety. A review of a Post Fall Evaluation, dated 03/03/10 at 5:05 AM, revealed a CNA heard Resident #1's alarm sounding. When the CNA entered the room, the CNA witnessed the resident had scooted off the side of the bed and onto the mat on the floor at the bedside. The facility investigated the incident and assessed the need	F 323		

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to offer the resident a snack during the night hours, if the resident woke up and to continue the current interventions.

A review of a Post Fall Assessment, dated 03/03/10 at 7:20 PM, revealed the resident's bed alarm was sounding. Staff entered the room and found Resident #1 lying on the mat on the floor at the bedside. The facility investigated the incident and assessed the need to place the resident in bed at 8:00 PM, to get the resident up at 5:00 AM and place the resident in the bed for a nap at 12:00 Noon.

A review of the quarterly MDS assessment, dated 08/13/10, revealed the facility assessed Resident #1's cognitive skills as severely impaired. The facility assessed the resident as requiring extensive assistance of two staff for bed mobility. The resident had a fall in the last 31-180 days. A review of a bed safety evaluation and falls risk assessment, dated 08/14/10, revealed the facility assessed the resident as having no awareness of the proximity of the edge of the bed while moving or rolling in bed and as a high risk for falls. The facility assessed the need to place a scoop/wing mattress on the bed.

A review of the Comprehensive Care Plan for at risk for falls and Self-Care Deficit, dated 08/18/10, revealed interventions for staff to keep the adjustable bed in the low position, place a mattress on the floor beside the bed at night, for the resident to be up at 5:00 AM, placed back in the bed at 12 Noon and bedtime at 8:00 PM, to offer the resident snacks if awake in the late night hours, to apply a bed sensor alarm when in the bed and to provide total care for bathing, dressing and hygiene needs. There was no documented

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F 323	Continued From page 13 evidence the facility updated the Comprehensive Care Plan to address the assessed need for extensive assistance of two staff for bed mobility. A review of the CNA Care Plan, undated, revealed the resident required the assistance of one staff for ADL care; even though, the facility had assessed the resident as needing the extensive assistance of two staff for bed mobility. A review of a Post Fall Assessment, dated 09/10/10 at 2:30 PM, revealed staff entered Resident #1's room and observed the resident lying on his/her left side on the mat. The resident's alarm did not sound. The facility investigated the incident and referred the resident for a therapy screen. In addition, the facility discontinued the bed sensor alarm and initiated a motion detector to the outer aspect of the bed. Further review of the Comprehensive Care Plan, dated 08/18/10, revealed no documented evidence the facility updated the Comprehensive Care Plan to address the discontinuation of the bed sensor alarm and the initiation of the motion detector. A review of a Post Fall Assessment, on 09/10/10 at 4:30 PM, revealed the resident was observed lying on the landing strip on the floor. The facility investigated the incident and determined the landing strip needed to be replaced with a mattress on the floor at the bedside. Interviews with two CNAs (#2 and #3) on 10/08/10 at 12:15 PM and 12:25 PM respectively revealed, Resident #1 was able to throw his/her legs over the scoop/wing mattress and then pull him/herself over the scoop/wing mattress. A review of the nursing progress notes, dated	F 323		

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F 323	Continued From page 14 09/29/10, and an interview with CNA #1, on 10/07/10 at 9:20 AM, revealed Resident #1 was in bed and had vomited. CNA #1 stated she entered the room and obtained washcloths from the wheelchair, that was beside the wall opposite from the bed. She wet the washcloths in the sink and placed them on the foot of the bed. The CNA revealed she removed the soft mattress from the floor beside the bed and raised the bed so she could provide care to the resident. She stated she observed the resident had vomited on the sheet, so she rolled the resident toward the wall (resident's right side) to roll up the dirty sheet and place a clean sheet on the mattress. She then rolled the resident towards her (resident's left side) to remove the dirty sheet and pull the clean sheet around the rest of the mattress. She stated before she stretched the clean sheet over the mattress, she observed vomit on the mattress. The CNA stated she either rolled the resident to his/her back or the resident rolled onto his/her back when she let go of the resident. The CNA stated she told the resident "just a minute", turned her back and walked (three steps) over to the wheelchair to obtain another washcloth. She stated when she turned back around, the resident was falling from the bed. She stated she rushed to the resident and was able to grab the resident's leg, but the resident's head hit the floor. She stated when she bent down to check on the resident, she observed the resident was bleeding from his/her head. The CNA stated she went to the door and called for the nurse. The CNA stated she was aware Resident #1 would roll out of the bed. She stated she did not think to press the call light for assistance or place the bed back in the low position and put the mattress back in place before turning her back on the resident and taking the three steps to the wheelchair to obtain	F 323		

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another washcloth. She stated one staff was needed to provide care to Resident #1 when in the bed.

An interview with Registered Nurse (RN) #1, on 10/06/10 at 4:40 PM, revealed he assessed the resident and noted a large hematoma on the left forehead with bleeding. He applied pressure to the injury and the bleeding stopped. He called for an ambulance to transfer the resident to the hospital. A review of the history and physical from the hospital, dated 09/29/10, revealed the resident was diagnosed with a subdural hematoma.

An interview with the Director of Nursing, on 10/07/10 at 4:10 PM, revealed the CNA should have used the call light to call for assistance or she should have lowered the bed and put the mattress back in place before walking away from the resident.