

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/11/2024
NAME OF PROVIDER OR SUPPLIER Ssm Health St Mary's Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 Maple Grove Dr Madison, WI 53719	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36253</p> <p>Based on interview and record review, the facility did not ensure that each resident environment remains as free of accident hazards as is possible for 1 of 3 residents reviewed for accidents (R1).</p> <p>R1 fell out of bed due to facility staff's failure to follow R1's plan of care and the facility did not ensure all staff were trained to help ensure a similar event did not occur.</p> <p>Findings include.</p> <p>R1 was admitted to the facility on [DATE]. Her most recent Minimum Data Set (MDS) includes a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 is cognitively intact. Her care plan states she is an assist of 2 with bed mobility due to potential for complications with deficits with Activities of Daily Living (ADLs). Her Kardex states, Bed mobility - 2 assist. Roll slowly. Quarter bedrails on left and right sides of bed. Additionally, her Kardex states she requires a Hoyer lift and 2 staff for transfers.</p> <p>On 10/27/24, the facility documented the following incident for R1:</p> <p>Around 10:50 AM, writer was charting at the nurses station when a CNA (Certified Nursing Assistant) yelled from the end of the hallway for writer to come and help. Writer raced to resident's room and found resident partially on her knees on the opposite side of the bed by the window. Resident's head was caught in between her bed and the side rail whilst the rest of her body was on the floor. Per CNA, she was assisting resident with toileting, so she rolled resident on her left side but somehow as she lifted her right leg to support with the rolling, resident slid. CNA said she managed to support resident's upper body and resident went down on her knees. Resident said she slid on the floor from her bed during cares.</p> <p>R1 was transported to the hospital after the incident where x-rays were negative. A facility interview with R1 on 10/29/24 indicated that R1's upper body had been stuck between her bed and the wall, and was not entangled, entrapped, or stuck in her side rail.</p> <p>The facility's Interdisciplinary Team (IDT) met on 10/30/24 and noted, IDT met to review fall. Root cause analysis completed. Root cause identified as inadequate amount of assistance used for bed mobility. Immediate intervention related root cause: CNA was educated on reviewing the Kardex. Plan of care ongoing.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility provided education and competency exams for some staff related to following resident care plans and Kardex.</p> <p>On 11/11/24 at 11:15 AM, Surveyor interviewed R1 who stated that she had not been trapped in her siderail on 10/27/24, and that her head was lower than the siderail and she had been wedged between the wall and the mattress. R1 stated that on 10/27/24 the CNA rolled her away towards the wall very hard and she rolled too far and into the space between the bed and the wall. R1 stated that because 2 staff are supposed to be assisting her, they leave her bed about a foot from the wall so that a second staff can fit between her bed and the wall to assist with cares. R1 stated that staff often transfer her and move her around in bed by themselves (only 1 staff). R1 stated this happens multiple times per week and that she often has to wait for hours as some of the CNAs have to wait for additional staff to be available to help with transfers and cares. R1 stated that she has been very afraid of falling out of bed again since 10/27/24 and has had to remind staff frequently who enter her room by themselves to find an additional staff member as she requires 2 assist. R1 stated that the previous weekend (Saturday, 11/9/24 and Sunday, 11/10/24), CNA D worked with her and did her cares in bed and transfers by himself. R1 stated that CNA D is a great CNA which is why she did not remind him to get an additional staff.</p> <p>Facility records indicate CNA D worked the AM and PM shift on R1's unit on both 11/9/24 and 11/10/24.</p> <p>It should be noted that CNA D was not on the list of educated staff that the facility provided to Surveyors. Additionally, according to the facility's current agency and in-house nursing staff, 8 additional staff who had been hired prior to R1's 10/27/24 fall and had worked on R1's unit since her fall had yet to receive any education or competency testing in accordance with the facility's post-event action plan.</p> <p>On 11/11/24 at 2:31 PM, Surveyor interviewed NHA A (Nursing Home Administrator) who stated that he had talked to R1 about the 10/27/24 fall shortly after it happened. NHA A stated that he did not ask R1 about how often she is assisted by only 1 staff and was unaware that it is happening frequently. NHA A stated that since the fall, the facility has been trying to get staff educated on following the Kardex but has some staff yet to educate.</p> <p>The facility was aware that staff were not following R1's care plan, resulting in a fall from her bed and did not ensure all staff were educated and CNA D had been performing cares by himself as recently as 11/9/24 and 11/10/24.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39849</p> <p>Based on observation, interview, and record review, the facility failed to ensure correct installation, use, and maintenance of bed rails for 4 of 5 (R3, R6, R7, and R8) residents reviewed.</p> <p>R3, R6, R7, and R8's bedrails were installed without a Bed System Measurement Device Test completed to ensure proper installation to reduce the risk of entrapment.</p> <p>Findings Include:</p> <p>The Facility policy, Bed Devices and Device Assessment, date of issue, March 21, 2024, indicates, in part: Policy .2.Physical devices will be reviewed for safety and used according to manufacturer's recommendations. 5.Physical devices include, but are not limited to, side rails (half or full); grab bars, halo bars, positioning poles .</p> <p>The Facility policy, Bed Inspection, date of issue, March 21, 2024, indicates, in part: Policy - It is the policy of this facility to conduct bed inspections to prevent entrapment and other safety hazards associated with bed rails, frames, and mattresses .The facility will conduct regular bed inspections, utilizing an interdisciplinary approach .to risk identification and prevention .Procedure - 1. Education: a. Facility staff will receive education as follows: .v. Procedure for inspection and maintenance of equipment .2. Equipment Management and Maintenance: .b. The Maintenance Department will conduct inspection of all bed frames, mattresses, and bedrails, as part of a regular maintenance program to identify areas of possible entrapment at least every 90 days .</p> <p>Example 1</p> <p>R3 was admitted to the facility on [DATE] with diagnoses that include, in part: Multiple Sclerosis, Age-related Osteoporosis, and Restless Legs Syndrome.</p> <p>On 11/7/24 at 1:52 PM, Surveyor went to R3's room. R3's door was open, however, R3 was not present. Surveyor noted one bed rail on the upper (head) side of the bed not facing the wall. Surveyor observed the head of the bed being elevated and the mattress pushed over at the top creating a gap between the bed rail and the mattress.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/7/24 at 3:00 PM, Surveyor interviewed MS C (Maintenance Supervisor) who indicated maintenance performs the installations of bedrails for the facility and receives the order from therapy for the installation. MS C indicated when he installs them, they have a measurement device to test for possible entrapment points and he performs this test at the time of installation. MS C indicated he has recently hired another employee that has not been trained on use of the measurement device for testing but is installing bed rails. Surveyor asked MS C if a staff member should be installing bed rails if they have not been trained to use the testing device. MS C indicated his plan was to test a batch together at the end of the month. Surveyor asked MS C if the bed rails should be tested on installation. MS C indicated he was not sure. MS C indicated he is aware of 6 to 7 installations in the last two weeks that have not been tested . Surveyor asked MS C how he knows what the measurements should be. MS C indicated they have a tool, and they follow the instructions for testing. Surveyor requested that MS C accompany Surveyor to R3's room to perform the measurement testing on R3's bedrail. During the observation MS C indicated a failed test and that the mattress is movable on the frame. MS C indicated that housekeeping comes in and moves the beds around and then the mattress can move. MS C indicated this is an issue with beds that have only one bedrail. MS C indicated when the bed is up against the wall the mattress doesn't move.</p> <p>On 11/7/24 at 4:04 PM, Surveyor interviewed MS C and asked if he know if R3's bedrail had been tested on installation. MS C indicated he didn't know MS C stated he believed it was recently installed and probably wasn't tested .</p> <p>The facility document labeled Residents with Side-Rails Present indicates an order date for R3 of 10/25/24.</p> <p>A Bed System Measurement Device Test for R3 dated 11/8/24 was provided by the facility. No previous Testing documentation was provided by the facility for R3.</p> <p>There is no evidence that R3's bedrail had a Bed System Measurement Device Test prior to 11/7/24 when the surveyor requested this to be completed.</p> <p>Example 2</p> <p>R6 was admitted to the facility on [DATE] with diagnoses that include, in part: Adult Failure to Thrive, Fusion of Spine, Muscle Weakness, and Parkinsonism.</p> <p>The facility document labeled Residents with Side-Rails Present indicates an order date for R6 of 8/7/24.</p> <p>A Bed System Measurement Device Test for R6 dated 11/8/24 was provided by the facility. No previous testing documentation was provided by the facility for R6.</p> <p>There is no evidence that R6's bedrails had a Bed System Measurement Device Test prior to 11/8/24.</p> <p>Example 3</p> <p>R7 was admitted to the facility on [DATE] with diagnoses that include, in part: Fibromyalgia, Chronic Pain, Spondylosis with Radiculopathy, Lumbosacral Region (a condition that occurs when nerve roots in the lumbosacral region are compressed or irritated), and Parkinson's Disease.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility document labeled Residents with Side-Rails Present indicates an order date for R7 of 10/23/24.</p> <p>A Bed System Measurement Device Test for R7 dated 11/8/24 was provided by the facility. No previous Testing documentation was provided by the facility for R7.</p> <p>There is no evidence that R7's bedrails had a Bed System Measurement Device Test prior to 11/8/24.</p> <p>Example 4</p> <p>R8 was admitted to the facility on [DATE] with diagnoses that include, in part: Hemiplegia and Hemiparesis affecting Left Non-Dominant Side (Complete Paralysis and Partial Weakness), History of Falling, and Muscle Weakness.</p> <p>The facility document labeled Residents with Side-Rails Present indicates an order date for R8 of 9/19/24.</p> <p>A Bed System Measurement Device Test for R8 dated 11/8/24 was provided by the facility. No previous Testing documentation was provided by the facility for R8.</p> <p>There is no evidence that R8's bedrails had a Bed System Measurement Device Test prior to 11/8/24.</p> <p>On 11/11/24 at 8:46 AM, NHA A (Nursing Home Administrator) provided a binder with bedrail information for residents as well as remedies that the facility had begun. The binder contained updated Bed System Measurement Device Test Results that NHA A (Nursing Home Administrator) indicates were completed on 11/7/24 and 11/8/24. The binder also contained the previous test results for residents who had this testing completed. Of note, no previous testing results were located in the binder for R3, R6, R7, and R8.</p> <p>A document titled Residents with Side-Rails Present was also provided to Surveyors. The document contained a sticky note that indicated Installation Dates.</p> <p>On 11/11/24 at 2:48 PM, Surveyor received a requested copy of the Resident side-rail list previously provided. The sticky note was no longer in place and order date was written in the Resident Name column above the handwritten dates present. NHA A indicated they do not have documentation of actual install dates and would go by the order date.</p> <p>On 11/11/24 at 1:20 PM, Surveyor interviewed MS C and asked if the bed rails aren't tested on installation how would they know they passed. MS C indicated there is only one way to install them. The only thing would be if the mattress was not the thickness it should be or if they have one rail with the mattress able to move. Surveyor informed MS C Surveyor was unable to locate any testing documents for R3, R6, R7, and R8 before 11/7/24 in the facility provided binder of information. Surveyor asked MS C if this meant that testing was not done prior to this date. MS C indicated he would have to check. Of note, no further documentation was provided to the Surveyor.</p> <p>On 11/11/24 at 1:28 PM, Surveyor interviewed NHA A who indicated that the bedrails should have the testing completed on installation.</p>		