STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035159	A. BUILDING _____ B. WING _____	11/21/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HORIZON POST ACUTE AND REHABILITATION CENTER	**4704 WEST DIANA AVENUE GLENDALE, AZ 85302**

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)
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, resident and staff interviews, policy review, and the bed user manual, the facility failed to ensure two residents environment remained free of accident hazards, by failing to ensure one resident's (#117) bed mattress was placed completely on the bed frame and one resident's (#331) bed was the right size for the resident. The deficient practice could result in injuries to residents. Findings include: -Resident #117 was admitted on (MONTH) 2, 2019, with [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 1, 2019 revealed the resident had potential impairment to skin integrity related to decreased mobility. The goal was that the resident would be free from injury. Interventions included identifying and documenting potential causative factors and eliminating/resolving where possible, and using caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Review of the care plan initiated (MONTH) 1, 2019, revealed the resident had a self-care performance deficit related to decreased mobility. The goal was that the resident would safely perform bed mobility and transfers with modified independence. Interventions included encouraging the resident to participate to the fullest extent possible with each interaction and that the resident may have bilateral grab bars for positioning. Review of the admission Minimum Data Set (MDS) assessment dated (MONTH) 9, 2019, revealed a score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident had intact cognition. The assessment included the resident required extensive assistance of two+ staff for bed mobility and transfers. During an interview conducted on (MONTH) 18, 2019 at 9:15 a.m. with resident #117, the resident was observed sitting on the right side of the bed. The bed mattress was observed leaning to the right in a downward position not supported by the bed frame. The metal bed frame, extenders were observed exposed on the left side of the bed. A Licensed Practical Nurse (LPN/staff #140) entered the room to administer medications and called for a Certified Nursing Assistant (CNA) to assist with repositioning the resident. After repositioning the resident, the LPN and CNA left the room with the right side of the mattress hanging over the bed frame and the metal bed frame, extenders exposed on the left side of the bed. An interview was conducted with the CNA (staff #172) on (MONTH) 19, 2019 at 1:20 p.m., who stated she remember repositioning resident #117 with the nurse. The CNA stated that she remembers the bed frame, extenders were exposed and thought the mattress may have been sliding off the bed. The CNA also stated that she should have checked the bed before leaving the room because the resident could get hurt on the exposed frame, extenders. An interview was conducted on (MONTH) 19, 2019 at 2:23 p.m. with the LPN (staff #140), who stated that he did notice the bed frame, extenders on the resident's bed were exposed. The LPN stated he did not know what was wrong with the bed and did not want to make the problem worse. He acknowledged that he and the CNA left the room with the frame, extenders exposed. He said that having the extenders exposed can be very dangerous to the resident. During an interview conducted on (MONTH) 20, 2019 at 9:09 a.m. with the Maintenance Supervisor (staff #96), staff #96 stated that when the extenders are visible, the resident could hit an arm or leg or get stuck in the extenders. He also stated that the resident's gown could get stuck in the extenders. He said that if the extenders are exposed, he would remove the resident from the bed for safety. The Maintenance Supervisor further stated that he received a call on (MONTH) 18 regarding the bed not elevating. He said that when he went to the room, the resident was not in the bed and the extenders were not exposed. An interview was conducted with the Director of Nursing (DON/staff #212) on (MONTH) 21 2019 at 9:40 a.m. The DON stated that staff receive training on bed safety during orientation and annually. She said that if the bed frame, extenders are exposed, staff should contact maintenance immediately. She also said that staff should try to adjust the extenders, so that extenders are not exposed. The DON stated that if there is a safety concern with the bed, staff should probably transfer the resident to a chair/wheelchair and have maintenance check the bed. -Resident #331 was admitted to the facility on (MONTH) 13, 2019, with [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 13, 2019, revealed the resident had a self-care performance deficit related to decreased mobility. The goal was that the resident would safely perform bed mobility and transfers. Interventions included bilateral grab bars for repositioning. Review of the admission MDS assessment dated (MONTH) 20, 2019, revealed a score of 15 on the BIMS indicating the resident had intact cognition. The assessment also revealed the resident required extensive assistance of two+ staff for bed mobility and transfers. During an interview conducted with the resident on (MONTH) 19, 2019 at 12:46 p.m., the resident stated staff were having difficulty turning and getting her up because the bed/mattress was too small. An interview was conducted on (MONTH) 19, 2019 at 1:20 p.m. with a CNA (staff #172), who stated that she heard a nurse say the resident needed a larger bed/mattress. The CNA also stated she has provided the resident care and that she thought the bed/mattress was too small. An interview was conducted on (MONTH) 19, 2019 at 2:11 p.m. with a Registered Nurse (RN/staff #200), who stated that bed size is based on the resident's weight and height. The RN stated the resident needed a Bariatric bed due to the resident's weight. An interview was conducted on (MONTH) 20, 2019 at 9:09 a.m. with the Maintenance Supervisor (staff #96), who said that if a resident said their bed was too small or too short, he would assess the bed size to see if another size was needed. He stated that there should be enough room on each side of the bed so care can be provided care safely. He also stated that he did not receive notice to assess the resident's bed size. On (MONTH) 20, 2019 at 11:20 a.m., an interview was conducted with a CNA (staff #102) who said when she repositioned the resident that morning; she was not able to see how close the resident was to the right edge of the bed. She stated that she thinks the bed is too small for the resident and it is not safe for the resident to be close to the edge. On (MONTH) 21, 2019 at 9:40 a.m., an interview was conducted with the DON (staff #212), who stated the size of a resident's bed is determined by the resident's height and weight. She said the resident has to be able to safely turn and reposition him or herself in the bed and the CNAs/nurses have to be able to turn and reposition the resident safely. The DON stated the resident should not be on the edge of the bed. The facility's policy on resident safety revised (MONTH) 2013 revealed it is the policy of the facility to create a safe environment for the resident. The policy also revealed room checks should be conducted routinely by staff to ensure 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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) safety of the residents, all faulty equipment should be reported immediately, and avoid leaving in the resident's room any equipment that might cause harm. Review of the User-Service Manual for Bed Frames dated (YEAR), revealed the product is intended for use as an adjustable mattress platform. Use of the product in a manner for which it is not designed could result in unproven or unsafe configuration, potentially resulting in injury or death. Use a mattress that is properly sized to fit the mattress deck, which will remain centered on the mattress deck relative to state and federal guidelines. The policy included the use of an improperly fitted mattress could result in injury or death. The policy also included the weight capacity of the bed should never be exceeded.