Acceptable POC 8/29/01 [illegible]

PRINTED: 7/27/01
FORM APPROVED
2567-L

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465082	A. BUILDING ______ B. WING ______	C 7/23/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTVIEW CARE CENTER	1053 W 1020 S PROVO, UT 84601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETE DATE
F 323 SS=K	483.25(h)(1) QUALITY OF CARE The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on record review, interviews and observation, it was determined that the facility failed to ensure that the resident environment remained as free of accidental hazards as was possible. The facility failed to assess the risk entrapment hazard of all residents admitted to or residing in the facility. Further, side rails were in use for 25 of 58 current residents (residents 1, 3, 4, 5, 6, 7, 9, 10, 14, 15, 22, 23, 24, 32, 37, 38, 40, 41, 42, 43, 44, 48, 54, 56, and 57). On 7/19/01, resident 6 was found expired by facility staff, one of which stated in her report "saw her feet on the floor, then I got closer and realized that her whole body was all wrapped up in the blankets on the floor and her head was between the side rail and the bed". Findings include: 1. Resident 6 was a 96 year old female who was admitted to the facility on 5/7/01 with diagnoses of hypertension, urinary tract infection, and stage I pressure ulcer. Upon her admission, resident 6 weighed 100 pounds, was 58 inches in height. She ambulated with a walker with assistance and due to a recent ankle sprain was using a wheelchair for mobility. 2. On 7/20/01 a review of employee #1, 2, and 3 statements dated 7/19/01 and the Physician's Death Summary dated 7/19/01 were reviewed. The	F 323 LH 8-29-01	F323 Assessments for side rail entrapment hazards were completed on 24 of 58 residents who had orders for the side rails. The assessment evaluation addresses the resident's cognitive status, bed mobility, transfer skills, balance, as well as the entrapment risks of the bed, mattress and equipment. Resident and family preferences are noted and documentation of the resident and family being educated on the risks of side rails are noted. These assessments were completed by July 21, 2001. Effective July 21, 2001, the revised side rail assessment form will be used on every resident's who are at risk for these concerns. July 21, 2001, bolsters were placed in every bed in the facility to eliminate any gap between the mattress and the bed frame.	Per telephone conversation 8-29-01 4:10 pm LH resident # 1, 3, 4, 5, ~~6~~, 7, 9, 10, 14, 15, 22, 23, 24, 32, 37, 38, 40, 41, 42, 43, 44, 48, 54, 56, 57

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marcia M. Findellen TITLE: Administrator (X6) DATE: 8-27-01

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information 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 323	Continued From page 1 information in the employee statements and Physician's Death Summary documented that during bedchecks on 7/19/01 at 3:00 AM resident 6 was found with her head between the side rail and the mattress. A review of report dated 7/19/01 by the nurses aide who found resident 6 documented, "Then we did rounds at 2:30 [AM] we got to her [resident 6's] room and I walked around the curtain & saw her feet on the floor, then I got closer and realized that her whole body was all wrapped up in the blankets on the floor and her head was between the side rail and the bed". The facility charge nurse was immediately notified and stated that she ordered the release of the side rail and placed resident 6 on the floor and checked for pulse and spontaneous respiration and found none. Due to the fact that resident 6 had a do not resuscitation order, the charged did not initiate cardio-pulmonary resuscitation.. The charge nurse notified the Administrator and the administrator notified the police. A review of the statement from the charge nurse dated 7/18/01 (correct date 7/19/01) at 4:30 AM documented, "Pt [patient] was sitting slanted on floor but neck & head were behind SR [side rail] bar between mattress & rails with her chin hung up on the bottom bar". 3. On 7/20/01 a review of resident 6's medical record was conducted with the following findings: Initial Assessments and Orders: a. Side Rail Rationale Screen dated 5/08/01 documented that "side rails do not appear to be	F 323 LH 8/29/01	Per telephone Conversation c̄ D.O.N. Rebecca 8/29/01 5:00pm. (Client # 3, 4, 5, 7, 9, 10, 14, 24, 32, 37, 38) Side rails usage was discontinued on eleven of the 24 residents by July 21, 2001. The rails were replaced with body pillows, beds closer to the floor, beveled mattresses, etc. The remaining 13 were evaluated for entrapment risks and side rail pads. body pillows, bolsters, etc. were used as needed. → Client # 1, 15, 22, 23, 41, 40, 42, 43, 44, 48, 54, 56, 57, All staff members were inserviced on the protocol for side rail use and the potential for entrapment by July 24, 2001. Inservices will be conducted quarterly to assure new staff are aware of the potential hazards.	

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F 323	Continued From page 2 indicated at this time." b. "Resident Risk Factor Scoring Tool" dated 5/08/01 documented that resident 6's total score was 17 which indicated that she was a moderate risk for falls; the scoring key was 10-19 for moderate risk. c. Minimum Data Set dated 6/05/01 Section P4b "Bedrails" documented that bed rails were not used. d. Admit Physician's Orders dated 5/07/01 for resident 6 documented that side rails were not needed. e. A review of incident reports from 5/7/01 until 7/20/01 documented that resident 6 had 4 falls since her admission date of 5/8/01. i. On 5/20/01 it was reported that resident 6 fell while using her walker for mobility. She had no reported injuries. ii. On 6/16/01 it was reported that resident 6 fell while using her walker for mobility. She had reported injuries of a scratch on her left elbow which did not require treatment. iii. A review of the incident report dated 7/13/01 documented that resident 6 "was found lying on her back on the floor in bedroom" at 7:00 PM. The report stated that resident 6 was "confused [and] trying to transfer self [from wheel chair]." iv. A review of incident report dated 7/17/01 documented that resident 6 was found at 5:30 AM "lying on back on floor beside bed". f. Resident's Side Rail Usage:	F 323	**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 soley because it is required by the provision of federal and state law.**	

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F 323	Continued From page 3 i. On 7/17/01 at 3:30 PM there was a physician's telephone order for resident 6 to have side rails placed on her bed. ii. Resident 6's care plan documented that side rails were added "for safety" on 7/17/01. iii. The facility did not complete an assessment to determine if the use of side rails was appropriate for resident 6 in accordance with the 1995 Food and Drug Administration (FDA) alert concerning side rail usage. iv. The facility did not complete an assessment of resident 6's entrapment potential due to her small size, cognitive status and mobility in accordance with the 1995 Food and Drug Administration alert concerning side rail usage. v. The facility did not complete an assessment of the bed and it's potential entrapment hazard to resident 6 in accordance with the 1995 Food and Drug Administration alert concerning side rail usage. g. During a telephone interview on 7/20/01 at 12:30 PM, the investigating detective from the Provo Police Department documented the death of resident 6 as "appears to be an accidental hanging". He stated that he had observed the mattress on the bed and it was soft and with no pressure on it, there was a gap between the bottom bar of the rail and the corner of the mattress of approximately 100 cm (centimeters). He stated he used his hand to put weight on the mattress and the gap increased to approximately 150 cm. On 7/20/01 at 3:10 PM when asked about risk assessments, Director of Nursing (DON) stated that a	F 323		

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F 323	Continued From page 4 new facility side rail rationale screening assessment had not been completed on resident 6 prior to implementing the use of side rails on 7/17/01. She indicated that when the physician ordered the side rails, the order was implemented without any assessment of the side rail entrapment hazard posed by resident 6's individual physical characteristics or by the bed that she occupied. On 7/26/01 at 10:50 AM a verbal report of the cause of death was received from the State Medical Examiner's Office. A physician in the Medical Examiner's Office indicated that the cause of death for resident 6 was documented as "positional asphyxia". h. Surveyor observation on 7/20/01 of resident 6's bed revealed that when the mattress was pushed to the headboard, there was approximately 6 inches between the end of the mattress and the footboard. The side rail was attached to the bed frame and without any pressure applied to the mattress, there was approximately 3-4 inches between the mattress and the side rail. When pressure was applied, the space between the mattress and the side rail increased, becoming approximately 9-10 inches; sufficient for a resident's head or other body part to be entrapped. 3. A review of the medical records' of the 24 of 58 residents who had orders for bed side rails documented that the facility had not completed assessments for side rail entrapment hazards in accordance with the 1995 FDA side rail alert for 24 of 24 residents utilizing side rails. During interviews on 7/20/01 at 4:00 PM, the facility administrator and DON stated that they were unaware	F 323		

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F 323	Continued From page 5 of the FDA safety alert for entrapment hazards with hospital bed side rails. They stated that assessments for entrapment hazards with bed side rail usage had not been completed on any of the residents currently using side rails. They stated that they had 24 other residents currently using bed side rails. They further stated that with a few exceptions, the same type of bed and mattress was utilized by all residents of the facility, including the 24 residents currently with physician orders for side rails. 4. The 1995 Food and Drug Administration (FDA), safety alert entitled "Entrapment Hazards with Hospital Bed Side Rails", was mailed to long term care facilities. The following paraphrased excerpts are contained with in the FDA safety alert. The FDA recommended the following actions to prevent deaths and injuries from entrapment in hospital bed side rails: 1. Inspect all hospital bed frames, bed side rails and mattresses as part of a regular maintenance program to identify areas of possible entrapment. Regardless of mattress width, length, and/or depth, alignment of the bed frame, bed side rail, and mattress should leave no gap wide enough to entrap a patient's head or body. 2. Be alert to replacement mattresses and bed side rails with dimensions different than the original equipment supplied or specified by the bed frame manufacturer. Not all bed side rails, mattresses, and bed frames are interchangeable. Variation in bed side rail design and thickness and/or density of the mattress may affect the potential for entrapment. 3. Check bed side rails for proper installation using	F 323		

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F 323	Continued From page 6 the manufacturer's instructions to ensure proper fit. 4. Additional safety measures should be considered for patients identified as high risk for entrapment. a. Such patients include those with altered mental status or general restlessness. b. Increased risk also occurs when the patient's size/weight are inappropriate for the bed's dimensions. 5. Bed side rails should NOT be used as a substitute for patient protective restraints. 6. Patients who need a protective restraint must be monitored frequently while wearing it. 7. If a protective restraint is used, follow your facility's protocol and the restraint manufacturer's instructions for proper use, in addition to federal, state, and local regulations regarding the use of protective restraints.	F 323		