STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465110	A. BUILDING _____ B. WING _____	C 7/11/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSSLANDS HEALTH CARE CTR	575 EAST 11000 SOUTH SANDY, UT 84070

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F 225 SS=E	483.13(c)(1)(ii) STAFF TREATMENT OF RESIDENTS 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 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 interviews and record review, it was determined the facility did not ensure that all allegations of abuse, neglect and misappropriation of	F 225 OK 8/28/02 UB	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Crosslands Rehabilitation & Health Care Center does not admit that the deficiencies listed on the CMS 2567 exist; nor does the facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. **F225** Corrective Action for Identified Residents The facility is committed to complying with the CMS requirement to report allegations of abuse, neglect and misappropriation of resident property to the State survey and certification agency, including for residents 1, 18, 15, 16, & 17. Identification of Residents Potentially Affected This has the potential to affect any resident who is the object of alleged violations including mistreatment, neglect or abuse; including injuries of unknown source and misappropriation of resident property.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Connie A. Kathman | TITLE: Administrator | (X6) DATE: Aug 16 '02

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 aft such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Utah Dept of Health
AUG 26 2002
Bur. of Medicare/Medicaid Prog
Certification and Res. Assessment

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F 225	Continued From page 1 resident property were reported to the State survey and certification agency. Specifically, the facility failed to report an allegation of possible neglect involving resident 1; the facility failed to report allegations of misappropriation of resident property, including $100.00 from resident 18; and, the facility failed to immediately report to the State survey and certification agency when allegations of physical abuse involving residents 15, 16, and 17 were made. Findings include: 1. On 6/24/02, the State survey and certification agency (SSA) began an abbreviated survey of this facility, after receiving an allegation that resident 1 may have been subject to neglect. A review of resident 1's medical record was initiated on 6/25/02. On 6/9/02, a facility nurse documented the following entry in resident 1's nursing notes: "0530 - CNA [certified nurse aide] came running to me saying that pt [patient] is caught in siderail. Resident arms were caught in siderail, one leg was on the bed most of her was off the bed. Resident was pale [and] very shaken. Freed arms from the bedrails. Injuries noted include: 1) Abrasion to the L [left] inner ankle 1 cm [centimeter] x 1.5 cm, cleansed [and] comfeel [wound dressing] applied. 2) Abrasion to the L outer great toe 0.5 cm x 0.5 cm, cleansed with NS [normal saline], comfeel applied. 3) L arm above elbow 3 cm x 2 cm abrasion with bruising. Kerlix [guaze dressing] with ice pack applied. 4) L wrist 3 cm x 1 cm abrasion with bruising Kerlix with ice pack applied. 5) Bruising to R [right] tempal [temple]. 6) Sm. [small] scratch over R eyebrow. 7) Small scratch to nose. 8) Inner thigh lg [large] amount of bruising [and] abrasion cleansed, comfeel applied, ice pack applied and 9) Abrasion 2 cm x 2 cm on R shoulder, cleansed and comfeel applied. ...Pt medicated for agitation [and] pain. MD notified of injuries. N/O [new order] for an x-ray of	F 225	Measure to Prevent Recurrence The Administrator and the Facility Department Managers, including the Staff Development Coordinator will review the Long-Term Care Survey manual; specifically, the regulations and the 'Guidance to Surveyors' section related to F225, by September 11, 2002. The corporate District Director of Clinical Operations will provide an inservice to the Administrator and the facility Department Managers on the requirements of F225, by September 11, 2002. The Administrator, or designee, will provide inservice training for licensed nurses (LN), including staff #7, 8 & 9; certified nursing aides (CNA) and nursing aides (NA) on reporting suspected abuse, possible neglect and/or misappropriation of resident property. The CNAs and the NAs will be instructed to report immediately to the LNs; the LN immediately reports to the Administrator, or designee; and the Administrator, or designee will immediately report to the state officials in accordance with state law, including the state survey and certification agency. Staff members 1, 2, 3, 4, 5 & 6 no longer work at the facility.	

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F 225	Continued From page 2 the L arm to R/O [rule out] fracture. Director of nursing notified, okay'd to have 1:1 [one on one] care. [Family member] notified of injuries. Will continue to monitor." Further review of nursing notes revealed that resident 1 was transported to an acute care hospital on 6/9/02 at 11:30 AM. A review of a local law enforcement agency's report, dated 6/13/02, was completed on 7/8/02. A police officer documented on this report that on 6/11/02, he responded to the facility to take a theft report. The police officer documented that while in the facility, ". . . I was advised of a neglect of a disabled adult that occurred Saturday/Sunday . . .While I was investigating the theft case, [Administrator] advised me of a neglect case she was also looking into. I asked her to tell me about the neglect. On Sunday 6/9/02 at 0530 hrs [hours] [facility nurse aide] found [resident 1] stuck in the side rails of her bed half on/half off. [Resident 1] reportedly has facial lacerations, a severely injured arm and shoulder, scrapes and bruises all over her arms and legs. . . ." An interview was held with the facility Administrator on 6/27/02 at 10:30 AM. The Administrator stated that she conducted an internal investigation into the circumstances that led to resident 1's being injured on the morning of 6/9/02. The Administrator stated, following her investigation, she did not feel resident 1 had been neglected. The Administrator stated she did not report to the SSA an allegation that resident 1 may have been neglected, prior to her investigation, or with the results of her investigation. 2. On 7/10/02, an interview was held with the facility's Administrator. Based on the local law enforcement report, dated 6/13/02, the facility's	F 225	Monitoring/Quality Assurance The Administrator, or designee, will report to the Performance Improvement (PI) Committee any allegations made. The PI Committee will review the actions taken to ensure compliance for all allegations of abuse, neglect and misappropriation of resident property. Monthly reports will be made to the Committee until 100% compliance is maintained for 2 month, and then as directed by the Committee. The Administrator will be responsible for continued compliance.	9/11/02

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F 225	Continued From page 3 Administrator was asked if resident's had reported stolen property. The Administrator stated residents had reported missing personal property. The Administrator was asked to provide to the surveyors a list of items reported missing by residents. The Administrator provided a form, which listed missing resident items, to the surveyors on 7/11/02. This form documented resident items, reported missing between 4/17/02 through 7/2/02. The form did not include resident names. Missing resident items included the following: a. 5/10/02 - Cordless phone with cradle; b. 5/16/02 - Electric razor; c. 5/25/02 - Watch, afghan, wedding ring, and glass lenses; d. 6/1/02 - Three big bottles of perfume; and, e. 6/10/02 - $100.00. On 7/11/02, during an interview, the Administrator identified resident 18 as the individual who reported missing $100.00 on 6/10/02. The Administrator stated that the resident items listed were not reported to the SSA as possible misappropriation of resident property. 3. Prior to this abbreviated survey start date, the SSA had received three, facility reported, allegations of abuse. The three allegations of abuse were as follows: a. Reported by facility staff on 5/30/02. The date of alleged abuse was 5/25/02. The allegation was that employee 1, a facility certified nurse aide, had struck resident 15 in the face several times. Facility staff reported employee 1 had been suspended pending the results of the investigation of the allegation. b. Reported by facility staff on 5/30/02. The date of the alleged abuse was 5/25/02. The allegation was that employee 2, a facility certified nurse aide, had hit resident 16 on the head. Facility staff reported	F 225		

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employee 2 had been suspended pending the results of the investigation of the allegation.

c. Reported by facility staff on 5/30/02. The date of the alleged abuse was 5/25/02. The allegation was that employee 3, a facility certified nurse aide, had been rough while repositioning resident 17. Resident 17 later was found to have bruises to both hands. Facility staff reported employee 3 had been suspended pending the results of the investigation of the allegation.

4. An interview was held with the facility's Staff Development Coordinator (SDC) on 7/11/02 at 8:30 AM. The surveyor asked the SDC to provide more details of the three facility reported allegations of abuse, involving residents 15, 16, and 17, respectively. The SDC gave the following information about the allegations of physical abuse:

a. The SDC explained that on 5/26/02, resident 15 reported to a family member that she had been hit by a facility staff member, while receiving assistance with a shower on 5/25/02. The SDC stated, on 5/26/02, resident 15's family member reported the alleged abuse to employee 5, a staff nurse. The SDC stated employee 5 wrote a note about the allegation of physical abuse involving resident 15 and a male nurse aide and placed it under the door of the Director of Nursing's (DON) office. The SDC stated 5/25/02 was a Saturday and that the following Monday was a holiday. Therefore, she, as well as the DON were out of the facility until Tuesday, 5/28/02.

The SDC stated that on Monday, 5/27/02, she received a call from the Certified Nurse Aide (CNA) Coordinator. She stated the CNA Coordinator reported resident 15's allegation of physical abuse. The SDC stated the CNA Coordinator reported that the alleged perpetrator was employee 4, a nurse aide. The SDC stated she directed the CNA Coordinator to

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remove employee 4 from the schedule until the allegation could be investigated.

The SDC stated on Tuesday, 5/28/02, she began an investigation into resident 15's allegation that she had been physically abused by employee 4. The SDC stated that employee 4 had been wrongly identified as the alleged perpetrator, and that the correct alleged perpetrator was employee 1. The SDC stated she did not report the alleged abuse to the SSA until 5/30/02.

b. The SDC stated that on 5/25/02, resident 16 informed employee 6, a facility nurse aide, that she had been hit by employee 2. The SDC stated the employee 6 requested resident 16 repeat the allegation to employee 7, a facility nurse. The SDC stated that employee 8, a facility nurse, was also present when resident 16 made the allegation of abuse to employee 7. The SDC stated that employee 7 completed a "write up" against employee 2, based on resident 16's allegation of abuse. The SDC stated employee 7 placed the "write up" under the door to the SDC's office.

The SDC stated on 5/27/02, she received a call from the facility's CNA Coordinator, in which the CNA Coordinator reported resident 16's allegation that she had been physically abused by employee 2. The SDC stated she directed the CNA Coordinator to remove employee 2 from the schedule until the allegation could be investigated. The SDC stated she did not report the allegation to the SSA until 5/30/02.

c. The SDC stated that on 5/26/02, resident 17's daughter reported to employee 9, a facility nurse, that resident 17 had bruises on her hands that were not present the day prior. The SDC stated employee 9 assessed the resident's injuries at the time the family member reported them and called the resident's physician, but that employee 9 did not report the injuries of unknown origin to the SDC. The SDC

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F 225	Continued From page 6 stated that resident 17's daughter approached her on 5/28/02 and reported the resident's bruised hands. The SDC stated resident 17's bruises were not investigated as injuries of unknown origin until the SDC began an investigation on 5/28/02. The SDC stated as she conducted an investigation into resident 17's injuries, staff reported observing employee 3 being rough with residents, including resident 17. The SDC stated, on 5/28/02, she removed employee 3 from the work schedule until the investigation could be completed. The SDC stated she did not report the injuries of unknown origin or possible abuse to the SSA until 5/30/02.	F 225		
F 323 SS=G	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 observations, interviews, and record review, it was determined that for 1 of 14 sampled residents, the facility did not ensure that a resident's environment was as free of accident hazards as was possible. Specifically, there was lack of supporting evidence that facility staff assessed the risks of resident 1's use of side rails as a safety risk, after the resident had demonstrated a propensity to get out of bed even with the side rails in use. Consequently, the side rails became an obstacle more than a protective device. Findings include: Resident 1 was admitted to the facility on 10/10/01, with diagnoses that included, dementia, depression with agitation, and rhabdomyolysis. Resident 1 was discharged to an acute care hospital on 6/9/02.	F 323 OK 8/28/02 VB	**F323** Corrective Action for Identified Resident Resident 1 did not return to the facility, therefore corrective action for that resident could not be taken. Identification of Residents Potentially Affected This has the potential to affect any resident that uses a side rail for any purpose other than an assistive device. Measures to Prevent Recurrence The Performance Improvement (PI) Committee will designate a PI Task Force to assess this area of concern and implement corrective measures. The PI Task Force will develop and implement	

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F 323	Continued From page 7 Rhabdomyolysis: "An acute, sometimes fatal disease in which the by-products of skeletal muscle destruction accumulate in the renal [kidney] tubules and produce acute renal failure. Rhabdomyolysis may result from crush injuries, the toxic effect of drugs or chemicals on skeletal muscle, extremes of exertion, sepsis, shock, and severe hyponatremia [low sodium content in the blood] among other diseases and conditions. ..." Reference: Taber's Cyclopedic Medical Dictionary, 19th Edition, copyright 2001, page 1884. An interview was held with a facility nurse on 7/10/02 at 2:15 PM. This nurse stated she was resident 1's nurse between 10:00 PM on 6/8/02 and 6:30 AM on 6/9/02. This nurse stated at approximately 5:30 AM, a nurse aide came to the nursing station and said to her, "come quickly [resident 1]'s arms are caught in the side rail." The nurse stated that she went immediately to resident 1's room. The nurse described to the surveyors her observation of resident 1 when she arrived in the resident's room. The nurse stated resident 1's bed was against the wall, and the right side rail was raised in a vertical position. The nurse stated the left side rail was in a horizontal position. The nurse reported that resident 1's arms were caught in the left side rail. She stated that resident 1's left wrist was caught between the side rail and the mattress of the bed. The nurse stated that resident 1's right arm was observed to be behind resident 1's head and caught in the side rail, at the elbow. The nurse stated that resident 1's head was not caught in the side rail, but was observed to be between resident 1's arms. The nurse stated that resident 1's torso was observed to be off the bed, facing away from the left side rail. The nurse stated that she observed resident 1's left buttock resting on the side of the mattress. The nurse stated that resident 1's left lower leg was observed to be resting on an egg-crate mattress that had been set on	F 323	a process to assess the safety of the beds, specific to each resident. The process will include assessments and care plans related to bed entrapment risk, fall risk and side-rail usage. The process will be completed on all facility residents by Sept 11, 2002. A communication tool to ensure care planned safety interventions are known to nursing care givers will be developed and implemented by the PI Task Force by September 11, 2002. Inservice training on the new process(s) will be provided to nursing staff by September 11, 2002, by the Staff Development Coordinator, or designee. <u>Monitoring/Quality Assurance</u> An audit tool will be developed and implemented to track compliance with safety interventions that have been put in place. The tool will be developed and implemented by the PI Task Force, by September 11, 2002. The PI Task Force will report progress to the PI Committee monthly, for two months, then as directed by the Committee. The Director of Nursing will be responsible for continued compliance.	9/11/02

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the floor, next to the bed. She stated the resident's right leg was going up and down in the air. The nurse stated the bed was not in the lowest position, but close to it, about 12 inches. She stated there was no bed alarm at that time, stating it had been approximately two weeks since she had last seen the bed alarm. The nurse stated she and the nurse aide freed resident 1 from the side rail and summoned help from another licensed nurse working at that time. The nurse reported resident 1 had injuries to her right elbow, left wrist, left lower leg, right thigh, right lower leg, and the right temple area of her face. The nurse stated she, as well as the other licensed nurse, dressed resident 1' injuries.

This nurse was asked if she had observed resident 1 attempting to get out of bed on a previous occasion. She responded by stating she had not observed the resident attempting to get out of bed, but that she had observed the resident on the floor next to her bed on one other occasion, about three months prior. She stated, at that time, the resident's side rails were in the horizontal position and the bed alarm was in the room, but not attached to the resident and it was not signalling. The nurse stated that resident 1 was frequently agitated in bed, flailing her arms and legs, hitting the side rails.

An interview was held with another facility nurse on 7/11/02 at 7:00 AM. This nurse stated she worked the graveyard shift beginning 6/8/02 through the morning of 6/9/02. She stated on that night she was not assigned to resident 1. She stated about 5:30 AM, a nurse aide came to her and stated the other licensed nurse (resident 1's nurse) needed her. This nurse reported she responded to resident 1's room and found the resident lying on the floor with the other licensed nurse and an aide attending to her. This nurse stated that the nurse aide had reported resident 1 had been found in the side rail. This nurse stated she conducted

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F 323	Continued From page 9 a head to toe assessment of resident 1 and found the resident to be cool, clamy and diaphoretic, making eye contact and responsive to the staff present. This nurse stated resident 1 had injuries to her right eyebrow, left side of her face, right arm above elbow, left arm above elbow, left wrist, back, right thigh, and left foot. The nurse also stated resident 1 had resolving bruises to both shins, from her knees to her ankles. On 6/26/02, an observation was made of the bed utilized by resident 1. Per observation, when the bed was placed in the lowest position, the top surface of the mattress was approximately 8 inches from the ground. The bed was equipped with two bed rails that pivoted on one end. The bed rails could be placed in two positions; vertically and horizontally. When in the vertical position, the bed rails were 12 inches from the head of the bed. When in the horizontal position, the bed rail was approximately 27 inches from the head of the bed and 30 inches from the foot of the bed. The bed rail was approximately two feet long and positioned at the center, along side of the mattress. When the bed was in the lowest position and the bed rail was in the horizontal position, the top of the bed rail was approximately 18 inches from the ground and 10 inches from the mattress top surface. A review of product information from the bed manufacturer was completed on 7/11/02. Per documentation in the product information, the top surface of the mattress is 8 1/2 inches from the ground, when the bed is in the lowest position. A review of resident 1's medical record was completed on 7/11/02. On 10/25/01, facility staff obtained a physician order which documented, "May use 1/2 side rail x [times] 2 for safety . . .". On 10/28/01, facility staff obtained a physician order which documented, "1/2 side rails x 2 for poor spacial awareness spastic	F 323		

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movement". This order remained in place and was listed among physician orders on resident 1's 6/1/02 through 6/30/02, physician recertification orders.

Facility staff completed a "Fall Risk Assessment" for resident 1 on 11/1/01. Facility staff assessed that resident 1 was a "high risk" for falls with a score of 27. Per assessment instructions, a score of 14 or higher was a "high risk" for falls.

Facility staff completed a "Physical Restraint Assessment" for resident 1 on 11/1/01. Facility staff assessed that resident 1 was able to ambulate with two person assistance and that she had a history of falls. Per documentation on the assessment, resident 1 was ". . . unable to follow simple directions . . ." and was ". . . combative/agitated . . ." and that resident 1 scored a 27 on a fall risk assessment, making her a high risk for falls. Facility staff documented the following restraint alternatives that had been implemented: Increased supervision; pillows; a self release belt; a lower bed; and a reclining or modified wheelchair prior to recommending the use of side rails, a geri chair, and a self release belt. Facility staff documented the following evaluation of resident 1's need for physical restraints, "Pt [patient-resident 1] unable to transfer safely, has generalized weakness, Hx [history] of falls." Facility staff documented the following recommendation for physical restraints for resident 1, "1/2 side rails x 2, geri chair, self release belt."

Facility staff reviewed resident 1's use of physical restraints on 1/17/02 and again on 4/8/02. This review was documented on a "Interdisciplinary Physical Restraint Assessment" form. Instructions provided on this form included, "Restrained residents should be assessed by the Interdisciplinary Team [IDT] on admission and at least quarterly to determine whether or not a resident is appropriate for restraint reduction,

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less restrictive restraint measures, or total restraint elimination. . . ." The "Interdisciplinary Physical Restraint Assessment" included a section for staff to complete a medical reason for restraint use. Per documentation, resident 1's medical reason was, "severely impaired coordination/[decreased] cognition [with] decreased safety awareness". On 1/17/02 and 4/8/02, facility staff documented that resident 1 was a candidate for continued use of side rails, on both sides of the bed.

Facility staff utilized a "Physical Restraint Consent" form to document a resident or their surrogate's consent for restraint usage. This form included potential risks and benefits associated with restraint use. Resident 1's medical record contained a "Physical Restraint Consent" form, dated 4/10/02. This was 167 days after the physician order for the use of side rails was obtained. Resident 1, nor a surrogate, signed this form. Facility staff documented, "Resident unable to sign - family has given verbal OK." The restraints identified on this form included, "1/2 s.r. [siderail] [up] x 2 in bed . . ." Facility staff documented the following medical reason for the physical restraint use, "Dementia, malaise and fatigue."

A review of comprehensive Minimum Data Set (MDS) assessments, for resident 1, was completed on 7/11/02. Facility staff completed an adminission MDS assessment on 10/17/01, and quarterly MDS assessments on 1/16/02 and on 4/8/02. On each of these assessments, facility staff documented resident 1 had severely impaired cognitive skills for daily decision making, had periods of restlessness, had an absence of speech, and rarely or never understood others. Facility staff assessed that resident 1 required total dependence on staff for dressing, toilet use, bed mobility, transfers from bed to chair, and bathing. Facility staff documented resident 1 did not ambulate,

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F 323	Continued From page 12 was unable to balance herself while standing without physical assistance, that she had fallen within the previous 30 days, and that other types of side rails had been used daily. On 4/8/02, facility staff also assessed that resident 1 had experienced a significant weight loss and had developed a pressure sore since the previous quarterly MDS assessment. A review of resident 1's comprehensive plan of care was done on 7/11/02. Resident 1's plan of care included the following problems: a. Physical Restraints - "Current status that necessitates restraint: Dx: [diagnosis] Dementia [with] anx [anxious] [and] psych [psychotic] feat [features]. Type of restraint approved by MD [medical doctor] and family: Siderails 1/2 [half side rails] x 2". The goals included, "Resident to have the least restrictive measures utilized. No injuries related to restraint use. No complications or behavior problems d/t [due to] restraint use ie: constipation, pressure sores, incontinence, loss of muscle tone, loss of balance, dehydration, loss of appetite, contractures, depression or reduced social contact...". The Approaches included, "Restraint assessment has been completed. Family and resident made aware of complications that may occur with use of a restraint as listed in Goals. Restraint to be applied properly to prevent accidental injury or impair circulation. Monitor resident frequently using a restraint. Release restraint q [every] 2 hours for at least 10 min [minute] intervals for toiling, exercise, and position change. Monitor for complications as listed. Notify MD is complications are noted. Eval [evaluate] resident at least quarterly for possible restraint reduction or discontinuation. Eval resident for possible rehab [rehabilitation] interventions." This problem was initially identified on 10/13/01, and was updated on 1/17/02 and 4/8/02, as being an on-going problem.	F 323		

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F 323	Continued From page 13 b. Fall Risk - "Based on fall risk assessment is found to be a risk for falls. Hx [history] of falls [with] injury. Poor balance. Weakness. Experiences confusion. Psychotropics [psychotropic medications]". The goals included, "Resident to remain injury free". The approaches included, "Maintain a safe environment, keep room free from clutter, spills, clean and etc. ... Assist with transfers/Amb [ambulation]. Keep bed in lowest possible position [with wheels locked. ... Protective Measures: Increased supervision Bed alarm. Restraints: 1/2 SR [side rails] [up] x 2. All Restraints to be approved by family and MD orders. ..." This problem was initially identified on 10/13/01, and was updated on 1/17/02 and 4/8/02, as being an on-going problem. A review of nursing notes, for resident 1, was completed on 7/11/02. Nursing staff documented resident 1 fell from her bed seven times between 1/7/02 and 6/9/02. The falls occurred on 1/7/02, 1/20/02, 1/31/02, 2/3/02, 2/8/02, 4/25/02, and 6/9/02. Nursing staff documented the following: a. 1/7/02 - "Went into pts [patients] room to give evening/H.S. [hour of sleep] meds. [medications]. Found pt laying on floor next to bed. Bed in low position [with] 1/2 siderail in up position. Called more staff to room. Body [check] and ROM [range of motion] done. Met [with] resistance. Pt very difficult to assess. Denies any c/o [complaints of] discomfort during assessment/ROM. ..." b. 1/20/02 at 2:15 PM - " Pt. FOF [found on floor] this am [morning] [at] 0645 [6:45 AM] by CNA [certified nurse aide]. Pt lying horizontal to bed [with] feet propped on top of bed. Pt noted to have red area to [upper] [right] shoulder and coccyx noted to be red and tender to touch. PERRLA [pupils-equal, round, reactive to light] - [no] other injuries noted. ...1330	F 323		

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[1:30 PM] coccyx noted to be swollen slightly. Attempt to apply ice but pt not compliant [with] keeping ice on area of swelling. Pt will flail arms and kick and move about. Will cont [continue] to monitor closely."

c. 1/31/02 at 5:30 AM - "CNA reported to me that pt's body was laying on blue eggcrate mattress [and] her legs were on the bed, it was noted that her upper lip was swollen, ice pack applied. [No] other injuries noted. Will continue to monitor."

d. 2/3/02 at 5:00 AM - "Resident found on floor this morning by CNA. Her bed was halfway down, blue eggcrate mattress was not on floor, but pt was laying on her blanket, pt was very active did not appear to be in pain or discomfort. ..."

e. 2/8/02 at 5:30 AM - " Pt FOF beside bed, has red spot on back possible bruising...".

f. 4/25/02 at 7:10 AM - "Resident found with upper torso hanging off her bed [and] head was laying on the floor [at] 0510 [5:10 AM]. Assisted back to bed. Edema above [right] eye [and] redness to [right] cheek noted on assessment. No other injuries noted. ..."

g. 6/9/02 at 5:30 AM - "CNA came running to me saying that pt is caught in siderail. Resident arms were caught in siderail, one leg was on the bed most of her was off the bed. Resident was pale [and] very shaken. Freed arms from the bedrails. Injuries noted include: 1) Abrasion to the L [left] inner ankle 1 cm [centimeter] x 1.5 cm, cleansed [and] comfeel [wound dressing] applied. 2) Abrasion to the L outer great toe 0.5 cm x 0.5 cm, cleansed with NS [normal saline], comfeel applied. 3) L arm above elbow 3 cm x 2 cm abrasion with bruising. Kerlix [guaze dressing] with ice pack applied. 4) L wrist 3 cm x 1 cm abrasion with bruising Kerlix with ice pack applied. 5) Bruising to R [right] tempal [temple]. 6) Sm. [small] scratch over R eyebrow. 7) Small scratch to nose. 8) Inner thigh lg [large] amount of bruising [and] abrasion cleansed,

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comfeel applied, ice pack applied and 9) Abrasion 2 cm x 2 cm on R shoulder, cleansed and comfeel applied. ...Pt medicated for agitation [and] pain. MD notified of injuries. N/O [new order] for an x-ray of the L arm to R/O [rule out] fracture. Director of nursing notified, okay'd to have 1:1 [one on one] care. [Family member] notified of injuries. Will continue to monitor."

A nurse' note, dated 6/9/02 at 7:30 AM, documented, "Pt. given 5 mg [milligrams] lortab [pain medication] 0.5 mg Ativan [antianxiety medication] po [by mouth] Pt. very calm. 1:1 nursing [with] CNA. Pt drank 1500 cc [cubic centimeters] fluid for breakfast - did not eat very much solid food. Large area of swelling noted to L [upper] arm/shoulder - ice cont. [continue] to be applied. 0930 [9:30 AM] - x-ray in to x ray L arm. Unable to obtain good x-ray r/t [related to] pt. moving around and limited movement to L arm. 1030 [10:30 AM] Pt. appears very pale, diaphoretic [perspiration] - weak - O2 [oxygen] sats [saturation] [checked] [at] 84% on RA [room air] [a normal O2 saturation on room air is 90% or above]. Pt put on O2 [at] 2 L [liters per minute] per N/C [nasal cannula]. O2 sats [up] to 95%. Dr. [name of doctor] notified and pt. transferred to [name of local hospital]. [Name of ambulance] called [at] 1100 [11:00 AM]. Pt left building approx [approximately] 1130 [11:30 AM]."

On 7/5/02, facility administration provided the State survey and certification (SSA) staff two "Resident Safety Findings and Review" forms, dated 1/28/02, and 2/4/02. The Administrator stated these forms were utilized following resident falls as a part of quality assurance. The following information was obtained from these forms:

a. 1/28/02 - Facility staff documented on this form the current intervention used to prevent resident 1 from falling; side rails. Additionally, two new

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F 323	Continued From page 16 interventions and plans of action to reduce resident 1's risk for falling from bed were added; keep resident 1's bed in the lowest position, and to use a bed alarm. b. 2/4/02 - Facility staff documented on this form the current interventions used to prevent resident 1 from falling; low bed, 1/2 siderails, and bed alarm. Addtionally, two new interventions and plans of action to reduce resident 1's risk for falling from bed were added; mattress or egg-crate (a foam pad) on floor and bed in low position documentation. The facility utilized a nursing assistant assignment sheet to inform nurse aide staff of specific resident care needs. A review of the nursing assistant assignment sheets for resident 1 was completed on 7/11/02. This form had been updated on 2/26/02. Per documentation on this sheet, resident 1 used siderails, times two, to approach the resident slowly, and to talk to her over and over. This form did not include the use of a bed alarm, the use of an egg-crate mattress next to the resident's bed, or the intervention of keeping the bed in the lowest position.	F 323		