Acceptable POC 7/29/03
[handwritten signature] RN

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 7/23/2003
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465152	A. BUILDING ____ B. WING ____	7/10/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOLOB CARE & REHABILITATION	178 SOUTH 1200 EAST ST GEORGE, UT 84790

(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) COMPLETE DATE
F 323 SS=J	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 observation, interview, and record review, it was determined that the facility failed to assess if residents who were using siderails were at risk for entrapment in the siderails due to their medical condition. This had the potential to place all residents in the facility who used siderails on their beds at risk for accidents involving side rail entrapment. It was additionally determined through review of the facility's "Unusual Occurrence Record" reports that 3 of the 20 sample residents had been entrapped in siderails (Residents 12, 86 and C3). Further, resident 86 required treatment in a hospital emergency room after being found with her neck inbetween her bed and the side rail. An interview was held with the Director of Nursing (DON) and the administrator on 7/9/03 at 3:30 PM. The DON stated that to her knowledge, the facility had not done any assessments on any residents to determine if the residents were at a risk for entrapment when using siderails on their beds. Due to the lack of individualized assessment of possible side rail entrapment, the facility was found to be in Immediate Jeopardy. Findings include: 1. Resident 86 was readmitted to the facility 3/27/03 with diagnoses of fractured hip, Alzheimers disease,	F 323 OK 7/29/03 [initials]	**F 323** ***The corrective action that will be accomplished for those residents found to have been affected by the deficient practice:*** 1- Resident 86: On 7-4-03, prior to readmission to the facility from the hospital visit, side rails were removed from the bed of resident 86. A telephone order was received from the resident's Physician to remove side rails. Care Plan and MDS were current and accurate in the chart after side rails were removed. 2- Resident 12: On 6-1-03, the day of resident 12's incident, side rails were removed from the resident's bed. A pre-restraining assessment for resident 12 was completed by facility nurse on 6-7-03. The recommendation from the assessment was to place resident 12 in a lowered bed turned to the wall. There was a physician's telephone order completed on 6-7-03, and signed by a facility RN. MDS was current and accurate in the chart after side rails were removed. 3- Resident C3: Resident Discharged. Nursing staff has been inserviced to report all incidents regarding side rail entrapment. 4- Legacy Wing Issue: The nurse noted in the survey was given training pertaining to the potential accident hazards posed by the	7-4-03 6-7-03 7-11-03 7-11-03

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 7-29-03

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 is 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 and hypertension. A complaint was received by the State Survey Agency on 7/8/03, alleging that resident 86 had been found caught in the siderail of her bed, was choking and had to be sent to the emergency room for treatment. Review of resident 86's medical record was done on 7/8/03. On 3/27/03, the day of admission, a facility nurse documented that 1/2 siderails were in place on both sides of resident 86's bed for turning and positioning. A significant change Minimum Data Set (MDS) assessment dated 5/6/03, completed by facility staff, documented that resident 86's cognitive skills for daily decision making were severely impaired and that resident 86 was totally dependant on one person for assistance with bed mobility and transfers. The MDS assessment also indicated that resident 86 had fallen in the past 30 to 180 days. The MDS assessment did not indicate that resident 86 used any type of siderails. A care plan for resident 18 dated 5/6/03 did not document that siderails of any kind were used. A nurse's note for resident 86 dated 7/3/03 at 10:00 PM, documented that resident 86 had been found choking on thick mucous and required suctioning. The note also documented that resident 86's family had been contacted and had requested that resident 86 be transferred to the emergency room. An "Unusual Occurrence Record" for resident 86 dated 7/3/03 at 11:00 PM, completed by a facility staff nurse, documented, "CNA [certified nursing assistant] making rounds found [patient] partially on bed against 1/2 side rail [and] choking. Pt. placed on	F 323	use of side rails without an appropriate assessment. ***<u>How the facility will identify other residents having the potential to be affected by the same deficient practice:</u>*** <u>1-3 Residents 86, 12, C3</u>: The IDT team (Director of Nursing, Administrator, Social Service Director, each Unit Manager, Director of Plant Operations, Staff Development Coordinator, Lead C.N.A.-RA) has assessed each resident for bed entrapment risk (see attached Entrapment Risk form). Those deemed to be at risk by the IDT team have had their side rail orders discontinued, their side rails removed, and MDS and care plans updated. For those insisting to keep one or both side rails, the facility has given the resident and/or responsible party side rail entrapment information (see attached A Guide to Bed Safety handout) and discussed with them the entrapment risk and have had each of these residents or responsible parties sign an informed consent for the use of side rail(s) (see attached Side Rails – Record of Informed Consent form). The Director of Nursing, Unit Managers, and Staff Development Coordinator completed a full chart audit of every resident to ensure compliance and consistency with MDS and resident care plans.	

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F 323	Continued From page 2 [left] side - encouraged to cough, spit out thick white mucus. Suctioned pt. transported to the [emergency room] by [emergency medical technician] via gurney." The ambulance record for resident 86 was obtained on 7/9/03. The record dated 7/3/03 at 10:50 PM, documented that the facility staff stated that resident 86 was found to have fallen out of bed with her neck between the bed and the rail. The assessment documented by the ambulance emergency medical technician stated that resident 86 was in moderate respiratory distress. Resident 86 was transported to the hospital per ambulance. The medical record for resident 86 was obtained from the hospital on 7/9/03. The emergency room admission record dated 7/3/03, documented that the chief complaint for resident 86 was respiratory distress and was a possible choking, "Pt. lodged between rail [and] bed..." The emergency room physician record dated 7/3/03, documented that resident 86 was having respiratory difficulties and that resident 86 had been found between the rail and the bed in the nursing facility. The physician also documented that resident 86 had an area of erythema (redness) on the neck and upper chest area. Further review of the hospital record revealed a facility nurse's note that had been sent to the hospital with resident 86 from the facility, and had been completed by a facility nurse. The nurse's note dated 7/3/03 at 10:00 PM, stated, "Pt found against the 1/2 rail [with] throat compressed on rail. Pt was choking [with] thick mucous which was suctioned while she was turned to L side...". The nurses note also stated that resident 86's family was called and they requested that resident 86 be sent to the emergency room.	F 323	The Entrapment Risk Assessment form has been placed in our nursing admission paperwork and is completed on each resident upon admission. Alternatives for side rails have been implemented (i.e. trapeze). Items to reduce entrapment risk from side rails (i.e. bed rail pads, bed rail wedge pads, gap guards) have been put in to place and used as needed. The Director of Plant Operations and Administrator have completed a room audit to visually check to ensure all side rails are as stated to ensure compliance. The Director of Plant Operations has completed a Bed Entrapment Assessment on each bed in the facility to ensure each bed is compliant and does not have equipment problems that could contribute to an entrapment risk. 4- Legacy Wing Issue: Nurses have been inserviced and are aware of the potential accident hazards posed by use of side rails without appropriate assessment. ***The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur:*** 1-4 Residents 86, 12, C3 and Legacy Wing Issue: Each resident will be re-evaluated quarterly for entrapment risk to ensure continued compliance to our entrapment risk program.	

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F 323	Continued From page 3 An interview was held on 7/9/03 at 3:10 PM, with the facility nursing assistant that had found resident 86 on 7/3/03. The nursing assistant (NA 1) stated that at approximately 10:00 PM on 7/3/03, she was making rounds before reporting off shift. NA 1 stated that resident 86 tried to get up all the time and fell a lot from the bed. NA 1 stated that when she entered resident 86's room, resident 86 was observed to be on a low bed with 1/2 side rail up on the left side of the bed and a mat on the floor. The right side of the bed was against the wall. NA 1 stated that resident 86 was lying on her left side with the bottom half of her legs and feet off the bed on the mat on the floor. She stated that resident 86's neck was wedged between the siderail and the mattress, and resident 86 was coughing and choking. NA 1 stated she called for help and a second nursing assistant (NA 2) entered the room. NA 1 stated that they (NA 1 and NA 2) removed resident 86 from between the mattress and the rail and placed resident 86 on her left side. The nursing assistant stated that a third nursing assistant (NA 3) went to inform the nurse of what was happening with resident 86. An interview was held on 7/9/03 at 3:05 PM, with NA 2. NA 2 stated that on 7/3/03, at approximately 10:00 PM, NA 1 called for help from resident 86's room. NA 2 stated she went to assist NA 1 and observed resident 86 to be wedged by the neck between the mattress and the siderail. She stated that resident 86 was lying on her left side and her legs and feet were off the bed on the mat on the floor. NA 2 stated that she and NA 1 removed resident 86 from between the mattress and the side rail and placed resident 86 on her left side. NA 2 stated that resident 86 was coughing. An interview was held with NA 3 on 7/9/03 at 3:00	F 323	The Entrapment Risk Assessment form has been placed in our nursing admission paperwork and is completed on each resident upon admission. Alternatives for side rails have been implemented (i.e. trapeze). Items to reduce entrapment risk from side rails (i.e. bed rail pads, bed rail wedge pads, gap guards) have been put in to place and used as needed. Facility now has ongoing training and inservices regarding side rails and entrapment risk. Training includes all-staff inservicing, nurses meetings, C.N.A. meetings, orientation, etc. New employee orientation now includes detailed training on entrapment risk program and the potential accident hazards posed by use of side rails without appropriate assessment. ***How the facility plans to monitor its performance to make sure that solutions are sustained and plan for ensuring that correction is achieved and sustained.*** 1-4 Residents 86, 12, C3 and Legacy Wing Issue: Progress and effectiveness of side rail and entrapment risk program will be monitored by the Director of Nursing and/or designee weekly and reviewed at each monthly Quality Assurance meeting X 12 and adjusted and changed for greater effectiveness as needed.	

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F 323	Continued From page 4 PM. NA 3 stated that he had not observed resident 86 caught in the rails. He stated that he was told by NA 1 and NA 2 to go and get the licensed nurse. An interview was held on 7/9/03 at 2:55 PM, with the licensed nurse who had been working on the evening of 7/3/03 with resident 86. The facility nurse stated that she had been in the hall passing out medications when NA 3 told her that resident 86 had been found half off the bed and was choking. The facility nurse stated that when she entered resident 86's room, the nursing assistants told her that resident 86 had been wedged between the mattress by the neck. The facility nurse stated that the nursing assistants had removed resident 86 from between the mattress and the side rail and had placed resident 86 on her left side. The facility nurse stated that resident 86 was coughing and that she had to suction her. The facility nurse stated she contacted resident 86's family and that resident 86 was sent to the hospital via ambulance. An interview was held with resident 86's family member on 7/10/03 at 10:00 AM. The family member stated that she was called by the facility nurse at approximately 10:30 on 7/3/03, and was told that resident 86 was having a difficult time breathing. The family member stated that when she arrived at the facility, the nursing assistants informed her that resident 86 had been found stuck in the siderail. An observation of resident 86 was done on 7/10/03 at 4:00 AM. Upon entering the room, resident 86 was observed to have both feet on the mat on the floor, was in a semi sitting position, lying on her left side with her head off of the edge of the bed. Resident 86 was observed to have an abrasion approximately 4 inches long and 1/4 wide across the base of the front of her neck and an abrasion in the center of her chest,	F 323	QA Nurse and/or designee will complete a weekly audit to ensure compliance with resident charting. Results from weekly audit will be reviewed at each monthly Quality Assurance meeting X 12 and will receive input from QA team and will make changes/adjustments to the side rail and entrapment risk program as needed to ensure continued compliance and maximum effectiveness.	

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F 323	Continued From page 5	F 323		

approximately 4 inches below the base of her neck.
2. Resident 12 was originally admitted to the facility on 6/23/02, and re-admitted to the facility on 5/21/03. Diagnoses included pneumonia, dementia, stage 3 pressure sore, congestive heart failure, anemia, hypertension, malaise, and arthritis. A review of resident 12's medical record was done from 7/8/03 through 7/10/03.

Resident 12's admission MDS, dated 6/3/03, was reviewed on 7/9/03. Facility staff documented the following:

a. Section P. Special treatments and procedures, Section 4. Devices and restraints, B. Other types of side rails used (e.g, half rail, one side) was scored as "0", not used.

b. The facility had scored resident 12 as a "0". Under section P.4.b.Other type of side rail used (e.g., half rail, one side), the MDS indicated that side rails had not been used for resident 12 in the last 7 days. This was contradicted by a physician telephone order for 1/2 side rails dated 5/22/03.

c. Section B. Cognitive Patterns. 4. Cognitive skills for daily decision-making. Resident 12 was scored as a "3" - Severely impaired.

d. Section G. Physical functioning and structural problems. A. Bed mobility. Scored as 3 self-performance and 2 support. 3 means extensive assistance, 2 means one person physical assistance.

A facility nurse made the following entry in the nurses' notes dated 6/1/03 at 4:30 PM:

"...Resident heard calling out - found on knees with head and left arm jammed between side rail and

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F 323	Continued From page 6 mattress on window side of bed. Assisted to sitting position. Examined. Small light red scrape on left inner arm - left flank... Can see no other injuries..." The facility nurse who made the nurses' notes entry was no longer employed at the facility and was contacted by telephone on 7/10/03 at 2:30 PM for an interview. She stated she had observed resident 12 with her arm and head in the side rail and the resident was on her knees. She documented that her "head was not jammed between the mattress and side rail, but was caught". The nurse indicated that she was able to free the resident's head without assistance. She further stated, "Her arm was jammed and had to be removed by staff. The resident was on her knees." A facility "Unusual Occurrence Report" dated 6/1/03 for resident 12 was reviewed on 7/9/03. The summary documented, "Heard calling out - Found on knees by window side of bed with head and left arm jammed between side rail and mattress. Freed. Examined. Scrape along left side. Slight scrape left inner arm. Unable to see any other injury at this time." On 7/10/03 at 2:30 PM, an interview by telephone was held with the facility nurse who made the nurses' note entry and completed the 6/1/03 "Unusual Occurrence" report for resident 12. The nurse stated that she saw the patient with her arm and head in the side rail. The resident was on her knees. She stated that resident 12's head was not jammed between the mattress and side-rail, but was caught. She stated that resident 12 was able to free her head without assistance but resident 12's arm was jammed and had to be removed by staff. The resident was on her knees. On 7/9/02 at 4:00 PM, a facility nursing assistant who assisted resident 12 on 6/1/03 was interviewed	F 323		

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F 323	Continued From page 7 regarding the occurrence with resident 12. The nursing assistant stated the following: "The resident was trying to get out of bed. Her personal alarm went off. This happened at shift change. The resident was on her left side. She was not wedged. She was lying on her own left arm, she up against the side-rail. She was in an awkward position." A pre-restraining assessment for resident 12 was completed by a facility nurse on 6/7/03, 6 days after the resident was found as indicated above. The recommendation from this assessment was to place resident 12 in a lowered bed to the wall. There was a physician's telephone order completed on 6/7/03, and signed by a facility RN. The order indicated to use a lowered bed to the wall, and a bed and chair alarm. 3. Resident C3 was an 84-year-old woman admitted to the facility on 4/25/03, and discharged home on 5/19/03. Resident had diagnoses, which include the following: Hip fracture, osteoporosis, anemia, constipation, hypertension and dementia. Resident C3's medical record was reviewed on 7/10/03. A facility nurse made the following entry in the nurses notes on 5/9/03, "...Resident was found still in bed with ½ rails up with left elbow caught between mattress and side rails with both legs off bed, while upper half of body remaining on bed. Whole underneath of elbow reddened. Upper arm by arm pit, reddened, but was not caught in railing and was wrapped in covers. Underneath left wrist reddened with 2 areas of separate bruising. Resident denies pain. Notified [physicians] office and daughter,..." The nurse who made this entry was no longer employed at the facility, and was not available for interview. Review of the facility "Unusual Occurrence" records	F 323		

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F 323	Continued From page 8 was done on 7/10/03. No evidence that the facility had documented the incident for resident C3 was found. The DON was interviewed on 7/10/03 at 9:00 AM. The DON stated that she had not been made aware of the incident. 4. On 7/9/03 at 3:30 PM, a facility RN who routinely works on the special needs unit was interviewed about the use of side rails for the residents on the Legacy Unit. He stated that the evening staff routinely put up the residents ½ side rails on both sides of the bed at night, so that residents can use them for positioning. The nurse also stated that ½ side rails were not restraints if they are ordered and used for turning and positioning. The nurse was unaware of the potential accident hazards posed by use of side rails without appropriate assessment.	F 323		
F 326 SS=E	483.25(i)(2) QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and medical record review, it was determined that for 4 of 20 sampled residents, the facility did not ensure that each resident received a therapeutic diet when there was a nutritional problem noted. This is evidenced by: 1. Resident 49 did not receive a low fat, low cholesterol diet as ordered by the physician. 2. Resident 12 did not receive a 2 gm (gram) sodium	F 326		

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F 326	Continued From page 9 diet as ordered by the physician. 3. Resident 69 did not receive renal ADA (diabetic) diet as ordered by the physician. 4. Resident 28 (31) did not receive a RCS (reduced concentrated sweets) fortified, TAT (texture as tolerated) no milk diet. Findings include: 1. Resident 49 was a 90- year- old female with diagnoses including senile delusion, atrial fibrillation, hypertension, congestive heart failure and esophagitis. On 7/9/03 resident's 49 medical record was reviewed. A review of the June 2003, re-certifications orders, signed by the physician, documented that a low fat/low cholesterol diet with skim milk was ordered on 5/5/03. a. Observations of the dinner meal on 7/7/03 reveled that resident 49 received whole milk and corned beef. According to the posted menu resident 49 should have received a chicken fajita and skim milk. b. Observations of the breakfast meal on 7/8/03 revealed that resident 49 received a fried egg, two biscuits with gravy and whole milk. According to the menu resident 49 should have received egg substitute, 1 slice of toast and skim milk. c. Observations of the lunch meal on 7/8/03 and the breakfast meal on 7/9/03 reveled that resident 49 received whole milk for both of these meals.	F 326 dc 7/29/03 DD	***F 326*** ***<u>The corrective action that will be accomplished for those residents found to have been affected by the deficient practice:</u>*** <u>1- Resident 49</u>: Resident will be served the appropriate diet. Please see below for specifics as to how this will be done. <u>2- Resident 12</u>: Resident will be served the appropriate diet. Please see below for specifics as to how this will be done. <u>3</u>- Findings do not identify a 3rd issue. It was skipped in 2567L. <u>4- Resident 28 (31)</u>: Facility believes resident was identified incorrectly. Resident identified as a she in findings. Resident listed as resident 28 is a he. Resident 28 listed on resident list does not receive dialysis. We will respond to this issue for Resident 31, a female who is on dialysis. The no milk diet was originally put into place at the request of the resident. Afterwards, Resident 31 repeatedly requested to have milk. It is evident that the resident likes milk as it is noted that she drank the milk each time it was given. An order was written for the resident to have milk. Resident signed a consent form (see attached contract feed form) on 1-28-03 stating that she voluntarily chooses not to adhere to her Doctor's order regarding	7-11-03

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F 326	Continued From page 10 2. Resident 12 was originally admitted to the facility on 6/23/02, and re-admitted to the facility on 5/21/03, with diagnoses which include the following: pneumonia, dementia, stage 3 pressure sore, congestive heart failure, anemia, hypertension, malaise, and arthritis. On 7/9/03, and 7/10/03 resident 12's medical record was reviewed. A physician order dated 5/21/03, documented resident 12 was to receive a 2-gram NA (sodium) diet. An interview was held with the facility cook and a dietary aide on 7/9/03 at 5:15 PM. The dietary staff stated that the residents who were on 2-gram sodium diets should have received low sodium cream of broccoli soup, low sodium crackers, low sodium turkey salad sandwich on regular bread, no potato chips, ½ peach on a lettuce leaf, lime chiffon dessert, 2% milk and coffee or tea. Observation of the dinner meal of 7/9/03 revealed that resident 12 received potato chips, a carton of milk, cream soup, regular crackers, a croissant filled with turkey salad, apricots and lime dessert. (3) 4. Resident 28 was admitted to the facility on 12/28/03 with diagnoses which include renal failure, anxiety syndrome, senile depressive disorder, senile delusions, diabetes type II, hypertension, insomnia, diarrhea, irritable bowel and constipation. Resident 28's medical record was reviewed on 7/7/03. According to resident's current re-certifications, an order dated June 2003, indicated that resident 28 was to receive a RCS (reduced concentrated sweets) fortified, TAT (texture as tolerated), no milk diet. a. On 7/7/03 at 5:30 PM resident received a	F 326	the diet he/she prescribed. Resident has the right to drink milk as she has requested. There was no nutritional problem noted for the "no milk diet". Resident will be served the appropriate diet unless she requests otherwise. Please see below for specifics as to how this will be done. <u>5- Resident 69</u>: Resident will be served the appropriate diet unless she requests otherwise. Please see below for specifics as to how this will be done. Resident 69 continues to request a regular diet meal. Resident has the right to eat a regular diet meal. Resident signed a consent form (see attached contract feed form) on 2-6-03 stating that she voluntarily chooses not to adhere to her Doctor's order regarding the diet he/she prescribed. ***<u>How the facility will identify other residents having the potential to be affected by the same deficient practice:</u>*** <u>1-5 Residents 49, 12, 69, 31 (28)</u>: All residents with orders for therapeutic diets when there is a nutritional problem have the potential to be affected by the same deficient practice. ***<u>The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur:</u>***	

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F 326	Continued From page 11 carton of milk on her evening meal tray. Resident 28 consumed 100% of the milk. b. On 7/8/03 at 12:15 PM the resident received a carton of milk on her noon meal tray. Resident 28 consumed 100 % of the milk. c. On 7/9/03 at 07:00 AM, the resident was gone to dialysis. There was a consumed breakfast tray sitting on her bedside table. The carton of milk was empty. 5. Resident 69 was admitted to the facility on 5/14/03 with diagnosis of fractured fibula and tibia, diabetes and renal insufficiency. Resident 69's medical record was review on 7/7/03. Resident 69 was admitted with a physician order for a Renal ADA (American Diabetes Association) diet. a. Observation of the breakfast meal on 7/8/03 revealed that resident 69 received one slice of toast with sausage gravy, 2 pats of margarine, one fried egg, whole milk, orange juice, and oatmeal. According to the menu, resident 69 should have received apple juice, one slices of toast, cereal, 2 pats of margarine, 2 packages of jelly, pears, and 4 ounces of 2% milk. b. Observation of the lunch meal on 7/8/03 revealed that resident 69 received regular roast, regular potatoes and gravy, regular creamed spinach, whole milk, one slice of bread and 2 pats of margarine and strawberry shortcake. According to the menu, resident 69 should have received low sodium roast, low sodium potatoes and gravy, low sodium spinach, and fresh strawberries.	F 326	1-5 Residents 49, 12, 69, 31 (28): Dietary staff have been inserviced and have received advanced training from Dietician regarding therapeutic diets, the need to serve accurately, and how to read the menu spreadsheet. Tray line procedure has been adjusted to ensure compliance with diets. Instead of the dietary aide, the cook now reads the tray card while dishing up each meal. This has proven to be effective. DON and/or designee is completing a daily (M-F) random audit of diet accuracy at mealtime to ensure compliance. Corrections, if any, are made immediately. ***How the facility plans to monitor its performance to make sure that solutions are sustained and plan for ensuring that correction is achieved and sustained.*** 1-5 Residents 49, 12, 69, 31 (28): Results from daily (M-F) audit are reviewed at each monthly Quality Assurance meeting and receives input from QA team. QA team will make changes/adjustments as needed to ensure continued compliance and maximum effectiveness. Continuance and frequency of audit will be determined by QA team; based on effectiveness of changes made to ensure compliance.	

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F 326	Continued From page 12 c. Observation of the dinner meal on 7/8/03 revealed that resident 69 received corn beef brisket, buttered new potatoes, a small can of V-8 juice, one slice of bread, 2 pats of margarine, one slice of banana cake, and a carton of whole milk. According to the menu resident 69 should have received low sodium beef brisket and gravy, low sodium new potatoes, cucumber onion salad, 2 slices of bread, margarine, and vanilla wafers. d. Observation of the breakfast meal of 7/9/03 revealed that resident 69 received scrambled eggs, one slice of toast, 2 pats of margarine, 2 packets of jelly, hot cereal, 2 orange slices, a small bowl of grapefruit sections, a carton of whole milk, and a small glass of orange juice. According to the menu resident 69 should have received cranberry juice, cereal, low sodium scrambled egg, 2 slices of toast, 2 pats of margarine, 2 packages of jelly, and 4 ounces of 2% milk.	F 326	***F 363*** ***<u>The corrective action that will be accomplished for those residents found to have been affected by the deficient practice:</u>*** <u>Issues 1-2:</u> The menu had been changed on each menu except the menu right outside of the Kolob Café. When it was brought to the kitchen's attention, it was too late to correct. <u>Issue 3</u>: Meal had already been served and eaten. It was too late to correct problem. ***<u>How the facility will identify other residents having the potential to be affected by the same deficient practice:</u>*** <u>Issues 1-3</u>: All residents eating in the facility have the potential to be affected by the same deficient practice. ***<u>The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur:</u>*** <u>Issues 1-3</u>: Dietary staff has been inserviced and have received advanced training from Dietician regarding the need to serve accurately, follow the menu and how to read the menu spreadsheet. Dietary staff have been trained that if there is a change in the menu, it must be noted on the resident's menu posted in the hall. Dietary Manager will provide continued guidance and follow-up.	7-11-03
F 363 SS=B	483.35(c)(1)-(3) DIETARY SERVICES Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of documentation, it was determined that the facility did not follow the approved menus. Findings includes:	F 363 OK 7/29/03 [initials]		

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F 363	Continued From page 13 1. Review of the menu, Week 2 of the spring and summer menu set, revealed that the menu was not followed as written for the evening meal on 7/7/03, and for the breakfast meal on 7/9/03. 2. Observation of the evening meal of the evening meal on 7/7/03 revealed that corned beef, buttered potatoes and cucumber salad were served for the evening meal. The posted menu documented that chicken fajitas with chopped tomatoes, lettuce, salsa and sour cream with Spanish rice and ice cream was to be served. An interview with the cook revealed that the meal had been changed because the staff had failed to thaw the appropriate meat. The changes to the menu were not posted and the residents were not aware of the changes 3. Observations of the breakfast meal on 7/9/03 revealed that hot cereal, scrambled eggs, toast and grapefruit were served for the breakfast meal. The posted menu documented that hot cereal; scrambled eggs with cheese toast and grapefruit were to be served. Observations of the meal reveled no cheese to be present on any eggs served. In an interview with the cook she stated that no cheese was put in or on the eggs that day. This would cause the calorie content and the protein content of the meal to be compromised.	F 363	Administrator and/or designee will complete a daily review to ensure meals are served as noted on menu. ***<u>How the facility plans to monitor its performance to make sure that solutions are sustained and plan for ensuring that correction is achieved and sustained.</u>*** <u>Issues 1-3:</u> Dietary Manager and/or designee will report progress and effectiveness of following menu at monthly Quality Assurance meeting. QA team will make changes/adjustments as needed to ensure continued compliance and maximum effectiveness. Review of Administrator and/or designee menu compliance audit will be reviewed at monthly Quality Assurance meeting. QA team will make changes/adjustments as needed to ensure continued compliance and maximum effectiveness. Continuance and frequency of audit will be determined by QA team; based on effectiveness of changes made to ensure compliance.	
F 369 SS=D	483.35(g) DIETARY SERVICES The facility must provide special eating equipment and utensils for residents who need them.	F 369		

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F 369	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation and interview and record review, it was determined that the facility had not assessed for, or provided, special eating equipment and utensils for 2 of 20 sample residents. (Residents 32 and 33.) Findings include: 1. Resident 32 was admitted to the facility on 9/30/02 with diagnosis of cerebral vascular accident, aphasia and hypothyroidism. Resident 32 had hemiparesis (paralysis) of his right side. Review of resident 32's medical record was done on 7/7/03. Resident 32 had a physician order dated 10/28/02 for a regular diet. A quarterly Minimum Data Set (MDS) assessment dated 4/11/03 for resident 32, completed by facility staff, documented that resident 32 had lost all voluntary movement on his right side. The MDS also documented that resident 32 required supervision with eating and did not have any special utensils to assist with eating. A care plan for resident 32 dated 10/13/02, completed by facility staff, documented that resident 32 was able to feed himself with minimal assistance. A nutritional assessment dated 4/11/03, completed by the facility food service supervisor, documented that resident 32 ate with his hands, needed some assist and had no adaptive devices. Observation of resident 32 was done on 7/7/03, during the noon meal, from 1:10 PM to 1:40 PM. Resident 32 was leaning to his right side in a wheel	F 369 OK 7/29/03 [initials]	***F 369*** ***<u>The corrective action that will be accomplished for those residents found to have been affected by the deficient practice:</u>*** <u>Resident 32</u>: Therapy completed a mini-evaluation for assistive devices during survey. We have put an assistive device (deep dish plate with dividers) in place. An order for finger foods has been obtained and implemented. Director of Nursing and/or designee (i.e. nurse in dining room) have monitored to ensure compliance. <u>Resident 33</u>: During survey, therapy completed a mini-evaluation for assistive devices. We have put an assistive device (deep dish plate with dividers) in place. Director of Nursing and/or designee (i.e. nurse in dining room) has monitored to ensure compliance. <u>Issue 3</u>: The interview noted was impromptu and the DON did not have the chart immediately in front of her to determine whether or not the resident had actually had an assessment. She was not aware if there was an assessment done for either of the residents identified. The surveyor confirmed that Resident 33 did in fact have an assessment done.	7-11-03

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F 369	Continued From page 15 chair and was unable to use his right side due to paralysis. Resident 32 was observed to use his left hand to eat and was missing the ring finger on his left hand. During this 30 minute observation, 2 facility staff were observed in the dining room but did not assist resident 32 with his meal. At the beginning of the observation, resident 32 had already been served his meal. Resident 32 was served a small portion of steak, long flat noodles, and diced beets on a regular flat plate. Resident 32 also received a slice of bread in a baggie, a pat of butter, a small bowl of jello, and a carton of milk unopened. Resident 32 was observed to pick up the piece of meat with his left hand and eat the meat. Resident 32 then tried to eat the noodles and the beets with his left hand. Resident 32 was observed to drop most of the noodles and beets on his lap. Resident 32 left the dining room at 1:40 PM. He did not eat any of the jello or bread or drink the milk. Observation of resident 32 was done on 7/7/03 during the evening meal from 5:40 PM to 6:35 PM. The resident across from resident 32 poured resident 32 a glass of water. Resident 32 held the glass of water in his hand and drank the water. At 5:57 PM, a dietary aide gave resident 32 a carton of milk and a small can of V-8 juice. Resident 32 was observed from 5:57 PM until 6:12 PM attempting to open the carton of milk with his left hand and his teeth. At 6:12 the director of nursing opened resident 32's milk and can of V-8 juice. At 6:15 PM resident 32 was served his meal on a regular plate. Resident 32 received 2 slices of corned beef brisket, new potatoes, a spiced apple ring, one slice of bread in a baggie, a pat of butter, and a slice of cake. Resident 32 was observed to eat the meat and potatoes	F 369	***How the facility will identify other residents having the potential to be affected by the same deficient practice:*** Resident 32, 33, Issue 3: Restorative nurse and/or designee will visually evaluate residents in 1 dining area of the building each week to identify any assistive devices needs. Dietary will continue to evaluate residents on admission and quarterly. ***The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur:*** Resident 32, 33, Issue 3: Restorative nurse and/or designee will visually evaluate residents in 1 dining area of the building each week to identify any assistive devices needs. Residents found needing assistive devices will be referred to therapy. Therapy will then evaluate and order, as needed, appropriate assistive devices. Dietary will continue to evaluate residents on admission and quarterly for assistive device needs. ***How the facility plans to monitor its performance to make sure that solutions are sustained and plan for ensuring that correction is achieved and sustained.*** *Resident 32, 33, Issue 3:* Restorative nurse findings will be reviewed at monthly Quality Assurance meeting. QA team will make	

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F 369	Continued From page 16 with his left hand. He also drank the milk and the juice. He picked up the cake and took one bite. The cake fell apart and dropped onto the floor. Resident 32 left the dining room at 6:35. Observation of resident 32 was done on 7/8/03, during the breakfast meal from 7:50 AM to 8:25 AM. Resident 32 had a can of orange juice and a carton of milk on the table. Both of the containers had been opened. Resident 32 was able to drink the fluids. At 8:05 AM, resident 32 was served his meal, on a regular plate, which consisted of one fried egg, 2 half biscuits with sausage gravy on them, hot cereal in a Styrofoam bowl, and a small bowl of pears. Resident 32 picked up the egg with his hand and ate the egg. Resident 32 then attempted to pick up one of the sausage gravy biscuits. The biscuit feel apart. Resident 32 then scooped the biscuit up with his fingers, dropping some on his lap and the table, and proceeded to lick the food off of his fingers. Resident 32 was observed to continue to eat the biscuits in this manner until they were gone. Resident 32 left the dining room at 8:25 AM. Resident 32 did not eat the cereal or the pears. An interview was held with resident 32's family member on 7/8/03 at 10:00 AM. The family member stated that resident 32 was able to use utensils to eat if the food was prepared and was not the type of food that would slide from the plate. The family member stated that a rimmed plate would be beneficial for resident 32 to help get the food on the utensils, then resident 32 would not have to use his fingers to eat. 2. Resident 33 was admitted to the facility on 7/15/03 with diagnosis of Parkinson's disease, atrial fibrillation, congestive heart failure and hypertension. Review of resident 33's medical record was done on	F 369	changes/adjustments as needed to ensure continued compliance and maximum effectiveness. Continuance and frequency of weekly dining room evaluations will be determined by QA team; based on effectiveness of changes made to ensure compliance.	

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F 369	Continued From page 17 7/8/03. Resident 33 was on a reduced concentrated sweets, no added salt diet. A quarterly MDS assessment dated 5/9/03 for resident 33, completed by facility staff, documented that resident 33 had a partial loss of voluntary movement in his hands. The MDS also documented that resident 33 required limited assistance with eating. A care plan for resident 33 dated 7/28/02 and updated 5/2/03, completed by facility staff, documented that resident 33 required a therapeutic diet, but did address any assistance needs. A nutritional assessment dated 5/3/03, completed by the facility food service supervisor, documented that resident 33 was able to feed him self and did not require any assistive devices. Observation of resident 33 was done on 7/7/03 during the noon meal from 1:10 PM to 1:50 PM. Resident 33 had already been served his meal. Resident 33 was leaning to the right in his wheel chair with his eyes closed. The wheelchair was positioned approximately one foot away from the table. Resident 33 had been served a small portion of streak, long flat noodles and diced beets on a regular flat plate. At 1:15 PM, a facility nurse approached resident 33 and he opened his eyes and the nurse gave him some medication. Resident 33 was observed to again lean to the right in his wheel chair and close his eyes. At 1:30 PM, resident 33 opened his eyes and sat up and picked up a spoon and attempted to eat some noodles. Resident 33 dropped the spoon and noodles on his lap. The spoon then fell on the floor. At 1:35 PM, resident 33 picked up a fork and attempted to eat the noodles. Resident 33 dropped the fork on the floor	F 369		

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F 369	Continued From page 18 and attempted to pick it up. At 1:37 PM a nursing assistant noticed resident 33 and went to the kitchen to get another fork. When the nursing assistant returned, she cut up resident 33's meat and noodles. She did not move resident 33 closer to the table. At 1:40 PM resident 33 picked up a fork with his left hand and attempted to eat the noodles. The noodles fell on resident 33's lap. Resident 33 then picked up a knife with his left hand a pushed the noodles off of his lap onto the fork and ate the noodles. From 1:45 PM until 2:00 PM, resident 33 was observed to eat the noodles and the meat by using a piece of bread in his left hand to push the food onto the fork in his right hand. 3. An interview was held with the DON and administrator on 7/8/03 at 4:30 PM. The DON stated that neither resident had been screened or assessed for the use of assistive devices for eating.	F 369	***F 371*** ***<u>The corrective action that will be accomplished for those residents found to have been affected by the deficient practice:</u>*** <u>Issue 1A</u>: The floor was deep cleaned during survey. <u>B</u>: Area has been deep cleaned. <u>C</u>: New aprons were purchased during survey. Staff was inserviced as to cleanliness of clothing and aprons. <u>D</u>: Jell-O (sticky red fluid) had recently spilled and was cleaned during survey. <u>E</u>: Health shakes were thrown out. All items that could not be accurately dated were thrown out during survey. <u>F</u>: Food was immediately removed from being stored on floor during survey. <u>G-H</u>: New aprons were purchased during survey. Staff was inserviced as to cleanliness of aprons and proper storage of towels.	7-11-03
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations, and interviews it was determined that the facility did not store, prepare, distribute, and serve food under sanitary conditions as evidenced by cleaning rags not being properly stored in sanitizing solution, areas of the kitchen in need of cleaning, multiple food items not being labeled and or dated in the walk in refrigerator, outdated food items being stored in the walk in refrigerator, improper handling of food and soiled clothing being worn by employees.	F 371 OK 7/29/03 [initials]	<u>Issue 2A</u>: The towels were corrected and stored properly. Staff was inserviced as to cleanliness of aprons and proper storage of towels. <u>B</u>: Dietary staff have been inserviced and have received advanced training from Dietician	

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F 371	Continued From page 19 Findings include: 1. During the initial inspection of the kitchen on 7/7/03 at 1:20 PM the following items were observed the kitchen: a. The floor of the kitchen was observed to have a build up of dirt and grease throughout the kitchen. The floor of the dish room was observed to have dirty standing water under the pot racks. The floor was not swept and had small piles of debris against the walls. b. The shelves below the tray line and through out the kitchen were observed to have scraps of food and other debris built up around the non food items stored there. c. Two employees were observed to be wearing clothing with large areas soiled by food and liquid. An employee observed to be loading dishes in the dish machine was wearing an apron soiled with food and liquid. d. An observation of the walk-in refrigerator revealed a sticky red fluid dripping from the top rack onto boxes and other items on the two shelves below. e. Six Health Shakes were thawed with no date of expiration on the boxes. A package of sausages and a package of deli beef brisket were not dated, a container of meat salad was not labeled or dated. A container of mayonnaise was opened and not dated. f. A box of roast beef, a box of chicken breast and a box of chicken and dumplings were stored on the floor of the freezer. g. On 7/7/03 at 5:45 PM during an observation of	F 371	regarding cleanliness and sanitation standards. Issue 3A: Dietary staff has been inserviced and have received advanced training from Dietician regarding cleanliness and sanitation standards. B: Dietary staff has been inserviced and have received advanced training from Dietician regarding cleanliness and sanitation standards. ***How the facility will identify other residents having the potential to be affected by the same deficient practice:*** All residents have the potential to be affected by the same deficient practice. ***The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur:*** All Issues: Each issue identified in survey has been discussed in detail with Dietary staff. Each dietary staff member has been inserviced and trained as to proper storing, preparing, distributing and serving food under sanitary conditions. Staff will receive continued training by Dietary Manager and Dietician regarding sanitation procedures, proper storing, preparing, distributing and serving of food. Issue 1 a, b, d: A Cleaning schedule has been implemented that addresses each area of the kitchen (see attached cleaning	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465152	A. BUILDING ______ B. WING ______	7/10/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOLOB CARE & REHABILITATION	178 SOUTH 1200 EAST ST GEORGE, UT 84790

(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 371	Continued From page 20 the tray line the following items were observed in the kitchen. h. Two dietary staff members were serving food, wearing aprons soiled with food and liquid, there was a wet towel on the kitchen prep table not stored in sanitation fluid and two wet towels in the sink not stored in sanitation fluid. 2. Observations of the kitchen on 7/8/03 at 7:35 AM revealed the following: a. Three wet towels were on the prep table not stored in sanitation fluid. b. A dietary staff member was observed to wipe a knife off on one of the wet towels and then use it to cut up an egg for a resident tray. 3. On 7/8/03 at 1:05 PM observations of the lunch tray line revealed the following: a. Two wet towels on the counter next to the tray line not in sanitation fluid. b. Three dietary staff members were observed to be wearing soiled aprons while serving food from the tray line. A dietary staff member was observed to remove meat from a steam table pan with her hand and tear up the meat using her hands. She was then observed to wipe her hands on her apron and repeat this several more times wiping her hands on a towel or her apron.	F 371	schedule). Each dietary staff member is required to complete his/her portion of the cleaning schedule after each meal to ensure sanitation guidelines and cleanliness are met. Dietary Manager and/or designee will monitor cleaning schedule completeness weekly to ensure compliance. Issue 1 c, e, f, h, & Issue 2-3: Each dietary staff member has been inserviced and trained regarding proper sanitation procedures (including those noted in survey). Staff will receive continued training by Dietary Manager and Dietician regarding sanitation procedures and issues. Monthly kitchen inspections will be performed by Dietician and/or designee to ensure continued compliance. Issue 1 c, h, 3 b: If aprons are found to be permanently soiled, soiled aprons will be thrown out and replacement aprons will be ordered. ***How the facility plans to monitor its performance to make sure that solutions are sustained and plan for ensuring that correction is achieved and sustained.*** Issue 1 a, b, d: Cleaning schedule compliance will be reviewed at monthly Quality Assurance meeting. QA team will make changes/adjustments as needed to ensure continued compliance and maximum effectiveness. Continuance and frequency of cleaning schedule completion will be determined by QA team; based on	
F 426 SS=D	483.60(a) PHARMACY SERVICES A facility must provide pharmaceutical services	F 426		

effectiveness of changes made to ensure compliance.

Issue 1 c, e, f, h, & Issue 2-3: Kitchen inspections will be reviewed at monthly Quality Assurance meeting. QA team will make changes/adjustments as needed to ensure continued compliance and maximum effectiveness. Frequency of kitchen inspections will be determined by QA team; based on effectiveness of changes made to ensure compliance.

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F 426	Continued From page 21 (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility did not provide pharmaceutical services to ensure the accurate administering of medications to meet the need of 1 of 20 sample residents. (Resident C3) Findings include: Resident C3 was admitted to the facility on 4/25/03 with diagnoses of fractured hip, osteoporosis, anemia and hypertension. Resident C3's medical record was reviewed on 7/10/03. 1. Resident C3's admission physician orders, dated 4/25/03, listed the medications resident C3 was to receive while in the facility. The medication Lasix 10 mg was included on the list, to be given every other day. A line had been drawn through the Lasix and written next to it was D/C (discontinue) 4/25/03. The medication was to be discontinued on the day of admission. Review of resident C3's mediation administration record (MAR) for April, 2003, revealed that resident C3 had been administered, by documentation, Lasix 10 mg on 4/26/03, 4/27/03, 4/28/03 and 4/29/03. On 4/30/03 the Lasix was discontinued. An interview was held on 7/10/03, with the facility nurse who had admitted resident C3. She stated that	F 426 OK 7/29/03 [initials]	***F 426*** ***<u>The corrective action that will be accomplished for those residents found to have been affected by the deficient practice:</u>*** <u>Issue 1-2</u>: Resident is discharged. **<u>How the facility will identify other residents having the potential to be affected by the same deficient practice:</u>** <u>Issue 1-2</u>: All residents receiving medications in the facility have the potential to be affected by the same deficient practice. ***<u>The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur:</u>*** <u>Issue 1</u>: Upon admission, every resident's medications will be double checked by two nurses to ensure there are no errors. Medical Records will not print MAR's without verification by Director of Nursing and/or designee. QA Nurse will review the MAR's weekly for all new admissions to verify accuracy and to ensure that two nurses have double-checked each new resident's MAR. <u>Issue 2</u>: Night shift nursing staff and/or designee will review all new telephone orders and verify that they are written on the MAR. Unit Manager's will follow-up	7-11-03

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F 426	Continued From page 22 the Lasix should have been discontinued on 4/25/03, on admission. 2. A physician order dated 4/27/03 at 11:30 AM, for resident C3, documented to administer Aspirin 325 mg once daily to resident C3. Review of resident C3's MAR for April 2003, revealed that the Aspirin had not been documented as being given to resident C3 until 4/29/03. An interview was held on 7/10/03 with the facility nurse that had received the physician order for the Aspirin for resident C3. The nurse stated that it was her fault the medication had not been given and an error had occurred.	F 426	on all telephone orders to ensure they have been placed on the MAR. QA Nurse and/or designee will complete a monthly triple check of medication orders to ensure continued compliance. ***How the facility plans to monitor its performance to make sure that solutions are sustained and plan for ensuring that correction is achieved and sustained.*** Issue 1-2: QA Nurse and Unit Manager's findings and progress will be reviewed at monthly Quality Assurance meeting. QA team will make changes/adjustments as needed to ensure continued compliance and maximum effectiveness. Continuance and frequency of MAR checks will be determined by QA team; based on effectiveness of changes made.	
F 514 SS=D	483.75(l)(1) ADMINISTRATION The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. This REQUIREMENT is not met as evidenced by: Based on record review and interview with facility staff, it was determined that the facility did not maintain the clinical record for 1 of 20 sample residents with accepted professional standards and accurate documentation. (Resident 86) Findings include: On 7/8/03, a review of resident 86's medical record was done.	F 514		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	Continued From page 23 On 7/3/03, resident 86 had been found in bed caught between the siderail and the mattress and was transferred to the hospital for treatment. When resident 86 was transferred to the hospital, a facility staff nurse sent documentation from resident 86's medical record to the hospital with the resident. The documentation included a copy of the nurses' note the facility staff nurse had written on 7/3/03 at 10:00 PM, describing the incident that had occurred with resident 86. On 7/9/03, a copy of resident 86's record from the hospital was obtained. In reviewing both the hospital record and the facility medical record on 7/9/03, it was discovered that the nurses note that had been sent to the hospital was not the same note that was in the facility medical record. On 7/10/03, a telephone interview was held with the facility staff nurse that had written the nurses note and sent resident 86 to the hospital. When she was asked why the two notes were different, she stated that a facility administrative nurse had asked her to re-write the note and only document what she had seen and not what the facility nursing assistants had told her had occurred with resident 86. On 7/10/03 at 2:00 PM a meeting was held with the facility administrator, director of nursing, and the staff developer. During the meeting the director of nursing and the staff developer stated that they had asked the nurse to change the documentation in resident 86's record. The administrator had not been aware that documentation had been changed.	F 514 OK 7/29/03 [initials]	***F 514*** ***<u>The corrective action that will be accomplished for those residents found to have been affected by the deficient practice:</u>*** Nursing staff has been inserviced on the proper way to clarify and/or correct documentation. ***<u>How the facility will identify other residents having the potential to be affected by the same deficient practice:</u>*** All residents have the potential to be affected by the same deficient practice. ***<u>The measures that will be put into place or systematic changes made to ensure that the deficient practice will not recur:</u>*** Proper documenting skills will be discussed ongoing at nursing staff meetings. Specific staff found to be deficient will receive further training or discipline as needed. ***<u>How the facility plans to monitor its performance to make sure that solutions are sustained and plan for ensuring that correction is achieved and sustained.</u>*** Training progress, effectiveness and compliance will be discussed at monthly QA meeting X 3 or until QA team feels issue is resolved. QA team will make changes/adjustments as needed to ensure continued compliance.	7-11-03

Bed Entrapment Assessment Form

Bed and bedrail safety Evaluation

Bedrails, including half rails, and grab bar type devices can be dangerous to the moderate to high-risk patient who uses them, especially if the devices are not evaluated for possible entrapment isk. Deaths caused by Bedrails include, but are not limited to : 1) Bedrail and mattress entrapment (head or body trapped between mattress and Bedrail); 2) Rail and in-bed entrapment (head trapped between widely spaced bars with bed rail latches failing, causing the rail to fall down, putting pressure on the neck) caused by excess spacing of vertical bars, and bed latch failure during shaking; and, 3) Rail and off-bed entrapment with legs first through the rails until the neck jams against the rail, or stomach first through the rails with the neck and head hyper-extended on the floor.

Resident's name: ______________________ Room # ________ Bed __________

Date of assessment: ______________________________

Equipment Problems (check)

- ☐ Gaps between mattress and bedframe (mattress should fit snuggly on bed).
- ☐ Mattress can slide toward either side of the bed and/or top to bottom of bed.
- ☐ Gaps between bed rail and mattress larger than 1 ½ inch (the bed rail should fit snug against the mattress, pads may be used to close the gaps).
- ☐ The space between the bed rail and mattress would allow for a body part to slip underneath the rail (check to see if mattresses compress enough to allow this).
- ☐ Bedrails at the right angle with the head board will allow for a head to go through (no more than a 2 inch space is allowed), that closes the head-trapping triangular space, or the grab-rail is placed with sufficient space from the headboard so that a head and body may pass through).
- ☐ String type position alarms used appropriately, anchored correctly, ets.
- ☐ The bars of the individual bed rail allow the head to go between the bars.
- ☐ Head and foot rails (split bed rails) have a large enough space between them that would allow a person's body to slip through partially.

IDENTIFY ANY RISKS NOTED WITH THE BEDRAIL AND/OR MATTRESS: (NO RAIL SHOULD BE USED UNLESS RISKS ARE CORRECTED).

The following precautions will be implemented to eliminate or minimize any entrapment risk.

- ☐ Side rails removed from the bed to prevent their usage.
- ☐ Appropriate spacer cushions will be used between the mattress and/or footboard to prevent mattress slippage.
- ☐ Non-skid material will be used underneath mattress to stabilize its position on the bed frame.
- ☐ Proper fitting pads or mesh will be used to cover side-rails in order to eliminate areas of possible entrapment.
- ☐ Body pillows placed in gaps between rails and mattress to eliminate possible entrapment.
- ☐ A larger mattress will be used which fits snugly against both the headboard and footboard.

Plant Operations Manager or Nurse Management Signature:

______________________________ Date: __________

Entrapment Risk

Resident assessment

Name: ______________________________ Date: ____________

Risk Factors

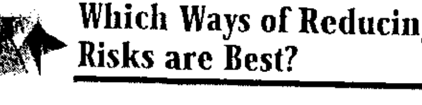
- ☐ Resident requires one or two side-rails in the up position while they are in bed.
- ☐ Resident has some form of dementia or other diagnosis which may hinder their thought process.
- ☐ Resident is able to roll, slide or otherwise independently alter their body position while in bed.
- ☐ Resident is of small stature which could allow one or more body parts to enter a space of possible entrapment.
- ☐ Resident is very active in bed, does not lie still or tries to climb out.

Any resident with one or more risk factors is considered a high risk for possible bed entrapment and will need to have their bed assessed for entrapment prevention.

Use Bed Entrapment Assessment Form

Nurse or Nurse Management Signature: ______________________________

Date: ____________ Review in I.D.T. meeting; Date: ____________



Which Ways of Reducing Risks are Best?

A process that requires ongoing patient evaluation and monitoring will result in optimizing bed safety. Many patients go through a period of adjustment to become comfortable with new options. Patients and their families should talk to their health care planning team to find out which options are best for them.

Patient or Family Concerns About Bed Rail Use

If patients or family ask about using bed rails, health care providers should:

- Encourage patients or family to talk to their health care planning team to determine whether or not bed rails are indicated.
- Reassure patients and their families that in many cases the patient can sleep safely without bed rails.
- Reassess the need for using bed rails on a frequent, regular basis.

To report an adverse event or medical device problem, please call FDA's **MedWatch Reporting Program at 1-800-FDA-1088.**

For additional copies of this brochure, see the FDA's website at
http://www.fda.gov/cdrh/beds/

For more information about this brochure, contact Beryl Goldman at 610-388-5580 or by e-mail at bgoldman@kcorp.kendal.org. She has volunteered to answer questions.

For information regarding a specific hospital bed, contact the bed manufacturer directly.

Developed by the Hospital Bed Safety Workgroup

Participating Organizations:

- AARP
- ABA Tort and Insurance PracticeSection
- American Association of Homes and Services for the Aging
- American Health Care Association
- American Medical Directors Association
- American Nurses Association
- American Society for Healthcare Engineering of the American Hospital Association
- American Society for Healthcare Risk Management
- Basic American Metal Products
- Beverly Enterprises, Inc.
- Care Providers of Minnesota
- Carroll Healthcare
- DePaul College of Law
- ECRI
- Evangelical Lutheran Good Samaritan Society
- Hill-Rom Co., Inc.
- Joint Commission on Accreditation of Healthcare Organizations
- Medical Devices Bureau, Health Canada
- National Association for Home Care
- National Citizens' Coalition for Nursing Home Reform
- National Patient Safety Foundation
- RN+ Systems
- Stryker Medical
- Sunrise Medical, Inc.
- The Jewish Home and Hospital
- Untie the Elderly, The Kendal Corporation
- U.S. Food and Drug Administration

October 2000

A Guide to Bed Safety

Bed Rails In Hospitals, Nursing Homes and Home Health Care: The Facts

Bed Rail Entrapment Statistics

Today there are about 2.5 million hospital and nursing home beds in use in the United States. Between 1985 and 1999, 371 incidents of patients* caught, trapped, entangled, or strangled in beds with rails were reported to the U.S. Food and Drug Administration. Of these reports, 228 people died, 87 had a nonfatal injury, and 56 were not injured because staff intervened. Most patients were frail, elderly or confused.

Patient Safety

Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe.

Historically, physical restraints (such as vests, ankle or wrist restraints) were used to try to keep patients safe in health care facilities. In recent years, the health care community has recognized that physically restraining patients can be dangerous. Although not indicated for this use, bed rails are sometimes used as restraints. Regulatory agencies, health care organizations, product manufacturers and advocacy groups encourage hospitals, nursing homes and home care providers to assess patients' needs and to provide safe care without restraints.

The Benefits and Risks of Bed Rails

Potential benefits of bed rails include:

- Aiding in turning and repositioning within the bed.
- Providing a hand-hold for getting into or out of bed.
- Providing a feeling of comfort and security.
- Reducing the risk of patients falling out of bed when being transported.
- Providing easy access to bed controls and personal care items.

Potential risks of bed rails may include:

- Strangling, suffocating, bodily injury or death when patients or part of their body are caught between rails or between the bed rails and mattress.
- More serious injuries from falls when patients climb over rails.
- Skin bruising, cuts, and scrapes.
- Inducing agitated behavior when bed rails are used as a restraint.
- Feeling isolated or unnecessarily restricted.
- Preventing patients, who are able to get out of bed, from performing routine activities such as going to the bathroom or retrieving something from a closet.

Meeting Patients' Needs for Safety

Most patients can be in bed safely without bed rails. Consider the following:

- Use beds that can be raised and lowered close to the floor to accommodate both patient and health care worker needs.
- Keep the bed in the lowest position with wheels locked.
- When the patient is at risk of falling out of bed, place mats next to the bed, as long as this does not create a greater risk of accident.
- Use transfer or mobility aids.
- Monitor patients frequently.
- Anticipate the reasons patients get out of bed such as hunger, thirst, going to the bathroom, restlessness and pain; meet these needs by offering food and fluids, scheduling ample toileting, and providing calming interventions and pain relief.

When bed rails are used, perform an on-going assessment of the patient's physical and mental status; closely monitor high-risk patients. Consider the following:

- Lower one or more sections of the bed rail, such as the foot rail.
- Use a proper size mattress or mattress with raised foam edges to prevent patients from being trapped between the mattress and rail.
- Reduce the gaps between the mattress and side rails.

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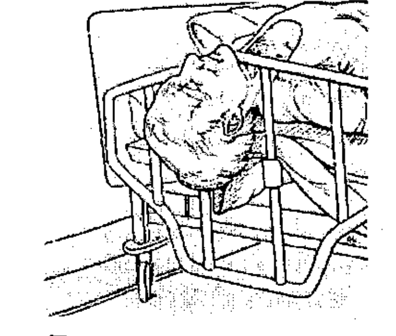
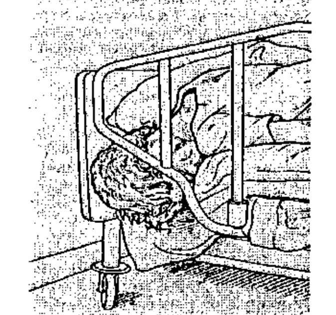
* *In this brochure, the term patient refers to a resident of a nursing home, any individual receiving services in a home care setting, or patients in hospitals.*

7 Entrapment Zones



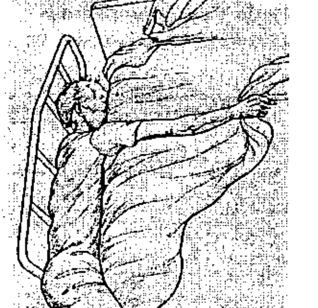
Zone 1 - Within Rail



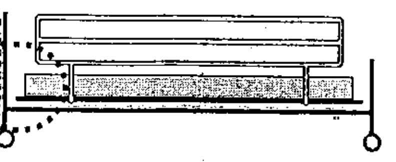
Zone 2 - Rail to Bed End (head/foot boards)

Zone 3 - Between Split Rails

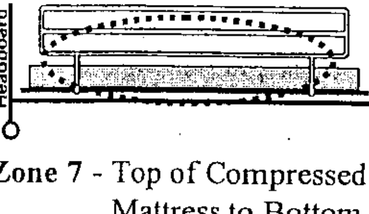
Zone 4 - Top of Compressed Mattress to Bottom of Rail (both ends)



Zone 5 - Rail to Mattress



Zone 6 - Bed Ends to Mattress (head/foot boards)



Zone 7 - Top of Compressed Mattress to Bottom of Rail Between Supports

Side Rails - Record of Informed Consent

Resident Name:

Room #:

I am requesting that I have side rails on my bed for repositioning. I recognize that side rails put me at risk for entrapment that may lead to serious injury including, but not limited to, contractures, strangulation, or death.

Resident Signature	Responsible Party Signature
Staff Signature	
Staff Signature	1ST QTR REVIEW DATE
Staff Signature	2ND QTR REVIEW DATE
Staff Signature	3RD QTR REVIEW DATE
Staff Signature	4TH QTR REVIEW DATE

DAILY CLEANING SCHEDULE

	MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY			SATURDAY			SUNDAY		
COOK - 1	Brea	Lun	Din	Brea	Lun	Din	Brea	Lun	Din	Brea	Lun	Din	Brea	Lun	Din	Brea	Lun	Din	Brea	Lun	Din
Range/Catch Pan																					
Grill																					
Blender Food Processor																					
Mixer																					
Slicer																					
Juice Dispenser																					
Knife Rack																					
All Counters / Cook's Tables																					
Wash Walls in Cook's Area																					
Dish Room																					
Kitchen Floors																					
Range Top (Burners)																					
Mixer																					
COOK - 2																					
Steam Tables																					
Toaster																					
Can Opener																					
Refrigerator (Evenings)																					
Freezer (Evenings)																					
Walk-in Sweep / Mop																					
Storeroom - Sweep / Mop																					
Cans Dusted in Storeroom																					
All Counters / Cook's Area																					
Wash Walls in Cook's Area																					
Dish Room																					
Kitchen Floors																					
Steamer																					
Microwave																					

DAILY CLEANING SCHEDULE

	MONDAY			TUESDAY			WEDNESDAY			THURSDAY			FRIDAY			SATURDAY			SUNDAY		
DIETARY AIDE - 1	Brea	Lun	Din	Brea	Lun	Din	Brea	Lun	Din	Brea	Lun	Din	Brea	Lun	Din	Brea	Lun	Din	Brea	Lun	Din
Carts																					
Tray Carts - Wipe / Sanitize																					
Lowerators - Clean In & Out																					
Milk Despenser																					
Hand Sink - Soap / Paper Towels																					
Dish Room																					
Garbage Disposal																					
Garbage Cans & Lids Washed																					
Dining Room Tables - Clean / Sanitize																					
Kitchen Floors																					
Mop Bucket - Empty / Clean																					
Cabinet in Kolob Café																					
Dish Room Floor - Clean / Dry																					
Walls in Dish Room & Hallway																					
Utility Cart																					
All Sinks																					
DIETARY AIDE - 2																					
Carts																					
Tray Carts - Wipe / Sanitize																					
Coffe Machine																					
Condiment / Silverware Bins / Cart																					
Ice Machine - Scoop																					
Dish Room																					
Garbage Disposal																					
Garbage Cans & Lids Washed																					
Dining Room Tables - Clean / Sanitize																					
Kitchen Floors																					
Mop Buckets - Empty / Clean																					
Cabinet in Dixie Diner																					
Dish Room Floor - Clean / Dry																					
Walls in Dish Room & Hallway																					
Windows & Doors (Evening)																					
Shine Steel in Dish Room (Evening)																					

WEEKLY DEEP-CLEANING SCHEDULE - TAMMY

	Initial and Date				
TAMMY	WEEK 1	WEEK 2	WEEK 3	WEEK 4	WEEK 5
Vent Hood Filters					
Freezer - Clean / Organize					
Refrigerator - Clean / Organize					
Drawers - Clean / Organize					
Cabinets in Dining Rooms - Clean / Organize					
Food Storage Bins - Clean / Label / Date					
Undershelves - Clean					
Tray Carts - Thoroughly Clean					
Pots & Pans Storage Cart - Thoroughly Clean					
Walls - Thoroughly Clean					
Behind Stoves, tables, etc - Thoroughly Clean					
Floor / Grouting					
Drains - Kitchen / Dish Room / Washroom					
Vents					
Legs on Tables / Pots & Pans Sink					
Dish Machine - Delime (Jeannie)					
Pipes behind Equipment					
Back Dock Area - Clean / Organize					
Store Room - Clean / Organize					
Dietary Office - Swept / Mopped (Jeannie)					
Janitor's Closet - Clean / Organize					
Chemical Closet - Empty / Thoroughly Clean					