TNTO YR 5-1203

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

PRINTED: 4/22/2003
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. BUILDING _____ B. WING _____	C 4/16/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	COMPLAINT NUMBER: UT00000748
MANOR CARE OF SOUTH OGDEN	5540 SOUTH 1050 EAST OGDEN, UT 84405	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 323 SS=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 record review and interview it was determined that the facility did not ensure that the resident's environment remained as free of accident hazards as possible. Resident 1 had a history of falls and was assessed and care-planned to have a low bed and mat placed on the floor adjacent to the bed. The facility unit manager was aware that resident 1's bed was broken and could not be lowered prior to his fall and a mat was allegedly not placed on the floor adjacent to resident 1's bed. The resident sustained a head injury requiring an emergency room visit with sutures. It was also documented that resident 1 had a hematoma as a result of the fall. Resident 1. Findings include: Resident 1 was admitted to the facility on 2/10/03 with diagnoses of pneumonia, dementia and a history of trans-ischemic attacks. A review of resident 1's current medical record was done 4/16/03. It revealed that the 5 day comprehensive MDS (Minimum Data Set) dated 2/21/03 section G (transfers) was marked that resident 1 required extensive two man assist. For ambulation the MDS indicated that the activity did not occur. Review of section J revealed that resident 1 had fallen in the past 30 days. A review of resident 1's initial fall assessment dated 2/10/03, revealed that resident 1 had fallen on 2/9/03 at the long term care facility where he had previously resided. It documented that he had	F 323 POC acceptable 5/13/03 Completion date 5/9/03 (Brownback RN)	The statements made on this plan of correction are not an admission of guilt and do not constitute an agreement with the alleged deficiencies herein. F 323 Quality of Care This facility does ensure that the resident environment remains as free from accident hazards as possible. 1. Resident 1's bed has been repaired and operates properly. Resident 1 has floor mat placed at bedside when in bed. 2. Nursing staff received in-service and written direction regarding need to ensure care-planned fall interventions are followed. A facility-wide audit was completed for residents at risk for falls. Interventions in care plans were checked and verified for implementation and appropriateness. Facility maintenance department completed house-wide audit of beds to ensure each functions properly. 3. A fall-intervention audit tool has been developed which facility managers and staff may use to periodically check to ensure care-planned interventions are in place and appropriate. Personnel are aware of location of replacement equipment and emergency-personnel contacts. When accident hazards are identified, immediate	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	NHA	5.9.03

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.

MAY 12 2003
5/9/03 MT

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F 323	Continued From page 1 experienced other falls at home and that a falls management program was required. Review of the initial fall assessment also revealed that resident 1 required extensive assistance with bed mobility and that resident 1's daughter had informed the facility staff that resident 1 "forgets that he cannot walk." Review of section B of the MDS named above revealed that resident 1's cognitive skills were moderately impaired. The New Admission With Device or New Device Order Assessment form dated 2/26/03 was reviewed and revealed that resident 1 had poor safety awareness. A record review of resident 1's care plan dated 2/10/03 was done on 4/16/03. Review of the problem number 1 revealed that resident 1 had a potential for falls related to a history of falls, diagnoses of dementia and a history of trans-ischemic attacks. Review of the approaches revealed that the nursing staff were to toilet resident 1 every 2 hours, have his bed against the wall, utilize a low bed in the low position with a mat on the floor and a body alarm. On 4/16/03 at 11:45 PM, during an interview with the facility nurse who took care of resident 1 at the time of the fall, she stated that resident 1 required a one to two person assist transfer and that he was wheel chair bound. She confirmed with a CNA (Certified Nursing Assistant) who worked with resident 1 that resident 1 was non-ambulatory, but did bear some weight when he was transferred from the bed to his wheel chair or visa versa. She stated that on 4/4/03 at approximately 2:30 AM, she had checked on resident 1 and he appeared to be asleep in his bed. At approximately 4:00 AM, she heard resident 1's bed alarm going off and went down the hall to investigate. She found resident 1 laying adjacent to the bed on the floor with a laceration to his head and there was no mat on the	F 323	action/fix will occur to ensure resident safety. 4. The Fall Intervention Audit Tool is updated by nurse management as intervention changes are reported in standup meetings or when directed by the IDT. DON will ensure compliance. Routine equipment maintenance and repair is to be monitored by Maintenance Department. Administrator to monitor and report to QA monthly for at least three months. Facility fall data is reported monthly at QI. 5. Date of completion: May 9, 2003.	

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F 323	Continued From page 2 floor. She also stated that it was at this time that she discovered that the bed was not in the low position and found out from the aide that it was broken. On 4/16/03 at 2:30 PM, the unit manager was interviewed. She stated that on 4/3/03, she was notified that resident 1's bed was broken so that it would not lower. She further stated that she attempted to contact the maintenance person, but was not able to contact him. The next day, after the fall, the maintenance man went into the room and fixed the bed. A resident census for 4/3/03 was printed out and it was determined that two low beds were available for use that same day on different units. On 4/16/03, record review of the interdisciplinary progress notes signed and dated 4/4/03 and timed 4:00 AM by the nurse who took care of resident 1 was done. It revealed that resident 1 had fallen out of bed and was found on the floor next to his bed. It further stated that resident 1 had a laceration to his right forehead just above the right eye orbit which measured approximately 3 inches in length by 1/4 inch in width and that resident 1 was sent to the emergency room for possible sutures. Another note, which was signed by the assistant director of nurses, dated 4/4/03 and timed at 9:30 AM revealed that resident 1 had returned from the emergency room after having received sutures and was noted to have a hematoma on his head.	F 323		