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

PRINTED: 01/19/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465069	A. BUILDING ______ B. WING ______	01/06/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT OGDEN NURSING & REHAB	375 EAST 5350 SOUTH 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) COMPLETION DATE
F 221 SS=K	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, resident record review, and facility staff interviews, it was determined that the facility did not ensure that restrained residents were properly assessed, and that the residents medical symptoms necessitated the implementation and use of physical restraints for 3 of 15 sample residents. (Residents 1, 4, and 10) Due to the lack of proper assessment, the facility was found to be in Immediate Jeopardy. (It should be noted that the facility has been cited for the past two years for the same deficiency.) Findings include: A complaint was received by the State Survey Agency, on 12/28/04, alleging that resident 10 had been found between the mattress of his bed and the siderails. In addition, the resident was restrained by a soft vest restraint. According to the complaint, resident 1 was transferred to the hospital due to "slow respirations and low oxygen" saturation levels. A review of resident 10's medical record was done on 12/29/04. 1. Resident 10 was admitted to the facility on 12/15/04 with diagnoses that included a fractured right ankle and cerebral vascular accident.	F 221	1/25/05 POC acceptable with addendum completion date 1/14/05 [signature] F221 By January 12, 2005, The Administrator, and Director of Nursing will assess all of our residents to ensure that the use or nonuse of restraints is appropriate. Least restrictive measures will be used. A new restraint policy will be developed and implemented by the Administrator, Director of Nursing, and hired Consultant by January 10, 2005 to ensure that our residents will be kept as safe as possible. (See attached policy). Soft waist restraints will never be used to restrain a resident in bed. Utah Department of Health. dropped at security JAN 24 2005 no receipt, no pm Bureau of Health Facility Licensing, Certification and Resident Assessment	01/14/05

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	1-21-05

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 A Medicare 5 day Minimum Data Set (MDS) assessment, dated 12/19/04, was completed for resident 10 by facility staff. Facility staff documented on the MDS assessment that resident 10's cognitive skills for daily decision making were severely impaired. Facility staff documented on the MDS assessment that resident 10 was physically abusive and resisted care. Facility staff documented on the MDS assessment that resident 10 required extensive assistance of one person for bed mobility and that resident 10 used full side rails on both sides of the bed and a trunk restraint. A care plan dated 12/15/04, was completed by facility staff for resident 10. One of the problems listed on the care plan for resident 10 was "Risk for fall or injury R/T (related to) fell prior to admit." The goal was "...will have no further fall or injury TNR (through next review)." The approaches to the problem were, "Encourage pt (patient) to use call light for assistance. Keep room free of debris et (and) clutter. SR (siderails) (up) X 2 (both sides of bed) while in bed 12/17/04." A "Physical Restraint Eval/Assessment/Consent" form dated 12/25/04, was completed by facility staff for resident 10. Facility staff documented on the form the following: a. Resident 10 was oriented, able to follow directions and had a fair to poor awareness of environment/safety. b. Resident 10 required the assistance of one or two persons for transfers, was unable to ambulate and had a history of falls. c. The least restrictive alternatives recommended for resident 10 were foot rests on the wheelchair and strengthening exercises.	F 221	Starting January 10, 2005 a bed position audit form will be completed by an assigned Certified Nursing Assistant This assignment from the Director of Nursing will take place each night. This information will show the position of each resident studied every hour for the majority of time that they are in bed. This study will run for he period of at least two weeks. This will assist the Administrator and Director of Nursing in identifying which residents are active, and those who do not show any change in positioning. It will also show if restraint changes are appropriate in keeping the residents safe. After the initial evaluation time, this same study will be done at least one day per month for selected residents, by an assigned Certified Nursing Assistant.	

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F 221	Continued From page 2 d. The least restrictive restraint types to be used if indicated for resident 10 were a lap buddy, tied soft waist and side rails on both sides of the bed. e. The frequency and reasons for alternative/restraints was to maintain safety. A signed physician telephone order dated 12/16/04, for resident 10, was for a soft waist restraint to be worn when in bed and in the wheelchair due to cerebral vascular accident with confusion and poor safety awareness. A signed physician telephone order dated 12/17/04, for resident 10, was for side rails up on both sides of the bed due to cerebral vascular accident and poor safety awareness. A review of resident 10's nurses' notes, completed by facility staff, revealed the following: On 12/15/04, timed from 4:30 PM to 5:00 PM, "found him (with) his lower body hanging out of the bed..." On 12/16/05 at 2:15 PM, "Found him hanging off the bed this (after) noon (with) pants down..." On 12/16/04 at 4"55 PM, "Heard noise come from pt (patient) rm (room)-he had been resting quietly in bed (after) P.T. (physical therapy.) Pt sitting on the floor next to the bed (with) his back leaning on the bed. He appears to have been trying to get OOB (out of bed) himself (and) slid off on to the floor. No injury noted...Phoned (physician) order received for SWR (soft waist restraint) to be worn in bed and in wc (wheelchair.)..." On 12/17/04 at 2:44 PM, "N.O. (nursing order) recd (received) (and) noted for SR (side rail) (up)	F 221	By January 12th, 2005, the Director of Nursing and Administrator will complete a new Entrapment Prevention Form for every resident in the facility. This will show the residents Medical Diagnosis to consider as restraint options are discussed. They will then assign a level of risk for each resident while in bed, as well as in their chair. Level 1 will indicate that no interventions or safety devices are necessary. Level 2 will note that safety devices are suggested, and Level 3 will be used for those residents who are at a high risk.	

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F 221	Continued From page 3 X2 (both sides of the bed) while in bed d/t (due to) CVA's (cerebral vascular accidents) poor safety awareness, pt trying to climb out of bed..." On 12/25/04 at 2:45 AM, an agency nurse working in the facility documented for resident 10 the following: "Nurse went into PT's (patient's) room and found Pt out of bed (with) waist restraint still on Pt and restricting Pts breathing. Pt was cut from restraint and V/S (vital signs) were taken and assessment was done-EMS (emergency medical system) was called (and) Pt was taken to ER (emergency room) for exam- Dr (doctor) (and) family notified." An interview was conducted on 12/29/04 at 1:30 PM with the agency nurse. The nurse stated that when he was assigned to the facility that he had received information that resident 10 was always trying to get out of bed, therefore the resident was placed in bed with both side rails in the up position and a soft waist restraint on. He stated that he had made "rounds" at approximately 2:45 AM, 45 minutes after the aides had made their "rounds". He stated that when he entered resident 1's room, he observed the resident to be "hanging from" the soft waist restraint and it appeared that the resident had slipped through/between the side rails and the bed mattress. On a facility incident report for resident 10, dated 12/25/04, the agency nurse documented the following: "Pt was found by nurse. Pt's soft waist restraint was in tact and still on Pt. Pt was out of bed,	F 221	The bed study, medical diagnosis, and risk category will be the data used by the Administrator and Director of Nursing in determining what type of devises are necessary to keep the resident safe. (See entrapment Prevention Form for possible remedies.) The Director of Nursing will identify all of the changes which are to be made regarding restraints. She will, with the assistance of her nursing staff, obtain an order from the resident's physician regarding the change. These changes will immediately be noted on the Certified Nursing Assistant's Assignment Sheets, and Residents Care Plan. They will then be noted on the resident's quarterly MDS when the resident is due.	

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F 221	Continued From page 4 facing down with waist restraint holding Pt's abdomen about 8-10" above the floor. Cast was off of R (right) leg. And pts legs appeared to be stuck between the bed rail and the mattress. The bed rail was in the full up position. The nurse quickly assessed the pts condition and situation-and went for help. Upon returning to the room with 2 other people the waist restraint was cut, the patient was released and lowered to the floor, placed in a supine anatomical position and assessed. Results of the assessment led the nurse to direct that an ambulance be called for transport to an emergency room - Oxygen was applied to the patient and vital signs were monitored as well as continuing assessment until EMS personal arrived...Pt had deep dermal imprint around waist from waist restraint (1) and bleeding from both elbows (2)..." There was no evidence in resident 10's medical record that the facility staff tried other interventions or less restrictive restraints before instituting the use of a soft waist restraint and siderails to keep resident 10 from getting out of bed. 2. Resident 1 was admitted to the facility in February 2001 with diagnoses including Alzheimer's disease with anxious features. Resident 1's medical record was reviewed on 12/29/04 and 1/3/05. A physician's telephone order, dated 1/15/04, documented that resident 1 was to use a SWR (soft waist restraint) while up in a chair, her wheelchair and in her low bed due to Alzheimer's with anxious features, unable to educate on call	F 221	Side rail arrows will immediately be adjusted on each resident's bed to reflect the proper order. The C.N.A. coordinator will confidentially post the new information regarding the restraint in the resident's room. They will also be identified with a yellow piece of paper outside their room to alert the staff that restraint changes have taken place in those rooms. These papers will remain up until February 14,2005, to ensure that the staff are aware of the changes. After that time, they will be taken down. However, the information will continue to be accessible through the C.N.A. information sheet.	

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F 221	Continued From page 5 light use, unsteady gait and history of falls. A review of the December 2004 physician re-certification orders documented an order for the SWR while up in chair, wheelchair and low bed due to Alzheimer's with anxious features, unable to educate on call light use, unsteady gait and history of falls. An annual MDS assessment, dated 11/10/04, was completed by facility staff for resident 1. Facility staff documented that resident 1's cognitive skills for daily decision making were moderately impaired. Facility staff documented that resident 1 was independent with bed mobility, and required extensive assistance with one person physical assist with transfers and used a trunk restraint. On 11/10/04, facility staff initiated a "Risk for Fall or Injury" care plan for resident 1. It documented that resident 1 was at risk for falls or injury related to Alzheimer's with anxious features as exhibited by a fall on 9/3/04 and she was unable to be educated regarding safety. The documented goal was for resident 4 to have no further fall or injury. Documented interventions included soft waist restraint while in wheelchair and while in bed. On 1/26/04, a "Physical Restraint Eval/Assessment/Consent" form was completed by facility staff for resident 1. The following was documented: a. Resident 1 was confused and oriented to name only, was able to follow directions at times and had poor awareness of environment/safety. b. Resident 1 required one person assistance with transfers and ambulation and had a history of	F 221	Our Restorative Therapy department will evaluate new residents. They will complete the Physical Restraint Evaluation / Assessment / Consent form on the day of admission, and give it to the Director of Nursing. She, with the assistance of the Administrator will make the proper assessment of which devices are necessary to keep the resident safe. The Director of Nursing will then obtain family consents if necessary, as well as physician orders. The Director of Nursing will assign a Certified Nursing Assistant to do a positioning sheet for the new resident for a specific time frame to ensure that the resident is safe with the designed safety devices.	

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F 221	Continued From page 6 falls. c. The least restrictive alternatives recommended for resident 1 were increased supervision and a low bed. d. The least restrictive restraint types to be used if indicated for resident 1 was a tied soft waist. e. The frequency and reasons for alternative/restraints was to maintain safety, enhance increased self mobility and repositioning, protect from life threatening injury due to falls, enable to remain seated when not being assisted to transfer/ambulate and they were to be used at all times. On 3/1/01, an "Entrapment Prevention Form" was completed for resident 1 by facility staff. This form was last updated on 11/10/04. Facility staff documented on the form that the side rails were sturdy and in good repair and the mattress was large enough to prevent unnecessary gap between headboard, footboard, and side rail danger. It was documented that resident 1 was not a "High Risk" for entrapment and that she was confused. A review of resident 1's nursing notes, completed by facility staff, revealed the following: On 2/20/04, a nursing note timed 2:15 AM to 2:35 AM documented that resident 1 was found by a facility CNA "lying on the floor mat next to the bed on her [right] side. PT (patient) had somehow rolled off the bed. Noted to have skin tear RFA (right forearm), reddness (sic) around waist area, back from SWR (soft waist restraint) [and] redness on mid back from leaning against SR (side rail)." On 6/27/04, at 2:30 AM, a nurse documented that	F 221	The Director of Nursing will complete a monthly audit for all of the residents who have restraints, or assisting devices to ensure compliance, (see audit sheet). Upon the residents M.D.S. review, or a significant change, the Director of Nursing and members of the I.D.T. team will review the restraint or assisting device plan to ensure that it remains to be the best plan possible for the resident. The Director of Nursing and Administrator will hold an in-service for all nursing staff on January 10th 2005, to discuss our new restraint policy, and train the staff. The use of all new equipment dealing with restraints will be discussed.	

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F 221	Continued From page 7 resident 1 was found by a CNA during rounds with her legs off of the left side of the bed, her upper body on the bed and her soft waist restraint was very tight. It was also documented that resident 1 had "... bruises noted on [right] hip [left] breast, [left] FA (forearm) [and] around abdomen where SWR (soft waist restraint) was." On 9/3/04, at 9:30 PM, a facility nurse documented that a CNA"... reported to this nurse that resident fell off bed between wall and bed and was laying on the floor under bed. SWR (soft waist restraint) still around waist. Has red marks for restraints around waist on shoulder." On 9/3/04, facility staff completed an incident report for resident 1. It documented that resident 1 had experienced a fall from bed and had an abrasion injury. The nurse documented, " Resident fell between wall and bed [with] restraints still around waist." It was further documented that resident 1 had, "Redness around middle of body where restraints were. Redness on shoulder." Nursing notes and "Monthly Nursing Assessments" from 9/4/04 through 12/23/04 documented that the facility staff continued to use a soft waist restraint on resident 1. There was no documentation that any other assessments or least restrictive measures were attempted for resident 1. Review of resident 1's medical record evidenced that no alternatives to the soft waist restraint had been implemented after it was documented that resident 1 had fallen out of bed and been injured by her soft waist restraint on at least 3 occasions.	F 221	Results of the restraint audits, policy changes, restraint totals, assisting devices used, etc will be shared by Nurse management in our monthly Quality Assurance Team meeting on January 13th, 2005, as well as monthly. The Quality Assurance Team will review and revise this program as necessary to ensure that proper care is always given to our residents. The Director of Nursing will be responsible to ensure compliance. On 12/27/04 an internal investigation was completed by the Administrator and Director of Nursing at Mt. Ogden Nursing and Rehabilitation center. The results of it's findings were shared with the survey team on 12/28/2004. Resident 10 had been discharged to the hospital.	

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F 221	Continued From page 8 3. Resident 4 was admitted to the facility on November 2004 with diagnoses including mild dementia. During the initial tour of the facility on 12/29/04 at 6:10 AM, resident 4 was observed by a surveyor to be in bed, lying on his right side. The bed's half siderails were observed to be in the up position on both sides of the bed and were positioned on the center of the bed. Resident 4 was observed to be wearing a soft waist restraint that was tied to the bed in the same area as the side rails were. Resident 4 was observed to moving his legs and appeared to be using his hands to try and remove the restraint. The mattress of resident 4's bed was observed to create a gap of 5 inches between the edge of the mattress and the siderail. During the observation, resident 4 asked the surveyor for a pair of scissors or a knife to cut the restraint loose. Periodic observations were made of resident 4 from 6:10 AM to 7:40 AM. Resident 4 remained in bed with the soft waist restraint in place, both side rails in the up position. Resident 4 continued to move around on the bed and try and remove the soft waist restraint. A review of resident 4's medical record was completed on 12/29/04, 1/3/05 and 1/4/05. On 11/30/04, there was a physician's telephone order that documented resident 4 was to use side rails up times 2 at night for dementia with potential for falls due to poor safety awareness. On 12/15/04, there was a physician's telephone order documenting resident 4 was to wear a soft waist restraint when in bed and in chair due to dementia with poor safety awareness with a	F 221	Resident #1 was placed on a low bed with a U mattress, as well as a pad by the side of the bed. She has been monitored hourly for several nights, and results have shown this to be an effective solution in keeping her safe. The soft waist restraint was immediately removed. She has also been placed in a geri chair while she is up during the day. She does not have a restraint in her chair. This has also been closely observed, and has found to be very effective in keeping her safe as well. Resident #4 has also been placed in a low bed with a mat on the floor, as well as a bed alarm. He has also been monitored hourly through the night and results have found him to be safe with these measures. He has had his soft waist restraint immediately removed. He is not restrained	

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F 221	Continued From page 9 history of multiple falls. An initial MDS assessment, dated 12/6/04, was completed by facility staff for resident 4. Facility staff documented that resident 4's cognitive skills for daily decision making were moderately impaired. Facility staff documented that resident 4 required supervision with bed mobility, limited assistance with one person physical assist with transfers and used full side rails on both sides of the bed. On 12/7/04, facility staff initiated a "Risk for Fall or Injury" care plan for resident 4. It documented that resident 4 was at risk for falls or injury as exhibited by he fell twice on 11/27/04, he had impaired vision and wore glasses and he had an unsteady gait. The documented goal was for resident 4 to have no further fall or injury during his stay at the facility. Documented interventions included provide assistance as needed, encourage patient to use call light and answer promptly and both side rails up at night. On 11/12/04, a "Physical Restraint Eval/Assessment/Consent" form was completed by facility staff for resident 4. The following was documented: a. Resident 4 was oriented, was able to follow directions and had good to fair awareness of environment/safety. b. Resident 4 required one person assistance with transfers, ambulated on his own with a walker or cane and had no history of falls. c. The least restrictive alternatives recommended for resident 4 were footrests on his wheelchair. d. The least restrictive restraint types to be used	F 221	while in his chair, which has been observed to be a safe measure for him. Also refer to plan of correction #323, 490, and 521.	

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F 221	Continued From page 10	F 221		

if indicated for resident 4 were a tied soft waist and both side rails at night.
e. The frequency and reasons for alternative/restraints was to maintain safety, protect from life threatening injury due to falls, to remind to call for assistance with all transfers and they were to be used at all times.

On 12/8/04, an "Entrapment Prevention Form" was completed for resident 4 by facility staff. Facility staff documented on the form that the side rails were sturdy and in good repair and the mattress was large enough to prevent unnecessary gap between headboard, footboard, and side rail danger. It was documented that resident 4 was not a "High Risk" for entrapment.

On 11/30/04, there was a physician's telephone order that documented resident 4 was to use side rails up times 2 at night for dementia with potential for falls due to poor safety awareness.

On 12/15/04, there was a physician's telephone order documenting resident 4 was to wear a soft waist restraint when in bed and in chair due to dementia with poor safety awareness with a history of multiple falls.

A review of resident 4's nursing notes, completed by facility staff, revealed the following:

On 12/15/04, at 2:30 PM, it was documented that resident 4 was found crawling around on the floor of his room and that the nursing assistant assisted the resident to sit on the bed. The notes indicated that a soft waist restraint was placed on the resident to "help prevent more falls". The note then documented that the nurse placed a call to the hospice case manger for an order for

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT OGDEN NURSING & REHAB	375 EAST 5350 SOUTH 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) COMPLETION DATE
F 221	Continued From page 11 the resident. On 12/17/04, at 11:35 AM, the nurse documented that the hospice nurse called the facility and stated that they were sending over a body alarm to try on resident 4 instead of the soft waist restraint. The note documented that the alarm was received and was placed on resident 2. On 12/19/04, at 5:00 PM, the nurse documented that the bed alarm was not effective because it was "not loud enough". Nursing notes document that the resident was found ambulating to the toilet. The note documented that resident 4 was "also found scooting on his buttock to the restroom" and "Stated he did not fall". The nursing notes from 12/19/04 through 12/26/04 documented that the facility staff continued to use a soft waist restraint on resident 4. There was no documentation that any other assessments or least restrictive measures were attempted for resident 4. Review of resident 4's medical record evidenced that no least restrictive alternatives to the use of both side rails and the soft waist restraint had been implemented. An interview was held with the director of nursing (DON) on 12/29/04 at 8:15 AM. The DON was asked what the process in the facility was for implementing restraints. The DON stated that she gave new residents about a week to assess how the resident was going to adjust to the new surroundings. If the resident was a fall risk and the resident attempted to get out of bed without assistance or falls, then an order was obtained for a soft waist restraint. If the resident continued to	F 221		

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F 221	Continued From page 12 try and get out of bed then an order was obtained for siderails on both sides of the bed.	F 221		
F 312 SS=E	483.25(a)(3) QUALITY OF CARE A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation of three meals, interview, and review of residents' medical records, it was determined that for 5 of 15 sample residents, the facility did not ensure the necessary services to maintain good nutrition. (Residents 1, 7, 11, 12, and 13) Findings include: Observations were made of the facility's dining room during the recertification survey on 1/4/05 through 1/6/04. There were four assisted tables observed with approximately 22 residents seated at the four tables. The facility nursing assistants were observed to be assisting residents from outside of circular shaped tables, assisting one resident at a time. The facility's meals are served at the following times: Breakfast 7:15 AM Lunch 12:00 PM Dinner 5:15 PM 1. Resident 11 was admitted to the facility on 5/18/00 with the diagnoses of insulin dependent	F 312	F312 On January 12, 2005, the Director of Nursing, and Dietary Manager will divide all of our residents who are "feeders' into two groups. One group at a time will be brought into the dining room for Breakfast and Lunch. Each resident at the table will be served at the same time, and the Certified Nursing Assistants will feed those residents simultaneously. No resident will have their food sitting in front of them, waiting to be fed for more than a few minutes. The dinner group, which is smaller, will be under the same protocol even though there is just one group.	01/14/05

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F 312	Continued From page 13 diabetes mellitus, senile psychotic condition, arthritis, gastroesophageal reflux disease and hypertension. A review of resident 11's medical record was done on 1/5/05. A quarterly Minimum Data Set (MDS) assessment, dated 10/13/04, was completed by facility staff for resident 11. Facility staff documented that resident 11 was totally dependant on one person for eating. Resident 11's care plan dated 2/4/04, included the problem of "Self care Deficit exhibited by total assist with feeding". Resident 11 was observed in the dining room with her breakfast meal on 1/4/05 at 7:30 AM. Resident 11 was observed at the assisted table with her breakfast meal uncovered without any assistance from 7:30 AM to 8:05 AM. At 8:05 AM, a nursing assistant began to assist resident 11 with her breakfast. The nursing assistant was not observed to offer to reheat resident 11's food. The nursing assistant fed resident 11 until 8:11 AM. Resident 11 ate 10% of her breakfast meal. Resident 11 was not assisted with her meal until 35 minutes after it had been served. On 1/5/05 at 7:50 AM, a facility nursing assistant was interviewed. The nursing assistant stated that the residents' breakfast meal started at 7:15 AM and they were served by 7:30 AM. Resident 11 was observed in the dining room with her breakfast meal on 1/5/05 at 7:50 AM. Resident 11 was observed at the assisted table with her breakfast meal untouched. At 7:51 AM,	F 312	Starting on January 12, 2005, each meal will be audited by a member of nurse management, or an appointed staff member, every day until January 26, 2005. After that time, this audit will be done monthly, (See audit form). These results will be shared monthly during our Quality Assurance meeting. During that time, the Quality Assurance Team will monitor, make changes or recommendations regarding this program. The Director of Nursing will hold an in-service for all Certified Nursing Assistants on January 10th, 2005, to instruct them on the new changes, and will be responsible to ensure compliance.	

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F 312	Continued From page 14 a facility nursing assistant was observed to assist resident 11 with her meal. The nursing assistant had not reheated the meal. At 8:05 AM, resident 11 consumed 100% of her cereal and 30 cc of fluid. At 8:07 AM, the nursing assistant stopped assisting resident 11 and helped two different residents to their rooms. Resident 11's intake record documented that resident 11 ate 50% Resident 11 was observed to be assisted to the dining room on 1/5/05 at 11:58 AM. Resident 11 was observed to be awake when the dietary aide served her lunch meal at 12:15 PM. At 12:40 PM, a facility nursing assistant was observed to tell resident 11 to wake up but did not assist resident 11 with her meal. At 12:55 PM, resident 11 received one to one assistance with her meal. The aide was observed to reheat resident 11's meal and had her lunch back to the table by 1:00 PM. Resident 11 was taken out of the dining room at 1:06 PM. Resident 11 was observed to have eaten 50% of her steak and 25% of her mashed potatoes and 30 cc of orange juice. Resident 11 was not assisted with her meal until 40 minutes after the meal had been served. Resident 11 was observed in the dining room with her breakfast meal on 1/6/04 at 7:30 AM. An aide was observed to assist resident 11 and another resident with their meals at 7:35 AM. A second aide provided one to one assistance with resident 11's meal at 7:55 AM until 8:00 AM. The aide left at 8:00 AM to help another resident. Resident 11 was not assisted with her meal from 8:00 AM until 8:10 AM. Resident 11 was assisted with her breakfast meal at 8:10 AM to 8:17 AM. At 8:25 AM, an aide was observed to reheat resident 11's	F 312	For Residents #1,7,11, 12, 13, as well as all other residents who require assistance in eating their meals, they will receive timely assistance (as indicated in this plan of correction). The Certified Nursing Assistant will also provide verbal cueing, encouragement, and any assistance needed in promoting success in the intake of their meal.	

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F 312	Continued From page 15 breakfast. Resident 11 was assisted out of the dining room at 8:43 AM. Resident 11 drank 10% of her water, 100 % of her supplement and juice. Resident 11 ate 50% of her breakfast meal. 2. Resident 13 was admitted to the facility on 3/6/03 with diagnoses of hypernatremia, renal failure, decubitus ulcer, hyperglycemia, anemia, edema, hypothyroidism, and organic brain syndrome. A review of resident 13's medical record was done on 1/5/05. A quarterly MDS assessment dated 11/17/04, was completed by facility staff for resident 13. Facility staff documented on the assessment that resident 13 required total assistance of one person for eating. Facility staff documented on resident 13's care plan on 3/10/04 a problem of "Potential For Alternation in ADL (activities of daily living) Status related to BLE (bilateral lower extremity) weakness, dementia, malnutrition exhibited by need for extensive assit (assist) with eating". Resident 13 was observed in the dining room with her breakfast meal on 1/4/05 at 7:35 AM. Resident 13 was observed at the assisted table with her breakfast meal uncovered without any assistance from 7:30 AM to 8:05 AM. The aide was not observed to offer to reheat resident 13' food. Resident 13 ate 10% of her breakfast meal. Resident 13 did not receive assistance with her meal for 35 minutes after she had been served. Resident 13 was observed to be assisted to the dining room on 1/5/05 at 12:00 PM. Resident 13	F 312		

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F 312	Continued From page 16	F 312		

was served her lunch meal at 12:14 PM. Resident 13 waited 20 minutes with her lunch meal in front of her uncovered and not being assisted. Resident 13 received one to one assistance with her lunch meal from 12:40 PM to 12:45 PM.. Resident 13 had consumed 100% of her potatoes and a 10% of her cabbage by 12:45 PM. Resident 13 was again assisted with her meal at 12:55 PM, ten minutes later. The staff did not offer to reheat resident 13's lunch meal. Resident 13 was assisted out of the dining room by 1:06 PM. Resident 13 had consumed 100% of her steak and drank 100% of her supplement and juice.

3. Resident 1 was admitted to the facility in February 2001 with diagnoses including Alzheimer's disease with anxious features.

Resident 1's medical record was reviewed on 12/29/04 and 1/3/05.

An annual MDS assessment, dated 11/10/04, was completed by facility staff for resident 1. Facility staff documented that resident 1 required extensive assistance with one person physical assist with eating.

An alteration in ADL (activities of daily living) care plan was completed by facility staff on 11/10/04. It documented that related to her Alzheimer's disease, resident 1 required extensive assistance with eating. A documented intervention was provide prompting and cueing with cares.

A potential for alteration in nutrition care plan was completed by facility staff on 11/10/04. It documented that resident 1 was at risk nutritionally related to a history of poor intake,

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F 312	Continued From page 17	F 312		

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decreased chewing and swallowing ability and the need for a mechanically altered diet. A documented intervention was encourage intake.

On 1/4/05, observations of resident 1 during the breakfast meal revealed the following:

At 7:28 AM, resident 1's lunch tray was placed in front of her. Resident 1 was not observed to attempt to feed herself and no staff member was observed to sit and assist her with her meal.

At 7:34 AM (6 minutes after her tray was delivered), a facility CNA was observed to stand and feed resident 1 one bite of her hot cereal. The CNA was observed to then leave to assist another resident.

At 7:42 AM (14 minutes after her tray was delivered and 8 minutes since she was last assisted with her meal), a facility CNA was observed to stand and assist resident 1 consume several bites of her cereal an a few sips of milk until 7:44 AM at which time she left to assist another resident.

At 7:50 AM (22 minutes after her tray was delivered and 6 minutes since she was last assisted with her meal), resident 1 was assisted with her meal by a facility CNA until 7:56 AM.

At 8:04 AM, resident 1 was taken from the dining room.

At no time during this observation was resident 1 observed to attempt to feed herself. Resident 1 was not observed to resist staff assistance with eating. At no time during the meal observation was resident 1's meal tray re-heated.

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F 312	Continued From page 18	F 312		

On 1/5/05 observations of resident 1 during the lunch meal revealed the following:

At 12:14 PM, resident 1's lunch tray was placed in front of her. Resident 1 was not observed to attempt to feed herself and no staff member was observed to sit and assist her with her meal.

At 12:26 PM (12 minutes after her tray was delivered), a facility CNA was observed to stand and feed resident 1 several bites of mashed potato. The CNA was observed to then leave to assist another resident.

At 12:35 PM (21 minutes after her tray was delivered and 9 minutes since she had been last assisted with her meal), a facility CNA was observed to stand and assist resident 1 consume one bite of food. The CNA was then observed to leave to assist another resident.

At 12:37 PM (23 minutes after her tray was delivered and 2 minutes since she had been last assisted with her meal), a second facility CNA asked the CNA who had been assisting resident 1 if she was done eating. The first CNA responded "no". At 12:38 PM, the second facility CNA assisted resident 1 with her meal until she had consumed 100%.

Resident 1 only received staff assistance to consume a few bites of her meal for the first 23 minutes after her tray was served and uncovered.

At no time during this observation was resident 1 observed to attempt to feed herself. Resident 1 was not observed to resist staff assistance with eating. At no time during the meal observation

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F 312	Continued From page 19 was resident 1's meal tray re-heated. 4. Resident 7 was admitted to the facility in August 2002 with diagnoses including Alzheimer's disease and history of a cerebrovascular accident. Resident 7's medical record was reviewed on 1/5/05. A quarterly MDS assessment, dated 11/10/04, was completed by facility staff for resident 7. Facility staff documented that resident 7 required extensive assistance with one person physical assist with eating. An alteration in ADL (activities of daily living) care plan was completed by facility staff on 8/19/04. It documented that related to Alzheimer's disease and history of a cerebrovascular accident, resident 7 required extensive assistance with eating. A documented intervention was provide assistance as needed. On 1/5/05 observations of resident 7 during the lunch meal revealed the following: At 12:14 PM, resident 7's lunch tray was placed in front of him. Resident 7 was not observed to attempt to feed himself and no staff member was observed to sit and assist him with his meal. At 12:20 PM (6 minutes after his tray was delivered), a facility CNA was observed to stand and feed resident 7 several bites of food. At 12:22 PM the CNA was observed to then leave to assist another resident. At 12:29 PM (15 minutes after his tray was	F 312		

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F 312		F 312		

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delivered and 7 minutes since he had been last assisted with his meal), a facility CNA was observed to stand and assist resident 7 consume a couple of bites of food. The CNA was then observed to leave to assist another resident.

At 12:52 PM (38 minutes after his tray was delivered and 7 minutes since he had been last assisted with his meal), a facility CNA asked him if he was finished eating then walked away. At 12:53 PM, a second facility CNA asked resident 7 if he was finished eating and walked away. Neither of the CNA's was observed to offer resident 7 any of his food.

At 12:54 PM, (40 minutes after his tray was delivered and 23 minutes since he had last been assisted with his meal), a facility CNA sat to assist resident 7. At 12:59 PM resident 7 was taken from the dining room.

At no time during this meal observation was resident 7 observed to attempt to feed himself. Resident 7 was not observed to resist staff assistance with eating. At no time during the meal
observation was resident 7's meal tray re-heated.

6. Resident 12 was admitted to the facility in July 2003 with diagnoses including history of a cerebrovascular accident with depressive features and failure to thrive.

Resident 12's medical record was reviewed on 1/5/05 and 1/6/05.

A quarterly MDS assessment, dated 10/6/04, was completed by facility staff for resident 12. Facility staff documented that resident 12 required

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F 312	Continued From page 21 supervision with set-up help with eating. An decrease in self-feeding ability care plan was completed by facility staff on 7/14/04. It documented resident 12 had a decrease in self-feeding ability related to a history of a cerebrovascular accident and a decrease in vision. A documented intervention was monitor self-feeding ability and monitor dietary intake. On 1/4/05 observations of resident 12 during the breakfast meal revealed the following: From 7:28 AM until 7:49 AM resident 12 was observed with his breakfast tray in front of him. Resident 12 was not observed to attempt to feed himself and no staff member was observed to cue, encourage or assist resident 12 to consume his meal. At 7:49 AM a facility CNA was observed to ask resident 12 to eat. Resident 12 was observed to be in his wheelchair backed away from the table at an angle. At 7:57 AM a facility CNA was observed to turn resident 12 in his wheelchair and push him up to the table. The aide was not observed to cue, encourage or assist resident 12 to eat. At 8:10 AM, after asking a facility CNA to add more sugar to his cereal (which was done) he took a few bites of his crisp rice cereal on his own. Resident 12 was not observed to eat any of the food on his plate. At no time during the 42 minutes that resident 12 was observed was he encouraged or assisted to consume his meal.	F 312		

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F 312	Continued From page 22 On 1/5/05 observations of resident 12 during the lunch meal revealed the following: At 12:14 PM, resident 12 was served his lunch tray. Resident 12 was not observed to consume any of his meal on his own. No facility staff were observed to encourage or assist resident 12 to eat. From 12:22 PM until 12:25 PM, a facility CNA was observed to stand and assist resident 12 consume a few bites of food. Resident 12 was not observed to refuse or resist assistance. At 12:30 PM (16 minutes after his tray was delivered and 5 minutes after he was last assisted with his meal) resident 12 was observed backing his wheelchair away from the table. A facility CNA asked resident 12 to eat. At 12:55 PM (41 minutes after his tray was delivered and 30 minutes after he was last assisted with his meal) a facility aide asked if he was going to eat. Resident 12 was not encourage or assisted to eat. At 12:59 PM (45 minutes after his tray was delivered and 34 minutes after he was last assisted with his meal) resident 12 was taken from the dining room. He had eaten 0% of the food items on his tray. With the exception of a facility CNA telling resident 12 to eat 2 times, during the 45 minutes that resident 12 was observed he was not encouraged or assisted to consume his meal.	F 312		
F 323	483.25(h)(1) QUALITY OF CARE	F 323		

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F 323 SS=K	Continued From page 23 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 for 3 of 15 sample residents, the facility did not ensure that the resident environment remained as free from accident hazards as possible. Specifically, the facility continued to place residents in situations, including the use of restraints, after the residents had become entrapped,or sustained injuries. (Residents 1, 3, and 10.) Based on the findings, the facility was found to be in Immediate Jeopardy. Findings include: A complaint was received by the State Survey Agency, on 12/28/04, alleging that resident 1 had been found between the mattress of his bed and the siderails. In addition, the resident was restrained by a soft vest restraint. According to the complaint, resident 1 was transferred to the hospital due to "slow respirations and low oxygen" saturation levels. A review of resident 10's medical record was done on 12/29/04. 1. Resident 10 was admitted to the facility on 12/15/04 with diagnoses that included a fractured right ankle and cerebral vascular accident. A Medicare 5 day Minimum Data Set (MDS)	F 323	F 323 Our Incident / Accident reports are reviewed each day during our census meeting by the Administrator, Director of Nursing, Social Worker, Physical Therapist, and Central Supply Associate. These team members make up an interdisciplinary team to strategize and advise should there be a need for immediate follow up or action. The Director of Nursing will research details if needed regarding items such as skin tears, bruises, etc, and note her findings on the incident report. She will implement action for such items which require changes to be made with restraint alternative devices, or restraints. Our Central Supply Associate will make recommendations regarding equipment changes if necessary.	01/14/05

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F 323	Continued From page 24 assessment, dated 12/19/04, was completed by facility staff for resident 10. Facility staff documented on the MDS assessment that resident 10's cognitive skills for daily decision making were severely impaired. Facility staff documented on the MDS assessment that resident 10 was physically abusive and resisted care. Facility staff documented on the MDS assessment that resident 10 required extensive assistance of one person for bed mobility and that resident 10 used full side rails on both sides of the bed and a trunk restraint. A care plan dated 12/15/04, was completed by facility staff for resident 10. One of the problems listed on the care plan for resident 10 was "Risk for fall or injury R/T fell prior to admit." The goal was "...will have no further fall or injury TNR (through next review)." The approaches to the problem were, "Encourage pt (patient) to use call light for assistance. Keep room free of debris et (and) clutter. SR (siderails) (up) X 2 (both sides of bed) while in bed 12/17/04." A "Physical Restraint Eval/Assessment/Consent" form dated 12/25/04, was completed by facility staff for resident 10. Facility staff documented on the form the following: a. Resident 10 was oriented, able to follow directions and had a fair to poor awareness of environment/safety. b. Resident 10 required the assistance of one or two persons for transfers, was unable to ambulate and had a history of falls. c. The least restrictive alternatives recommended for resident 10 were foot rests on the wheelchair and strengthening exercises.	F 323	The Director of Nursing will make referrals to Physical Therapy, Social Service, or Treatment Nurse, as indicated. Reports regarding incident / accident report totals, specifics, an trends will be reported by the Assistant Director of Nursing, and Care Plan Coordinator at our monthly Quality Assurance Meeting. The Administrator will be ultimately Responsible to ensure compliance. Also refer to plan of correction #221, 490, and 521.	

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d. The least restrictive restraint types to be used if indicated for resident 10 were a lap buddy, tied soft waist and side rails on both sides of the bed.
e. The frequency and reasons for alternative/restraints was to maintain safety.

An "Entrapment Prevention Form" was completed for resident 10 by facility staff on 12/16/04. Facility staff documented on the form that the side rails on the bed were sturdy and in good repair and the mattress was large enough to prevent unnecessary gaps between the headboard, footboard and side rail danger.

Facility staff documented that resident 10 was active while in bed, did not lie still or tried to climb out and was confused. The facility staff determined that resident 10 was not a "High Risk" for entrapment.

A signed physician telephone order dated 12/16/04, for resident 10, was for a soft waist restraint to be worn when in bed and in the wheelchair due to cerebral vascular accident with confusion and poor safety awareness.

A signed physician telephone order dated 12/17/04, for resident 10, was for side rails up on both sides of the bed due to cerebral vascular accident and poor safety awareness.

A review of resident 10's nurses' notes, completed by facility staff, revealed the following:

On 12/15/04, timed from 4:30 PM to 5:00 PM, "found him (with) his lower body hanging out of the bed..."

On 12/16/05 at 2:15 PM, "Found him hanging off

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F 323	Continued From page 26 the bed this (after) noon (with) pants down..." On 12/16/04 at 4"55 PM, "Heard noise come from pt (patient) rm (room)-he had been resting quietly in bed (after) P.T. (physical therapy.) Pt sitting on the floor next to the bed (with) his back leaning on the bed. He appears to have been trying to get OOB (out of bed) himself (and) slid off on to the floor. No injury noted...Phoned (physician) order received for SWR (soft waist restraint) to be worn in bed and in wc (wheelchair.)..." On 12/17/04 at 2:44 PM, "N.O. (nursing order) recd (received) (and) noted for SR (side rail) (up) X2 (both sides of the bed) while in bed d/t (due to) CVA's (cerebral vascular accidents) poor safety awareness, pt trying to climb out of bed..." On 12/25/04 at 2:45 AM, an agency nurse working in the facility documented for resident 10 the following: "Nurse went into PT's (patient's) room and found Pt out of bed (with) waist restraint still on Pt and restricting Pts breathing. Pt was cut from restraint and V/S (vital signs) were taken and assessment was done-EMS (emergency medical system) was called (and) Pt was taken to ER (emergency room) for exam- Dr (doctor) (and) family notified." An interview was conducted on 12/29/04 at 1:30 PM with the agency nurse. The nurse stated that when he was assigned to the facility that he had received information that resident 10 was always trying to get out of bed, therefore the resident was placed in bed with both side rails in the up position and a soft waist restraint on. He stated	F 323		

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that he had made "rounds" at approximately 2:45 AM, 45 minutes after the aides had made their "rounds". He stated that when he entered resident 1's room, he observed the resident to be "hanging from" the soft waist restraint and it appeared that the resident had slipped through/between the side rails and the bed mattress.

On an "Investigative Data Sheet" for resident 10, dated 12/25/04, the same nurse documented the following:

"Pt was found by nurse. Pt's soft waist restraint was in tact and still on Pt. Pt was out of bed, facing down with waist restraint holding Pt's abdomen about 8-10" above the floor. Cast was off of R (right) leg. And pts legs appeared to be stuck between the bed rail and the mattress. The bed rail was in the full up position. The nurse quickly assessed the pts condition and situation-and went for help. Upon returning to the room with 2 other people the waist restraint was cut, the patient was released and lowered to the floor, placed in a supine anatomical position and assessed. Results of the assessment led the nurse to direct that an ambulance be called for transport to an emergency room - Oxygen was applied to the patient and vital signs were monitored as well as continuing assessment until EMS personal arrived...Pt had deep dermal imprint around waist from waist restraint (1) and bleeding from both elbows (2)..."

The hospital emergency room admission notes for this incident indicated that the resident was observed to have the following injuries; "open, weeping wound L (left) to umbilical {measuring from umbilicus to center of back - Approx

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F 323	Continued From page 28 (approximately) 3-4" (inches) wide); "L leg shows severe bruising worsening toward inside of ankle."; and, "L arm shows dk (dark) bruising (with) skin tears around wrist." Resident 10 was discharged from the facility on 12/25/04 and admitted to the local hospital. On 12/29/04, two nurse surveyors inspected the bed that resident 10 had occupied while in the facility. There was a gap from the top of the mattress to the headboard that measured 6 inches and a gap from the foot of the mattress to the footboard that measured 2 inches. There was a 3 inch gap between the edge of the mattress and the siderails. The siderails could be moved away from the mattress making the gap 4 inches between the mattress and the siderails. An interview was held with the director of nursing (DON) on 12/29/04 at 1:20 PM. The DON stated that the bed was exactly the same as it had been when resident 10 was in the facility. 2. Resident 3 was admitted to the facility on 7/7/04 with diagnoses which included anoxic brain damage, muscle spasms, convulsions and dysphagia. A review of resident 3's medical record was done on 12/29/04. An admission MDS assessment dated 7/20/04, and a quarterly MDS assessment dated 10/20/04, were completed by facility staff for resident 3. Facility staff had documented on the assessments that resident 3's cognitive ability for	F 323		

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daily decision making was severely impaired, and that resident 3 required extensive assistance with bed mobility and transfers. Facility staff also documented that resident 3 was unable to ambulate.

A "Fall Risk Care Plan" was completed by facility staff for resident 3 on 7/28/04 and updated 10/20/04. Facility staff documented that resident 3's fall risks were related to anoxic brain injury, muscle spasms and convulsions and that resident 3 exhibited an unsteady gait and impaired vision. The goal of resident 3's care plan was that resident 3 would not fall or have an injury. The interventions were side rails X 2, frequent visual checks, notify doctor and family of changes and administer medications as ordered by the doctor.

A "Physical Restraint Eval/Assessment/Consent" form dated 7/28/04, was completed by facility staff for resident 3. Facility staff documented on the form the following:

a. Resident 3 was confused, unable to follow directions,and had a poor awareness of environment/safety.
b. Resident 3 required the assistance of 2 persons for transfers, was unable to stand, or ambulate, had contractures of the right hand and had a history of falls in the past 3 months.
c. The least restrictive alternative recommended for resident 3 were footrests on the wheelchair, increased supervision and strengthening exercises.
d. The least restrictive restraint types to be used if indicated for resident 3 were tied soft waist and siderails on both sides of the bed.
e. The frequence and reasons for alternative/restraints was to maintain safety,

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F 323	Continued From page 30 protect from life threatening injury due to falls at all times while in bed. An "Entrapment Prevention Form" was completed for resident 3 by facility staff on 7/28/04. Facility staff documented on the form that the side rails were sturdy and in good repair and the mattress was large enough to prevent an unnecessary gap between headboard, footboard and side rail danger. Facility staff documented that resident 3 was active while in bed, did not lie still or tried to climb out. The facility staff determined that resident 3 was not a "High Risk" for entrapment. A signed physician telephone order dated 7/20/04, was for side rails up on both sides of the bed due to safety and mobility related to medical condition. A review of resident 3's nurses' notes, completed by facility staff, revealed the following: On 11/30/04 at 3:30 AM, "Heard resident scream, different from his usual. Went to check on him and found him with head @ (at) foot of bed, his buttocks down between S.R. (side rail) and bed, one foot on floor the other up on bed. Wedged in tight, had to remove pad and side rail to release him. Body check done. Abrasion across (upper) back and his chest. 2nd toe of left foot, elbow and ankle. Assisted up into bed. B.P.(blood pressure) 180/92, P(pulse) 110, R (respirations) 24 T (temperature) 99. Will continue to monitor...". On an "Investigative Data Sheet" dated 12/1/04, a facility nurse documented that resident 3 had	F 323		

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been found with his head at the foot of the bed, with his buttocks down between the side rail and bed with one foot and leg on the floor and one still up on the bed. The nurse had documented that resident 3 was "wedged in tight", and the pad and siderail had to be removed to release the resident. The nurse also documented that resident 3 had sustained a large abrasion across his upper back and across his chest, and had abrasion on the second toe of the left foot, elbows and ankle.

On 12/2/04, the "Investigative Data Sheet" was reviewed by the facility DON. The DON documented on the form, "Resident unable to tell me what occurred. (Physician) assessed resident nothing needed at present. Nurse instructed CNA's (certified nursing assistants) on proper positioning."

On 12/29/04 at 6:40 AM, resident 3 was observed by two survey staff to be in bed with full siderails up on both sides of the bed. The right siderail had a pad on it the left side rail did not. There was a 4 inch gap between the top of the mattress and the headboard. There was a 3 inch gap between the edge of the mattress and the siderails. The siderails could be moved away from the mattress making the gap 4 inches between the mattress and the siderails.

An interview was held with the DON on 12/29/04 at 8:15 AM. The DON stated that she was aware of the incident with resident 3 on 12/1/04. The DON stated that the facility was considering placing resident 3 on a low bed but had not initiated the change yet.

There was no evidence in resident 3's medical

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record that the facility had re-assessed the use of siderails for resident 3. The was no evidence that the facility had made any changes to resident 3's bed or care to ensure that resident 3 did not become entrapped again.

3. Resident 1 was admitted to the facility in February 2001 with diagnoses including Alzheimer's disease with anxious features.

A review of resident 1's medical record was completed on 12/29/04 and 1/3/05.

An annual MDS assessment, dated 11/10/04, was completed by facility staff for resident 1. Facility staff documented that resident 1's cognitive skills for daily decision making were moderately impaired. Facility staff documented that resident 1 was independent with bed mobility, and required extensive assistance with one person physical assist with transfers and used a trunk restraint.

On 11/10/04, facility staff initiated a "Risk for Fall or Injury" care plan for resident 1. It documented that resident 1 was at risk for falls or injury related to Alzheimer's with anxious features as exhibited by a fall on 9/3/04 and she was unable to be educated regarding safety. The documented goal was for resident 4 to have no further fall or injury. Documented interventions included soft waist restraint while in wheelchair and while in bed.

On 1/26/04, a "Physical Restraint Eval/Assessment/Consent" form was completed by facility staff for resident 1. The following was documented:

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a. Resident 1 was confused and oriented to name only, was able to follow directions at times and had poor awareness of environment/safety.
b. Resident 1 required one person assistance with transfers and ambulation and had a history of falls.
c. The least restrictive alternatives recommended for resident 1 were increased supervision and a low bed.
d. The least restrictive restraint types to be used if indicated for resident 1 was a tied soft waist.
e. The frequency and reasons for alternative/restraints was to maintain safety, enhance increased self mobility and repositioning, protect from life threatening injury due to falls, enable to remain seated when not being assisted to transfer/ambulate and they were to be used at all times.

On 3/1/01, an "Entrapment Prevention Form" was completed for resident 1 by facility staff. This form was last updated on 11/10/04. Facility staff documented on the form that the side rails were sturdy and in good repair and the mattress was large enough to prevent unnecessary gap between headboard, footboard, and side rail danger. It was documented that resident 1 was not a "High Risk" for entrapment and that she was confused.

On 1/15/04, there was a signed physician's telephone order that documented resident 1 was to use a soft waist restraint while up in chair, wheelchair and low bed due to Alzheimer's with anxious features unable to educate on call light use, unsteady gait and history of falls.

A review of resident 1's nursing notes, completed

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F 323	Continued From page 34 by facility staff, revealed the following: On 2/20/04, a nursing note timed 2:15 AM to 2:35 AM documented that resident 1 was found by a facility CNA "lying on the floor mat next to the bed on her [right] side. PT (patient) had somehow rolled off the bed. Noted to have skin tear RFA (right forearm), reddness (sic) around waist area, back from SWR (soft waist restraint) [and] redness on mid back from leaning against SR (side rail)." On 6/27/04, at 2:30 AM, a nurse documented that resident 1 was found by a CNA during rounds with her legs off of the left side of the bed, her upper body on the bed and her soft waist restraint was very tight. It was also documented that resident 1 had "... bruises noted on [right] hip [left] breast, [left] FA (forearm) [and] around abdomen where SWR (soft waist restraint) was." On 9/3/04, at 9:30 PM, a facility nurse documented that a CNA"... reported to this nurse that resident fell off bed between wall bad and was laying on the floor under bed. SWR (soft waist restraint) still around waist. Has red marks for restraints around waist on shoulder." On 9/3/04, facility staff completed an incident report for resident 1. It documented that resident 1 had experienced a fall from bed and had an abrasion injury. The nurse documented, " Resident fell between wall and bed [with] restraints still around waist." It was further documented that resident 1 had, "Redness around middle of body where restraints were. Redness on shoulder." Nursing notes and "Monthly Nursing	F 323		

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F 323	Continued From page 35 Assessments" from 9/4/04 through 12/23/04 documented that the facility staff continued to use a soft waist restraint on resident 1. There was no documentation that any other assessments or least restrictive measures were attempted for resident 1.	F 323		
F 325 SS=D	483.25(i)(1) QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interviews it was determined that the facility did not ensure that 1 of 15 sampled residents maintained acceptable parameters of nutritional status. Specifically, this resident did not receive appropriate timely dietary interventions to prevent significant weight loss. Resident identifier 4. Calculating weight loss percentages are done by subtracting the current weight from the previous weight, dividing the difference by the previous weight and multiplying by 100. Significant weight losses are as follows: 5% in one month, 7.5% in 3 months and 10% in 6 months. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000.) Findings include: Resident 4 was admitted to the facility in	F 325	F 325 OK with addendum All residents will be weighed on the day of admission, as well as monthly, by our Restorative Therapy Assistants. These weights will be reviewed by the Dietary Manager for residents who demonstrate a weight loss. Once identified, they will be tracked by our weight and wound committee which meets bimonthly. The Dietary Manager and Dietician will update interventions and care protocols on each of these residents during the meetings.	01/14/05

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F 325	Continued From page 36 November 2004 with diagnoses including pneumonia and mild dementia. Resident 4's medical record was reviewed on 1/3/05 and 1/4/05. A review of resident 4's weight history, obtained from the "Resident Vitals History" form in the medical record revealed the following: 11/23/04 162 pounds 12/1/04 160 pounds 12/6/04 152 pounds. This represents a significant weight loss of 8 pounds or 5% in 5 days. 12/13/04 152 pounds. This represents a significant weight loss of 10 pounds or 6.1% in 20 days. On 1/5/05, the facility weighted resident 4. Resident 4 weighted 153 pounds. Upon admission, it was documented that resident 4 had 1+ lower extremity bi-lateral edema. In the most recent nursing notes there was no mention of edema. There was no documented evidence that resident 4 was ordered a diuretic medication to help decrease the edema documented. A review of resident 4's dietary progress notes was completed on 1/3/05 and 1/4/05. There was an initial dietary assessment completed, dated 11/26/04 and 2 progress notes dated 11/26/04 and 11/30/04. On 11/26/04, the dietary manager (DM) completed an initial "Nutrition Risk Assessment" and progress note. It was documented that resident 4 weighted 162 pounds had stable meal	F 325	Assignments will be made to appropriate departments. The nurse will obtain physician orders if necessary. The Dietician will screen all residents for identified risks by 1/14/05. For residents identified, interventions will be in place by 1/14/05. The Dietary Manager will share the results in our monthly Quality Assurance Meeting. The Quality Assurance Dept will continue to monitor, review and revise to ensure that this program continues to be effective. The Dietary Manager will be responsible to ensure compliance.	

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F 325	Continued From page 37 intakes, some edema and was at moderate nutritional risk. The DM documented that resident 4's weight had been stable and wanted ice cream for an afternoon snack. She further documented that she would begin a high calorie supplement twice a day for added calories. On 11/30/04, the facility's registered dietitian (RD) completed a progress note and documented that resident 4 was at 98% of his desirable weight, and that his diet was adequate to meet his nutritional needs and that his weight and meal intakes would be assessed. There was no documented evidence that the RD re-assessed resident 4's nutritional needs based on the significant weight loss that began in December 2004, evaluated the dietary interventions in place to assess their adequacy to meet resident 4's nutritional needs or recommended additional dietary interventions to try and prevent further weight loss. On 1/6/05, the facility DON (director of nursing) stated that resident 4 was noted to have edema upon admission and that would add 4-5 pounds to resident 4's admission weight. (It should be noted that the documentation indicated resident 4 lost 8 pounds in 1 week). On 1/6/05, at 7:48 AM, the facility's DM was interviewed. She stated that the reason resident 4's weight loss had not been addressed was that he was due to be reviewed by the IDT (interdisciplinary) team on 1/5/05 but that he had been overlooked and not reviewed. She stated that she wrote a progress note on 1/5/05 and that resident 4 wanted to continue to receive his ice cream in the afternoon and that he would let her	F 325	Resident #4 was reviewed by the dietary manager, and again by the weight an wound committee which includes a registered dietician. His snacks were increased, as well as prompting and interventions from the Certified Nursing Assistants. Resident #4 is showing some weight gain. Also refer to plan of correction #312	

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F 325	Continued From page 38 know if he wanted any other snacks. She further stated that resident 4's supplement had been increased to 8 ounces with meals.	F 325		
F 426 SS=E	483.60(a) PHARMACY SERVICES A facility must provide pharmaceutical services (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, observation and record review, the facility did not provide pharmaceutical services to meet the needs of each resident. Specifically, 4 of 15 sampled residents were not administered medications per physician orders. Residents: 3, 8, 9 and 16 Findings included: 1. Resident 3 was admitted to the facility in July 2004. On 1/5/05, a record review of resident 3's physician orders was completed. On 12/1/04, there was a physician's order that documented to discontinue the medications Flonase and Sinemet. On 1/5/05, a review of resident 3's December 2004 MAR (medication administration record) documented that resident 3 had been given Sinemet and Flonase through December 3rd 2004, after these medications had been discontinued.	F 426	F 426 On 1/10/2005 an in-service was held by the Director of Nursing for all of the Nurses to discuss the proper administration of medications, as well as following physician orders. The attending nurse should note the order of medication to be given, check the medication ensuring that it is as ordered, dispense the medication, and chart it as given. Any medications not matching the specific physician's order should be corrected immediately with the pharmacy, or the physician. OK [handwritten signature]	01/14/05

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F 426	Continued From page 39 2. Resident 8 was admitted to the facility in December 2001 with diagnoses including hypercholesterolemia. On 1/3/05, a review of resident 8's physician telephone orders was completed. On 11/29/04 there was an order for resident 8 to have a fasting lipid panel drawn that day and every 6 months and if the LDL (Low-Density Lipoprotein) was elevated greater than 130 mg/dl (milligrams per deciliter) then to begin Lipitor 10 mg by mouth every day. A review the laboratory section of the medical record revealed a fasting lipid profile dated 12/2/04 that indicated the LDL level was 189 mg/dl. A review of resident 8's December 2004 and January 2005 MAR revealed that Lipitor had not been started per the physician's telephone order dated 11/29/04. On 1/4/05, during an interview with the nurse who was caring for resident 8, she stated that they had not yet started the Lipitor for resident 8. 3. Resident 16 was admitted to the facility in September 2003. On 1/4/05, a review of resident 16's physician's orders was completed. On 12/29/04, a physician's telephone order documented that 16 was to receive Folic Acid 1 mg by mouth daily. On 1/4/05, during the morning medication pass, it	F 426	When an order is received from a physician, the responsible nurse will note the order change in the appropriate area such as treatment sheet, or Medex. A copy of the order will be given to the Director of Nursing as well as the Medical Records Clerk to see that those orders are properly noted on the M.D.S., Care Plan, and new month's Med-ex. An audit will be performed 1/11/2005 by the Medical Records Clerk and assisting nurses to see that any additional orders have not been missed, or processed in error. This information will be shared monthly with our Quality Assurance Team by the Medical Records Clerk. The Quality Assurance Team will continue to revise, review, and advise as necessary.	

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F 426	Continued From page 40 was observed that resident 16 did not receive Folic Acid. A review of the January 2005 MAR revealed that resident 16 had not received Folic Acid during the month of January 2005. On 1/4/05, during an interview with the facility nurse caring for resident 16, she stated that resident 16 had received Folic acid at the end of December 2004, but the order did not get carried over to the January 2005 MAR's. 4. Resident 9 was admitted to the facility in May 2003. His diagnoses included depression. Resident 9's medical record was reviewed on 1/5/05 and 1/6/05. On 11/15/04, the IDT (interdisciplinary) team reviewed resident 9's psychotropic medications in a psychotropic drug review meeting. At the time of the 11/15/04, psychotropic drug review meeting, resident 9 was receiving Zoloft (an anti-depressant medication) 200 mg every day. This dose of Zoloft had been originally ordered by resident 9's physician on 6/9/04. On 11/15/04, during the psychotropic drug review meeting, the IDT team recommended that resident 9 discontinue the Zoloft 200 mg every day and begin Lexapro (an antidepressant medication) 20 mg every day. On 11/20/04, resident 9's physician signed the "Psychotropic Drug Review" form that he agreed to the IDT team's recommendation to change the Zoloft 200 mg daily to Lexapro 20 mg daily.	F 426	The Director of Nursing will be responsible to ensure compliance. Also refer to plan of correction #514.	

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F 426	Continued From page 41	F 426		

A review of resident 9's November 2004 MAR was completed. It was documented that resident 9 received Zoloft 200 mg from 11/21/04 through 11/30/04.

A review of resident 9's December 2004 MAR was completed. It was documented that resident 9 received Zoloft 200 mg from 12/1/04 through 12/31/04.

There was no documented evidence that resident 9's anti-depressant medication was changed per the physician's order dated 11/20/04.

On 1/6/05, at 9:25 AM, the facility's DON (director of nursing) was interviewed. She stated that after the psychotropic team meets and makes recommendations that the recommendation form gets send to the physician by the ADON (assistant director of nursing). She stated that when the form is returned by the physician to the ADON, that the ADON personally hands them to the resident's nurse and that the changes are then to be made by the nurse. She stated that the returned recommendation form signed by the resident's physician was like a telephone order.

On the afternoon of 1/6/05, the facility's MDS coordinator brought in resident 9's December 2004 physician re-certification orders and stated that because the physician had signed the December 2004 re-certification orders that still listed Zoloft 200 mg as the anti-depressant medication that this was what was to be given. A review of the December 2004 physician re-certification orders documented that they had been signed by the physician on 12/4/04. Resident 9 still should have received Lexapro 20

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F 426	Continued From page 42 mg from 11/20/04 through 12/4/04.	F 426		
F 465 SS=F	483.70(h) PHYSICAL ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, the facility did not provide an environment which was safe and sanitary. The facility did not have vacuum breakers in two hopper rooms which were to protect against possible cross connections between the waste water and the potable drinking water system. Findings include: On 1/5/05, during an observation of the 300 and 400 hall hopper rooms, it was noted that the hoses dipped down inside the hoppers and into the water. There was no vacuum breakers between the hoses and the faucets to prevent contaminated water from back-flowing or siphoning into the clean or potable water system (National Plumbing Code).	F 465	F 465 The Director of Maintenance will replace both of the vacuum breakers on the hoses in the hopper rooms. This was corrected during survey. OK [illegible]	01/14/05
F 490 SS=K	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 490		

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F 490	Continued From page 43 Based on a recertification survey with subsequent extended survey, conducted 12/29/04 through 1/06/05, and resultant finding of Immediate Jeopardy and Sub-Standard Quality of Care, it was determined that the facility was not being administered in a manner that enabled it to use its resources either efficiently or effectively to ensure that residents were provided the opportunity to attain or maintain their highest practicable physical, mental and psychosocial well-being. Specifically: 1. The facility did not ensure that residents were free from any physical restraints not required to treat the resident's medical symptoms. 2. The facility did not ensure that the resident environment remained as free from accident hazards as possible. The facility continued to place residents in situations, including the use of restraints, after the residents had become entrapped,or sustained injuries, one of which required emergency medical treatment. Additionally, the facility was found to be non-compliant in the following areas: 1. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition. 2. The facility did not ensure that residents maintained acceptable nutritional status, such as body weight. 3. The facility did not ensure that pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) met	F 490	F490 The Administrator will coordinate some consulting training specifically to the understanding of the Restraint protocol which should be used within the facility. Ann E. Lee personally approved consultant Christine Johnson for this purpose. The initial visit and training began on January 10, 2005. A follow-up visit is scheduled for January 19, 2005. The administrator will also be personally involved in conducting, compiling data, and ensuring that important areas are discussed during our Quality Assurance meeting scheduled on January 13, 2005, as well as others which are held monthly.	01/14/05

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F 490	Continued From page 44 the needs of each resident. 4. The facility did not ensure that it provided a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 5. The facility did not ensure that the quality assurance committee effectively developed and implemented appropriate plans of action to correct identified quality deficiencies. 6. The facility did not ensure that resident clinical records were maintained in accordance with accepted professional standards of practices, and that records were complete and accurately documented. Findings include: On 12/29/04, a recertification survey was initiated. On 12/29/04, facility administration was noticed of the elements of Immediate Jeopardy and Sub-Standard Quality of Care. The determination of Immediate Jeopardy and Sub-Standard Quality of Care was based on the finding of significant non-compliance in the areas of Resident Behavior and Facility Practices [42 Code of Federal Regulations (CFR) 483.13 (a) Tag F-221] and Quality of Care [42 CFR 483.255 (h) (1) Tag F-323]. 1. Facility administration did not enure that residents were free from physical restraints that were not required to treat a residents medical symptoms. (Scope and severity "K" refer to Tag F-221) 2. Facility administration did not ensure that	F 490	Cie @ addendum A risk management focus will be adopted for each quarter. The selected item will be initiated with input from all of our Quality Assurance team members. Our first quarter's topic will be restraint safety, and the reduction of restraints. We have a Nursing Consultant on contract, and will be using her as needed. Also refer to plan of correction # 221, 323, 312, 325, 465, 521, 514, and 426.	

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F 490	Continued From page 45 resident environment remained as free from accident hazards as possible. The facility continued to place residents in situations, including the use of restraints, after the residents had become entrapped,or sustained injuries, one of which required emergency medical treatment. (Scope and severity "K" refer to Tag F-323) 3. In addition to the area of Immediate Jeopardy and Sub-Standard Quality of Care, the facility administration did not effectively and efficiently use its resources to ensure that each resident attained or maintained their highest practicable, physical, mental and psychosocial well-being in the following areas of deficient practice cited during the recertification and extended survey completed 1/5/05. a. Facility administration did not ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition. (Scope and severity "E", refer to Tag F-312) b. Facility administration did not ensure that residents maintained acceptable nutritional status, such as body weight. (Scope and severity "D", refer to Tag F-325) c. Facility administration did not ensure that pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) met the needs of each resident. (Scope and severity "E", refer to Tag F-426) d. Facility administration did not ensure that it provided a safe, functional, sanitary, and comfortable environment for residents, staff and	F 490		

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F 490	Continued From page 46 the public. (Scope and severity "F", refer to Tag F-465) e. Facility administration did not ensure that resident clinical records were maintained in accordance with accepted professional standards of practices, and that records were complete and accurately documented. (Scope and severity "E", refer to Tag F-514) f. Facility administration did not ensure that the quality assurance committee effectively developed and implemented appropriate plans of action to correct identified quality deficiencies. (Scope and severity "K", refer to Tag F-521)	F 490		
F 514 SS=E	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, the facility did not maintain clinical records on each resident in accordance with accepted professional standards of practices that were complete and accurately documented. Residents: 3 and 9. Findings included: 1. Resident 3 was admitted to the facility on 7/7/04 with diagnoses which included anoxic brain damage, muscle spasms, convulsions and	F 514	F 514 The Director of Nursing will provide an in-service for all of the Nurses on January 10, 2005. The following information will be presented and discussed: Each time the nurse obtains an order from the physician, weather it is through a Telephone Order, Clinic Visit Sheet, Lab Sheet, Physician Progress Notes, or Psychotropic Sheets, a copy will be run for the	01/14/05

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F 514	Continued From page 47 dysphagia. On 1/3/05, a record review of resident 3's Physician Orders dated 12/1/04 was done. It revealed that there were orders to decrease Lortab to 5 mg every 6 hours as necessary for pain and that Flonase and Sinemet were to be discontinued. A record review of the Recertification Orders signed by the physician on 12/9/04 was done. It revealed that the physician had signed for Lortab, Flonase and Sinemet to be continued as prior to 12/1/04. On 1/11/05 at 12:00 PM, during an interview with the facility ADON (Assistant Director of Nursing), she stated that the recertification orders should have been changed to reflect the physician orders written on 12/1/04 before they were given to the physician to sign. 4. Resident 9 was admitted to the facility in May 2003. His diagnoses included depression. Resident 9's medical record was reviewed on 1/5/05 and 1/6/05. On 11/15/04, the IDT (interdisciplinary) team reviewed resident 9's psychotropic medications in a psychotropic drug review meeting. During this meeting the IDT team agreed to discontinue resident 9's anti-depressant medication Zoloft and begin the anti-depressant medication Lexapro. On 11/20/04, resident 9's physician signed the "Psychotropic Drug Review" form that he agreed to the IDT team's recommendation to change the Zoloft 200 mg daily to Lexapro 20 mg daily.	F 514	Director of Nursing and the Medical Records clerk. The Medical Record Clerk will then make the appropriate adjustment on the recert for the following month. The nurse will immediately make the necessary adjustments on the Medex, and the Treatment sheets. The house Physician will continue to receive a list from the Medical Records Clerk listing those residents who need to be see. He will also list those additional residents seen during his visit, and will leave a copy of the list for the Medical Records Clerk upon leaving. This process will be initiated on 1/12/05, and will assist us in seeing that orders are not missed.	

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F 514	Continued From page 48 A review of resident 9's November 2004 MAR was completed. It was documented that resident 9 received Zoloft 200 mg from 11/21/04 through 11/30/04. A review of resident 9's December 2004 MAR was completed. It was documented that resident 9 received Zoloft 200 mg from 12/1/04 through 12/31/04. There was no documented evidence that resident 9's anti-depressant medication was changed per the physician's order dated 11/20/04. On 1/6/05, at 9:25 AM, the facility's DON (director of nursing) was interviewed. She stated that after the psychotropic team meets and makes recommendations that the recommendation form gets send to the physician by the ADON (assistant director of nursing). She stated that when the form is returned by the physician to the ADON, that the ADON personally hands them to the resident's nurse and that the changes are then to be made by the nurse. She stated that the returned recommendation form signed by the resident's physician was like a telephone order. There was no documented evidence that facility staff identified that resident 9's anti-depressant was not changed per the physician's order dated 11/20/04.	F 514	Starting 1/11/05, the Medical Records Clerk, along with the assisting nurses will audit each current chart to ensure that all orders are correct, and that no additional ones have been missed. This information will be shared at our Quality Assurance meeting on 1/13/05, and will continue to be shared monthly. The Quality Assurance Team will continue to revise, review, and advise as necessary. As a monthly check, the Assistant Director of Nursing will audit the former month's Medex with the new month's Recert before placing them in the current chart. The Medical Records Clerk will be responsible to ensure compliance.	
F 521 SS=K	483.75(o)(2)&(3) ADMINISTRATION The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of	F 521		

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F 521	Continued From page 49 action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. This REQUIREMENT is not met as evidenced by: Based on a review of the facility Quality Assurance Committee Meeting minutes and interview with the facility Administrator and director of nursing (DON), it was determined that the facility did not ensure that the quality assurance committee effectively developed and implemented appropriate plans of action to correct identified quality deficiencies. Findings include: 1. An interview was held with the facility DON on 1/06/05 at 1:55 PM. The DON stated that the facility held Quality Assurance Committee meetings on a monthly basis. The DON stated that the committee consisted of the Administrator, the DON, social services, care plan coordinator, dietary manager, director of staff development, recreation director, business office manager, maintenance, and the medical director attended quarterly. 2. A review of the facility Quality Assurance Committee Meeting minutes was done on 1/6/05. The documentation indicated that the facility had been reviewing all residents with restraints on a monthly basis. The review included all residents that were restrained and that the restraints were appropriately assessed before placing the	F 521 See addendum	Resident #3's orders have since been corrected, and the medication is being dispensed by his nurse as ordered. The Director of Nursing has met with Resident #9 to discuss this order. He has decided that he would like to continue with the Zoloft medication, and his doctor has agreed. The nurse has obtained a clarification order. F 521 The Quality Assurance Team consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Care Plan Coordinator, Director of Staff Development, Housekeeping Supervisor, Dietary Manager,	 01/14/05

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465069	A. BUILDING ______ B. WING ______	01/06/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT OGDEN NURSING & REHAB	375 EAST 5350 SOUTH 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) COMPLETION DATE
F 521	Continued From page 50 residents in restraints. In the August 2004, Quality Assurance Committee Meeting minutes, it was documented that a resident had been caught in the siderails. 3. An interview was held with the Administrator on 1/6/05 at 2:30 PM. The administrator stated that the facility had not implemented a plan of action in August 2004, to address the appropriateness of the restraint or the entrapment of the resident in the siderails. The Administrator stated that the facility had not implemented a new "Entrapment Policy" until 12/28/04. 4. A review of the facility inservice training was done on 1/6/05. The last inservice that addressed "restraints" was dated 7/23/04. There was no evidence that the facility had provided any education to facility staff on restraint use or the potential entrapment risks associated with the use of restraints. 5. The facility's quality assessment and assurance committee did not implement corrective action plans to ensure that residents were properly assessed and free from any physical restraints not required to treat the resident's medical symptoms resulting in harm to residents. (Refer to Tag F-221) 6. The facility's quality assessment and assurance committee did not implement corrective actions plans to ensure that the residents environment was as free from accident hazards as possible resulting in harm to residents. (Refer to Tag F 323)	F 521	Maintenance Supervisor, Social Worker, and Activities Director. This team meets quarterly, and the same team without the Medical Director meets monthly to discuss how our facility has preformed throughout the month in many different care areas. Areas such as residents accidents / incidents, weight loss, restraints, bed sores, and infection control are areas of discussion. Tools for departmental policy reviews will be implemented to audit for deficient practices, and reviewed quarterly, and monitored by the Administrator. Our specific Quality assurance focus for the first quarter will be the reduction, and safe practices of restraints, as well as implementing the use of restraint alternative devices to enhance the quality of our resident's lives.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465069	A. BUILDING ______ B. WING ______	01/06/2005

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			The Administrator will ultimately be responsible for compliance of this issue. Also refer to plan of correction #221, 323, and 490.	

Mt. Ogden
Nursing & Rehabilitation Center
375 East 5350 South • Washington Terrace, Utah 84405
(801) 479-5700 • FAX (801) 476-8913

Plan of Correction
Addendum
01/24/2005

Tag #	**Addendum**
F323	On 12/25/2004 resident #10 was discharged to the hospital. Resident #1 was placed on a low bed with a mat on the floor along the side of the bed. She has been monitored hourly through the night for several nights. The results have shown this to be an effective solution in keeping her safe. The soft waist restraint while in bed was removed on 12/28/2004. She was also placed into a geri chair without a restraint, and has been observed to be doing very well. Resident #3 was placed in a low bed with a mat on the floor along the side of the bed. His soft waist restraint was immediately removed. A self release belt was applied on 12/29/04. Through our monitoring, on 1/03/05 it was decided by the Administrator and Director of Nursing due to his difficulty in staying positioned in his geri chair, to change his self release belt to a pelvis positioning belt to keep him positioned in his chair. He has been monitored by the Administrator, Director of Nursing and direct care staff, and is doing great.
F323	On January 10, 2005 the Director of Nursing will have an in-service for all nursing staff to discuss restraints, and accidents. The new restraint policy will be discussed as well. On 1/13/05 the Quality Assurance committee will be in-serviced and trained regarding accidents.
F325	Those residents who have been identified as "At Risk" for weight loss will be weighed by the Restorative Therapy Assistants at least once every two weeks. This information will be shared monthly with the weight and wound committee.
F323	The Director of Nursing or assigned nursing staff member will complete a compliance audit once a week to ensure that all of the restraints or restraint

alternatives are in place. This audit frequency will stay in place until further directed by our Quality Assurance Committee. It will however always be done no less than monthly throughout the year.

F426

The Medical Records Clerk will audit those residents who are due weekly for our Inter Disciplinary Team conference. This audit will include checking those residents physician orders against medication and treatment sheets. The Assistant Director of Nursing will monthly check the Medication sheets against the former months Recert to check for errors.

465

The Maintenance Director will check the vacuum breakers monthly to ensure that they are working properly. This information will be shared with our Quality Assurance Team monthly.

F490

Monthly, the Quality Assurance Team will monitor the effectiveness of Administration in our Quality Assurance meeting. Those items stated in our plan of correction will be discussed and the effectiveness of our audits will be explored. Should additional direction be needed, our nurse consultant will be brought in to assist us.

F521

Our Quality Assurance Team will meet monthly to discuss the effectiveness of the items stated in our plan of correction. Each quarter, we will select a new area of risk management to monitor, in addition to what we are presently monitoring. These findings, as well as future audits, will be shared monthly in our Quality Assurance meeting

F 323

Monitoring will be preformed daily Monday through Friday by the Administrator, Director of Nursing, Social Worker, Physical Therapist, and Central Supply Clerk in discussing any incident or accident. On the weekends, information regarding accidents, or incidents will be shared with the Nurse Manager on call. Monthly discussion will take place in our Quality Assurance committee to discuss trends, and follow up regarding incidents or accidents.

F490

Administration will be monitored monthly by our Quality Assurance Team during Quality Assurance meeting. All items reported to be completed in this plan of correction will be followed up on by the committee.

F465

Our Quality Assurance meeting will be held on January 13, 2005, and monthly thereafter.

Ray Wilde - Administrator

1-24-05
Date

MOUNT OGDEN NURSING & REHAB

PHYSICAL RESTRAINT EVAL/ASSESSMENT/CONSENT

RESIDENT____ DATE__________

This facility promotes the dignity and independence of our residents. Residents have a right to live without fear of physical restraint. The use of restraints is prohibited for purposes of discipline or staff convenience, and are used solely to treat a resident's medical symptoms. When alternatives to restraints are not effective, the interdisciplinary team evaluates the least restrictive restraint to promote safety and attain/maintain the highest practical, physical, mental and psychosocial function of the resident. The following evaluations have occurred, and the recommendations are as follows.

REFERRAL REASON

ASSESSMENT FOR RESTRAINTS;

I. Cognition/Judgment

Comatose_____ Confused_____ Oriented_____ Times_____

Follows directions Able to_____ Unable to_____

Awareness of environment/safety

Good__________ Fair__________ Poor__________

II. Ambulation/transferring ability

Sit to stand__________Independent__________ Assist required of 1 ___ Assist required of 2 ___

Standing Posture: Erect_____ Leans right_____ Leans Left_____ Leans Back_____ Slumps_____

Ambulation: Independent _____Assist required of 1_____ Assist required of 2_____ Unable_____

Contracture: _____Yes __________No Site____

History of falls last 3 months _______No____ Yes

III. Sitting Posture

Leans to the right_____ Leans to the left_____ Leans front_____ Leans back_____ Slumps_____

IV. Symptoms / Diagnosis that indicate need for restraint________________________________

V. Alternatives recommended

Least restrictive alternatives: ______footrests on w/c ______gait training ______geri chair_____ non-slip fabric ______increased supervision ______pillow/pads ______pommel cushion _____postural support _____tilted w/c _____Low bed _____strengthening exercises by PT/RTA/CNA/OTHER

Staff / family / resident education ____

Environmental changes / staff intervention ____

VI. Restraint type least restrictive to be used if indicated:

_____Geri chair _____Lap buddy _____ Mats on floor _____Side rails x1 x2 ______Self release belt

______ Crotch restraint ______Other

VII. Frequency and reasons for alternative/restraints:

_____Maintain safety
_____Enhance increased self mobility and repositioning
_____Maintain an upright position despite decreased upper body strength
_____Protect from life threatening injury due to falls
_____To enable nutritional support of medical treatment to proceed
_____Enable to remain seated when not being assisted to transfer/ ambulate
_____~~Enable to interact socially in the environment~~
_____To remind to call for assistance with all transfers
_____At all times _____While in bed _____While in chair _____During meals _____During activities
_____While ambulating _____Other____

Assessment completed by____________________ PT / RTA
Date____________________
Assessment reviewed by IDT team members:Date____________ SSW____________
TRT____________________ NSG____________________
DON____________________ Dietary____________________
PT____________________ MDS coordinator____________________

VIII. Potential benefits;
- Prevention of falls which could result in injury
- Protection from other accidents/ injuries
- Protection of other residents from physical harm
- Aid in maintaining proper positioning and feeding
- Increased feeling of safety/ security by the resident
- Allow medical treatment to proceed with interference

Potential risks;
- Incontinence
- Injury from fall/injury from the restraint
- Functional decline
- Skin breakdown / abrasions
- Circulatory compromise
- Decreased social contact

I understand that we will re-evaluate the continued need and possible options for restraint use on a continual basis with the goal to become restraint- free.

______I consent to the use of restraints for the reasons stated above and understand the risks involved.

______I do not consent to the use of restraints and understand the risk involved

____

Resident / Legal Representative / Guardian **Date**

____

Facility Representative **Date**

IX. Physician notified_____Yes _____No **Orders received _____Yes _____No**
X. Care planned _____Yes _____No **Consent sent_____Yes _____No**
XI. Consent signed and in chart _____Yes _____No

Quarterly review by IDT team / Recommendations
Date/ recommend
1.______________________________
2.______________________________
3.______________________________
4.______________________________

Date ________ Telelphone Consent received by: ____________________
Responsible person spoken to: ____________________

Mt. Ogden Nursing and Rehabilitation Center
Restraint Alternative Enhanced
Policy

Procedure

Upon admission the Restorative Therapy Assistant will evaluate each new resident using the "Physical Restraint Evaluation / Assessment / Consent" tool. This information will be given to the Director of Nursing, who will also consider the medical needs of the resident. She will then place each resident into one of three categories by filling out the "Entrapment Prevention" form. This evaluation will consider both in the chair and while in bed.

1- Low Risk - These residents require no special safety interventions
2- Medium Risk - These residents require some safety interventions.
3- High Risk - For residents who require substantial interventions to keep them safe.

A team consisting of the Administrator, and the Director of Nursing, with input if needed from the Physical Therapist, will make a determination that a restraint is necessary. They will identify the least restrictive safe alternative to be used, and specify the times and conditions for use. A positioning study may be required to give additional data in making a final decision.

Should a restraint be necessary, the Social Service Worker will notify the Resident (or family member when appropriate), of the plan for the restraint use. This will be noted on the bottom of the consent form. The form will then be sent out for their signature. The assigned nurse will then obtain an order from the Resident's physician.

Restraints will not be applied simply because of a family request. Restraint use will be addressed immediately on the Care Plan, and CNA assignment sheet, and further on the MDS as it becomes due.

In the event that an emergency restraint is required to protect the resident from immediate harm, an emergency restraint may be applied with the consent of the Director of Nursing, or Administrator for no more than 24 hours. The doctor must be notified immediately of need for restraint use.

The facility will conduct regularly scheduled education for staff, residents, and families regarding benefits and risks of restraints as well as procedures for restraint use. This will be performed during staff meetings, and during the IDT conference.

Least restrictive measures considered will be things such as low beds with floor mats, bed alarms, self releasing belts in wheelchairs and recliners, pummel cushions, lap buddies, geri chairs, short top side rails, and speciality mattresses.

Residents should never be tied in bed. The use of soft waist restraints in bed or while in a chair is prohibited.

Findings regarding restraint use, as well as restraint alternative devices will be shared monthly at the facility's Quality Assurance meeting.

Entrapment Prevention Form

Date of Review______________________ Room#____________________

Resident Name____

Risk Category: 1-low risk, 2-medium risk, 3-high risk

_____Bed____

_____Chair____

Medical Diagnosis to consider_____________________________________

_____Mattress large enough to prevent unnecessary gap between headboard, footboard, and side rail danger.

Possible Remedies

_____Half side rails

_____ Side rail pads

_____ Pummel cushion in W/C

_____Self release belt in W/C or recliner

_____Bed alarm

_____Geri Chair

_____ Moving mattress to the floor with mat.

_____ Pillows or padding placed in mattress gaps.

_____ Non-skid surface placed on the bottom of the pad in chair

_____ Other________________________________

This form should be filled out by the Bed Inspection team. After which, this should be reviewed during the residents MDS.

Signature of Team Member______________________________

DATE	TIME	

LAST NAME | FIRST NAME

Room No.	Patient No.	Attending Physician

USSN-011

NURSES PROGRESS NOTES

MOUNT OGDEN NURSING & REHAB

PHYSICAL RESTRAINT EVAL/ASSESSMENT/CONSENT

RESIDENT____ DATE____________

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ASSESSMENT FOR RESTRAINTS;

I. Cognition/Judgment

Comatose_____ Confused_____ Oriented_____ Times_____

Follows directions Able to_____ Unable to_____

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Good__________ Fair__________ Poor_________

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Sit to stand__________Independent__________ Assist required of 1 ___ Assist required of 2 ___

Standing Posture: Erect_____ Leans right_____ Leans Left_____ Leans Back_____Slumps_____

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Contracture: _____Yes __________No Site____

History of falls last 3 months ________No__________________________________Yes

III. Sitting Posture

Leans to the right_____ Leans to the left_____ Leans front_____ Leans back_____ Slumps_____

IV. Symptoms / Diagnosis that indicate need for restraint______________________________

V. Alternatives recommended

Least restrictive alternatives: ______footrests on w/c ______gait training ______geri chair_____ non-slip fabric

______increased supervision ______pillow/pads ______pommel cushion _____postural support _____tilted w/c

_____Low bed _____strengthening exercises by PT/RTA/CNA/OTHER

Staff / family / resident education ____

Environmental changes / staff intervention____

VI. Restraint type least restrictive to be used if indicated:

_____Geri chair _____Lap buddy _____ Tied soft waist _____Side rails xl x2 ______Self release belt

______ Crotch restraint ______Other

VII. Frequency and reasons for alternative/restraints:

_____Maintain safety
_____Enhance increased self mobility and repositioning
_____Maintain an upright position despite decreased upper body strength
_____Protect from life threatening injury due to falls
_____To enable nutritional support of medical treatment to proceed
_____ Enable to remain seated when not being assisted to transfer/ ambulate
_____~~Enable to interact socially in the environment~~
_____To remind to call for assistance with all transfers
_____At all times _____While in bed _____While in chair _____During meals _____During activities
_____While ambulating _____Other____

Assessment completed by_______________________PT / RTA
Date________________________________
Assessment reviewed by IDT team members:Date__________________SSW_______________________________
TRT__________________________________ NSG____
DON__________________________________ Dietary______________________________________
PT___________________________________ MDS coordinator__________________________________

VIII. Potential benefits;
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Resident / Legal Representative / Guardian **Date**

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Date/ recommend
1.____
2.____
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Date ________ Telelphone Consent received by: ____________________________
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