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F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and resident interviews, it was determined that the facility did not promote care for the resident's in a manner that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Specifically, the facility did not answer the resident's call lights in a timely manner or respect the privacy of their bodies. Findings include: On 3/27/06, facility staff were asked to assist in gathering a group of 6 to 8 alert and oriented residents for a confidential group interview. Facility staff assisted in gathering 9 residents for this group interview. On 3/28/06 at 1:30 PM, a confidental group interview was conducted with nine alert and oriented resident's. When the surveyor asked the group if their call lights were answered in a timely manner, 6 out of 9 residents answered that they have had to wait up to 30 mintues before their call light were answered. Two out of the 9 residents stated that they had soiled themselves while waiting for their call light to be answered. On 3/2706 at 1:03 PM, the call light for the "Americana" room was observed to be ringing. No aides could be seen in the vicinity, but two	F 241	See Attached original POC accepted 4/20/06. Revised 4/27/06 revised POC acceptable completion date 4/24/06 [illegible] RN Utah Department of Health 8/3/06 AUG 0 4 2006 7005 3110 0002 1997 2649 Bureau of Health Facility Licensing, Certification and Resident Assessment	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 6-3-06

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 241	Continued From page 1 nurses were observed sitting at the nurse's station. At 1:11 PM, an aide was observed to enter the room and offer help the the resident. This was 8 minutes after the call light began to ring. On 3/28/06 at approximately 8:05 AM, an observation was made of a facility staff nurse administering a medication injection to resident 4 in the hall, with staff and other residents present. The facility staff nurse administered the medication by pulling the residents dress up on one side and then injecting it into her upper thigh.	F 241		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and medical record review it was determined that for 1 of 18 sampled residents the facility did not provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Specifically, Resident 15 was observed to be eating her morning meal on 3/29/06 without her physician ordered oxygen resulting in resident 15 having an initial oxygen saturation of 76% on room air.	F 309	See Attached	

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Findings include:

Resident 15 was readmitted to the facility on 9/21/04 with diagnosis which included, hypertension, dementia, gatrointestinal bleed, schizophrenia, and anxiety disorder.

On 3/30/06 resident 15's medical record was reviewed.

The February recertification physician orders directed staff to "Encourage resident to use O2 (oxygen) to keep sats (oxygen saturations) greater that 90%."

On 3/29/06 at 7:50 AM resident 15 was observed sitting in the Brentwood dining area eating her breakfast meal without wearing her oxygen. The nurse assigned to the Brentwood unit was asked to get an oxygen saturation reading for resident 15. The initial oxygen saturation reading was 76%. The oxygen saturation reading went up to 83% while the nurse was conducting the test. During the time the oxygen saturation registered 83% resident 15 was sitting at the table not talking or eating. Before the initial reading was taken resident 15 was oberved to have cyanotice lips and have shortness of breath while talking with the nurse.

On 3/29/06 at 7:50 AM the nurse assigned to the Brentwood unit was interviewed. She stated that she was not sure if resident 15 wore oxygen at all times but she thought that she did. The nurse then asked a Certified Nursing Assistant (CNA) assigned to the Brentwood unit if resident 15 wore oxygen at all times. The CNA responded that the staff remove the oxygen at meal times.

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F 309	Continued From page 3 On 3/29/06 at 7:55 AM the other CNA assigned to the Brentwood unit was interviewed regarding the oxygen use of resident 15. The CNA responded that resident 15 does wear the oxygen at all times but the staff had just gotten her in the shower and forgot to put it back on.	F 309		
F 324 SS=G	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews it was determined that for 2 out of 18 sampled resident's, the facility did not ensure that each resident received adequate supervision and assistive devices to prevent accidents. Specifically, Resident 10 and Resident CL2 sustained multiple falls, some with injuries, without the facility implementing interventions or reassessing the residents between falls. Findings include: 1. Resident 10 was admitted to the facility on 8/03/01 with the following diagnoses: dementia, osteoporosis, degenerative joint disease, and depression. Resident 10's medical record was reviewed on 3/28/06.	F 324	See ATTAChed	

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F 324	Continued From page 4 Resident 10's Comprehensive Minimum Data Set (MDS) dated 7/24/05, revealed under "Transfer-How resident moves between surfaces-to/from: bed, chair, wheelchair, standing position" that resident 10 was coded as needing limited assistance with one person physical assist. Documentation revealed under "Walk in room", that resident 10 was coded for limited assistance with one person physical assist. Documentation was also found in the MDS dated 7/24/05, that the following RAP (Resident Assessment Protocol) problem areas were triggered and checked as being addressed in careplan: delirium cognitive loss visual function communication ADL's (activities of daily living) urinary incontinence behaviors falls nutrition pressure ulcers psychotropics. No documentation was found in resident 10's medical record that a fall careplan had ever been initiated. Resident 10's "Fall Risk Assessment" revealed the following assessment dates and scores: On 7/24/05 resident 10 assessment score was 14 On 10/23/05 resident 10's assessment score was 10	F 324		

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F 324	Continued From page 5 On 1/21/05 resident 10's assessment score was 12 Resident 10's "Fall Risk Assessment" done 1/21/06, scored her as not having any falls in the past three months, although resident 10 did have a fall on 12/30/05. This would score resident 10 at a 14 instead of a 12. The fall risk assessment form reveals that a "total score of 10 or above represents High Risk." The fall risk assessment also reveals the following under "Instructions: .... If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls. A prevention protocol should be initiated immediately and documented on the careplan". The director of nurse was interviewed on 3/30/06 at approximately 3:15 PM in the presence of other facility nurse managers and three nurse surveyors. She was asked for a copy of the "prevention protocol" that should be "initiated immediately" if a resident was found to be HIGH RISK for falls. The director of nurse stated that they did not have a prevention protocol. During a interview on 3/30/06 the nursing administration confirmed that resident 10 had not been careplanned for falls. Nursing administration could not provide any documentation to evidence that the facility had reassessed or re-evaluated resident 10 after her falls to ensure her safety. No documentation was found in resident 10's medical record that a prevention protocol had	F 324		

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F 324	Continued From page 6 been implemented, although each of resident 10's fall risk assessments had been scored a 10 or higher. Review of resident 10's "Legal Confidential Investigative Data Sheets", revealed the following falls: - On 12/30/05 at 1:15 PM, documentation was found under "Details Of Incident": "CNA (Certified Nursing Assistant) was in room had back turned and heard Pt fall. She turned around and helped Pt into chair and told another CNA and she went to get nurse. Checked Pt for injuries. No c/o (complaint of) {increased} pain or discomfort.....Documented under " Report of injuries": "pt. has small 1/2cm (centimeters) skin tear to {right} forearm area....." No documentation could be found in resident 10's medical record that a fall careplan had been initiated or that interventions were implemented to prevent further falls. -On 1/09/06 at 8:00 PM, documentation was found under "Details Of Incident": " Pt found on floor in front of blue chair, sitting." Documented under " Report of injuries": "{none} noted. No documentation could be found in resident 10's medical record that a fall careplan had been initiated or that interventions were implemented to prevent further falls. -On 1/11/06 at 8:40 AM, documentation was found under "Details Of Incident": "CNA (Certified Nursing Assistant) found pt on floor next to chair, lying on {right} side checked pt for injuries. Has	F 324		

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dime size abrasion like to {right} midback. No other problems noted.......No other injuries noted. Documented under " Report of injuries": "small abrasion to {right} midback. No other injuries.

No documentation could be found in resident 10's medical record that a fall careplan had been initiated or that interventions were implemented to prevent further falls.

-On 1/24/06 at 4:45 PM, documentation was found under "Details Of Incident": "found pt. sitting {up} on floor next to chair, appears to have slid out of chair. Checked pt. and {no} injuries noted. Assisted in bed. pt. very weak but pleasant. Denies any {increase} discomfort {at} this time. Documented under " Report of injuries": "none apparent".

No documentation could be found in resident 10's medical record that a fall careplan had been initiated or that interventions were implemented to prevent further falls.

-On 2/06/06 at 7:50 AM, documentation was found under "Details Of Incident": "CNA (certified Nursing Assistant) found pt. on floor sitting {up} next to chair. Chair was tipped over. Appears to have slipped out of chair. Checked pt. for bruises or scratches. {none } noted. Documented under " Report of injuries": " {none} noted".

Review of resident 10's medical record revealed a physician telephone order dated 2/06/06, that documented the following order: "Soft lap restraint while in w/c (wheelchair)". No other documentation could be found that the facility implemented a fall careplan.

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Review of resident 10's "Nursing Assistant Care Record" for February 2006 revealed that facility staff was not consistent with ensuring that resident 10's soft waist restraint was in place daily.

-On 2/17/06 at 8:30 AM, documentation was found under "Details Of Incident": " soft waist restraint was untied and pt slid forward, she was found sitting on her bottom {with} her back against chair in a upright position" Documented under " Report of injuries": "sm bruise on her {right buttock and a tiny scratch on her {left} ring finger. {no} serious injury are noted and pt doesn't seem to be in any pain".....(resident 10's family member) was contacted and wonders whether she would be better off back in the Alzheimer unit due to increased supervision".

No documentation could be found in resident 10's medical record that a fall careplan had been initiated, that interventions were implemented by the facility, or that resident 10 had been reassessed for fall precautions or further use of restraints.

-On 3/15/06 at 8:00 AM, documentation was found under "Details Of Incident": " Pt. was in chair {with} soft waist restraint unattended CNA (certified Nursing Assistant) found her on floor. Pt. not able to state what happened. Documented under " Report of injuries": " Pt. has red marks on her back. Also has red marks on ribs/abdomen from the soft waist restraint".

No documentation could be found in resident 10's medical record that a fall careplan had been

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initiated, that interventions were implemented by the facility, or that resident 10 had been reassessed for fall precautions or further use of restraints.

Resident 10 had 7 falls from 12/30/05 to 3/15/06. There was no documentation to evidence that the facility staff re-assessed or re-evaluated resident 10 to protect her from further injuries caused by her repeated falls.
Resident CL2 was admitted to the facility on 11/18/05 with diagnosis which included, Bowel obstruction, multi-infarct dementia, macular degeneration, chronic renal failure and nausea and vomitting.

Resident CL2's closed medical record was reviewed on 3/30/06.

Review of the medical record revealed that facility staff completed a "Fall Risk Assessment"for CL2 on 11/18/05. Resident CL2 total fall risk assessment score was 19. This score indicates that resident CL2 was at high risk for falls.

Review of facility incident reports and nursing notes revealed that on 11/21/05 at 8:40 AM resident CL2 sustained a fall. It was documented on the incident report under the section, "Details of Incident"that, "pt. (patient) found on floor [at] bedside...tried to get up out of his w/c (wheel chair) and slipped to the floor."

Review of physician orders for resident CL2 revealed that on 11/21/05 facility staff obtained physician orders for resident CL2 to have a soft waist restraint when up in the wheel chair and a bed alarm for safety.

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Review of physician orders for resident CL2 revealed that on 11/30/05 facility staff obtained a physician's order for resident CL2 to get up in the Geri chair as needed.

On 12/14/05 it was documented on a facility incident report under the section "Details of Incident", "pt. was in w/c [with] soft waist restraint on. when staff found pt. on Lt (left) side [with] w/c and restraint on..."

No careplan for resident CL2's fall or the use of restraints could be located in the medical record. No documentation could be found to show that facility staff reassessed resident CL2's fall risk or safety while in the wheel chair with the soft waist restraint. No documentation could be found in the medical record to show facility staff implemented different interventions to avoid resident CL2 sustaining further falls.

On 12/16/05 at 6:00 AM it was documented on a facility incident report under the section "Details of Incident", "CNA (Certified Nursing Assistant) found pt. in lobby with his w/c tipped over, waist restraint still intact. CNA X 2 (times two) assisted him up. Checked pt. for injuries and small abrasion to R (right) elbow...Pt. very confused and anxious this AM (morning)."

No careplan for resident CL2's fall or the use of restraints could be located in the medical record. No documentation could be found to show that facility staff reassessed resident CL2's fall risk or safety while in the wheel chair with the soft waist restraint. No documentation could be found in the medical record to show facility staff implemented

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different interventions to avoid resident CL2 sustaining further falls.

On 12/20/05 at 1:30 AM it was documented on a facility incident report under the section "Details of Incident", "pt. was found in lobby on hands and knees [with] w/c on his back. waist restraint still tied to w/c."

No careplan for resident CL2's fall or the use of restraints could be located in the medical record. No documentation could be found to show that facility staff reassessed resident CL2's fall risk or safety while in the wheel chair with the soft waist restraint. No documentation could be found in the medical record to show facility staff implemented different interventions to avoid resident CL2 sustaining further falls.

On 12/21/05 at 3:30 PM it was documented in the nurses' progress notes that, "Resident tipped w/c over again - CNA caught him before he hit the floor. We put him in geri-chair [with] lap tray for safety..."

No careplan for resident CL2's fall or the use of restraints could be located in the medical record. No documentation could be found to show that facility staff reassessed resident CL2's fall risk or safety while in the wheel chair with the soft waist restraint. No documentation could be found in the medical record to show facility staff implemented different interventions to avoid resident CL2 sustaining further falls.

Review of resident CL2's closed medical revealed no documentation of a "Pre-Restraining Assessment". According to one of the facilities

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physical therapists and the facilities Director of Nursing this form is filled out on every resident that has a restraint. The "Pre-Restraining Assessment" form states, "This form has been developed to adequately assess all aspects of the resident's well-being (physical, mental, emotional, environmental, and social considerations) prior to the use of either medication interventions or physical restraining devices in order to identify the least restrictive intervention..."

On 3/30/06 at 10:30 AM one of the facilities physical therapists was interviewed. He stated that the rehab manager does all of the restraint evaluations. He further stated that on the long-term care side of the building if the nurses feel a resident needs a restraint they will call physical therapy for the evaluation and recommendation. The physical therapist also stated that if a resident tips over in his wheel chair with the restraint still intact the resident should be re-evaluated the first time it happens for safety.

On 3/30/06 two facility CNA's were interviewed regarding resident CL2 and his falls. Both CNA's confirmed that resident CL2 tipped over in the wheel chair frequently with the restraint still intact. The CNA's additionally stated that resident CL2 was confused and required a lot of care and supervision.

On 3/30/06 at 10:50 AM the Director of Nursing was interviewed. She stated that the facilities rehab manager makes the recommendations for restraints. She further stated that before instituting a restraint a pre-assessment form is filled out, the resident is talked about in the fall committee meeting and then recommendations

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F 324	Continued From page 13 are made. The Director of Nursing went on to say that when a resident sustains a fall if the facility does an assessment and finds no injuries the facility staff will just monitor the resident. When asked about a resident falling over in a wheel chair with the restraint still intact the Director of Nursing stated that the resident would not be safe with that type of restraint and the facility would need to let the doctor know about the incident.	F 324		
F 371 SS=E	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on interview and observation of the kitchen it was determined that the facility did not store, prepare, distribute and serve food under sanitary conditions. Findings include: The following observations were made on 3/27/06 from 8:25 AM until 8:45 AM. 1. In the freezer: a. One package of unknown meat not labeled or dated. b. One plate of unidentifiable food covered with saran wrap not labeled or dated.	F 371	See Attached	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465104	A. BUILDING ____ B. WING ____	03/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREM NURSING & REHABILITATION	**575 EAST 1400 SOUTH OREM, UT 84058**

(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 371	Continued From page 14 c. The temperature of the freezer according to the internal thermometer was 10 degrees Fahrenheit. 2. In the Dry Storage bins: a. A measuring scoop in the cornmeal, sugar and oatmeal bins. 3. In the Refrigerator: a. Opened bottle of Sweet -N- Sour sauce not dated. b. Opened bottle of Sesame Ginger dressing with no date. 4. General Kitchen area a. The kitchen floor had debris and dirt. Dirt and debris were observed under the appliances throughout the kitchen. b. Dried food particles on the neck of the mixer that could possibly fall into a new batch of food thus contaminating the new food item. The following observations were made on 3/28/06 from 7:10 AM until 7:30 AM. 1. The freezer temperature according to the internal thermometer was 18 degrees Fahrenheit. 2. During tray line for the morning meal the Cook was observed to leave tray line six times to go retrieve bowls, and tongs. He also broke tray line	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465104	A. BUILDING ______ B. WING ______	03/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OREM NURSING & REHABILITATION	575 EAST 1400 SOUTH OREM, UT 84058

(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 371	Continued From page 15 to cook eggs to order and retrieve items such as cottage cheese and yogurt. The Cook did not wash his hands or change his gloves each time he broke tray line. After leaving tray line to retrieve items or cook food the cook was observed to touch toast and plates with the dirty gloves. On 3/28/06 at 3:00 PM the freezers that are kept outside were observed. The freezer that contained the hamburger meat was observed to have a temperature of 32 degrees Fahrenheit. The meat was observed to have condensation forming on the packages indicating it was unthawing. On 3/28/06 at 3:10 PM the dietary manager was interviewed. She stated that all of the freezers locked. She was unaware that the freezer containing the hamburger was not closing and the temperature was registering 32 degrees Fahrenheit. She further stated that some of the food must have fallen down and kept the freezer from latching or sealing correctly. The dietary manager then proceeded to move meat in the freezer and try to secure the freezer door. Upon last observation the freezer door was still not securing correctly.	F 371		

Although we do not agree with the findings of this deficiency, the following is our plan of correction.

F 241: After reviewing deficiency F 241, the Administrator and Director of Nursing have implemented the following interventions to ensure that all residents receive care in a manner and in an environment that maintains or enhances dignity and respect in full recognition of his or her individuality.

1. Residents in the confidential group interview were not identified; therefore, corrective action could not be taken at this time for those individuals.
2. For all residents in the facility, call lights will be answered in a timely manner. Within 5 minutes or less. To accomplish this:
   a. All nursing staff will be responsible for answering call lights. Other staff members will also answer call lights when possible and perform the task if within their scope of practice, or notify the person responsible to perform the task required. In-service given on 4/10/06 to re-enforce this practice.
   b. C.N.A. Supervisor and staff will make periodic checks at least weekly, to determine how long it is taking for call lights to be answered.
   c. C.N.A. Supervisor will do a random verbal check, at least weekly, with residents to determine if their call lights were answered in a timely manner.
   d. When it has been determined that a call light is taking too long to be answered, an investigation will take place, and appropriate corrections will be made.

3. Resident #4 and all residents will be encouraged to have their insulin given in the privacy of their room. Unless they sign a request form, requesting to have their insulin given at the nurse's medication cart, or in the dining room. Dignity will be maintained in the following way:
   a. For those residents who request insulin at the nurse's medication cart or in the dining room, the nurses will protect their dignity by giving the insulin in the arm. However, when as with resident #4, residents request that the injection site always be in the thigh, their dignity will be protected with a towel, or lap blanket when giving insulin in a public place.
   b. All nursing staff have been in-serviced on 4/10/06 in regards to maintaining each resident's dignity by encouraging all residents to have their insulin shots while in their rooms. When residents request that their insulin be given in a public place, their dignity will be maintained as much as possible with a covering if necessary.

The Administrator and the Director of Nursing as well as the Nursing Managers are responsible for compliance for this standard to ensure that the facility promotes care for all residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This standard will be reviewed weekly in our Q.A. / I.D.T. meetings, and implemented into our quality assurance system 4/24/06.

Call Light Weekly Checks/Verbal Interviews Concerning Call Lights

Date: ______________________ **Wing:** ____________

ROOM #; BED	TIME OF DAY	LENGTH OF TIME TAKEN	REASON	ACTION TAKEN

ADDITIONAL INFORMATION

Verbal Interview

State resident' room # and bed and then explain concern.

Action Taken

Orem
Nursing & Rehabilitation Center
575 East 1400 South • Orem, UT 84097
Phone (801) 225-4741 • Fax (801) 226-8197

Permission/Request Authorization

I ____ on this day ____________
Name Date

Request/give permission to ____
Name of Facility

______________________________ ______________________________
Signature of resident Signature of responsible party if applicable.

F 309: After reviewing deficiency F 309, the Administrator and Director of Nursing have implemented the following interventions to ensure that all residents receive and the facility provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

1. Resident # 15 will have her oxygen on at all times, unless it is determined that it is not necessary to wear it at times when her saturation level remains above 90% on room air.
2. Saturation checks will be done at least weekly. Oxygen will be removed for a 5 minute period, and saturation level checked, to determine the % of saturation on room air.
3. All residents on oxygen with an order to keep saturation above or equal to 90% will be evaluated at least weekly to determine the true saturation value on room air.
4. Nursing staff have been in-serviced on 4/10/06 to review this standard.

The Administrator and the director of nursing as well as the Nursing Managers are responsible for compliance for this standard to ensure that the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This standard will be reviewed weekly in our Q.A./I.D.T. meetings and implemented into our quality assurance system 4/24/06.

April 20, 2006

Orem Nursing and Rehab

Oxygen Policy

Policy Statement

It is the responsibility of this facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Policy Interpretation and Implementation

All residents with an order for oxygen will have the oxygen on at all times unless it is determined that it is not necessary to wear it at times when saturation levels remain above 90% on room air. Levels will be determined by the following procedures.

1. At least weekly the oxygen will be removed for a 5 minute period.
2. Saturation levels will be taken and recorded on the Treatment Sheet in the MAR.
3. When saturation levels remain above 90% for an extended period of time the oxygen may be removed for a period of time. Saturation checks will be taken periodically and recorded to ensure levels remain above 90%.
4. When signs and symptoms are present such as cyanosis, which indicate lack of oxygen, the oxygen will be replaced immediately.

Although we do not agree with the findings of this deficiency the following is our plan of Correction.

F 324: After reviewing deficiency F324, the Administrator and Director of Nursing have implemented the following interventions to ensure that all residents receive adequate supervision and assistance devices to prevent accidents.

1. Resident # 10 has been using an alarm device, a soft waist restraint, and had been moved closer to the nurses' station on 2/21/06. She was later moved into the smaller secured unit on 4/12/06, when a place became available, to receive maximum supervision.
2. Resident #CL2 is a resident who had already been discharged on 12/21/05.
3. All other residents will receive adequate supervision and assistance devices to prevent accidents, by implementing the following interventions.
    a. All residents will be assessed on admission by using the new Fall Risk Assessment Tool.
    b. If resident is a fall risk or a high fall risk, measures will be implemented accordingly. (see bottom of Fall Risk Assessment tool)
    c. All falls will be investigated and new measures implemented according to specific needs. (see new investigation tools)
    d. With each fall, an incident report will be completed, care plan addressed, and incident discussed at weekly Q.A./ I.D.T. meetings, and new measures implemented if applicable.
    e. Nursing staff was in-serviced on 4/10/06.

The Administrator and the Director of Nursing as well as the Nursing Managers are responsible for compliance for this standard to ensure that the facility ensures that all residents receive adequate supervision and assistance devices to prevent accidents. This standard will be reviewed weekly in Q.A./I.D.T. meetings, and implemented into our quality assurance system 4/24/06.

Revised September 25th, 2000

OREM NURSING AND REHABILITATION
FALLS/INCIDENTS

Policy Statement

It is the responsibility of this facility to provide and sustain an environment that promotes cares for residents in a manner and in an environment that helps maintain the highest practicable physical, and mental, well-being.

Policy Interpretation and Implementation

1. **All incidents will be recorded on an incident report, and care plan addressed.**
2. **Primary Care Physician and Family member will be contacted.**
    a. **If no injury noted and incident happened on weekend or late at night, PCP can be contacted the next working day.**
    b. **Family members can be contacted the next day if incident happened late at night.**

Procedures

1. **Stay with the resident and call for assistance.**
2. **Nurse and/or physical therapist exam for any injury.**
3. **Give medical care as needed.**
4. **Take vital signs and assess condition of resident.**
5. **Check resident frequently, carry out physician's orders for care,**
6. **Chart for 72 hours.**

Orem Nursing and Rehab
Fall Prevention Policy

It is the policy of *Orem Nursing Rehab* to identify residents at risk for falls and to implement a fall prevention approach to reduce the risk of falls and possible injury. The Fall Prevention Approach is incorporated with the facility's Quality Improvement and Safety Committees.

Every resident will be evaluated for falls upon admission and subsequently thereafter when the resident's condition changes or at least quarterly. The care plan will state the goals, interventions and approaches for every resident who is identified as being at risk for falls. Staff will be trained to be alert to risk and hazards for falls in the environment. The falls prevention approaches will be evaluated by the Quality Improvement Committee to determine the effectiveness of the approaches. With the recommendations of the committee, changes will be implemented to reduce falls risk in the facility.

Procedure:

Within three days of admission, the resident will be assessed for risk of falls. Nursing staff will complete the falls assessment.

Residents will be assessed at least quarterly and following any change in condition such as:

- Weakness secondary to flu or colds
- Sprains of lower extremities
- Upon return from hospital stay
- Change in medication
- Change in wheelchair or walker
- Room assignment
- Glasses prescription change
- Change in continence
- UTI diagnosis

Based on the results of the falls assessment, the interdisciplinary team will determine the best approach to implement for fall prevention, adjust the care plan, inform the family and resident and implement comprehensive fall prevention management approach.

Direct Care Providers will be instructed regarding approaches and goals for the management of the resident falls risk.

Any resident experiencing a pattern of falls (2 or more during a 30-day period) or an injury from a fall will be referred for a falls assessment to be completed by the nurse or therapist.

If a resident experiences a fall, nurses will complete an incident report and document the fall in the resident record, as well as the 24-hour report. Daily entries regarding the status of the resident's condition will occur each shift for 72 hours following the incident.

FALL RISK ASSESSMENT

Resident's Name: ______________________________ Age: _______ Date: ________

Diagnosis: ______________________________

Risk factors: (check all that apply)

	Previous falls
	Visual impairment (cataracts, macular degeneration, glaucoma)
	Cardiovascular disorder (orthostatic hypotension, syncope, arrhythmia)
	Balance/gait disorder (Parkinson, stroke, cane/walker use)
	Lower extremity weakness
	Arthritis in knees/hips
	Bladder dysfunction (incontinence, frequency, nocturia)
	Communication disorder (dysphasia, dysarthria)
	Impaired mobility, assistance with transfers
	Cognitive dysfunction (dementia, depression, anxiety, fear of falls, denial of physical limitations)
	Psychotropic medications

Clinical Condition Parameters	Dates:			
Mental Status Alert....0 Confused @ times....3 Completely confused....4 Non-responsive....1				
Ambulatory Status History of falls....1 Independent....1 Ambulate with assist x1....2 Ambulate with assist x2....3 Chair bound....2 Unable to ambulate....0				
Ability to Communicate No problems....0 Some difficulty....2 Moderate difficulty....3 Unable to communicate....4				
Incontinence (bowel and/or bladder) Continent, no assistance required....0 Continent, requires assistance....1 Foley catheter....2 Incontinent....3				
Medications (Sedatives, psychotropics, pain) None....0 Takes 1-2 of these....2 Takes 3-4 of these....4 Resident has had a change in meds....1				

Post Fall Investigation

Residents Name: ______________________ **Physician:** ______________________

Reported By: ______________________ **Date:** ____________ **Time:** ____________

To be completed by charge nurse before leaving shift. All areas must be completed or marked not applicable. Charge Nurse should investigate and question staff on duty to ensure accuracy of information. Attach to incident report and make certain information is given to DON or Administration within 24 hours.

Witness

Was a staff member with the resident during the incident? ☐ Yes ☐ No

Did anyone witness the fall? ☐ Yes ☐ No If yes, name:

How many nursing staff members were working on the unit when fall occurred?

Notification

Date & Time Physician notified:

Date & Time family or responsible party notified:

Documentation

Has the incident been documented in the Nurse's Notes? ☐ Yes ☐ No

Internal Risk Factors and Underlying Health Problems

☐ Cardiac Dysrhthmia ☐ Decline in cognitive skills ☐ Loss of leg or arm movement ☐ Osteoporosis ☐ Syncope ☐ Amputee (one or both legs) ☐ Manic depressive ☐ Balance problem ☐ Other If other, specify:	☐ Frequent Nocturia ☐ Bedfast (within 7 days of fall) ☐ Unsteady gait ☐ Seizure disorder ☐ Chronic ☐ Acute condition ☐ Alzheimer's ☐ Parkinson's ☐ Hypotension	☐ Symptoms of acute illness ☐ Hypertension ☐ Incontinence ☐ Hip fracture ☐ Joint Pain ☐ Dementia ☐ Hemiplagia ☐Quadriplegia ☐ Difficulty with communication

External Risk Factors

Medications -- Check any that were administered prior to or after the fall, and indicate how close to the fall it was given. Also, if medication was given prior to the fall, not if med was just recently initiated or had dosage changed.

☐ Antipsychotic ☐ Antianxiety ☐ Hypnotic ☐ Laxative	☐Antidepressant ☐Cardiovascular ☐ Diuretic	______________________ ______________________ ______________________ ______________________ ______________________ ______________________

Appliances and Devices

Restraints used prior to fall ❑ Yes ❑ No If yes, type of restraint: ____________

Shoes fit and in good condition ❑ Yes ❑ No

Cane/Walker in use and in good condition ❑ Yes ❑ No

Wheelchair in use and in good condition ❑ Yes ❑ No

Prosthesis fit properly ❑ Yes ❑ No

Side rail in use ❑ Yes ❑ No Length – R ________ L ________ Padded ________

Low bed, special perimeter, scoop mattress, mattress on floor, bed, chair, personal alarm in use? Explain:

____

____

Environmental Situation Hazards

❑ Poor Lighting ❑ Patterned carpet ❑ Poorly arranged furniture ❑ Wet floors	❑ Obstacles in path ❑ Furniture moves easily ❑ Other Specify: ____________

What was the resident doing or trying to do when incident occurred?

____

Was resident responding to bowel or bladder emergency? ❑ Yes ❑ No

Has resident had other recent falls (within the last 30 days, check Nurses Notes)? If so, were they like this one? How?

____

____

Drawing on all known facts in this case, what was the cause of the fall? ____________

____

Immediate Approach

Check off any immediate Approach implemented after this fall.

<u>Fall from Bed</u>	<u>Fall from Chair</u>	<u>Fall while Ambulating</u>
❑ Move bed in hall to monitor ❑ Get resident up ❑ Personal alarm ❑ Check resident on regular schedule (q 15 minutes) ❑ Leave light on ❑ Open door for increased lighting ❑ Anticipate needs ❑ Offer snacks ❑ Mattress on floor ❑ Mattress on floor next to bed	❑ Personal alarm ❑ Change in routine ❑ Offer activity for hands ❑ Take to bathroom on schedule ❑ Involve in an activity	❑ Clear Path ❑ Assist with ambulating ❑ Put to bed ❑ Toilet or Change ❑ Involve in an activity ❑ Glasses on

❑ Take to bathroom on individual schedule		

List any other intermediate interventions put into place to prevent repeated occurrence?
____
____

Long – Term Follow – Up Interventions Being Started

Therapy evaluation needed ❑ Yes ❑ No   Has physician been contacted ❑ Yes ❑ No
New equipment needed ❑ Yes ❑ No   Who was contacted to get it: __________

Medications need adjustment or reassessment ❑ Yes ❑ No

Was physician notified of request ❑ Yes ❑ No

Needs clothing or shoes ❑ Yes ❑ No   Was social services notified ❑ Yes ❑ No

Maintenance needs to fix something ❑ Yes ❑ No   Was maintenance notified ❑ Yes ❑ No

Supervision needed for activities ❑ Yes ❑ No   Who has been informed: __________

Other follow – up explain:

Indicate here that you have updated the residents record with the interventions stated on this form:
Nurses Name: ____________________ **Date:** __________ **Time:** ________

Indicate any new intervention put into place and communicated to the staff on the following shift:
Nurses Name: ____________________ **Date:** __________ **Time:** ________
❑Verbally ❑ 24-hour report ❑ Written Report ❑ Risk Alert Form

This section is to be completed by the RN Supervisor, Restorative Department, and Fall Committee.

Consider if any of the below items are needed		
❑ Non-slip footwear ❑ Non-slip strips or floor mats ❑ Bed or Chair alarm ❑ Non-slip material on chair	❑ Low bed ❑ Additional night light ❑ Pommel cushion ❑ Care planning changes	❑ Remove wheels from bed ❑ Rearrange furniture ❑ Bolsters to wheelchair ❑ Transfer aides

24 – Hour review completed by:		
Name:	Title:	Date:
Name:	Title:	Date:

Approaches being taken or follow-up being initiated ❑ Yes ❑ No

Fall Committee Review
Approaches being taken or follow-up being initiated ☐ Yes ☐ No
Residents record has been updated ☐ Yes ☐ No
Interventions communicated to Staff ☐ Yes ☐ No
Comments:
Date & Time Reviewed:
Date: ___/___/___ **Time:** ___:___ ☐ AM ☐ PM

OREM NURSING AND REHAB NO. ____________________

INCIDENT REPORT

PERSON INVOLVED	(LAST NAME)	(FIRST NAME)	(MIDDLE INITIAL)
❑ PATIENT/RESIDENT ❑ VISITOR	❑ Male ❑ Female Age	ROOM #	SHIFT:

DATE OF INCIDENT	TIME OF INCIDENT ❑ AM ❑ PM	EXACT LOCATION OF INCIDENT ❑ Residents Room ❑ Hallway ❑ Bathroom ❑ Other (Specify) ____________

RELEVANT DIAGNOSIS:

RESIDENT'S CONDITION BEFORE INCIDENT
❑ Alert ❑ Oriented ❑ Disoriented ❑ Sedated ❑ Other ____________

RESTRAINT IN USE?
❑ Yes ❑ No
Type:

WERE FULL SIDE RAILS PRESENT? ❑ Yes ❑ No ❑ N/A
❑ UP ❑ Down ❑ X1 ❑ X2

LOW BED IN USE?
❑ Yes ❑ No

WAS ALARM ON? ❑ Yes ❑ No
Type ____________

CALL LIGHT IN REACH? ❑ Yes ❑ No

MENTAL CONDITION
❑ WELL ORIENTED ❑ SLIGHT CONFUSED ❑ LANGUAGE PROBLEM
❑ DEPRESSED ❑ UNCOOPERATIVE ❑ OTHER (EXPLAIN)

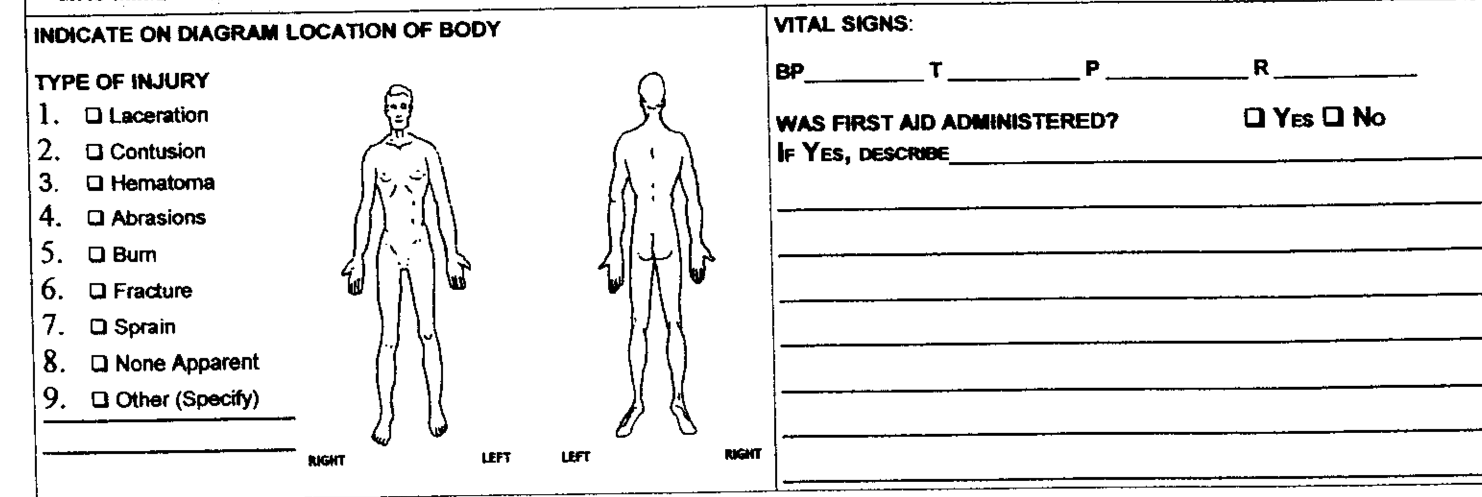
LOCATION	TYPE OF OCCURENCE	PERSONNEL INVOLVED	AMBULATORY PRIVILEGE
❑ PATIENT ROOM ❑ CORRIDOR/HALLWAYS ❑ BATHROOM ❑ PHYSICAL THERAPY ❑ DIETARY ❑ LAUNDRY ❑ LOBBY ❑ PARKING LOT ❑ OTHER ________	❑ FALL FROM BED ❑ FALL GETTING IN OR OUT OF BED ❑ FALL FROM CHAIR, STRETCHER, ETC. ❑ FALL WITH WALKER (AMBULATORY) ❑ FALL WHILE AMBULATORY (UNASSISTED) ❑ FALL WHILE AMBULATORY (ASSISTED) ❑ OTHER(SPECIFY)____________	❑ REGISTERED NURSE, LPN ❑ NURSING ASSISTANT ❑ VISITOR ________ ❑ VOLUNTEER ________ ❑ PHYSICAL THERAPIST ❑ HOUSEKEEPING EMPLOYEE ❑ DIETARY EMPLOYEE ❑ OTHER(SPECIFY)________	❑ UNLIMITED ❑ NONE ❑ LIMITED WITH ASSISTANCE ❑ NOT SPECIFIED (EXPLAIN)________

DESCRIBE CLOTHING WORN BY RESIDENT (Shoes, Socks, No Clothes, Wet Clothes, Pants Too Long, And ETC.)

EQUIPMENT INVOLVED ❑ Yes ❑ No	LIST ALL INVOLVED (Wheelchair, Walker, ETC.)	DESCRIBE EQUIPMENT CONDITION (Brakes On/Off)

Room Condition (Floor clear, dry, free of debris, etc.):

***WAS IMMEDIATE INTERVENTION TAKEN? ❑ Yes ❑ No


INDICATE ON DIAGRAM LOCATION OF BODY

TYPE OF INJURY
1. ❑ Laceration
2. ❑ Contusion
3. ❑ Hematoma
4. ❑ Abrasions
5. ❑ Burn
6. ❑ Fracture
7. ❑ Sprain
8. ❑ None Apparent
9. ❑ Other (Specify)

VITAL SIGNS:

BP________ T________ P________ R________

WAS FIRST AID ADMINISTERED? ❑ YES ❑ NO

IF YES, DESCRIBE____________________

04/21/06

F371: After reviewing deficiency F 371, the Administrator and Dietary Manager have implemented the following interventions to ensure that the facility stores, prepares, distributes, and serves food under sanitary conditions.

1. Perishable items delivered to the kitchen that is placed under refrigeration will be labeled and dated
2. Temperatures of refrigeration units recorded daily.
3. Measuring scoops will not be left in bins filled with food.
4. Floors and serving areas are to be cleaned at the end of each meal and as needed.
5. Deep cleaning of floors done nightly.
6. Used appliances to be cleaned by the end of the shift.
7. Staff in-serviced on cross contamination issues upon hiring, twice a year and as needed,
8. Staff in-serviced 4/20/06 on Kitchen Sanitation Policy.

The Administrator and the Dietary Manager are responsible for compliance for this standard to ensure that the facility stores, prepares, distributes, and serves food under sanitary conditions. This Standard will be reviewed weekly in or Q.A./ I.D. T. meetings, and implemented into our quality assurance system 4/24/06.

<u>Kitchen Sanitation Policy</u>

The Purpose of this policy is to ensure that the facility stores, prepares, distributes and serves food in a sanitary condition.

Implementation

1. **Every perishable item delivered to the kitchen that is placed under refrigeration will be labeled and dated.**

2. **Temperatures of refrigeration units to be taken and recorded daily at the beginning of the morning shit.**

3. **Measuring scoops are not to be left inside the bins.**

4. **Floors and serving areas are to be clean at the end of each meal and as needed.**

5. **Deep cleaning of floors nightly.**

6. **Used appliances to be clean by the end of the shift.**

7. **Staff in-serviced on cross contamination issues upon hiring, twice a year and as needed.**

Freezers: checked & locked by am cook at end of shift.

April 2006

Freezer	# 1	# 2	# 3	# 4	# 5	# 6
1						
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Freezers: checked & locked by pm cook at end of shift.

April 2006

Freezer	# 1	# 2	# 3	# 4	# 5	# 6
1						
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DAILY TEMPERATURE RECORD

MONTH: APRIL YEAR: 2006

LOCATION: WALK - IN

DATE	TIME	TEMPERATURE	RECORDED BY
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5			
6			
7			
8			
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