DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

acceptable POC 1/01 Delende

PRINTED: 11/30/20
FORM APPROVE
2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. BUILDING _____ B. WING _____	C 11/20/2001

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAYSON NURSING AND REHAB	EAST HIGHWAY 91 PO BOX 860 PAYSON, UT 84651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 324 SS=G	483.25(h)(2) QUALITY OF CARE 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 record review, interview with facility staff, and observation of the facility handicapped bathroom, it was determined that the facility did not ensure that a resident who was assessed at risk for falls, was supervised to prevent accidents. Subsequently, a resident that was assessed at risk for falls was left unattended in the bathroom and fell and sustained a fractured hip. (Resident 1) Findings include: Resident 1, an 85 year old male, was admitted to the facility on 6/12/01 with diagnoses of senile dementia, diabetes, hypertension, angina and atrial fibrillation. Review of resident 1's clinical record revealed a quarterly Minimum Data Set (MDS) dated 9/20/01 that documented the following: Under section B2., Memory, it was documented that resident 1 had problems with long and short term memory. Under section B4., Cognitive Skills For Daily Decision Making, it was documented that resident 1 was severely impaired. Under section G1, a, Transfer, it was documented that resident 1 required extensive assistance of one person physically assisting him. Under section G1, section i., Toilet use, it was documented that resident 1 required extensive assistance of one person physically assisting him. Under section G3., Test For Balance, it was documented that resident 1 was unable to balance while sitting or standing without physical help. Under	F 324	On November 23, 2001 a general in-service was conducted by the Assistant Administrator. The in-service reviewed proper supervision given to residents to help prevent falls or accidents of residents. In addition to the general in-service, this facility began conducting mini in-services for nursing staff each day held during shift change beginning on November 26, 2001. These mini in-services will be oral and written information to help the nursing staff be educated on proper procedures of providing better care to the residents. On December 14, 2001 the mini in-service was "Providing a Safe Environment for the Resident". This mini in-service also discussed not leaving any residents unattended who are considered unsafe in shower room, bathroom, or other similar area's. Each week, during the mini in-service, the educator will discuss proper supervision given to residents to help prevent falls or accidents for eight weeks. After this period, the Quality Assurance Committee will review all resident falls or accidents and make the determination if weekly in-servicing of proper supervision needs to be continued. If not, the weekly in-servicing focusing on prevention of falls and accidents will cease. However, each quarterly Quality Assurance Committee Meetings will discuss and track the falls and accidents of residents as will the Safety Committee which shall monitor this on a monthly basis. The Administrator will be responsible as a member of these committee's to see that these issues are discussed.	01/18/02

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark D Yeates | TITLE: Administrator | (X6) DATE: 12-17-01

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days aft such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 324	Continued From Page 1 section J4., Accidents, it was documented that resident 1 had fallen in the past 31-180 days. Review of resident 1's Complete Care Plan Report that had been updated 9/20/01, revealed under problem 6, that resident 1 was a high risk for falls. The goal for problem 6 documented that resident 1 would have no injuries from falls. The approach to problem 6 documented that resident 1 would be assisted as needed and monitored closely. Review of a Fall Risk Assessment for resident 1 dated 9/20/01, documented that resident 1 had a shuffling gait, a loss of balance while walking or standing and used a walker for ambulation. Review of the nurses notes for resident 1 revealed that resident 1 had been found on the floor on 7/1/01, 7/7/01, and 8/28/01. Review of the monthly summaries completed by facility staff nurses for resident 1 for the months of September 2001, and October 2001, revealed that resident 1 had fallen twice each month. A nurses note dated 11/4/01 at 2:30 PM documented,"Apparently fell while unattended in handicap bathroom - c/o [complains of] left hip pain - unable to stand [without] pain or move leg [without] pain - contacted MD [medical doctor] & he ordered to have him sent to the ER [emergency room] for Xray & evaluation." Review of a facility Incident report dated 11/4/01 and timed 3:00 PM, documented that resident 1, "Apparently fell while unattended in B/R [bathroom] L [left] hip pain. Called MD, had transferred for Xray for possible fx [fracture].	F 324		

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F 324	Continued From Page 2 Review of the hospital emergency room report dated 11/4/01 for resident 1, documented that resident 1 had an Xray and had sustained a fracture of his left femoral neck (fractured hip). During an interview with the facility assistant administrator (AA) on 11/20/01, she stated that she had not been in the facility on the day of the incident but had read the documentation in resident 1's record and discussed the incident with the director of nursing (DON). The AA stated that resident 1 had a history of falls but had not fallen recently. The AA also stated that the facility staff member that had left resident 1 unattended in the bathroom had been a new employee. The employee had been hired on October 19, 2001. The AA stated that the employee had had no previous experience as a nursing assistant. The AA stated that the employee had not had any formal training. The employee had been assigned to work with another nursing assistant in the patient care area. A telephone interview was held with the DON on 11/21/01. The DON stated that she had been in the facility the day the incident occurred and had talked with the employee that had left resident 1 unattended. The DON stated that she told the employee, "I know you are new and probably didn't know that you should not have left (residents name) unattended." A telephone interview was held with the facility nurse that had been on duty the day of the incident on 11/22/01. She stated that another facility staff member had come to her to tell her that resident 1 was on the floor in the bathroom. She stated that when she went into the bathroom, resident 1 was lying on the floor on his left side and his pants were down around his ankles. She also stated that when the staff first tried to get into the bathroom to help resident 1, they had not been able to get in due to the resident being on the	F 324		

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F 324	Continued From Page 3 floor in front of the door. A facility staff member had to go outside and get into the bathroom through the window to help resident 1. Observation of the bathroom where resident 1 had fallen on 11/4/01 was done on 11/20/01. The commode was approximately 8 feet from the door to the bathroom and the door opened into the bathroom.	F 324		