TN to J.B. 1-21-03

3ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED 2567-L STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465059 12/18/2002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COMPLAINT RICHFIELD CARE CENTER **83 EAST 1100 NORTH** NUMBER./ RICHFIELD, UT 84701 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 698 F 698 SS=G This REQUIREMENT is not met as evidenced by: See attached

Men of borrection

Poc accepted

1/21/03

dati of compliance
changed to 1/20/03 F 323 483.25(h)(1) QUALITY OF CARE The facility must insure that the resident environment remains as free of accident hazards as is possible. Based on record review and interviews, it was determined that for 1 of 6 sampled residents and 2 supplemental residents, the facility did not ensure that a resident's environment was as free of accident hazards as possible. Specifically, the facility staff assessed a resident on 3/21/02 to be at a safety risk from the use of bedside rails but the facility staff continued to use the bedside rails from 3/24/02 until 4/20/02. Consequently, on 4/20/02 the resident was injured secondary to falling out of bed with side rails Findings included: Resident 1 was admitted to the facility on 3/21/02, with diagnoses that included Alzheimer's disease and urinary retention. Resident 1 was discharged to an acute care hospital on 4/21/02. 1) An interview was held with a facility CNA on 12/17/02 at 3:45 PM. The aide was asked to describe what had happened on the evening of 4/20/02 at 12:00 PM. The aide stated that she was resident 1's aide, working the graveyard shift beginning 4/20/02Utah Dont, of Hoelth through the morning of 4/21/02. At approximately 7099 3220 0002 SIBZ 0613 12:00 PM, resident 1's bed alarm was sounding. The aide went into the resident's room. Resident 1 was found on the floor at the side of the bed. She stated Bar, or stand in the cold very Cepitite at one of the list represent that both bedside rails were in the up position. With the help of the nurse and aide, resident 1 was assisted Jan 13,2003 LABORATORY, DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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

CMS-2567L

ATG112000

DEPARTMENT OF HEALTH AND HUM/

Event ID J7C311

Facility ID:

UT0069

If continuation sheet 1 of 6

PRINTED: 12/31/2002

STATEMENT OF DEFICIENCIES (X1) PROVIDED OF THE CONTROL OF THE CONT					2567	<u>/-l</u>		
AND PLAN OF CORRECTION		OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				B. WING			С	
N/	AME OF I	PROVIDER OR SUPPLIER	465059			12/	18/2002	
					ΓΑΤΕ, ZIP CODE	121	10/2002	_
R	HCHFI	ELD CARE CENTER	83 EAST RICHFIE	1100 NORTH LD, UT 8470	1			
	(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	DROVIDERIC BLAN OF GO			
	PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE . DEFICIENCY)	SHOULD BE	D BE	
	F 698	Continued From page 1		F 698				_
		to a standing position	and put back to bed. When					
		settled in bed, residen	t 1 started moaning and				1	
		groaning and calling	for his mother. The aide stated				ĺ	
		that the nurse then as	sessed resident 1 and found that				ĺ	
		his right hip was red a	and swollen. The aide was told					
	ļ	to get a gurney and to	take resident 1 over to the	1				- 1
		emergency room for x	-rays.					1
	1		-					ı
	1	The aide was asked if	she had observed resident 1					١
	- 1	attempting to get out of	of bed, or observed resident 1				ł	ı
	- 1	caught in the side rails	s, or had found him on the floor	1				1
	í	on previous occasions.	She stated that she hadn't					- 1
	- 1	observed him trying to	get out of bed. The aide				1	١
	- 1	nowever, had found re	sident 1 on the floor next to his]			1	1
	}	bed. She had found res	ident 1 with one leg in the					ı
		bedside rail and the oth	ner leg under the bedside rail					1
		and she had also found	resident 1 at the foot of the	1		,		ı
		bed with both legs dang	gling over the footboard.					
		The aide was asked if s	he could recall being told not	}				
		to use bedside rails on i	resident 1. The gide ctated that					
	1 2	sne doesn't remember b	eing told not to use bedside					1
rails. The aide further stated that she does remember		stated that she does remember			İ			
	t	that the resident had or	ders for physical restraints.			į		
				}		ĺ		1
	A	he I DN	on 12/17/02 at 9:50 AM with			}		
	1	Marsh and A 31 Sasa	esident's unit manager in					1
	ı,	viaich and April of 200	2. She stated that on 4/19/02			1		
	8	the stated that ahadia	1 entangled in the side rails.			1		
	r	ails at that time The T	ontinued the use of the bedside	1		}		ı
	1 tr	one we was single. The L	PN was asked what did she do			ļ	į	
	[]	sed. She stated that all	dside rails were no longer	}				
	re	eport to discontinue the	e instructed staff and aides in	}		ĺ		i
	re	emove or immobilize th	e use of side rails but did not	ļ				
	1	or milliodilize tr	leiii.					
	A	n interview was bald -	n 12/12/02 + 0.65 + 5					
	l lith	ne DON (director of	on 12/18/02 at 9:30 AM with rsing). The DON stated that	ĺ				
		Or (Gircoloi Oi Hu)	rangs. The DON stated that 1	į.				

<u> </u>	ROTOR MEDICARE	E VIEDICAID SERVICES						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE	SURVEY	
465059						С		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	TATE, ZIP CODE	12/	18/2002	
RICHFIELD CARE CENTER			83 EAST 1	.100 NORTH LD, UT 8470	I			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
	the family had reporteresident would slide of the floor to get around On 12/18/02, between CNA's, who work throinterviewed. The aide of them had witnessed facility of being entra	ded to the facility that a down off the bed and cod. 1:00 PM and 1:30 PM ough out the facility, we see asked individual of the heard of any reside pped in side rails or phenormal of the prediction of the heard of an attraction of the administrator was held to the administrator of the de rails occurring in the regulating bedside rails a separate restraint sa separate restraint sa conference of the defendance of the defenda	M, 11 were ally, if any ents in the hysical ach aide y physical d on ted that he ls up just strator fety of the side rails tying an 2 ld have es	F 698				
] .	On 3/21/02 a Physical Need for Side Rails and Hazards" form for resid	d Potential for Entrapt	nent					

the "Risk for entrapment" section, impaired

PRINTED: 12/31/2002 FORM APPROVED

						·	<u> </u>
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU.		A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE COMPI	
		465059		B. WING _		12/	18/2002
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE	121	18/2002
RICHFI	ELD CARE CENTER			l100 NORTH LD, UT 8470			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	STEMENT OF DEFICIENCIE MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
	cognition, inabilities and frequent position "One or more checks risk." On the same for of side rails" section is rails needed at this time. A review of resident 1 completed on 12/18/0 orders for the use of be March and April of 200 A review of resident 1 March of 2002 were conversed to the same same section.	to use call light for assing required were checindicate that the residerm in the "Determinate the was documented that me." I's physician's orders volumented resident and the me. I's care plans for April ompleted on 12/18/02 dressing the use of bed of the medical of the medical polymer. It is assessment the facility of the medical control of the medical control of the medical control of the medical polymer. It is not so that the resident of the medical polymer is as documented that the resident of the medical polymer is not so the medical polymer is not so the medical polymer is not so that is not so the medical polymer is not so that is not	cked off. ent is at ion on use t "No side was sician's onth of and There dside rails. data set) ity staff impaired ad periods elf ners and oility and esident s unable d fallen "Sideplace ot. was	F 698			

PRINTED: 12/31/2002 FORM APPROVED

STATEMENT OF DESCRICTORS AND PLANOF CORRECTION AS BULLINNS B. WINO			WEDICARE & WEDICAID SERVICES					2567-	
NAME OF PROVIDER OR SUPPLIER RICHFIELD CARE CENTER STREET ADDRESS, CITY, STATE ZIP CODE 83 EAST 1190 NORTH RICHFIELD, UT 84701 CALCAID DEFENDENCY NUST BE PRICEDED BY RICH. EGULATORY OR ISE DEPRIFYING NORMATION) FREDRY LAG CONTINUED FROM THE APPROPRIATE COORDINATE CONTINUES DEPAILED BY RULL EGULATORY OR ISE DEPAILED NORMATION) FOR 420/02 at 2:00 PM it was documented, "Pt. slid OOB (out of bed) this PM and was found on the floor next to his bed, (zero)injuries or pain noted." On 4/20/02 at 12:00 midnight it was documented that, "Pt. found on knees 9 side of bed. Assisted back to bed. Noted R (right) fermar swollen et (and) painful to touchresident sent to ER (emergency room)" On 4/21/02 at 13:40 AM nursing note, a late entry-nursing note dated 4/19/02 was written. It documented that " (Resident's) bed alarm ringing. Entered room to find him attempting to go over et around SR (side rail) on bed. One leg stuck in rail other on floor. (zero) injuries but had side rails de'd d't (due to) greater potential for injuries with him attempting to get OOB in this fashion." 3) A review of resident 1's incident reports was completed on 12/18/02. On 4/20/2 at 5:00 PM it was documented, in the description of unusual occurrence to include injury section, that "aid found (resident) sitting on the floor by his bed. Checked for injuries. No injuries noted." In the unit manager investigation section it documented that, "Had been in bed and attempted to get himself OOB, Has weakness et slid to floor. O injuries." In the commentativapdates section dated 44/4/02 it documented that, "Had been in bed and attempted to get himself OOB, Has weakness et slid to floor. O injuries. This is part of his routine behavior."	STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	A. BUILDIN	NG		SURVEY	
RICHFIELD CARE CENTER SI EAST 1190 NORTH RICHFIELD, UT 84701 ING ID (EACH DESIGNACY STATEMENT OF DESIGNACES) FRETEX (EACH DESIGNACY MUST BE PRECEDED by WILL) FREGULATORY OR LSC IDENTIFYING INFORMATION) FROM CREGULATORY OR LSC IDENTIFYING INFORMATION) FROM CREATERING IN THE APPROPRIATE DEFICIENCY) FROM CREATERING IN THE APPROPRIATE DEFICIENCY FROM CREATERING IN THE APPROPRIATE FROM CREATERING IN THE APPROPRIA			465059		B. WING		12/		
RICHFIELD, UT 84701 SUMMARY STATEMENT OF DEPICEMENCES PROFESS PLAN OF CORRECTION (EACH DEPICEMENCY MUST BE PRECEDED BY FULL TAG (EACH DEPICEMENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-RETERINCE) OF A 12/10/10/2 at 2:00 PM it was documented, "Pt. shid OOB (out of bed) this PM and was found on the floor next to his bed. (zero)injuries or pain noted." On 4/20/02 at 2:00 DM it was documented that, "Pt. found on knees @ side of bed. Assisted back to bed. Noted R (right) fermir swollen et (and) painful to touchresident sent to ER (emergency room)" On 4/21/02 at 3:40 AM it was documented, "Pt. will be admitted to (acute care hospital) for fx (fractured) R femire et (and then) do'd (discharged) from (facility). Following the 4/21/02 at 3:40 AM nursing note, a late entry-nursing note dated 4/19/02 was written. It documented that " (Residen's) bed alarm ringing. Entered room to find him attempting to go over et around SR (side rail) on bed. One leg stuck in rail other on floor. (zero) injuries with him attempting to get OOB in this fashion." 3) A review of resident I's incident reports was completed on 12/18/02. On 4/2/02 at 5:00 PM it was documented, in the description of timustal occurrence to include injury section, that "aid found (resident) sitting on the floor by his bed. Checked for injuries. No injuries moted." In the unit manager investigation section it documented that "Had been in bed and attempted to get himself OOB. Has weakness et slid to floor. O injuries." In the occurrence type section it documented that "Had been in bed and attempted to get himself OOB. Has weakness et slid to floor. O injuries. The forecurrence type section it documented that "This is part of his routine behavior"	NAME OF I	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	TATE, ZIP CODE	12/	18/2002	
FREEN TAG REBULATORY OR USE DESCRIPTING INFORMATION) F 698 Continued From page 4 On 4/20/02 at 2:00 PM it was documented, "Pt. slid OOB (out of bed) this PM and was found on the floor next to his bed. (zero)injuries or pain noted." On 4/20/02 at 12:00 midnight it was documented that, "Pt. found on knees @ side of bed. Assisted back to bed. Noted R (right) femur swollen et (and) painful to touchresidents ent to ER (emergency room)" On 4/21/02 at 3:40 AM it was documented, "Pt. will be admitted to (acute care hospital) for ix (fractured) R femur et (and then) dc'd (discharged) from (facility). Following the 4/21/02 at 3:40 AM nursing note, a late entry-nursing note dated 4/19/02 was written. It documented that "(Resident's) bed alarm ringing. Entered room to find him attempting to go over et around SR (side rail) on bed. One leg stuck in rail other on floor (zero) injuries but had side rails dc'd dl' (due to) greater potential for injuries with him attempting to get OOB in this fashion." 3) A review of resident I's incident reports was completed on 12/18/02. On 4/2/02 at 5:00 PM it was documented, in the description of unusual occurrence to include injury section, that "aid found (resident) sitting on the floor by his bed. Checked for injuries. No injuries noted." In the unit manager investigation section it documented that, "Had been in bed and attempted to get himself OOB. Has weakness et sild to floor. O injuries." In the occurrence type section it documented that the fall was "unattended." In the comments/updates section dated 4/4/02 it documented that the fall was "unattended." In the comments/updates section dated 4/4/02 it documented that the fall was "unattended."	RICHFI			RICHFIE	1100 NORTH LD, UT 8470	[)1			
On 4/20/02 at 2:00 PM it was documented, "Pt. slid OOB (out of bed) this PM and was found on the floor next to his bed. (zero)injuries or pain noted." On 4/20/02 at 12:00 midnight it was documented that, "Pt. found on knees @ side of bed. Assisted back to bed. Noted R (right) femur swollen et (and) painful to touchresident sent to ER (emergency room)" On 4/21/02 at 3:40 AM it was documented, "Pt. will be admitted to (acute care hospital) for fx (fractured) R femur et (and then) dc'd (discharged) from (facility). Following the 4/21/02 at 3:40 AM nursing note, a late entry-nursing note dated 4/19/02 was written. It documented that "(Resident's) bed alarm ringing. Entered room to find him attempting to go over et around SR (side rail) on bed. One leg stuck in rail other on floor. (zero) injuries but had side rails dc'd d/t (due to) greater potential for injuries with him attempting to get OOB in this fashion." 3) A review of resident 1's incident reports was completed on 12/18/02. On 4/2/02 at 5:00 PM it was documented, in the description of unusual occurrence to include injury section, that "aid found (resident) sitting on the floor by his bed. Checked for injuries. No injuries noted." In the unit manager investigation section it documented that, "Had been in bed and attempted to get himself OOB. Has weakness et slid to floor. O injuries." In the occurrence type section it documented that the fall was "unattended." In the comments/updates section dated 4/4/02 it documented that "This is part of his routine behavior	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE APPROPRIATE	COMPLETE	
On 4/20/02 at 2:00 PM it was documented, in the "description of unusual occurrence to include injury"		On 4/20/02 at 2:00 Pl OOB (out of bed) this next to his bed. (zero) On 4/20/02 at 12:00 r that, "Pt. found on known to bed. Noted R (right to touchresident seron 4/21/02 at 3:40 All be admitted to (acute of R femur et (and then) (facility). Following the 4/21/02 late entry-nursing noted documented that " (Entered room to find he around SR (side rail) cother on floor. (zero) in d/t (due to) greater pot attempting to get OOB 3) A review of resident completed on 12/18/02 On 4/2/02 at 5:00 PM in description of unusual section, that "aid found by his bed. Checked for In the unit manager involutional documented that, "Had get himself OOB. Has enjuries. "In the occurred documented that the fall in the comments/updated in the comments/updated in the commented that "This et mobility"	M it was documented, PM and was found or injuries or pain noted midnight it was documes @ side of bed. Ass.) femur swollen et (and to ER (emergency rown it was documented, care hospital) for fx (fidd'd (discharged) from at 3:40 AM nursing rown at 3:40 AM nursing rown bed. One leg stuck injuries but had side ratential for injuries with in this fashion." It was documented, in occurrence to include a (resident) sitting on the injuries. No injuries restigation section it been in bed and attern weakness et slid to flow ence type section it as section dated 4/4/02 is part of his routine but was documented, in injuries are section dated 4/4/02 is part of his routine but was documented, in injuries and the section dated 4/4/02 is part of his routine but was documented, in it was documente	the floor " ented sisted back (d) painful com)" "Pt. will ractured) note, a ritten. It ringing. over et in rail (ils dc'd in him) ras the floor noted." pted to cor. O	F 698				

CMS-2567L

ATG112000

Event ID J7C311

Facility ID: UT0069

If continuation sheet 5 of 6

PRINTED: 12/31/2002 FORM APPROVED

CENTERS FOR MEDICARE	& MEDICAIL SERVI	ICES		2567-
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C
	465059		D. 11210	12/18/2002
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STATE, ZIP CODE	
DICHEIL D CADE CENTED		83 EAST 110	00 NORTH	

RICHFIELD CARE CENTER		ICHFIELD, UT 8470	1	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 698	Continued From page 5 section, that "Down for nap. Tried getting up. fall just slid OOB. No signs of injury No c/o (complaint of) pain." In the "unit manager investigation" section it documented that, "Doe a bed alarm-alarm was checked to be sure it was working order Cont (continue) with ½ rails." In "occurrence type" section it documented that the was "unattended." On 4/20/02 at 12:00 midnight it was document the description of unusual occurrence to includinjury section, that "Pt found on knees @ side assist to stand et transfer to bed. Noted (right) femur swollen and protruding pt. not able to be turned. Pt. c/o pain." In the "unit manager investigation" section it documented that, "In speaking with CNA she stated SR was up on (resident's) bed. He was to not have side rails u kept going around over et getting stuck in the Swhen up Has bed alarm. It was turned on et the what brought CNA et nurse into room. Found redness/swelling after placed in bed et attempte turning for cares. Sent to ER for evaluation et revealed fx (fractured) femur. Dc'd to (acute ca hospital). "In the "occurrence type" section it documented that the fall was "unattended." 4. A review of all incident reports from January until the present was completed on 12/18/02. In incidents of entrapment could be found.	es have as in n the ne fall ted, in le of bed - upper e upper e p d/t SSR nat is ed x-ray's are		

CMS-2567L

ATG112000

Event ID J7C311

Facility ID: UT0069

If continuation sheet 6 of 6

RICHFIELD REHABILITATION AND CARE CENTER

A member of the Heritage Management Family. Caring professionals serving western communities.

Complaint Survey Deficiency Response

12-18-2002

F698

F323 483.25 (h) (1) Quality of Care

Based on record review and interviews, it was determined that for 1 of 6 sampled residents and 2 supplemental residents, the facility did not ensure that a resident's environment was as free of accident

Specifically, the facility staff assessed a resident on 3/21/02 to be at a safety risk from the use of bedside rails but the facility staff continued to use the bedside rails from 3/24/02 until 4/20/02. Consequently, on 4/20/02 the resident was injured secondary to falling out of bed with side rails up.

Response:

Resident # 1 continues to be placed on a low bed without side rails on it, and the bed placed against the

Every patient bed will continue to be assessed on a monthly basis and more frequently as required, to ensure that all beds are free from potential entrapment hazards and are in good repair. This will be documented by the unit managers and turned in to the administrator each month, and will continue to be reviewed in monthly QA meetings.

All residents will continue to be assessed by a licensed nurse upon admission, and reevaluated at least quarterly thereafter for risk of entrapment and physical restraint/side rail utilization. Appropriate

All employees will be given continuing education by the staff development coordinator about accident hazards and restraints to insure that the resident environment remains as free of accident hazards as is possible. New employees will be educated upon hire and continued training will be given at least annually and as needed thereafter.

The facility safety committee will continue to monitor and review all residents who are an entrapment risk and who have any form of restraint in place, and will report to the facility quality assurance committee on a Date of compliance 2/15/03 1/20/03 Rer Elain Blackboom

Signed

Elaine Blackburn, Administrator

1/13/03