TN W2B. 1-21-03

DEPARTMENT OF HEALTH AND HUM/ SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/31/2002
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465059	A. BUILDING _____ B. WING _____	C 12/18/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	COMPLAINT NUMBER
RICHFIELD CARE CENTER	83 EAST 1100 NORTH RICHFIELD, UT 84701	UT00001171

(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 698 SS=G		F 698	See attached Plan of correction POC accepted 1/21/03 date of compliance changed to 1/20/03	

This REQUIREMENT is not met as evidenced by:
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 up.

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 4/20/02 through the morning of 4/21/02. At approximately 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 that both bedside rails were in the up position. With the help of the nurse and aide, resident 1 was assisted

Utah Dept. of Health
7099 3220 0002 5182 0613
Jan 13, 2003

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elaine Blackburn — TITLE: Administrator — (X6) DATE: 1/13/03

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

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F 698	Continued From page 1 to a standing position and put back to bed. When settled in bed, resident 1 started moaning and groaning and calling for his mother. The aide stated that the nurse then assessed resident 1 and found that his right hip was red and swollen. The aide was told to get a gurney and to take resident 1 over to the emergency room for x-rays. The aide was asked if she had observed resident 1 attempting to get out of bed, or observed resident 1 caught in the side rails, or had found him on the floor on previous occasions. She stated that she hadn't observed him trying to get out of bed. The aide, however, had found resident 1 on the floor next to his bed. She had found resident 1 with one leg in the bedside rail and the other leg under the bedside rail, and she had also found resident 1 at the foot of the bed with both legs dangling over the footboard. The aide was asked if she could recall being told not to use bedside rails on resident 1. The aide stated that she doesn't remember being told not to use bedside rails. The aide further stated that she does remember that the resident had orders for physical restraints. An interview was held on 12/17/02 at 9:50 AM with the LPN who was the resident's unit manager in March and April of 2002. She stated that on 4/19/02 she had found resident 1 entangled in the side rails. She stated that she discontinued the use of the bedside rails at that time. The LPN was asked what did she do to make sure that the bedside rails were no longer used. She stated that she instructed staff and aides in report to discontinue the use of side rails but did not remove or immobilize them. An interview was held on 12/18/02 at 9:30 AM with the DON (director of nursing). The DON stated that	F 698		

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F 698	Continued From page 2 the family had reported to the facility that at home the resident would slide down off the bed and crawl on the floor to get around. On 12/18/02, between 1:00 PM and 1:30 PM, 11 CNA's, who work through out the facility, were interviewed. The aides were asked individually, if any of them had witnessed or heard of any residents in the facility of being entrapped in side rails or physical restraints of any kind within the last year. Each aide replied that they had not seen or heard of any problems with residents being entrapped in physical restraints of any kind. An interview with the administrator was held on 12/18/02 at 2:00 PM. The administrator stated that in May of 2002 she became aware of the inappropriate use of side rails occurring in the facility. The CNAs were pulling bedside rails up just because they were on the beds. The administrator stated that she formed a separate restraint safety committee and the ADON (assistant director of nursing) was responsible for tracking. Since the formation of the restraint safety committee, side rails have been either removed or immobilized by tying them down. The administrator stated that if an incident report had been done for the 4/19/02 entrapment occurrence for resident 1, it would have been discussed the next morning and remedies implemented at that time. 2) A review of resident 1 medical record was completed on 12/18/02. On 3/21/02 a Physical Restraints- "Evaluation of Need for Side Rails and Potential for Entrapment Hazards" form for resident 1 was completed. Under the "Risk for entrapment" section, impaired	F 698		

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F 698	Continued From page 3	F 698		

cognition, inabilities to use call light for assistance and frequent positioning required were checked off. "One or more checks indicate that the resident is at risk." On the same form in the "Determination on use of side rails" section it was documented that "No side rails needed at this time."

A review of resident 1's physician's orders was completed on 12/18/02. There were no physician's orders for the use of bedside rails for the month of March and April of 2002.

A review of resident 1's care plans for April and March of 2002 were completed on 12/18/02. There were no care plans addressing the use of bedside rails.

On 12/18/02 a review of resident 1's 4/4/02 comprehensive admission MDS (minimum data set) was completed. On this assessment the facility staff documented that resident 1 had moderately impaired cognitive skills for daily decision making, had periods of restlessness and sometimes could make self understood, sometimes could understand others and needed only limited assistance with bed mobility and transfer. Facility staff documented that the resident needed extensive assistance to ambulate, was unable to balance self without physical help and had fallen within the last 30 days.

A review of resident 1's nursing notes for the month of March and April of 2002 was completed on 12/18/02.
On 3/24/02 at 10:00 AM it was documented "Side rails (up) on bed when pt. (patient) sleeping-place call light with in reach."
On 4/2/02 at 1700 it was documented that "Pt. was found sitting on the floor by his bed. (Checked) him for injuries. (zero) injuries.

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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 touch…resident 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 et mobility…" On 4/20/02 at 2:00 PM it was documented, in the "description of unusual occurrence to include injury"	F 698		

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F 698	Continued From page 5 section, that "Down for nap. Tried getting up. Not a fall just slid OOB. No signs of injury No c/o (complaint of) pain." In the "unit manager investigation" section it documented that, "Does have a bed alarm-alarm was checked to be sure it was in working order Cont (continue) with ½ rails." In the "occurrence type" section it documented that the fall was "unattended." On 4/20/02 at 12:00 midnight it was documented, in the description of unusual occurrence to include injury section, that "Pt found on knees @ side of bed - assist to stand et transfer to bed. Noted (right) upper 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 up d/t kept going around over et getting stuck in the SR when up Has bed alarm. It was turned on et that is what brought CNA et nurse into room. Found redness/swelling after placed in bed et attempted turning for cares. Sent to ER for evaluation et x-ray's revealed fx (fractured) femur. Dc'd to (acute care hospital)."In the "occurrence type" section it documented that the fall was "unattended." 4. A review of all incident reports from January 2002 until the present was completed on 12/18/02. No incidents of entrapment could be found.	F 698		

HM
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 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 up.

Response:
Resident # 1 continues to be placed on a low bed without side rails on it, and the bed placed against the wall on one side with a floor pad on the other side.

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 interventions will be implemented as assessed.

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 monthly basis.

Date of compliance ~~2/15/03~~ 1/20/03 per Elaine Blackburn

Signed
Elaine Blackburn

Elaine Blackburn, Administrator
1/13/03

83 East 1100 North Richfield, Utah 84701 (435) 896-8211 FAX (435) 896-8217