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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465079	A. BUILDING ______ B. WING ______	C 10/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE TERRACE FOUNDATION	225 NORTH 200 WEST LOGAN, UT 84321

(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 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 record review and interview, it was determined that the facility did not provide adequate supervision by staff to prevent an accident. Specifically, 1 of 7 sample residents experienced a fall resulting in the resident having injuries which required surgery. Resident identifier 1. Finding include: Resident 1 was admitted to the facility on 10/7/05 with diagnoses that included Alzheimer's disease, dementia, osteoporosis, history of falls, anemia, dizziness, history of chronic hypoxia and renal insufficiency. Resident 1's closed clinical record was reviewed on 10/18/05. A Medicare 5 day assessment, dated 10/11/05 that covered observation dates of 10/7/05 to 10/20/05, documented that resident 1 had long term and short term memory problems and the resident's cognitive skills for daily decision making were moderately impaired. The facility staff documented that resident 1 needed extensive assistance with transfers and was totally dependent for ambulation. Resident 1 had a fall assessment, dated 10/7/05, to determine fall risk category. Section VI. History	F 324	As a part of our continuous quality improvement process, this plan of correction was being worked on as soon as the fall occurred, prior to the survey team's arrival.	
			1. A new fall protocol (see Exhibit A) will be made indicating that no resident will be left alone on the toilet who has been here less than one week. After one week a new fall assessment will be done. This re-assessment will be used to indicate whether or not a resident is considered safe if left alone on the toilet. Responsibility: Fall Prevention Coordinator and Head Nurses	11/30/05
			2. If the resident is determined to be a high fall risk, a leaf (See Exhibit B) will be placed above their name plate on the outside door of their room. In addition, a leaf will be placed over the toilet in their bathroom with their name on it to alert staff that the resident cannot be left alone on the toilet. Responsibility: Fall Prevention Coordinator and Head Nurses	11/30/05
			All current residents will be re-assessed and a leaf will be placed above the name plate on their room doors as well as in the bathroom of those who are determined to be at a high risk for falls. Responsibility: Fall Prevention Coordinator and Head Nurses	11/30/05

POC acceptable 11/2/05 Completion date 11/30/05 [signature] RN

Utah Department of Health
10-28-05
OCT 31 2005
ED 66690875 US
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alyce Bosl RN NHA
TITLE: Administrator
(X6) DATE: 10/28/05

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

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F 324	Continued From page 1 Of Falls In The Past 6 Months documented that resident 1 had 1-2 falls. The total score for the fall assessment was 20 points (pts) which placed resident 1 in the moderate risk: 11-20 pts. A history and physical, dated 9/23/05, documented that resident 1 has a history of chronic dizziness with frequent falls. An interim care plan, dated 10/7/05, documented High Risk for Falls, increased supervision as needed to monitor status as needed. Consider use of bed alarms and other safety devices as needed. Nurses notes, dated 10/7/05 at 1610 (4:10 PM), documented the following entry, "Res (resident) was very confused on arrival and didn't know where she was or what month it was....Res (resident) is a fall risk and pressure alarm put in place....Res (resident) has SOB (shortness of breath) when ambulating or going up stairs and oxygen wore per (by) nasal cannula on 2 liters to keep sats (level of oxygen saturation) above 90%. Res (resident has history of chronic hypoxia....Res (resident) needs frequent reorientation and supervising". Nurses note, dated 10/7/05 at 2045 (7:45 PM), documented the following entry, "Res (resident) has been confused throughout shift. Frequently redirected et (and) reoriented by staff. Res (resident) has pressure alarm on while in wheelchair, but continues to try to stand without assistance. Has had constant supervision while in wheelchair. ...Will continue to monitor for high fall risk". Nurses note, dated 10/9/05 at 2040 (7:40 PM),	F 324	4. A section regarding the most recent history and physical will be put on the fall assessment. (See Exhibit C)	11/30/05
			Responsibility: Fall Prevention Coordinator and Head Nurses	
			5. Residents who have pressure alarms or by other means are deemed to be at a high risk for falls will not be left alone while sitting on the toilet.	11/30/05
			Responsibility: Fall Prevention Coordinator and Head Nurses	
			6. If a Resident refuses to have staff attend them while they are on the toilet, they and/or their Responsible Party will sign a Managed Risk Agreement to that effect. (See Exhibit D)	11/30/05
			Responsibility: Fall Prevention Coordinator and Head Nurses	
			7. A form (See Exhibit E) will be created that will be filled out for every Resident who has fallen which will list interventions tried and what we plan to do in an effort to reduce or stop future falls. This form will be signed by the charge nurse and the CNA who is responsible for the Resident.	11/30/05
			Responsibility: Fall Prevention Coordinator	

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F 324	Continued From page 2 documented the following entry, "Is alert, but confused to situation et (and) place". Nurses note, dated 10/10/05 at 1000 (10:00 AM), documented the following entry, "Assisted resident to toilet after she verbalized need to go. She was able to use hand rails and assist with transfer. Handed resident call light and instructed her to call when finished. Checked on resident a few minutes later, and she was found on floor in bathroom, lying on right side. Resident able to bear weight and was assisted from floor. She denies pain. Assessed resident to have no change to LOC (level of cognitive) or ROM (range of motion)....Alarm and 02 (oxygen) in place. Will cont (continue) to monitor". Nurses note, dated 10/10/05 at 1600 (4:00 PM), documented the following entry, " Resident having difficulty bearing weight this afternoon and verbalizes pain in rt (right) hip. Assessed by physical therapist who noted discrepancy in length of legs....Called LRH (Logan Regional Hospital) ER (emergency room) and gave report prior to transfer. Resident transferred via (by) non-emergency transport at 1610 (4:10 PM)". Nurses note, dated 10/10/05 at 1630 (4:30 PM), documented the following entry, " Reported that I had placed note in bathroom indicating that resident was not to be left alone in bathroom". Nurses note, dated 10/10/05 at 2125 (9:25 PM), documented the following entry, "Called back at 1910 (7:10 PM) and received report that resident had a hip fracture and would be having surgery in AM (the next morning)". Incident/Accident Report, dated 10/10/05,	F 324	8. A Fall Prevention Coordinator will be chosen, who will monitor and oversee the fall prevention process. Random audits will be done each week to ensure the program is being done correctly and effectively. Responsibility: Administrator 9. Staff will be educated regarding fall prevention and the Plan of Correction. (See Exhibit F – this exhibit shows those who have been educated thus far, however additional education will occur and records will be kept to demonstrate that it has been done.) Responsibility: Administrator, Fall Prevention Coordinator and Head Nurses 10. This Plan of Correction was incorporated into the Sunshine Terrace quality assurance/ improvement Plan on Friday, 10/28/05. (See Exhibit G)	11/30/05 11/30/05 11/30/05

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F 324	Continued From page 3	F 324		

documented the following nurses entry, "I took her into the bathroom, I was able to tell her to hold onto the handrails, and she was able to reach for them....I removed the chair alarm as I assisted [her] to the toilet. She had some difficulty pivoting to the toilet and did need assist as I guided her right foot with mine forward and assisted her to sit on the toilet. I handed her the pull cord and indicated for her to pull it when she was finished, to which she responded "okay". I felt it was okay to leave her in the bathroom, as I knew from the weekend, that she did not move about nor attempt to get out of bed or wheelchair independently

I moved the wheelchair out of the bathroom, pulled the bathroom door part way closed and also pulled the room door half closed as I stepped out. As I left the room, [a certified nurse assistant (CNA)] was at the kiosh charting and I told her that I assisted [the resident]to the toilet and asked her to listen for her [the resident]...A few minutes later, I asked [the CNA] who was still at the kiosk to check on her [resident]...[the CNA] went into the room, came back out and said that [the resident]was on the floor.

I then went in and found [the resident]lying diagonally in the bathroom, with her head towards the sink and feet towards the door. She was lying on her right side, with her right leg bent underneath her...At that time I felt her hip, did not feel any abnormality, asked her if it hurt, and she responded no. We then assisted her to bend her knees which she was able to do...assisted her to a standing position and then she took about three steps for us and we placed her back on the toilet to finish...

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F 324	Continued From page 4 I did notice intermittent levels of confusion during the day... When [the physical therapist] reported that he noted some discrepancies noted by difference in length of legs and inward rotation, we then called the doctor, got an order to transport and make the arrangements to send her to the ER (emergency room)". Physical Therapy Evaluation, dated 10/10/05, documented the following entry, " Pt (patient) c/o (complained of) moderate to severe pain in R (right) hip area in standing, with transfers and with PROM/AAROM (passive and active range of motion); minimal to no discomfort stated in sitting. Pain reproduced by joint approximation to R (right) hip. Leg length discrepancy noted to be about 1/2 inch shorter on R (right) LE (lower extremity). Only able to bear weight on R (right) leg with max. (maximum) Ax2 (assist times 2 people)and weight shifting;...Signs and symptoms consistent with possible hip fracture/dislocation. Discussed finding with nurse and recommended pt (patient) get an x-ray". In an interview with the staff nurse that assessed resident 1 after she fell, on 10/18/05 at 1:40 PM, she stated "she (resident) was cognitive enough to ask to use the toilet , I handed her the call light. She seemed to be with it, we had side rails up while in bed, all week-end did not make any attempts to move, all I could go by is what I observed here". The staff said she did an assessment of resident 1 and that she denied pain, did not notice any shortening of the residents leg, she (staff nurse) then placed resident 1 back on the toilet.	F 324		

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F 324	Continued From page 5 The staff nurse confirmed that she did remove resident 1 from a pressure alarm prior to putting resident 1 on the toilet. There was no documentation in the nurses notes or the incident/accident report that resident 1's right leg was assessed for any type of rotation. In interview with CNA 1, on 10/19/05 at 1:00 PM, she said that residents at risk for falls and that are confused are placed on the new pressure alarms. She also said when a resident requires a pressure alarm for fall risk the resident should not be left on a toilet alone. In an interview with CNA 2, on 10/19/05 at 1:30 PM, she said that residents at risk for falls will be assessed and have some type of fall prevention device and require close supervision and should not be left on toilet alone.	F 324		

EXHIBIT A

Fall Risk Assessment Protocol

1- A fall assessment is to be completed within 2 hours of admission.
2- A notification leaf will be placed in the bathroom and on the resident's door to notify staff of the fall risk.
3- Staff will remain in the bathroom with each new admission for the first 7 days after admission.
4- A new fall assessment will be completed after the 7 day assessment period.
5- If the resident is found to be stable during this assessment time the notification leaf will be removed from the bathroom.
6- If a resident requires a pressure alarm or restraint, staff will consider them a high fall risk and the leaf will remain in the bathroom. High risk interventions will be implemented.
7- If a resident refuses to be monitored in the bathroom during the week assessment a managed risk agreement form will be filled out.
8- If at anytime a resident is placed on an alarm system or restraint, a new fall assessment will be completed.
9- After each fall the resident will be assessed by the Fall Prevention Coordinator and a fall summary record will be filled out. This will assess old interventions tried and new interventions to be initiated.

EXHIBIT D

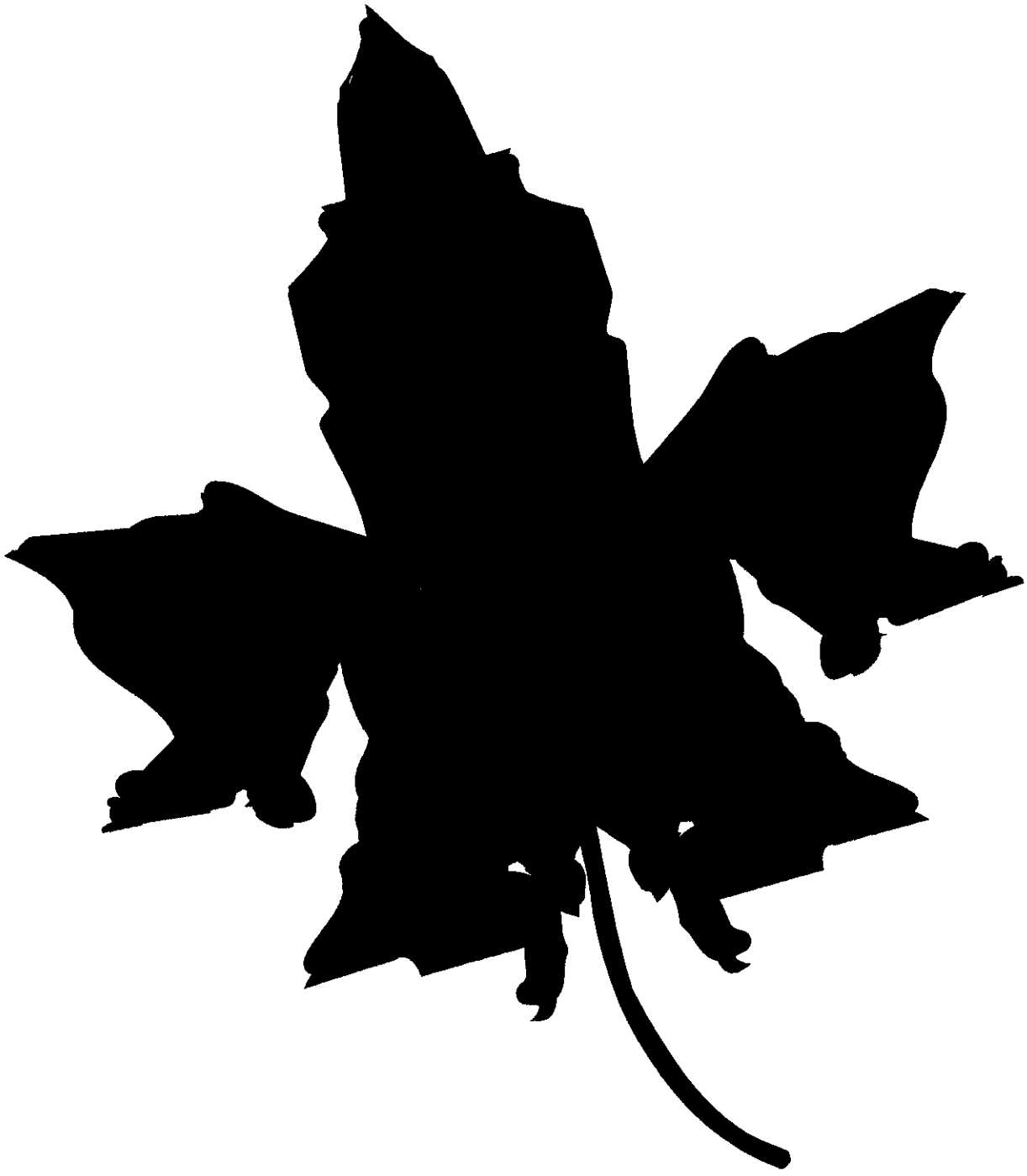

EXHIBIT C

SUNSHINE TERRACE FALL ASSESSMENT

Resident's Name:	Assessment completed by: (name and signature)	Date:

INSTRUCTIONS: This assessment is to be completed on all residents upon admission and annually thereafter.

1- **Check applicable items and indicate points at the right.**
2- **Add all points and note total score below. Determine which fall risk category this resident falls under and follow appropriate protocols.**

		FYI
I. AGE:	80 years or older ☐ Younger than 80 years ☐	
II. H & P:	**No notation of falls (0 pts)** ☐ **Hospitalization d/t fall (AUTOMATIC HIGH FALL RISK)** ☐ Dizziness (1 pt) ☐ Weakness (3 pts) ☐ Seizures (2 pts) ☐ **Alarm or lap robe (AUTOMATIC HIGH FALL RISK)** ☐	____pts
II. PHYSICAL ABILITY:	Independent (0 pts) / 1 Assist (1 pt.) / 2 Assist (2 pts.) A. Transfers: ☐ ☐ ☐ B. Ambulation: ☐ ☐ ☐	____pts
III. MENTAL STATUS:	Oriented at all times or comatose (0 pts) ☐ Confused at all times (1 pt.) ☐ Intermittent confusion (4 pts) ☐	____pts
IV. NEW ADMIT or ANNUAL:	New admit (2 pts) ☐ Annual (0 pts) ☐	____pts
V. ELIMINATION:	Continent/Independent (0 pts) ☐ Catheter/Ostomy (1 pt) ☐ Incontinent/Dependent (1 pt) ☐ Continent/dependent (2 pts) ☐ Incontinent/Independent (3 pts) ☐	____pts
VI. HISTORY OF FALLS IN PAST 6 MONTHS:	No falls (0 pts) ☐ 1-2 falls (2 pts) ☐ Multiple falls (4 pts.) ☐	____pts
VII. VISUAL IMPAIRMENT:	No Impairment (0 pts) ☐ Impairment (1 pt) ☐ Impairment corrected (0 pts) ☐ Not corrected/Refuses glasses (1 pt) ☐	____pts
VIII. AUDITORY IMPAIRMENT:	No Impairment (0 pts) ☐ Impairment (1 pt) ☐ Impairment corrected (0 pts) ☐ Not corrected/Refuses hearing aids (1 pt) ☐	____pts
IX. GAIT AND BALANCE:	Wandering Behavior (1pt) ☐ Use of assistive device (2 pts) ☐ Neuromuscular dysfunction (2 pts) ☐ Balance deficiencies/ unsteady gait (2 pts) ☐	____pts
X. MEDICATIONS:	No medications (0 pts) ☐ Diuretics/Laxatives (1 pt) ☐ Antidepressants/sedatives/hypnotics/psychotropic – 1 med (1 pt) ☐ More than 1 psych med (2 pts) ☐	____pts
XI. BEHAVIORS:	Combative/Aggressive Episodes (1pt) ☐	____pts
CATAGORIES:	**TOTAL SCORE:** **Low risk 0-10pts** ☐ **Moderate Risk: 11-20pts.** ☐ **High Risk: 21-31pts.** ☐ **(If resident was taken to the hospital d/t a fall, or if they have a restraint or alarm, they are automatically a HIGH FALL RISK!!!!)**	____pts

EXHIBIT D

SUNSHINE TERRACE SKILLED NURSING AND REHABILITATION CENTER
MANAGED RISK AGREEMENT

This agreement is entered into by the resident and/or his/her responsible party for and in behalf of: _____

1. The Resident and/or his/her Responsible Party do not wish to follow the facility protocol or recommendation regarding the following issue:

_____

_____

_____

_____

2.

POTENTIAL RISKS	AVAILABLE OPTIONS

3. Sunshine Terrace recommendations: _____

_____

_____

4. Resident preferences: _____

_____

_____

5. Agreed upon option: _____

_____

6. Assigned responsibilities: _____

_____

I have discussed the possible problems and risks associated with these events with a representative of Sunshine Terrace and I understand the ramifications and risks to the aforementioned person if these behaviors or events continue. I understand that by signing this agreement, I am directing Sunshine Terrace to allow the aforementioned person to continue in the manner set forth above and will remove all liability and to hold harmless Sunshine Terrace and all those who are employed there in regards to these specific behaviors and events. I knowingly and willingly have made a decision to allow this risk agreement to be enforced by Sunshine Terrace. This agreement can be reviewed and/or revised at any time. If any changes need to be made, a new agreement must be signed by all parties involved.

_____ _____

Resident/Responsible Party Signature (Date) Facility Representative Signature (Date)

EXHIBIT C

FALLS SUMMARY RECORD

Resident Name:_____ Date:_____ Wing:_____

LOCATION OF FALL(S)	TIME OF FALL(S)
❑ Bathroom ❑ Bedside ❑ Hallway ❑ Other:_____ _____ _____	❑ Morning (6:30 A.M. - 2:30 P.M.) ❑ Evening (2:30 P.M. - 10:30 P.M.) ❑ Night (10:30 P.M. - 6:30 A.M.) **COMMENTS:** _____ _____

RISK FACTORS	
❑ More than 4 medications ❑ Psycho-active medications ❑ A new medication(s) ❑ Lasix or other dieuretic ❑ Confusion/dementia ❑ Urinary tract infection or otherwise sick ❑ Cluttered room or area ❑ Not using or inappropriate use of assistive device(s)	❑ Previous history of falls ❑ Improper shoes (non-supportive or heavy, thick soles that catch) ❑ Incontinent ❑ Poor vision ❑ Medical condition such as: stroke, hypotension, seizures, cardiac problems, etc. ❑ Unsteady gait ❑ Restraint(s) If yes, which one(s): _____

REASONS FOR FALL(S) (Was any equipment involved? i.e., walkers, wheelchairs, lifts, etc.)	FALL PREVENTION DEVICES OR INTERVENTIONS PREVIOUSLY USED
_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	❑ Bed alarm/chair alarm ❑ Walker/assistive device ❑ Low bed ❑ Room move (i.e., closer to the nurses station) ❑ Geri-chair ❑ Saddle-horn cushion ❑ Tilt cushion ❑ Proper wheelchair fit ❑ Lap buddy ❑ Self release belts ❑ Anti-tip wheels ❑ Bed cane ❑ Other:_____

NUMBER OF FALLS IN THE LAST 30 DAYS:	P.T. INVOLVEMENT
	Referral made to P.T. ❑ Yes ❑ No Date when referral was made:_____ .

DOCUMENTATION	EDUCATION OF STAFF AND/OR RESIDENT
Detailed charting in nurses notes. ❑ Yes Every shift charting sticker on chart. ❑ Yes	_____ _____

PLAN OF ACTION TO PREVENT FUTURE FALLS

Signature of Charge Nurse:_____

Signature of assigned CNA:_____