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LICENSURE VIOLATIONS

300.610a)
300.682a)1)2)3)4)
300.1210d)6)
300.1220b)3)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.682 Nonemergency Use of Physical Restraints

a) Physical restraints shall only be used when required to treat the resident's medical symptoms or as a therapeutic intervention, as ordered by a physician, and based on:

1) the assessment of the resident's capabilities and an evaluation and trial of less restrictive alternatives that could prove effective;

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2) the assessment of a specific physical condition or medical treatment that requires the use of physical restraints, and how the use of physical restraints will assist the resident in reaching his or her highest practicable physical, mental or psychosocial well being;

3) consultation with appropriate health professionals, such as rehabilitation nurses and occupational or physical therapists, which indicates that the use of less restrictive measures or therapeutic interventions has proven ineffective; and

4) demonstration by the care planning process that using a physical restraint as a therapeutic intervention will promote the care and services necessary for the resident to attain or maintain the highest practicable physical, mental or psychosocial well being. (Section 2-106(c) of the Act)

Section 300.1210 General Requirements for Nursing and Personal Care

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

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b) The DON shall supervise and oversee the nursing services of the facility, including:

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements were not met as evidenced by:

Based on observation, interview, and record review, the facility failed to assess and document the risks versus benefits and medical symptom justifying the use of restraints for 1 of 1 residents (R7) reviewed for a wedged mattress in the sample of 15. The wedged mattress positioning was determined to be a restraint, an entrapment and suffocation hazard.

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Findings include:

On 7/9/13 at 10:10 AM, R7 was observed asleep in bed with her face against a mat on the wall. The left side of the bed was against the wall. There was a mat propped between the bed and the wall, extending just above R7's head on the mattress. The right side of the mattress had 2 vinyl covered foam wedges that covered the length of the mattress between the mattress and the bed frame. These wedges raised the length of the right side of the mattress 45 degrees off of the bed frame. This created a V-shaped crevice in which the resident was lying. The wedges were not secured to the bed frame. The wedges were not secured to the mattress. The mattress was not secured to the bed frame. There was also a pressure pad alarm on the bed and another mattress on the floor beside the bed.

On 7/9/13 at 12:00 PM, R7 was awake in bed, flailing her right leg about, rubbing her right foot on the wall on her left side, and pushing her right foot against the wall at the foot of the bed. R7 was lying in the V-shaped crevice between the mattress and the wall with the mattress in the wedged position 45 degrees above the bed frame. There was a pressure pad alarm on the bed and another mattress on the floor beside the bed.

On 7/9/13 at 1:10 PM, after completing perineal care for R7, E9 and E10, Certified Nurses Aides (CNA's), repositioned R7's mattress to the wedged position. E10 lifted the right side of R7's mattress while R7 was in the bed. E9 pushed wedges between the mattress and the bed frame along the length of the right side of mattress, raising the mattress 30 degrees off of the bed

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frame. R7 had 2 scabbed areas and an abrasion on her left knee, and a scabbed area on her right foot second toe. E9 stated these areas were from R7 rubbing against the wall.

On 7/10/13 at 11:37 AM, R7 was awake in bed, flailing her right leg about, rubbing her right foot on the wall on her left side, and pushing her right foot against the wall at the foot of the bed. R7 was lying in the V-shaped crevice between the mattress and the wall with the mattress in the wedged position 30 degrees above the bed frame. There was a pressure pad alarm on the bed and another mattress on the floor beside the bed.

R7's July 2013 Physician's Order Sheet (POS) documents a diagnosis (in part) of brain tumor. The POS does not have a Physician's order for wedging R7's mattress.

R7's Care Plan, dated 1/28/13, has no documentation of the approach of the wedged bed positioning. There is no assessment for the wedged bed positioning. There is no Restraint Assessment for the wedged bed positioning. R7's Quarterly Minimum Data Set (MDS), dated 4/22/13, documents no restraints are used for R7.

In an interview on 7/9/13 at 10:10 AM during the initial tour of the Facility, E3, Assistant Director of Nurses (ADON), stated, "(R7) has a history of a brain tumor and has random flailing movements. This (the wedged bed positioning) is what we came up with to keep her (R7) from flipping out of bed."

In an interview with E9, CNA, on 7/9/13 at 1:10 PM, when asked how much they are supposed to

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raise the mattress, E9 stated, "We tip it more if she (R7) tries to roll over that (pointing to the wedged mattress)." The mattress was raised 30 degrees off of the bed frame at the time of the interview.

On 7/10/13 at 12:45 PM, E2, Director of Nurses (DON), stated "(R7) probably had this (wedged mattress positioning) since 12/5/12. She (R7) was having such issues with getting out of bed, this keeps her from getting out of bed. This decreases it. (Z1) (R7's Physician) and (Z3) (R7's Psychiatrist) worked together with us to come up with this to use. We attempted prior: floor mat, floor mat alarm, mattress on floor, 2 mattresses on floor because she (R7) would just roll. She (R7) can just roll right out of a scoop mattress. We are slowly trying to remove things, but she (R7) actually kicks the mat up on the wall. I worry that (R7) will remove the wall pad and pull it over herself. She (R7) can and did that on 6/18/13. I worry about suffocation from the wall pad. I don't see the wedging of the mattress as a potential for (R7) to suffocate. I reviewed (R7's) Chart. I don't see that we had anything in the Care Plan about wedging the mattress or an assessment for this. We are doing this to keep her from getting out of bed, but she can get out, so how can that be a restraint? She (R7) got herself out of bed with it wedged two times in April (2013). She (R7) ended up on the floor mattress and had no injuries."

On 7/10/13 at 12:45 PM, E3, ADON, stated "She (R7) is at risk for injury with her repetitive movements. That is why we have been putting a mat against the wall. This (wedged mattress positioning) is the result of IDT (Interdisciplinary Team) working on progressive interventions for

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her (R7). I don't think the mattress could slide out from under her (R7) and wedge her (R7) between the mattress, the wall, and the bed frame because the wedges under the mattress are up against the rail of the bed frame."

In an interview on 7/17/13 at 11:20 AM, Z1, Medical Director and R7's Physician, Z1 stated she wasn't aware of the positioning of the mattress for R7 and had no input on how they did it.

On 7/17/13 at 3:20 PM, Z3, R7's Psychiatrist, stated regarding R7's wedged mattress, "I had no input on that. I know she (R7) has been on that (the wedged mattress) a long time."

The facility's undated Restraint Policy documents, in paragraph 3, "A restraint is any manual method or physical or mechanical device, material or equipment attached or adjacent to the residents body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." In paragraph 4, "If a restraint is used to enable the resident to attain or maintain his or her highest practicable level of function, this facility will be evidence of consultation with appropriate health professionals, such as occupational or physical therapists. This consultation will consider the use of less restrictive therapeutic prior to using restraints. The use of therapeutic intervention will be justified through the care planning process and will demonstrate that these interventions promote the care and services necessary for the resident to attain or maintain the highest practicable well-being."

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F9999	Continued From page 48 (A) 300.1210b) 300.1210d)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect	F9999		

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F9999	Continued From page 49 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: Based on observation, record review, and interview, the facility failed to properly assess, evaluate, and monitor the use of side rails and failed to follow the U.S. Food and Drug Administration guidelines to reduce the risk for entrapment for 2 of 3 residents (R10, R11) reviewed for side rail entrapment hazards in the sample of 15. Evaluation and measurement of the side rails in the facility indicated the side rails to be a potential entrapment hazard. Findings include: 1. The U.S. Food and Drug Administration (FDA) publication "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment - Guidance for Industry and FDA Staff" issued March 10, 2006 documented "To reduce the risk of head entrapment, opening in the bed system should not allow the widest part of a small head (head breadth measured across the face from ear to ear) to be trapped." The publication documented "FDA is therefore using a head breadth dimension of 120 mm (millimeters) (4 3/4 inches) as the basis for its dimensional limit recommendations." The publication documented regarding neck entrapment "To	F9999		

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reduce the risk of neck entrapment, openings in the bed system should not allow a small neck to become entrapped." The publication documented "The FDA is recommending 60 mm (2 3/8 inches) as an appropriate dimension for neck diameter." The publication documented regarding chest entrapment "The openings in a bed system should be wide enough not to trap a large chest through the openings between split rails. The FDA's dimensional limit for the chest is 12 1/2 inches." The publication documented a potential area for entrapment as "Zone 1: Within the Rail."

2. R11's Quarterly Minimum Data Set (MDS), dated 6/9/13, documents R11 is severely impaired for decision making.

R11's July 2013 Physician's Order Sheet (POS) documents an order, "1/2 side rail x 1 up while in bed as an aid for positioning."

R11's Care Area Assessment Summary, dated 6/10/13, documents, "She (R11) does utilize 1/2 side rail x 1 to help aide in her bed mobility. She (R11) will grasp the side rail."

R11's Fall Care Plan, dated 12/17/12, documents R11 has a history of falls. Approaches include: 1/16/11 - bed pad alarm, 1/16/11 - 1/2 side rail up x 1 while in bed, 4/2/11 - bed against the wall, 5/20/11 - floor mat and floor mat alarm next to bed while resident is in the bed. R11 is able to propel self independently.

R11's Nurse's Notes dated 5/20/13 document, "Res (resident) hit and bit staff, continues to be agitated and abusive to staff."

On 7/10/13, upon request for R11's Side Rail

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Assessment, E3 presented an untitled document for R11 dated 3/12/13 with "startling" and "create sense of being trapped or jailed" marked as risks. "Entanglement of limbs in rail, trauma or injury if limb/body strikes rail, death, and entrapment" are not marked as risks for R11.

In an interview on 7/10/13 at 9:45 AM, E11, Certified Nurses Aide (CNA) stated, R11 "rolls side to side in bed and sits straight up in bed. She (R11) uses the side rail sometimes. She (R11) gets agitated sometimes when being put to bed, she likes to be up to roam the hallways."

In an interview on 7/10/13 at 11:40 AM, E5, CNA, stated, "It has been 6 months or so since (R11) has tried to get out of bed. She (R11) rolls over and sits up but she doesn't try to get out of bed."

On 7/9/13 at 10:05 AM during initial tour of the facility, R11 was asleep in bed. R11's bed was against the wall on the right side and the left half side rail was up. R11 also had a bed alarm, a floor mat, and a floor mat alarm in place.

3. On 7/9/13 at 9:30 AM during initial tour of the facility, R10 was lying in bed positioned on his back with Oxygen at 4 liters by nasal cannula. R10 had bilateral half side rails up on his bed.

On 7/10/13 at 11:35 AM, R10 was seated in a geriatric chair moving his arms.

R10's Quarterly MDS, dated 5/26/13, documented R10's cognition was severely impaired.

R10's Nurse's Notes, dated 6/30/13 9:30 AM, documents "In geri (geriatric) chair and

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attempting to get up by self out of chair. Stating, help me, help me. Anxious. Roxanol and Ativan given. Layed down in bed."

R10's Nurse's Notes, dated 7/3/13 7:40 PM, documents "up in gerichair (geriatric) this shift. Very restless this shift, kept throwing legs off of chair."

On 7/10/13 at 11:50 AM, E5 stated "He (R10) is unable to turn by himself. We turn him from side to side. He (R10) will grab the side rails when we ask him to. He (R10) does move his arms."

4. On 7/9/13 at 1:00 PM, R10's right side rail and R11's left side rail were measured. These side rails were of the same type. There were two areas which measure 8 inch wide x 8 inch long between the bars of the rails and another area with 7.5 inch wide x 17 inch long between in Zone 1. These side rails did not meet the FDA dimensional limit recommendations.

5. In an interview on 7/10/13 at 12:45 PM, E3, Assistant Director of Nurses (ADON), stated, "these are new ones we just got in, we weren't aware there was a problem with the side rails."

6. In an interview on 7/10/13 at 12:45 PM, E2, DON, stated, "She (R11) has had this side rail since her admission. I don't know how long R10 has had them."

(A)