Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001663	A. BUILDING: ______ B. WING ______	11/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HEALTH CARE CENTER	1450 26TH STREET HIGHLAND, IL 62249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
S9999	Final Observations	S9999		

Statement of Licensure Violations

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. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

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
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:
Based on observation, record review, and

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interview the facility failed to thoroughly evaluate siderails and bolsters for entrapment hazards and implement progressive interventions to prevent falls for 4 of 4 residents (R4, R6,R7, R12) reviewed with a history of falls in the sample of 15, and two residents (R20, R21) in the supplemental sample. This failure resulted in R7 becoming entangled in the siderail and falling from bed.

Findings Include:

1. The US FDA publication "Hospital Bed System Dimensional Assessment Guidance to Reduce Entrapment-Guidance for Industry and FDA Staff" issued March 10, 2006 documents, in part, "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 documents, "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 documents "FDA is recommending 60 mm (2 3/8 inches) as an appropriate dimension for neck diameter." The publication documents regarding chest entrapment, "The openings in a bed system should be wide enough not to trap a large chest through the opening between split rails. The FDA's dimensional limit for chest is 12 1/2 inches."

The publication documents a potential area for entrapment as "Zone 6: Between the End of the Rail and the Side Edge of the Head or Foot Board. Zone 6 is the space between the end of the rail and the side edge of the headboard or foot board. This space may present a risk of either neck entrapment or chest entrapment. In

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addition, any V-shaped opening between the end of the rail and the head or footboard may present a risk of entrapment due to wedging. This space may change when raising or lowering the head or foot sections of the bed. This space may increase ,decrease, become less accessible or disappear entirely. Thus, in some positions, the potential for entrapment and encourages facilities and manufactures to report entrapment events at this zone."

2. Significant Change Minimum Data Set (MDS) dated 8/19/2014 documents R7 as having long and short term memory deficits. It documents R7 as requiring extensive assistance from two staff members with bed mobility and transfers. The Facility Fall Risk Assessment dated 8/19/2014 documents R7 as high risk for falls.

The Side Rail Rationale Screen dated 8/19/2014 for R7 documents, in part: "Resident is not ambulatory. Resident has had a decline in safety awareness. Resident has demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed. The resident is not at a risk for entrapment, but not limited to agitation, small body mass and/or gaps between the side rail and the bed."

Progress Notes dated 8/19/2014 at 6:02 PM document R7 was observed with "..body halfway out of bed with R (right) side on siderail."

8/19/2014 at 7:01 PM, Z4, Registered Nurse - Hospice, documented,in part, "Call received from (E6) staff nurse. He (E6) stated pt (patient) rolled out of bed (R7)....He (E6) states pt has a canoe mattress and she has to get over the rail and bolster in order to fall out of bed and feels this poses a danger to the pt (R7)."

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On 8/19/2014, The Facility Interview /Investigative Record written by E6, Licensed Practical Nurse (LPN) documents, " Called to room 245....Res (resident) off left side of bed, head resting on the floor mats, right leg and buttocks held up by siderail..."

On 10/30/2014 at 9:00 AM, E6 Registered Nurse (RN) and E8 LPN stated, E8 saw the position R7 was in at this time of fall from bed on 8/19/2014. E6 got a sheet and laid in R7's bed to demonstrated the position of R7 at the time of the fall on 8/19/2014 as follows: E6 rolled from her back to her left side. E7's right leg was up over the raised siderail with her left hip and leg were against the siderail. E6 bent at the waist, moved off the mattress demonstrating her head, left shoulder, left arm and torso off the bed in the space between the headboard and the side rail. E8 agreed this was the position R7 had been in at the time of the fall.

On 8/31/2014, an Injury of Unknown Origin Report documents R7 as having a bruise under her right arm. The report documents, "Probable or likely etiology: Resident leaning against bedrail, increased anxiety, arms of Broda chair not padded, also note soft fall 8/19/2014."

On 10/28/2014 at 9:50 AM, R7 was lying in bed with the bilateral P-shaped helper rails in the down position creating a 1/2 siderail in the middle of the bed. R7 was restless and moving about the bed.

On 10/29/2014 at 9:50 AM, R7 was lying in bed with bilateral siderails in the middle of the bed. R7 was restless, grabbing and pulling on the rails.

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On 10/30/2014, at 8:55 AM, Zone 6, the space between the headboard and the siderail was 30.5 inches distance on the left side of the bed and 16.5 inches in the same space on the right side of the bed.

On 10/30/2014 at 9:00 AM, during the interview with E6 and E8, they stated R7's bed had been brought in by the Hospice provider, but was changed after the fall on 8/19/2014. E6 and E8 agreed R7 is currently in the same type of bed with siderails, when in the down position are in the middle of the bed frame, the same position as when R7 fell on 8/19/2014.

3. R6's Admission MDS dated 6/12/2014 documents his cognition is moderately impaired and he requires extensive assist of 2 staff for transfer, bed mobility ambulation and bathing.

On 6/19/2014 at 1:15 AM the Facility's Situation, Background, Assessment, Response (SBAR) form documents R6 was , "...Found on the floor next to bed". No new intervention was added to the Plan of Care.

On 6/19/2014 at 8:30 PM the SBAR form documents R6 was, " found res (resident) face down on floor between bed and nightstand." No new intervention was added to the Plan of Care

On 6/20/2014 at 12:18 AM the SBAR form documents, Resident (R6) found on floor next to bed." The form documents side rails and an alarm were added to his Plan of Care.

The Fall Assessments for R6 dated 6/21, 7/2, 8/1 and 9/2/2014 all document him at "High Risk" for falls.

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On 10/28/2014 at 1:15 PM, R6 was lying in bed with a siderail in the middle of the bed frame. The gap from the head board to the siderail was 13 inches.

October 2014 Physician's Orders for R6 does not have an order for side rails. R6's clinical record did not have a restraint assessment for bilateral side rails.

On 10/30/2014, E2, Director of Nursing (DON) stated we do not consider R6's grabber bar side rail as a restraint.

The Facility provided documentation for the "No Guard Assist Rail" documents, " The Product Description: 1/2 rail that attaches to midsection of the bed. Offers three positions that provide safety while the resident is in the bed. Promotes healthy transfers in the up position, swivels out of the way for easy access and caregiver assisted transfers......View the Bed Rail Entrapment Risk Notification Guide."

4. The Physician's Order Sheet (POS), dated 10/2014 for R4 documents diagnoses, in part, "Generalized Seizures, Parkinson's Disease with Behavioral Disturbance. The POS has no orders for the use of side rails or bolsters to R4's bed. The MDS, dated 8/14/2014, documents R4 is moderately impaired with cognition, is non ambulatory, has limited range of motion to all extremities, has unsteady balance and requires extensive assistance with transfers. The Fall Risk Assessment, dated 8/14/2014, documents R4 is a high risk for falls.

On 10/28/2014 at 9:35 AM, R4 was asleep on her back. There were two wide bolsters to the middle edges of R4's bed. R4 had 1, P-shaped helper

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side rails in the raised position. There was a large gap from the head of the bed to the side rail measuring 13 1/2 inches. A fall mat was next to the bed and R4 had a pressure pad alarm on the bed. R4's bed was positioned next to the wall.

The Behavior Tracking for 10/2014 documents R4 has physically aggressive behaviors with staff, at times kicking and hitting during care. There was no side rail assessment or restraint assessment for the use of the bolsters or the P-shaped helper rails in R4's clinical record. There is no documentation of the risk, including entrapment, versus benefits of the use of these devices for R4.

The Care Plan, dated 8/14/2014, documents R4 has had falls from the bed on 8/14/2014 and 11/19/2013.

5. The POS for 10/2014 for R12 documents diagnoses, in part, as "Parkinson's Disease, Personal History of Fall, Closed Femur Fracture, Dementia with Behavioral Disturbance and Abnormal Posture." The MDS dated 8/13/2014 documents R4 has unsteady balance with normal range of motion (ROM) to the upper extremities, and limited ROM to the lower extremities and requires extensive assistance for bed mobility and transfers.

The POS for 10/2014 documents an order for 1/2 grab bars X 2 for bed mobility and for the use of bolsters placed in the middle of the bed. The Fall Risk Assessment, dated 5/12/2014 and 6/27/2014 documents R12 is a high risk for falls.

On 10/30/14 at 9:08 AM, R12's bed had 2, P-shaped helper rails in the up position with 2 roll bolsters in the center edges of the bed. A 15 inch

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space was between the helper rails and the head board of R12's bed.

On 10/30/2014, at 1:45 PM, E9 and E10, Certified Nurses Aides, (CNA) transferred R12 from the wheelchair to bed with a gait belt. R12 grabbed the P-shaped helper rail with her right hand. At that time, E9 stated, "(R12) uses the side rails, grabs onto them and tries to swing her feet over too. She doesn't like to lay down." E19 stated, "(R12) climbs out of bed at night. That's the reason for the bolsters. (R12) grabs the side rails to sit up sometimes."

R12's Care Plan, dated 9/17/2014, documents R12 has a history of falling from the bed and wheelchair. There is no assessment documented to include the risks, including entrapment, and benefits for the use of the helper rails or roll bolsters in use on R12's bed.

6. The POS for R20 for 10/2014 documents diagnoses, in part, as "Closed Fracture of Acetabulum, Compression Fracture and Osteoporosis and Legal Blindness. The MDS, dated 10/14/2014, documents R20 has normal range of motion to all extremities, unsteady balance and is moderately impaired with cognition.

On 10/28/2014 at 9:35 AM through 10/30/2014 at 9:05 AM, the 2 P-shaped helper rails were attached to R20's bed. The space between the head of the bead and the rails was 15 inches.

The POS for 10/2014 documents an order for "bed and chair alarm placed on resident this afternoon due to unsafely transferring self without assist." The Fall Risk Care Plan, updated 10/12/2014, documents R20 has had falls from

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S9999	Continued From page 8 the bed on 9/17/2104 and 10/12/2014, increasing the risk of entrapment from the use of the side rails. The Report of Incident SBAR-Actual or Suspected Fall, dated 9/17/2014 at 12:40 PM, documents R20 "slid out of bed in her sock feet with 2 siderails up, pad alarm failed to sound and pad alarm replaced. (R20) left facility via ambulance for complaint of right hip and pelvic pain, negative for fracture. At last bed check when 1/2 side rail placed down, severed the cord on alarm." There was no assessment in R20's clinical record for the use of the P-shaped helper side rails, including the risks versus benefits for the use of these devices on R20's bed. On 10/30/2014, at 11:30 AM, E5, MDS/Care Plan Coordinator reported no resident in the facility had been assessed for the use of the P-shaped helper rails because they were only being used in the up position to help residents turn and reposition. E5 reported she was unaware if any resident's P-shaped side rails were being used in the down position in the middle of the beds. The Facility's policy and procedure, entitled, 'Fall Management', document, in part, "PURPOSE-To evaluate risk factors and provide interventions to minimize risk, injury and occurrences. ASSESSMENT GUIDELINES-May include, but are not limited to: Fall risk factors/Fall history, MDS/Falls Care Area Assessment, Post fall evaluation and observation. EQUIPMENT- Fall prevention equipment may include, but is not limited to: Alarms, sensor mats, transfer poles, floor pads, non-skid mats, handrails, grab bars, trapeze, adaptive equipment, transfer lifts, etc.	S9999		

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(and other things).

7. On 10/30/14, at 1:15 PM, R21 was observed laying in bed with both helper rails / side rails lowered, positioned at the middle of the mattress. R1 was observed to intermittently pull against the rail then stop then try again. When approached, R21 stated, "please don't leave, I'm waiting for my father to come."

R21' chart contained S-BAR Forms that documented several falls from bed on 3/20/14, 5/04/14, and 5/6/14. R21's Fall Assessment dated 7/18/14 documented she had a score of 14 / high risk for falls. The Minimum Data Set (MDS) dated 7/22/14 documented a cognitive score of 6 / severely impaired. R21's Care Plan dated 5/5/14, documented R21 had intermittent confusion, was chair bound, and had poor gait and balance.

On 10/31/14 at 11:10 AM, E5, MDS Nurse stated that no residents in the facility had no restraint assessments for R21 or any resident in the facility for the the use of helper rails. E5 stated that the rails should not be placed in the down position, as they are helper rails, and should have only been in the up position on R21's bed. The space between the head board and the side rails was 13 inches.

(A)

300.680a)
300.682a)1)
300.682a)2)
300.1220b)3)
300.3240a)

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Section 300.680 Restraints
a) The facility shall have written policies controlling the use of physical restraints including, but not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars and lap trays, and all facility practices that meet the definition of a restraint, such as tucking in a sheet so tightly that a bed-bound resident cannot move; bed rails used to keep a resident from getting out of bed; chairs that prevent rising; or placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Adaptive equipment is not considered a physical restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room do not, in and of themselves, restrict freedom of movement and should not be considered as physical restraints. The policies shall be followed in the operation of the facility and shall comply with the Act and this Part. These policies shall be developed by the medical advisory committee or the advisory physician with participation by nursing and administrative personnel.

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;
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

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psychosocial well being;

Section 300.1220 Supervision of Nursing Services
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

These requirements were not met as evidenced by:
Based on observation, record review and interview, the facility failed to identify the medical justification, properly assess the risks versus benefits, evaluate and monitor the use of side rails for four of six residents (R4, R6, R7, R12) reviewed for side rails in the sample of 15 and 41 residents (R20, R21, R22, R28 through R65) in the supplemental sample.

Findings include:

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1. Significant Change Minimum Data Set (MDS) dated 8/19/2014 documents R7 as having long and short term memory deficits. It documents R7 as requiring extensive assistance from two staff members with bed mobility and transfers. The Facility Fall Risk Assessment dated 8/19/2014 documents R7 as high risk for falls.

The Side Rail Rationale Screen dated 8/19/2014 for R7 documents, in part: "Resident is not ambulatory. Resident has had a decline in safety awareness. Resident has demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed. The resident is not at a risk for entrapment, but not limited to agitation, small body mass and/or gaps between the side rail and the bed."

Progress Notes dated 8/19/2014 at 6:02 PM document R7 was observed with "..body halfway out of bed with R (right) side on siderail."

8/19/2014 at 7:01 PM, Z4, Registered Nurse - Hospice, documented,in part, "Call received from (E6) staff nurse. He (E6) stated pt (patient) rolled out of bed (R7)....He (E6) states pt has a canoe mattress and she has to get over the rail and bolster in order to fall out of bed and feels this poses a danger to the pt (R7)."

On 8/19/2014, The Facility Interview /Investigative Record written by E6, Licensed Practical Nurse (LPN) documents, " Called to room 245....Res (resident) off left side of bed, head resting on the floor mats, right leg and buttocks held up by siderail..."

On 10/30/2014 at 9:00 AM, E6 Registered Nurse (RN) and E8 LPN stated, E8 saw the position R7 was in at this time of fall from bed on 8/19/2014.

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E6 got a sheet and laid in R7's bed to demonstrated the position of R7 at the time of the fall on 8/19/2014 as follows: E6 rolled from her back to her left side. E7's right leg was up over the raised siderail with her left hip and leg were against the siderail. E6 bent at the waist, moved off the mattress demonstrating her head, left shoulder, left arm and torso off the bed in the space between the headboard and the side rail. E8 agreed this was the position R7 had been in at the time of the fall.

On 8/31/2014, an Injury of Unknown Origin Report documents R7 as having a bruise under her right arm. The report documents, "Probable or likely etiology: Resident leaning against bedrail, increased anxiety, arms of Broda chair not padded, also note soft fall 8/19/2014."

On 10/28/2014 at 9:50 AM, R7 was lying in bed with the bilateral P-shaped helper rails in the down position creating a 1/2 siderail in the middle of the bed. R7 was restless and moving about the bed.

On 10/29/2014 at 9:50 AM, R7 was lying in bed with bilateral siderails in the middle of the bed. R7 was restless, grabbing and pulling on the rails.

On 10/30/2014 at 9:00 AM, during the interview with E6 and E8, they stated R7's bed had been brought in by the Hospice provider, but was changed after the fall on 8/19/2014. E6 and E8 agreed R7 is currently in the same type of bed with siderails, when in the down position are in the middle of the bed frame, the same position as when R7 fell on 8/19/2014.

2. The Physician's Order Sheet (POS), dated 10/2014 for R4 documents diagnoses, in part,

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"Generalized Seizures, Parkinson's Disease with Behavioral Disturbance. The POS has no orders for the use of side rails or bolsters to R4's bed.

On 10/28/2014 at 9:35 AM, R4 was asleep on her back. There were two wide bolsters in the middle edges of R4's bed. R4 had 1, P-shaped helper side rails in the raised position. There was a large gap from the head of the bed to the side rail measuring 13 1/2 inches. A fall mat was next to the bed and R4 had a pressure pad alarm on the bed. R4's bed was positioned next to the wall.

The Behavior Tracking for 10/2014 documents R4 has physically aggressive behaviors with staff, at times kicking and hitting during care. There was no side rail assessment or restraint assessment documenting the risks versus benefits for the use of the bolsters or the P-shaped helper rails in R4's clinical record.

The Care Plan, dated 8/14/2014, documents R4 has had falls from the bed on 8/14/2014 and 11/19/2013.

3. On 10/30/14 at 9:08 AM, R12's bed had 2, P-shaped helper rails in the up position with 2 roll bolsters at the center edges of the bed. A fall mat was next to the bed.

The POS for 10/2014 for R12 documents diagnoses, in part, as "Parkinson's Disease, Personal History of Fall, Closed Femur Fracture, Dementia with Behavioral Disturbance and Abnormal Posture. The MDS dated 8/13/2014 documents R4 has unsteady balance with normal range of motion (ROM) to the upper extremities, and limited ROM to the lower extremities and requires extensive assistance for bed mobility.

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The POS for 10/2014 documents an order for 1/2 grab bars X 2 for bed mobility, and a order for the use of bolsters placed in the middle of the bed. There is no assessment for the use of the side rails or bolsters for R12 in her clinical record to include risks versus benefits, entrapment risks. There is no medical justification for the use of the siderails and bolsters .

On 10/30/2014, at 1:45 PM, E9 and E10, Certified Nurses Aides, (CNA) transferred R12 from the wheelchair to bed with a gait belt. R12 grabbed the P-shaped helper rail with her right hand. At that time, E9 stated, "(R12) uses the side rails, grabs onto them and tries to swing her feet over too. She doesn't like to lay down." E19 stated, "(R12) climbs out of bed at night. That's the reason for the bolsters. (R12) grabs the side rails to sit up sometimes."

R12's Care Plan, dated 9/17/2014, documents R12 has a history of falling from the bed and wheelchair.

4. The POS for R20 for 10/2014 documents diagnoses, in part, as "Closed Fracture of Acetabulum, Compression Fracture and Osteoporosis and Legal Blindness. The MDS, dated 10/14/2014, documents R20 has normal range of motion to all extremities, unsteady balance and is moderately impaired with cognition.

On 10/28/2014 at 9:35 AM through 10/30/2014 at 9:05 AM, the 2 P-shaped helper rails were attached to R20's bed.

The POS for 10/2014 documents an order for "bed and chair alarm placed on resident this afternoon due to unsafely transferring self without

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assist." There is no order for R20 for the 2 P-shaped helper rails attached to R20's bed. The Fall Risk Care Plan, updated 10/12/2014, documents R20 has had falls from the bed on 9/17/2104 and 10/12/2014, increasing the risk of entrapment from the use of the side rails.

There was no assessment regarding the risks versus benefits of using the P-shaped helper rail in R20's clinical record for the use of the P-shaped helper side rails.

On 10/30/2014, at 11:30 AM, E5, MDS/Care Plan Coordinator reported no resident in the facility had been assessed for the use of the P-shaped helper rails because they were only being used in the up position to help residents turn and reposition. E5 reported she was unaware if any resident's P-shaped side rails were being used in the down position in the middle of the beds.

The Facility policy and procedure entitled, 'Restraint Devices, Physical', dated 2006, documents, in part, "PURPOSE: To restrict movement to protect the resident during treatment and diagnostic procedures. To prevent the resident from injuring himself or others. Restraints of any type will not be used as punishment or as a substitute for more effective medical and nursing care or for the convenience of the facility staff. To improve the resident's mobility and independent function. To treat medical symptoms. ASSESSMENT GUIDELINES--May include but are not limited to: Ability to understand instructions and ability to make self understood. Behavior and mood state. Functional ability. Safety. Potential to injure self or others. Cooperation. Ability to move in bed. Ability to transfer safely. PHYSICAL RESTRAINTS are define as any manual method or physical or

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S9999	Continued From page 17 mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." PROCEDURE- Assess resident's need for restraint device use. Obtain informed consent for restraint device use. Obtain physician's order for restraint device." The Facility's policy and procedure, dated 2008, entitled 'Side-rails, Use and Safety of' documents, in part, "It is the policy of this facility to utilize bed side rails in a safe manner, which prevents injury, when any type of rail is required to assist with bed mobility or used per resident's request for an increased sense of security; or when full bilateral rails are deemed necessary by the Interdisciplinary Team (IDT) as a physical restraint per restraint policy and procedure. PURPOSE-To meet residents' safety needs. To use side rails safely. ASSESSMENT GUIDELINES- Resident desire for the use of bed rails and/or reasons to use bed rails. Risks versus benefits associated with use (if restrictive). Type of rails (if any) most appropriate for use. PROCEDURE-1. Side rail safety assessment will be done by a licensed nurse and/or the IDT on admission and when changes to existing bed rail use is deemed indicated." 5. R6's Admission MDS dated 6/12/2014 documents his cognition is moderately impaired and he requires extensive assist of 2 staff for transfer, bed mobility ambulation and bathing. On 6/19/2014 at 1:15 AM the Facility's Situation, Background, Assessment, Response (SBAR) form documents R6 was , "...Found on the floor next to bed". No new intervention was added to the Plan of Care.	S9999		

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On 6/19/2014 at 8:30 PM the SBAR form documents R6 was, " found res (resident) face down on floor between bed and nightstand." No new intervention was added to the Plan of Care

On 6/20/2014 at 12:18 AM the SBAR form documents, Resident (R6) found on floor next to bed." The form documents side rails and an alarm were added to his Plan of Care.

The Fall Assessments for R6 dated 6/21, 7/2, 8/1 and 9/2/2014 all document him at "High Risk" for falls.

On 10/28/2014 at 1:15 PM, R6 was lying in bed with a siderail in the middle of the bed frame.

October 2014 Physician's Orders for R6 does not have an order for side rails. R6's clinical record did not have a restraint assessment regarding the risks versus benefits for bilateral side rails.

On 10/30/2014, E2, Director of Nursing (DON) stated we do not consider R6's grabber bar side rail as a restraint.

The Facility provided documentation for the "No Guard Assist Rail" documents, " The Product Description: 1/2 rail that attaches to midsection of the bed. Offers three positions that provide safety while the resident is in the bed. Promotes healthy transfers in the up position, swivels out of the way for easy access and caregiver assisted transfers......View the Bed Rail Entrapment Risk Notification Guide".

7. On 10/30/14, at 1:15 PM, R21 was observed laying in bed with both helper rails / side rails lowered, positioned at the middle of the mattress.

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R1 was observed to intermittently pull against the rail then stop then try again. When approached, R21 stated, "please don't leave, I'm waiting for my father to come."

R21' chart contained S-BAR Forms that documented several falls from bed on 3/20/14, 5/04/14, and 5/6/14. R21's Fall Assessment dated 7/18/14 documented she had a score of 14 / high risk for falls. The Minimum Data Set (MDS) dated 7/22/14 documented a cognitive score of 6 / severely impaired. R21's Care Plan dated 5/5/14, documented R21 had intermittent confusion, was chair bound, and had poor gait and balance.

On 10/31/14 at 11:10 AM, E5, MDS Nurse stated that no residents in the facility had no restraint assessments for R21 or any resident in the facility for the the use of helper rails. E5 stated that the rails should not be placed in the down position, as they are helper rails, and should have only been in the up position on R21's bed. The space between the head board and the side rails was 13 inches.
(A)

Imposed Plan of Correction

Plan of Correction for: **Highland Health Care Center**
Survey Type: **Annual Health Survey**
Survey Date: **November 05, 2014**

F- Tag: F221

Corrective Actions which will be accomplished for those residents found to have been affected by the deficient practice:

This one occurrence was isolated to R4. Restraint Assessment and risk versus benefits was completed on R4, R6, R7, R12, R20, R21, R22, R28-R65 on 10-30-2014. On 10-30-2014 all side rails in question (IHRAILAE-DLX) were removed.

How the facility will identify other residents having the potential to be affected by the same deficient practice:

On 10-31-2014, a review was completed for use of side rails by facility staff to identify any other resident(s) who might have the potential to be affected by alleged deficient practice.

The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. The facility must look at the existing system and determine if a change is necessary to correct the deficiency. If a system does not exist or if a revision to an existing system is necessary, then the facility must develop one.

Side rail use will be assessed upon admission, quarterly and with any significant change in condition to determine opportunity for least restrictive restraint measures, or total elimination. Risks versus benefits of side rail/restraint use will be provided to the resident and/or responsible party prior to use or as soon as practicable in the event of emergent need by the Director of Nursing Services, Assistant Director of Nursing, and/or designee.
In-service education was initiated on 10-29-2014 and completed on 11/03/2014, on side rail/restraint use to licensed staff.
Weekly audit will be conducted on restraint use, potential to reduce, by DON and/or designee for 8 weeks.

Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent:

An audit will be conducted weekly for 8 weeks on all residents for side rail/restraint use. Audit will include assessment of restraint for least restrictive device, as well as risks versus benefits of device utilized. Findings from this process will be reported at least quarterly to the facility's Quality Assessment and Assurance Committee for review and/or recommendations.

Date of Corrective Action Completed:
12/02/14 (Abated 10/30/14)

accepted

Imposed Plan of Correction

Plan of Correction for: **Highland Health Care Center**
Survey Type: **Annual Health Survey**
Survey Date: **November 05, 2014**

F- Tag: F323

Corrective Actions which will be accomplished for those residents found to have been affected by the deficient practice:
R4, R6, R7, R12, R20 and R21 remain in the facility and have had incidents with side rails causing injury.

How the facility will identify other residents having the potential to be affected by the same deficient practice:
On 10/30/2014, nursing management completed a review of all residents (33 of 33) that require side rails. All assessments and care plans have been updated. The Interdisciplinary Team (therapy, dietary, social service, nursing, housekeeping, activities) Rounds have been completed on every resident in the facility, 10/31/2014.

The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. The facility must look at the existing system and determine if a change is necessary to correct the deficiency. If a system does not exist or if a revision to an existing system is necessary, then the facility must develop one.
Licensed nursing staff in-servicing was initiated on 10/29/2014 and again on 11/03/2014 on adequate supervision of resident, use of use of side rails, proper incident investigation, documentation, and new progressive intervention identification for minimizing falls and injuries.

Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and are permanent:
The Director of Nursing will designate an administrative staff member to complete a weekly QA audit fall management tool for 8 weeks on residents triggering risks for falls. This audit will include a review of risk factor assessments, risk care plan interventions, short-term post occurrence interventions and long-term post-fall preventions plans. Nursing management will conduct IDT walking rounds & reassess fall risk post occurrence. Any concerns or problems identified in this process will be promptly reported to the Director of Nursing Services and/or designee for follow up and/or corrective actions. Further audits will be completed as designated by audit findings and facility need. Findings from this process will be reported at least quarterly to the facility's Quality Assessment and Assurance Committee for review and/or recommendations.

Date of Corrective Action Completed:
12/2/14 (Abated 10/30/14)

accepted