

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

PRINTED: 07/18/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045313	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/09/2008
NAME OF PROVIDER OR SUPPLIER ST ANDREWS PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3501 COLLEGE AVENUE CONWAY, AR 72032	
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F 000	INITIAL COMMENTS	F 000		
F 323 SS=K	<p>Complaint #13683 substantiated (all or in part) with deficiencies cited at F323 and F490</p> <p>483.25(h) ACCIDENTS AND SUPERVISION</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #13683, substantiated (all or in part) in these findings.</p> <p>A. Based on observation, record review and interview, the facility failed to ensure the Q-strait wheelchair and occupant restraint system in the facility van were applied in accordance with the manufacturer's instructions to prevent potential accidents/injuries for 2 (Residents # 5 and 6) of 6 case mix residents who required transfers via wheelchair in the facility van (Residents #1 through 6). This failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to Resident #5, who slid out the wheel chair during transportation and sustained a cervical (C2 dens) fracture and Resident #6 who was transported via wheelchair in the facility van with the Q-strait system incorrectly applied and had the potential to affect 42 residents who required wheelchair transport via the facility van according to the Staff Development Coordinator on 7/8/08. The facility was informed of the Immediate Jeopardy</p>	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 323	Continued From page 1 condition on 7/8/08 at 1:02 p.m. The findings are: 1. Resident #5 had diagnoses of Alzheimer's Dementia with Agitation, Parkinsonism, and Degenerative Joint Disease. The Quarterly Minimum Data Set (MDS) dated 5/22/08 documented the resident had short and long term memory problems, was moderately impaired in cognitive skills for daily decision making, totally dependent on two + persons for transfers, balance while sitting/trunk control was unsteady but able to rebalance self without physical support and had limitation in range of motion and partial loss of voluntary movement of both legs. a. The Nurses Notes dated 7/2/08 at 10:55 a.m. documented, "[Resident] coughing and requesting H2O (water), T (temperature) 101.1, eyes matted this a.m... Transfer to [hospital] via facility van..." b. The Nurses Notes dated 7/2/08 at 4:00 p.m. documented, "[Resident] returned to facility 4:00 p.m. [with] new orders - S/T (skin tear) on [left] [lower] extremity - S/T on [right] side of nose [with] bruising d/t (due to) fall in van during transport." c. The Nurses Notes dated 7/3/08 at 3:30 a.m. documented, "[Resident] acting odd - mental status change noted. [Resident] aware of name - unaware of surroundings & occurrences of pervious day... Bruising increasing to face around eyes and nasal bridge. Called... on call MD... Returned call @ 4:08 a.m. Rec'd (received) order to transfer to ER (emergency room) for CT (computered tomography)/evaluation..."	F 323			

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F 323	<p>Continued From page 2</p> <p>d. The hospital "Doctor's Order Sheet" dated 7/3/08 at 6:30 a.m. documented, "...Dx (diagnosis) C2 (cervical 2nd vertebrae) dens fracture; closed head injury - minor..." The Imaging Services report of the CT of the cervical spine documented, "Diffuse osteopenia mildly limits assessment. There is an exaggerated lordosis of the cervical spine with thoracic spine kyphosis. 3 mm (millimeter) anterolisthesis of C4 on C5, C6 on C7, and C7 on T1 is noted with 1 to 2 mm anterolisthesis of C5 on C6. This is likely secondary to degenerative change, which is very pronounced at these levels, as well as facet degenerative change as there is no significant prevertebral soft tissue swelling at these levels. There is a transverse fracture through the base of the dens of C2..."</p> <p>e. The DMS (Division of Medical Services)-762, Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property & Exploitation of Residents in Long Term Care Facilities, dated 7/8/08 documented, "...Section II - Complete Description of Incident: At approximately 4:00 p.m. [7/2/08] the resident was being transported in facility van from [hospital] after examination due to elevated temp (temperature). She was diagnosed with Bacterial Pneumonia. [Hospital] called for facility van to pick up resident. Resident returned with IV (intravenous) and oxygen. Resident was in the back of the the van and when the van driver stopped at an intersection the driver heard a noise. When she looked around the resident was in the floor of the van. The driver stated that she then slammed on her brakes. The resident was yelling for the CNA (Certified Nurses Assistant) to put her back in her chair. The CNA attempted to assist the resident back in the chair. She was</p>	F 323			

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F 323	<p>Continued From page 3</p> <p>unable to return resident to her chair so she called the facility for assistance. The facility contracted physical therapist went to assist the CNA to help the resident... Section III - Findings and Actions Taken:... [PT] (physical therapist) (contract) who assisted TCNA (transport CNA) states that the chair was still 'strapped in' when they returned the resident to her wheelchair..."</p> <p>1) The OLTC (Office of Long Term Care) Witness Statement Form completed by CNA #1 (transport CNA) documented, "I took [Resident #5] to the [hospital] ER. As we were getting out of the van I noticed she was very low in her chair, about to fall, so I proceeded to the ER where I asked for and received help, setting [Resident # 5] up straight in her chair. When the [hospital] ER called I went to pick up [Resident # 5]. On the way back to [facility], as we were approaching the stop light at College and Farris road, I began to break. I heard a noise and [Resident #5] say something. I looked in the rearview mirror and she was not in her chair. Out of fear I then slammed the breaks and put the van in park. I rushed to the back of the van. She was on the floor... I then attempted to lift her. I could not [lift] her on my own. So I leaned her against the wheel well and called [facility]. I told them there was an emergency and accident, that [Resident #5] has fallen and that I needed help... said okay, pull into a parking lot, we are sending someone. Shortly after that [physical therapist] arrived... "</p> <p>2) The OLTC Witness Statement Form completed by the contract physical therapist documented, "At approximately 3:50 p.m. a phone call was received at 200 hall nursing station by... LPN (Licensed Practical Nurse) from [CNA #1] who was the driver of the [facility]</p>	F 323			

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F 323	<p>Continued From page 4</p> <p>transportation van. [CNA #1] was very upset and stated that her patient in transport had fallen from the wheelchair when the van came to a stop and she needed help. I, [physical therapist] was standing at the desk doing notes and offered to go help transfer the resident to the wheelchair... The patient was lying supine with her back leaned against the passenger side... The wheelchair was still strapped in...."</p> <p>f. On 7/8/08 at 10:10 a.m., CNA #1 was asked to take this surveyor out to the van to demonstrate how the wheelchair and [Resident # 5] were secured on 7/2/08 when [Resident # 5] fell out of the wheelchair during transport. CNA #1 demonstrated that 2 straps hooked to the front of wheelchair frame. Then CNA #1 pulled the wheelchair back as far as it would go and secured the back straps to the back of the wheelchair after criss crossing the straps. The the seat belt (pelvic belt) was taken around the wheels and frame and hooked in front of the resident. CNA #1 was asked if the seat belt went around the wheelchair frame. CNA #1 stated, "If the wheelchair has holes it goes through that." CNA #1 was asked holes where. CNA #1 stated, "Slots under the arm rest area". CNA #1 was asked was anything going on that day with [Resident #5]. CNA #1 stated, "She wasn't sitting up very well. She kept slouching to the sides then she'd sit up for a while then slouch over again."</p> <p>g. On 7/8/08 at 10:30 a.m., the Assistant Administrator was asked for the manufacturer's recommendations for the wheelchair tiedowns and seat belt. The Assistant Administrator stated, "I've been here five years and haven't seen any."</p> <p>h. On 7/8/08 at 11:10 a.m., CNA #1 was asked if</p>	F 323			

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F 323	<p>Continued From page 5</p> <p>the seat belt/pelvic belt was still hooked around Resident #5 when she stopped. CNA #1 stated, "She was on the floor of the van a little on her right side. We had to unhook the seat belt to get her back up in the wheelchair."</p> <p>2. Resident #6 had diagnoses of Diabetic Ulcer, Non Insulin Dependent Diabetes Mellitus, and Severe Right Hip Arthritis. The Medicare 5 day MDS dated 6/14/08 documented the resident had short term memory problems and modified independence in cognitive skills for daily decision making, totally dependent on 2 plus staff for transfers and limitation in range of motion and partial loss of voluntary movement of one leg..</p> <p>a. On 7/8/08 at 10:35 a.m., the transportation log was reviewed. The transportation log documented Resident #6 was transferred via facility van from and to the facility on 6/16/08 and 6/30/08.</p> <p>b. On 7/8/08 at 10:37 a.m., CNA # 1 took the resident to the facility van via wheelchair. CNA #1 loaded the resident into the van via lift and hooked the front tiedowns of the wheelchair. CNA #1 then took the pelvic belt (seat belt) over the outside of the wheelchair's wheels and across the front of the wheelchair frame. The pelvic belt/seat belt did not touch the resident and the belt was approximately 8 to 9 inches above the seat of the wheelchair. CNA #1 then hooked the back tiedowns to the wheelchair.</p> <p>c. On 7/9/08 at 11:25 a.m., the resident was asked if the seat belt was placed around her during transport in the van. The resident stated, "No, they hook it around the wheelchair."</p>	F 323			

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F 323	<p>Continued From page 6</p> <p>3. On 7/8/08 at 11:50 a.m., the Assistant Administrator presented an inservice dated 5/16/03 regarding the use of the hydraulic lift, wheelchair straps, safety features and belt of new van. The original manufacturer's recommendations were attached to the inservice sign in sheet. The manufacturer's recommendations for the Q'straint wheelchair and occupant restraint system documented, "Pre-boarding recommendations:... List of belts for each passenger and chair location: 2 front wheelchair tiedowns; 2 rear wheelchair tiedowns; 1 upper torso belt occupant tiedown; 1 pelvic belt occupant tiedown... Securing the passenger: 4. Attach the Occupant Tiedowns. Pass the loose ends of the pelvic belt around the occupant and downward toward the rear wheelchair tiedowns... Note: Pelvic belt should pass between the gap in the side panels and the seat, or between the gap in the seat and back rest. Make sure both sides of the pelvic belt are securely fastened. Belt should bear upon the bony structure of the body and should be worn low across the front of the pelvis with junction between the lap and shoulder belts located near the passenger's hip... 5. Attach the Upper Torso Belt: If necessary, connect the upper torso belt to either the left or right pin of the pelvic belt... Warnings: Occupant restraints should not be held away from the body by the wheelchair components or parts such as the wheelchair armrest or wheels... The restraint system should be used in accordance with these instructions..."</p> <p>4. On 7/8/08 at 11:55 a.m., the Maintenance Director, Assistant Administrator, and CNA #1 were taken to the facility van. CNA #1 was asked to demonstrate how the seat belt/pelvic belt was applied. CNA #1 took the seat belt/pelvic belt</p>	F 323			

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F 323	<p>Continued From page 7</p> <p>around the outside of the wheels and in front of the wheelchair frame. This surveyor could lift the straps up approximately 4 to 5 inches resulting in a gap of approximately 12 inches between the seat belt/pelvic belt and the wheelchair seat. The Maintenance Director, Assistant Administrator, and CNA #1 were asked did you know the pelvic belt/seat belt should go between the gaps of the seat and side panel or gaps between seat and bottom of wheelchair then around the resident and not around the frame of the wheelchair. Maintenance Director, Assistant Administrator, and CNA #1 stated, "No". The Maintenance Director, Assistant Administrator, and CNA #1 were asked if the torso belt was used. The Maintenance Director, Assistant Administrator, and CNA # 1 stated, "No."</p> <p>5. The Immediate Jeopardy was removed and scope/severity reduced to a "G" on 7/8/08 at 3:30 p.m. when the facility implemented the following Plan of Removal:</p> <p>a. On 7/8/08 at 1:10 p.m., the Q-strait system in the facility van was deemed in operational order (straps, seat belts, tie downs, hooks, etc) by maintenance but all transports or residents in the facility van were stopped immediately.</p> <p>b. Until all staff that are authorized to operate the van (both in facility and those off work) are inserviced. 7 of 9 staff authorized to operate the van will be inserviced by 7/8/08 at 9:00 p.m. by Maintenance regarding proper application of the seat belt and transport of residents per manufacturer's recommendation guidelines. The other 2 transporters will be trained by 7/9/08 at 9:00 a.m. The Supervisory staff who will be monitoring will be trained by 7/11/08 at 4:00 p.m.</p>	F 323			

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F 323	Continued From page 8 The in-service will include a return demonstration of the correct application of the Q-strait. c. The Maintenance Director/Charge LPN/Week end supervisor will monitor all transports daily prior to and upon return x (times) 2 weeks to assure seat belt is applied correctly. At the end of 2 weeks any staff member who has not been monitored in that 2 week period will report to Maintenance Director/Charge LPN/Weekend supervisor for monitoring prior to transporting residents. d. The Staff Development Coordinator will audit/monitor weekly randomly to assure that seat belt is applied correctly x 4 weeks. e. All new staff members added to drivers list will be trained on policy and will return demonstrate proper application. They will then be monitored by Maintenance Director/designee x 2 weeks for compliance. The vehicle policy will be updated to include the manufacturers's recommendation for proper use of seat belt (Q-strait). All negative findings will be corrected immediately and will be discussed at the weekly Q.A. (Quality Assurance) meeting. B. Based on observation, record review and interview, the facility failed to ensure interventions were developed and consistently implemented to reduce the potential for injury/falls for 2 (Residents #2 and 3) and failed to ensure a personal alarm was in use for 1 (Resident #3) of 4 case mix resident who had a history of falls (Residents # 1, 2, 3, and 4). These failed practices had the potential to affect 38 residents who were at risk for falls according to the listing received from the Administrator on 7/9/08. The	F 323			

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F 323	Continued From page 9 findings are: 1. The facility's policy titled "Incident and Accident Reporting" documented, "Purpose: To provide guidelines for reporting and tracking incidents and accidents. Through this process to decrease the instances of incidents and accidents. Policy: 1. Accident/incident report forms will be completed on any resident that is involved in a situation that results in injury or altercation... Responsibility: It is the responsibility of the charge nurse to fill out incident and accident forms when an incident occurs. They must complete an investigation and implement any interventions necessary to ensure the residents/staff safety following the incident..." 2. Resident #2 had diagnoses of Alzheimer's, Glaucoma, Cerebrovascular Accident and Degenerative Joint Disease. The Quarterly MDS dated 4/14/08 documented the resident had short and long term memory problems, was moderately impaired in cognitive skills for daily decision making, and required supervision ambulating in the corridor, on the unit and off the unit. a. The care plan reviewed on 4/14/08 documented, "Problem/Need: Resident requires assistance with ADL's (Activities of Daily Living)... Approaches:... Ambulation: I (independent) [with] walker... Problem/Need: Resident is at risk for falls... Interventions:... 3. Encourage use of applicable safety devices: cane, walker, w/c (wheelchair) etc..." b. The Nurse's Notes dated 7/3/08 at 9:45 a.m., written by the Director of Nurses (DON) documented, "[Resident] tells charge nurse that he fell approx (approximately) 10 minutes ago while walking in room. C/O (complained of) low	F 323			

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F 323	<p>Continued From page 10</p> <p>back discomfort and states hit head. [Resident] vague re: (regarding) events leading to fall or exactly where head hit floor. [Resident] up at doorway standing w/o (without) walker. This RN (Registered Nurse) assessed low back - there is a small abraded area to [left] lower back, sensitive to touch... On call physician... notified of fall. N.O. (new order) to send to ER (Emergency Room) for evaluation..."</p> <p>c. The Accident/Incident Report form dated 7/3/08 at 9:30 a.m. documented, "...Recommended steps to prevent recurrence: [Blank]. There were no new interventions documented on the plan of care.</p> <p>d. The Nurse's Notes dated 7/5/08 at 4:45 a.m. documented, "Pt (patient) found in floor, bleeding laceration head. Pressure applied, notified MD (Medical Doctor) per policy. Sent to ER..."</p> <p>e. The Accident/Incident Report form dated 7/5/08 at 4:45 a.m. documented, "...Describe exactly what you observed or heard: Pt. found in floor. Laceration [R] side of head. States fell hit entertainment cent. C/O (complained of) R hip pain. Sent to [hospital]. Recommended steps to prevent recurrence: [Blank]. There were no new interventions documented on the plan of care.</p> <p>f. On 7/7/08 at 12:48 p.m., the DON was asked what was the intervention following the 7/3/08 fall. The DON stated, "Sent to ER". The DON was asked if that helped prevent/minimize the potential for other falls. The DON stated, "No. [Resident #2's] supposed to use his walker and I reminded him to use it. We are always having to do that." The DON was asked whose supposed to develop/document steps to prevent recurrence.</p>	F 323			

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F 323	<p>Continued From page 11</p> <p>The DON stated, "Whoever completes the I & A [Incident and Accident] report. The DON was asked what were the documented interventions following the 7/5/08 fall. The DON stated, "None." The DON was asked if the resident was sent to the Emergency Room twice following falls with no new interventions implemented. The DON stated, "Yes."</p> <p>3. Resident #3 had diagnoses of Vascular Dementia with Behavioral Disturbances and Seizures. The Quarterly MDS dated 6/12/08 documented the resident had short and long term memory problems and was moderately impaired in cognitive skills for daily decision making.</p> <p>a. The care plan reviewed on 3/20/08 documented, "Problem/Need: Resident requires assistance with ADL's... Approaches:... Transfers: Limited [assistance] 1 [staff] ; Ambulation: Limited 1... W/C: [Independent] [with] supervision... Problem/Need: Resident is at risk for falls... Interventions:... 6/19/08 Place personal alarm while [up] in w/c and in bed."</p> <p>b. The Nurse's Notes dated 6/18/08 at 11:00 p.m. documented, "CNA came to nurse during shift change and reported [resident] on floor. [Resident] sitting in front of closet on opposite side of room. [Resident] was trying to put clothes on over another layer of clothes and fell..." There was no I & A report submitted for this fall.</p> <p>c. The Nurse's Notes dated 6/24/08, untimed, documented, "...Called to room @ 3:00 p.m. by CNA. [Resident] was in the bathroom floor on her knees..." There was no documentation as to the personal safety alarm being present or if it was working.</p>	F 323			

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

PRINTED: 07/18/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045313	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/09/2008
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F 323	Continued From page 12 The Accident/Incident Report form dated 6/24/08 at 3:00 p.m. documented, "...Recommended steps to prevent recurrence: [Blank]." There were no new interventions documented on the plan of care. There was no documentation as to the personal safety alarm being present or if it was working. d. The Nurses Notes dated 6/26/08 at 11:00 p.m. documented, "CNA walking the hall found [resident] on floor on [right] side of bed, sitting against the wall by the door; c/o (complained of) [left] thigh tenderness..." The Accident/Incident Report form dated 6/26/08 at 11:00 p.m. documented, "...Recommended steps to prevent recurrence: Pressure alarm for bed and chair." There were no new interventions documented on the plan of care. There was no documentation as to the personal safety alarm being present or if it was working. e. The Nurses Notes dated 7/6/08 at 2:35 p.m. documented, "[Resident] fell in between bathroom door and bathroom, apparently she was ambulating on her own, small laceration to [right] [upper] eye..." The Accident/Incident Report form dated 7/6/08 at 2:30 p.m. documented, "... Recommended steps to prevent recurrence: Encourage [resident] to ask for assist when needing to go to bathroom." There was no documentation as to the personal safety alarm/pressure alarm being present or if it was working. f. On 7/8/08 at 9:17 a.m. and 10:21 a.m. and on 7/9/08 at 9:15 a.m., the resident was in bed. The	F 323			

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

PRINTED: 07/18/2008
FORM APPROVED
OMB NO. 0938-0391

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F 323	Continued From page 13 personal safety alarm was not on the bed. g. On 7/9/08 at 12:48 p.m., the DON was asked about the fall of 6/24/08 and 6/26/08: "Do you know if the personal safety alarm was present/working and was the resident up in the wheelchair or in bed prior to the fall." The DON stated, "I don't know." The DON was asked about the fall of 7/6/08: "Do you know if the personal safety alarm was present/working and was the resident up in the wheelchair or in bed prior to the fall." The DON stated, "I don't know. I haven't worked this I & A". The DON was asked do you know that the resident does not have the personal safety alarm on when in bed. The DON stated, "No." The DON was asked who monitored to ensure the personal safety alarm was on when the resident was in bed as per the plan of care. The DON stated, "My new ADON (Assistant Director of Nursing) will be doing that, no one is currently."	F 323			
F 490 SS=K	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Complaint #13683, substantiated (all or in part) in these findings. Based on record review and interview, the facility failed to ensure facility administration and nursing administration had a system in place to ensure staff were educated and knowledgeable of the	F 490			

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

PRINTED: 07/18/2008
FORM APPROVED
OMB NO. 0938-0391

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F 490	<p>Continued From page 14</p> <p>procedure for application of the Q-strait wheelchair and occupant restraint system in the facility van in accordance with the manufacturer's instructions to prevent potential accidents/injuries for 2 (Residents #5 and 6) of 6 case mix residents who required transfers via wheelchair in the facility van (Residents #1 through 6). This failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to Resident #5, who slid out the wheel chair during transportation and sustained a cervical (C2 dens) fracture and Resident #6 who was transported via wheelchair in the facility van with the Q-strait system incorrectly applied and had the potential to affect 42 residents who required wheelchair transport via the facility van according to the Staff Development Coordinator on 7/8/08. The facility was informed of the Immediate Jeopardy condition on 7/8/08 at 1:02 p.m. The findings are:</p> <p>1. Resident #5 had diagnoses of Alzheimer's Dementia with Agitation, Parkinsonism, and Degenerative Joint Disease. The Quarterly Minimum Data Set (MDS) dated 5/22/08 documented the resident had short and long term memory problems, was moderately impaired in cognitive skills for daily decision making, totally dependent on two + persons for transfers, balance while sitting/trunk control was unsteady but able to rebalance self without physical support and had a limitation in range of motion and partial loss of voluntary movement of both legs.</p> <p>a. The Nurses Notes dated 7/2/08 at 10:55 a.m. documented, "[Resident] coughing and requesting H2O (water), T (temperature) 101.1, eyes matted this a.m... Transfer to [hospital] via facility van...."</p>	F 490			

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

PRINTED: 07/18/2008
FORM APPROVED
OMB NO. 0938-0391

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F 490	Continued From page 15 b. The Nurses Notes dated 7/2/08 at 4:00 p.m. documented, "[Resident] returned to facility 4:00 p.m. [with] new orders - S/T (skin tear) on [left] [lower] extremity - S/T on [right] side of nose [with] bruising d/t (due to) fall in van during transport." c. The Nurses Notes dated 7/3/08 at 3:30 a.m. documented, "[Resident] acting odd - mental status change noted. [Resident] aware of name - unaware of surroundings & occurrences of pervious day... Bruising increasing to face around eyes and nasal bridge. Called... on call MD... Returned call @ 4:08 a.m. Rec'd (received) order to transfer to ER (emergency room) for CT (computered tomography)/evaluation..." d. The hospital "Doctor's Order Sheet" dated 7/3/08 at 6:30 a.m. documented, "...Dx (diagnosis) C2 (cervical 2nd vertebrae) dens fracture; closed head injury - minor..." The Imaging Services report of the CT of the cervical spine documented, "Diffuse osteopenia mildly limits assessment. There is an exaggerated lordosis of the cervical spine with thoracic spine kyphosis. 3 mm (millimeter) anterolisthesis of C4 on C5, C6 on C7, and C7 on T1 is noted with 1 to 2 mm anterolisthesis of C5 on C6. This is likely secondary to degenerative change, which is very pronounced at these levels, as well as facet degenerative change as there is no significant prevertebral soft tissue swelling at these levels. There is a transverse fracture through the base of the dens of C2..." e. The DMS (Division of Medical Services)-762, Facility Investigation Report for Resident Abuse,	F 490			

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F 490	Continued From page 16 Neglect, Misappropriation of Property & Exploitation of Residents in Long Term Care Facilities, dated 7/8/08 documented, "...Section II - Complete Description of Incident: At approximately 4:00 p.m. [7/2/08] the resident was being transported in facility van from [hospital] after examination due to elevated temp (temperature). She was diagnosed with Bacterial Pneumonia. [Hospital] called for facility van to pick up resident. Resident returned with IV (intravenous) and oxygen. Resident was in the back of the the van and when the van driver stopped at an intersection the driver heard a noise. When she looked around the resident was in the floor of the van. The driver stated that she then slammed on her brakes. The resident was yelling for the CNA (Certified Nurses Assistant) to put her back in her chair. The CNA attempted to assist the resident back in the chair. She was unable to return resident to her chair so she called the facility for assistance. The facility contracted physical therapist went to assist the CNA to help the resident... Section III - Findings and Actions Taken:... [PT] (physical therapist) (contract) who assisted TCNA (transport CNA) states that the chair was still 'strapped in' when they returned the resident to her wheelchair..." 1) The OLTC (Office of Long Term Care) Witness Statement Form completed by CNA #1 (transport CNA) documented, "I took [Resident #5] to the [hospital] ER. As we were getting out of the van I noticed she was very low in her chair, about to fall, so I proceeded to the ER where I asked for and received help, setting [Resident # 5] up straight in her chair. When the [hospital] ER called I went to pick up [Resident # 5]. On the way back to [facility], as we were approaching the stop light at College and Farris road, I began to	F 490			

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F 490	<p>Continued From page 17</p> <p>break. I heard a noise and [Resident #5] say something. I looked in the rearview mirror and she was not in her chair. Out of fear I then slammed the breaks and put the van in park. I rushed to the back of the van. She was on the floor... I then attempted to lift her. I could not [lift] her on my own. So I leaned her against the wheel well and called [facility]. I told them there was an emergency and accident, that [Resident #5] has fallen and that I needed help... said okay, pull into a parking lot, we are sending someone. Shortly after that [physical therapist] arrived... "</p> <p>2) The OLTC Witness Statement Form completed by the contract physical therapist documented, "At approximately 3:50 p.m. a phone call was received at 200 hall nursing station by... LPN (Licensed Practical Nurse) from [CNA #1] who was the driver of the [facility] transportation van. [CNA #1] was very upset and stated that her patient in transport had fallen from the wheelchair when the van came to a stop and she needed help. I , [physical therapist] was standing at the desk doing notes and offered to go help transfer the resident to the wheelchair... The patient was lying supine with her back leaned against the passenger side... The wheelchair was still strapped in..."</p> <p>f. On 7/8/08 at 10:10 a.m., CNA #1 was asked to take this surveyor out to the van to demonstrate how the wheelchair and [Resident # 5] were secured on 7/2/08 when [Resident # 5] fell out of the wheelchair during transport. CNA #1 demonstrated that 2 straps hooked to the front of wheelchair frame. Then CNA #1 pulled the wheelchair back as far as it would go and secured the back straps to the back of the wheelchair after criss crossing the straps. The the seat belt</p>	F 490			

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045313	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/09/2008
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F 490	<p>Continued From page 18</p> <p>(pelvic belt) was taken around the wheels and frame and hooked in front of the resident. CNA #1 was asked if the seat belt went around the wheelchair frame. CNA #1 stated, "If the wheelchair has holes it goes through that." CNA #1 was asked holes where. CNA #1 stated, "Slots under the arm rest area". CNA #1 was asked was anything going on that day with [Resident #5]. CNA #1 stated, "She wasn't sitting up very well. She kept slouching to the sides then she'd sit up for a while then slouch over again."</p> <p>g. On 7/8/08 at 10:30 a.m., the Assistant Administrator was asked for the manufacturer's recommendations for the wheelchair tiedowns and seat belt. The Assistant Administrator stated, "I've been here five years and haven't seen any."</p> <p>h. On 7/8/08 at 11:10 a.m., CNA #1 was asked if the seat belt/pelvic belt was still hooked around Resident #5 when she stopped. CNA #1 stated, "She was on the floor of the van a little on her right side. We had to unhook the seat belt to get her back up in the wheelchair."</p> <p>i. On 7/8/08 at 1:20 p.m. the listing of 9 employees authorized to transport residents in the van was compared to the inservice dated 5/16/03. There was only one employee common on both listings.</p> <p>j. On 7/8/08 at 2:45 p.m., CNA # 1 was asked who trained her regarding the correct application of the Q'straint system. CNA #1 stated, "[CNA #2] the previous transporter and is no longer here."</p> <p>2. Resident #6 had diagnoses of Diabetic Ulcer, Non Insulin Dependent Diabetes Mellitus, and</p>	F 490			

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

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F 490	<p>Continued From page 19</p> <p>Severe Right Hip Arthritis. The Medicare 5 day MDS dated 6/14/08 documented the resident had short term memory problems and modified independence in cognitive skills for daily decision making.</p> <p>a. On 7/8/08 at 10:35 a.m., the transportation log was reviewed. The transportation log documented Resident #6 was transferred via facility van from and to the facility on 6/16/08 and 6/30/08.</p> <p>b. On 7/8/08 at 10:37 a.m., CNA #1 took the resident to the facility van via wheelchair. CNA #1 loaded the resident into the van via lift and hooked the front tiedowns of the wheelchair. CNA #1 then took the pelvic belt (seat belt) over the outside of the wheelchair's wheels and across the front of the wheelchair frame. The pelvic belt/seat belt did not touch the resident and the belt was approximately 8 to 9 inches above the seat of the wheelchair. CNA #1 then hooked the back tiedowns to the wheelchair.</p> <p>c. On 7/9/08 at 11:25 a.m., the resident was asked if the seat belt was placed around her during transport in the van. The resident stated, "No, they hook it around the wheelchair."</p> <p>3. On 7/8/08 at 11:50 a.m., the Assistant Administrator presented an inservice dated 5/16/03 regarding the use of the hydraulic lift, wheelchair straps, safety features and belt of new van. The original manufacturer's recommendations were attached to the inservice sign in sheet. The manufacturer's recommendations for the Q'straint wheelchair and occupant restraint system documented, "Pre-boarding recommendations:... List of belts</p>	F 490			

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

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F 490	Continued From page 20 for each passenger and chair location: 2 front wheelchair tiedowns; 2 rear wheelchair tiedowns; 1 upper torso belt occupant tiedown; 1 pelvic belt occupant tiedown... Securing the passenger: 4. Attach the Occupant Tiedowns. Pass the loose ends of the pelvic belt around the occupant and downward toward the rear wheelchair tiedowns... Note: Pelvic belt should pass between the gap in the side panels and the seat, or between the gap in the seat and back rest. Make sure both sides of the pelvic belt are securely fastened. Belt should bear upon the bony structure of the body and should be worn low across the front of the pelvis with junction between the lap and shoulder belts located near the passenger's hip... 5. Attach the Upper Torso Belt: If necessary, connect the upper torso belt to either the left or right pin of the pelvic belt... Warnings: Occupant restraints should not be held away from the body by the wheelchair components or parts such as the wheelchair armrest or wheels... The restraint system should be used in accordance with these instructions..." 4. On 7/8/08 at 11:55 a.m., the Maintenance Director, Assistant Administrator, and CNA #1 were taken to the facility van. CNA #1 was asked to demonstrate how the seat belt/pelvic belt was applied. CNA #1 took the seat belt/pelvic belt around the outside of the wheels and in front of the wheelchair frame. This surveyor could lift the straps up approximately 4 to 5 inches resulting in a gap of approximately 12 inches between the seat belt/pelvic belt and the wheelchair seat. The Maintenance Director, Assistant Administrator, and CNA #1 were asked did you know the pelvic belt/seat belt should go between the gaps of the seat and side panel or gaps between seat and bottom of wheelchair then around the resident	F 490			

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

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F 490	<p>Continued From page 21</p> <p>and not around the frame of the wheelchair. Maintenance Director, Assistant Administrator, and CNA #1 stated, "No". The Maintenance Director, Assistant Administrator, and CNA #1 were asked if the torso belt was used. The Maintenance Director, Assistant Administrator, and CNA # 1 stated, "No."</p> <p>5. The Immediate Jeopardy was removed and scope/severity reduced to a "G" on 7/8/08 at 3:30 p.m. when the facility implemented the following Plan of Removal:</p> <p>a. On 7/8/08 at 1:10 p.m., the Q-strait system in the facility van was deemed in operational order (straps, seat belts, tie downs, hooks, etc) by maintenance but all transports or residents in the facility van were stopped immediately.</p> <p>b. Until all staff that are authorized to operate the van (both in facility and those off work) are inserviced. 7 of 9 staff authorized to operate the van will be inserviced by 7/8/08 at 9:00 p.m. by Maintenance regarding proper application of the seat belt and transport of residents per manufacturer's recommendation guidelines. The other 2 transporters will be trained by 7/9/08 at 9:00 a.m. The Supervisory staff who will be monitoring will be trained by 7/11/08 at 4:00 p.m. The in-service will include a return demonstration of the correct application of the Q-strait.</p> <p>c. The Maintenance Director/Charge LPN/Week end supervisor will monitor all transports daily prior to and upon return x (times) 2 weeks to assure seat belt is applied correctly. At the end of 2 weeks any staff member who has not been monitored in that 2 week period will report to Maintenance Director/Charge LPN/Weekend</p>	F 490			

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

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F 490	Continued From page 22 supervisor for monitoring prior to transporting residents. d. The Staff Development Coordinator will audit/monitor weekly randomly to assure that seat belt is applied correctly x 4 weeks. e. All new staff members added to drivers list will be trained on policy and will return demonstrate proper application. They will then be monitored by Maintenance Director/designee x 2 weeks for compliance. The vehicle policy will be updated to include the manufacturers's recommendation for proper use of seat belt (Q-straint). All negative findings will be corrected immediately and will be discussed at the weekly Q.A. (Quality Assurance) meeting.	F 490			