

F323 Case Studies

1. Resident A's clinical record noted that he had impaired cognitive skills, left-sided paralysis from a stroke, and periods of agitation, and was found on 4/27/07 "slid down in his wheelchair with the seat belt around his chest." He had a 0.2 cm wide and 1 cm in length, indentation on his chest that was black and yellow in color. A post-fall assessment stated, "Slid down under seat belt – increased agitation." Recommendations were to keep occupied, continue tab alarm and seat belt, and discourage time alone in his room.

Six days later, on 5/3/07, a CNA found the resident in his room, slid down in the wheelchair with the belt restraint around his neck. The facility called 911 and the ambulance transported Resident A to the hospital, which admitted him for inpatient psychiatric services due to "agitated depression with combativeness."

Resident A returned to the facility on 5/20/07, again with orders for a seat belt restraint for "agitation and fall risk." At 8:30 PM that evening, a CNA found Resident A slid down in the wheelchair, sitting on the right foot with his arm through seat belt. The recommendation was to remove the seat belt and leave on the pedals.

On 5/24/07, surveyor observed the resident sitting in his wheelchair in his room with the seatbelt on. The nursing assistant who was assigned to care for the resident stated that she had not worked for a week and was not aware that the care plan had been changed and that the seat belt had been discontinued.

Q: What severity level should be considered for this example?

2. During the initial tour of the facility on 3/22/07, Surveyor #11111 observed Resident B open the door to the soiled utility room. (Resident B's most current quarterly MDS dated 2/5/07 identified him to have short and long term memory problems with severe cognitive impairment.) Resident B looked in the room for about ten seconds then turned around and left the area. No staff was present. Surveyor #1111 then entered the unlocked room and observed the following:

Within the room, on a shelf approximately three feet from the floor, the following products were stored:

- Two one-quart spray bottles of Morning Mist labeled, "Keep out of the reach of children."
- Three- one-quart hand spray bottles of Upholstery Stain Remover labeled, "Keep out of reach of children."
- One quart spray bottle of Butchers Double Play labeled, "Danger may cause eye burns and skin irritation." The bottle had a regular screw cap.
- One quart bottle of Lime Away labeled, "Danger may cause chemical burns."

A shelf on the adjacent wall, above the floor scrubber machine, held the following items:

- One gallon of a Germicide disinfectant labeled, "Danger-Keep out of the reach of children."
- One quart Carpet Pre- Spray Spin Buff Cleaner labeled, "DO NOT DRINK."

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The soiled utility room is located on the hallway to the main dining room. All residents (including those who are confused/cognitively impaired) must pass the soiled utility room door to enter the main dining room for meals and attend activity programs provided in the main dining room. Twenty of the facility's 78 residents are identified as being confused and ambulatory.

The Maintenance Supervisor stated that he had received several reports over the last week that the door had not been locking but that he had never been able to replicate the problem and didn't know what needed fixing.

Q: What severity level should be considered for this example?

3. During the initial tour of the facility on 6/4/07, Surveyor #1111 observed Resident C to have a cast on her right arm.

During record review, Surveyor #1111 noted that the facility assessed Resident C to be at moderate risk for falls following her admission on 4/30/07. The initial care plan dated 5/1/07 noted that Resident C was at risk for falls and listed interventions that included transferring Resident C with the assist of two and a gait belt. This approach was also documented on the nursing assistant care cards, which all CNAs are trained to use per surveyor interview of Nurse Manager A on 6/4/07.

Nurse's Notes dated 5/15/07 at 7:00 a.m. noted that Resident C fell during the transfer from the bed to the wheelchair and was sent to the hospital due to complaints of pain in her right arm. Resident C returned to the facility at 11:00 a.m. with a cast on her right arm, a diagnosis of a non-displaced fracture and an order for Vicodin. On 6/5/07, Surveyor #1111 reviewed the facility's investigation of the incident on 5/15/07. The investigation noted that CNA A attempted to transfer Resident C by herself without the gait belt. During this transfer, Resident C fell and fractured her arm. The resident has been on pain medication since the fall. The investigation also noted that CNA A admitted that she knew the care plan and knew that another nursing assistant would be able to help her in a few minutes but decided not to wait because she thought she could complete the transfer by herself.

Q: What severity level should be considered for this example?

4. The facility had assessed and identified residents who were at risk for falls but had not developed care plans that specifically addressed how to reduce the risk/prevent falls, did not modify their approaches for care after residents experienced numerous falls, and did not implement measures to better ensure the safety of residents at risk of falling.

All the care plans for residents with falls contain the goal of being "free from falls." Approaches for preventing falls were the same on all the care plans and were not individualized for the particular resident.

The facility's falls-prevention policy and procedure addresses care before a fall and after a fall. It

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does not address efforts to reduce the number of falls. The Director of Nurses stated that the facility's goal is not to prevent falls but to prevent injuries from falls.

As a matter of policy, the facility does not use clip alarms to alert staff that a resident may be attempting to stand or lean. The facility uses only bed and chair pad alarms; however, these are so sensitive that they will not alarm if lightly covered by the hand, a blanket or a soft pillow. Twenty-two of the facility's 109 residents use these alarms.

Example #1 – Resident F is blind and unable to use a call light. Resident F fell from her bed on 1/28/07 at 2:30 AM. Surveyor interview confirmed that the bed alarm was not functioning because it had been turned off during cares and not turned back on. Eleven days later (2/8) Resident F again fell from her bed at 5:50 AM. The bed alarm did not function. Although staff wrote, "falls will continue to be a problem," no changes were made to the resident's care plan. On 2/12/07, Resident F again fell from bed and staff interviews confirm that the alarm did not activate. Per record review, Resident F was in a great deal of pain following this fall and was subsequently diagnosed with a left hip fracture. Resident F told the surveyor on 3/1/07 that she only gets up when she has to go to the bathroom and no one answers her call light. She stated that no one ever asked her why she had tried getting up. There is no toileting schedule in place.

Example #2 - Resident G had 18 falls from 3/9/06 to 2/23/07. Falls occurred on: 3/9/06, 4/4/06, 4/21/06, 8/21/06, 9/28/06, 10/20/06, 10/21/06, 11/5/06, 12/3/06, 12/11/06, 12/16/06 (x2), 12/20/06, 12/27/04, 1/9/07, 1/11/07, 1/24/07, and 2/23/07. At least ten falls occurred from a chair or wheelchair. In most cases staff did not evaluate possible reasons for the fall and did not reevaluate the effectiveness of the care plan to determine if changes needed to be made. The only change to the care plan occurred on 1/11/07 after the resident had sustained a large amount of bleeding after falling from the wheelchair. A releasable belt was applied at this point, however, charting following the fall on 2/23/07 noted that the resident had unbuckled his seat belt and staff interviews revealed that he continued unbuckling the seat belt. Staff did not develop or implement new approaches. Resident G resides in his room at the end of the hallway which is the farthest from the nurse's station.

Resident G's physician took the resident off of Coumadin, despite a history of atrial fibrillation, because the physician was worried about bleeding that might occur when the resident fell.

Q: What severity level should be considered for this example?