

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14E717	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2013
NAME OF PROVIDER OR SUPPLIER BETHALTO CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 815 SOUTH PRAIRIE STREET BETHALTO, IL 62010		
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F9999	<p>FINAL OBSERVATIONS</p> <p>LICENSURE VIOLATIONS 300.680a) 300.1210a) 300.1210b) 300.2420j)</p> <p>Section 300.680 Restraints</p> <p>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.</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and</p>	F9999			

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F9999	<p>Continued From page 26</p> <p>the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)</p> <p>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:</p> <p>Section 300.2420 Equipment and Supplies</p> <p>j) There shall be a sufficient quantity of resident care equipment of satisfactory design and in good condition to carry out established resident care procedures. This shall include at a minimum the following: wheelchairs with brakes, walkers, metal bedside rails, bedpans, urinals, emesis basins, wash basins, footstools, metal commodes, over the lap tables, foot cradles, footboards, under the mattress bed boards,</p>	F9999			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F9999	<p>Continued From page 27</p> <p>trapeze frames, transfer boards, parallel bars and reciprocal pulleys.</p> <p>These requirements are not met as evidenced by:</p> <p>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 six of six residents (R1, R2, R4, R7, R8 and R9) reviewed for siderails in the sample of 15 and four residents (R16-R19) in the supplemental sample.</p> <p>Findings include:</p> <p>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 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)</p>	F9999			

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F9999	<p>Continued From page 28</p> <p>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."</p> <p>2. R1, R2, R4, R7, R9, R16, R17, R18, and R19 have the same type of half side rails. The Zone 1 areas of these side rails were measured on 7/30/13 at 9:00 AM. There were two areas which measure 8.5 inch long x 8 inch wide between the bars of the rails and another area with 17 inch long x 7.75 inch wide between in Zone 1. These side rails did not meet the FDA dimensional limit recommendations. R8's side rails have an area which measures 17 inch long x 7.75 inch wide in Zone 1. These side rails did not meet the FDA dimensional limit recommendations. All had normal range of motion for upper extremities and were able to use the side rails for turning and positioning.</p> <p>3. On 7/30/13 at 9:55 AM, R8 was lying in her bed. A 1/2 side rail was up on the left side of her bed. There was a large gap in the center of the side rails measuring 7.5 inches wide by 17 inches long.</p> <p>On 7/30/13, during the initial tour of the facility from 7:50 AM through 8:55 AM, E17, Admission Coordinator, stated R8 utilized the left 1/2 side rails for positioning.</p> <p>R8's Physician's Order Sheet (POS), dated 12/22/11 documented "Left 1/2 side rail while (up) in bed to assist c (with) bed mobility."</p>	F9999			

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F9999	<p>Continued From page 29</p> <p>R8's Minimum Data Set (MDS), dated 7/10/13 documented she had limited range of motion of her upper extremities on one side.</p> <p>R8's Restorative Program Sheet, dated 7/8/13 documented "She does have L (left) side rails she utilizes to help assist staff c (with) bed mobility"</p> <p>R8's Side Rail Assessment, dated 7/17/13 documented "Evaluated use of top 1/2 L (Left) rail. (R8) was able to demonstrate how she uses the L 1/2 rail to aid positioning." The Assessment did not document any potential risks or benefits from the use of side rails.</p> <p>4. R7's July 2013 POS documents an order, "Bilateral 1/2 side rails to assist with bed mobility while in bed."</p> <p>R7's Side Rail Assessment, dated 7/3/13, documents (in part) in the section, "Visual evaluation of bed mobility and transfer to/from bed: She (R7) is still able to grab onto rails et (and) assist rolling body over."The Side Rail Assessment has nothing marked under the section "Potential Risks from Use of Side Rails".</p> <p>On 7/30/13 at 9:45 AM, R7 was lying in bed moving left arm around. R7's bed had both half side rails up.</p> <p>5. On 7/30/13 at 10:00 AM, R4 was lying in bed with her 1/2 side rails up on each side of the bed. Again, at 11:00 AM, R4 was lying in bed with her side rails in the up position.</p>	F9999			

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F9999	<p>Continued From page 30</p> <p>R4's Side Rail Assessment, 5/2/13, documented R4 had 1/2 side rails on the top of her bed. The Side Rail Assessment documented "(R4) has the need for side rails to help her c (with) bed mobility d/t (due to) her current condition c hells et (and) coccyx." The side rails assessment did not document any potential risks for the use of her side rails.</p> <p>R4's Minimum Data Set (MDS), dated 6/13/13, documented she had limited range of motion on one side for her upper extremities.</p> <p>6. On 7/30/13 at 8:00 AM R2 was lying in bed with his 1/2 side rails up on both sides of the bed. The bilateral side rails were padded. R2 was reaching under the padding, holding the side rail and repositioning himself.</p> <p>R2's Side Rail Assessment dated 5/15/13, documented R2 had bilateral 1/2 rails at the top half of his bed. The Side Rail Assessment documented R2 grabs onto the rails to pull himself over and up in bed. The Side Rail Assessment does not document any potential risks for the use of the side rails.</p> <p>R2's MDS dated 6/6/13, documented he had no range of motion loss in his upper extremities and is moderately impaired with cognition.</p> <p>7. On 7/30/13 at 8:00 AM R16, R17, R19 observed to have bilateral 1/2 side rails on their beds. The side Rail Assessments for each resident document they are indicated for increased independence and bed mobility. The side rails observed did not meet the FDA regualtions for safety. The assessments did not document the risks for the use of the side rails.</p>	F9999			

