### Summary Statement of Deficiencies

**F 323**

**SS=D**

**483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES**

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.

This REQUIREMENT is not met as evidenced by:

Based upon observations, staff and family interviews and record reviews the facility failed to properly apply a belted pommel cushion for 1 of 1 sampled Resident (Resident #3) at risk for falls.

**Findings Include:**

Resident #3 was admitted to the facility on 1/15/09 with diagnoses of anemia, hypertension, asthma, urinary tract infections and muscle weakness. The Minimum Data Set (MDS) dated 10/20/11 indicated Resident #3 cognition was severely impaired and required total assistance with activities of daily living. The MDS also indicated the mobile device used was a wheelchair and that a fall had occurred since admission or on a prior admission. The care plan indicated Resident #3 to be at risk.

A record review of the facility fall risk assessments dated 8/8/11 and 11/8/11 indicated Resident #3 was at high risk for falls.

A record review of the facility incident log report dated August 2011 to November 2011 revealed

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### Corrective Action

**Corrective Action Affected Resident:**

Resident #3

Resident #3 was assessed by Therapy. The Pommel cushion was discontinued.

Physical therapy was started to ensure proper positioning and comfort.

**Corrective Action for Those with Potential to be affected:**

A resident audit was completed to ensure that all cushions currently being used are applied correctly. This audit revealed no negative findings.

Staff have been in-serviced about the proper use of pulla cushion by the Clinical Competency Coordinator.
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the resident experienced a fall on 11/8/11.

A record review of the facility incident report
dated 11/8/11 indicated Resident #3 appeared to
have scooted out of her wheelchair and was
found laying on the floor on her right side. There
was bruising found to her right hip.

An interview and observation on 11/30/11 at
10:55am with Resident 1’s #3 Family Private
Sitter revealed Resident #3 wearing a black belt
around her waist with an attachment in front to
hold the belt together. The Private Sitter
indicated she wears this belt daily.

An interview on 11/30/11 at 11:02am with
Nursing Assistant (NA) #1 revealed Resident #3
wore a belt around her waist due to she wiggled
a lot. Resident #3 has attempted to get up by
herself and when lying in bed, slides down to the
foot of the bed. Resident #3 was unable to
remove the belt herself due to contractures of the
hands.

An observation on 11/30/11 at 1:57pm occurred
for Resident #3. Resident #3 had contractures of
the hands. A black belt was attached around her
waist with the belt buckle located in the front.
Resident #3 was asked to remove the belt upon
command. Resident #3 responded "yes" and
"no". She did not reach for or unfasten the belt.

An interview on 11/30/11 at 2:36pm with a prior
Falls Prevention Nurse #1 revealed falls were
discussed weekly. She indicated Resident #3 did
not have a self release belt. She indicated it
would be a problem having on a self release belt,
if a resident was unable to remove it themselves.

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Systematic Changes to prevent
Deficient Practice:
Staff have been educated on how to properly
Use of a pommel cushion: straps on a pommel
Cushion should never be used to strap on
Residents. Cushion straps are to be strapped
Properly on wheelchairs to keep cushion
in place.

Staff also instructed to review residents
Care cards before attacking or assisting
Residents with positioning device.
Staff must verify with nurse prior to
Applying a seatbelt.
Nursing staff will refer to therapy prior to
Initiating a seat belt to ensure all other
Interventions have been used.

How will Corrective Action be monitored?
An audit was developed by The DHS. The DHS
Or designee will audit cushions and application
Correctly weekly times four weeks, the monthly
times three months.
All audit outcomes will be discussed at
Monthly performance improvement
Meeting for four months and further
Action will be carried out as indicated.

Completion Date for Corrective Action
Will be 12-23-11.
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 323</td>
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She indicated there must be a mix up with a different wheelchair, when they were cleaned. She indicated she would follow-up on this.

An interview and observation on 11/30/11 at 2:56pm with a Physical Therapist (PT) and Nurse #1 revealed that it was a pommel cushion with a belt attachment instead of a self release belt on Resident #3 wheelchair. The PT indicated the belt attachment should be connected to the back of the wheelchair instead of the Resident. Nurse #1 indicated NA #1 needed education on proper fastening of the pommel cushion. The PT indicated the wheelchair cushion was there to prevent Resident #3 from sliding out.

An interview on 11/30/11 at 3:27pm with NA #2 revealed she has seen wheelchair cushions before but is unaware of the pommel cushions with belt attachments.

An interview on 11/30/11 at 3:35pm with NA #3 revealed pommel cushions with belts are attached to the wheelchair for safety and comfort. The pommel cushion belt attachment should not be attached to the resident’s waist.

An interview on 11/30/11 at 4:01pm with the Staff Development Coordinator revealed she had in-serviced staff on restraints. If belts are not indicated on the care guides and care plan, staff should not use belts on residents.

A record review of the facility care guides for Resident #3 did not indicate a wheelchair cushion with a belt attachment to be used.

An interview on 11/30/11 at 4:16pm with the
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<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tr>
<td>F 323</td>
<td>Continued From page 3 Director of Nursing (DON) revealed a lot of staff was new and there were few residents with a pommel cushion with a belt attachment. She has not had an opportunity at this time to educate staff on proper attachment and information regarding a pommel cushion with a belt attachment. The DON acknowledged that shift nurses should have noticed the belt fastened and that there was nothing on the care plan about a use of a belt. The pommel cushion should have been fastened to the back of the wheelchair. Resident #3 was placed at risk due to improper pommel cushion attachment.</td>
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