

**Iowa Department of Inspections and Appeals  
Health Facilities Division  
Citation**

Citation Number: 6578		Date: July 13, 2017		
Facility Name: Ridgewood Specialty Care		Survey Dates: June 26, 27, 28, 29, 2017		
Facility Address/City/State/Zip 1977 Albia Road		HL		
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

58.28(3)f	<p><b>58.28(3) Resident safety.</b>  <b>f. Residents shall be protected against physical or environmental hazards to themselves. (I, II, III)</b>  <small>[ARC 1398C, IAB 4/2/14, effective 5/7/14]</small></p> <p><b>DESCRIPTION:</b></p> <p>Based on record review, observations, and staff interviews, the facility failed to ensure the resident environment remained as free from accident hazards as possible for 2 of 12 residents sampled (Residents #3 and #7). Specifically, the facility failed to implement a system to ensure gaps in side rails were not large enough to create the risk for entrapment for Residents #3 and #7. The failure to ensure the side rails did not have a large gap which the resident could become entrapped put Residents #3 and #7 at risk of serious injury, impairment, or death due to entrapment within the gap. The facility reported a census of 55 residents.</p> <p>Findings include:</p> <p>1. Review of the Food and Drug Administration's (FDA) Hospital Bed Safety Workgroup article, "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings", dated April 2003, indicated, in pertinent part, "...Use of bed rails should be based on patients' assessed medical needs and should be documented clearly and approved by the interdisciplinary team...Bed rail use for patient's mobility and/or transferring, for example, turning and positioning within the bed and providing a hand-hold</p>	I	<b>\$2000.00</b> <b>Held In</b> <b>Suspension</b>	Upon Receipt
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	<p>for getting into or out of bed, should be accompanied by a care plan...Inspect, evaluate, maintain, and upgrade equipment(beds/mattresses/bed rails) to identify and remove potential fall and entrapment hazards and appropriately match the equipment of patient needs, considering all relevant risk factors...If it is determined that bed rails are required...The mattress to bed rail interface should prevent an individual from falling between the mattress and bed. Maintenance and monitoring of the bed, mattress, and accessories such as patient/caregiver assist items...should be ongoing..."</p> <p>According to the FDA's Guidance for Industry and FDA Staff article, "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," issued 3/10/06, "For 20 years, FDA has received reports in which vulnerable patients have become entrapped in hospital beds while undergoing care and treatment in health care facilities. The term "entrapment" describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. FDA received approximately 691 entrapment reports over a period of 21 years from January 1, 1985 to January 1, 2006. In these reports, 413 people died, 120 were injured, and 158 were near-miss events with no serious injury as a result of intervention. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population</p>			
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	<p>most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. Entrapments have occurred in a variety of patient care settings..."</p> <p>An undated facility document entitled "Bed Rails" listed the following guidelines:</p> <ol style="list-style-type: none"> <li>1. All residents will be evaluated for the appropriateness for use of bed rails prior to initiation on admission.</li> <li>2. Ongoing use of bed rails will be evaluated quarterly, change in condition, and with change of equipment.</li> <li>3. Evaluations will include risk of entrapment.</li> <li>4. Risks and benefits of bed rail usage will be discussed with resident and family representative and informed consent will be obtained prior to usage.</li> <li>5. Care Plan will address bed rail usage and reason for device.</li> <li>6. Assure that the bed's dimensions are appropriate for the resident's size and weight.</li> <li>7. Follow the manufacturer recommendations and specifications for installing and maintaining bed rails.</li> </ol> <p>The MDS(Minimum Data Set) assessment tool, dated 6/6/17, listed diagnoses for Resident #3 included cerebrovascular accident(stroke) and hemiplegia(one sided paralysis). The MDS stated the resident required supervision and setup assistance for eating, limited assistance of 1 staff for bed mobility, and extensive assistance of 1 staff for transfers, walking, dressing, toilet use, personal hygiene, and bathing. The MDS stated the resident did not utilize a bed rail</p>			
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	<p>and listed the resident's BIMS(Brief Interview for Mental Status) as 8 out of 15, indicating moderately impaired cognition. The MDS stated the resident had 1 fall without injury since the previous assessment.</p> <p>A care plan entry, dated 3/2/17, stated the resident had 2 1/2 side rails up to promote independence with bed mobility. The care plan stated the resident had falls on 3/8/17 and 3/15/17 and had difficulty walking and weakness.</p> <p>The resident's "Side Rail Rationale Screen", dated 3/2/17, stated the resident:</p> <ul style="list-style-type: none"> <li>a. had an alteration in safety awareness related to cognitive decline</li> <li>b. had a history of falls</li> <li>c. had difficulty with balance or poor trunk control</li> <li>e. took medication that would require increased safety precautions</li> <li>f. expressed a desire to have the side rails up while in bed to promote independence</li> </ul> <p>An observation on 6/25/17 at 3:08 p.m. revealed the resident lying on the back in bed resting on his/her elbows. One side of the bed was against the wall and both sides of the bed had side rails up covering 3/4 of the length of the bed.</p> <p>An observation on 6/25/17 at 3:42 p.m. revealed the resident remained in bed with both side rails up.</p> <p>An observation on 6/25/17 at 3:53 p.m. revealed Staff E CNA(Certified Nursing Assistant) assisted the</p>			
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	<p>resident out of the bed.</p> <p>During an observation on 6/26/17 at 2:45 p.m., the surveyor was able to place her head completely through 2 vertical bars of the side rails in between the top bar of the side rail and the top of the mattress of the resident's bed.</p> <p>During an observation on 6/27/17 at 9:00 a.m., Resident #3's bed was outside with no mattress. The vertical slats of the bed measured 8 inches. The Maintenance Supervisor was present and concurred with the surveyor approximately how high a mattress would reach. The space between where the top of the mattress would be and the top rail measured 9 inches.</p> <p>A 1/25/17 facility document entitled "Bed Evaluation" revealed staff initials on the following dates: 3/15/17, 4/25/17, 5/25/17, and 6/9/17. The form did not describe what the bed evaluation entailed.</p> <p>A facility document entitled "Physical Plan Preventative Maintenance" dated 1/25/17, stated the facility must conduct regular inspection of all bed frames, mattresses and bed rails, if any, as part of regular maintenance program to identify areas of possible entrapment.</p> <p>A facility "Quality Improvement Project Plan", dated 6/26/17, stated all resident's beds would be assessed to ensure the side rail measurements were within the regulatory standards of 4 3/4 inches and the facility would replace all beds with more than the allotted</p>			
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	<p>spacing.</p> <p>During an interview during initial tour on 6/25/17 at 1:45 p.m., the DON(Director of Nursing) stated the resident did not speak and was not interviewable.</p> <p>During an interview on 6/26/17 at 2:49 p.m., the DON stated she thought the gap between side rails should be no greater than 8 inches. She stated the facility did not have a physician's order for side rails for the resident.</p> <p>During an interview on 6/26/17 at approximately 3:30 p.m., the Nurse Consultant stated the facility removed the resident's bed.</p> <p>During an interview on 6/27/17 at 10:47 a.m., Staff H CNA(Certified Nursing Assistant) stated she saw the resident scoot down in bed to the end but did not see the resident attempt to crawl over the side rails.</p> <p>During an interview on 6/27/17 at 10:51 a.m., Staff G CNA stated she saw the resident sit up in bed but did not see him/her attempt to get out of bed.</p> <p>During an interview on 6/28/17 at 9:57 a.m., the Maintenance Supervisor stated he thought the requirements for the bed rail measurements were to be no greater than 8 inches between bars. He stated he started measuring the bed rails around the beginning of the year and was using 8 inches as the guideline.</p> <p>2. The Quarterly Minimum Data Set (MDS- a federally</p>			
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	<p>mandated resident assessment tool) with an assessment reference date of 03/21/2017 revealed a BIMS (Brief Interview of Mental Status) of 3 which indicated severe long and short term memory deficits. Resident # 7 required extensive assistance from 2 staff for bed mobility, transfers, dressing, personal hygiene, and toilet use. The MDS documented complete incontinency of both bowel and bladder. The resident only understood verbal communications and could reply appropriately on a limited basis. The assessment documented height and weight as 4 foot 8 inches and 122 pounds. Active diagnoses included Alzheimer's Disease, a seizure disorder, Downs Syndrome, and had experienced at least 1 fall prior to admission to the facility.</p> <p>The plan of care with a problem onset date of 12/14/2016 directed facility staff to supply the resident with a pressure reduction mattress and 2 half side rails to promote independence and bed mobility. Resident # 7 became a Hospice patient for comfort cares on 06/23/2017.</p> <p>The facility's Side Rail Rational Screen with an assessment date of 03/21/2017 indicated side rails would provide safety and promote independence of movement for the resident. Resident # 7's poor visual acuity and decreased hearing complicated communication and understanding. A fracture to the right ankle and decline in overall function increased the risk of falls. The plan of care documented only 1 staff person needed to assist with transfers and personal cares.</p>				
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	<p>The Fall Risk Assessment completed on 03/31/2017 revealed a score of 16. A score of 10 or above indicated a high risk for falls.</p> <p>An observation on 06/26/2017 at 12:10 P.M., found Resident # 7 in bed with the head of the bed elevated approximately 30 degrees. The resident laid on the left side. A Hospice representative sat in a chair by the head of the bed. A tan overlay air pad could be seen over the mattress on the bed.</p> <p>On 06/26/2017 at 12:25 P.M., Staff I and Staff J (certified Nursing Assistants) provided cares for Resident # 7 and positioned the resident on the right side with a body pillow behind, and the head of the bed up approximately 30 degrees.</p> <p>At 1:05 P.M. on 06/27/2017, Staff J repositioned the resident higher in bed (slid down) on his/her back and rolled the bed up to the 60 degree range. This placed the resident's head 18 to 20 inches from the top of the mattress.</p> <p>Around 1:10 P.M., as Staff J attempted to give the resident nourishment, this Surveyor sat on the right side of the bed by the upper side rail. Resident # 7's eyes unfocused and calling for mom and dad. The upper half bed rail measured approximately 2 foot horizontally and 1 foot 6 inches vertically with the upper bars 4 inches apart and the lower bar to the mattress/frame 7.5 inches. A tan overlay air pad laid on top of the mattress and raised the resident approximately 1/2 to</p>			
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	<p>1 inch. The head of the bed touched the wall and the sides extended out into the room.</p> <p>Observations of the dark blue/black mattress at the half way point between the upper and lower rail from top of the bed to the bottom displayed a worn and frayed area brown in color and approximately 8 inches wide. The raised upper half rail angled higher at the center point of the bed where the mattress bends when the head of the bed is raised. When the head of the bed is raised, the blue/black mattress crushed down to around a half inch in depth.</p> <p>The area where the mattress met the bend of the bed when raised to the 60 degree range left a gap under the lowest bed rail bar to the mattress of 7.5 inches by 10 inches from the end of the bed rail (toward the center of the bed) to the mattress angles upward to form a "V" shape opening.</p> <p>A review of the medical record nursing notes of 06/26/17 and 6/27/2017 revealed:          06/26/2017 at 12:10 P.M., Resident # 7's bed in high fowler position (60 to 90 degrees for the head of the bed). The resident's wrists and hands twitching.          06/26/2017 at 1:30 P.M. The bed still is the high fowler position.          06/27/2017 at 08:30 A.M., the resident repositioned and the head of the bed left in a high fowler position.          06/27/2017 at 11:30 A.M., Resident # 7 yelling and restless. The restlessness continued through 12:30 P.M.</p> <p>A more recent Safe Bed Environment Evaluation form dated 06/26/2017 (due to a bed change) provided an</p>			
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	<p>assessment of factors including the resident being non-ambulatory, consciousness fluctuation, a history of falls, poor bed mobility and balance, effects of medications, and a diagnosis of a seizure disorder. The screen failed to identify the resident's compromised visual acuity along with a decrease in cognitive ability and safety awareness. Interventions included bed positioning devices, body pillows, wedges, and one way slides for beds. Hospice would deliver bed half rails appropriate to this particular bed. (Delivered on 06/27/2017).</p> <p>On 06/27/2017 the facility contacted the resident's representative by phone concerning the Bed Rails Informed Consent and Release form and documented an agreement to utilize side rails on the bed. Observation of Resident # 7 in the bed supplied by Hospice on 06/27/2017 at 11:40 A.M. found the bed and rails to fit together without gaps or possible entrapment issues.</p> <p>The facility Administrator and Director of Nursing were informed of the Immediate Jeopardy on 06/28/2017 at 11:00 A.M., due to the risk of entrapment for Resident # 3 by the use of a full bed rail which did not meet the requirement of only 4.75 inches between rails; and Resident #7's side rail gap of 7.5 by 10 inches when the head of the bed was in the raised position. The facility failed to identify the potential for side rail entrapment.</p> <p><b>FACILITY RESPONSE:</b></p>			
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