Citation Numb 7000	er:			Date: July 22	e, 2019
Facility Name: QHC Winterset			Survey June 17	Dates: -20, 2019	
Facility Address/City/State/Zip 411 East Lane St Winternet 14 50272					
Winterset, IA 50273		JKM			
Rule or Code Nature Section		re of Violation	Class	Fine Amount	Correction date

56.6(1)	481—56.6(135C) Treble and double fines.	I	\$23250 (\$7750 x 3)	Upon Receipt
	56.6(1) Treble fines for repeated violations. The		treble fine	
	director of the department of inspections and appeals shall treble the penalties specified in rule		(held in	
	481—56.3(135C) for any second or subsequent		suspension)	
	class I or class II violation occurring within any 12-			
	month period, if a citation was issued for the same class I or class II violation occurring within that			
	period and a penalty was assessed therefor.			
58.28(3)e	481—58.28(135C) Safety. The licensee of a nursing			
	facility shall be responsible for the provision and			
	maintenance of a safe environment for residents and personnel. (III)			
	58.28(3) Resident safety			
	e. Each resident shall receive adequate			
	supervision to protect against hazards from self,			
	others, or elements in the environment. (I, II, III)			
	DESCRIPTION:			
	Based on the United States Food & Drug			
	Administration's Guide, observations, clinical record			
	review, and staff interviews, the facility failed provide adequate nursing supervision to protect against			
	hazards when they failed to assess bed rails for the			
	risk of entrapment and obtain consent for the use of			
	side rails for 5 out of 50 beds reviewed for side rail			
1	safety (Resident #21, #20, #51, #103, #1). This failure			Page 1 of 1

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,		ЈКМ			
Rule or Code Section	Natur	e of Violation	Class	Fine Amount	Correction date
	safety. The facility report Findings include: The website article upda Beds (https://www.fda.g hospital-devices-and-su published by the United Administration (FDA), in information: Between January 1, 199 received 901 incidents of entangled, or strangled included 531 deaths, 15 cases where staff need injuries. Most patients w The efforts of the FDA a Workgroup (HBSW) hav of Hospital Bed System Guidance to Reduce Er provides recommendati hospital beds and for fa (including hospitals, nur residences). Healthcare facilities dev safety programs should	A States Food & Drug included the following factual 85 and January 1, 2013, FDA of patients caught, trapped, in hospital beds. The reports 51 nonfatal injuries, and 220 ed to intervene to prevent vere frail, elderly or confused. and the Hospital Bed Safety ve culminated in FDA's release on Dimensional and Assessment intrapment. This guidance ions for manufacturers of new incilities with existing beds rsing homes, and private			

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If, within thirty (30) days of the receipt of the citation, you (1) do not request a formal hearing or; (2) withdraw your request for formal hearing, and (3) pay the penalty; the assessed penalty will be reduced by thirty–five percent (35%) pursuant to Iowa Code section 135C.43A (2013).

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		ЈКМ			
Rule or Code Section	Natur	e of Violation	Class	Fine Amoun	Correction t date
	their facilities' risk mana The Guidance for Indus System Dimensional an Reduce Entrapment iss following documentation Introduction This guidance provides hospital beds (the terms bed" are used interchar document and include a siderails) and hospital b provides recommendati threatening entrapment systems (as used in this system" encompasses components, including the head and foot board, ar the bed). It characterize entrapment, identifies th openings that are poten recommends dimension <u>Background</u> For 20 years, FDA has vulnerable patients have beds while undergoing care facilities. The term event in which a patient entangled in the space	stry and FDA Staff Hospital Bed ad Assessment Guidance to sued on 3/10/06 included the n: recommendations relating to s "medical bed" and "hospital ngeably throughout this adult medical beds with bed accessories. The guidance ions intended to reduce life- s associated with hospital bed s guidance, "hospital bed the bed frame and its the mattress, bed side rails, nd any accessories added to es the body parts at risk for ne locations of hospital bed that entrapment areas, and hal criteria for these devices.			

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Wintersel, IA 50275		ЈКМ			
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1		1	1	1 8
	may result in deaths and serious injuries.			
	Key Body Parts at Risk			
	Three key body parts at risk for life-threatening			
	entrapment in the seven zones of a hospital			
	bed system discussed in this guidance are the head,			
	neck, and chest. International anthropometric data			
	references have been used to determine the relative			
	sizes of these body parts for the population at greatest			
	risk for entrapment and to provide a guide for the			
	dimensional limits that would reduce their risk of			
	entrapment.			
	a. Head - To reduce the risk of head entrapment,			
	openings 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.			
	Country-specific anthropometric data show that a 1st			
	percentile female head breadth may be as small as 95			
	mm (3 ³ / ₄ inches). A dimension of 120 mm (4 ³ / ₄ inches)			
	encompasses the 5th percentile female head breadth			
	in all data sources used to develop these			
	recommendations, and includes 1st percentile female head breadth as reported in some data sources. FDA			
	is therefore using a head breadth dimension of 120			
	mm (4 $\frac{3}{4}$ inches) as the basis for its dimensional limit			
	recommendations. This dimension is consistent with			
	the dimensions recommended by the HBSW and the			
	IEC (International Electrotechnical Commission).			
	Potential Zones of Entrapment			
	This guidance describes seven zones in the hospital			
	bed system where there is a potential for patient			
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Facility Name		-	Survey	Datasi	• • • • • • • • • • •	, _0.0
QHC Winterse			June 17		9	
Facility Addre	ss/City/State/Zip					
Winterset, IA		JKM				
		JKM				
Rule or Code Section	Natur	e of Violation	Class	Fine /	Amount	Correction date
Occilon						
	entrapment. Entrapmer articulated bed position intermediate positions.	nt may occur in flat or s, with the rails fully raised or in				
	a. Zone 1 - Within the Rail - Zone 1 is any open space within the perimeter of the rail. Openings in the rail should be small enough to prevent the head from entering. A loosened bar or rail can change the size of the space. The HBSW and IEC recommend that the space be less than 120 mm (4 ¾ inches), representing head breadth.					
	2. An observation completed on 6/20/19 at 9:12 a.m. of all the bed side rails in the facility revealed the following rooms contained quarter side rails on both sides of the bed with measurements greater than 4 and 3/4 inches (") within the perimeter of the side rails:					
	 a. Room 106B - Resident #51 sat in a wheelchair beside the bed during measurement, both bed rails in the up position. b. Room 204A - Resident #21 not present in room at time of measurement, right side rail against wall in up position left one down. c. Room 310A - Resident #20 not present in room at time of measurement, both side rails in down position, only 1 bed in room. d. Room 311B - Resident #103 lay in the first bed by the door during measurement, right side rail against the wall in the up position left one down. e. Room 507A - Resident #1 lay in bed during the measurement, both bed rails in the up position, and stated she used the rail for positioning. 					

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Winterset, IA 50273		ЈКМ			
Rule or Code Nature of Section		e of Violation	Class	Fine Amount	Correction date

Each side rail contained the same style of side rails with 3 rungs within the side rail. The spaces within the rails measured:		
 a. space towards head of bed - 5 and 3/4" width, 7 and 3/4" length, 9" diagonal b. center space - 7 and 1/4" width, 7 and 3/4" length, 10" diagonal c. space towards end of bed - 7" width, 7 and 3/4" length, 9 and 3/4" diagonal 		
The Zone recommendations for Zone 1 within the rail: Any open space between the perimeters of the rail can present a risk of head entrapment. FDA recommended space less than 4 and 3/4"		
1. Observation on 6/20/19 at 9:34 a.m. revealed a surveyor with her head thru the middle section of the side rail. This finding reported to the Administrator at 9:40 a.m. The Administrator stated the facility would remove and replace the side rails immediately.		
On 6/20/19 at 12:38 p.m. the Administrator and the Nurse Consultant reported 5 beds with that type of side rail removed from the building and placed outside by the dumpster after they became aware of the concern for potential for entrapment with the side rail measurements. The Administrator stated discussed a plan moving forward to ensure proper side		
rail/equipment use. The Nurse Consultant reported facility to complete side rail assessments for residents to determine if need or type of side rail.		

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2. According to the Minimum Date Set Assessment too dated 6/6/19, Resident #21 had diagnoses of Alzheimer's disease and glaucoma and experienced severe memory impairment and displayed fluctuating inattention and disorganized thinking. The MDS revealed the resident required limited physical assistance of 1 staff for bed mobility and transfers and did not identify that the resident used bed rails.		
 a. On 4/1/19, the care plan focus area documented the resident displayed altered thought processes. b. On 4/2/19, the care plan identified a risk for falls related to antidepressant medication use, glaucoma, and c. Alzheimer's disease. d. On 4/26/19, the facility revised the care plan to identify a moderate risk for falls and directed staff to round hourly and anticipate the resident's needs (offer drinks, water, offer to take to restroom). e. On 5/8/19, the care plan identified the resident had impaired visual function. 		
Observation on 6/17/19 at 11:33 a.m., revealed: Resident # 21 sat next to the nurses station in a regular chair and made multiple attempts to stand by herself with a wheeled walker. At 2:19 p.m., Resident #21 lay in bed with a quarter side rail in the up position. Resident # 21 yelled for help, sat up in bed, and tried to scoot to the end of the bed. After a couple of unsuccessful attempts, Resident # 21 lay back down.		
On 6/20/19 at 10:00 a.m., clinical record review		Page 7 of 1

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1000					,
Facility Name:			Survey I	Dates:	
QHC Winterse	t		June 17	-20, 2019	
Facility Address/City/State/Zip 411 East Lane St Winterset, IA 50273					
		ЈКМ			
Rule or					Correction
Code	Natur	e of Violation	Class	Fine Amour	nt date
Section					
	revealed Resident #21's hard chart contained a form titled Use of Side Rails Education Sheet/Consent Form. The form documented the resident requested side rails be used per preference for mobility and/or safety but the form failed to contain a date or signature of the resident or resident representative. The record also contained a Side rails Risk Assessment for the				

 also contained a Side rails Risk Assessment for the use of Side Rails that contained the resident's name and room number on it but was otherwise left blank. 3. According to the MDS assessment dated 4/4/19, Resident # 20 had a diagnoses of non-Alzheimer's dementia and a Brief Interview for Mental Status (BIMS) score of 03 (severe cognitive impairment). The MDS documented the resident displayed with fluctuating behaviors of inattention and disorganized thinking and was fully dependent of staff. A score of 03 indicated. The MDS revealed the resident totally dependent upon 1 person for bed mobility and 2 persons for transfers. The MDS recorded bed rails not used. The care plan focus area revised 1/24/19 identified a risk for injury related to non-compliance with transfers. On 2/8/19 the care plan identified a high risk for falls related to gait, balance problems, generalized weakness, incontinence, and psychoactive drug use. On 2/11/19 the care plan documented the resident attempted self-transfers, required assistance of 2 persons of a bala misming and self. 	
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personal and to help minimize notantial for falling from	
persons, and to help minimize potential for falling from	
bed, staff directed to use a bolstered mattress.	
On 6/20/19 at 10:00 a.m. record review revealed	

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Rule or Code Section	Natur	e of Violation	Class	Fine A	mount	Correction date
		record lacked a bed side rail for the use of side rails.				
	 #51 identified a BIMS secognition. The MDS revindependent with bed m documented diagnoses depressive disorder and The care plan focus are mobility deficits and at trelated to chronic arthriti (causes inflammation of (rheumatoid arthritis) in contractures in knees. Ithe resident no longer a dependent. On 6/5/19 the care plan related to mobility deficit chronic pain, and use o opioid, antianxiety, and On 6/20/19 at 10:00 a.m Resident #51's clinical massesment or consent 6. The electronic record the resident newly adm 	nobility and transfers. The MDS that included recurrent major d chronic pain syndrome. ea revised 12/15/17 identified times needed assist with ADLs tis, ankylosing spondylosis f the spinal joints), RA				

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	 risk for falls related to history of falls, use of walker, decreased strength, natural aging process, and diagnoses of muscle weakness, TIA (Transient Ischemic Attack), COPD (Chronic Obstructive Pulmonary Disease), Alzheimer's disease, and dementia with behaviors. The care plan direct staff to provide frequent checks of the resident. On 6/20/19 at 10:00 a.m. record review revealed Resident #103's clinical record lacked a bed side rail assessment or consent for the use of side rails. 7. The MDS assessment dated 6/5/19 for Resident #1 documented a new admit to the facility. 					

The care plan focus area dated 6/7/19 identified a risk for falls related to a history of falling, hip displacement, and Afib (atrial fibrillation).

On 6/20/19 at 10:00 a.m. record review revealed Resident #1's clinical record lacked a side rail assessment or consent for the use of side rails.

FACILITY RESPONSE:

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