STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035207	A. BUILDING _____ B. WING _____	**06/28/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SPRINGDALE VILLAGE HEALTHCARE	**7255 EAST BROADWAY ROAD MESA, AZ 85208**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on observations, clinical record review, interviews and policy review, the facility failed to ensure that one resident's (#10) environment was free from accident hazards, which resulted in a fall with injury and subsequent hospitalization . The deficient practice could result in further falls with injuries. Findings include: Resident #10 was readmitted to the facility on (MONTH) 24, (YEAR), with [DIAGNOSES REDACTED]. Review of the self care deficit care plan initiated on (MONTH) 28, (YEAR), revealed the resident required contact guard assistance from staff for transfers in and out of the bed, chair or wheelchair. Review of a care plan for fall risk revised on (MONTH) 9, (YEAR), revealed the resident was at risk for falls related to unsteady gait and/or balance. The goal included for the resident's level of independence to be maintained while reducing the likely hood of falls or injury. Interventions included to keep the floor free from clutter and observe the resident in her personal environment for safety. Review of the quarterly Minimum Data Set (MDS) assessment dated (MONTH) 28, (YEAR), revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The assessment also documented that the resident required limited assistance from staff for transfers, and that the resident had not had any falls since admission.A nursing progress note dated (MONTH) 6, (YEAR) stated, writer was told by aide that patient was using curling iron in her room, placing it on bed. Aide spoke to patient concerning this. This writer went to speak with patient, asked if anyone spoke with her about the curling iron, patient replied no one had spoke to her about it. Writer informed patient that she cannot use the curling iron (which was on her night table) in this facility due to fire code regulations. Patient acknowledged with ok. Review of a social services progress note dated (MONTH) 6, (YEAR), revealed the social worker and case manager spoke with the resident about the curling iron, and there was an agreement that the resident would only use the curling iron when supervised by staff in the shower room. The curling iron was removed from the resident's room and was given to nursing to store. The note further stated that the social worker talked with the resident about her belongings being disorganized and intruding on her roommates side of the room. The note also included that a power strip was observed hanging from the resident's bed and that maintenance was informed, and the plan was to mount the power strip for the resident's safety. A nursing progress note dated (MONTH) 20, (YEAR) at 3:48 p.m. stated, aide found patient yelling out, lifted dresser of pt's R leg, then called writer to room. Writer found patient lying flat on her back on floor, bare feet, call light not on. Patient had numerous wires and cords tangled around her feet and under her back .patient has a large hematoma on her R leg, no other injuries noted. A nursing progress note dated (MONTH) 20, (YEAR) at 4:00 p.m., stated emergency medical transport (EMT) reported that the resident's hematoma had ruptured when moving the resident for transport, and there was a significant amount of blood in the room that needed to be cleaned. Review of the facility's post fall huddle report dated (MONTH) 20, (YEAR), revealed the resident was transferring herself from the bed to the wheelchair, and the bed was not locked. The resident fell on to the floor, then got tangled in her numerous cords causing the nightstand to fall on her. The report stated the cause of the fall was the bed was not locked and there were too many cords near the resident. The resident was sent to the hospital. The report concluded that the intervention to prevent the fall from happening again would be to make sure the bed was locked. However, the report did not address the issue of the resident becoming tangled in numerous cords and pulling the nightstand down on top of her. Further review of report revealed an attached staff in-service sign-in sheet dated (MONTH) 20, (YEAR). The subject was ensure patients bed in the locked position every shift. The subject matter did not address the concern regarding the numerous cords. Review of the hospital records revealed a physician's progress note dated (MONTH) 26, (YEAR), stating the resident had [MEDICATION NAME] trauma to the right lower extremity resulting in hematoma. The resident was status [REDACTED]. The note stated blood loss was anticipated with dressing changes given the large open friable wound and venous hypertension. A hospital physician's progress note dated (MONTH) 27, (YEAR), indicated the resident received received a transfusion of 1 unit of blood due to low hemoglobin levels. Review of the clinical record revealed the resident was readmitted to the facility on (MONTH) 29, (YEAR). Review of the care plan for fall risk revealed an intervention was added on (MONTH) 7, 2019, to ensure the locks on the bed were in the locked position. However, the care plan did not address the concern regarding the numerous cords as a causative factor in the fall. An interview was conducted with the resident on (MONTH) 24, 2019 at 10:01 a.m. She stated that in (MONTH) (YEAR), she was transferring from her bed to the wheelchair. She said that she leaned on the bed which was unlocked, and the bed rolled away from her and she fell . She said on the way down, she grabbed something on the nightstand/dresser, and the dresser fell on her leg. She said she received a crush wound on her right leg. At this time an observation of the resident's room was conducted and the room appeared cluttered. The entire wall facing the foot of the resident's bed was lined with equipment, including an electric wheelchair in the corner of the room, a wooden chair and a manual wheelchair. The seat of the wooden chair contained linens and an oscillating fan which was approximately 18-24 inches tall. The seat of the manual wheelchair contained a large package of incontinence briefs, a hoyer sling and two wheelchair footrests. Further observations revealed there was a dresser next to the resident's bed, which was approximately 3 feet tall, 2 feet wide and 2 feet deep. The dresser had one top drawer and a bottom cabinet. On top of the dresser were stacks of papers, a nebulizer machine and a bi-pap machine, each with cords dangling down the side and back of the dresser. There was also an oxygen concentrator and a portable air conditioner near the head of the resident's bed. Both machines were plugged in and operating. In addition, there were cords observed on the floor under and behind the resident's bed, however, no cords were observed on the floor in foot traffic areas. The resident's bed was locked. An interview was conducted on (MONTH) 26, 2019 at 9:58 a.m., with a charge nurse (staff #5). She said the resident was transferring herself from the bed and the bed moved away from her and the resident fell . She said the dresser then fell on top of the resident's right leg. She said when she arrived in the resident's room, staff had already removed the dresser from on top of the resident's right leg. She said the resident had cords wrapped around her legs from a power strip that had been attached to the dresser. She said the resident was completely tangled in cords. She said the bed was away from the resident at an angle. She stated the resident had a solid hematoma on her right leg. She said she worked on making room for

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) the EMT to arrive, and when they came in the room, she left to prepare paperwork for the resident's transfer to the hospital. She said the EMT then came and told her they broke the hematoma in the room and there was a lot of blood. An observation of the resident's room was conducted on (MONTH) 26, 2019 at 11:40 a.m. The resident's bed was in the locked position. The resident's dresser was still stacked with papers, the nebulizer and the bi-pap machine. There was a curling iron resting on the handle of the dresser drawer, with a cord that was not plugged in. During the observation, the resident said she did not use the curling iron independently, but she calls staff to assist her when she wants her hair curled. She said the curling iron was designed to shut off automatically after ten minutes of non-use. The electric wheelchair, the manual wheelchair and the wooden chair still remained against the wall which was opposite of the foot of the resident's bed, with the same linens, supplies and equipment stacked on top. The oxygen concentrator and the portable air conditioner were still near the head of the resident's bed. Both machines were plugged in and operating. There was no power strip observed on top of or attached to the resident's dresser. However, there were still several cords which were dangling from the dresser drawer and down the side and back of the dresser from the [MEDICAL CONDITION] machine, the nebulizer machine and the curling iron. An interview was conducted on (MONTH) 26, 2019 at 3:09 p.m., with a Licensed Practical Nurse (LPN/staff #87). She said that she heard a noise coming from the resident's room, and she went to see what was going on. She said when she arrived, the resident was on the floor and staff were clearing the room. She said staff used a hoyer lift to get the resident back into bed, and that the resident had a hematoma on her right leg. She said within thirty minutes, EMT's had arrived and were preparing the resident for a transfer to the hospital. She said the EMT's stated the hematoma had burst around the time the resident transferred to stretcher. She said the EMT's then left with the resident. An observation was conducted from the doorway of the resident's room on (MONTH) 27, 2019 at 5:46 a.m. The curling iron was still resting on the resident's dresser handle, with the cord dangling down the front of the dresser. The [MEDICAL CONDITION] machine was on top of the dresser, along with a gallon-sized water jug and stacks of papers. The top dresser drawer was partially open, with the nebulizer machine resting inside the drawer. There were cords trailing down the side and back of the dresser. The resident's electronic health record (EHR) was reviewed on (MONTH) 27, 2019. Across the top of the screen was a banner which stated, curling iron will be kept in cabinets above charts at nurses station. An interview was conducted with the Director of Nursing (DON/staff #16) on (MONTH) 27, 2019 at 6:40 a.m. She said the banner on the EHR is not really part of the resident's care plan. She said she did not know who had access to view or modify the banner. She said that she did have access, but she did not know what other staff members could access it. Another interview was conducted with staff #16 on (MONTH) 27, 2019 at 10:42 a.m. She said her expectation for fall and accident prevention was for staff to keep the room free of clutter, keep the call light and common items within reach of the resident, and ensure beds were locked. She said some residents had a preference to accumulate personal items, but staff would be expected to keep the room orderly. She said the appropriateness of having a power strip would be evaluated by maintenance and that residents were not to have extension cords. Regarding this resident's fall, she stated that she was aware that the resident's bed ended up at an angle away from the resident. She said the resident's cords were on top of the dresser and that is what had caused it to fall on the resident's leg. She said at the time, the resident was very specific about the arrangement of her room, and she would spread her items to the other side of the room. She said staff would educate the resident that she could only use her side of the room and had attempted to clean up the resident's room multiple times. Review of a facility's policy for Safety and Supervision of Residents revealed that resident safety and accident prevention was a facility-wide priority. Employees should be trained on potential accident hazards and demonstrate competency on how to identify and prevent avoidable accidents. Facility oriented and resident oriented approaches would be used together to consider the hazards identified in the environment and individual resident risk factors, and then adjust interventions accordingly. Risk factors and environmental hazards would include: bed safety, falls and safe movement of residents.