

4-22-22 Weekly Clinical Update

Did you know that according to current QCOR data, 58.0% of Kansas facilities surveys completed result in a G+ citation for F689 Free of Accident Hazards/Supervision/Devices? The number 2 G+ tag is F600 ANE, and the percentage is 8%...amazing!

Citation Frequency Report

State Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Kansas Active Providers=322		Total Number of Surveys=50
F0689	Free of Accident Hazards/Supervision/Devices	29	7.5%	58.0%

Let's just look at some of the G+ tags posted to the KDADS website this year. NOTE: Some of these occurred in surveys in 2021 but were posted in 2022.

SW: SS=J (Past Non-compliance): Failed to provide sufficient supervision to 1 resident to prevent an elopement; resident exited facility via intentionally unalarmed exit door & walked approximately 1 mile to a convenience store

NE: SS=G: Failed to ensure environment was free of trip hazards, failed to investigate causative factors for falls & failed to develop interventions in response to 1 resident's change of condition & need for increased assistance; this deficient practice resulted in a fall with a fx for 1 resident who was cognitively impaired, at risk for falls & had a hx of falls with injury; resident fell & sustained a shoulder fx which required evaluation & treatment at ER at acute care hospital

NE: SS=J (Abated to D): Failed to provide adequate supervision for 1 resident, who was independent with ambulation in a w/c, was at high risk for elopement, had poor safety awareness & a BIMS of 2; resident exited facility w/o staff knowledge or supervision; facility staff were alerted by a family visitor that resident was outside facility alone in parking lot placing resident in immediate jeopardy

SW: SS=J (Abated to D): Failed to provide appropriate supervision to cognitively impaired resident, identified by facility as at risk for wandering & who exhibited prior exit seeking behaviors, to prevent an elopement; resident left facility w/o staff knowledge through an open window in another resident's room & traversed through a residential neighborhood to a local gas station almost a mile away & located near active rail road tracks & within 600 feet of a major highway placing resident in immediate jeopardy

SE: SS=G: Failed to ensure 1/3 residents remained safe from falls when staff left resident unattended on toilet, resident fell twice in 2 days & sustained a fx of knee

SW: SS=J (Abated to G): Failed to provide appropriate assistance for transfers to 3 residents; due to these incorrect transfers, 1 resident endured 2 rib fx's when assisted to commode by CMA & CNA w/o CP'd full lift for transfers; CNA used a sit-to-stand lift for 2nd resident alone resulting in fall with a right humerus fx & 3rd resident experienced a fall with closed head injury when CNA did not ensure CNA had ahold of gait belt while resident ambulated

SW: SS=G: Failed to thoroughly complete fall investigations for each resident to include identification of causal factors r/t fall &/or new fall prevention interventions to prevent future falls after each fall experienced by 3 residents; due to these failures, 1 resident fell multiple times, endured a subacute subdural hematoma, fell again later same day & staff found resident unresponsive

SW: SS=J (Past Non-Compliance): Failed to provide sufficient supervision to cognitively impaired resident who eloped from facility for approximately 8 minutes w/o staff knowledge within a mile of a busy 4-lane highway & within a quarter mile of a busy 4-lane intersection next to live railroad tracks placing resident in immediate jeopardy

SE: SS=K (Abated to G): Failed to ensure appropriate and safe transfers for residents that included 1 resident who required a w/c transportation, fell from the w/c due to staff failure of a seatbelt application resulting in a fracture of the right patella; failed to ensure 1 resident remained free of accidents when resident sustained a fractured patella after CNA failed to apply the facility van's seatbelt over the resident's wheelchair after assisting resident into the van, and then at a stop sign, CNA became distracted, which caused her foot to slip off the brake and hit the gas pedal, causing the van to rear-end the car in front of the van & impact caused unsecured resident to slip and fall from chair and land on resident's knees, which resulted in the patella fracture. Residents who were ID'd as using van in immediate jeopardy

SW: SS=G: failed to follow care planned fall prevention interventions for 1 resident to prevent falls from the lift chair when Physical Therapy Consultant GG plugged in the lift chair, and then left the remote within resident's reach & resident raised the lift chair to the highest position, then fell forward on her face, which resulted in a nasal fracture

NW: SS=G: Failed to identify and implement resident centered interventions and evaluate resident's toileting needs and patterns in order to prevent falls for 1 resident, who was at risk for falls; resident had multiple falls, with 3 specifically related to toileting or bathroom needs, which resulted in bruising, hematoma, facial fractures, facial lacerations, and head injuries

NE: SS=G: Failed to ensure staff followed 1 resident's plan of care to have two staff members assist resident with transfers using a sit to stand lift; CNA transferred resident using the lift without assistance from a second qualified staff member & during this transfer, resident became weak, resident's legs buckled, and resident slid to her knees; as a result, resident sustained a femur fracture on resident's left lower extremity

NE: SS=G (Past Non-Compliance): Failed to ensure that a Hoyer lift full body sling strap was fully inserted and clasped into the hook on the lift arm of the Hoyer lift; as a result, resident slipped from the sling and was lowered to the floor, which resulted in a fractured left ischial tuberosity

SE: SS=G: Failed to ensure staff transferred 1/3 residents as CPd with a mechanical lift for 1 resident when staff directed resident to stand holding onto a grab bar in shower room which resulted in staff assisting resident to floor & staff also failed to use mechanical lift to move resident off of floor; resident sustained bilateral distal femur fx's that required surgical intervention

NW: SS=G (Past Non-Compliance): Failed to ensure 1 resident remained free from accidents & hazards when CNA prepared a hot pack & placed it to resident's hip w/o consulting nurse on duty & w/o assessment actual temperature of hot pack; as result, resident sustained 2 second degree burns to hip

NW: SS=G (Past Non-Compliance): Failed to implement safety protocols while using a w/p lift chair to prevent falls; as result, resident fell out of w/p lift chair & sustained a hip fx

The sheer number is pretty alarming. Please take a moment to review these then go back to your own center's policies & protocols to make sure you have appropriate procedures in place. Here are a few trends:

- Elopement risk assessments and appropriate elopement prevention interventions in place including periodic elopement drills
- Appropriate protocols for use of mechanical lifts including competency demonstrations for both your own staff and agency staff
- Appropriate electric lift chair safety assessments
- Training of staff on root cause analysis then developing appropriate fall prevention interventions based on causal factors
- Transportation policies to include safety measures in vans

Hope these suggestions help to reduce these costly tags...costly to the well-being and safety of residents and costly financially and regulatorily to facilities.