F309 – Review of a Resident with Dementia – Compliance Example
A resident with dementia was admitted after hospitalization for a hip fracture she sustained while showering at home. The social worker's note, the nurses' notes and the care plan all included information from the family: they had reported on admission that the resident was now very fearful of showers. The RAI indicated choosing the method she was bathed was "very important" and the resident's daughter stated she preferred sponge baths due to her fear of showers. The interventions in the care plan were implemented consistently across all shifts and levels of staff. The nurses and social workers documented ongoing discussions with family and reassessments to ensure the resident's needs were being met and that no new issues had been identified. The criteria for compliance were met.

F309 – Review of a Resident with Dementia - Level 4 Severity Non-compliance Example
A resident with dementia was admitted after hospitalization for a hip fracture she sustained while showering at home. The social worker's note, the nurses' notes and the care plan all included information from the family: they had reported on admission that the resident was now very fearful of showers. The RAI indicated choosing the method the resident was bathed was "very important" and her daughter stated she preferred sponge baths due to her fear of showers.
In addition to the basic facts noted above in the level 4 severity non-compliance example:
• The surveyor observed an occurrence of bathing for the resident described above during the survey. The resident displayed substantial distress and fearfulness, calling out "help me," crying, striking out and grabbing at the staff, and made repeated attempts to get out of the shower chair.
• The staff member present called for a second staff member to help her complete the shower. Despite the resident's cries for help, no other staff members intervened or attempted to determine whether or not her distress warranted a different approach to the bathing routine/schedule.
• Significant psychological distress was noted during the bathing and for the remainder of the day and was documented in the nurse's notes.
• The surveyor observed that no other staff members intervened to assess the resident's situation or consult the care plan during or after the bathing.
• The surveyor interviewed direct care staff and nurses on the unit. One licensed nurse stated, "That resident always yells out during her shower" and attributed this to her dementia. Neither CNA interviewed was aware that the resident had sustained a hip fracture during a shower prior to admission.
• The resident's fear of bathing was noted in the care plan; however during interviews/observations, direct care staff could not articulate this information about the resident.
• The staff admitted they had not considered alternative routines/approaches for bathing this resident, despite the fact that the family had reported the resident's fear of showers and despite repeated episodes of distress.
• In addition to the staff being unaware of the resident's fear of showers, they also failed to investigate for other causes of the behavior.
• Upon further investigation related to quality assurance, there was no evidence that a physician attends QA&A meetings regularly.
• In reviewing staff training records, it appears that nursing assistants have not received training on how to care for residents with dementia.

What is the evidence for non-compliance?

• Resident exhibits adverse reaction to showers with verbal distress, combative behavior, and continuous struggling to get out of the chair.

• Facility failed to consider and rule out possible causes such as pain related to hip fracture while sitting in a shower chair or possible discomfort with the approach being used to bathe. Facility also failed to recognize the risk of a fall or injury due to combative behavior that required two staff members.

• Facility failed to develop and attempt alternate interventions.

• No staff member intervened despite the staff member present calling for help and hearing resident's cries for help and her obvious distress.

• Facility failed to assess the effects of the interventions and try to modify interventions based on those assessments.

• Facility failed to develop a care plan intervention related to trying to reduce or eliminate extreme reactions to showers;

• Staff had appropriate care plan but failed to communicate across shifts and caregivers; and

Why is this Immediate Jeopardy?

See Decision-Making Grid with Components of Immediate Jeopardy below. Based on the severity of the resident's reaction, there was evidence that the resident experienced actual psychological harm. In addition, there was immediacy since the repeated attempts at showering the resident resulted in resident-to-staff altercations and placed her at risk for serious physical harm.

Furthermore, there was no evidence of physician participation in the QA&A committee and no evidence that nurse aides received required training in caring for and communicating with residents with dementia. This suggests a lack of effective systems and processes for the assessment and treatment of a resident with dementia. If so, these systems failures place this and potentially other residents with dementia at risk for serious harm. The facility is culpable for a deficient practice that must be addressed immediately in order to prevent further harm to this and other residents (surveyors may wish to consider whether or not there is a need to expand the sample).