DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/18/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465159	A. BUILDING ______ B. WING ______	08/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN RIDGE TRANSITIONAL CARE	963 EAST 6600 SOUTH SALT LAKE CITY, UT 84121

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for 2 of 10 sample residents, the facility did not ensure that the residents' physician was notified when the residents' had a change in	F 157 9/6/06 POC acceptable completion date 9/8/06	"This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is herby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope of severity regarding any of the deficiencies cited are correctly applied." F 157 Patient Specific: Patients 1 and 3 have been discharged. Other Patients: In the event of a significant change in the resident's physical, mental, or psychosocial status the physician will be notified within a timely manner. Systemic Changes: In the event of a significant change in the resident's physical, mental, or psychosocial status the physician will be notified within a timely manner. Licensed nursing staff will be inserviced on 9/7/06 regarding notification of M.D. with significant changes of condition and proper documentation of the notification. Monitors: The Clinical Nurse Manager will perform a daily audit of the Physician Communication Form Log to ensure timely notification of significant changes of condition. The Clinical Nurse Manager will report findings at the quarterly QA meeting. Date of Compliance: 9/8/06	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/7/06

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.

Utah Department of Health
SEP 1 2006
Bureau of Health Facility Licensing
8500 2227 8243
8/31/06

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condition. (Residents 1 and 3)

Findings include:

1. Resident 3 was admitted to the facility in July 2006 with diagnosis of diabetes and hypoglycemia.

Resident 3's medical record was reviewed on 8/15/06.

In a nurses note dated 7/30/06 at 4:00 PM, a facility nurse documented that resident 3 had a sore on his right second toe. The nurse also documented that resident 3's name was placed on the podiatry list.

On 8/2/06, a facility nurse received a physician order for resident 3 that included antibiotics, dressing changes and a post op shoe to be worn in place of tennis shoes until the pressure ulcer was resolved.

The facility did not notify the physician of the change of condition until 3 days after the pressure ulcer was discovered.

2. Resident 1 was admitted to the facility on 7/31/06 with a diagnoses which included pneumonia. Resident 1 was noted to be admitted on two (2) antibiotics for the pneumonia (Cefuroxine 500 mg [milligrams] by mouth two (2) times a day for 7 days and Azthromycin 500 mg by mouth every day for 7 days.

Documented on an Interdisciplinary Progress Notes dated 8/6/06 was information that "pt.

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appears to have a phebitis (sic) to RFA (right forearm) from old IV (intravenous) site, warm pack applied. Redness, warmth & (and) edema noted".

Documented on an Interdisciplinary Progress Notes dated 8/7/06 was information that "pt's pharmacy says today is the last day that they have orders to fill the... ABX (antibiotics) double ABX Rx's (prescription) they are scheduled to d/c (discontinue) tomorrow. Made ... Nurse Manager aware.

A facility nurse documented on an Interdisciplinary Progress Notes dated 8/8/06 at 2200-0600 (10:00 PM to 6:00 AM) that "pt continues ABX for TX (treatment) of pneumonia..."

The nurse in charge for Resident 1 was asked if there was a mechanism for notification of the physician when there was a change in the condition of a patient. The nurse stated that the clinical nurse manager would be notified through a communication note and if the clinical nurse manager felt the physician needed to be notified she (clinical nurse manager) would call the physician. The nurse in charge for Resident 1 showed this surveyor the communication book in which those notes are documented.

A communication note dated 8/5/06 (day before the documented incident), made reference to a phlebitis in the right arm of Resident 1. There was a squiggly line drawn through the communication note and under the note was listed to continue the Cefuroxine 500 mg two (2) times a day and the Azthromycin 500 mg every

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day. The date for these two antibiotic reorders was 8/8/06.

In an interview conducted 8/15/06 at 3:10 PM, the clinical nurse manager was asked to explain how she determined when the physician needed to be notified regarding a change in condition. The clinical nurse manager stated that if a note went in the communication book a call was made to the physician no matter whether she felt it is necessary or not. She stated that the facility practice was to just go ahead and notify the physician. If there were orders, then the clinical nurse manager would write the orders. She stated that the "squiggly line" meant that the physician or nurse practitioner had seen the communication and this was their way of indicating they had seen the communication. The clinical nurse manager stated that if there were orders when the notes were reviewed by the physician or nurse practitioner then orders would be generated under the physician's order sheet.

The clinical nurse manager was asked about the note for Resident 1 dated 8/5/06 in the communication book, and the nurse's comment documented on 8/6/05. She was asked if the physician was notified regarding the change in condition. She stated yes the physician had been notified that was why the order for 8/8/06 was to continue the antibiotics. This state surveyor questioned why the delay from 8/5/06 to 8/8/06 before orders were written and the clinical nurse manager stated that since the patient was already on antibiotics Resident 1 was covered and the order for 8/8/06 was to cover the phlebitis. The surveyor asked if an order had been obtained for the warm compresses that had been applied.

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F 157	Continued From page 4 The clinical nurse manager could not find an order.	F 157		
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined that the facility did not ensure that facility nurses were washing their hands during the medication pass. Findings include: 1. On 8/16/06, an observation of a medication pass was done from 7:30 AM to 8:00 AM. The facility nurse was observed while passing medications to 4 different residents. The first resident was given medications by mouth and was administered insulin in the abdomen. The facility nurse was observed to handle the souffle cup and the cup of water the resident had touched. The facility nurse was then observed to return to the medication cart and set up mediations for the next resident. This was observed for the next 3 residents. The facility nurse did not wash or	F 444	F 444 Patient Specific: No specific patients were identified. Other Patients: To ensure infection control the nurses are required to follow proper hand-washing protocols. Systemic Changes: Staff will be inserviced on 9/7/06 regarding infection control and proper hand-washing protocols. Monitors: The A.D.O.N will observe med passes weekly to ensure appropriate hand-washing techniques. The findings will be reported at the quarterly QA meeting. Date of Compliance: 9/8/06	

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sanitize his/her hands between residents. The facility nurse had touched a resident to administer the insulin, handled the souffle cups the residents had touched, and handled the water glasses including the rim that the resident had drank from.

2. A medication pass was conducted on 8/15/06 beginning at 4:00 PM and concluding at 4:30 PM. The facility nurse passed medications to seven (7) patients during the medication pass.

The facility nurse was going through the medication administration record and marking on small medicine cups with an indelible pen, medications that were going to be administered later (no medications were dispensed). The facility nurse poured medications for a resident along with a cup of water. The facility nurse went to find the resident, administered the medications then took the medicine and water cups to the trash. The nurse was observed to lift up the top of the trash can with his hand, toss the cups in the trash then went back to administering medications without hand washing. The nurse continued to administer medications to two other residents without washing hands. For one resident who received medication, the facility nurse was observed to pop the tablets out of the bubble pack into his hands and then place the medications in a medicine cup then go to the patient and administer the medication.

3. A second medication pass occurred on 8/16/06 from 7:30 to 8:00 AM.

The medication nurse was observed to be going through the medication administration record as the surveyor approached. The surveyor noted

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there was a bottle of hand sanitizer located on the top of the medication cart. The nurse administered medications to two (2) residents without washing or sanitizing her hands after touching the lip of water cup or medicine cup after the residents had taken the medications. The nurse donned gloves for one resident who needed a sublingual (under the tongue) medication and after administration removed the gloves then sanitized her hands. The facility nurse was observed to scratch her nose then continued to pour medications and administer to another resident without washing or sanitizing her hands.

4. An interview was held with the facility director of nursing (DON) on 8/16/06 at 9:30 AM. The DON stated that the facility policy and procedures followed the Lippincott Manual of Nursing Practice, and gave the surveyor a copy of the manual to review.

In the Lippincott Manual Of Nursing Practice, by Sandra M. Nettina, MSN, RN,CS,ANP, chapter 31, Infectious Diseases, page 958, under Fundamentals of Standard Precautions, Handwashing, it was documented, " Handwashing is the single most important measure to reduce the risks of transmitting microorganisms. Washing hands as promptly and thoroughly as possible between patient contacts; after contact with blood, body fluids, secretions, excretions, and contaminated equipment or articles; and after gloves are removed is vital for infection control...."