| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 309 SS=G | 483.25 QUALITY OF CARE<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record review and interview it was determined that the facility did not provide the necessary care and services to attain or maintain the highest practicable physical well being for 1 of 4 sample residents (resident 2). Specifically, resident 2 did not receive prompt assessment and services when she presented with a change in condition in her mental status prior to being transferred to another facility.<br><br>Findings Included:<br><br>1. Resident 2 was admitted to the facility on 6/25/04 with diagnoses which included hypertension, hyperlipidemia, hypothyroidism and muscle spasms.<br><br>Resident 2's medical record was reviewed on 12/20/05.<br><br>A quarterly minimum date set (MDS) assessment was completed on 9/5/05. The MDS documented under section B., that resident 2 had a short term memory problem and no problem with long term memory. Facility staff documented that resident 2 had no problem with memory recall or ability. Facility staff documented that resident 2's cognitive skills for daily decision making were | F 309 | January 21st 2006<br><br>Resident was discharged to another facility.<br><br>An inservice for all nurses will be given by the DON / designee related to neurological observation and assessment on Monday 1/16/05.<br><br>All licensed nursing staff will complete a neurological observation form on all residents with head injuries.<br><br>The DON or designee will complete an audit on all fall acute charting weekly to insure compliance of neurological observation forms for all residents with head injuries.<br><br>Trends will be reported to the monthly QA meeting until a decreased frequency is deemed appropriate. | |

1/19/06 POC unacceptable completion date 1/21/06 Bmannbank RN

Utah Department of Health
A64
JAN 13 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 1/13/06

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.

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| F 309 | Continued From page 1<br>modified independence. Under indicators of delirium/periodic disordered thinking/awareness, facility staff documented that resident 2 had no problems with periods of lethargy or that her mental function varied over the course of the day.<br><br>On 11/4/05 at 1:20 AM, LPN 1 (licensed practical nurse) documented the following in the "Alert Charting...", "...Unattended fall...Res (resident) found in Main DR (dining room) floor on back [with] electric w/c (wheelchair) behind her. This nurse noted [drops] of blood on window sill. Res confused [with] noted lethargy upon 1st examination...RN (registered nurse) to steri-strips across 1 inch laceration above [left] eye [and] across bridge of nose 1/8 inch laceration this nurse found upon exam..." LPN 1 marked on this Alert Charting that resident 2 was alert, oriented, increased confusion and lethargy.<br><br>On 11/4/05 at 1:40 AM, LPN 1 documented the following on a nurses note as a "LATE ENTRY", "...Res (resident) monitored [every hour] after fall; res responded to physical stimuli [and] verbal stimuli. Awake at time lethargy present..."<br><br>Documentation regarding the hourly monitoring could not be located in resident 2's medical record.<br><br>On 11/4/05, on the 6:00 AM to 6:00 PM shift, LPN 2 documented the following in the "Alert Charting...", "Pt (patient) discharged to [another facility] 1st thing this AM...Noticed [increased] confusion [and] [increased] lethargy this AM. Meds were not given before she left..." LPN 2 marked that resident 2 had increased confusion and lethargy. LPN 2 did not mark that resident 2 was alert and oriented. | F 309 | | |

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| F 309 | Continued From page 2<br><br>On 11/4/05 at 6:30 AM, the LPN Unit Manager documented the following on a nurses note, "Upon arriving [at] work I was informed resident had fallen out of her w/c (wheelchair) I went in to see resident who was sleeping I woke her [and] asked if she was ok or having pain at her fall she said "no" I'm ok. At 0700 (7:00 AM) I called [resident's son] [and] left a message. He called back [at] 0730 (7:30 AM) I described [resident 2's] lacerations to her forehead and to her nose which were both steri-stripped with [no] bleeding...At 0817 (8:17 AM) res (resident) was being taken out to front door by [another facility's] van driver to dis-charge, resident was sleeping, but woke when I spoke to her. I then call [sic] DON (director of nurse's) [DON at receiving facility's name] explained the fall and asked her to assess her when she ([resident 2's name]) arrived, [DON 2] stated she would do so..."<br><br>On 11/4/05, LPN 2 documented the following in the "Discharge Summary/Post Discharge Plan of Care", "...Pt (patient) was been alert- Getting up per self. (above this someone documented "I do not agree with this.") Fell 0015 (12:15 AM) on 11/4. Has a laceration above left eye [and] bridge of nose. She LOC (level of consciousness) [decreased] during the NOC (night). I was thinking to send her to hospital this morning." The discharge summary was signed by LPN 2 and resident 2's daughter-in-law.<br><br>Based on the documentation it was noted that resident 2 sustained a fall at approximately 12:15 AM. Facility staff completed an assessment and obtained vital signs at the time of the fall. There was no documentation in the medical record to provide evidence that facility staff continued | F 309 | | |

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| F 309 | Continued From page 3<br>ongoing assessment of resident 2's vital signs, oxygen saturations or level of consciousness.<br><br>On 12/20/05 at 10:15 AM, LPN 2 who was assigned to resident 2 on 11/4/05 was interviewed. LPN 2 stated on 11/4/05 she received report from the night nurse that resident 2 had a fall. She stated she assessed resident 2 and noted that resident 2 was not as alert as normal. She stated she felt resident 2 needed to be seen by a doctor but was waiting for other nurse's to come in and assess resident 2 before having her seen. She further stated that she did not complete a neurological check on resident 2 because there were people there to transfer resident 2 to another facility. She stated she felt pressure from the family to get the resident discharged.<br><br>Based on review of the November 2005 nursing schedule it was noted that LPN 2's shift began at 6:00 AM. Resident 2 was not discharged from the facility until approximately 8:30 AM (2 1/2 hours after LPN 2's shift began).<br><br>On 12/20/05 at 10:25 AM and 2:50 PM, the LPN Unit Manager was interviewed. The LPN Unit Manager stated that when she reviewed the unusual occurrence reports on 11/4/05 she noted resident 2 had a fall that night. She stated she went in at 6:30 AM and assessed resident 2. The LPN Unit Manager stated resident 2 was alert and oriented and she asked resident 2 if she needed pain meds and the resident replied "No". She stated at about 8:30 AM, when resident 2 was on her way out of the facility she assessed that resident 2 was sleepy and that she could not wake the resident up. She stated that a family member told her to just leave the resident alone, | F 309 | | |

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that they would take care of her at the receiving facility. The LPN Unit Manager stated she "felt nervous about it" and called the DON at the receiving facility and advised her of the fall and to complete a neurological check when resident 2 arrived.

On 12/20/05 at 11:15 AM, the DON of the transferring facility was interviewed. The DON stated that on 11/4/05, the LPN Unit Manager called her and stated at 7:00 AM, resident 2 was fine and then when the resident was leaving the LPN Unit Manager noted a change in condition and "didn't feel good about it" so she called the DON at the receiving facility and told the DON to complete a neurological check on resident 2 when she arrived. The nurse surveyor asked the DON of the transferring facility if facility staff transported resident 2 to another facility when they were aware that resident 2 had experienced a change in condition. The DON stated, "yes because the LPN Unit Manager knew [the DON at the receiving facility] and the LPN Unit Manager called [the DON at the receiving facility] and gave her a "warning" of what was occurring. The DON of the transferring facility reviewed resident 2's medical record on 12/20/05 and was not able to find any other documentation or vital signs regarding resident 2's fall on 11/4/05.

On 12/20/05 at 11:45 AM, the DON of the receiving facility was interviewed over the phone. She stated that she did receive a call from the other facility regarding resident 2's fall and cut to her forehead. She stated the call was a more "for your information call" and the facility did not tell her that resident 2 had experienced or was experiencing a change in condition. The DON of the receiving facility stated they never advised her

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to complete a neurological check on the resident. She stated when the resident arrived the resident was not responsive and they initiated an assessment and neurological check. The DON of the receiving facility stated vital signs were completed and resident 2's oxygen saturation was in the 60's. The DON of the receiving facility stated they applied oxygen and immediately transported the resident to a local emergency room.

According to Fundamentals of Nursing Concepts, Process, and Practice (Seventh Edition, Copyright 2004 by Pearson Education, Inc., Upper Saddle River, New Jersey 07458, Page 517). Normal oxygen saturation levels range from 95% to 100% and an oxygen saturation level "below 70% is life threatening." Further, Brunner & Suddarth's Textbook of Medical-Surgical Nursing (10th Edition edited by Suzanne C. Smeltzer and Brenda Bare, Copyright 2004, Lippincott Williams & Wilkins, Page 484) states, "Values less than 85% indicate that the tissues are not receiving enough oxygen, and the patient needs further evaluation."

The emergency room evaluation, dated 11/4/05, revealed that resident 2 was given a Glasgow Coma Score of 6. Her neurological check documented that she would not open her eyes on command, to voice or spontaneous; had no verbal response and withdrew from pain.

According to Fundamentals of Nursing Concepts, Process, and Practice (Seventh Edition, Copyright 2004 by Pearson Education, Inc., Upper Saddle River, New Jersey 07458, Page 603). "The Glasgow Coma Scale was originally developed to predict recovery from a head injury; however, it is

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used by many professionals to assess LOC (level of consciousness). It tests in three major areas: eye response, motor response, and verbal response. An assessment totaling 15 points indicates the client is alert and completely oriented. A comatose client scores 7 or less."

On 12/20/05 at 2:45 PM, the van driver was interviewed over the phone. He stated that he remembered transporting resident 2 on 11/4/05. He stated resident 2 would not respond and he had to drive the electric wheelchair with the resident in it onto the van. He stated he was in the facility for 30-45 minutes and never saw any staff assess resident 2 or complete vital signs. He stated a family member was with resident 2. He stated as soon as facility staff completed the discharge paperwork they told him he could take resident 2.

On 12/20/05 at 3:00 PM, resident 2's daughter-in-law was interviewed over the phone. She stated on the day of her mother-in-laws discharge she came into the facility and found resident 2 up in her electric wheelchair with her head back and a breakfast tray in front of her. She stated that she tried to wake resident 2 up and the resident would not wake up. She stated a staff member came in and tried to wake resident 2 up and could not. She stated the staff member stated "they probably have her all drugged up due to her fall." She stated she arrived to the facility about 30 minutes before resident 2 left and that the van driver was there as well. The daughter-in-law stated that she was in resident 2's room the entire 30 minutes and no staff came in and assessed resident 2. She stated that the van driver drove resident 2's wheelchair with the resident in it onto the van.

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| F 309 | Continued From page 7<br>She stated no one stopped them to assess resident 2. The daughter-in-law further stated that she never refused to allow facility staff members to provide care and services to her mother-in-law. She stated when she signed the discharge summary it documented that her mother-in-law had been alert and was getting up by herself and she documented on the form that she did not agree with that.<br><br>A statement from LPN 2 was provided to the survey team after the survey was completed. LPN 2 documented the following, "...[resident 2's daughter-in-law], the family member, came in at 7:00 AM. I told her I was concerned about [resident 2] since she fell last night and I wanted to do vital signs and call the doctor...I was pressured by the family to get her discharged..."<br><br>Based on interview with the daughter-in-law, the daughter -in-law stated she did not arrive to the facility until approximately 8:00 AM (2 hours after the day shift began). On 11/4/05, LPN 2 and LPN Unit Manager stated in interviews that the daughter-in-law was insistent on getting the resident out of the facility without appropriate assessment and treatment. However, no documentation regarding the daughter-in-law's behavior and refusal of treatment could be located in the medical record and in interviews with the daughter-in-law she stated that "no one ever tried to stop us or assess her. I never refused care." | F 309 | | |