DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

ATG
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465093	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 3/16/00

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GODFREY'S FOOTHILL RETREAT INC	775 NORTH 200 EAST BRIGHAM CITY, UT 84302

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F 314 SS=G	483.25(c) Requirement QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This Requirement is not met as evidenced by: Based on observation, interviews with staff, review of resident medical records, review of the facility's policies and procedures and review of Wound Care Team meeting minutes, it was determined that for 1 of 13 current sample residents, the facility did not ensure that a resident who entered the facility without pressure sores did not develop pressure sores unless the individual's condition demonstrated that they were unavoidable. The facility also did not ensure that a resident with a pressure sore received the necessary treatment and services to promote healing and prevent infection. Resident identifier: 1. Findings include: 1. Resident 1 was an 82 year old female who was admitted to the facility on 8/12/94 with the diagnoses of multi-infarc dementia, seizure disorder, hypertension, degenerative joint disease, chronic obstructive pulmonary disease, a hiatal hernia, hypothyroidism, and a cerebral vascular accident (stroke). After determining that resident 1 was at risk for	F 314 EJ	**"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Brigham City Nursing and Rehab. Center does not admit that the deficiencies listed on the HCFA 2567 exist, nor does the Facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal and/or regulatory or administrative proceedings all deficiencies, statements, facts, and conclusions that form the basis for each deficiency."** **How will the corrective action be accomplished for Those residents found to Have been affected by the Deficient practice ?** Resident #1 was placed on a pressure-Reducing mattress on 1/4/00. This Resident continues to be on this mattress. Treatments for this resident will be done As ordered by the attending physician.	POC acceptable 5-1-00 EJ

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 4-11-2000

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is 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 314	Continued From page 1 developing pressure sores in August of 1999, the facility did not follow its own policy for "skin breakdown prevention" which required the use of pressure relieving devices to be implemented. The first pressure relieving devices (foot booties) were not implemented until 12/7/99 when resident 1 had been identified with a "black heel". The facility did not apply these booties as ordered by the physician for 10 of the 23 possible days in December of 1999, 31 of 31 days in January 2000, and 5 of 29 days in February 2000. The second pressure relieving device (pressure mattress) was not implemented until 1/4/00, 28 days after the pressure sore was first identified by nursing, when it was recommended to nursing by the physical therapist. Neither of the pressure relieving devices were care planned. The facility's wound care team did not meet from 11/30/99 to 1/7/00, a period of five weeks, during which time resident 1 developed the "black heel". The pressure sore increased in size from "4 cm (centimeters) round" on 12/22/99 to 7.5 cm by 8 cm on 1/7/00. Treatment to the "black heel" was first ordered on 1/4/00. There was no documentation to evidence that the treatment ordered by the physician was performed 22 of the possible 27 days in January 2000 or 8 of 9 possible days in February 2000. When the treatment to the pressure sore of resident 1 was taken over by physical therapy on 2/10/00, he described the wound to have "moderate purulent" drainage which produced a "moderate foul" odor. On 2/15/00, the physician ordered antibiotics for this infection. Neither the dietitian or the dietary manager were members of the facility's wound care team. The presence of the pressure sore to the heel of resident 1 was not relayed to the dietitian until 3/15/00 when the surveyor was asking staff if the dietitian was aware of the pressure sore. This was 98 days after the pressure sore was first observed by	F 314	**How will the facility identify other residents having the Potential to be affected by The same deficient practice?** All residents have the potential to be Affected by the deficient practice. **What measures will be put Into place or systematic Changes made to ensure that The deficient practice will not Recur?** All nurses will be inserviced by the DNS On proper wound documentation and Performing accurate assessments. The Inservice will be conducted on 5/1/00. The facility is also in the process of implementing a Treatment Nurse position 8 hours a day, 7 days a week. This person will be responsible for performing all of the treatments and wound care in the facility during this time. This will assist in the continuity of wound care and assure that treatments are performed consistently.	

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F 314	Continued From page 2 nursing staff. The dietitian confirmed that she was "not made aware until today, that's why I wrote the order for increased protein." There was no documentation to evidence that turning and repositioning of resident 1, as required by her care plan, was performed on 89 days out of a possible 98 days (12/7/99 through 3/15/00). On 8/21/99, resident 1 had been evaluated by a facility nurse as "at risk to develop pressure sores". The facility's policy regarding "Skin Breakdown Prevention" states that "1. Resident will have a risk assessment (Pressure Risk Assessment) completed upon admit (Nursing Skin Assessment) and at least quarterly to assess risk. 2. Residents who are at risk will be provided turning monitors, pressure relieving mattresses, and /or pressure relieving cushions for wheelchairs. 3. Residents who are at risk will have appropriate referrals for improving mobility (Rehab), improving nutrition (Dietary), and decreasing friction/incontinence and pressure (Nursing). 4. Residents who are at risk will be reviewed periodically by the Wound Care Team to determine effectiveness of preventative measures." The care plan the facility had developed for resident 1, "Potential...DQ formation" did not include the use of pressure relieving devices as an intervention as required by the facility policy on skin breakdown prevention.	F 314	The wound management system in the facility Will be as follows: All residents admitted to this facility will Have a total body skin assessment completed upon admission and at least weekly thereafter. The total body skin checks will be Documented on the residents skin record. All residents will have a Skin Risk Assessment completed upon admission And at least quarterly or with any significant Change on the MDS. Those residents identified "at risk" for skin breakdown will have preventative measures implemented and addressed on the care plan. All pressure sores will be measured weekly And documented on the residents skin record. To maintain communication throughout All disciplines regarding the status of any Residents with pressure sores, a weekly Pressure Sore report will be utilized. This Report will be distributed weekly and used As a monitoring tool by the DNS. All residents at risk with skin breakdown Will be reviewed at the weekly "Skin and Weight Meeting". The staff at this meeting Will include representatives from Nursing, Dietary, Activities, and Therapy Departments. Minutes will be kept and All in attendance will receive a copy. Copies will also be given to the DNS And administrator.	

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F 314	Continued From page 3 The MDS (minimum data set), a mandatory comprehensive assessment completed by facility staff, dated 12/8/99, documents that resident 1 was totally dependent for all activities of daily living, including bed mobility (how the resident moves to and from lying position, turns side to side, and positions body while in bed). This MDS also documented that the facility was not using a pressure relieving device on the bed of resident 1. On 11/26/99, a nurse's monthly summary for resident 1 documents, "...no skin excoriation, DQ (decubitus ulcer/pressure sore) form. (formation) or s/s (signs and symptoms) of UTI (urinary tract infection) noted." On 12/7/99, a nurse's note describes "...Black heel noted on R (right) foot and small DQ (decubitus ulcer/pressure sore) on L (left) big toe. Booties applied for protection with pillow under thigh." The nurse's note did not provide a description of the wound to the resident's right foot. The Nurse's Clinical Guide, Wound Care, Cathy Thomas Hess, Springhouse, 1995, pg. 13 reads, "Assessment and documentation of wounds throughout the healing process are critical to proper management and healing. When assessing a wound and documenting findings, include the following factors: - classification by degree of tissue layer destruction or color - anatomic location that includes extremity and nearest bony prominence or other anatomic landmark - size that specifies length, width, depth, and tunneling, using consistent units of measure	F 314	**How will the facility monitor its Performance to make sure that Solutions are sustained?** The facility will conduct monthly Quality Assurance Committee Meetings and review the weekly Pressure ulcer reports. Any Concerns will be addressed And a plan of action developed **Responsible Party:** Director of Nursing **Completion Date:** May 5, 2000	

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F 314	Continued From page 4 - appearance of wound bed and surrounding skin - drainage, specifying amount, color, and consistency - pain or tenderness, which may indicate infection, underlying tissue destruction, or vascular insufficiency - temperature, which may indicate pressure ulcer formation, if the skin is intact, or an underlying infection On 12/8/99, the physician ordered "Booties on while in bed for L (left) and R (right) heel blisters until healed." There is no documentation to evidence that facility staff applied those booties, as ordered, for 10 of the 23 possible days in December of 1999, 31 of 31 days in January 2000, and 5 of 29 days in February 2000. There is no further documentation in the resident's medical record regarding the "blister" or "small DQ" on the left foot. The MDS, dated 12/8/99, documented that resident 1 had a stage 2 pressure sore. Based on the 12/7/99 nurses note which identified the "black heel", the staging of the wound was inaccurate. The Health Care Financing Administration, Resident Assessment Instrument, Version 2.0, pg. 3-135, states "If necrotic eschar is present, prohibiting accurate staging, code the ulcer as Stage "4" until the eschar has been debrided (surgically or mechanically) to allow staging." The next documentation of the wound to the right heel of resident 1 was found on the "Decubirus/Pressure Ulcer Risk Assessment and Record". The entry was dated 12/22/99, 15 days after the initial observation, and documented the wound at a stage 2, measuring "4 cm (centimeters) round", a "large blister intact".	F 314		

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F 314	Continued From page 5 On 1/4/00, physical therapy progress notes document, "Observed R heel wound per nursing request. Blackened eschar on medial heel. No drainage noted. Encouraged nursing to provide pressure relief mattress, pillow under calf, and frequent position changes." On 3/15/00, during an interview with the physical therapist, he was asked why his 1/4/00 note contained a recommendation for a pressure relief mattress. The physical therapist replied, "she wasn't on a pressure relief mattress before then." On 1/4/00, the physician ordered a treatment for the pressure sore to the right heel of resident 1 "4 X 4 with kerlex wrap to R heel until healed. Pressure mattress." The order for the pressure relief mattress came 28 days after the "black heel" wound was initially observed by nursing staff. On 1/7/00, the same facility nurse who had measured the heel wound on 12/22/99, photographed the right heel wound of resident 1 and measured it to be "7.5 cm X (by) 8 cm" and described the color as "red/yellow - black". From 12/22/99 to 1/7/00, the wound increased in size from "4 cm round" to "7.5 X 8 cm". The care plan the facility had developed for resident 1, "Potential...DQ formation" included the intervention "Turn and position q2h (every 2 hours) and prn (as necessary)." During the review of all nurse's notes from the day the wound was first observed (12/7/99) until during survey on 3/15/00, and review of the treatment sheet for December 1999,	F 314		

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F 314	Continued From page 6 January 2000 and February 2000, it was determined that the facility did not provided turning and repositioning a total of 89 days out of a possible 98 days. There was no documentation in the nurse's notes or on the monthly treatment sheets for resident 1 to evidence that the physician's order from 1/4/00 (4 X 4 with kerlex wrap to R heel until healed) was followed. The January 2000 treatment sheet for resident 1 is missing documentation that the dressing change was performed for 22 of the possible 27 days. The February 2000 treatment sheet is missing documentation that the dressing change was performed 8 of the possible 9 days. On 2/9/00, the physician ordered that physical therapy take over the wound care for resident 1. When the physical therapist took over the wound care of resident 1 on 2/10/00, he described the wound to have "moderate purulent" drainage which produced a "moderate foul" odor. An order for a culture of the wound was obtained and found to have "staphylococcus haemolyticus". When the physician was notified of these results, he wrote an order for "Cipro (an antibiotic) 500 BID (twice daily) X 10 days." During interview with the physical therapist on 3/15/00, he stated he was on the wound care team. When asked how often the wound care team met, he stated "every two weeks approximately". During review of the wound care team minutes, it was revealed that there was a 5 week period, from 11/30/99 to 1/7/00, in which there was no documentation that the wound care team met. It was during this 5 week period that resident 1 developed	F 314		

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F 314	Continued From page 7 her pressure ulcer which increased in size from 4cm on 12/22/99 to 7.5 by 8 cm on 1/7/00. There is no documentation to evidence that the wound care team discussed the pressure sore to the right heel of resident 1 prior to 1/7/00. During interview with the director of nurses and the physical therapist on 3/15/00, they were asked if the dietary manager or dietitian were on the facility's wound care team. Both stated that neither the dietary manager nor the dietitian were on the wound care team. This was confirmed in interviews with the dietary manager and dietitian on 3/15/00. During further interview with the facility's dietitian on 3/15/00 at 11:40 AM, she was asked if she had been aware of the pressure sore on the right heel of resident 1. The dietitian stated that she was "not made aware until today, that's why I wrote the order for increased protein." The dietitian was not made aware of the pressure sore to the right heel of resident 1 until 3/15/00, a total of 98 days after the wound was first noted by nursing staff. The diet for resident 1 had not been modified to include extra protein for healing of the pressure sore until 98 days after it was first noted by nursing staff. Observation of the pressure sore to the right heel of resident 1 on 3/15/00, revealed a stage 3 pressure sore measuring approximately 4cm by 2.5 cm with a depth of approximately .25 cm. The wound appeared reddish-pink in color and did not appear to have any signs or symptoms of infection. The facility did not ensure that resident 1 did not develop a pressure sore. The facility did not provide the necessary treatment and services to promote healing and prevent infection of the pressure sore	F 314		

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F 314	Continued From page 8 when it did develop.	F 314		
F 496 SS=D	483.75(e)(5)-(7) Requirement ADMINISTRATION Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This Requirement is not met as evidenced by: Based on record reviews and interviews, it was determined that the facility did not seek registry verification for 7 of 17 nurse aides before allowing them to provide direct care to residents. (Refer to Employee Roster, employees #1 through #7.) Findings include: 1. The mandated abuse prohibition protocol sample (which included 1 recently hired aide) was expanded	F 496 ETD	**How will the corrective action be accomplished for Those residents found to Have been affected by the Deficient practice ?** No specific residents were identified. **How will the facility identify other residents having the Potential to be affected by The same deficient practice?** All residents have the potential To be affected. **What measures will be put Into place or systematic Changes made to ensure that The deficient practice will not Recur?** All staff identified during the survey Have had a check through the registry. The SDC has been inserviced On contacting the state registry For all new hires and re-hires. The facility has a system in place As of 3/4/00 in which all nursing Staff who are hired (or re-hired)	

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F 496	Continued From page 9 to include the 17 aides hired since March 3, 1999 - after the previous recertification survey. The Health Occupations Registry was consulted on March 14, 2000, and it was learned that the facility did not call t determine if the names of 7 of these nurse aides were listed on the state abuse registry. 2. During an interview on March 16, 2000, the facility's Staff Developer said she called the registry if the aides were Certified Nurse Assistants to determine if they were qualified. She acknowledged that when untrained/non-certified nurse aide applicants were considered for employment, she did not call the registry.	F 496	Will be checked through the Registry and the verification Logged on a "Registry Log". Additionally, all employees Will have a re-verification Through the registry annually. Which will be tracked on the "Registry log" as well. **How will the facility monitor its Performance to make sure that Solutions are sustained?** The facility will review the "Registry Verification Log" in the Quality Assurance Committee monthly for 3 Months and then quarterly Thereafter. Any issues or concerns Identified will have a plan of action Developed. **Person Responsible:** SDC **Date of Completion:** May 7, 2000	

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F 496	Continued From page 10	F 496		