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

COMPLAINT NUMBER: UT00038160

PRINTED: 08/08/2005
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
	465095	A. BUILDING _____ B. WING _____	C 08/01/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTUS ST JOSEPH VILLA	451 BISHOP FEDERAL LANE SALT LAKE CITY, UT 84115

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F 157 SS=G	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:	F 157	F157 Resident 2 was the resident identified by the surveyor as the only resident effected by the failure to follow facility procedure. The Staff Educator and DON met with the nurses who did not follow facility procedure for notification of family and physician related to changes in the resident's condition and/ or treatment. The nurses were educated using facility procedure as a basis for education on August 11 and 12, 2005. There is a potential for any resident to be effected by this failure to follow procedure. To prevent further failures to follow the facility procedure, the facility Safety and Quality Committee Report will be placed on clipboards, being purchased by Aug 19th, to hang behind each nurse's station. The Resident at Risk Coordinator and/or Supervisor will make daily, morning rounds to each unit to review any Reports on the clipboards. A thorough review of the form will be conducted prior to leaving the unit and any omissions, will be immediately remedied by the Resident at Risk Coordinator and/or the nurse on duty. On completion the Resident at Risk Coordinator will deliver all forms to the DON or designee for a second review. 8/24/05 Per telephone conversation with DON all compliance dates per this page are 9/15/05 Added with permission Bissenbacher RN	09/15/05

8/24/05 POC acceptable Compliance date 9/15/05 Bissenbacher RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Ewer — TITLE: Administrator — (X6) DATE: August 24, 2005

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 157	Continued From page 1 Based on interview and medical record review, it was determined that for 1 of 4 sample residents (resident 2), the facility did not immediately consult with the resident's physician when there was a need to alter treatment. Specifically, one resident had an open blister from an unknown source on her shoulder and the physician was not consulted to obtain orders to treat the wound. In addition, the facility did not notify the resident's family member. Findings include: Resident 2 was re-admitted to the facility on 4/15/03, with diagnoses which included rheumatoid arthritis, hypertension, esophageal reflux, constipation, migraines and osteoarthrosis. On 7/21/05 at 4:00 PM, a facility nurse documented the following on a "Safety and Quality Committee Report", "...During bed bath aide called me to see a 10 cm (centimeter) open blister on top of [right] shoulder, resident has no idea how it occurred..." Under "Actions" the facility nurse marked the box which stated no action was taken. On 7/27/05, resident 2's medical record was reviewed by a nurse surveyor. There was no documentation regarding the 10 cm open blister found on resident 2's right shoulder on 7/21/05. There was no documentation in the medical record of resident 2 to evidence that the physician was notified of the open blister identified on 7/21/05. There was no documentation to evidence that physician orders were obtained to provide	F 157	The Director of Nursing or designee will: 1) Ensure all forms are completed per facility protocol and identify incidents with the Resident at Risk Coordinator that require further investigation, 2) Ensure all licensed staff are educated annually on facility policy related to Notification of family and physician when there is a change in treatment or condition of a resident. The next licensed staff meeting, scheduled for Tuesday, August 23, 2005, will be a mandatory meeting for licensed staff and will include a thorough review of this topic. Minutes will be sent to staff not in attendance at the meeting with requirements for completion of the form highlighted. The Resident-at-Risk Coordinator will identify the number of resident events in which there are omissions on the facility Safety and Quality Committee Report. The number of reports needing corrections due to omissions will be reported to the Quality Council beginning with the results from August 22 to August 31, 2005 and monthly thereafter. The first report to the quality Council will be September 15, 2005. The DON or designee has responsibility for implementing and monitoring the plan of correction.	

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F 157	Continued From page 2 treatment for the open blister identified on 7/21/05. On 7/27/05 at 12:43 PM, the open blister was observed by a nurse surveyor and a facility nurse. The opened blister was covered with a dressing. The dressing was peeled back by the facility nurse and revealed a wound that was 5 cm by 3 cm in diameter. The facility nurse stated to the nurse surveyor that the wound was being cleaned with normal saline and then triple antibiotic ointment was placed on the wound and the wound was covered with a dressing. Resident 2 stated to the nurse surveyor that she believed the blister was caused by the hot packs that the therapist places on her shoulders. On 7/27/05 at 1:15 PM, the third floor supervisor was interviewed. When the supervisor was asked how the blister of resident 2 was being treated, she stated that there was no dressing to the opened blister. She further stated that it was left open to the air. On 8/1/05 at about 9:30 AM, resident 2's physician was interviewed over the phone. Resident 2's physician stated that on 7/22/05, he received a message about the blister on resident 2's right shoulder. He stated that the facility staff did not inform him that the blister was opened and required treatment. Resident 2's physician stated that facility staff stated that resident 2 "was okay". Resident 2's physician then stated that on 7/29/05, the facility notified him of the opened blister on resident 2's right shoulder and stated it was caused by a burn. Resident 2's physician stated he gave an order for treatment of the burn. When resident 2's physician was asked about the heat therapy he stated, "I don't recall giving	F 157		

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F 157	Continued From page 3 orders for heat packs." It should be noted that the physician was not notified of the blister until 1 day after it was identified and was not notified that the blister was opened and caused by a burn until 8 days after it was identified. The July 2005 physician re-certification orders were reviewed by a nurse surveyor. There was no documentation of an order for heat therapy to resident 2's shoulders. There was no evidence in the medical record of resident 2 to evidence that the family was notified of the open blisters identified on 7/21/05. On 8/1/05 at 10:50 AM, resident 2's family member was interviewed over the phone. Resident 2's family member stated that she saw the burn on 7/27/05 when she was visiting resident 2. She further stated she was not ever informed by facility staff of the open blister/burn on resident 2's right shoulder.	F 157		
F 225 SS=G	483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225		

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F 225	Continued From page 4 The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, it was determined that the facility did not investigate and report incidents of potential abuse (including injuries of unknown origin) and therefore, was not preventing facility residents from further potential abuse and injury. During the complaint survey, completed 7/27/05 through 8/1/05, record review revealed three	F 225	F225 Resident #1 and #2 were identified as the residents where the facility failed to meet the requirement of investigation and reporting of possible abuse. There is a potential for any resident with an injury of unknown origin to be affected by failure to thoroughly investigate injuries of unknown origin. The facility has reviewed its policy and procedure related to reporting of possible neglect or abuse and revised it to meet state and federal regulations. The Resident at Risk Coordinator or designee will review each Safety and Quality Committee Report within 24 hours of receipt and will identify any injuries of unknown origin. Utilizing techniques of root cause analysis the injury will be investigated within 5 days of occurrence and prepare a report for review by the facility administrator. The Administrator will review the report and submit to the State Survey Agency within the 5 day time frame. The report will be attached to the Safety and Quality Committee Report. If further investigation is required beyond the 5 day requirement for reporting to the State Survey Agency due to unavailability of involved persons, it will be so noted in the 5 day report to the State Survey Agency. At the completion of the investigation a final report will be prepared by the Resident at Risk Coordinator, reviewed by the administrator and forwarded to the State Survey Agency.	09/15/05

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F 225	Continued From page 5 incidents of injuries of unknown origin (resident 1 and 2) where the facility failed to investigate or report these occurrences. Findings include: 1. A review of the facility's policy and procedures, relating to abuse, was completed on 8/2/05. The policies directed the following, "...Bruises, skin tears and other injuries that are not witnessed shall be reported to the Administrator and the abuse reporting protocol will be initiated. e. An investigation of the bruise/injury shall be initiated. The [State Survey Agency] shall be called...and informed an investigation has started. Within 5 days, the results of the investigation are to be provided, in writing, to the [State Survey Agency]. The supervisor will question staff that provided direct care and/or services to the resident. Any information gathered will be added to the variance report..." 2. On 7/27/05, surveyors reviewed records maintained by the State Survey Agency, which related to the facility. Incidents of facility self reported allegations of abuse, injuries of unknown origin and neglect were among the records. Since April 2005, the facility had not reported any of these incidents. In addition to a review of facility self reported allegations of abuse and injuries of unknown origin, the surveyors reviewed documentation of reports received by Adult Protective Services (APS). On 5/11/05, APS had received a report of a resident to resident altercation. There were no other incidents reported to APS since May 2005. 3. Upon medical record review of survey sample	F 225	The Resident-at-Risk Coordinator will report the number of injuries without an identifiable cause and the action taken to the Quality Council monthly beginning with the time period August 22 to August 31, 2005 and monthly thereafter. The first report to the Quality Council will be September 15, 2005. The administrator or his designee will be responsible for monitoring this plan.	

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F 225	Continued From page 6 residents and review of the facility's "Safety and Quality Committee Report", surveyors identified three injuries of unknown origin. a. A review of the "Safety and Quality Committee Report" was completed during the survey and there was a report, dated 6/5/05, regarding resident 1 which documented the following, "...Aide found abrasion (2) on pts (patients) back when she was getting him ready for bed. He was out last night [with] sister until after 10 p.m. and he doson't [sic] remember when it happened or how..." The "Supervisor's Investigation Report" regarding the bruising documented the following, "...Abrasion on back...Was out [with] sister last night late. Pt (patient) can't remember if he fell or anything..." The report did not document an investigation regarding the abrasions found on resident 1's back on 6/5/05. Review of resident 1's medical record revealed a nursing noted 6/5/05 at 8:15 PM, which documented the following, "When aide was putting pt (patient) to bed she found to [sic] long abrasions on his back almost parralel [sic] to ea (each) other. Pt was out [with] sister last night and did not come back until after midnight. Pt doesn't remember when and how it happened." A nursing note documented the following in resident 1's medical record on 6/7/05 at 6:45 AM, "Two long abrasions red [and] angry on [left] side of back..." On 7/27/05 at 11:05 AM, a facility nurse who cares for resident 1 was interviewed. She stated that resident 1 returned from a leave of absence	F 225		

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F 225	Continued From page 7 with the abrasions. She further stated that she was not working that day but talked with the patient a few days later and he could not recall what had happened. She further stated that she talked to the sister and the sister denies anything had happened to the resident. Facility staff were not able to provide any documented evidence that the abrasions found on resident 1's back on 6/5/05, had been investigated or reported to the State Survey Agency. b. A review of the "Safety and Quality Committee Report" was completed during the survey and there was a report, dated 7/12/05, regarding resident 1 which documented the following, "...CNA (certified nursing assistant) noted bruising while toileting [sic] pt (patient) this evening..." The "Supervisor's Investigation Report" regarding the bruising documented the following, "...[right] buttock (the whole buttock purplish et (and) swollen)...Bruising appears to be less than 24 [hours] old..." The report did not document an investigation regarding the bruising found on resident 1's buttocks on 7/12/05. Review of resident 1's medical record revealed a nursing noted 7/13/05 at 2:15 PM, which documented the following, "Bruising to [right] buttocks unchanged from last evening..." On 7/27/05 at 11:05 AM, a facility nurse who cares for resident 1 was interviewed. She stated that she did not work on 7/12/05 but worked on 7/13/05 the day after the bruising was found. She stated she did not know how the bruising occurred.	F 225		

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F 225	Continued From page 8 Facility staff were not able to provide any documented evidence that the bruising found on resident 1's buttock on 7/12/05, had been investigated or reported to the State Survey Agency. c. A review of the "Safety and Quality Committee Report" was completed during the survey and there was a report, dated 7/21/05, regarding resident 2 which documented the following, "...During bed bath aide called me to see a 10 cm (centimeter) open blister on top of [right] shoulder, resident has no idea how it occurred..." The "Supervisor's Investigation Report" regarding the blister to resident 2's shoulder did not document an investigation regarding the blister found on resident 2's shoulder on 7/21/05. On 7/27/05 at 12:43 PM, the open blister was observed by a nurse surveyor and a facility nurse. The opened blister was covered with a dressing. The dressing was peeled back by the facility nurse and revealed a wound that was 5 cm by 3 cm in diameter. The facility nurse stated to the nurse surveyor that the wound was being cleaned with normal saline and then triple antibiotic ointment was placed on the wound and the wound was covered with a dressing. Resident 2 stated to the nurse surveyor that she believed the blister was caused by the hot packs that the therapist places on her shoulders. On 7/27/05, the aide who found the blister on the shoulder of resident 2 was interviewed. She was asked if anyone had interviewed her about how she found the blister and what might have	F 225		

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F 225	Continued From page 9 happened to resident 2. The aide stated "no". On 7/27/05 at 1:40 PM, the therapist who worked with resident 2 was interviewed. He stated that he worked with resident 2, on 7/21/05, and after he applied the heat packs he massaged her shoulders and did not notice any redness. The therapist then stated 2 days later he saw resident 2 and she told him she got burned and he noted there was a dressing to her shoulder. The therapist was also asked if anyone had come to question him regarding what had happened to resident 2. The therapist stated "no". On 7/27/05 at 1:15 PM, the third floor supervisor was interviewed. She stated that the burn was caused from heat therapy and the therapist rubbing resident 2's shoulders. Facility staff were not able to provide any documented evidence that the 10 cm blister found on resident 2's right shoulder on 7/21/05, had been investigated to confirm a cause or reported to the State Survey Agency. 4. An interview was held with the administrator on 7/27/05 at 11:00 AM. The surveyor asked the administrator if any injuries of unknown origin had been reported and investigated. The administrator stated that he had not sent any reports regarding injuries of unknown origin since the Spring of 2005. He stated he would only send a report in if there was inappropriate care given or abuse. He further stated that they do investigate and determine if abuse has occurred from staff or others towards the residents.	F 225		
F 309 SS=G	483.25 QUALITY OF CARE	F 309		

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F 309	Continued From page 10 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. This REQUIREMENT is not met as evidenced by: 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, mental and psychosocial well being for 1 of 4 sample residents (resident 2). Specifically, resident 2 did not receive prompt assessment and services when she presented with signs of a burn. Findings include: Resident 2 was re-admitted to the facility on 4/15/03, with diagnoses which included rheumatoid arthritis, hypertension, esophageal reflux, constipation, migraines and osteoarthrosis. The medical record of resident 2 was reviewed on 7/27/05. On 7/21/05 at 4:00 PM, a facility nurse documented the following on a "Safety and Quality Committee Report", "...During bed bath aide called me to see a 10 cm (centimeter) open blister on top of [right] shoulder, resident has no idea how it occurred..." Under "Actions" the facility nurse marked the box which stated no action was taken.	F 309	F309 Resident #2 was identified by the surveyor in the report. Assessment of the resident and interview of the resident provided no indication that the resident did not maintain her highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and care plan. The resident's level of functioning was unchanged. There is a potential for any resident to be affected by failure to focus on preventive care. The Resident-at-Risk Coordinator and the DON or designee will review all the Safety and Quality Committee Reports for Documentation of action taken. All injuries will require documentation of action taken to treat any injuries. Failure to record such action by the licensed staff will be recorded by the Resident-at-Risk Coordinator and the licensed staff member will be educated on appropriate policy. The resident-at-Risk Coordinator will report to the Quality Council all reports that did not have the appropriate action taken and documented and the number of staff educated. The Resident-at-Risk Coordinator will maintain a log of all staff educated and dates of the education as well as topic to be reported to the Quality Council. The first report will cover August 22 to August 31, 2005 and will be reported September 15, 2005. The DON or designee has responsibility for implementing and monitoring the plan of correction.	

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

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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
	465095	A. BUILDING _____ B. WING _____	C 08/01/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTUS ST JOSEPH VILLA	461 BISHOP FEDERAL LANE SALT LAKE CITY, UT 84115

(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 309	Continued From page 11 On 7/27/05, resident 2's medical record was reviewed by a nurse surveyor. There was no documentation regarding the 10 cm open blister from 7/21/05 (when the blister was identified) until 7/27/05 (when the surveyor reviewed the medical record). There was no documentation to evidence that physician orders were obtained to provide treatment for the open blister identified on 7/21/05. On 7/27/05 at 12:43 PM, the open blister was observed by a nurse surveyor and a facility nurse. The opened blister was covered with a dressing. The dressing was peeled back by the facility nurse and revealed a wound that was 5 cm by 3 cm in diameter. The facility nurse stated to the nurse surveyor that the wound was being cleaned with normal saline and then triple antibiotic ointment was placed on the wound and the wound was covered with a dressing. Resident 2 stated to the nurse surveyor that she believed the blister was caused by the hot packs that the therapist places on her shoulders. On 7/27/05 at 1:40 PM, the therapist who worked with resident 2 was interviewed. He stated that he worked with resident 2, on 7/21/05, and after he applied the heat packs he massaged her shoulders and did not notice any redness. The therapist then stated 2 days later he saw resident 2 and she told him she got burned and he noted there was a dressing to her shoulder. The July 2005, physician re-certification orders were reviewed by a nurse surveyor. There was no documentation of an order for heat therapy to resident 2's shoulders.	F 309		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTUS ST JOSEPH VILLA	451 BISHOP FEDERAL LANE SALT LAKE CITY, UT 84115

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F 309	Continued From page 12 On 7/27/05 at 1:15 PM, the third floor supervisor was interviewed. She stated that the burn was caused from heat therapy and the therapist rubbing resident 2's shoulders. The third floor coordinator stated that there was no dressing to the opened blister. She further stated that it was left open to the air.	F 309		