POC acceptable as of 4/30/01 SDL RN

DEPARTMENT OF HEALTH AND HU N SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 4/16/01
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465055	A. BUILDING _____ B. WING _____	C 4/9/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEDERAL HEIGHTS REHAB AND NURS	41 S 900 E SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 157 SS=G	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES 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 s483.12(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 s483.15(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 interviews with facility staff and resident C2's physician, it was determined that the facility failed to notify resident C2's physician that the resident fell on 1/17/01, until 2/7/01. When the physician was notified on 2/7/01,an x-ray was ordered that revealed the resident had	F 157	This Plan of Correction is being submitted in accordance with specific regulatory requirement and should not be construed as an admission of guilt or agreement with any of the deficiencies cited on the HCFA 2567-L; 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 proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiencies. F157 NL 4/30/01 SDL **Corrective Action for Identified Resident** Resident C2 no longer resides at Federal Heights. **Identification of Residents Potentially Affected**: Residents that have accidents/incidents that have the potential for requiring physician intervention have the potential to be affected **Measures to Prevent Recurrence** Licensed nursing staff will be in-serviced by 4/27/01 by the Director of Nursing or Designee on the facility policy of notifying a resident's physician of an accident/incident and documenting the notification in the residents medical record. APR 27 04/26/01 KT	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brian Davis | TITLE: Administrator | (X6) DATE: 4/23/01

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 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 fractured her right hip. Findings include: Review of resident C2s clinical record on 4/4/01, revealed a nurses note dated 1/17/01 that documented that the resident had fallen in the hall at 11:00 PM on 1/16/01. The was no documentation that the physician had been informed of the fall until 2/7/01. A nurses note dated 2/7/01, documented that at the residents son's request, the physician was notified that the resident was complaining of pain in the right hip. The physician ordered an x-ray to be done on that date, which revealed that the resident had a fractured right hip. Review of a facility incident report dated 1/16/01, at 11:00 PM, revealed documentation that the physician had not been notified of the fall. During an interview with the facility director of nursing on 4/4/01, she stated, that the physician had not been notified of the fall when it occured. During a telephone interview with resident C2s physician on 4/6/01 at 11:00 AM, she stated that she had not been notified of the fall until 2/7/01, at which time she ordered an x-ray. She also stated that if she had been notified of the fall when it occurred, she would have ordered an x-ray at that time to rule out the possibility of a fracture.	F 157	**Monitoring/Quality Assurance** The Director of Nursing or Designee will develop audit tools by 4/27/01 to audit physician notification of accidents/incidents and the documentation of the notification in the resident's medical record. Audits will be done weekly for 6 weeks beginning 4/27/01. Reports will be given to the Performance Improvement Committee (Quality Assurance) for 2 months starting May 2001 and then continue as directed by the Performance Improvement Committee The Director of Nursing will be responsible for continued compliance. Corrective action will be completed by 4/30/01	
F 224 SS=G	483.13(c)(1)(i) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written	F 224		

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	policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (Use F224 for deficiencies concerning mistreatment, neglect or misappropriation of resident property.) This REQUIREMENT is not met as evidenced by: Based on record review and interview with resident C2s physician and facility staff, it was determined that the facility failed to notify the physician that the resident had fallen on 1/16/01, until 2/7/01. On 2/7/01, at the families insistence, the physician was notified of the fall and that resident C2 had been complaining of right hip pain. The physician ordered an x-ray on that date, which revealed that the resident had a fractured right hip. Due to the failure of the facility to notify the physician at the time of the fall, diagnosis and treatment of the hip fracture was not implemented for 22 days. Finding include: Review of resident C2s clinical record on 4/4/01 revealed a nurses note dated 1/17/01, at 4:00 AM, that documented that resident C2 had fallen at 11:00 PM on 1/16/01, in the hall. The note did not document that the physician was notified. Review of a facility incident report dated 1/16/01 ay 11:00 PM, documented that the physician was not notified. Nurses notes dated 1/22/01, 1/23/01, documented that resident C2 was complaining of hip pain. Review of the physical therapy progress notes dated 1/18/01 through 2/1/01, on 4/4/01, documented," Another fall was reported on morning of 1/18/01, pt.		F224 **Corrective Action for Identified Resident** Resident C2 no longer resides at Federal Heights. **Identification of Residents Potentially Affected**: Residents with accidents/incidents that have the potential for requiring physician intervention have the potential to be affected **Measures to Prevent Recurrence** Licensed nursing staff will be in-serviced by 4/27/01 by the Director of Nursing or Designee on the facility policy of notifying a resident's physician of an accident/incident and documenting the notification in the resident's medical record. **Monitoring/Quality Assurance** The Director of Nursing or Designee will develop audit tools by 4/27/01 to audit physician notification of accidents/incidents and the documentation of the notification in the residents medical record. Audits will be done weekly for 6 weeks beginning 4/27/01. Reports will be given to the Performance Improvement Committee (Quality Assurance) for 2 months starting May 2001 and then continue as directed by the Performance Improvement Committee The Director of Nursing will be responsible for continued compliance. Corrective action will be completed by 4/30/01	

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F 224	Continued From page 3 [patient] falling in hallway early AM. Pt. was able to get out of bed and ambulate the hallway prior to the fall; as reported by nursing notes. Pt. c/o [complains of] (R) [right] LE [lower extremity] pain in thigh and foot... Pt. not willing to work on any activities in weight bearing X [times] 2 weeks....worsening function due to new onset of pain after most recent fall on 1/17/01...Will again 'hold' skilled PT [physical therapy] tx {treatment] sessions until pt's pain subsides or is controlled, allowing greater pt. participation..." A nurses note dated 2/7/01 late entry documented," per son's request and pt c/o R hip- Dr. [doctor] _____ notified and ordered x-ray of R hip and femur to R/O [rule out] Fx [fracture]." A review of the x-ray report dated 2/7/01 revealed that resident C2 had an acute intertrochanteric fracture of the right hip. Resident C2 was transferred to the hospital on 2/7/01, for treatment of the hip fracture. During a telephone interview with resident C2s physician on 4/6/01, at 11:00 AM, she stated that she had not been notified of the fall that occurred on 1/16/01, until 2/7/01. She stated at that time she ordered an x-ray. She also stated that if she had been notified of the fall when it occurred, she would have ordered an x-ray at that time to rule out the possibility of a fracture. She stated she did not know why the facility had neglected to notify her of the fall. She stated that she had reviewed the clinical reord after the resident was discharged. She stated that it was clear from the documentation in the clinical record, especially the physical therapy progress notes, that the resident was experiencing pain and had decreased	F 224		

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F 224	Continued From page 4 in function since the fall on 1/16/01. During an interview with the facility director of nursing (DON) on 4/4/01, she stated that the resident had frequently complained of pain and had "staged" falls in the past. The resident had been x-rayed on previous occasions after falls, which were negative for fractures. When the resident fell on 1/16/01, the staff had indicated to the DON that the resident "appeared to fall on purpose." She stated that because of the history of the resident "staging falls and complaining of pain in the past," the facility did not feel that notification of the fall to the physician was necessary.	F 224		