Utah Dept of Health

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

PRINTED: 1/6/03
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465055	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED C 12/31/02

Jan 21, 2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEDERAL HEIGHTS REHAB AND NURS	**41 SOUTH 900 EAST 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 314 SS=G	483.25(c) 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 medical record review, observation and interviews, it was determined that the facility did not 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 pressure sores from developing. This occurred in 2 of 12 sampled residents. Resident 12 was admitted to the facility with a pressure sore to the left buttocks which the facility did not treat and did not implement preventative measures to prevent further breakdown and the resident developed another pressure sore to the right buttock. Resident 2 developed a pressure ulcer on the right heel which the facility failed to treat. Resident identifiers: 2, 12. Findings include: The closed medical record for resident 2 was reviewed on 12/31/02 and documented the following: Resident 2 was admitted to the facility on 10/25/02 with diagnoses that include open reduction and internal fixation of left hip fracture, profound mental retardation, hemiplegia and osteoporosis. Resident 2	F 314	This plan of correction is prepared and submitted as required by law. Federal Heights by submitting this plan of correction does not admit that the deficiency listed on the CMS-2567L form exists, nor does the facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency. The facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency cited. **Corrective Action for Identified Residents** No specific corrective action for resident # 2 was instituted because resident # 2 was discharged from the facility on 12-4-02. Resident # 12's left hip pressure ulcer was resolved on 1-15-03. Resident # 12's right buttocks pressure ulcer was showing improvement at the time of the resident's discharge from the facility on 1-20-03. **Identification of Residents Potentially Affected** All residents who are admitted to the facility with a pressure wound (s) and those who develop a pressure wound (s) in the facility have the potential to be affected. **Measures to Prevent Recurrence** The Director of Nursing or Designee will in-service the licensed nursing staff by February 28, 2003 on: Inservices have begun and will continue through 2/28/03 + periodically thereafter	1/23/03

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]

TITLE: Administrator

(X6) DATE: 1-21-03

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	F 314		

was discharged from the facility on 12/4/02.

A nurse note, dated 11/26/02 at 11:00 PM, documented "Pt [patient] has been very combative today... there was 3+ pitting edema to the [right] lower extremity . She also has a 5 cm [centimeter] round blister on heel that is filled with fluid. Pt has been wearing soft protective boots all the time. Notified and left message [with] MD about this..."

A nurses note, dated 11/28/02 at 8:30 PM, documented that the blister on the right foot had broken open. The nursing note further documented "Called and notified MD. Wrapped [with] bandage (Kerlix). Will have nsg [nursing] staff [change] w/d [wet to dry] QS [every shift] till resolved as per MD."

A nurses noted dated, 11/29/02 at 3:30 AM, documented "Pt kicked my hands away while trying to do dsg [dressing] [change] to open blister. dsg was dry [without] drainage."

No further documentation could be found in the medical record to show that there had been any more dressing changes done before the resident was discharged on 12/4/02.

Physician orders were reviewed and no orders could be found for treatment of the heel blister.

In an interview with the wound nurse, on 12/31/02 at 1:30 PM, she stated that the heel ulcer had never been reported to her. She stated that the CNAs [certified nursing assistants] do skin checks when they bathe the residents and report any problems to the nurse and that the nurses are supposed to do weekly skin checks on all residents. She further stated that she reviews the wound care book daily for any new orders

1. Braden risk assessments to be done on admit, yearly and quarterly.
2. Care planning and instituting preventive measures on all residents that assess as high risk on the Braden risk assessment.
3. Weekly skin checks to be done and documented by the licensed nurses.
4. Utilizing the 24-hour report at the morning stand up meeting as a communication tool to notify wound nurse and other staff on the presence of pressure ulcers.
5. Timely interventions of the staff nurse upon discovery of a pressure ulcer with documented reports to the physician and the wound nurse.
6. Wound nurse to report the pressure ulcers to the WIND (weight, intake, nutrition and decubitus) Committee and to the registered dietitian.

The Director of Nursing or designated will in-service by February 28, 2003, the certified nursing assistants on observing the residents' skin for breakdown on bath days. Any irregularities are to be reported to the licensed nurses.

Monitoring/Quality Assurance

An audit tool will be developed by the Director of Nursing or designee by January 31, 2003 to audit compliance with:

Utah Dept. of Health
2003
Bur. of Medicare/Medicaid Prog.
Certification and Res. Assessment
Jan 21, 2003

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F 314	Continued From page 2 and that she is the one who stages pressure sores. In an interview with resident 2's admitting physician at the new facility, on 12/30/02 at 9:00 AM, he stated that resident 2 had a dressing on her right heel that was dated 11/28/02 and when the dressing was removed the blister on the right heel was observed to be filled with purlent fluid. 2. Resident 12 was admitted to the facility on 12/23/02 with the diagnoses of right eye blindness, hemorrhoids, anemia, spinal fusions, pneumonia, dehydration, hypertension, diabetes mellitus, left below the knee amputation, neurogenic bladder, hypercholesterolemia, angina and chronic urinary tract infections. An admit skin assessment nurses note, dated 12/23/02 at 9:00 PM, documented, "Skin assessment done pt admit [with] stage II pressure ulcer to [left] buttocks approx 1 cm cirm (circumference) shallow open area. Pt had a Comfeel on site. Will cleanse site [and] reapply new Comfeel on site..." A "Weekly Nurses Note and Skin Assessment" dated 12/25/02, documented, "...Skin Turgor gd (good)..." No further documentation could be found in the medical record concerning the pressure ulcer that was identified on 12/23/02. No further documentation could be found in the medical record to show that there had been any more treatments done to the pressure ulcer. Physician orders were reviewed and no orders could be found for treatment of the pressure ulcer on resident 12's left buttocks.	F 314	• Braden Risk Assessments • Notification of physician of development of pressure ulcer (s) • Care planning and institution of preventative interventions for high risk residents • Weekly documentation of checks by licensed nurses • Timely interventions for residents identified with pressure ulcers The Director of Nursing or Designee will do audits weekly for six weeks with reports to the Performance Improvement Committee (Quality Assurance) at the February and March Committee meetings. Audits and reports will then be done as directed by the Committee. The Director of Nursing will be responsible for continued compliance. Completion date: February 28, 2003	

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F 314	Continued From page 3 The care plan for resident 12, dated 12/30/02, did not address a problem with skin integrity. The facility did not care plan the concern of pressure sores or any type of skin breakdown. The "Braden Scale for Predicting Pressure Sore Risk" assessment was in resident 12's medical record but had not been completed. During an interview on 12/31/02 at 9:10 AM, a facility nurse stated that resident 12 had a foley catheter and a bandage on his left lower extremity. On 12/31/02 at 9:10 AM, resident 12 was observed in his wheelchair at the nurse's station. There were no pressure relieving devices on resident 12's wheelchair. During an interview on 12/31/02 at 9:15 AM, a facility CNA stated that he thought resident 12 had breakdown, he was not able to identify where but stated he could show the surveyor. On 12/31/02, at 9:20 AM, two registered nurse surveyors performed a skin check on resident 12 with the assistance of the facility nurse. The survey nurses observed a pressure ulcer located on the right buttocks. The facility nurse stated it was approximately 1.5 cm and a stage II pressure ulcer. The survey nurse also observed a pressure ulcer located on the left buttocks. The facility nurse stated it was approximately 0.5 cm and a stage II pressure ulcer. The two pressure ulcers observed by the nurse surveyors did not have any protective covering over them. The facility nurse stated she was not aware that resident 12 had any breakdown. During and interview on 12/31/02 at 9:50 AM, the	F 314		

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F 314	Continued From page 4 facility wound nurse stated that she was the one who wrote the admit skin assessment for resident 12 on 12/23/02. She further stated that she did not write an order to treat the pressure ulcer because she more concerned with resident 12's medication orders, which were confusing. The wound nurse stated she was not aware of any other breakdown on resident 12 until today when the facility nurse advised her. She further stated that she would contact the physician today concerning the pressure ulcers. In an interview with the Administrator, on 12/31/02 at 2:00 PM, she stated that she was aware of problems with wound care and had begun implementing changes e.g., hiring a wound specialist consultant, had implemented a new wound tracking form and providing inservice for the nursing staff on the new procedures.	F 314		