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

PRINTED: 05/16/2005
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
	465078	A. BUILDING ______ B. WING ______	C 04/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CARE CENTER	4285 SOUTH HIGHLAND DRIVE SALT LAKE CITY, UT 84124

(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 698 SS=J	This REQUIREMENT is not met as evidenced by: Past Non-Compliance 42 CFR 483.25(l)(1) Quality of Care F - 329 Scope/Severity - J Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for 1 of 9 sampled residents, the facility failed to ensure that a resident did not receive a medication in excessive dose. Specifically, resident 1 received Methotrexate 10 mg (milligrams), everyday between 3/13/05 and 3/17/05. Resident 1 should have only received Methotrexate 10 mg, two times a week, on Fridays and Saturdays. Resident 1's condition deteriorated and she died as a result of the excessive dosage of Methotrexate. The State Survey Agency determined, upon investigation on 4/20/05, that facility staff had implemented corrective measures to ensure residents were free from unnecessary	F 698	Conditions which led to the finding of immediate jeopardy were corrected April 11, 2005, prior to the beginning of the survey Utah Department of Health MAY 26 2005 Bureau of Health Facility Licensing, Certification and Resident Assessment	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: ADM.
(X6) DATE: 5/25/05

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465078	A. BUILDING ______ B. WING ______	C 04/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CARE CENTER	4285 SOUTH HIGHLAND DRIVE SALT LAKE CITY, UT 84124

(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 698	Continued From page 1 medications that lead to the determination of Immediate Jeopardy. The facility removed Immediate Jeopardy on 4/11/05. Findings include: Methotrexate is a medication used in the treatment of certain cancers, psoriasis and rheumatoid arthritis. According to the Nursing 2005 Drug Handbook; Lippincott, Williams, and Wilkins; pages 955 to 958, the following. Nursing considerations for this medication include: "Methotrexate may be dosed daily or once weekly, depending on the disease. To avoid administration errors, be aware of which disease the patient has." "Watch for signs and symptoms of bleeding (especially G.I.) and infection." The following is listed under Patient Teaching: "Advice patient to watch for signs and symptoms of infection (fever, sore throat, fatigue) and bleeding (easy bruising, nose bleeds, bleeding gums, tarry stools)." Side effects for this medication include: stomatitis, thrombocytopenia, and anemia, septicemia, and sudden death. Resident 1 was admitted to the facility, on 3/4/05, with diagnoses that included congestive heart failure, atrial fibrillation, diabetes mellitus, rheumatoid arthritis, and psoriasis. Resident 1 arrived to the facility with physician orders from the discharging hospital. These orders were dated 3/4/05. The orders included, "Methotrexate NA 2.5 mg (milligram) tab (tablets), 10 mg PO (by mouth) FR-SA (Friday and Saturday) @ 0900" Upon admission to the facility on 3/4/05, a facility registered nurse transcribed resident 1's	F 698		

MD

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465078	A. BUILDING ______ B. WING ______	C 04/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CARE CENTER	4285 SOUTH HIGHLAND DRIVE SALT LAKE CITY, UT 84124

(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 698	Continued From page 2 physician orders onto a facility form, "Physician Admission Orders". Rather than transcribing; "Methotrexate NA 2.5 mg (milligram) tab (tablets), 10 mg PO (by mouth) FR-SA (Friday and Saturday) @ 0900", the registered nurse transcribed; "Methotrexate 10 mg p.o. (by mouth) q am (every morning)". Resident 1's admission orders also included an order to transfer the resident's care to the facility's house physician. Resident 1's attending physician (the facility's house physician/Medical Director) signed the transcribed "Physician Admission Orders". There was no date on the Physician Admission Orders to identify when the attending physician signed the orders. The facility "Nursing Admission Assessment", dated 3/4/05, documented that resident 1 had no problems with her mouth or bruising. The only concern identified on the "Body Assessment" was hard skin with a corn on the sole of the resident's right foot. A review of resident 1's comprehensive plan of care revealed that potential side effects or adverse drug reactions were not addressed related to the resident's methotrexate use. Review of resident 1's MAR (medication administration record) for the month of March 2005, revealed the facility nursing staff had documented that Methotrexate 10 mg had been administered to resident 1 every day from 3/5/2005 to 3/17/2005. According to the admitting physician orders, from the discharging hospital, resident 1 should have only received three10 mg doses of the Methotrexate during that time frame: Saturday, 3/5/05; Friday, 3/11/05; and Saturday, 3/12/05. Per documentation on the MAR, resident	F 698		

MD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465078	A. BUILDING ____ B. WING ____	C 04/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CARE CENTER	4285 SOUTH HIGHLAND DRIVE SALT LAKE CITY, UT 84124

(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 698	Continued From page 3	F 698		

Continued From page 3

1 received 10 extra doses of Methotrexate.

A review of physician orders for resident 1 revealed a telephone ordered, dated 3/17/05. The physician ordered resident 1's Methotrexate be held until further notice. The physician also prescribed the following laboratory tests; Protime with International Normalizing Ratio, a serum and urine Uric Acid Levels, a complete blood count, and a complete metabolic profile. Also on 3/17/05, resident 1's attending physician prescribed Acyclovir cream to be applied to the resident's lips five times a day until they were healed. On 3/18/05, a physician's telephone order was received to provide resident 1 Magic Mouthwash, as needed, and Robitussin cough suppressant for coughing and throat discomfort. On 3/20/05, a physician's telephone order was received to transfer the resident to the emergency room.

A review of resident 1's nursing notes revealed the following entries:

a) 3/16/05, 12:00 to 6:30 PM. A facility nurse documented that resident 1's lower lip and right hand were swollen. The nurse documented that resident 1 stated the swelling had been present for three days. The nurse documented that resident 1's attending physician was notified at 6:30 PM, and that the physician prescribed Benedryl 25 mg, every six hours as needed for possible allergic reaction. The nurse documented that she would notifiy resident 1's daughter of the resident's new medication orders and that she would continue to monitor the resident's swelling.

b) 3/17/05 at 8:00 PM. A facility nurse documented that resident 1 was alert and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465078	A. BUILDING ______ B. WING ______	C 04/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CARE CENTER	4285 SOUTH HIGHLAND DRIVE SALT LAKE CITY, UT 84124

(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 698	Continued From page 4 oriented and that she had fallen around 7:00 PM. The nurse documented that resident 1 had been attempting to get up to throw a tissue away and fell onto her right hip. The nurse documented the resident had a large hematoma on her right hip and three small hematomas on her right shoulder. The nurse documented the resident had active range of motion, and had no complaints of pain. c. 3/18/05 at 2:00 PM. A facility nurse documented that resident 1 had a decreased ability to perform in physical therapy and that the resident had fallen the night before. The nurse documented that resident 1's family had been notified. The nurse documented that resident 1 had bruising to her right side. The nurse documented that resident 1's lips continued to be swollen, red, and with open lesions. The nurse documented that she applied Acyclovir cream to the resident lips and received an order for Magic Mouthwash. The nurse documented "Herpes" to the resident's lips. d) 3/19/05 at 11:00 AM. A facility nurse documented that resident 1 continued to have sores on her lips and in her mouth. The nurse documented that the Magic Mouthwash helped to relieve the resident's mouth pain. The nurse further documented that resident continued to have nose bleeds. Note: This was the first nursing note documentation in which resident 1's nose bleed was identified. e) 3/20/05 at 6:45 AM. A facility nurse documented that resident 1 had been experiencing a nose bleed since 6:00 AM. The nurse documented that ice packs and pressure had been applied to the bridge of resident 1's nose without relief. The nurse documented that	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465078	A. BUILDING ____ B. WING ____	C 04/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CARE CENTER	4285 SOUTH HIGHLAND DRIVE SALT LAKE CITY, UT 84124

(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 698	Continued From page 5	F 698		

resident 1 had stated that she had to have her right nares cauterized six months prior. The nurse documented that an ambulance was called. At 7:00 AM, the nurse documented that resident 1 was transferred to an acute care hospital emergency room for treatment of her nose bleed, accompanied by her daughter.

f) 3/20/05 at 12:40 PM. A facility nurse documented that she was notified by the acute care hospital that resident 1 had been admitted to the hospital. The nurse documented that resident 1's attending physician was then notified.

Upon arrival to the acute care hospital, resident 1 was diagnosed as having pancytopenia, and nose bleeds. Resident 1 remained in the acute care hospital, until she passed away on 3/22/05 at 4:30 AM. On 3/20/05 at 1:57 PM, the following interdisciplinary note was documented, ". . . admitted with nosebleed requiring cauterization in the ER (and with) pancytopenia. Incorrectly she has been receiving 10 mg DAILY methotrexate at ECF (extended care facility) since discharge from (name of acute care hospital) on March 4 (pt is prescribed 10 mg on only weekly Fri & Sat for Psoriasis). I spoke with nursing home staff - she has been receiving 10 mg MTX (Methotrexate) QD (everyday) since March 4. MTX stopped on March 17 b/c (because) pt developed oral herpetic lesions and daughter voiced concern regarding MTX daily dosing. . . ."

A review of resident 1's Death Certificate revealed the resident's immediate cause of death was "Bleeding", due to, or a consequence of "Methotrexate Toxicity".

An interview was conducted with the facility's

MQ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465078	A. BUILDING ______ B. WING ______	C 04/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CARE CENTER	4285 SOUTH HIGHLAND DRIVE SALT LAKE CITY, UT 84124

(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 698	Continued From page 6 Administrator, Director of Nursing, Nurse Consultant, Consultant Pharmacist, and Corporate Official on 4/20/05, beginning at 2:20 PM. The following information was provided to the surveyors regarding the facility's investigation of resident 1's Methotrexate medication errors: a) The Consultant pharmacist stated the pharmacy received and filled resident 1's Methotrexate order, as prescribed by the discharging hospital physician; Methotrexate 2.5 mg tablets, 10 mg to be given every Friday and Saturday. He stated the medication was sent to the facility in a bubble pack, containing 16 tablets. He stated that four bubbles contained four 2.5 mg tablets each. The pharmacist stated the amount of Methotrexate sent to the facility on 3/4/05, should have been sufficient to last through 3/18/05. b) The facility Adminstrator provided a copy of the label for Methotrexate, filled on 3/4/05. This label was consistent with the consultant pharmacist's statements. c) The consultant pharmacist stated that on 3/12/05, a facility nurse faxed the pharmacy a refill order sheet for Methotrexate 10 mg, to be given every morning. He stated the pharmacy filled a 15 day supply of the medication as documented on the refill form; Methotrexate 10 mg, every morning. The pharmacist stated the medication was filled without first clarifying if the medication order had been changed from 10 mg every Friday and Saturday to 10 mg every morning. The surveyors asked the consultant pharmacist if the nurses would have been able to administer	F 698		

MA

PRINTED: 05/16/2005
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
	465078	A. BUILDING ______ B. WING ______	C 04/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CARE CENTER	4285 SOUTH HIGHLAND DRIVE SALT LAKE CITY, UT 84124

(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 698	Continued From page 7 the Methotrexate 10 mg, every day from 3/5 through 3/11/05, as was documented on resident 1's Medication Administration Record. The consultant pharmacist stated that the facility nursing staff could not have been administering the Methotrexate every day, between 3/5 and 3/11/05, because the pharmacy had only provided enough medication for four doses. d) The Director of Nursing (DON)stated that three licensed facility nurses had been written up for documenting that they had administered Methotrexate 10 mg to resident 1 when they had not actually given the medication. The DON provided documentation to support that the three licensed nurses had been counselled. e) The consultant pharmacist, DON, Administrator, and Nurse Consultant all agreed that, based on their investigation, resident 1 did receive Methotrexate 10 mg, every morning, between 3/13/05 and 3/17/05. f) The DON stated that resident 1 received the wrong dose of Methotrexate because the registered nurse that admitted the resident to the facility made an error in transcribing the physician orders. g) The Administrator provided a copy of a Medication Error Report, dated 3/17/05. This Medication Error Report included documentation that resident 1 was given Methotrexate 10 mg everyday, and that the, "error was given from 3/5/05 thru 3/17/05". The reason for the medication error was documented as, "Admit orders were transcribed in error."	F 698		