DEPARTMENT OF HEALTH AND HUM SERVICES
HEALTH CARE FINANCING ADMINISTRATION

received 2/28/02 AJ

PRINTED: 2/6/20
FORM APPROVE
2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465109	A. BUILDING _____ B. WING _____	1/31/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLADAY HEALTHCARE CENTER	4782 SOUTH HOLLADAY BOULEVARD SALT LAKE CITY, UT 84117

(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 interview with the DON (director of nursing service) it was determined that the facility did not prevent 1 of 3 supplemental and 15 sample residents from developing a pressure sore that was clinically avoidable. Resident identifiers: 1 Findings include: Resident 1 was admitted to the facility on 11/11/01 with diagnoses that included diabetes, open reduction and internal fixation of left hip fracture, Alzheimer's disease with dementia and osteoporosis. Review of resident 1's Admission Nursing Assessment form, dated 11/11/01, documented that resident 1's skin was warm, dry and the hip incision was intact without redness or drainage, and except for bruises on her arms and hands bilaterally and a scrape on her right elbow, there was no mention of any other problems with the resident's skin. Under the Functional Status section of the assessment, it was documented that the resident's mobility was impaired, requiring 2 person assist with transfers and that physical therapy was to assist with ambulation.	F 314	This Plan of Correction is prepared and submitted as required by law. Holladay Healthcare Center by submitting this plan of Correction does not admit that the deficiency listed on the HCFA-2567L exist, 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. F 314 G **CORRECTIVE ACTION FOR IDENTIFIED RESIDENT** Once the left heel ulcer was identified, Resident #1 continued on the Therarest, pressure reducing, mattress. A heel protector bootie was applied to her right foot and a theraboot was applied to her left foot to keep pressure off of the left heel. The ulcer was cleansed with normal saline. Collagenase with polysporin powder was applied, followed with a telfa dressing two times a day. Later the treatment was changed to: Bacitracin ointment applied to the healthy tissue around the left heel ulcer and betadine was applied to the eschar. Followed by non-adherant dressing with kerlex daily.	

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Utah Dept. of Health

MAR - 5 2002

Bur. of Medicare/Medicaid Prog.
Certification and Res. Assessment

12/27/02 HM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Dianne F. Allen 2.27.02 Adm

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 aft 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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Review of the admission Minimum Data Set (MDS) assessment, dated 11/21/01, documented that resident 1 required extensive assistance of 2 staff for transfers and ambulation. Under (section M.) skin condition, it was documented that resident 1 had no pressure sores. For foot problems and care, the MDS documented that the resident did not receive preventative or protective foot care.

Review of resident 1's nursing note, dated 12/4/01 at 4:00 AM, documented "Pt [patient] has necrotic area L [left] heel-unstageable [with] yellow drainage. Heel protectors placed on pt." Review of Pressure Sore Record, filled out by the wound nurse, dated 12/4/01, documented that the heel ulcer measured 5 x 3.5 cm [centimeters]. The nurse's note, dated 12/4/01, was the first documentation that resident 1 had acquired a heel ulcer. The ulcer presented with eschar before it was identified by the facility.

Resident 1's care plan for skin integrity at risk, dated 11/11/01 indicated the staff was to use a pressure relieving mattress and to reposition the resident every 2 hours. No mention was made to implement preventive measures such as heel booties or keeping the resident's heels from resting on the bed.

Review of pressure sore risk assessment, done 11/11/01, documented that resident 1 was at risk for the development of a pressure sore, there was no plan to provide additional preventative measures. A resident who is recovering from hip surgery is at risk for heel ulcers, especially on the affected side.

In an interview with the DON, on 1/30/02 at 1:30 PM, regarding resident 1's heel ulcer she stated that the resident was "non-compliant and due to her Alzheimer's and dementia she was a difficult patient to care for."

Dietary interventions included: NCS. pureed, enriched high calorie, high protein , and snacks three times per day .Resident #1 was being seen by physical therapy for ambulation therapy. She was also being followed by the WIND (wound, intake, nutrition and decubitus) Committee, which included input from the Registered Dietitian. The wound nurse was following her with weekly assessments. The ulcer was showing good progress when she discharged on 2-3-02.

IDENTIFICATION OF RESIDENTS POTENTIALLY AFFECTED

All residents with limited mobility and history of DVT, diabetes,PVD history of pressure ulcers, nutritional deficiet have the potential to be affected.

MEASURES TO PREVENT RECURRENCE

The Director of Nursing or Designee will inservice the licensed nursing staff by March 26, 2002 on:

1. Braden or Norton risk assessments being done on admit, yearly and quarterly by licensed nursing.
2. Care planning and instituting preventive measures consisting of therarest mattress, geomatts,egg crates, heel protectors special overlays and beds as need and special positioning equipment as needed on all residents that assess as high risk on the Braden or Norton risk assessment.

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Review of resident 1's MDS assessments, dated 11/21/01, 12/6/01 and 1/7/02 (section E, 4a-e) Behavioral Symptoms, did not document any behavioral concerns. Review of resident 1's nursing assistants flow sheet records for November 2001, December 2001 and January 2002, revealed there was no documentation to show that resident 1 had refused any interventions. Review of nursing notes dated 11/11/01 through 1/6/02, no documentation could be found to indicate that resident 1 refused care or was uncooperative.

Resident 1 was observed, on 1/29/02 at 1:40 PM, during a dressing change to the L heel. The resident was cooperative and did not resist care.

3. Skin assessments will be done and documented on as follows: on admission, re-admission, weekly by 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 (wiithin shift discovered) of a pressure ulcer with reports to the physician and the wound nurse.
6. ADON to review body assessment sheets everyday and to be notified with new pressure areas by licensed nurse within 24 hours week days and 48 hours on the weekend.
7. Wound nurse to report to the WIND (weight, intake, nutrition and decubitus) Committee weekly and to the registered dietitian.

The Director of nursing will inservice by March 26, 2002 the certified nursing assistants on observing the residents skin for breakdown on bath days. Any irregularities are to be reported to the licensed nurses.

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MONITORING/QUALITY ASSURANCE

An audit tool will be developed by the Director of Nursing or designee by March 8, 2002 to audit compliance with Braden/Norton Risk Assessments; care planning and institution of preventative interventions for high risk residents; weekly documentation of skin checks by the licensed nurses; and timely (within 24 hrs weekdays and 48 hours on weekend) 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 at the March and April 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: April 1, 2002