DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 4/19/01
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	C 4/17/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VALLEY HEALTH CENTER	3706 W 9000 S WEST JORDAN, UT 84088

POC accepted 5/21/01 ESTL

(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=D	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES	F 157		

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 interview with the resident's family, review of the resident's medical record, review of the incident report, and review of the facility's policy regarding accidents, it was determined that the facility did not notify the resident's family when there was an accident involoving the resident, which required

St Estl

see next page

See also addendum page to plan of correction dated 5/22/01.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rachelle Johnson
TITLE: Administrator
(X6) DATE: 5/10/01

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 informatio 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 physician intervention, and resulted in a significant change in resident's physical status and failed to alter treatment. Specifically, the facility did not notify the daughter of one resident when her mother was involved in an accident in the facility van which resulted in facial lacerations and a right distal femoral fracture. Also, the facility did not notify the resident's daughter when, after the van accident, the resident developed two pressure sores in two weeks. Resident identifier: 1. Findings include: 1. Resident 1 was an 83 year old female who was re-admitted to the facility on 9/30/00. On 2/12/01 at approximately 11:40 AM, resident 1 was riding in the facility van when the van driver "had to slam on brakes" to avoid a car accident. The incident report, dated 2/12/01, documents that resident 1 "fell forward striking her head and knee." The incident report also documented that resident 1 sustained lacerations to her face and a hematoma and swelling to her right knee. The 2/12/01 incident report for resident 1 and the medical record for resident 1 were reviewed on 4/17/01. After review of the incident report and review of the medical record for resident 1, there was no documentaion to evidence that the facility notified the family of resident 1 of this accident or the injuries sustained related to the accident. During interview with the resident 1's daughter on 4/18/01 at 9:45 AM, she was asked if the facility had notified her of the accident which occured on 2/12/01 or of the injuries sustained by her mother related to	F 157	1. Resident 1 as identified in the findings is no longer at our facility. 2. All residents injuries/change of conditions will be reviewed. 3. An inservice was done on with all nursing staff regarding the policy on informing family members of change of condition and injuries. The administrator will review all incident reports and check for family notifications. 4. Incident reports and family notifications will be reviewed quarterly in QA. An initial evaluation will be discussed in department head meeting on 5-14-01. It will be reviewed in QA on 6-14-01.	

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F 157	Continued From page 2 the accident. The daughter stated, "They did not call me. I found out when I went in on Friday the 16th (February 2001) and saw my mother." Within the two weeks following the 2/12/01 accident, resident 1 developed two pressure sores. The "Weekly Skin Assessment Form" filled out by a facility nurse on 2/26/01, documented two pressure sores. The first pressure sore was described as "4 cm (centimeter) soft L (left) heel - black". The second pressure sore was described as " 3 X (by) 2 cm stg (stage) II blister". During the same interview with the daughter of resident 1 on 4/18/01, she was asked if the facility had notified her of the pressure sores found on her mother. The daughter stated, "No." The facility's policy entitled "RESIDENT INCIDENT REPORTS" was reviewed on 4/17/01. The policy required that "THE PHYSICIAN AND THE RESIDENT'S FAMILY MUST BE NOTIFIED ON ALL INCIDENTS THAT OCCUR WITH THE RESIDENT--ESPECIALLY ONE WITH EVIDENCE OF INJURY. NO EXCEPTIONS!! DOCUMENTATION MUST BE PRESENT IN THE RESIDENT'S RECORD TO SUBSTANTIATE THE NOTIFICATIONS OF BOTH."	F 157		
F 324 SS=G	483.25(h)(2) QUALITY OF CARE The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 324		

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F 324	Continued From page 3 Based on interviews with facility staff, review of resident medical records, review of facility incident reports, and review of the facility's van use protocol, it was determined that the facility did not ensure that a resident received an assistance device to prevent an accident. Specifically, one resident received injuries when the facility van came to an abrupt stop to avoid a car accident. The facility staff had not restrained the resident in a seat belt. Resident identifier: 1. Findings include: 1. Resident 1 was an 83 year old female who was re-admitted to the facility on 9/30/00. Review of a facility incident report revealed that on 2/12/01 at approximately 11:40 AM, resident 1 was riding in the facility van when the van driver "had to slam on brakes" to avoid a car accident. The incident report documented that resident 1 "fell forward striking her head and knee." Further documentation on the incident report of 2/12/01 reveals that resident 1 sustained facial lacerations and a hematoma and swelling of the right knee. Resident 1 was assessed by the nurse practitioner on 2/12/01. The progress note written by the nurse practitioner on 2/12/01 documented, "Asked to assess pt (patient) acutely by nsg (nursing) who report pt (patient) fell out of her w/c (wheelchair)." The nurse practitioner's progress note includes a statement from resident 1 which read, "My knee R (right) hurts so bad, I think its broken." An x-ray of the resident's right leg was obtained two weeks later on 2/26/01. The x-ray results showed a "PROBABLE RIGHT DISTAL FEMORAL FRACTURE."	F 324	1. Resident 1 as identified in the findings is no longer at our facility. 2. All residents being transported in facility van will be subject to protocol. 3. An inservice was done on showing the proper way a resident is restrained in the van. The van driver will be responsible to ensure that each passenger is securely restrained before the van is in operation. The medical records director will randomly check for compliance. 4. Compliance, ban safety, and inservice needs will be addressed each quarter in QA. This issue will be reviewed initially in department head meeting on 5-14-01. It will be reviewed in QA on 6-14-01.	

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P 324	Continued From page 4	F 324		

Both staff (van driver and recreational therapist) who were with resident 1 during the van incident on 2/12/01 were interviewed.

During interview with the van driver on 4/17/01 at 10:25 AM, he stated that resident 1 had not been wearing a seatbelt on 2/12/01. He stated that the recreational therapist had strapped the wheelchair in place, but had not restrained the resident with a seatbelt. He further stated that he "should have double checked to see that she had been belted in, but I didn't."

During interview with the recreational therapist on 4/17/01 at 1:04 PM, she stated that she couldn't remember who strapped resident 1 into the van. She stated that she assumed that the van driver would check to make sure everyone was belted in. She stated that she thought the van driver had strapped resident 1 and that he had probably thought she had done it.

The facility's "VAN USE PROTOCOL WHEN TRANSPORTING PATIENTS" was reviewed on 4/17/01. Item 3 documents, "Seat belts must be worn by the van driver and the resident at all times while the van is in motion."

Facility staff did not provide a seatbelt for resident 1 while riding in the facility van on 2/12/01. When the van came to an abrupt stop, resident 1 fell from her wheelchair hitting her face and knee. Resident 1 sustained injuries related to her fall from the wheelchair during the van ride. The facility did not ensure that resident 1 received an assistance device, namely a seatbelt, to prevent an accident. The facility did not follow their own protocol regarding the use of

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F 324	Continued From page 5 seatbelts when transporting residents.	F 324		

May 22, 2001

Please include the following with my plan of correction in behalf of South Valley Health Center.

Regarding F - 157

1. Completion date to be June 14, 2001
2. The mentioned inservice was held on April 25, 2001.
3. Administrator will review incident reports as they are reported and submitted. This could be as often as daily if incidents occur daily.
4. If the Administrator finds that a family member or guardian has not been notified, a call will be made immediately by the Administrator. Corrective action will immediately be taken with the staff member.
5. Incident Reports/family notification policy is attached.

Regarding F - 324

1. Completion date to be June 14, 2001.
2. The mentioned inservice was held on March 22, 2001. This date was prior to the survey date of April 17, 2001 because the deficiency was previously discovered by the facility and ombudsman.
3. The Medical Records Director will be checking for correct positioning of wheelchair, appropriate straps used correctly to fit wheelchair and resident, and all necessary documentation that is to be left in vehicle at all times. Checks will be performed randomly, but at least 3 times per week.

(Rachelle Johnson)

Changes made with verbal permission of Administrator via telephone conversation on 5/21/01 @ 4:54 PM.