11/14/02
JS

South Valley Health Center

November 6, 2002

Plan of Correction F-314

This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.

The following measures were taken on behalf of resident 1.

- The facilities contracted Podiatrist (hereafter referred to as "Doctor 1") was contacted on August 14, 2002 by staff to see Resident 1.
- Doctor 1 consulted on Resident 1, August 14, and ordered: heel protectors for both feet, keep heals off footrest at end of bed, remove foot of bed if necessary.
- On August 30, a CNA reported to the nurse an open wound on the left heal. The nurse contacted the facilities Medical Director and obtained orders to apply Multidex powder and telfa island bid until healed. The treatment was transcribed to the resident's treatment pages.
- On September 7, 2002, a Weekly Skin Assessment form was generated.
- On September 16, Doctor 1 consulted and ordered more extensive daily dressing application and wound cultures. Cultures were obtained.
- On September 17, a detailed Weekly Skin Assessment form was completed. Wound care measures were transcribed to treatment pages. Dietary supplement 120 ml. for increased protein intake was added to Resident 1's MAR.
- On September 17, cultures returned + for MRSA.
- On September 18, Vancomycin IV was started.
- On September 25, a Weekly Skin Assessment form was completed noting granulation was occurring. Dressing changes continued and OMCI suspension boots were in use.
- On October 9, 2002, a dietary consultation was completed.
- On October 15, dietary recommendations were implemented.
    - Juice tid with protein fortification
    - MVI, Zinc, vitamin C, and iron
    - Dietary supplement was increased
    - High protein milk tid
    - Arginaid powder bid
- On October 15 a Weekly Skin Assessment form was completed.
- On October 30, Resident 1 passed away.

* * * * * * * * * * * * *

It is the policy of South Valley Health Center to provide residents with appropriate care to prevent, and when necessary, provide treatment for pressure sores. The following Nursing Policies and Procedures (measures) are implemented as part of a comprehensive skin care program at South Valley Health Center. The program has three directed initiatives. First, a program of prevention that includes routine nursing activities to prevent skin breakdown and assessment of high risk factors upon resident admission. Second, a program of regular skin assessment and intervention. And third, the initiation of treatment should skin breakdown occur.

Prevention

Routine nursing measures include but are not limited to:

- Bathing residents three times a week or more often as necessary.
- Application of lotion, powder, or other skin barriers as indicated.
- Regular checking and change of briefs when soiled or wet.
- Use of protective padding and repositioning.
- Dietary review and intervention to maintain nutrition and hydration.

Assessment and Intervention

Licensed nursing staff generate skin assessments each week during resident bathing. The assessments are scheduled in every residents treatment plan. New admission standard orders generated by computer all include this assessment in the first order location of the residents treatment plan. The nurse fills out a Weekly Skin Assessment form and forwards it to the Director of Nurses. Once a week the Director of Nurses compiles a Weekly Skin Check Report. The reports are faxed to the Registered Dietitian for review prior to weekly Nutrition at Risk meetings. NAR meetings are held to review dietary needs and recommendations. During this meeting the dietary needs of all residents at risk are addressed. The recommendations are implemented by nursing staff and the dietary manager within three working days of receipt. Weekly monitoring of the progress and resolution of pressure sores are continued until healed.

Treatment

Treatment of a pressure sore is initiated immediately upon discovery by nursing staff. A Weekly Skin Assessment form is completed and submitted that day to the Director of Nurses. Treatment of the pressure sore is dependent on its stage of development and clinical presentation. South Valley Health Center policy is to contact the house medical officer for treatment instructions and orders. Treatment orders are transcribed into the residents treatment plan and are implemented immediately. Usual orders include a dressing application to be changed once or twice daily, and measures employed to off-load the wound area. Monitoring includes initiation of a Photographic Wound Documentation record. A new photograph is taken at weekly intervals to track healing progress, or lack thereof. In addition, a more extensive evaluation tool, the Weekly Pressure Ulcer Healing Assessment, is also used to document wound condition and progress. Both of these forms are kept in the resident's treatment plan until the wound is healed.

To further enhance current compliant care and treatment, all nursing staff are required to attend an in-service covering wound care, wound detection and monitoring scheduled December 4, 2002. Doctor 1 and the Director of Nurses will present the in-service. Quality Assurance meetings are held each quarter and track the incidence and prevalence of pressure sores stages I – IV.

The administrator will attend the weekly NAR meeting and assure successful implementation of the complete plan of correction.

All measures are in place on or before December 11, 2002.

Trent Bangerter
Administrator

PLAINT

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PRINTED: 10/22/02
FORM APPROVED
2567-L

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
	465108	A. BUILDING _____ B. WING _____	C 10/15/02

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SOUTH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

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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 observations, interviews and record review, it was determined that the facility failed to provide the necessary services to resident 1 to prevent her from developing pressure sores. Additionally, when resident 1 developed multiple pressure sores the facility failed to: promptly assess the sores; to develop and consistently implement nursing interventions; to promptly assess the resident's nutritional needs and then implement nutritional recommendations. Findings include: Resident 1 was admitted to the facility on 4/3/98, with diagnoses including Alzheimer's disease, osteoarthritis, hypertension, congestive heart failure, and degenerative joint disease. On 10/15/02 at 2:00 PM, an observation of resident 1's skin condition was made. The observation was made as the registered nurse completed dressing changes to the resident's pressure sores. Resident 1 skin breakdown was observed as follows: a. Right foot (i) outer ankle - The resident had an open wound. The facility nurse estimated the wound dimensions as 1" x 1.5" and to be a stage IV pressure sore. The wound had a whitish yellow center and	F 314		

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

Trust Counselor — 11-7-02

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.

See attached plan of correction

CMS-2567L ATG112000 Event ID: DYEW11 Facility ID: UT0080 If continuation sheet 1 of 14

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erythema to the surrounding tissue.

(ii) lateral foot - The resident had an open wound. The facility nurse estimated the wound dimensions as .25" x .25" and to be a stage IV pressure sore.

(Note: Resident 1 also had a skin tear on the top of her foot that was 1" x 1.5".)

b. Left foot

(i) heel - The resident's heel was covered with black eschar. The facility nurse estimated the black eschar to be 3" x 2", and that the wound was a stage IV pressure sore.

(ii) inner ankle - The resident had three wounds around her outer ankle. The facility nurse estimated these wounds to be 1/2" x 1/2" at a stage III, 1/2" x 1/4" at a stage II to III, and 1/8" x 1/8" at a stage II.

(iii) top of foot - The resident had an open wound on the top of her foot. The facility nurse estimated the wound to be 1/8" x 1/8" at a stage III.

(iv) outer foot - The resident had a blister on the outer portion of her left foot. The facility nurse estimated the blister to be .75" x .5".

c. Right buttock - The resident had a wound on her right buttock. The facility nurse stated this wound was a stage II pressure sore. There was no dressing to this pressure sore.

A review of resident 1's medical record was completed on 10/15/02. Facility staff completed an Annual Minimum Data Set (MDS) assessment for resident 1 on 1/3/02, Quartley MDS assessments on 4/2/02 and 6/21/02, and a Significant Change MDS assessment on 9/24/02.

On 1/2/02, facility staff assessed that resident 1 required supervision for bed mobility. On 4/2/02 and 6/21/02, facility staff assessed that resident 1 required

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limited assistance for bed mobility. On 9/24/02, facility staff assessed that resident 1 required extensive assistance for bed mobility. Also on 9/24/02, facility staff assessed that resident 1 had experienced a deterioration in her ability to perform activities of daily living.

On 1/3/02, 4/2/02, and 6/21/02, facility staff documented that resident 1 had no pressure sores. On 9/24/02, facility staff documented that resident 1 had three stage III pressure sores.

On 1/3/02, facility staff documented the following skin treatments for resident 1: Application of ointments/medications (other than to feet); and, other preventative/protective skin care (other than to feet). On 4/2/02, facility staff documented the following skin treatments for resident 1: Application of ointments/medications (other than to feet); other preventative/protective skin care (other than to feet); and added nutrition/hydration intervention to manage skin problems. On 6/21/02, facility staff documented no preventative skin treatments for resident 1. On 9/24/02, facility staff documented the following skin treatments: Turning/repositioning program; nutrition or hydration intervention to manage skin problems; ulcer care; application of dressings (with or without topical medications) other than to feet; and, application of ointments/medications (other than to feet). On 9/24/02, facility staff also assessed that resident 1 had the following foot problems: Resident has one or more foot problems; infection of the foot; open lesions on the foot; received preventative or protective foot care; and, applications of dressings (with or without topical medications).

A review of resident 1's care plan was completed on 10/15/02. On 9/25/02 with updating on 10/2/02, facility staff identified a problem of actual and/or potential for skin breakdown related to incontinence of bowel and bladder, decreased mobility, and multiple pressure sores. The goals for this identified

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problem were that resident 1 would have no further breakdown for the next 90 days, and that the resident's pressure sores would show healing in the next 90 days. Facility staff documented the following interventions for resident 1: Turn and repostion every two hours; provide supplements as orderd; provide treatments as ordered; pressure relief mattress and cushion in chair; medications as ordered; and, diet as ordered.

A review of podiatry progress notes for resident 1 was completed on 10/15/02. On 8/14/02, a podiatry note included documentation that resident 1 had pre-ulcerative areas on her heels, with the left being greater than the right. The podiatrist documented the area was positive for erythema, or redness and that there were no open lesions noted. The podiatrist documented that he wrote an order to get resident 1 a heel cushion to both heels and to keep the resident's heels off the foot rest. The podiatrist also documented that the resident's foot board if necessary.

The next podiatry progress note for resident 1 was dated 9/16/02. The podiatrist documented that resident 1's left medial heel ulcer measured 8 x 6.5 x 0.3 centimeters (cm). The podiatrist documented that resident 1's left posterior heel ulcer measured 3 cm in diameter and that it was positive for cellulitis, with macerated margins and thick sloughing skin. The podiatrist documented this pressure sore had heavy serous drainage. The podiatrist documented the pressure sore on resident 1's left posterior heel was stage III. The podiatrist documented that strict off loading was needed for the resident's posterior left foot. The podiatrist documented that resident 1 was to be provided with a heel suspension boot.

The next podiatry progress note for resident 1 was dated 9/30/02. The podiatrist documented that resident 1's left heel pressure sores were 5 x 2 cm at stage II, and 8 x 5 cm at stage III. The podiatrist documented that resident 1 also had a stage III

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pressure sore to her right lateral ankle, which measured 2 cm in diameter, a pressure sore to the resident's 5th right styloid process, which measured 1cm in diameter. The podiatrist documented the right lateral ankle had eschar present. The podiatrist documented he debrided each of the pressure sores. The podiatrist documented that staff were to continue off loading both feet off the bed and to put heel suspension boots on resident 1 when they arrive from the supplier.

The next podiatry progress note was dated 10/9/02. The podiatrist documented that resident 1's left medial heel pressure sore was 3 x 1 x 0.2 cm with eschar 6 x 0.3 cm. The podiatrist documented an worsening of the dorsal left foot pressure sores. The podiatrist directed staff to keep the resident in heel suspension boots.

The next podiatry progress note was dated 10/14/02. The podiatrist documented that resident 1 had a new stage II pressure sore to her dorsal right foot due to her left boot. The podiatrist documented that the pressure sores to both of resident 1's feet were improving. The podiatrist directed staff to keep resident 1's boot on at all times and that the supplier was still working on the right foot boot.

A review of physician progress notes for resident 1 was completed on 10/15/02. On 9/12/02, resident 1's attending physician completed a 60 day examination of the resident. The attending physician documented that resident 1's skin was without breakdown, having no pressure sores.

A review of nursing notes for resident 1, between 8/3/02 and 10/15/02, was completed on 10/15/02. Nursing staff made the following entries regarding resident 1's pressure sores: (Note: Between 8/14/02, when a podiatrist documented pre-ulcerative areas on the resident's heels, and 8/30/02, there were no

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nursing note entries to document the resident's skin condition or protective and preventative measures implemented.)

a. 8/30/02 - A nurse documented receiving a report from a nurse aide that resident 1 had an open area on the back of her left heel. The nurse documented the pressure sore was a stage II and 3 x 5 cm. At that time, the nurse documented that the resident's attending physician was notified and an order for Multidex powder with a Telfa island dressing was to be applied two times a day until the pressure sore healed.

b. 9/14/02 - A nurse documented, during resident 1's shower, a blister on the bottom of the resident's left foot ruptured. The nurse documented the blister was 4 cm in diameter and that a culture was obtained from the drainage per physician orders. The nurse documented that physician orders were obtained for debridement of the blister by the Director of Nursing (DON) and Assistant Director of Nursing (ADON). The nurse also documented that the physician ordered an Absorb dressing to the blister area, to be done daily and as needed. The physician ordered a wet to dry dressing to the resident's left heel, to be done daily and as needed. The nurse documented the resident was started on Levaquin 500 mg daily for 10 days.

c. 9/15/02 - A nurse documented that resident 1's blister was draining and that redness was noted.

d. 9/16/02 - A nurse documented that resident 1's left heel dressing was changed and a large amount of yellow, foul smelling drainage was noted. Nursing staff documented the left heel pressure sore was stage II. The nurse documented that a blue heel protector was placed on the resident. The nurse documented that resident 1's left heel was debrided by the DON and that the resident's attending physician was called and that a referral to a podiatrist was made. The nurse documented the following orders from the podiatrist: Retake cultures in AM and send for culture and sensitivity; Alginate with a dry sterile dressing to

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large pressure sore; Accuzyme treatment to the left posterior heel pressure sore everyday, do Alginate dressing two times a day if necessary; x-ray three view of left foot; keep left heel off bed with pillows, use pads to off load; and, take foot rest off of bed. (Note: 9/16/02 was the first nursing note entry to document the use of a heel protector, 33 days after the resident was noted to have pre-ulcerative areas on her heels, on 8/14/02.)

e. 9/18/02 - A nurse documented that the podiatrist ordered Vancomycin to be administered to resident 1 based on the left heel wound culture results.

f. 9/20/02 - A nurse documented, ". . . right heel healing - mod [moderate] amount of serous drainage - small amt [amount] of odor when wound is open. . ."

g. 9/21/02 - A nurse documented, ". . .right heel dressing changed. . ."

h. 9/22/02 - A nurse documented that resident 1's left foot dressing change was done and that drainage and that a small amount of foul odor was noted. The nurse also documented that both of resident 1's heels were floated, and that a foot protector was on the resident's left foot.

i. 9/23/02 - A nurse documented that the podiatrist was in to debride resident 1's left foot pressure sores and to apply a dressing.

j. 9/24/02 - A nurse documented that the dressing to resident 1's left foot was increased to two times a day.

k. 9/25/02 - A nurse documented that there was a small amount of sero-sanguineous drainage and necrotic/eschar present over most of resident 1's left heel.

l. 9/26/02 - A nurse documented that both of resident 1's feet were off loaded.

m. 9/27/02 - A nurse documented, ". . . removed dressing from L [left] foot wound. Wound appears less red, note: cellulitis appears much improved, wound is weeping much less. Areas of the wound edge appearing to be granulating. An eschar dark

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black over heal [sic] [about] 1/2 dollar in size present. . . . R [right] foot has 2 stage 2 pressure wounds. They were washed [and] duoderm applied. Heal [sic] protectors are ordered for both feet."

n. 9/28/02 - A nurse documented that resident 1 had eschar on her left heel and that the old blister site on the same foot was red with a small amount of bloody drainage. The nurse documented that isolation "MRSA" (Methicillin Resistant Staphylococcus Aureus) precautions were in place.

o. 9/29/02 - A nurse documented that resident 1's feet and heels were in protective boots and floated off of the bed. The nurse documented that the resident's left heel had black eschar on it and that the resident's right ankle had open areas with a small amount of drainage. The nurse documented that the resident's right ankle pressure sores were new as compared to the previous week.

p. 10/1/02 - A nurse documented that resident 1 went to a vascular surgeon on that date and that the surgeon indicated resident 1 had end stage peripheral vascular disease and gangrene to her left foot. The nurse documented the following options given by the vascular surgeon: pain control and no surgery; or, left leg above the knee amputation. The nurse documented that the vascular surgeon recommended pain control and no surgery.

q. 10/2/02 - A nurse documented resident 1 had a Methicillin Resistant Staphylococcus Aureus (MRSA) infection of her left heel wounds. The nurse also documented that the resident's pressure sores had serous drainage.

r. 10/6/02 - A nurse documented that resident 1's left heel has black eschar present, and the right ankle has some drainage. The nurse documented that resident 1's heels were floated and that protective boot was on the resident's left foot.

s. 10/12/02 - A nurse documented that resident 1's left foot had a few weepy areas remaining.

t. 10/13/02 - A nurse documented that resident

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1's left foot wounds had sanguineous drainage on the top and medial sides and that there was eschar over the heel. The nurse documented the wound was malodorous.

u. 10/14/02 - A nurse documented that the podiatrist debrided resident 1's left heel pressure sore.

A review physician orders, between 8/14/02 and 10/14/02, was completed on 10/15/02. Physician orders, related to resident 1's pressure sores were as follows:

a. 8/14/02 - Heel cushions to both heels. Keep heels off foot rest at the end of bed, remove foot rest if necessary.

b. 8/30/02 - Apply Multidex powder and Telfa island dressing to stage II pressure sore on left heel. Change two times a day.

c. 9/14/02 - 1) Levaquin 500 mg daily after a culture and sensitivity of left foot blister fluid was obtained. 2) Debridement to blister area left foot, per DON or ADON. 3) Absorb dressing to blister area for three days, then non-sticking dressing, change daily and as needed. 4) Wet to dry dressing to left heel as needed.

d. 9/16/02 - Clean left heel wound with simple soap, pat dry. Apply Multidex powder cover with 4 x 4 pads and wrap. The dressing was to be changed two times a day. Blue foot protector on at all times. Elevate foot in bed.

e. 9/16/02 - 1) Retake cultures in AM tomorrow and send for culture and sensitivity. 2) Alginate dressing to large ulcer and cover with a dry sterile dressing, up to two times a day if necessary. Accuzyme to posterior heel ulcer everyday. 3) X-Ray of left foot. 4) Keep left heel off bed with pillows, use pads to off load. 5) Take foot rest off of bed.

f. 9/17/02 - Please add 120 milliliters (ml) of Novasource 2.0 two times a day with medication pass for increased protein.

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F 314	Continued From page 9 g. 9/24/02 - 1) Call for vascular consult. 2) Increase dressing changes to left foot to two times a day using prior order technique. 3) Trental 400 mg three times a day. h. 9/25/02 - Telfa island to right heel open area daily until healed or use duoderm. i. Undated - 1) Heel protector to right foot, keep up off bed. 2) Apply Actizyme to eschar on left foot, then wet to dry to remainder, cover with an gauze pad and wrap. j. Undated - Apply Accuzyme, cover with a Telfa island, and wrap with Cling to right foot pressure sores daily. k. 10/3/02 - Apply Nutrafil to granulated tissue and apply Accuzyme to areas of eschar on right foot daily. May use Dermagran instead of Nutrafil. l. 10/11/02 - Culture wound on left heel. m. 10/14/02 - 1) Dermagran to dorsal and medial left foot ulcers. Accuzyme or gladase to eschar on posterior left heel ulcer. 2) Dermagran covered with a dry sterile dressing to all ulcers on the right foot. 3) Keep heel boot on foot at all times. Cover exposed bolt with moleskin. A review of treatment records for resident 1, between 8/02 and 10/14/02, was completed on 10/15/02. Facility staff document resident 1's pressure sore dressing changes on the treatment records. Per documentation, facility staff did not complete a dressing change to resident 1's pressure sores as follows: a. August 2002 - Multidex powder and cover with Telfa to left heel two times a day. One dressing change missed on 8/30/02. b. September 2002 (i) Multidex powder and cover with Telfa to left heel two times a day. Missed sixteen times between 9/1/02 and 9/14/02; 9/1, 9/2, 9/3, 9/4, 9/5, 9/6, 9/7, 9/8, 9/9, 9/10, 9/11, and 9/12. (ii) Alginate with a dry sterile dressing to	F 314		

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	465108	A. BUILDING _____ B. WING _____	C 10/15/02

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large ulcer on left heel daily, and up to two times daily. Missed four times between 9/16/02 and 9/25/02; 9/17, 9/19, 9/20, and 9/21.

(iii) Accuzyme to posterior left heel ulcer daily. Missed four times between 9/16/02 and 9/25/02; 9/17, 9/19, 9/20, and 9/21.

c. October 1 through 14, 2002 - Accuzyme, cover with Telfa pad and wrap with Cling daily. Missed five times between 10/1/02 and 10/14/02; 10/5, 10/7, 10/9, 10/11, and 10/12.

A review of Medication Administration Records (MAR) for resident 1, between August 2002 and October 14, 2002, was completed on 10/15/02. Facility staff documented resident 1's house supplement on the MAR. Facility staff were providing resident 1 with 60 ml of house supplement, three times a day, beginning 3/27/02. On 9/17/02, a telephone order was received to add 120 ml of Novasource 2.0 two times a day to resident 1, during medication pass. Between 9/16/02 and 9/27/02, facility staff were documenting that resident 1 was receiving the 60 ml of house supplement three times a day, plus 120 ml of Novasource 2.0 two times a day. After 9/27/02, the Novasourse was discontinued because the order was, "same as above", referring to the house supplement 60 ml, three times a day, dated 3/27/02. Facility staff do not document that resident 1 received Novasource 120 ml, two times a day, on any date after 9/27/02.

A review of nutritional assessments for resident 1 was completed on 10/15/02. On 1/2/01, a consulting registered dietitian signed a nutritional assessment for resident 1. On this assessment, the resident was assessed as being obese and having a stable weight. The resident's skin was assessed to be intact. The resident was assessed as requiring 55 grams of protein per day, based on a 0.8 grams per kilogram of body weight calculation. Resident 1 was receiving a

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regular, no added salt diet. The plan was to continue the current nutritional care plan.

Quarterly Nutritional Assessments were completed for resident 1 on 3/28/02 and 6/26/02. On each of these assessments, resident 1's skin was assessed as being fragile but intact. The resident's diet was noted to be mechanical soft, no added salt. On the 6/26/02 assessment, food service supervisor documented that resident was receiving 60 ml of house supplement beginning 3/27/02. There were no changes to resident 1's nutritional careplan on either of these assessments.

On 10/9/02, a consulting registered dietitian completed a nutritional assessment for resident 1. On this assessment, resident 1 was assessed as having stage III to stage IV pressure sores. Resident 1's protein needs were assessed to be 130 grams per day, using a 2.0 gram per kilogram of body weight calculatation. This was an increase of 75 grams of protein per day, from the last full nutritional assessment completed 1/2/01. The consulting registered dietitian made the following recommendations on 10/9/02: 1) 8 ounces of juice, three times a day with two scoops of Propass Protein Powder. 2) Multivitamin with minerals. 3) Zinc Sulfate 220 mg daily for 45 days and then off for 30 days and repeat until the wounds have healed. 4) Vitamin C 500 mg two times a day. 5) Ask physician if he desired to order Iron Sulfate 325 mg three times a day. 6) Increased protein skim milk. 7) Arginaid powder, two packets per day, for wound healing. Per documentation, this was the first nurtritional assessment completed for resident 1 since she developed pressure sores on 8/14/02.

An interview was held with the consulting registered dietitian on 10/15/02 at 11:05 AM. This was the same registered dietitian who completed resident 1's nurtritional assessment on 10/9/02. The registered dietitian stated that the interventions that she

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recommended on 10/9/02, were not previously implemented for resident 1. The registered dietitian stated that the facility went for a period of time without a registerd dietitian consultant prior to her coming to the facility on 10/2/02. The registered dietitian stated that the food service supervisor at the facility may not have had the expertise to provide nutritional recommendations for a resident 1's pressure sores. The surveyor asked the registered dietitian if resident 1 was receiving necessary nutritional support from the time she developed pressure sores on 8/14/02, until the nutritional assessment on 10/9/02. The registered dietitian stated resident 1 was not receiving the necessary nutritional interventions and that the interventions were lacking in the areas that she made recommendations. The surveyor asked the registered dietitian if the nutritional interventions she had recommended on 10/9/02 had been implemented. She responded that they have not. She stated the facility's DON had not contacted resident 1's physician to get authorization to implement the recommendations.

An interview was held with resident 1's nurse on 10/15/02 at 2:30 PM. The nurse stated that she was not aware, until that date, that resident 1 had a pressure sore on her buttocks.

An interview was held with a certified nurse aide on 10/15/02 at 11:15 AM. The certified nurse aide stated that he had first noticed a small red area on resident 1's right buttock on the previous Thursday, 10/10/02. He stated that the area was now bigger. He stated that he reported the reddened area to a nurse on 10/10/02. This nurse aide stated he had been employed at the facility for several weeks and that he had noticed staff were not keeping resident 1's feet off of her bed. He stated that on several occasions when he came on shift in the morning, resident 1 would be in bed with her feet laying on the bed.

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