TW

Title EI 6-2402

DEPARTMENT OF HEALTH AND HUM[illegible] SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 5/30/02
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	N/A A. BUILDING _____ B. WING _____	5/23/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

POC accepted 7/8/02 GD

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F 253 SS=E	483.15(h)(2) ENVIRONMENT The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by: Eleven of fifteen resident rooms/bathrooms, two of two shower rooms, one of one beauty shops, one of one dining, dressing and utility room, revealed housekeeping and maintenance services was not provided routinely. Findings include: Observation of the facility, from 5/20/02-5/23/02, revealed the following: The lower half of the exit door in the dining room was missing paint. By the utility room, there was a dark red rust area by the floor and on the door frame measuring four to six inches. There as a crack in the wall above the door frame of the utility room, and a crack in the ceiling from where the wall and ceiling meet. Dressing room 15 had some dark red rust areas in the toilet, multiple small holes in flooring close to toilet, and a six to eight inch area of paint missing on the wall by cupboard. Shower room 14 had multiple holes in the wall varying in size from one-half to two and one- half inches. Shower room 16 had multiple holes in the wall varying in size from one-half to two and one-half, and a dark	F 253	PINE RIDGE CARE CENTER IS TAKING PROPER STEPS TO CORRECT AND ENSURE CONTINUED COMPLIANCE WITH F TAG 253 BY 1) SECURING THE SERVICES OF 2 FTE STAFF AND 2 PART TIME EQUIV. STAFF MEMBERS TO DO LAUNDRY AND MAINTENANCE. 5/27/02 2) THE FACILITY IS NOW ON A MAINTENANCE SCHEDULE. AT THIS TIME 75% of TALLED DEFICIENCIES HAVE BEEN CORRECTED WITH REMAINING 25% TO BE COMPLETED WITHIN 30 DAYS. 6/19/02 3) ONE ROOM WILL BE ASSESSED / RE ASSESSED EACH MONTH FOR MAINTENANCE POINTS TO BE REPAIRED OR REPLACED BY BOTH THE ADMINISTRATOR 6/14/02	

GD 6/24/02

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUR[illegible] TITLE (X6) DATE

Administrator 6/21/02

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 stated above 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.

Utah Dept of Health

JUN 21 2002
#507642 #7
Bur. of Medicare/Medicaid Prog.
Certification and Res. Assessment

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F 253	Continued From page 1 red area about 4 inches up off of the floor by the privacy curtain. Room 1: There was dime to quarter size holes in the ceiling, paint was peeling above the closets, residents' clothing cabinets were not shutting properly. Room 3: The ceiling was missing paint by the middle bed, approximately seven to nine inches in size. Bed C's privacy curtain was hanging down by the window, and the bathroom sink was dripping water which would not stop when the knob was tightened. Room 4: The window in room 4 had a crack, approximately one foot in size and the window screen was bent. The closet door was missing a doorknob on the closet by the bathroom. There was no front privacy curtain on bed B. The front tile by toilet was moldy, standing water was observed on the floor in the bathroom and the sink had a leaky faucet. The vinyl on the wall by the mirror and glove box was peeling up approximately six to eight inches by one to two inches. Room 5: There was no light bulb in bed B's lamp and the second lamp by bed B didn't work. There were 2 patched holes in the ceiling by bed B's privacy curtain, measuring approximately four to six inches, which had not been painted. The doors to bed C's closet would not close properly. Observation of the bedroom floor revealed black scuff marks which appeared to penetrate the top of the floor which measured approximately six to twelve inches and there were multiple holes measuring approximately two to four inches in the flooring. Bed A's light cover was cracked approximately three to six inches. There was a leaky faucet in the bathroom sink and some dark red rust areas in the toilet.	F 253	AND THE MAINTENANCE DEPARTMENT HEAD. 4) EACH MONTH THE ENTIRE FACILITY AND GROUNDS WILL HAVE A WALK-THROUGH BY ADMINISTRATOR, HEAD OF MAINTENANCE AND D.O.N. TO DETERMINE THE "NEXT PROJECT." 5/27/02 5) ALL CORRECTIONS ARE BEING TRACKED AND IMPROVEMENTS ARE BEING DOCUMENTED BY MAINTENANCE DEPT. HEAD AND ADMINISTRATOR 6/19/02 7/21/02	

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F 253	Continued From page 2 Room 6: There was a leaky faucet in the sink and dark red rust areas in the toilet. The blinds would not go down on the window. Room 7: Bed "A" had multiple gashes in the wall, measuring approximately two to four inches. The toilet had multiple dark red rust areas in the bowl and the water tank lid was being held in place by a black bunjee cord. There was a leaky faucet in the bathroom sink. There were two to three holes in the wall above toilet paper measuring approximately one-half to one inch. The toilet paper dispenser was located behind the toilet which would cause the user to have to turn 180 degrees to reach the toilet paper. Room 10: There was paint missing on the wall by bed C's headboard measuring approximately ten to twelve inches. The blinds on the window did not work. There was a dark red rust area at the base of the toilet. There was a hole in the linoleum on the wall above toilet measuring approximately two to three inches, and multiple black marks on bathroom floor linoleum. Room 11: The blinds would not close and were missing one slat. There were many scuff marks located on the floor adjacent to the door measuring approximately one to four inches in size. Room 12: The blinds would not open on the window. There was no paint around the light fixture and half of the door frame. The toilet was missing bolts. There was a dark red rust area under the toilet seat. There were multiple large worn stains in the linoleum. The linoleum had large scratches that measured approximately one to two feet, throughout the bedroom. Room 13: There was no cold water in the bathroom sink. The lights by bed B were not working. There	F 253		

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F 253	Continued From page 3 were multiple dark red rust stains in the toilet. The blinds would not close on the window. There was approximately six inches of the baseboard missing just outside the bathroom. There was a three feet by four inch area by bed C's lamp that had not been painted. There was a six by four inch area by the window that had not been painted. Room 17: The light cover above the bed was cracked approximately four to six inches and was coming off on the front, right side.	F 253		
F 282 SS=D	483.20(k)(3)(ii) RESIDENT ASSESSMENT The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, it was determined that for 1 of 8 sample residents, the facility staff were not following resident's plan of care. Resident identifier: 15 Findings include: Resident 15 was admitted to the facility on 7/25/96, with the diagnoses of dementia with anxious features, dementia with depressive features, hypertension, congestive heart failure, arthritis elbow, and failure to thrive. Review of resident 15's medical record, on 5/21/02, revealed a physicians order for a soft waist restraint when up in wheelchair, remove every two hours and give range of motion times ten minutes times four. Review of resident 15's care plan, dated 4/02, revealed	F 282	PINE RIDGE CARE CENTER HAS CORRECTED THE DEFICIENCIES NOTED WITH F 282 FOR PATIENT IDENTIFIER: 15 PINE RIDGE HAS ALSO IMPLEMENTED NEW AND IMPROVED TRACKING FOR ALL ENABLERS/RESTRAINTS TO ENSURE: 1) DRS. ORDERS ARE CARRIED OUT PRECISELY 2) FACILITY PROTOCOL IS FOLLOWED	6/3/02 6/3/02 6/3/02 6/3/02

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F 282	Continued From page 4 concern for "injury R/T (related to) falls manifested by falls with in past 31-180 days." Resident goals: "resident will be free from injury due to falls." Approach plan: "soft waist restraint when up in wheelchair, remove every two hours, give range of motion times ten minutes times four." During observation, on 5/21/02 at 4:22 PM, resident 15 was observed in her wheelchair with a cream colored canvas belt around her waist. The restraint appeared to have been altered from it's original form. During observation, on 5/22/02, resident 15 was observed at 7:15 AM at dinner table, in her wheelchair without a restraint on. At 1:30 PM, resident was observed in dining area watching T.V., without her restraint on. On 5/22/02, the DON (director of nurses) was interviewed regarding the restraint on resident 15. The DON confirmed that the restraint on resident 15 was not a soft waist restraint as ordered be the physician. The DON stated that he would get the correct restraint for the resident. The DON also stated that the facility did not have pamphlets from the manufacturer to verify proper application of the restraint. During observations, on 5/23/02 at 7:15, 8:00, 10:00 and 11:00 AM, resident 15 was observed in her wheelchair with a soft waist restraint on. However, it was improperly applied being eight to ten inches from her abdomen, which would allow her to easily slip under the restraint. Review of the most recent "physical and chemical restraint assessment and quarterly review", dated 3/22/02, does not describe a medical reason for use of a physical restraint.	F 282	3) A QUARTERLY REVIEW WILL BE CONDUCTED IN CONJUNCTION WITH THE MDS / IDT MEETINGS FOR EACH PATIENT TO ASSESS APPROPRIATENESS OF ENABLER/RESTRAINT AND QUALITY OF LIVING WITH SAME. 4) INSERVICING WILL TAKE PLACE FOR RESTRAINTS PARTICULARLY THOSE ON PATIENTS 5) QA TEAM WILL ADDRESS QUARTERLY. QA TEAM DISCUSSED ON 6/12/02	6/3/02 6/14/02 6/12/02

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F 287 SS=B	483.20(f)(1-4) Resident Assessment Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: Admission assessment; Annual assessment updates; Significant change in status assessments; Quarterly review assessments; A subset of items upon a resident's transfer, reentry, discharge, and death; Background (face-sheet) information, if there is no admission assessment; Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by HCFA and the State. A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month, including the following: Admission assessment; Annual assessment; Significant change in status assessment; Significant correction of prior full assessment;	F 287	A NEW MDS COORDINATOR HAS BEEN HIRED TO COMPLETE ALL ADMISSION, ANNUAL, SIGNIFICANT CHANGE AND QUARTERLY REVIEW ASSESSMENTS FOR FTAG 287. ALL TRANSMITTED ASSESSMENT VALIDATION REPORTS ARE BEING KEPT BY THE MDS COORDINATOR AND THE QA TEAM WILL REVIEW THESE QTRLY FOR ACCURACY AND COMPLIANCE. THE SUBSET ITEMS FOR TRANSFER, REENTRY, DISCHARGE, AND DEATH WILL ESPECIALLY BE DISCUSSED. GTL 6/24/02	6/3/02

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F 287	Continued From page 6	F 287		

Significant correction of prior quarterly assessment;

Quarterly review;

A subset of items upon a resident's transfer, reentry, discharge, and death;

Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

The facility must transmit data in the format specified by HCFA or, for a State which has an alternate RAI approved by HCFA, in the format specified by the State and approved by HCFA.

This REQUIREMENT is not met as evidenced by:

Based on interview with facility DON (Director of Nursing), and "Center of Medicare and Medicaid Services State-End of Month Roster Report (CMS)" for April, 2002, it was determined that the facility did not transmit to the state MDS system the appropriate transmittal (discharges) for 5 previously discharged or deceased residents identified on the state CMS report. These 5 residents were supplemental residents. Resident identifiers: 19, 20, 21, 22, and 23.

Findings include:

During the facility's recertification survey, May 20, 2002 through May 23,2002, the facility was provided a Medicare and Medicaid Services State-End of the Month Roster Report (CMS). There were 5 of 46 residents listed on the Center for Medicare and Medicaid Services State-End of the Month Roster Report (CMS) April, 2002, who had not had a current discharge transmitted tot the state MDS system in the last four months.

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F 287	Continued From page 7 On 4/21/02, the DON (Director of Nursing) confirmed that some of the records had not been transmitted to the state MDS system.	F 287		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interviews, it was determined that the facility staff did not ensure that one of eight sample residents received the necessary care and services to attain or maintain the highest practicable physical well-being. Resident identifiers: 16. Findings include: Resident 16 was admitted to the facility on 10/17/96, with a readmission date of 1/29/02. Diagnoses include: dementia, seizures, constipation, chronic conjunctivitis, pneumonia and rigidity. Review of resident 16's medical record, on 5/20/02, revealed a physician's telephone order for a vest restraint during meals to keep patient upright while being fed and to D/C (discontinue) after meals. Review of resident16's care plan, dated 5/8/02,	F 309	FOR R TAG 309 PRESENT DEFICIENCIES FOR PATIENT 16 HAVE BEEN CORRECTED, DRS. ORDERS HAVE BEEN REVIEWED AND PATIENT HAS BEEN GIVEN CORRECT ENABLER/RESTRAINT DURING MEALS TO PROMOTE HIGHEST LEVEL OF INDEPENDENCE AND SAFETY. NEW TRACKING PROCEDURES ARE IN PLACE TO ASSURE ALL OTHER RESIDENTS ARE RECEIVING OPTIMAL CARE. 1) PLAN OF CARE REVIEWED BY 6/3/02

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F 309	Continued From page 8 revealed the concern for "Injury, potential for R/T (related to) decreased weakness." Resident goals: "remains free of bodily injury." Approach plan: "vest restraint while eating." During observation on 5/21/02 at 4:45pm, and 5/22/02 at breakfast and lunch, resident 16 was observed in the dining room, in her wheelchair with a vest restraint on. The restraint was applied four inches below shoulders inhibiting movement of both her arms. Resident 16 was observed trying to maneuver her hands to her food, but the way in which the restraint was applied did not allow her to participate in mealtime activities. During observation on 5/23/02, resident 16 was observed at the dinner table without her vest restraint on. The resident was observed leaning forward with her head lying on the dinning room table. When the surveyor asked the nurse aide where resident 16's vest restraint was, the nurse aide stated "it wasn't in her room this morning. I looked all over her room and couldn't find it." During an interview with the Administrator on 5/22/02, he stated that resident 16 seems to "fall forward onto the table. We just need the right restraint for her."	F 309	NEW DIRECTOR OF NURSING FOR ALL PATIENTS. 2) INSERVICING DONE ON 6/14/02 FOR PROPER MANAGEMENT OF RESIDENT 16'S SITUATION. ~~AND/OR~~ 6/14/02 3) CONTINUING INSERVICING WILL BE DONE MONTHLY ONGOING 4) QA TEAM WILL ADDRESS QUARTERLY 6/12/02	
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	F 314	REFER TO DIRECTED PLAN OF CARE	

[redacted] Carol K.

[redacted] TEAM

Kim G.

Directed Plan of Correction and Directed In-Service Training
Pine Ridge Care Center

This is the Directed Plan of Correction (DPOC) for the recertification survey ending 5/23/02 with a finding of actual harm for two residents with pressure sores. Previously, the facility was cited at a Substandard level (a pattern of actual harm) in pressure sores for the survey ending 11/28/01.

Pine Ridge Care Center is being directed to accomplish the following items as part of an acceptable plan of correction:

The facility must obtain and use the services of a registered nurse consultant who has no affiliation with Pine Ridge Care Center. The name of the registered nurse consultant must be submitted to and approved by the Bureau of Medicare/Medicaid Program Certification and Resident Assessment, attention Ann E. Lee and also to the Bureau of Health Facility Licensing, attention, Joel Hoffman. Completed 6/18/02

The nurse consultant must perform on-site visits to Pine Ridge Care Center, at least 3 times a week, to monitor compliance with each area of concern mentioned in this DPOC. The registered nurse consultant will assist the facility to establish effective systems and efficient monitoring of those systems. The registered nurse consultant must document each visit, what was monitored and the findings of the audits. Copies of all audits must be faxed to the State Survey Agency on a weekly basis. STARTED 6/20/02

The registered nurse consultant must provide in-services regarding pressure sores as follows:

Pressure Sores - to include prevention, assessment, staging, treatment, nutrition, appropriate dietary intervention, monitoring of labs (such as protein/albumin), current standards of practice, and documentation. The in-services regarding pressure sores must be provided to all nurses and nurse aides who provide care within the facility.

<u>Pressure Sores</u>

The facility will establish a skin team to include a registered nurse and at least one other person. Both of these individuals must be familiar with skin integrity problems and appropriate treatments. The skin team will meet at least every 7 days. The skin team will perform a skin check (at least every 7 days) of each resident who has been identified by nursing staff as having skin breakdown. The skin team will assess, measure each wound and evaluate the effectiveness of the treatment of the skin breakdown. Skin team meeting minutes will be kept and will detail which residents were discussed, what interventions were recommended, the person responsible to provide the intervention, and follow up to ensure that recommendations were put in place. STARTED 6/12/02

Each resident will be evaluated for his/her risk for developing pressure sores at least every 3 months. Skin risk assessments will be performed by a nurse. The skin team, with the assistance of the RN consultant, will develop policies and procedures which describe what interventions 6/20/02

will be applied for all residents who score high risk. There will be a specific area in the resident's medical record to document that the interventions were provided, as per the policy. The nurse providing the interventions will initial and date each intervention at the time it was initiated. The skin team will develop a system to ensure and frequently monitor (at least twice every 7 days) the application of all appropriate preventive measures as indicated by the skin risk assessment results (i.e. pressure relieving devices, supplements, etc.)

Each resident in the facility will have a complete skin check at least every 7 days. These skin checks will be performed by a nurse. The head of the skin team will develop a monitoring tool to ensure that all skin checks are completed. The head of the skin team will perform at least 5 random observations every 7 days, of residents evaluated as being "at risk" for pressure sores, to ensure that skin checks performed by nursing staff are accurate. The head of the skin team will also ensure that issues of skin breakdown are made known to the physician, and if orders are received, are transcribed to the treatment sheet. All dressings within the facility will be dated. The head of the skin team will perform 2 random observations, at least every 7 days, to ensure that dressings are being changed as ordered by the physician. The head of the skin team will also monitor documentation on the treatment sheet to ensure compliance with physician's orders. The skin team must ensure that care plans are updated to address both residents with potential for breakdown as well as those with actual skin breakdown.

STARTED 6/14/02

The skin team must develop a way to ensure that the dietitian is notified of skin breakdown within 72 hours of the time the breakdown was identified. The skin team will also be responsible to ensure that the physician is made aware of dietary recommendations which would promote the healing of a pressure sore or skin breakdown.

DISCUSSED WITH DIETICIAN 6/20/02 - PHYSICIAN 6/12/02 @ QA mtng.

Documentation will be kept to show evidence that all tasks within this DPOC have been completed.

The Administrator will designate, in writing, a person responsible to perform random observations of residents to ensure that incontinence cares and repositioning are provided at least every 2 hours. These random observations will be performed at least 2 times a week and will be documented as to which residents were observed and the results of the monitoring.

STARTED 6/21/02

Skin integrity/wound care policies will be reviewed by the RN consultant as well as the skin team to ensure current standards of practice. Review and acceptance of these policies will be documented.

RN consultant activities, as well as this DPOC, must be incorporated into the facility's Quality Assessment and Assurance Program.

The facility must retain the services of the RN consultant until the facility has achieved substantial compliance in the area of pressure sores. Once substantial compliance is achieved, the facility must continue to monitor compliance in the area of pressure sores.

6/20/02

Pre-approved consultants include:

Paula DeAnda, RN
Christine Johnson, RN

The facility may chose one of these consultants or may submit the name of another consultant who by training and experience meets the qualifications needed to meet the requirements of the Directed Plan of Correction.

Results of all monitoring, performed by the facility and the RN consultant, will be kept and will be faxed weekly to the State Survey Agency.
(Fax # 801-536-0948)

Please feel free to call with questions.

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F 314	Continued From page 9	F 314		

developing.

This REQUIREMENT is not met as evidenced by:
This is a repeat deficiency from the survey ending 11/28/01.

Based on observation, interview of facility staff, and review of resident medical records, the facility's skin care policy and review of the directed plan of correction from the survey ending 11/28/01, it was determined that for 2 of 8 sample residents (13 and CR1) , the facility did not ensure that a resident who entered the facility without pressure sores did not develop pressure sores. The facility also did not ensure that residents with pressure sores received the necessary treatment and services to promote healing or prevent new sores from developing. Two additional residents (1 and 7) were scored at high risk to develop pressure sores and did not have pressure relieving devices to help prevent new sores from developing. It was also determined that the facility was not following the directed plan of correction it received following their survey ending 11/28/01 in which pressure sores were cited at a harm level. Resident identifiers: 13, CR1, 1 and 7.

Findings include:

Resident 13 was a 73 year old male admitted to the facility on 7/16/01 with the diagnoses which include: dementia with memory loss, coronary artery disease, hypertension, depression with anxiety, peripheral vascular disease, arthritis, confusion, kyphosis, and most recently subdural hematoma and brain bleed.

Resident 13 was assessed for pressure sore risk on 12/3/01 and the facility staff gave him a score of 10. Resident 13 was again re-evaluated for pressure sore risk on 12/20/01, and received a score of 10. The

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most recent re-assessment for pressure sore was done on 3/26/02, and resident was scored an 11. The facility's "Pressure Ulcer Risk Assessment" documented that a score of "8 or above represents HIGH RISK".

Resident 13's care plan (unable to read date) says the following:
Concern: Potential for skin integrity alteration, related to bowel and bladder incontinence and head laceration manifested by unsteady gait.
Goal: Will be free from any loss of skin integrity.
Approach: Use helmet for head and keep family secured at all times. Keep in wheelchair with lap buddy in place. Provide good peri care with each incontinence episode. Change diapers and or clothing as necessary. Toilet every two hours and as needed.

On 5/16/02 11:00 PM - 07:00 AM shift nurses notes document the following: "patient's buttocks has pressure areas on both cheeks. looks like carpet rash from scrubbing on floor." Physicians orders dated 5/16/02 say: "Add eggcrate cushion to chair at all times, Apply skin prep to buttocks with each incontinence pad change. Aloe vesta with zinc BID (two times per day) to buttocks."

Resident 13's care plan was not updated to accurately reflect the change is resident's condition. Resident 13's care plan did not address the need for pressure relieving devices, or turning and positioning to prevent pressure.

Nurses Notes dated 5/19/02 state the following: "...gluteal fold with decreased redness. rug burn of left buttocks decreased in size and redness. Skin prep applied. Aloe vesta not yet received from pharmacy...." The facility physician ordered the aloe vesta treatment on 5/16/02. On 5/19/02, the aloe vesta

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had not been delivered to the facility from the pharmacy.

The MDS's (minimum data set) dated 1/14/02, and 4/15/02 for resident 13, did not indicate that resident had pressure relieving devices to his bed or wheelchair. There was no documentation in the nurses notes which reflected that resident 13 had pressure relieving devices in his wheelchair or his bed.

On 5/22/02, the registered nurse surveyor, and facility cna (certified nursing assistant) performed a routine skin check on resident 13. Resident 13 had two stage II pressure sores on his coccyx area. Resident 13 had a pressure sore on his left coccyx area measuring 1cm by .5 cm. Resident 13 had another pressure sore on his right coccyx area measuring 1cm by 1 cm.

Observation on 5/20, 5/21, and 5/22 revealed resident 13 had an eggcrate cushion to his geri chair, but no pressure relieving device of any type on his bed. The bed mattress was not one that relieved pressure.

On 5/22/02 at 09:10 AM, during a second observation of resident 13's pressure sores by an additional registered nurse surveyor and the DON, (Director of nursing), the DON stated that he wasn't aware that the reddened area had opened, and wasn't aware that resident 13 now had two stage II pressure sores. The DON also verified that resident 13 did not have a pressure relieving device to his bed mattress. On 5/22/02, the facility notified the physician that resident 13 had two stage II pressure sores, and obtained orders and treatment for them.

Resident 13's cna documentation was reviewed. Documentation showed that resident 13 was not turned and repositioned on the night shift every two hours, for

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10 out of 21 days in May, 2002.

2. Resident CR1 was a 91 year old female who was admitted to the facility on 12/7/00 with diagnoses which included hypertension, cerebral vascular accident, dementia, osteoarthritis and deep vein thrombosis. Resident CR1 expired on 4/13/02, prior to the recertification survey.

On 12/03/01, resident CR1 was assessed by facility staff for her risk of developing pressure sores and scored a 9. On 1/11/02, a second pressure ulcer assessment for resident CR1 was completed in which the resident scored a 10. On 3/3/02, another pressure ulcer assessment was completed in which resident CR1 was scored at 14. The facility's "Pressure Ulcer Risk Assessment" documented that a score of "8 or above represents HIGH RISK".

The MDS for resident CR1, dated, 12/11/01, documented that this resident needed the physical assistance of one person for bed mobility (how the resident moves to and from a lying position, turns side to side, and positions body while in bed).

A care plan addressing skin issues was initiated on 1/03 (no year noted). The interventions documented included:

- egg crate mattress
- pad in w/c (wheelchair)
- reposition every 1-2 hours in bed or w/c
- skin check by nurses and call MD if breakdown

The "Weekly Nurses Note & Skin Assessment" for resident CR1, dated 11/08/01, did not document any skin breakdown and did not document the use of a pressure relieving device to the resident's bed.

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The "Weekly Nurses Note & Skin Assessment" for resident CR1, dated 11/27/01, did not document any skin breakdown and did not document the use of a pressure relieving device to the resident's bed.

The "Weekly Nurses Note & Skin Assessment" for resident CR1, dated 12/13/01, did not document any skin breakdown and did not document the use of a pressure relieving device to the resident's bed.

The "Weekly Nurses Note & Skin Assessment" for resident CR1, dated 12/20/01, did not document any skin breakdown and did not document the use of a pressure relieving device to the resident's bed.

On 12/29/01, the facility notes on a "Decubitus/Pressure Ulcer Report" that resident CR1 had two stage II pressure sores on the resident's left buttocks. The first pressure sore measured 1 cm (centimeter) by 1 cm and the second pressure sore measured 2 cm by 2 cm.

At this time, on 12/29/01, the physician ordered the staff to place duoderm to the left hip of resident CR1 every 3 days and when needed.

A nurse's note, dated 1/7/01, documented that resident CR1 "was examined for DQs (decubitus ulcers/pressure sores) at 1600 (4:00 PM) - She has two on L (left) buttock...both are stage II."

The "Weekly Skin Assessment", dated 1/8/02, does not document the presence of any pressure sores or use of pressure relieving devices to the bed of resident CR1.

The "Decubitus/Pressure Ulcer Report" which had been initiated on 12/29/01 when the pressure sores were first identified, was updated again on 1/8/02 to

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reflect the presence of two stage II's to the left buttock of resident CR1.

A care plan addressing "Skin integrity impairment" was not initiated until 1/14/02, 17 days after the identification of the two stage II pressure sores.

Another "Weekly Skin Assessment, dated 1/10/02, was completed by a different nurse than on 1/8/02 and continued to document no pressure sores or use of pressure relieving devices to the bed of resident CR1.

The "Weekly Skin Assessment", dated 1/23/02, is the first skin assessment which mentions skin breakdown and the use of pressure relieving device to the bed of resident CR1. There was no documentation in the medical record of resident CR1 to evidence that the facility had provided preventive devices to her bed at the time she was identified at high risk to develop pressure sores . There was no documentation in the medical record of resident CR1 from 12/29/01 through 1/22/02 to evidence that staff had provided a pressure relieving device to her bed to help protect against the development of additional pressure sores.

There was no documentation in the medical record of resident CR1 to evidence that treatments were completed as ordered on 1/4/02, 1/11/02.

3. Resident 7 was a 95 year old female who was admitted to the facility on 6/12/97 with the diagnoses of dementia, cerebral vascular accident, congestive heart failure, and obsessive compulsive disorder.

On 1/10/02, resident 7 was assessed by the facility for pressure sore risk and scored a 9. On 3/26/02, resident 7 was again assessed by the facility for pressure sore risk and scored a 10. The facility's "Pressure Ulcer Risk Assessment" documented that a

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score of "8 or above represents HIGH RISK".

The MDS for resident 7, dated, 2/25/02, documented that this resident needed the physical assistance of one person for bed mobility (how the resident moves to and from a lying position, turns side to side, and positions body while in bed). The MDS did not document the use of pressure relieving devices for resident 7.

The facility completed a care plan for resident 7 which addressed the "Potential for alteration in skin breakdown r/t (related to) urinary incontinence..." The facility's care plan for this potential problem did not address the use of pressure relieving devices.

The "Weekly Skin Assessment" performed by the facility nurses documented the following information regarding resident 7:

3/17/02 "slight redness to buttocks"
4/20/02 "buttocks red"
4/27/02 "buttocks red"
5/11/02 "buttocks red, but skin not broken"

On 5/20/02 at 3:00 PM, resident 7 was observed lying on her bed which had on it a regular mattress. No type of pressure relieving device was observed on the bed.

On 5/21/02, resident 7 was observed lying on her bed, flat on her back, from 1:35 PM to 4:35 PM, a total of three hours without being turned or repositioned.

On 5/22/02 at approximately 9:30 AM, the Director of Nurses and one registered nurse surveyor performed a skin check on resident 7. Resident 7's buttocks was reddened, but there was no break in the skin.

4. Resident 1 was a 87 year old woman, admitted to

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the facility in March, 2001, with diagnoses which include: Dementia with psychosis, osteoporosis, failure to thrive, Parkinson's features, peripheral vascular disease, and degenerative joint disease.

Resident 1 was assessed for pressure sore risk on 12/20/01, and the facility staff gave her a score of 10. Resident 1 was again re-evaluated for pressure sore risk on 3/26/02, and received a score of 11. A score of 8 or higher represents a high risk for developing a pressure sore.

Resident 1's nurses notes dated 12/27/01 document the following: "...skin check today right hip healed, but has a 1.5 cm by 1.5 cm stage II ulcer on left gluteal fold. Need order from MD for treatment."

During an observation on 5/20, 5/21, and 5/22/02 resident 1 did not have any pressure relieving devices on her wheelchair or her bed.

Resident 1's MDS, dated 4/18/02 did not indicate that resident 1 had pressure relieving devices to either her bed or wheelchair.

Resident 1's care plan dated 1/3/01, (the nurse surveyor could not find documentation/care plan in reference to skin integrity prior to 1/3/01) nursing approaches to have pressure ulcer clear up are:

1. Keep resident dry and clean.
2. Turn and reposition every 1-2 hours.
3. Take resident to toilet every 2 hours during the day.
4. Eggcrate mattress on bed.
5. Pad for wheelchair
6. use lotion as necessary.
7. Reposition in wheelchair every 2 hours.
8. Eats 75% to 100% of meals.

On 5/22/02 during an interview with the DON

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(Director of Nursing), the registered nurse surveyor asked him how he notifies the facility dietician when a resident has a pressure sore. The DON stated "why would I need to notify the dietician?" The nurse surveyor explained to the DON that residents with wounds need more protein to promote healing.

On 5/22/02, during an interview with the facility dietician, the registered nurse surveyor asked dietician how the facility nursing staff contacts her when a resident gets a pressure sore. She stated that there is no system in place to notify her. She stated that when she comes to work, she has to ask the nurses which residents have pressure sores. The facility dietician stated that she was not aware that resident 1 had a pressure sore in December, 2001.

Resident 1's cna (certified nursing assistant) documentation was reviewed for December, 2001. Documentation showed that resident 1 was not turned and repositioned 5 out of 31 days on the day shift, and 16 out of 31 days on the afternoon shift.

5. The facility's policy for "Decubitus Ulcer Prevention" documents that staff will "assess risk using Briggs pressure ulcer risk assessment form on all new admissions and quarterly with the MDS schedule. If score of eight or greater the prevention protocol will be implemented per the skin care team."

Skin policy interventions #3, #5 and #6 document that the facility will "reposition patient every two hours and position with pillows or apply special equipment over mattress to protect bony prominence", "utilize preventive equipment, i.e.: egg crate, elbow pads, heel protectors, as indicated...", and "maintain proper nutrition and hydration".

The facility was not following their own policy for in

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providing "preventive equipment" to those residents at high risk for skin breakdown. (Resident 13, CR1, 7 and 1)

The facility did not follow its own policy by providing repositioning to high risk residents.

It was not possible to assess whether the residents were receiving adequate nutrition as the facility was not monitoring protein or albumin levels on any of the 4 residents cited within this deficiency.

U.S. Department of Health and Human Services, Number 15, Quick Reference Guide for Clinicians Pressure Ulcer Treatment, December 1994 page 6-7. "The goal of nutritional assessment and management is to ensure that the diet of the individual with a pressure ulcer contains nutrients adequate to support healing.... Nutritional support: Encourage dietary support intake or supplementation if an individual with a pressure ulcer is malnourished. If the dietary intake continues to be inadequate, impracticable, or impossible, nutritional support should be used to place the patient into positive nitrogen balance (approximately 30 to 35 calories/kg/day/ and 1.25 to 1.50 grams of protein/kg/day) according to the goals of care. As much as 2.00 grams of protein/kg may be needed. "

6. Due to the facility being cited at a Substandard level (a pattern of actual harm) in the area of pressure sores at the last recertification survey, ending 11/28/01, the facility was given a directed plan of correction. Below is an outline of the areas on the directed plan of correction in which the facility did not follow as required.

The directed plan of correction stated:

a. "Treatment and preventive measures are to be

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F 314	Continued From page 19 implemented as indicated from the assessments." The facility had not provided preventive measures, specifically pressure relieving mattresses, to any of the four residents cited in this deficiency. Each of these residents were assessed by the facility as being "high risk". b. "A monitoring tool must be developed to ensure that all skin checks are completed, preventive measures are in place and treatments are being done as indicated." On 5/22/02 at 2:15 PM, the Director of Nurses (DON) was asked if this was being performed as mandated by the directed plan of correction. The DON stated, "no". c. "The head of the skin team will perform at least 2 random observations every 7 days, of residents evaluated as being 'at risk' for pressure sores, to ensure that skin checks performed by nursing staff are accurate." On 5/22/02 at 2:17 PM, the DON was asked if this was being performed as mandated by the directed plan of correction. The DON stated, "no". d. "The head of the skin team will also monitor documentation on the treatment sheet to ensure compliance with physician's orders." On 5/22/02 at 2:19 PM, the DON was asked if this was being performed as mandated by the directed plan of correction. The DON stated, "no".	F 314		
F 329 SS=D	483.25(l)(1) QUALITY OF CARE Each resident's drug regimen must be free from	F 329	UPON FURTHER REVIEW IT WAS DETERMINED THAT HCTZ WAS	

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F 329	Continued From page 20 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 review of resident medical records it was determined that for 1 of 8 sampled residents, the facility did not ensure that each resident's drug regimen was free from unnecessary drugs. Specifically, a resident was on duplicative drug therapy, receiving three antihypertensive medications at the same time, in the presence of adverse consequences which may have indicated the dose should be reduced or discontinued. Resident identifier: 13. Findings include: Resident 13 was a 73 year old male admitted to the facility on 7/16/01 with diagnoses of dementia with memory loss, coronary artery disease, hypertension, depression with anxiety, peripheral vascular disease, arthritis, confusion, kyphosis, and more recently, brain bleed and subdural hematoma. Resident is blind in one eye. "Duplicative drug therapy" is any drug therapy that duplicates a particular drug effect on the resident. Duplicative drug therapy should prompt the facility to evaluate the resident for accumulation of adverse effects. (Interpretive guidelines F329 unnecessary drugs). On 5/21, 5/22, and 5/23, resident 13's medical record	F 329	IN ADVERTENTLY PLACED BACK ON M.A.R BY PHARMACY. TO CORRECT THIS PROBLEM: 1) CHARGE NURSES WILL SCREEN MAR FOR ANY INCONSIS-TENCIES AT CHANGE-OVER (END OF MONTH). A (MAR) DOUBLE CHECK WILL BE MADE BY TWO NURSES AND THEN REPORT WILL BE MADE TO D.O.N. 6/18/02 INSTITUTED RESIDENT 13 HAS BEEN REEVALUATED BY MEDICAL DIRECTOR AND HCTZ WAS D/C'd AND OTHER MEDS REEVALUATED FOR APPROPRIATENESS. PSYCHOTROPIC TEAM HAS REEVALUATED ALL PATIENTS FOR 6/20/02	

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F 329	Continued From page 21	F 329	DUPLICATIVE THERAPY AND WILL DO SO QUARTERLY.	

was reviewed. It was noted that upon admission, July 16, 2001, resident 13 was started on three antihypertensive medications. (antihypertensive medications are used to lower blood pressure, for residents who have high blood pressure) Resident 13 was started on atenolol 50 mg (milligrams) one daily every morning, plendil 10 mg one every morning, and HCTZ (hydrochlorothiazide) 50 mg one every morning.

On January 9, 2002, the facility physician wrote an order to discontinue the use of HCTZ. This order was written on a physician's order sheet. January 9, 2002 nurses notes document the following: "Dr. saw patient today at 9:00 AM, discontinued HCTZ..."

Resident 13 did not receive HCTZ for the remainder of January 2002, February, and March 2002. During this time, resident 13 was only on the other two antihypertensive medications, plendil and atenolol. Resident 13 started receiving HCTZ again in April, 2002, and into May, 2002. The three medications were HCTZ 25 mg one every morning, plendil 10 mg every morning, and atenolol 25 mg one tablet every day. Nurses notes and physician progress notes do not discuss what prompted the need to add HCTZ back to resident 13's drug regime.

HCTZ has potential adverse effects. 2002 PDR page 2108 & 2109 reveals the following adverse reactions. Body as a whole: "weakness", cardiovascular: "hypotension, including orthostatic hypotension (may be aggravated by other antihypertensive drugs)", nervous system: vertigo, dizziness, headache and restlessness." Orthostatic hypotension is defined as: "the lowering of blood pressure when the client moves from a sitting to a standing position, results from reduced blood volume and is a side effect of antihypertensive medications." Perry and Potter Basic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	5/23/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 329	Continued From page 22	F 329		

Nursing, 2nd edition, page 239.

Nursing 2002 Drug handbook page 806 & 807, Patient teaching for HCTZ should include: "advise patient to avoid sudden posture changes and to rise slowly to avoid orthostatic hypotension."

Nursing 2002 Drug handbook page 262 reveals the following about drug-drug interaction (using atenolol with another antihypertensive) when two antihypertensives are used together. "enhanced hypotensive effect, use together cautiously."

Plendil has general precautions. 2002 PDR, pages 624 & 625, reveals the following: "causes hypotension. " Adverse reactions: "hypotension, syncope, (fainting) insomnia, depression, anxiety disorders, irritability, nervousness, and somnolence."

Resident 13 sustained multiple falls from 12/01 through 4/02. Nurses Notes document the following falls:

December, 2001: 3 falls
January, 2002: 7 falls
February, 2002: 5 falls
March, 2002: 4 falls
April: 12 falls
May: 0 falls, (resident placed in Geri chair 4/30/02)

Resident 13 sustained 12 falls in April, 2002, the month that the medication HCTZ was restarted. Resident 13 was taken to the hospital three times in April, 2002 after falling. Resident 13 went to the hospital on 4/5/02, after hitting his head on the corner of a wall, receiving a cut to top back of his head, with moderate bleeding. Resident 13 also went to the hospital on 4/11/02 after falling. Resident 13 sustained a large laceration on the back of his head which was

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F 329	Continued From page 23 bleeding, requiring 5 staples and a tetanus shot. Resident 13 slipped to the floor two times from wheelchair on 4/15/02. Resident was sent to the hospital on 4/16/02 for a CT scan. Resident sustained a small sub dural hematoma and a small intra cranial bleed. Resident 13 is also on seroquel, an antispychotic medication. Nursing 2001 drug handbook reveals the following about seroquel. "adverse reactions, causes orthostatic hypotension." "Interactions, drug-drug: antihypertensive, increased effects, monitor blood pressure."	F 329		
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility did not store, prepare, distribute, and serve foods under sanitary conditions. Findings include: Observations made during survey, 5/20/02 through 5/23/02, revealed the following: 1. On 5/20/02, kitchen cleaning rags were observed to be on the counters when not is use, rather than in a bucket of sanitizing solution. 2. On 5/21/02, observation revealed that the window screen located in the storage room was bent, which could allow flies and bugs to enter into the kitchen. 3. On 5/21/02, observation revealed that the window	F 371	PINE RIDGE IS NOW IN COMPLIANCE WITH THIS F TAG 371 AS EVIDENCED BY: 1) INSERVICING HAS BEEN DONE WITH ALL KITCHEN STAFF AS TO GENERAL KITCHEN CLEANLINESS ESP. RAGS ON COUNTERS. DIETARY MANAGER AND ADMINISTRATOR WILL MAKE RANDOM OBSERVATIONS OF KITCHEN	

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	46A047	A. BUILDING _____ B. WING _____	5/23/02

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F 371	Continued From page 24 screen located in the kitchen, near the counter and cupboards, was torn, which could allow flies and bugs to enter into the kitchen. 4. On 5/20/02, observation revealed that there was one light fixture in the back storage room was not covered. 5. On 5/21/02, observation revealed that three rubber spatulas had cracked rubber, which could flake off, and get into resident's food. 6. On 5/20/02, observation revealed that there were two boxes of moldy green beans, sitting out on the counter. 7. On 5/21/02, a log containing the facility's dishwasher wash and rinse temperatures were reviewed. From 4/12/02 through 5/21/02, there were 8 out of 35 days that the rinse temperature did not reach 180 degrees. 180 degrees is the required temperature needed to sanitize the dishes. Interview with facility Dietary Manager, revealed that she was not aware that the rinse temperature needed to be 180 degrees.	F 371	TO MAKE SURE RALS ARE STORED PROPERLY, EQUIPMENT IS IN GOOD REPAIR, FOOD IS STORED PROPERLY AND WATER TEMP FOR RINSE CYCLE IS AT 180 DEGREES. WATER TEMPS WILL BE DOCUMENTED DAILY NON-COMPLIANT FOOD WILL BE DISPOSED OF IMMEDIATELY.	5/30/02
F 520 SS=D	483.75(o)(1) ADMINISTRATION A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. This REQUIREMENT is not met as evidenced by: Based on interview, it was determined that the facility did not include a physician in their quality assessment (QA) and assurance committee meetings.	F 520	MEDICAL DIRECTOR WILL ATTEND QTRLY QA MEETING. DR. HAS ATTENDED 6/12/02 QA MTNG.	6/12/02

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F 520	Continued From page 25 Findings include: The Administrator and Director of Nurses were interviewed on 5/23/02 at approximately 3:30 PM. During the interview, they stated that they held QA meetings monthly. When asked if the physician had attended the QA committee meetings at least quarterly, they both stated that he had not.	F 520		

Addendum to POC for Pine Ridge Care Center

June 28, 2002

F - 282

For resident 15, the Soft waist restraint was d/cd on 6/2/2002. Order for lap buddy initiated. A Psychotropic meeting is conducted on her quarterly for medication review.
A Posey representative came in and did inservicing for the staff on 6/10/2002 so that those who do cares for any residents with enablers/restraints understand how they are to be fitted and what their purpose is.

Restraints are monitored by D.O.N and reported to QA team quarterly.

Copy of restraint protocol attached.

F - 309

Tracking: DON will monitor each resident at their IDT meeting and will report to QA team. New CNAs will be inserviced as to restraints/enablers so that they are applied appropriately. The DON, Administrator, or member or Therapy team will provide the inservices.

F - 314

Resident 1 A weekly skin assessment is being performed, nutritional status monitored and weight taken weekly, Geo mat placed on bed and pressure relieving device placed in W/C, heel protectors on while in bed, assisted with transfers, and psychotropic meeting quarterly.

Resident 7 - Same as resident 1.

Resident 13 - Same as residents 1 and 7 with addition of low bed, geri chair with foot rest due to falls, and a helmet on while not in geri chair.

F - 329 - When nurses screen MAR for errors they will verify all telephone orders, verbal orders, etc. in chart. Initialization of MAR will be done by reviewing nurse. Psychotropic team includes SSW, Administrator, DON, and Pharmacist. Recommendations by team will be addressed in QA meeting and since administration involved with psychotropic meeting needed changes can occur immediately to protect residents or improve condition. All changes will of course go through Medical Director as needed.

F - 371 - Dietary manager will monitor and present state of kitchen to QA team quarterly. 1. Inservicing done with kitchen help to address rags on counters 5/24/2002. 2. Repairs made to screens to keep out flies on 5/27/2002. 3. Different screen in place 5/27/2002 4. Light fixture covered 5/21/2002 5. Rubber spatulas replaced 5/21/2002 6. Food will be monitored daily by dietary manager. 7. 180 degree temp for rinse cycle will be monitored 2 times daily.

F - 520
Physician attendance will be monitored by administrator quarterly.