TN to LB 8-7-03

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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
	465117	A. BUILDING _____ B. WING _____	C 7/15/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	COMPLAINT NUMBER
MANOR CARE OF SOUTH OGDEN	5540 SOUTH 1050 EAST OGDEN, UT 84405	UT00001000

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 314 SS=G	483.25(c) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined the facility did not ensure 1 resident received effective pressure relieving devices and effective treatments to prevent pressure sore from developing and /or worsening. (Resident 1) Findings include: Resident 1's medical record was reviewed on 7/15/03. Resident 1 was admitted on 5/21/03 with diagnoses that included open reduction internal fixation of right hip fracture, and senile dementia with depressive features. A resident who is recovering from hip surgery is at risk for pressure ulcers. Reference: U.S. Department of Health and Human Services AHCPR Publication No. 92-0048 May 1992 titled Preventing Pressure Ulcers states, "Persons who are in a coma or who are paralyzed or who have a hip fracture are at special risk...When mental awareness is lowered, a person cannot act to prevent pressure ulcers". An admission assessment, dated 5/21/03, documented that resident 1 had a red area on the left buttock. The	F 314	POC acceptable 8/11/03 Completion date 8/15/03 Rosenbank RD AUG - 7 2003 # 4030094 HT	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/6/03

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.

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F 314	Continued From page 2 impaired [secondary] to left hip fracture and dementia". The DON said per phone conservation, on 7/17/03 at 12:00 PM, the 6/5/03 note was a review of the resident for the previous week (5/30/03 to 6/5/03). Pressure Ulcer Report, which was started on 5/30/03, documents a stage II pressure ulcer measuring 0.8 X 1.8 that had erythema (red area) and a scant amount of serous (clear yellowish) drainage. Assessment was repeated every week from 5/30/03 to 6/24/03, when the report documents the pressure ulcer was resolved. Physician orders, dated 5/29/03, stated, "Cleanse lt. (left) inner buttock [with] NS (normal saline), apply ABX (antibiotic ointment), cover [with] Primapore until site heal (healed). [Change] QD (every day) & PRN (as needed)." On 5/30/03 a new order was written it stated, "St. (stage) II [pressure ulcer] on buttocks, apply IntraSite and Primapore QD (every day) and PRN (as needed) until healed." The RAPS (Resident Assessment Protocols) which was completed with the admission MDS (Minimum Data Set), dated 5/28/03, for resident 1 documented the resident triggered for pressure ulcer. The MDS also documents the following: 1. Section G., which documents ADL (Activities of Daily Living), under bed mobility it documented resident 1 required extensive assistance. 2. Section M., which documents skin treatment, under pressure relieving device(s) for chair and Pressure relieving device(s) for bed nothing was not marked. The Medicare 14 day MDS assessment, dated 6/3/03, on resident 1's medical record documented the following:	F 314	The statements made on this plan of correction are not an admission of guilt and do not constitute an agreement with the alleged deficiencies herein. F 314 Quality of Care Based on comprehensive assessment this facility ensures that residents who enter the facility without pressure sores do not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable and residents having pressure sores receive necessary treatment services to promote healing, prevent infection and prevent new sores from developing. 1. Resident 1 has been reassessed for skin risk and appropriate devices are in place. The pressure area identified had resolved prior to the time of this survey. Resident 1's skin is checked daily paired with a weekly assessment. 2. The skin program is revised and residents reassessed using the Braden Scale. Residents identified at high risk are placed on pressure relieving surfaces to minimize risk of skin breakdown. 3. Newly admitted residents are assessed at time of admission	

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F 314	Continued From page 1 Skin Risk assessed the resident as follows: 1. Nutritional intake, 1 - Adequate, 2. Activity, 1 - Walk/help, 3. Body mobility, 1 - Slightly limited. A score of 3 reveals no skin risk, no intervention indicated. Review of resident 1's physical therapy notes from the hospital, dated 5/20/03, state " Due to pt (patient) pn (pain) level and inability to ambulate and perform transfer/bed mobility S (without) extensive assistance pt is appropriate for SNF (Skilled Nursing Facility) care. Plan on D/C (discharge) pt tomorrow to SNF". Had the facility scored the resident as extensive, a score of 4 would have indicated skin risk and would require intervention. Skin remains intact in Stage I pressure ulcers, these lesions are not ulcers in the usual sense. Reference: U.S. Department of Health and Human Services AHCPR Publication No. 92-0048 May 1992 titled Preventing Pressure Ulcers stated . "Identification of a Stage I pressure ulcer is critical for indicating the need for more vigilant assessment and preventive care. Stage 1: Nonblanchable erythema (red area) of intact skin, the heralding lesion of skin ulceration." There was no documentation in the resident's medical record that the red area on the left buttock was blanchable. Review of the Interdisciplinary Progress Notes from 5/21/03 to 5/29/03 has no documentation of skin assessment for resident 1. On 5/30/03, 9 days after the resident was admitted, the notes stated, "a stage II pressure ulcer on the left buttock measuring 0.8 X 1.8 cm., geo-mat and gel cushion in place as pressure relief device, will monitor." Interdisciplinary Progress Notes dated 6/5/03, stated, "Mobility severely	F 314	employing a visual, full body skin check. 4. Admission documentation is reviewed by the Interdisciplinary Team during the daily morning meeting following each admission. Resident condition is reviewed and changes are made to ensure that areas of concern are identified and preventative measures are implemented. Assistant Directors of Nursing are responsible for auditing the process monthly and the Director of Nursing will ensure on-going compliance. Issues identified are taken to and reviewed by the Quality Improvement Committee for further analysis and review. 5. Date of completion: August 15, 2003.	

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F 314	Continued From page 3 1. Section M., which documents skin treatment, under pressure relieving device(s) for chair and Pressure relieving device(s) for bed nothing was not marked. The facility Support Surfaces, Prevention and Treatment documents the following: 1. Prevention > 9 and/or Stage I, use Foam Overlay, If Foam Overlay not available then use gel or alternating air. In an interview, on 7/15/03 at 1:10 PM, the DON confirmed that preventive measures were not documented in the resident's medical record as being put into place until 5/30/03 and there was no documentation that the red area was blanchable. The care plan for resident 1, dated 5/30/03, documented, "Patient [decreased] mobility d/t (due to) hip fx. (Fracture), [increased] risk skin break down. Goals, stage II (pressure Ulcer) to buttocks will be resolved by next 90 days. Approaches, geomat, gel pad for w/c (wheelchair), keep skin clean and dry, assist [with] positioning, drsg (dressing) [changes] per M.D. orders, encourage adequate nutrition intake". Nothing was written prior to 5/30/03. In an interview with the ADON, on 7/15/03 at 1:10 PM, she said I knew when the resident was admitted the red area would break through and it had been discussed in the Interdisciplinary Team Meeting. The DON agreed the red area on the resident's buttock was discussed in the Interdisciplinary Team Meeting.	F 314		