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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 46A049	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 1/28/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD COMMUNITY CARE CENTER	11 SOUTH MAIN MAYFIELD, UT 84643

COMPLAINT NUMBER 6749

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 309 SS-G	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 interviews with the Administrator, the Director of Nursing, facility nursing staff, Physical Therapist staff, and Physicians, and on review of the medical records, it was determined the facility did not provide the necessary services to maintain the highest practical physical well-being for 1 dependent resident who was assessed by facility nursing and the contracted physical therapist as having experienced a dislocated right hip while at the facility but who was not referred to a radiologist or physician until five days later. Resident 16. Findings include: Resident 16 was admitted to the facility on 8/8/00 with diagnoses including Alzheimer's dementia. Following a temporary discharge on 7/31/02, resident 16 was readmitted to the facility on 8/5/02 with an additional diagnosis of fractured right hip with an open reduction internal fixation (surgical repair). Following a subsequent temporary discharge on 8/29/02 for a closed reduction of dislocated right hip, resident 16 was readmitted to the facility on 8/31/02. MEDICAL RECORD REVIEW: On 1/22/03, resident 16's medical record was	F 309	The highest practical, physical well being of resident #16 was achieved by the corrective action of sending him to Utah Valley Hospital on Aug 29, 2002, for a closed reduction of his dislocated right hip. The facility's nurses will improve their identification of other residents who could have the potential for decrease in physical well-being by attending an inservice on improving the skills of assessment and documentation. Documentation of the communications with physicians and family members will also be emphasized in the inservice training. Review of charting on those residents who are unable to verbalize their pain or change in how they feel because of any form of dementia or speech impairment will be discussed. Methods for assessing pain for these types of residents will be agreed upon. The facility's lines of communication and what constitutes an incident will be reviewed. The director of nursing and the administrator will be more specific in their charting of observations when the other nurses are unsure of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cindy N Peterson
TITLE: Administrator
(X6) DATE: 2-19-03

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 aft such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1 reviewed. The comprehensive Minimum Data Set assessment (MDS), dated 8/19/02 and the quarterly MDS assessment, dated 11/11/02, documented that resident 16's ability to make decisions, section B4, was "3", "severely impaired", which documented resident 16 was rarely or never able to make his own decisions. It was, also, documented the resident's ability to communicate was highly impaired. Section C4, was assessed as "3", which documented the resident was "rarely/never" able to make himself understood. Section C6 was assessed as "3", which documented the resident was "rarely/never" able to understand others. The plan of care for resident 16, dated 8/23/02, documented the resident was unable to describe his needs or wants and that the staff were to anticipate and provide all of his needs, monitor for his non-verbal cues as to what is needed. It was documented, in the plan of care, that resident 16 was totally dependent upon staff for all aspects of his daily activities of living. The plan of care for resident 16 documented that the resident was unable to verbally communicate pain but that his facial expressions confirmed when he was. The facility's plan of care documented that staff was to maintain resident 16's comfort with proper positioning and medication and that the resident's physician would be consulted as needed. The nurse's note dated 8/8/02, documented that resident 16 was "doing well" and that he had a pained look on his face when he was "up to walk." The next nurse's note, dated 8/25/02 AM by nurse 2, documented, "Reported by night nurse that [resident] had been in pain all night. Unable to bear wt [weight]. ® [right] leg is rotated in and hip is swollen." The nurse's note documented that resident 16 was placed on bed rest and was given pain medication every four hours. The nurse's note documented that resident 16 was being turned every two hours and that he had	F 309	their assessments or the condition warrants possible transport to doctor. DON and Administrator will chart the reasoning behind their choice of action or no action. The accusation of resident # 16 having a dislocated hip for 5 days is still denied by this facility. But, because of inadequate documentation and communication between the nursing staff, physical therapist, and the physician, we cannot dispute this finding. Any changes in documentation of physical therapy notes will be reviewed by medical records as to the accuracy of the changes made and the proper initials indicating a change was made. The physical therapy tech will be instructed not to use PT after her charting. The DON and the facility's Administrator, who is also an RN, observed the resident every day between Aug. 25 and Aug. 29 and his level of pain and the appearance of his hip varied significantly	

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F 309	Continued From page 2 facial grimacing when he was turned. Nurse 2's next note, dated 8/25/02 at 2:45 PM, documented that two of resident 16's family members had been notified of the change of condition. Neither note documented that a physician had been consulted. The nurse's note, dated 8/25/02 PM, documented that resident 16's right hip was protruding, that he was on complete bed rest, that the resident acted as if he was in pain and distress, and that he was medicated for pain at bedtime and again at 12:30 AM. On 8/26/02, the morning nurse documented that resident 16, "Continues to have pain in ® hip. Meds [medications] given." The night nurse documented that resident 16 had been medicated for pain. The nurse's note by nurse 2, dated 8/27/02 day shift, documented that physical therapy had been at the facility working with resident 16 and the night nurse documented that resident 16 had been medicated for pain at bedtime. The nurse's notes by RN1, also dated 8/27/02, documented that resident 16 received medication for complaints of pain when he was being put in bed. On 8/29/02, the nurse's note documented that resident 16 had been taken out of the facility for an X-ray which confirmed the resident's hip was dislocated. It also documented that resident 16 was sent by ambulance, at 3:30 PM, to the hospital for surgery. Physical therapy progress notes for resident 16 were reviewed on 1/22/03. The physical therapy progress notes documented that resident 16 ambulated 250 feet on 8/16/02 with improving balance, 300 feet on 8/20/02 without	F 309	throughout the day depending on what position he was in and the position of both his legs. The ER doctor at Utah Valley Hospital had no way of knowing how long his hip was dislocated, as he stated in your quote on page eleven of your interviews, "I can't say it was not subluxation" (partial dislocation) but I don't know how they (nursing facility staff) would have known that." We disagree because the facility's nursing staff observed the joint change position and appearance over the period of five days. The primary care physician also felt that things were handled properly and did not seem upset or concerned that resident #16's care was in any way mishandled or neglected. The fact that so many people were watching, monitoring, and observing resident #16 should be indicative of the quality of care he was receiving and continues to receive at this facility. The facility's medical director and the quality assurance committee will review our policies again on what constitutes an emergency transport incident and what he feels confident in letting us assess before	

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F 309	Continued From page 3 complaints or discomfort, and 300 feet on 8/21/02 with improved standing balance. On 8/16/02, the physical therapist aide documented, in the physical therapy progress notes, that resident 16 had no complaints during therapy, that his balance was improving and he had ambulated 250 feet with front wheeled walker and minimum assist with a shuffle gait. On 8/20/02, the physical therapist aide documented that resident 16 stated his hip sometimes hurt, but that he had ambulated 300 feet with hand held assistance and performed passive exercises without complaints or discomfort. On 8/21/02, the physical therapist aide documented that resident 16's standing balance was improving and he had ambulated 300 feet with hand held assistance. On 8/23/02, the physical therapist aide had documented that resident 16 was pleasant and cooperative. The physical therapist aide documented that resident 16 ambulated 200 feet with moderate hand-hold assist. The physical therapist aide, also, documented resident 16 appeared to be tired and easily fatigued on that date. On 8/27/03, the physical therapist aide documented, "Nursing staff feels pins may have shifted. Doesn't tolerate wt (weight) bearing. Will talk with MD (medical doctor) & (and) get X-rays." The physical therapist aide documented that resident 16 had been muscle guarding more than usual on that date and the resident was unable to tolerate weight bearing secondary to a possible dislocation. The physical therapist further documented that resident 16 would need to be reassessed after the resident had been X-rayed and had seen his physician. On 8/29/02, the physical therapist saw resident 16 at the facility. The physical therapist documented that all	F 309	transporting, in a timely manner, to promote the highest practicable physical, mental, and psychosocial well-being of our residents. Because there was no fall or specific incident with resident #16 which actually caused the dislocation and because it was an ongoing process, Resident #16's condition was not addressed as an incident report requiring review by the quality assurance team at the time. Any nurse at our facility has the ability and duty to call a resident's doctor, or a doctor on call at our local hospital, to order an emergency transport.	

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F 309	See below	F 309	See below	

F 309

Continued From page 4

therapy was held (not provided) and that the physical therapist spoke with staff about the resident's need for a physician's consultation and X-rays. The physical therapist documented that physical therapy would continue to be held until after the physician was consulted.

An X-ray report for resident 16, dated 8/29/02, documented, "Interval placement of a right femoral head and neck prosthesis with superior dislocation relative to the native acetabulum. No findings to suggest fracture or loosening."
"Radiologic Diagnosis:
1. Right femoral head and neck prosthesis. Superior dislocation of the right hip."

Review of the Medication Administration Records (MAR), on 1/22/03, revealed resident 16 had been receiving Lortab 7.5 milligrams prn (as needed) for hip pain. The MAR revealed resident 16's pain medication pattern increased on and after 8/24/02. The MAR for resident 16's prn pain medication documented:

Date:	Day Shift	Night shift	Daily Total
8/5/02	0 Lortab	1 Lortab	1
8/6/02	1 Lortab	0	1
8/7/02	2 Lortab	2 Lortab	4
8/8/02	2 Lortab	2 Lortab	4
8/9/02	4 Lortab	1 Lortab	5
8/10/02	2 Lortab	2 Lortab	4
8/11/02or p	1 Lortab	2 Lortab	3
8/12/02	3 Lortab	2 Lortab	5
8/13/02	2 Lortab	1 Lortab	3
8/14/02	3 Lortab	0	3
8/15/02	2 Lortab	1 Lortab	3
8/16/02	3 Lortab	0	3
8/17/02	3 Lortab	1 Lortab	4
8/18/02	3 Lortab	1 Lortab	4

F 309 (Provider's Plan of Correction)

As part of our quality assurance follow-up of our care, the families of our residents will be surveyed as to their opinion about us providing the necessary care to maintain the highest practical physical, mental, and psychosocial for our residents on an annual basis. The family of resident # 16 was not interviewed by the complaint surveyors and the daughter was here on the day Resident #16 was taken to the doctor and she did not observe him in severe pain. She actually fed him lunch before they went to the doctor. She agreed totally with the process we went through in getting him the care he needed. And the fact that resident #16's family wanted him returned to this facility should convey their confidence that he was being provided the highest possible practical care. We communicate with our families frequently and consult with them about possible choices of care and well-being and will continue to do so. The family survey will help us identify concerns of the

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F 309	Continued From page 5	F 309		

8/19/02 3 Lortab 0 3
8/20/02 3 Lortab 0 3
8/21/02 2 Lortab 0 2
8/22/02 4 Lortab 0 4
8/23/02 3 Lortab 1 Lortab 4
8/24/02 5 Lortab 5 Lortab 10
8/25/02 3 Lortab 2 Lortab 5
8/26/02 5 Lortab 2 Lortab 7
8/27/02 3 Lortab 3 Lortab 6
8/28/02 7 Lortab 3 Lortab 10
8/29/02 3 Lortab Left facility 3

Resident 16's history and physical records were reviewed on 1/22/02. The orthopedic surgeon, who had assessed resident 16 at the hospital on 8/29/02, documented, "The patient is an 82-year-old male who three weeks ago underwent hemiarthroplasty of the right hip. The patient apparently dislocated it five or six days ago, and for some reason, the nursing home decided to investigate it today."

INTERVIEWS:

On 1/27/03 at 1:15 PM, a telephone interview was conducted with the physical therapy aide who had been the most frequent provider of physical therapy for resident 16 in August 2002, following a surgical repair of the resident's fractured right hip. The physical therapist aide stated that the facility nursing staff had reported to her, on 8/27/02, that they thought the resident's right hip was dislocated and they stated they were going to contact resident 16's physician to get an X-ray of the resident's right hip. The physical therapist aide stated that she had been "very surprised to learn that they didn't take care of it that day," because she had observed resident 16 to be in more severe pain than she had seen previously. The physical therapist aide stated that, prior to 8/27/02, resident 16 had demonstrated some discomfort by

Provider's plan of correction:

families we have infrequent contact with. Some families and residents make it known that they don't want to go to the hospital or have any invasive procedures performed. It is our job to consider their rights and advance directives concerning all care. This may mean not giving antibiotics or having x-rays if it is their desire not to do so. Force feeding, even if they have a significant weight loss, is another issue we talk to families frequently about, especially with residents like #16, who is end stage dementia.

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F 309	Continued From page 6 muscle guarding when she worked with him. but that resident 16's pain appeared to be very different on 8/27/02. The physical therapist aide stated that resident 16 was not able to verbalize his discomfort but the resident had displayed a grimacing facial expression and the resident would not let her touch his hip very much. The physical therapist aide stated that on 8/27/02, resident 16 would reach over and try to move her hand away and that the resident's right hip did appear to be displaced. The physical therapist aide stated that, on 8/27/02, she was only able to provide limited passive exercises for resident 16 because the resident was not able to ambulate or bear weight due to the increased pain in his hip. The physical therapist aide stated that after resident 16's hip was put back in place, "the hip was a little tender but not anything like it was before." The physical therapists stated that, prior to 8/27/02, resident 16 had been progressing with his rehabilitation program and that the resident had demonstrated no evidence of the his hip popping in and out. On 1/27/03 at 11:05 AM, a telephone interview was conducted with the physical therapist who was, also, working with resident 16. The physical therapist stated that he remembered going to the facility on 8/29/02 to work with resident 16. The physical therapist stated that he had learned from the facility nursing that they thought resident 16 had a dislocated right hip. He stated he had been communicating with the physical therapist aide who thought the facility had called the physician on 8/27/02. The physical therapist stated the nursing facility staff had not contacted the resident's physician regarding the possible dislocated hip. The physical therapist stated that he called resident 16's physician on 8/29/02 and an X-ray was ordered. The physical therapist stated	F 309	The inservice training for the nurses, the quality assurance meeting, and review with the medical director about polices, will be completed by March 15, 2003. The family surveys will go out in the mail by Feb. 28, 2003. The return and review of those surveys will be an ongoing evaluation of quality improvement and effectiveness of the facility's Plan of Correction. The quarterly ~~IDT~~ QA+IDT meetings will be used to review the quality of care and accuracy of charting for every resident in order to assess the improvement in performance related to obtaining the highest practical, physical well-being of all residents.	by 3-15-2003 Shauna [illegible] 2-20-03 c permission from Cindy Poteiner

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F 309	Continued From page 7 that it was his impression resident 16's physician was not aware of the concern with resident 16's hip prior to the physical therapist's telephone call. Resident 16's primary physician was interviewed by telephone on 1/27/03 at 2:20 PM. Resident 16's physician stated he was not notified of resident 16's possible dislocated hip until 8/29/02. He stated that, on that date, he ordered an X-ray of the resident's hip. The physician stated that resident 16 was sent back to the hospital for repair of the dislocated hip on 8/29/02. The physician stated he was notified of resident 16's dislocated hip by a telephone call that was documented as having been received on 8/28/02, but that the call was received the same day as the X-ray. The X-ray was dated 8/29/02. The physician's notes, provided by resident 16's primary physician, documented that the physician's first notification from the facility regarding the resident's hip displacement was on 8/28/02. The physician clarified this date to be 8/29/02. On 1/22/03 at 10:20 AM, an interview was conducted with a certified nurse aide (CNA) who provided physical assistance to resident 16 for his activities of daily living (ADLs). The CNA (CNA1) stated that she worked with resident 16 about 2 or 3 times a week during the day. CNA1 stated that resident 16 had been working with physical therapy following the surgery to repair the resident's hip fracture and the resident was beginning to do much better before he had to go back to the hospital. CNA1 stated that resident 16 was ambulatory and, because of his confusion, they sometimes had to stop him from running in the hallways. When asked specifically about resident 16's comfort level between 8/25/02 and 8/29/02, CNA1 stated the resident had more pain, especially whenever he had to be moved or transferred. CNA1 stated that	F 309		

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F 309	Continued From page 8 the pain was evident by the expression on resident 16's face and he would grab onto her arms or a chair or whatever was close. CNA1 stated that when the pain in resident 16's hip got better, he became much less resistant to cares that needed to be provided. On 1/22/03 at 10:45 AM, an interview was conducted with a registered nurse (RN) who had been working the night shift during August 2002. The RN (RN1) stated that she had not been working with resident 16 on 8/25/02, but that she had worked with the resident during the following week. RN1 stated that resident 16 had been in a little bit more pain than before 8/25/02, and that the Director of Nursing (DON) was notified. RN1 stated that resident 16 had been receiving routine pain medication after his surgical hip repair, but that that there was some breakthrough pain between 8/25/02 and 8/29/02. RN1 stated the pain was evident by resident 16's grimacing. On 1/22/03 at 11:30 AM, three CNA's were interviewed. Each of the CNA's stated they had worked with resident 16 between the dates of 8/25/02 and 8/29/02. The three CNA's stated that during those dates, resident 16 would not ambulate but would only get up to the wheelchair or commode with assist. The CNA's stated the therapist had noticed a problem with resident 16's hip. On 1/27/03 at 5:00 PM, a telephone interview was conducted with nurse 2, who worked with resident 16. Nurse 2 stated that she didn't know exactly when resident 16's hip was dislocated, but that she had received the report from the night nurse. Nurse 2 stated that she checked resident 16's hip and it looked dislocated. Nurse 2 stated that she had the DON come in to check it the following day but it didn't look the same. They decided to just watch it. Nurse 2 next saw resident 16 on 8/27/02, the day the physical therapist	F 309		

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F 309	Continued From page 9 aide was in, when she noticed a his hip didn't look right again. She put the resident on bed rest. Nurse 2 stated that she had noticed resident 16's hip didn't look right when she worked two days later. She stated that was the day when the physical therapist was in to see resident 16 "and he called the physician." On 1/27/02 at 5:10 PM, nurse 3 was interviewed by telephone. Nurse 3 stated that on Saturday, 8/24/02, when the aides tried to get resident 16 up, they noticed something was wrong and notified her. Nurse 3, in turn, notified the Administrator. Nurse 3 stated that it was difficult to know what was happening because of the resident's dementia and inability to communicate. They decided to watch him. Nurse 3 stated that another nurse notified resident 2's family on 8/25/02. Nurse 3 stated that up until that time, resident 16 had been walking great. Nurse 3 was asked about the procedure for contacting the physician. She stated that, except in cases of emergency, it was customary at their facility to contact the Administrator or DON first and that the administrative staff would make the decision to call the physician or to have the nurse call the physician. The Administrator, who was a registered nurse, and the Director of Nursing (DON) where interviewed on 1/22/03. The Administrator stated she had been called by a nurse and she had gone over to the facility several times to check resident 16's hip. The Administrator stated that she did not document any of those assessments. She stated she found residsent 16 to be okay. The Administrator stated the DON had also assessed resident 16's hip several times and she had found no problem. The Administrator stated that they suspected resident 16 was having muscle spasms, which were causing the residents hip to slip in and out of joint. The Administrator stated that their theory was	F 309		

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FORM APPROVE
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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
	46A049	A. BUILDING ______ B. WING ______	C 1/28/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD COMMUNITY CARE CENTER	11 SOUTH MAIN MAYFIELD, UT 84643

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F 309	Continued From page 10 proven because there was no surgery to repair resident 16's hip, it was a closed reduction and fixation. She stated that was why resident 16 was put on medication for muscle spasms in September 2002. On 1/28/03 at 3:55 PM, the orthopedic surgeon who repaired resident 16's dislocated hip stated he on call when resident 16 was admitted to the hospital on 8/29/02. Regarding the procedure of repairing resident 16's dislocated hip, the surgeon stated, "When I put it in, it took me pulling with all of my might. I had stretch marks on my shoulders." When asked for his opinion regarding the possibility of resident 16's hip joint being worn enough that it could have been moving in and out of the socket, the surgeon stated, "If it came out, it did not go back in on its own." The physician further stated, "I can't say it was not a subluxation, (partial dislocation) but I don't know how they (nursing facility staff) would have known that." The surgeon stated that he had been told resident 16's hip had been out a while, but he was not certain if it had been several days or a week. The surgeon stated that he had called the facility wondering why a physician had not been called sooner. The surgeon stated he was told, when he called, that they had not called because they were told not to.	F 309		