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

PRINTED: 06/30/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. BUILDING ______ B. WING ______	C 06/13/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST LAKE CARE CENTER	1001 NORTH 500 WEST PROVO, UT 84601

(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) COMPLETION DATE
F 309 SS=G	483.25 QUALITY OF CARE	F 309	7/13/05 POC acceptable completion date 8/11/05 [signature]	

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 and record review, it was determined the facility did not provide the necessary care and services to maintain the highest practicable physical and psychosocial well-being for one of 2 quadriplegic residents in the facility. Specifically, the resident was hospitalized, on 2 occasions, with hypotension which had not been treated by the facility according to the resident's plan of care and her established medical regimen. (Resident 1)

Procardia (nifedipine) is the medication usually prescribed to lower blood pressure to treat autonomic dysreflexia in patients with spinal cord injury. It was determined that resident 1 experienced an unusual (paradoxical) effect from the medication. Resident 1's blood pressure dropped (hypotension) when she experienced autonomic dysreflexia and her blood pressure increased when she was given Procardia.

Findings included:

Resident 1 was admitted to the facility August 2003 with diagnoses that included quadriplegia

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 7/11/05

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are 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 secondary to a spinal chord injury, hypotension, and urinary tract infections. Resident 1's medical record was reviewed on 6/13/05. Resident 1's plan of care included problem number 18, dated 6/9/04, of hypotension. It was documented that the facility staff had reviewed and continued the plan of care on 8/23/04, 11/22/04, and 2/28/05. The problem was re-written as number 20 on 5/20/05. The facility's goal for resident 1 was that her blood pressure would remain within normal limits. Approaches the nursing staff were to use to help the resident meet that goal included, "*Medications as ordered" to include "Procardia PRN (to be given as needed)". Resident 1's March 2005 Medication Administration Record (MAR) revealed the resident had an order, dated 10/1/2003, for Nitropaste for the diagnosis of autonomic dysreflexia, to be given as needed for low blood pressure. In addition, the order included instructions that the nurse could "GIVE NIFEDIPINE 10 MG [milligrams] Q30M (EVERY 30 MINUTES). A second order, dated 6/7/04, revealed resident 1 was to receive Procardia [nifedipine] 10 mg SL PRN for autonomic dysreflexia. A hand written note revealed the medication administration instructions were "Emergency hypotension put liquid under tongue." The facility nurses administered the emergency medication to resident 1 on 3/16/05, 3/17/05, 3/24/05 and 3/25/05. The May 2005 MAR revealed the 10/1/03 and the 6/7/04 orders for nitropaste and Procardia	F 309	F309 Resident 1 was discharged. Licensed nurses will be inserviced on: A. Autonomic dysreflexia Symptoms, Treatment, Prevention. B. The importance of following a residents plan of care specifically physicians orders and medications. C. Hypotention. Resident 1 was discharged. Licensed nurses will be inserviced on providing necessary care and services to all residents according to their plan of care specifically following and administering medications per order that regulate blood pressure and proper DX with medication. Medical Records will monitor Medication records for proper documentation and D.O.N. will review thru Quality Assurance committee. Inservice will also include care of residents with autonomic dysreflexia, symptoms, treatment, prevention and hypotension. This will be completed by August 11th, 2005	

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F 309	Continued From page 2 continued unchanged, but the hand written administration instructions were not carried over to the May MAR. Resident 1 received the Procardia on 5/7/05 and 5/10/05 for low blood pressure, at the resident's request. The physician's recertification of orders for resident 1, signed 6/7/05, revealed the 10/1/03 and the 6/7/04 orders for nitropaste and Procardia were to continue unchanged. The June 2005 MAR revealed resident 1's 10/1/03 and 6/7/04 orders for Procardia and nitropaste continued without change until 6/3/05. Nurses' documentation on the MAR revealed resident 1 was not given nitropaste or Procardia during June 2005. A. The first incident: Review of resident 1's behavior charting, dated 6/1/05, revealed the resident had been out of the facility and returned at 11:00 PM with "bright affect smiling et pleasant". The resident stated to a facility nursing assistant that she needed her blood pressure checked. At 11:45 PM, resident 1's blood pressure was reported by the nursing assistant to be 84/62. The resident requested her Procardia. The agency nurse was unfamiliar with resident 1's medication regimen and did not administer the medication. Resident 1 became upset with the nurse. The nurse documented that she stated to resident 1 that she had to review the resident's "chart and assess the situation." It was documented that resident 1's "blood pressure slowly dropped a little to 75/50." Resident 1 called a family member who in turn called an ambulance. It was documented that resident 1 was transported to the hospital.	F 309		

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F 309	Continued From page 3 The agency nurse was interviewed by telephone on 6/15/05 at 9:30 AM. The nurse stated that on her night shift of 5/31/05 at about 11:30 PM, resident 1 requested Procardia. The nurse stated she called the Director of Nursing in her office concerning the situation. The nurse stated the DON advised the medication not be given. The nurse stated that she called the physician who stated, 'Don't give it, but if she continues to demand to go to the hospital, you can send her.' The nurse stated that she was still on the telephone with the physician when the ambulance arrived to transport resident 1 to the hospital. The Emergency Medical Services report for resident 1, dated 6/1/05, was reviewed on 6/16/05. The document revealed that resident 1 was found lying supine on care center bed, alert and oriented. The narrative revealed resident 1 complained that her blood pressure was steadily dropping but the facility nurse would not give medication to help the resident's hypotension. The narrative revealed that resident 1 had received the medication from her family member prior to transport and the resident's blood pressure "did improve." On 6/16/05, hospital records were reviewed for resident 1's admission of 6/1/05. On 6/1/05, the hospital emergency center physician documented that the resident had presented with hypotension. "She apparently has autonomic hypotension due to her quadriplegia and will often have to take some Procardia and Nitroglycerin which paradoxically helps increase her pressure. Apparently the staff and nurse was not familiar with this regimen for some reason and would not give it to her. She decided to	F 309		

07/11/2005 MON 14:43 [TX/RX NO 7339] 006

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come to the hospital then and she had a significant other give her the Procardia and nitroglycerin. It came up a little bit from about 70/45 to about 90/60." Resident 1's "blood pressure 110/70 when she first got here, but then it actually was down in the 80s systolic over 50s diastolic most of the time."

The "FINAL DIAGNOSIS", on the emergency room report revealed resident 1 had hypotension, dehydration, and urinary tract infection. Resident 1 was admitted to the hospital.

The hospital's final report for resident 1's 6/1/05 admission revealed, "[Resident 1] apparently has autonomic hypotension due to her quadriplegia and will often have to take some Procardia and nitroglycerin which paradoxically helps increase her pressure. Apparently the staff and nurse was not familiar with this regimen for some reason and would not give it to her. She decided to come to the hospital then and she had a significant other give her the Procardia and nitroglycerin. It came up a little bit from about 70/45 to about 90/60. She is still feeling weak though."

Resident 1 was discharged from the hospital back to the facility on 6/2/05. The physician orders, dated 6/2/05 included orders for nitroglycerin 2% ointment 1 inch to be applied topically every 6 hours as needed, and Procardia 10 mg to be given orally as needed for " ***HYPOTENSION *** "

A facility nurse's note for resident 1, dated 6/2/05 at 4:00 PM, revealed resident 1 returned from the hospital with all medication orders unchanged plus an order for an antibiotic. The nurse

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F 309	Continued From page 5	F 309		

documented that resident 1 was concerned about receiving her Procardia as ordered. The nurse documented that she "stated it would be taken care of".

A facility nurse's note, dated 6/3/05, and a hand written notation on resident 1's printed MAR for June 2005, revealed an order had been received to change the resident's Procardia prescription to read "Give only if BP [blood pressure] [is greater than] 130."

B. The Second Incident:
A facility nurse's note for resident 1, dated 6/5/06 at 00:10 AM, revealed the resident had "called ambulance [without] telling facility / nurse." The nurse documented resident 1 had stated she felt a headache between her eyes and felt that her blood pressure was about to drop. The nurse documented that the nursing assistants had monitored resident 1's blood pressure. Resident 1's blood pressure readings were documented at:
11:30 PM, 114/72
11:45 PM, 97/76
11:50 PM, 90/67.
The facility nurse documented resident 1's family member gave the resident Procardia without physician's orders and the resident's blood pressure was 95/67 at 11:55 PM and 94/59 at 00:10 AM.

The Emergency Medical Services report for resident 1, dated 6/5/05, was reviewed on 6/16/05. The document revealed that resident 1 had dysreflexia and used Procardia to bring her blood pressure up. Resident 1's blood pressure "was 90/60 on arrival et [and] [the facility] staff would not administer Procardia as pt [resident 1] requested. Pt called "911"." It was documented

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F 309	Continued From page 6 that resident 1 stated to the emergency crew that she was "afraid they're going to let me die." The document revealed resident 1's family member arrived at the facility and administered Procardia before the resident was transported to the hospital and the resident's blood pressure "did go up". On 6/16/05, hospital records were reviewed for resident 1's admission of 6/5/05. On 6/5/05, the hospital emergency center physician documented that the resident had a history of autonomic dysreflexia and hypotension. The physicians history and physical revealed the resident had been admitted four days prior for similar symptoms and treatment was begun, at that time, for a urinary tract infection as well as the resident's hypotension. Resident 1 "was given a dose of Procardia prior to coming, but continued to have low blood pressures in 70 systolic." Resident 1 was admitted to the hospital. The hospital admitting notes, dated 6/5/05 at 3:20 AM revealed that resident 1's hypotension had responded to intravenous fluid, Procardia, nitroglycerin and atropine in the emergency department. "THE ASSESSMENT AND PLAN" for resident 1 revealed, "We will continue IV fluid hydration and treat with these medications as needed." The hospital physician's orders, dated 6/5/05 at 8:20 AM, revealed resident 1 was to be transferred "to the 5th Floor for Cardiac monitoring Keep same medications". The hospital physician's notes, dated 6/8/05 at 1:48 PM, revealed the resident had orthostatic	F 309		

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hypotension secondary to autonomic dysreflexia and had been "given nifedipine with good results."

On 6/8/05, the hospital physician documented that resident 1 was being discharged to the transitional care unit with the same orders, which included nifedipine 10 milligrams sublingually as needed for "systolic blood pressure less than 90." The physician documented, "[Resident 1] has been treated in the past by spinal cord specialist at [medical center], [Doctor] and apparently he has prescribed sublingual nifedipine for orthostatic hypotension in [resident 1]'s case. Apparently the nifedipine has a paradoxical effect on [resident 1]'s blood pressure. When [resident 1]'s blood pressure goes below 90 and she feels symptomatic, a dose of sublingual nifedipine improves [resident 1]'s blood pressure.

On, 6/10/05, resident 1 was discharged from the hospital to another facility. The physician's "BRIEF HISTORY" revealed resident 1 had "a paradoxical reaction to sublingual nifedipine for her orthostatic hypotension. She received numerous doses of that medication during her hospital stay, and her blood pressure always paradoxically increased . . . The patient has agreed to only take the nifedipine should her blood pressure be less than 90 and she is symptomatic."

Documentation by a hospital social services worker, dated 6/5/05, revealed that resident 1 did "not feel safe returning" to this facility.

An interview was conducted with the Director of Nursing (DON) on 6/13/05 at 4:45 PM. The DON stated that she had been in the facility late the evening of 5/31/05 and morning of 6/1/05, when

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F 309	Continued From page 8 resident 1 requested nifedipine for her low blood pressure. The DON stated the agency nurse called concerning the resident's request, and that she stated not to give the medication. The DON stated that the physician was called and he did not want the nifedipine given. The DON was requested to assist the surveyor in locating the original physician's orders for treatment of resident 1's autonomic dysreflexia. The DON stated that the original orders could not be located and she did not know who resident 1's physician had been when the orders were received.	F 309		