corrections to POC / by telephone with Administra 02/21/01 HS

POC acceptable Linda Boulden

DEPARTMENT OF HEALTH AND H AN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/17/01
FORM APPROVED
2567-L

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 465067 | A. BUILDING _____ B. WING _____ | 1/10/01 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ROCKY MOUNTAIN CARE CLEARFIELD | 1450 S 1500 E CLEARFIELD, UT 84015 |

| (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 |
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| F 252 SS=E | Based on observation the facility did not provide a safe, clean, comfortable and homelike environment as evidenced by: 20 of 20 resident bathrooms and rooms were unclean or had areas on walls or floors in need of significant repair. (Room identifiers 101, 106, 114, 116, 119, 203, 204, 205, 207, 209, 301, 305, 307, 311, 312, 401, 403, 406, 407, 408)<br><br>Findings include:<br><br>On 1/4/01, during the environmental survey task, all resident restrooms and rooms were observed. Five restrooms or rooms from each hall were selected to identify problems.<br><br>1. Resident room 101 was observed to have an area beside bed B, which measured three feet by two feet, with wallpaper scraped off or hanging partially attached to the wall.<br><br>2. Resident room 106 was observed to have a metal door frame, that extended from the top of the outside of the door to the floor, that was attached only at the top of the door with one screw.<br><br>3. The resident bathroom in room 114 was observed to have white caulking around the bottom of the toilet and the linoleum, that was lifting or completely pulled away from the floor. The toilet caulking had areas that were stained a dark brown color around the edges. A mirror had been removed and replaced above the sink. The area behind the original mirror was left unpainted and there were two screws left in the wall. Between the two resident beds was an area on the wall, 18 inches by 8 inches, that had been | F 252 | 02/02/01 HS<br><br>F252<br>1. Room 101, bed B will have wallpaper removed and walls repaired. Maintenance will do a monthly inspection to identify problems. Date completed: March 10, 2001<br><br>2. Room 106, doorframe will be fixed. Maintenance will do a monthly inspection to identify problems. Date completed: March 10, 2001<br><br>3. Room 114, old caulking will be scrapped off and new caulking will be applied. The area above the sink will be repaired and painted. The wall between the beds will be repaired and painted. Maintenance will do a monthly inspection to identify problems. Date completed: March 10, 2001 | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Heather Woodbury

TITLE: Administrator 2/2/01

(X6) DATE: 03/10/01

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 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 252 | Continued From page 1<br>repaired. The repaired area had not been smoothed or textured to blend with the original look of the wall.<br><br>4. Resident room 116 was observed to have a scrape on the wall, beside bed A, that measured 1and 1/2 feet by 1 and 1/2 feet. There was a scrape, beside bed B, that measured 1 foot by 1 foot. The scrapes extended deep into the wall board.<br><br>5. Resident room 119 was observed to have two areas, beside bed A, that measured 4 inches by 4 inches,<br>with paint scraped off. The resident bathroom revealed brown stains in all corners of the bathroom and all along the coving where it met the floor.<br><br>6. Resident room 203 was observed to have an area on the wall, behind the resident's recliner for bed B, where the wallboard was damaged and unrepaired, that measured 18 inches by 4 inches.<br><br>7. Resident room 204 was observed to have three scraped areas, behind bed B, that measured 4 feet by 4 inches, where paint was off. The linoleum directly under the sink had a large dark brown stain. There was brown debris in all four corners of the floor. The lid to the tank of the toilet had a crack that extended across the top from the front edge to the back edge.<br><br>8. Resident bathroom 205 had an accumulation of rust, above the top of the towel rack, that measured 4 inches in diameter. The linoleum had brown debris in all four corners and along the bottom of the coving around the entire area of the bathroom.<br><br>9. Resident bathroom 207 had an area on the wall beside the sink where paint was peeling 9 inches | F 252 | 4. Room 116, scrape on wall by bed A will be patched and painted. The scrape on the wall by bed B will be patched and painted. Maintenance will do a monthly inspection to identify problems. Date completed: March 10, 2001<br><br>5. Room 119, wall by bed A will be sanded, smoothed, and painted. Brown stains will be removed from bathroom. Maintenance will do a monthly inspection to identify problems. Date completed: March 10, 2001<br><br>6. Room 203, wall behind recliner will be patched and repainted. Maintenance will do a monthly inspection to identify problems. Date completed: March 10, 2001<br><br>7. Room 204, wall behind bed B will be patched and painted to match the room. The linoleum will be deep cleaned to remove stains under the sink and the corners. The toilet lid will be replaced. Maintenance will do a monthly inspection to identify problems. Date completed: March 10, 2001<br><br>8. Room 205, towel rack will be replaced and linoleum deep cleaned. Maintenance will do a monthly inspection to identify problems. Date completed: March 10, 2001<br><br>9. Room 207, area by sink will be sanded and painted to match the room. The floor will be deep cleaned to remove debris in corners. Maintenance will do a monthly inspection to identify problems. Date completed: March 10, 2001 | |

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| F 252 | Continued From page 2<br>long. There was a hole 2 inches in diameter, within that area, that was not repaired. There was brown/orange debris in all four corners of the floor.<br><br>10. Resident bathroom 209 had brown discoloration along the edges of the coving of the entire floor. There was a round grey stain on the linoleum in front of and along the edges of the toilet base. There was a hole in the wall beside bed A, that had been repaired but not painted.<br><br>11. Resident bathroom 301had brown and grey stains in front and around the edges of the toilet base on the linoleum. One of the bathroom windows had a piece of plastic taped over the window. The tape holding the plastic was not adhering at the bottom and along two edges of the window frame. There was a large scrape on the wall, behind bed B, that measured 1 foot by 1 foot.<br><br>12. Resident bathroom 305 had a grey stain on the linoleum in front of the toilet. The white caulking at the front of the toilet base was removed. The white caulking around the edges and back of the toilet base were stained a brown color and lifting in several areas. The grab bar on the wall was not present and the screws were left in the wall. There were two scrapes on the wall behind bed B. One measured 18 inches and the other measured 8 inches by 4 inches.<br><br>13. Resident bathroom 307 linoleum was stained grey over the entire floor. On the linoleum, where the coving meets the linoleum, was a buildup of dark brown stain and debris.<br><br>14. Resident bathroom 311 had grey, brown stains on the linoleum in front of and around the edges of the | F 252 | 10. Room 209, bathroom will be deep cleaned to remove stains along the edges of the toilet. The hole will be patched and painted. Maintenance will do a monthly inspection to identify problems. Date completed: March 10, 2001<br><br>11. Room 301, bathroom will be deep cleaned and the stains removed. The plastic tape will be removed. The scrape on wall will be patched and painted to match room. Maintenance will do a monthly inspection to identify problems. Date completed: March 10,2001<br><br>12. Room 305, bathroom will be deep cleaned and stains removed. The caulk will be removed and new caulk put in its place. The holes in the bathroom wall will be fixed. Wall behind bed B will be repaired. Maintenance will do a monthly inspection to identify problems. Date completed: March 10, 2001<br><br>13. Room 307, bathroom will be deep cleaned to remove stains. Maintenance will do a monthly inspection to identify problems. Date completed: March 10, 2001<br><br>14. Room 311, bathroom will be deep cleaned and stains removed. The cove will be replaced. Maintenance will do a monthly inspection to identify problems. Date completed: March 10, 2001 | |

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| F 252 | Continued From page 3<br>toilet base. There were brown stains at the edges of the coving where the coving meets the linoleum. In the corners of the bathroom the coving did not come together leaving a space for debris to collect.<br><br>15. Resident bathroom 312 had brown stains on the linoleum under the sink. The toilet lid was stained with brown along the inside edges. The plastic faucet handle, on the hot side, had a two inches deep, dark green buildup, inside the plastic .<br><br>16. Resident bathroom 401 had an unpainted area, behind and to the side of the toilet, that measured 1 foot by 5 inches. The paint was chipped and not present in areas on the toilet ring, making it unsanitizable. There was an electrical outlet behind bed A. An area around the electrical outlet that measured 2 feet by 1 foot had been repaired. The repair consisted of uneven wall filler with areas deeply grooved.<br><br>17. Resident bathroom 403 had a large grey stain on the linoleum in front of the toilet. There was an unrepaired area on the wall above the sink at the edge of the soap dispenser in a rectangular shape where the paint was not present. There were two areas on the wall, behind bed A, where a solid, textured wallpaper had been completely torn off in one area and another area that had been torn but remained attached at one edge. There was a hole in the wall above bed B, 2 inches in diameter.<br><br>18. Resident bathroom 406 had a grey stain on the linoleum in front of the base of the toilet. There was a crack in the linoleum running from the door toward the sink that measured 6 inches long. The wall area between the two resident beds had several holes that | F 252 | 15. Room 312, bathroom will be deep cleaned and stains removed. The toilet seat and faucet will be replaced. Maintenance will do a monthly inspection to identify problems. Date completed: March 10, 2001<br><br>16. Room 401, area behind and to the side of the toilet will be painted. The toilet seat will be replaced. The wall behind bed A will be repaired. Maintenance will do a monthly inspection to identify problems. Date completed: March 10, 2001<br><br>17. Room 403, bathroom floor will be deep cleaned and stains removed. Area above sink will be painted. The wallpaper will be repaired behind bed A. Hole above bed B will be repaired. Maintenance will do a monthly inspection to identify problems. Date completed: March 10, 2001<br><br>18. Room 406, bathroom will be deep cleaned to remove stains. Floor will be replaced. Holes will be patched and painted to match the room. Maintenance will do a monthly inspection to identify problems. Date completed: March 10, 2001 | |

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| F 252 | Continued From page 4<br>were not repaired, making them unsanitizable.<br><br>19. Resident bathroom 407 had a brown stain on the linoleum to the right side of the toilet. There was a wet area in the center of the stain. The white caulking at the front, right edge of the toilet base was not present, leaving a distinct opening between the linoleum and the bottom of the toilet base into the space under the toilet base, making it unsanitizable.<br><br>20. Resident bathroom 408 had a grey, brown stain on the linoleum in front of the toilet. The linoleum had brown debris collected along the edge of the coving where the coving meets the linoleum. The toilet lid had areas where the paint was missing and chipped, making it unsanitizable. | F 252 | 19. Room 407, bathroom will be deep cleaned and the stains removed. Toilet seal will be replaced. The caulking will be replaced. Maintenance will do a monthly inspection to identify problems. Date completed: March 10, 2001<br><br>20. Room 408, bathroom will be deep cleaned to remove brown stains on the floor in front of the toilet, and remove debris from corners. The toilet lid will be replaced. Maintenance will do a monthly inspection to identify problems. Date completed: March 10, 2001<br>F252 A cleaning schedule for resident rooms. Each will be cleaned daily. 1 Room will be deep cleaned each day by house keeping as assigned. | |
| F 276 SS=D | Based on interview and record review, it was determined the facility did not complete quarterly assessments using the Minimum Data Set (MDS) assessment instrument which is specified by Utah State and approved by Health Care Finance Administration (HCFA) for 3 of 17 residents reviewed. Residents: 62, 67, and 76<br><br>Findings include:<br><br>In an interview with the Director of Nurses (DON) and the MDS nurse, on 1/4/01 at 3:15 PM, they stated the facility was using a new software program to input the MDS assessments. They further stated a hand written MDS assessment form was put in the | F 276 | A monthly check of each room will be conducted by house keeping. Results will be reviewed in quarterly QA. | |

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| F 276 | Continued From page 5<br>charts along with the new form they were using. They stated they left the handwritten copy in the residents' records because they knew the typed computerized forms did not contain all the required information.<br><br>Record review of the MDS assessments for residents 62, 67, and 76 revealed the MDS quarterlies did not include complete documentation of the required information. Required information that was not available on the facility's new quarterly MDS form included: Dates and Signatures of Persons Completing Parts of the Assessment - section AA9, Memory/Recall Ability - Section B3 a-e, Activities of Daily Living (ADL) Support Provided - section G1 B a-j, Test for Balance - section G3 a-b, Task Segmentation - section g7, Bowel Elimination Pattern - section H2 c, Diseases - section I1 m, r-t, v-w, z, ee, ff, rr, Infections - section I2 a-i, k, l, Problem Conditions - section J1 a-b, d-e, g-h, j-l, n-o, Oral Problems - section K1 a-b, d, Height and Weight - section K2 a-b, Nutritional Approaches - section K5 a, Other Skin Problems - section M4 a-h, Skin Treatments - section M5 a-j, Foot Problems - section M6 a-g, Injections - section O3, Special Treatments - section P1a a-s, P1b A and B a-e, Nursing Rehabilitation - section P3 a-k, Physician Visits - section P7, and Physician Orders - section P8.<br><br>1. Resident 62 was a 93 year old female who admitted to the facility, on 4/28/93, with diagnosis including fractured left hip, stroke, atrial fibrillation, urinary tract infection, insomnia, constipation, and pressure ulcer.<br><br>Review of resident 62's records on 1/3/01, documented the resident's MDS assessments were | F 276<br><br>276 | F276 Quarterly Assessments will be completed using the assessment instrument specified by Utah and HCFA. This will be accomplished by:<br><br>• The software problem resulting in incomplete printing of the quarterly reviews and incorrect format for the MDS assessments was corrected by Rocky Mountain Care Management's computer department during the survey.<br>• The quarterly reviews will include all information as required by Utah and HCFA.<br><br>• Corrected forms will be printed, signed and put in charts to replace incomplete forms in all resident charts.<br><br>• Resident 62, 67, and 76 MDS forms will be reprinted and placed in their charts.<br><br>• The director of clinical operations, medical records staff, and the administrator will monitor for compliance on an ongoing basis.<br><br>1/10/01<br>Any computer issues with the MDS will be reviewed quarterly in QA. | |

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| F 276 | Continued From page 6<br>completed as required until the 11/10/00 quarterly MDS assessment. Resident 62's 11/10/00 MDS was typed in the facility's new format and did not include the information listed above. The hand written worksheet for the 11/10/00 MDS did not have the reason for assessment, the notation indicating if it was an original or corrected copy of the form, a signature by the person coordinating the assessment, did not have signatures of any persons completing parts of the assessment, and did not have the MDS completion date.<br><br>2. Resident 67 was a 77 year old female who admitted to the facility, on 1/14/98, with diagnoses including insulin dependent diabetes mellitus, dementia with depressive features, chronic urinary tract infection, old cerebral vascular accident, and edema.<br><br>Review of resident 67's records on 1/4/01, documented the resident's MDS assessments were completed as required until the 12/15/00 quarterly MDS assessment. Resident 67's 12/15/00 MDS was typed in the facility's new format and did not include the information listed above. The hand written worksheet for the 12/15/00 MDS did not have the reason for assessment, the notation indicating if it was an original or corrected copy of the form, a signature by the person coordinating the assessment, did not have signatures of all persons completing parts of the assessment, and did not have the MDS completion date.<br><br>3. Resident 76 was an 88 year old female who admitted to the facility, on 9/30/99, with diagnoses including hip fracture, fluid volume depletion, syncope, diabetes mellitus, dementia, and urinary | F 276 | | |

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| F 276 | Continued From page 7<br>tract infection.<br><br>Review of resident 76's records on 1/4/01, documented the resident's MDS assessments were completed as required until the 12/1/00 quarterly MDS assessment. Resident 76's 12/1/00 MDS was typed in the facility's new format and did not include the information listed above. | F 276 | | |
| F 309 SS=D | 483.25QUALITY OF CARE<br><br>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<br>Based on observation of a treatment procedure for resident 58's pressure ulcer, it was determined the facility did not provide the highest practicable nursing care when providing wound treatment for 1 supplementary resident. Resident 58<br><br>Findings include:<br><br>During an observation of a dressing change procedure for resident 58, on 1/4/01 at 10:30 AM, a facility nurse was observed to compromise the integrity of a stage IV pressure ulcer on the resident's buttocks.<br><br>Observation of the procedure revealed the nurse:<br><br>1. Washed her hands and put on clean gloves. The nurse removed the outer soiled dressing and disposed of it with the soiled gloves. | F 309 | F309 Each resident must receive and the facility must provide the necessary care and services to obtain or maintain the highest practicable physical, mental and psychosocial well being in accordance with comprehensive assessment. This will be accomplished by:<br><br>• The nurse will receive individual inservice training by the DON. Teaching will include gloving, handwashing, sterile field, and correct procedure for a dressing change.<br>• Educational inservice has been scheduled by the DON on 2/1/01for all nurses to review dressing change procedures.<br>• Nurses will demonstrate dressing change procedure at least yearly following educational review of techniques. DON and DSD will observe and record proficiency.<br>• DON and DSD will monitor compliance on an ongoing basis.<br><br>2/1/01 | |

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| F 309 | Continued From page 8<br>2. Put on clean gloves and washed the residents rectal area with a peri wipe (premoistened cleansing cloth). Disposed of the peri wipe and the soiled gloves.<br><br>3. Put on clean gloves and removed the soiled wound packing with her fingers. The nurse sprayed the wound with Constant Clens, a wound cleanser.<br><br>4. Then the nurse, without washing her hands or changing her gloves, picked up sterile 4 x 4's (gauze sponges) and patted the edges of resident 58's pressure ulcer. The nurse was then observed placing the soiled 4 x 4's into the wound bed and twisting them around inside the pressure ulcer.<br><br>5. Without washing her hands or changing her gloves, the nurse used her fingers to place a new packing into the wound.<br><br>6. The nurse removed her gloves, washed her hands, and regloved before applying a sterile adhesive dressing over the wound. | F 309 | | |
| F 314 SS=G | 483.25(c)QUALITY OF CARE<br><br>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<br>Based on observation, medical record review and interview the facility did not ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical | F 314 | | |

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| F 314 | Continued From page 9 | F 314 | | |

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 occurred in two of 19 sampled residents. Resident 14 developed a skin breakdown on the heel which the facility did not consistently assess nor were preventative measures implemented until after the breakdown was present. Resident 56 developed a pressure sore to the coccyx which was not treated for 12 days after the first mention of its presence in the nurse's notes. Interviews revealed the facility did not have a system in place to monitor residents for skin break down and consistently assess the stage, size and progress of healing. Resident identifiers: 14, 56.

Findings include:

RESIDENT 14

1. Resident 14 was an eighty one year old female who was admitted to the facility on 10/16/00, with the following diagnoses: total hip replacement, high blood pressure, depression, history of deep vein thrombosis, anemia, osteoporosis and gastric esophageal reflux. She was admitted to rehabilitate from the hip surgery.

2. Medical record review revealed the following:

a. Review of the form titled Nursing History and Physical Assessment dated 10/16/00, the day of admission, documented that resident 14's skin was "WDI [warm, dry and intact] with exception of L [left] hip 15" incision with staples draining purulent [milky colored] drainage sc [scarce] to mod

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| ROCKY MOUNTAIN CARE CLEARFIELD | 1450 S 1500 E CLEARFIELD, UT 84015 |

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| F 314 | Continued From page 10<br>[moderate] amount. Open (blister like) area L [left] groin opsite [clear dressing] covering open scab area distal [lower end] incision open to air. There was no mention of other problems with the resident's skin. No mention was made of the implementation of preventative measures such as heel booties, pressure relieving devices for the bed and keeping the resident's heels from resting on the bed. The only mention of the resident's feet was that the left foot was slightly swollen. Under the Functional Status section it was documented that the resident's mobility was impaired, requiring a two person assist with walking, transferring, bed mobility and dressing and grooming.<br><br>b. Review of the admission fourteen day Minimum Data Set (MDS) Nursing Home Resident Assessment and Care Screening form dated 10/29/00, revealed that resident 14 required extensive assistance and one person support with bed mobility and transferring. She had not walked yet. She was totally dependent on staff for locomotion on and off the unit, requiring a one person assist for these tasks.<br><br>Under section M. skin conditions no mention was made of pressure sores. For skin treatment the MDS indicated the resident was on a turning/positioning program, received surgical wound care and application of dressings, and "other preventative or protective skin care (other than to the feet)". Under number 6 titled "Foot problems and care" the form indicated that "Resident has one or more foot problems-e.g., corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems". The items dealing with open lesions on the foot and infection of the foot were not checked. | F 314 | F314 Residents entering the facility without pressure sores will not develop pressure sores unless clinically unavoidable. This will be accomplished by the following measures:<br><br>1. Resident 14 will be assessed by the charge nurse for risk factors that may contribute to further skin breakdown. Pressure relief measures—heel pads, heels off bed and recliner footrest with pillow, turning schedules, resting periods, skin care, toileting, —will be incorporated into current plan of care. An acute care plan will be written by the nurse to address the heel breakdown including treatment and interventions for pressure relief. Weekly clinical notes will be written by nurses to reflect the progress of the wound and measures to relieve pressure. Notations will be made daily on the treatment record by the nurse to document treatment interventions. Weekly skin checks will be done by the nurses to monitor for additional breakdown. Monthly/summaries/assessments written by nurses will reflect overall skin condition and necessary interventions. The dietician will assess and document nutritional status and needs of the resident including vitamin supplements, increased calories, and increased protein for healing. A significant change of condition MDS will be completed by the IDT to capture the wound information. | |

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| F 314 | Continued From page 11<br>c. Review of resident 14's nurse's progress notes revealed the following:<br><br>There was no mention of redness, break down or problems with the skin on the feet or mention made of using pressure relieving devices or keeping the residents heels off the bed surface until 11/12/00. On 11/8 /00 and 11/11/00 the nurse stated that the skin was warm dry and intact.<br><br>On 11/12/00 the following comment was made in the nurse's notes: "Dressing applied to L [left] heel. 1+ purple, hard area heel with no drainage or odor. Heel booties on when up and in bed. Pressure relieved from heels with pillows. To monitor."<br><br>The nurse's notes mentioned dressing changes but the left heel pressure area was not described, staged or measurements given until 12/11/00, almost a month later, when the following was stated: "Dressing cont. (continues) to L. heel 2.5 cm. discolored intact area. No s/s [signs and symptoms] of infection noted."<br><br>Another nurses note dated 12/22/00, indicated that the left heel was healed.<br><br>d. Review of the physician's orders revealed a telephone order dated 11/11/00, which stated: "Dsg. [dressing] L. heel. Check and change Q [every] day. Keep heals off bed. Apply heel protectors".<br><br>e. Review of the Treatment Administration Record for November 2000, included the physician's order for the dressing to the left heel as well as to "Float heels off bed - apply heel protectors". The date listed for the order on the treatment sheet was 11/12. It was not initialed by the nursing staff as done until | F 314 | | |

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| F 314 | Continued From page 12<br>11/13/00. Review of the October 2000 treatment record did not include monitoring or applying any pressure relieving devices or to keep the heels of the bed.<br><br>f. Review of resident 14's care plan revealed the following:<br><br>Problem #8, dated 10/30/00, was listed as "Potential for impaired skin integrity". The goal was listed as "Resident will have no skin break down x 30 days". The interventions were to assess skin with bathing and activities of daily living, ensure skin is clean, dry, and lubricated, ensure position changes every two hours and encourage nutrition and hydration. There was no mention of pressure relieving devices or to keep the heels from resting on the bed.<br><br>A page of the care plan titled "Acute/Temporary" listed problem #2A as "Impaired Skin Integrity R/T [related to] L. heel break down". The goal stated: "Resident will have intact skin L. heel x 14 days and the interventions were to assess heel daily, apply dsg.'s [dressings] as per orders, keep pressure off heels, apply heel booties, and reposition Q [every] 2 hours and PRN [when necessary]. The date listed on the care plan for this problem was dated 11/11/00.<br><br>g. Review of the medical record revealed no documentation of skin assessments to ascertain if the resident was at risk for skin break down and in need of pressure relieving interventions. There was no documentation of periodic visual inspections of the resident's skin surface by licensed staff.<br><br>h. Review of the nutritional care plan and progress notes did not address the resident's skin break down | F 314 | | |

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| F 314 | Continued From page 13 | F 314 | | |

and possible need for increased protein to facilitate healing. The dietician's progress notes dated 10/28/00, indicated the resident's height was 64"and her weight was 139 pounds and stated that the resident's "meal intakes have been fair - poor for all meals".

INTERVIEWS:

1. During an interview with the licensed nurse caring for Resident 14 on 1/10/00, she stated the resident did have a pressure sore on her heel which was now healed. When asked where the surveyor could find documentation of assessments of the sore's progress she indicated it would be in the treatment book.

Review of the treatment book revealed the following:

a. On 11/11/00, there was a description of the heel which stated, "L. (left) heel hard area 1+ purple in color 0 drainage. Dry dressing applied for protection. Blue booties and heel floating on pillows to keep pressure off heel.

b. There was one picture of a heel pressure sore in the book. It was dated 11/30/00, and showed an area which was brown in color and peeling. There was no written description, measurements or stage of the breakdown on the sheet the photo was mounted on. There was no other documentation concerning the heel in the treatment book.

2. During an interview with the Director of Nurses on 01/10/01, when asked whether the facility had a skin team or system in place to track pressure sores she stated they did not. She also indicated that there was not a policy in place for staff to perform weekly

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| F 314 | Continued From page 14<br>skin assessments on residents. She stated that these were items which they were planning on implementing in the near future.<br><br>RESIDENT 56<br><br>Resident 56 was an 80 year old female who admitted to the facility on 2/1/99 with the following diagnoses: rheumatoid arthritis, Alzheimer's dementia, , coronary artery disease, hypertension, osteoporosis, constipation, and history of breast cancer. Resident 56 was documented by facility nursing staff to have a stage II pressure ulcer on 8/31/00 but no treatment order was obtained until 9/12/00, 12 days later.<br><br>1. Medical record review of nursing monthly summaries and photographic wound documentation revealed the following:<br><br>Review of resident 56's nursing monthly summaries documented the resident's skin to be warm, dry and intact until August, 2000. The nursing monthly summary for resident 56, dated 8/31/00, documented the resident's skin condition to be, " WD&I (warm, dry, and intact) exception with DQ (decubitus ulcer/pressure ulcer) on coccyx, stage II". A stage II pressure ulcer is defined in the facilities Policy and Procedure for decubitus ulcers to be "skin blisters or superficial skin break". The pressure ulcer was documented to be, "2cm (centimeters) diameter" with no drainage.<br><br>Review of photographic wound documentation for resident 56, dated 9/8/00, revealed a photo of the pressure ulcer on resident 56's coccyx and documentation that the wound was "stage II", measured "1cm x 1cm" with no measurable depth, | F 314 | 2. Resident 56 has been reassessed by the charge nurse for factors that could contribute to further breakdown. The pressure sore has been reevaluated and dressing changes ordered 1/29/01. The MD was notified and the infection was treated with antibiotics. Additional pressure relief measures were implemented including last up/first down status, and side lying only. The dietician will evaluate the resident for nutritional needs including vitamin supplements, increased calories, and increased protein for wound healing. A significant change of condition MDS will be completed by 1/31/01 to address all areas of change including skin problems. A care plan will be written to reflect the current status of the resident. Weekly progress notes will be written by nurses to monitor the progress of the wound. Weekly skin checks will be done by the nurse to assess for further breakdown and to assess for pressure relief needs. | |

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| F 314 | Continued From page 15<br>was colored "white around pink" and there was no drainage or odor.<br><br>Review of photographic wound documentation for resident 56, dated 9/14/00, revealed a photo of resident 56's pressure ulcer and documentation that the wound measured "2cm x 1cm" with depth documented as "stage II", color was "dark pink", there was a "small amount" of drainage, but no odor.<br><br>Review of photographic wound documentation for resident 56, dated 10/12/00, revealed a photo of the pressure ulcer on resident 56's coccyx and documentation that the wound was "stage II", measured 1cm x 1 1/2 cm" with no depth or drainage. The wound color was documented as "white/pink", and there was no odor.<br><br>Review of photographic wound documentation for resident 56, dated 10/20/01, revealed a photo of the pressure ulcer on resident 56's coccyx and documentation that the wound was "stage II', 1 1/2cm x 1 1/2cm with no depth or drainage. The wound color was documented as "white around site red blister", and there was a "foul" odor.<br><br>Review of photographic wound documentation for resident 56, dated 11/2/00, revealed a photo of the pressure ulcer on resident 56's coccyx and documentation that the wound was "stage II", "1cm x 1cm" with no depth, and had no drainage. The wound color was documented as "white center" and it had a "foul odor".<br><br>Review of photographic wound documentation for resident 56, dated 11/25/00, revealed a photo of the pressure ulcer on resident 56's coccyx and | F 314 | | |

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| F 314 | Continued From page 16<br>documentation that the wound was "stage II", 1cm x 1cm, with no depth or drainage. The wound color was documented as "pink and white" and it had a "foul odor".<br><br>2. Review of nurses progress notes and physician's orders revealed:<br><br>Review of resident 56's licensed nurse's progress notes documented, "Skin dry/intact" on 8/2/00. There was no mention of skin condition on 8/9/00. On 8/1/6/00 it was documented that resident 56's "Skin warm and dry". There was no mention of the resident's skin condition on 9/8/00. Licensed nurses progress notes for resident 56, dated 9/11/00, documented "[physician] office called re: Stage II DQ coccyx." The notes did not mention a return call regarding a treatment order nor that any nursing measures had been implemented.<br><br>The 9/12/00 licensed nurse's progress note documented, "Stage II DQ to coccyx continues on pain meds [medications]." No other treatment was documented at that time. There were no other licensed nurse's progress notes in resident 56's record for eight weeks. On 11/16/00 it was documented that her diet order was "changed from regular to pureed", but no skin assessment was documented at that time.<br><br>Review of physician's orders for resident 56 documented one telephone order, dated 9/12/00 at 0900, for "Viasorb dressing to coccyx - change 3-5 days prn." No other physician orders for pressure ulcer treatment were located in resident 56's chart.<br><br>3. Review of resident 56's MDS and care plan revealed the following: | F 314 | | |

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| F 314 | Continued From page 17<br><br>Review of resident 56's MDS assessments dated from 5/12/99 through 6/23/00 documented the resident had no pressure ulcers and no history of pressure ulcers in the past 90 days. On resident 56's 9/8/00 quarterly MDS assessment, the resident was assessed as having one stage II pressure ulcer. On the annual MDS assessment, dated 11/27/00, resident 56 was assessed as continuing to have one stage II pressure ulcer.<br><br>Licensed nurses progress notes, dated 9/12/00 at 8:00 AM, documented resident 56's care was reviewed and her care plan was updated.<br><br>Resident 56's current care plan, problem number eight, "Physical mobility impaired secondary to dementia" documented an approach to caring for the resident as, "Turn and reposition Q two hours - [to] three hours and prn [as needed]".<br><br>Resident 56's care plan, problem number nine was, "Impaired skin integrity R/T pressure M/B [manifested by] stage II PU [pressure ulcer] coccyx". The approaches to caring for resident 56 included, "Keep pressure off area as much as possible ensure frequent position changes", "Ensure nutrition hydration" and "consult with MD as needed".<br><br>In an interview with the nurse caring for resident 56, on 1/9/01, the nurse stated, "I have a call in to the doctor for a treatment change. The treatment we have isn't helping at all".<br><br>Review of the physician's orders and the nurse's notes for resident 56, on 1/10/01 at 10:00 AM, did not include any notations or physician's orders on 1/8/01, 1/9/01 or 1/10/01 that would indicate a concern with | F 314 | | |

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| F 314 | Continued From page 18<br>the current treatment, assessment of the progress of the wound, or a call to notify the physician.<br><br>4. Interviews with the Director of Nursing (DON) and an interdisciplinary team (IDT) nurse revealed the following:<br><br>During an interview, on 1/10/01 at 8:20 AM, the DON indicated treatment had not begun as soon as the pressure ulcer had been identified. The IDT nurse stated, "The daughter [of resident 56] brought it [the pressure ulcer] to our attention at the 9/12/00 IDT meeting." The IDT nurse further stated, "Then I checked back and saw the nurse had identified it [the pressure ulcer] 8/31/00." The IDT nurse stated a physician's order was then obtained for treatment of resident 56's pressure ulcer.<br><br>5. Observation of resident 56's pressure ulcer on 1/10/01 at 9:40 AM revealed:<br><br>Resident 56's pressure ulcer was 2cm diameter and 1/2cm deep, as measured by the facility nurse who was caring for the resident. The pressure ulcer on resident 56's coccyx had a moist yellowish center with a white/gray rim and it had a foul odor. The pressure ulcer on resident 56's coccyx was observed to involve a full thickness of skin exposing subcutaneous tissue. The facilities Policies and Procedures for decubitus ulcers defines a stage III pressure ulcer as a, "full thickness skin loss exposing subcutaneous tissue".<br><br>6. Review of nutritional interventions as documented in the nutrition notes, the nutrition assessment, and the nutrition care plan revealed:<br><br>Resident 56's nutrition progress notes dated 9/12/00 | F 314 | | |

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| F 314 | Continued From page 19<br>documented skin condition to be "redness bottom" and "patient condition is the same". The nutrition notes, dated 11/16/00, documented resident 56's diet had "changed to puree per MD [physician]".<br><br>Resident 56's nutritional assessment, dated 11/28/00, documented a "stage II coccyx", but did not document caloric, protein, or fluid needs nor any need for changes in nutritional approaches. The same assessment documented resident 56 to weigh 82 pounds, which was below her ideal body weight of 95 to 116 pounds. On the 11/28/00 nutritional assessment, resident 56's intake at meals was documented as poor to fair. On the 11/27/00 MDS assessment resident 56 was documented, under nutritional problems - K4, as not leaving 25 percent or more of her meals uneaten, which indicated intake was not a problem for the resident.<br><br>Resident 56's nutritional care plans were reviewed. The care plan problem number four, dated 11/28/00, documented resident 56 had, "Potential for nutritional risk related to the following: Less than ideal body weight, Often leaves 25 percent or more uneaten at meals, Pressure ulcer, Impaired ability to feed self R/T hypertension, Alzheimer's dementia, teeth problem". The goal was documented to "Improve or maintain nutritional status as evidenced by the following TNR [through next review]: Adequate intake of 50% or more at most meals, Weight stable between 83 to 95 [pounds]". Approaches included: "Provide diet as ordered, Provide assistance as needed at mealtimes, Monitor and record food consumption, Monitor and weigh as ordered, Monitor nutritional labs as are available, Assess for skin breakdown, Monitor for signs and symptoms of dehydration, Offer extra fluid through day, Supplemental as ordered". | F 314 | | |

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| F 314 | Continued From page 20<br>The previous care plan problem number four, dated 9/12/00, did not document a pressure ulcer. The 9/12/00 care plan had the identical goal and all of the same approaches, but it had additional approaches that were deleted from the 11/28/00 revision for the pressure ulcer. Nutritional approaches that had not been included on the 11/28/00 revised care plan, which documented existence of a pressure ulcer, included: "Cater to the resident's food preferences, Encourage intake of high calorie foods, extra margarine and less whole milk, Monitor tolerance to diet, Try oral care frequently". The nutritional care plan did not address extra protein or calories to promote healing of the pressure ulcer.<br><br>7. The administrator provided surveyors with a copy of the facility's Policies and Procedures for care and prevention of decubitus ulcers on 1/10/01. Review of the policy and procedures revealed:<br><br>The facility was to assess and "identify residents who are particularly prone to the development of pressure ulcers". Factors to be considered in the assessment were listed. Although no skin assessment was located in the chart, resident 56 was identified on the 11/27/00 MDS as having several of the factors listed, including: "Residents with an alteration in mentation", "Residents with an alteration in mobility", and Incontinent residents".<br><br>The facility was to, "On each shift, examine residents prone to decubitus for development of redness, discoloration, or blisters over pressure areas". The pressure areas listed included the "Sacrum and coccyx", which is were resident 56 developed a pressure ulcer. The pressure ulcer had progressed to stage II before a concern was first documented in | F 314 | Residents will not develop pressure sores after admission unless proven clinically unavoidable. Processes to be implemented to accomplish this include:<br><br>1. The nurses will complete thorough skin assessments on admission and follow through with notification of MD for appropriate wound care orders, inclusion of wound care on the treatment record, an acute care plan, and follow through with treatment.<br>2. Pressure sores and contributing factors will be assessed by the nurse. Appropriate interventions per facility policy and skin care protocols will be initiated to prevent advanced stages of ulcers.<br>3. All residents will receive weekly skin checks by the charge nurses. Findings will be documented on a weekly skin assessment form. All residents will be assessed quarterly by the IDT for risk factors which could lead to further breakdown.<br>4. The dietician will be notified of skin/wound problems at the monthly weight and skin meeting by the DON or DSD. | |

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| F 314 | Continued From page 21<br>resident 56's medical record on 8/31/00.<br><br>In the facility's Policies and Procedures, under treatment protocols" for stage II pressure ulcers, lists the first step as "Notify DON or assistant DON". Nursing administration was first notified of resident 56's stage II pressure ulcer by the resident's daughter on 9/12/00.<br><br>The Policies and Procedures described the documentation that was to be made for residents with pressure ulcers. Documentation was to include: "Record treatment and photo documentation weekly. "Record in Clinical Notes weekly or as condition or level of care warrants. Inform physician of adverse reactions as needed. Notes should include:<br>(1) Treatment ordered<br>(2) Stage (circle I, II, III, or IV)<br>(3) Site<br>(4) Size<br>(5) Shape (diameter and depth in cm.)<br>(6) Drainage<br>(7) Progress<br>(8) Date<br>(9) Signature".<br>There were six photos and assessments in resident 56's chart to cover the 18 weeks between the date the pressure ulcer was first documented, 8/31/00, and the end of survey, 1/10/01. The last photographic wound documentation was dated 11/25/00. | F 314 | 5. The manager of clinical operations will assess skin related issues accurately through the MDS process. Significant change of condition MDS assessments will be completed with initial onset of pressure sores or with progression of sores to stage 3 or 4.<br>6. A skin team, including the charge nurse, the DON, the DSD and the manager of clinical operations, will review skin assessment, wound treatments, preventative measures, and care plans weekly to insure adequate wound/skin intervention.<br>7. An educational inservice for nurses has been scheduled for 2/8/01by the DON to address wound/skin care.<br>8. An educational inservice for certified aides has been scheduled for 2/8/00to address skin care.<br>9. Inservices will be scheduled at least yearly by the DON or DSD to educate staff about skin/wound care.<br>10. Skin and wound records will be reviewed monthly at Department Head/CQI meetings and quarterly at Quality Assurance meetings.<br>11. Overall compliance will be monitored by the DON monthly. 2/8/01 | |
| F 371 SS=E | Based on observation of the kitchen and food | F 371 | | |

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|---|---|---|---|
| | 465067 | A. BUILDING _____ B. WING _____ | 1/10/01 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ROCKY MOUNTAIN CARE CLEARFIELD | 1450 S 1500 E CLEARFIELD, UT 84015 |

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| F 371 | Continued From page 22<br>temperature checks it was determined that the facility did not store, prepare, distribute and serve food under sanitary conditions.<br><br>Findings include:<br><br>The following observations were made 01/03/01 from 8:55 AM - 9:20 AM.<br><br>1. In the walk-in refrigerator:<br>a. A tray containing individual serving cups of butter was unlabeled and undated.<br><br>b. A box of open chocolate chips were damp, the top of the box was moldy.<br><br>c. Diet jello dated 12/18/00. ( 16 days old) Leftover food should be used or thrown away within 72 hours after initial use.<br><br>d. An expired container of sour cream dated 12/04/00 and an expired container of cottage cheese dated 12/27/00.<br><br>2. At 9:10 AM whole kernel corn, BBQ (barbeque) sauce and mashed potatoes were observed on the steam table and at 9:20 AM ribs were observed being placed on the steam table for the lunch meal. Lunch service does not begin until approximately 11:15 AM.<br><br>3. In the storeroom:<br>a. A box of plastic spoons, a box of plastic forks and a box of plastic knives were observed to be open and not properly covered. Single-service and single- use articles should be stored where they are not exposed to splash, dust or other contamination. Knives, forks and spoons that are not pre-wrapped | F 371 | F371<br><br>1. The walk-in is checked each a.m. and all expired foods are discarded. This task is added to the daily cleaning schedule. In addition, it is the responsibility of each cook to assure all foods, leftovers are dated. This task is also added to the written daily cleaning schedule and is checked-off each day upon completion. The Dietary Manager monitors the performance of these tasks.<br><br>2. An in-service was held on 1-24-2001, hosted by Nicholas Food Company and Dietary Manager. Another in-service is scheduled for 2-23-2001. Areas of concentration are as follows:<br>A. Serve Safe Techniques B. Proper dating techniques C. Labeling and safe storage time limits D. Proper thawing techniques E. Maintaining safe temperatures in the kitchen, including equipment, food, and proper food holding time and temperature. In-service will include a written pre-test and post-test that will be retained in employees file.<br><br>It is recognized from the state survey report that food should not be placed in the steam table prior to 1 hour before time of service. This is posted in the kitchen and the cook is accountable for adhering to this action. | |

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| F 371 | Continued From page 23<br>shall be presented so that only the handles are touched by employees. Reference guidance: U.S. Public Health Service FDA 1999 Food Code, page 117.<br><br>b. A bag of corn meal was open and undated.<br><br>4. A hole in the dish room wall was observed which was approximately 20 inches long and 5 inches high, the tiles were broken out and the hole extended through the wall board. This makes it unsanitizable.<br><br>On 01/03/01 temperature checks during the lunch meal and observation of the kitchen revealed:<br><br>1. At 11:45 AM a temperature check of the hot foods prepared for the lunch meal, using the facility thermometer, included chicken strips at 130 degrees farenheit, mixed vegetables at 138 degrees farenheit, ground chicken strips at 117 degrees farenheit, and creamed corn at 103 degrees farenheit. These temperatures were taken after the first lunch seating and hall trays had been completed but prior to the beginning of the second lunch seating.<br><br>2. At 12:30 PM, using the facility thermometer, temperatures were taken of the hot foods placed in the dining room steam table prior to the second lunch seating. Temperatures included chicken strips at 116 degrees farenheit, ground chicken at 130 degrees farenheit, and creamed corn at 128 degrees farenheit These foods were not re-heated prior to serving. Temperatures were again taken, using the facility thermometer at 1:05 PM after the completion of the lunch service and included barbeque ribs at 122 degrees farenheit, chicken strips at 116 degrees farenheit, ground chicken at 120 degrees farenheit, | F 371 | 3. Employees have been instructed to close boxes of plastic silverware after each use. Instruction included counsel on proper handling of utensils. A sign has also been placed as a reminder. In addition, employees will be briefed on all actions of correction regarding the survey. They will also have a communication to sign indicating they understand the areas of infraction and correction.<br><br>4. Maintenance Department has scheduled repair of hole in wall. Will be completed by 2/15/2001.<br><br>1. Temperatures of food in the steam table will be taken and recorded before and after meals are served to residents. This will be repeated for second dining.<br><br>2. An in-service was held on 1-24-2001, hosted by Nicholas Food Company and Dietary Manager. Another in-service is scheduled for 2-23-2001. Areas of concentration are as follows: A. Serve Safe Techniques B. Proper dating techniques C. Labeling and safe storage time limits D. Proper thawing techniques E. Maintaining safe temperatures in the kitchen, including equipment, food, and proper food holding time and temperature. In-service will include a written pre-test and post-test that will be retained in employees file. | |

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| F 371 | Continued From page 24<br>whole kernel corn at 130 degrees farenheit and tator tots at 120 degrees farenheit.<br><br>Hot foods are to be maintained at 140 degrees farenheit or above when served from trayline.<br><br>3. At 1:10 PM on 01/03/01, a roast was observed sitting in a pan of water in the sink by the steam table. When this surveyor asked the cook what was in the pan, she stated it was a roast she was thawing for the supper meal. Potentially hazardous food shall be thawed under refrigeration that maintains the food temperature at 41 degrees farenheit or less or completely submerged under running water at a water temperature of 70 degrees farenheit or below with sufficient water velocity to agitate and float off loose particles in an overflow or as part of a cooking process if the food that is frozen is thawed in a microwave oven and immediately transferred to conventional cooking equipment, with no interruption in the process.<br>Reference guidance: U.S. Public Health FDA 1999 Food Code, pages 61-62.<br><br>On 01/04/01 observation of the kitchen revealed:<br><br>1. At 10:05 AM rice and beef tips were on the steam table for the lunch meal. Lunch service does not begin until approximately 11:15 AM.<br><br>On 01/09/01 a food temperature check revealed the following:<br><br>1. At 12:50 PM, after the completion lunch service, using the facility thermometer, chicken gravy was 130 degrees farenheit, milk was 50 degrees farenheit, cranberry juice was 50 degrees farenheit and peach | F 371 | 3. An in-service will be held on 2-23-2001, hosted by Nicholas Food Company and Dietary Manager. Areas of concentration are as follows:<br>A. Serve Safe Techniques B. Proper dating techniques C. Labeling and safe storage time limits D. Proper thawing techniques E. Maintaining safe temperatures in the kitchen, including equipment, food, and proper food holding time and temperature. In-service will include a written pre-test and post-test that will be retained in employees file.<br><br>correction Date 02/23/01 | |

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| F 371 | Continued From page 25<br>and grape juice was 52 degrees farenheit.<br><br>Hot foods are to be maintained at 140 degrees farenheit or above when served from trayline. Cold foods are to be maintained at or below 41 degrees farenheit when served from trayline. | F 371 | | |
| F 463 SS=D | Based on observation and interview the facility did not provide a call light communication system from toilet facilities that were accessible and used by residents as evidenced by: Two restrooms across from the administrator's office and one restroom in the physical therapy gym had no call light systems present.<br><br>Findings include:<br><br>On 1/3/01, at 12:30 PM, observation revealed two restrooms located across from the administrator's office had no call light systems present. One restroom adjacent to the physical therapy gym had no call light system present.<br><br>Interviews:<br><br>On 1/3/01, at 12:40 PM, during an interview with the administrator, she was questioned concerning the restrooms across from her office and the restroom adjacent to the physical therapy gym. The administrator stated that the two restrooms across from her office were accessible to all residents in the facility if they had a need. She also stated that the | F 463 | F463<br><br>Restrooms across form Administrators office and the restroom adjacent to the physical therapy gym have been locked and have key access only.<br><br>Maintenence Supervisor to monitor.<br><br>Correction Date 03/10/01 | |

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| F 463 | Continued From page 26<br>restroom in the physical therapy gym was used for occupational therapy instruction but if the residents needed to use it, they would have access to it.<br><br>On 1/3/01, at 1:20 PM, during an interview with a physical therapy aid, he was questioned concerning the restroom adjacent to the physical therapy gym. When asked if he had assisted residents to the restroom, he stated that the residents were assisted by the physical therapy staff into the restroom. He also, stated that if the residents needed more assistance, the certified nurse aid caring for that resident would be called to assist the staff with the resident in the restroom. | F 463 | | |