PRINTED: 01/05/20
FORM APPROVED
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A061	A. BUILDING _____ B. WING _____	C 12/29/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPANISH FORK NURSING AND REHAB	46 NORTH 100 EAST SPANISH FORK, UT 84660

(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 157 SS=G	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and review of resident clinical records, it was determined that for 1 of 1 residents with pressure sores, the facility did not notify the physician of a significant change in the	F 157	1/25/05 POC acceptable with addendum dated 2/15/05 Lmpellum RN PLEASE SEE ENCLOSED POC.	02/15/05

Utah Department of Health
JAN 18 2004
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ADMINISTRATOR	01-13-05

...y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ...owing 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 ...s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ...gram participation.

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F 157	Continued From page 1	F 157		

resident's physical health when there was a need to alter treatment or to add a new form of treatment. Specifically, the facility did not notify the physician of a new (third) pressure sore which was discovered 10/26/04. The facility did not notify the physician when the wound was noted to have a "foul odor" on 12/4/04. The facility did not notify the physician that the three pressure sores on the resident's buttocks had a lime green drainage (observed by the registered nurse surveyor on 12/29/04). The facility also did not notify the physician that this same resident had a blood sugar of 369. The nurse then proceeded to give the resident insulin when the resident routinely received oral hypoglycemics, not insulin. Resident identifier: 2

Findings include:

1. Resident 2 was a 91 year old female who was admitted to the facility on 8/14/03.

a. The Minimum Data Set (MDS), a mandatory comprehensive assessment of the resident completed by facility staff, documented on 8/18/04 that resident 2 had no pressure sores and had no history of pressure sores in the previous 90 days. The MDS also documented that resident 2 needed total assistance with transfers, did not ambulate and was frequently incontinent of urine. The MDS did not document the use of any pressure relieving devices for the resident's bed or wheelchair.

On 10/15/04, facility staff received a physician's order regarding resident 2 to "clean pressure ulcers with sterile saline. Dress with duoderm Q3d and PRN (every 3 days and whenever

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F 157	Continued From page 2 necessary). Lanaseptic when sores have skin cover." The next day, 10/16/04, nurse's notes documented the presence of "two pressure sores on buttocks bilaterally. Duoderm placed. Sores are 1 cm around, just 1 skin width deep..." This note was the first documentation in the nurse's notes of skin breakdown although the physician's orders reflect that the wounds were discovered the previous day. A nurse's note dated 10/26/04, documented the presence of a third pressure sore, "...3rd breakdown noted." The was no documentation in the medical record of resident 2 to evidence that the physician was notified of this new pressure sore area. There was no documentation to evidence that physician's orders were obtained to treat this new third pressure sore. A nurse's note dated 10/27/04, documented "...Sores on buttocks open. New sore in the crack of the buttock. Bandaid applied." The nurse's note dated 12/4/04, documented "Drsg (dressing) change to buttock. Wound has foul odor." There was no documentation in the medical record of resident 2 to evidence that the physician was notified of the "foul odor" emanating from the wound, or which wound or wounds was producing the foul odor. On 12/14/04, 10 days after the note documenting the "foul odor", the facility faxed the physician a note which read "2 bedsores - getting worse. What to do?" The physician's written response was "Using duoderm? Wash soap water, keep dry." There was no documentation to evidence that staff notified the physician of the "foul odor".	F 157		

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F 157	Continued From page 3 There was no description of what "getting worse" meant. A nurse's note on 12/27/04 documented, "...Sore on coccyx wider and deeper today." Observation of the three pressure sores on the buttocks of resident 2 was performed by a registered nurse surveyor and the facility nurse on 12/29/04 at approximately 4 PM. There were two stage 2 pressure sores, one on each side of her gluteal fold. The first measured approximately 2cm by 1 cm. The second measured approximately 2cm by 2cm. The third wound was located at the top of her gluteal fold and measured approximately 3cm by 2 cm and was 2.5 cm deep. The white gauze pads pulled from the three pressure sores had a lime green colored drainage on them. Green drainage can be indicative of an infection. The facility nurse replied that sometimes "Multidex" will do that. On 1/3/05 at 10:15 AM, DeRoyal, the makers of Multidex Gel were called. The clinical director of DeRoyal stated that Multidex does not cause a greenish drainage. It should be noted that dressings taken off the wounds of resident 2 were not duoderm, as ordered by the physician on 12/14/04. Also, there was no documentation of the greenish drainage in the resident's clinical record or that the facility had notified the physician of the green drainage. A telephone interview was conducted with resident 2's physician on 1/3/05. He was asked if facility staff had notified him of a third pressure sore. He stated "no". When asked if they had notified him of the "foul odor", he stated that he could not remember if they had or not.	F 157		

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F 157	Continued From page 4 b. On 4/28/04, a facility nurse recorded a blood sugar of 369. The nurse then documented "Gave reg (regular) insulin per house protocol but only gave 4 units d/t (due to) res (resident) doesn't get insulin usually and reaction unknown. Will CTM (continue to monitor) and tell next nurse so they are aware. Blood sugars for res are usually approx (approximately) WNL (within normal limits)." The medical record of resident 2 did not contain documentation to evidence that the nurse notified the physician when the blood sugar for resident 2 became elevated at 369 (The nurse noted that the resident's blood sugars are usually within normal limits.) There was no documentation to evidence that the nurse notified the physician to obtain directions on how to proceed with resident 2 and the high blood sugar. There was no documentation to evidence that the nurse notified the physician that she administered insulin to resident 2 when this resident did not regularly receive insulin and controlled her blood sugars with an oral hypoglycemic.	F 157		02-15-04
F 252 SS=D	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that 1 of 3 oxygen concentrators inspected did not contribute to a safe environment.	F 252		

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F 252	Continued From page 5 Findings include: Three oxygen concentrators which were currently in use for residents were observed on 12/29/04. One of the three concentrators had a cord which was not in good repair. The outer rubber sheath was torn which allowed the exposure of inner wires and insulation.	F 252		01/60y
F 314 SS=G	483.25(c) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of medical records, it was determined that the facility did not ensure that 1 of 1 residents with pressure sores received the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. Specifically, resident 2 developed three pressure sores between 10/15/04 and 10/26/04. The physician was notified of the first two which were identified on 10/15/04, but not the third pressure sore which was identified on 10/26/04 to which the nurse's notes document "bandaid applied". Observation of this third pressure sore on 12/29/04, revealed it to be a stage 3 with dimensions approximately 3cm by 2 cm with a	F 314		

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F 314	Continued From page 6	F 314		2/15/05

depth of 2.5cm. There was no documentation to evidence that dressing changes were performed to the pressure sores as ordered (every 3 days and when necessary). There was no documentation at all of dressing changes to the pressure sores between 10/27/04 and 12/4/04, a period of 37 days, after which a nurse documented "wound has foul odor". There was no documentation in the medical record to evidence that the physician was notified of the "foul odor" emanating from the wound on 12/4/04. Nurse's notes documented using a "donut" cushion in the resident's chair, which is contraindicated for individuals with pressure sores. There was no documentation to evidence that a pressure relieving device was used on the resident's bed until 11/11/04, 27 days after pressure sores were initially identified. Observation of the three pressure sores on the resident's buttocks and coccyx on 12/29/04 revealed them to have greenish colored drainage which was not noted in the resident's medical record. Resident identifier: 2.

Findings include:

Resident 2 was a 91 year old female who was admitted to the facility on 8/14/03.

The Minimum Data Set (MDS), a mandatory comprehensive assessment of the resident completed by facility staff, documented on 8/18/04 that resident 2 had no pressure sores and had no history of pressure sores in the previous 90 days. The MDS also documented that resident 2 needed total assistance with transfers, did not ambulate and was frequently incontinent of urine. The MDS did not document the use of any pressure relieving devices for the resident's

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F 314	Continued From page 7 bed or wheelchair. The medical record for resident 2 did not contain any type of pressure ulcer risk assessment. On 10/15/04, facility staff received a physician's order regarding resident 2 to "clean pressure ulcers with sterile saline. Dress with duoderm Q3d and PRN (every 3 days and whenever necessary). Lanaseptic when sores have skin cover." The next day, 10/16/04, nurse's notes documented the presence of "two pressure sores on buttocks bilaterally. Duoderm placed. Sores are 1 cm around, just 1 skin width deep..." This note was the first documentation in the nurse's notes of skin breakdown although the physician's orders reflect that the wounds were discovered the previous day. Nurse's note 10/17/04 - "Drsg (dressing) on L (left) buttock intact and on tight. R (right) buttock drsg loose. Took drsg off, cleaned sore with sterile saline and applied duoderm. Sore slightly deeper...Res (resident) c/o (complains of) pain r/t (related to) sores...using donut when in geri chair." Nurse's note 10/18/04 - "Placed donut under res on geri chair..." The use of donut cushions can cut off circulation to the surrounding tissues which may inhibit healing or cause additional skin breakdown. A nurse's note dated 10/26/04, documented the presence of a third pressure sore, "...3rd breakdown noted." The was no documentation in	F 314		

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the medical record of resident 2 to evidence that the physician was notified of this new pressure sore area. There was no documentation to evidence that physician's orders were obtained to treat this new third pressure sore.
A nurse's note dated 10/27/04, documented "...Sores on buttocks open. New sore in the crack of the buttock. Bandaid applied."

The October, November and December 2004 Treatment Sheets for resident 2 were reviewed on 12/29/04. None of the three sheets recorded an order to treat any wound. There was no documentation on any of the three treatment sheets to evidence that staff were performing dressing changes to the pressure sores as ordered. The facility nurse was interviewed on 12/29/04 at approximately 3 PM. She was asked where the staff would record dressing changes to wounds. The nurse replied "the treatment sheets".

A review of all the nurse's notes, from 10/15/04 through 12/29/04, was performed during the survey on 12/29/04. Based on the documentation present in the nurse's notes, resident 2 received dressing changes to her pressure sores on the following days. Please note that the physician had ordered the initial two pressure sores to have dressings changed every 3 days and as necessary.

October 2004:

16th
17th
18th
20th
26th

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F 314	Continued From page 9 27th November 2004: There were no nurses notes which documented the performance of dressing changes to resident 2. December 2004: 4th 16th 19th 20th 22nd 26th 27th 28th 29th It should be noted that there were 37 days between the dressing change documented on 10/27/04 and the next recorded dressing change dated 12/4/04. The nurse's note dated 12/4/04, documented "Drsg (dressing) change to buttock. Wound has foul odor." There was no documentation in the medical record of resident 2 to evidence that the physician was notified of the "foul odor" emanating from the wound, or which wound or wounds was producing the foul odor. On 12/14/04, 10 days after the note documenting the "foul odor", the facility faxed the physician a note which read "2 bedsores - getting worse. What to do?" The physician's written response was "Using duoderm? Wash soap water, keep dry." There was no documentation to evidence	F 314		

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that staff notified the physician of the "foul odor". There was no description of what "getting worse" meant.

A nurse's note on 12/27/04 documented, "...Sore on coccyx wider and deeper today."

It should also be noted that three complete blood counts were obtained from resident 2, two in November 2004 and a third in December 2004. On 11/15/04, the white blood count for resident 2 was 21.6 (normal 3.6 -10.6). On 11/26/04, the white blood count for resident 2 was 23.5. On 12/9/04, white blood cell count for resident 2 was 20.5. An elevated white blood cell count can indicate an acute infection in the body.

Observation of the three pressure sores on the buttocks of resident 2 was performed by a registered nurse surveyor and the facility nurse on 12/29/04 at approximately 4 PM. There were two stage 2 pressure sores, one on each side of her gluteal fold. The first measured approximately 2cm by 1 cm. The second measured approximately 2cm by 2cm. The third wound was located at the top of her gluteal fold and measured approximately 3cm by 2 cm and was 2.5 cm deep. The white gauze pads pulled from the three pressure sores had a lime green colored drainage on them. Green drainage can be indicative of an infection. The facility nurse replied that sometimes "Multidex" will do that. On 1/3/05 at 10:15 AM, DeRoyal, the makers of Multidex Gel were called. The clinical director of DeRoyal stated that Multidex does not cause a greenish drainage. It should be noted that dressings taken off the wounds of resident 2 were not duoderm, as ordered by the physician on 12/14/04. Also, there was no documentation of

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F 314	Continued From page 11 the greenish drainage in the resident's clinical record or that the facility had notified the physician of the green drainage. An interdisciplinary team note, dated 11/11/04, documented under "Performance Improvement Recommendations for resident"..."Put air mattress on bed." This air mattress was the first pressure relieving device noted to be placed on resident 2's bed. It was not placed until 11/11/04, 27 days after the initial discovery of the first two pressure sores. It should also be noted that the only measurement of the wounds was performed the day after their initial discovery, 10/16/04. No other documentation of wound size was found in the medical record. A review of the care plan for resident 2 revealed that it was not updated to reflect the pressure sores which were discovered 10/15/04 and 10/26/04, nor did the care plan contain staff interventions such as dressing changes, the placement of appropriate pressure relieving devices or notifying the physician with changes.	F 314		02-15-04
F 354 SS=E	483.30(b)(1)-(3) NURSING SERVICES Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	F 354		02/15/05

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F 354	Continued From page 12 The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interviews with facility administration and review of the facility nursing schedule it was determined that the facility did not have a RN (registered nurse) for at least 8 consecutive hours a day, 7 days a week. Findings include: A review of the nursing scheduled showed there was no RN coverage on the following dates: October 2004: 1, 2, 4, 5, 6, 9, 10, 12, 15, 16, 17, 19, 22, 23, 25, 29, and 30. November 2004: 1, 2, 3, 5, 7, 8, 10, 12, 13, 14, 15, 16, 21, 22, 24, 26, 27, 28, and 30. December 2004: 3, 4, 6, 7, 9, 12, 13, 14, 17, 18, 19, 20, 21, 24, 28, 29, and 31. In an interview with the assistant administrator on 12/29/04 she stated that there were currently two registered nurses employed by the facility.	F 354		02-15-05
F 363 SS=E	483.35(c)(1)-(3) DIETARY SERVICES Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363		

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(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 363	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility did not follow the approved menus. Findings included: Review of the Week 1 menu, revealed that the menu was not followed as written for the Lunch meal on 12/26/04, 12/28/04, and 12/29/04. Observations of the lunch meal on 12/29/04 revealed that battered fish, baked potato, corn and a chocolate bar was served for lunch. The menu documented the following to be served; roast beef, mashed potatoes with gravy, carrots, rolls and lemon meringue pie. In an interview with the cook she stated that she was serving Tuesday¿s meal because Wednesday¿s meal was served on Sunday. She also stated that she was substituting corn for the mixed vegetables because she was going to use them in the evening meal¿s soup. This substitution would have increased the starch in the meal and decreased the vegetable serving. She was not sure what meal was substituted for the previous days for lunch. When the menu was changed so many times, it caused confusion, and also left the potential for errors on the therapeutic diets.	F 363		2/01/05
F 494 SS=D	483.75(e)(2)-(3) ADMINISTRATION A facility must not use any individual working in	F 494		02/01/05

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A061	A. BUILDING _____ B. WING _____	C 12/29/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPANISH FORK NURSING AND REHAB	46 NORTH 100 EAST SPANISH FORK, UT 84660

(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 494	Continued From page 14	F 494		

the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of ss483.151-483.154 of this part; that individual has been deemed or determined competent as provided in s483.150(a) and (b).

A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section.

This REQUIREMENT is not met as evidenced by:

Based on interviews and review of facility personnel files, it was determined that 2 nurse aides had been permanently employed by the facility for longer than four months without becoming a certified nurse aide (CNA). Nurse Aide A was not certified at the end of the inspection (6 months after hire) and CNA employee B, was not certified at the end of the inspection (7 months after hire). Employee identifiers: A and B.

Findings include:

According to the State Operations Manual (SOM) Interpretive Guidelines, a "'permanent employee' is defined as any employee you expect to continue working on an ongoing basis." Facility personnel files were reviewed on 12/29/04 and revealed the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A061	A. BUILDING _____ B. WING _____	C 12/29/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPANISH FORK NURSING AND REHAB	46 NORTH 100 EAST SPANISH FORK, UT 84660

(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 494	Continued From page 15 Employee A was hired on 6/24/04. There was no documentation to evidence that employee A had become certified. During interview with the Administrator on 12/29/04, she stated that employee A was not yet certified. Employee A was 2 months over the four month time limit to become certified. Employee B was hired 5/18/04. There was no documentation to evidence that employee B had become certified. During interview with the Administrator on 12/29/04, she stated that employee B was not yet certified. Employee B was 3 months over the four month time limit to become certified.	F 494		
F 514 SS=D	483.75(l)(1) ADMINISTRATION The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. This REQUIREMENT is not met as evidenced by: Based on interview and review of resident clinical records, it was determined that for 1 of 1 residents with pressure sores, the facility did not maintain a clinical record that was complete or accurately documented. Findings include: Resident 2 was a 91 year old female who was admitted to the facility on 8/14/03. Resident 2 developed three pressure sores	F 514		02-01-05

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A061	A. BUILDING _____ B. WING _____	C 12/29/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPANISH FORK NURSING AND REHAB	46 NORTH 100 EAST SPANISH FORK, UT 84660

(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 514	Continued From page 16 between 10/15/04 and 10/26/04. There was no documentation to evidence that dressing changes were performed to the pressure sores as ordered (every 3 days and when necessary). There was no documentation at all of dressing changes to the pressure sores between 10/27/04 and 12/4/04, a period of 37 days, after which a nurse documented "wound has foul odor". There was no documentation in the medical record to evidence that the physician was notified of the "foul odor" emanating from the wound on 12/4/04. It should also be noted that the only measurement of the wounds was performed the day after their initial discovery, 10/16/04. No other documentation of wound size was found in the medical record. A review of the care plan for resident 2 revealed that it was not updated to reflect the current status of the resident (the pressure sores which were discovered 10/15/04 and 10/26/04), nor did the care plan contain staff interventions such as dressing changes, the placement of appropriate pressure relieving devices or notifying the physician with changes.	F 514		12-15-05

ATTACHMENT 1

PHYSICIAN'S TELEPHONE ORDERS

NAME: [redacted] Resident #2 D.O.B.

ALLERGIES:

MEDS:

Sp. Fork Nursing

PHONE #: 798 6220 ext 3 PHARMACY:

SUBJECTIVE:

2 bedsores - getting worse. What to do?

PLAN:

Wash soap water Keep Dry Duoderm?

TIME:

INITIALS: FBM

DATE: 12-14-04

DX:

PHYSICIAN

Signature of Nurse Receiving Order [redacted]	Time	SIGNATURE OF PHYSICIAN	Date

PHYSICIAN'S T

problem.

Signature of Nurse Receiving Order [redacted]	Time	SIGNATURE OF PHYSICIAN	Date

ATTACHMENT 3

Hales Rest Home:

Protocol for SLIDING SCALE:

Check blood sugar - subtract 100 ÷ 30 = give that units of Regular Insulin
Recheck blood sugar and chart in residents records.

10-26-99

Hales Rest Home:

Protocol for glucose monitoring...

All Diabetics:
Assess glucose 3x wk
FBG: Mon & Fri • 0700
R-Gluc: WED. • 1700
Assess pts for s/s of hypo/hyperglycemic reactions -

DATE: 10-2-04 **NURSE'S REPORT SHEET**

ATTACHMENT 4

5C	[redacted]	OK combative	OK	Refused meds Insulin given
1B	[redacted]	OK	OK	Tyl prn 2100
7B	[redacted]	OK	OK	ok
3A	[redacted]	OK	OK	OK
1A	[redacted]	OK	OK	
11D	RES 2 [redacted]	Lanaseptic start of Breakdown	OK	Lanaseptic
6B	[redacted]	Tylenol ii	[illegible] Tylenol 1200	ok
9B	[redacted]	OK	OK	OK
2A	[redacted]	OK - Ibuprofen ii	OK Ibuprofen 1100	Ibuprofen 2000
5B	[redacted]	OK - very happy singing	OK	lanaseptic Lok -
NOTES				

ATTACHMENT S

PRESSURE ULCER, CARE AND PREVENTION OF

BASIC RESPONSIBILITY: LICENSED NURSE AND NURSING ASSISTANT

If performed by individuals other than those listed in Basic Responsibility, check all that apply.

PROCEDURE
PERFORMED BY: ☐CNA ☐LPN,LVN ☐RN ☐Licensed Therapist ☐PT ☐OT ☐SLP ☐RT
☐_____ ☐_____ ☐_____ ☐_____

PURPOSE

To prevent and treat further breakdown of pressure sores.

GENERAL RESIDENT RIGHTS GUIDELINES

- If resident is in his/her room, knock on the door, wait for a response and identify yourself.
- Identify resident and explain reason for procedure.
- Explain benefits of the procedure to the resident.
- Explain safety measures of the procedure to the resident.
- Explain the adverse effects and/or complications of the procedure to the resident.
- Place call light within reach and instruct resident to call for assistance, if needed.
- Screen and drape resident for maximum privacy.
- Include resident's family and surrogate health care decision-makers in care planning when possible.

GENERAL GUIDELINES FOR ASSESSMENT MAY INCLUDE, BUT ARE NOT LIMITED TO:

- Skin at risk.
- General condition of skin.
- Any pain; report to physician.
- Status of peripheral circulation.
- Nutritional status.
- Hydration/fluid balance.
- Weight (over/under ideal or usual body weight).
- Mobility status.
- Limitation in range of motion and deformities.
- Deformities.
- Incontinence of bowel and bladder.
- Use pressure ulcer risk assessment tools per facility policy. Briggs has a Pressure Sore Risk Assessment, Norton Plus Pressure Ulcer Scale and the Braden Scale for Predicting Pressure Sore Risk available. These assessment tools may be included in the facility computerized medical record.

GENERAL INFECTION CONTROL GUIDELINES

1. Observe (standard) universal precautions or other infection control standards as approved by appropriate facility committee.
2. Wash your hands before and after all procedures. Wear gloves when appropriate.
3. Clean and dry skin well before procedure.
4. Apply preventive measures to maintain skin integrity, if necessary.
5. Dispose of disposable equipment appropriately.
6. Thoroughly clean all equipment used and return to appropriate storage area.
7. Dispose of soiled linen appropriately.

EQUIPMENT

1. Skin lotion.
2. Elbow protector.
3. Heel protector.
4. Pressure reducing mattress.
5. Pressure reducing chair pad.

6. Foot cradle.
7. Pillows.

PROCEDURE

1. Observe skin. Any persistent reddened area that remains after pressure is relieved is a high risk area for a pressure ulcer to begin.
2. Apply skin lotion gently to dry skin.
3. Change bed linen whenever wet or soiled.
4. Keep sheets dry and free of wrinkles and debris as possible.
5. Use pressure reducing devices to relieve pressure.
6. Turn the resident every two hours and position with pads or pillows to protect bony prominences.
7. Active and passive range of motion may be ordered by the physician to improve circulation.
8. Whenever possible, teach the resident to change his position at regular intervals and shift his weight in wheelchair.
9. Use elbow and heel protectors if needed.
10. Use bed cradle to relieve pressure of bed clothing, if needed.
11. Assist resident at mealtime to assure adequate nutrition.
12. Offer fluids frequently for adequate hydration.

TREATMENT

Treatment of pressure ulcers will vary depending on the orders of the attending physician. The nurse is responsible for carrying out the treatment as ordered by the attending physician and for implementing measures to prevent pressure ulcers.

POSSIBLE RELATED MINIMUM DATA SET TRIGGERS

1. ADL function/rehabilitation potential.
2. Psychosocial well-being.
3. Dehydration/fluid maintenance.
4. Pressure ulcers.
5. Nutritional status.
6. Cognitive loss and dementia.
7. Physical restraints.

GENERAL DOCUMENTATION GUIDELINES

(Key Issues to be Considered to Develop Care Plan May Include)
Documentation may appear on any form used in the facility. Date and time may be preprinted on the form. Frequency of documentation should follow facility policy.

- Date, time (or shift), as appropriate.
  Other Documentation May Include:
- Date, time, treatment to pressure ulcer.
- Preventive measures used.
- Condition of the resident's skin.
- Physician notification, if appropriate.
- Preventive equipment used.
- If a pressure ulcer is present, the licensed nurse is responsible to record condition of the skin, including stage, size, site, depth, color, drainage and odor as well as the treatment provided. Notification of the physician is required when a new pressure ulcer is identified as well as when treatment is not effective.
- Signature and title.

GENERAL RESIDENT CARE PLAN DOCUMENTATION GUIDELINES

PROBLEM

- Identify the appropriate problem under which to list the pressure ulcer care as an approach.
- Identify and treat the underlying cause of the pressure ulcer.
- Consider listing possible risks and complications.

a reasonable time riod.

Charting Requirements for Wound Care:

Must include the following with each visit:

- ❑ Wound status (open, intact, stage of wound, etc.)
- ❑ Wound bed color (red/pink, black, yellow, etc.)
- ❑ Wound edges (intact, dehissed, maturation present, etc)
- ❑ Skin color, including width of discoloration (red, pink, black, etc.)
- ❑ Drainage color (dark red, serosanguineous, serous, purulent, etc.)
- ❑ Drainage amount (quarter size on dressing, dressing saturated, etc.)
- ❑ Odor (foul, mild, etc.)
- ❑ Dressing condition upon arrival (intact, edges loose, etc.)
- ❑ Type of dressing applied

Must be at least weekly:

- ❑ Wound measurements (length, width, depth)

Charting Requirements for Pain Assessment:

Must included the following with each visit:

- ❑ COLDERR Assessment
  - Complaint
  - Onset
  - Location
  - Duration
  - Exacerbation
  - Radiates
  - Response
- ❑ Rating on 1 – 10 Scale

ATTACHMENT 6

RESIDENT CARE COORDINATOR
JOB DESCRIPTION

UNDER THE DIRECTION OF THE DIRECTOR OF NURSING AND ADMINISTRATION,THE RESIDENT CARE COORDINATOR SHALL:

TRANSCRIBE ALL IDT CARE PLAN REVIEW SHEETS INTO THE RESIDENTS RECORD.

REVIEW RESIDENT RECORDS FOR COMPLETENESS AND TO ENSURE THAT THE CARE PLANS REFLECT THE CURRENT STATUS OF THE RESIDENT.

REVIEW NURSES NOTES FOR COMPLETENESS AND ACCURACY AND REPORT FINDINGS TO THE DON.

REVIEW ALL LABS AND LAB ORDERS FOR FOLLOW THROUGH AND COMPLETENESS.

REVIEW ALL TREATMENT SHEETS TO ENSURE THAT ALL TREATMENTS GIVEN ARE BEING PROPERLY DOCUMENTED.

WORK CLOSELY WITH THE DON TO ENSURE THAT ALL PATIENT CARE REGIMENS ARE BEING FOLLOWED.

ATTACHMENT 7

products
where to buy - U.S.
where to buy - International
warranty
U.S. retail price list
FAQ's
product info downloads
CEU programs
case studies
medicare info
industry resources
industry events
product care
lifestyles
share a lifestyle

search go ▶

ROHO Medical Products

There are no greater defenses against wounds and disease than those contained in t human body. But often these defenses need an ally. A partner in the healing process ROHO® DRY FLOATATION® technology is that partner.

The soft, flexible, interconnected air cells that comprise ROHO DRY FLOATATION products are adjustable to provide a customized fit to a client's sitting or lying shape. an individual's body shape changes, the cushion adjusts to facilitate blood flow.

- NEW! MEDICARE SEATING POLICY SEP 04 UPDATE

- LOW AIR LOSS SUPPORT SURFACES
- SEAT CUSHIONS
- SUPPORT SURFACES
- BACK SUPPORT SYSTEMS
- XSENSOR PRESSURE MAPPING SYSTEMS
- SEATING ACCESSORIES
  - ***NEW!*** **DESIGNER COVERS NOW AVAILABLE!**
- SPECIAL APPLICATION CUSHIONS
- CUSTOM - SPECIAL DESIGN TECHNIQUES
- REPLACEMENT PARTS

We highly recommend distribution through a certified rehab professional when orderi and fitting ROHO Group products.

ATTACHMENT 8

[redacted]

RAP TRIGGERED.

PRESSURE ULCERS

GOAL . NO SKIN PROBLEMS OR LOSS OF SKIN INTEGRITY.

APPROACH.

CONTINUE GOOD SKIN AND PERI CARE MAKE SSURE RESIDENT IS KEPT CLEAN AND DRY.WATCH FOR ANY REDNESS OR CHANGE IN SKIN INTEGRITY. REPORT TO NURSING.

RAP TRIGGERED.

PSYCHOTROPIC DRUG USE..

GOAL.

TO PROVIDE RESIDENT WITH AN ENHANCED QUALITY OF LIFE.

APPROACH.

CONTINUE MEDS AS ORDERD. EVALUATE THE NEED FOR MEDICATION AT ALL QA AND IDT MEETINGS. KEEP MEDICATIONS AT A MINIMUM.

ATTACHMENT 9

Pay Per... Ending

No.

NAME [redacted]

EXTRA TIME			REGULAR TIME			
	Tuesday	MONDAY	A.M. IN OUT NOON IN OUT P.M. IN OUT			
		TUESDAY	A.M. IN OUT NOON IN OUT P.M. IN OUT			
		WEDNESDAY	A.M. IN OUT NOON IN OUT P.M. IN OUT			
		THURSDAY	A.M. IN OUT NOON IN OUT P.M. IN OUT			
		FRIDAY	A.M. IN OUT NOON IN OUT P.M. IN OUT			
		SATURDAY	A.M. IN OUT NOON IN OUT P.M. IN OUT			
		SUNDAY	A.M. IN OUT NOON IN OUT P.M. IN OUT			
TOTAL			TOTAL			

NAME [redacted]

DATE _____ No. _____

EXTRA TIME		REGULAR TIME	
	MONDAY	A.M. IN	
		NOON OUT	
		P.M. IN	
		P.M. OUT	
	TUESDAY	A.M. IN	
		NOON OUT	
		P.M. IN	
		P.M. OUT	
	WEDNESDAY	A.M. IN	
		NOON OUT	
		P.M. IN	
		P.M. OUT	
	THURSDAY	A.M. IN	
		NOON OUT	
		P.M. IN	
		P.M. OUT	
	FRIDAY	A.M. IN	
		NOON OUT	
		P.M. IN	
		P.M. OUT	
	SUNDAY	A.M. IN	
		NOON OUT	
		P.M. IN	
		P.M. OUT	
TOTAL		TOTAL	

THIS SIDE OUT

9659

adams

Pay Period Ending

No.

NAME [redacted]

EXTRA TIME			REGULAR TIME			
Sat	7.00	MONDAY	A.M. IN OUT			
18 Reg			NOON IN OUT			
Sun	11		P.M. IN OUT		04 OCT 3 AM 5:10	
Mon	13.5	TUESDAY	A.M. IN OUT			
			NOON IN OUT			
33 reg Tues	9.75		P.M. IN OUT			
~~Thurs~~ ~~Fri~~ ~~Wed~~	2.25	WEDNESDAY	A.M. IN OUT			
			NOON IN OUT			
Fri ~~Fri~~	7.5		P.M. IN OUT			
~~Mon~~	10.25	THURSDAY	A.M. IN OUT	FF	04 OCT 12 AM 6:30	
~~Wed~~	8.25		NOON IN OUT			
~~34.5~~ 20.5			P.M. IN OUT			
~~Fri~~	8	FRIDAY	A.M. IN OUT			
~~Sat~~	~~8~~		NOON IN OUT			
			P.M. IN OUT			
~~Sun~~		SATURDAY	A.M. IN OUT			
			NOON IN OUT			
			P.M. IN OUT			
		SUNDAY	A.M. IN OUT			
			NOON IN OUT			
			P.M. IN OUT			
TOTAL			TOTAL			

Pay Period Ing

No.

NAME [redacted]

EXTRA TIME			REGULAR TIME		
Sun	8	MONDAY	A.M. IN OUT		
Mon	9.75		NOON IN OUT		
39.25 reg + OT			P.M. IN OUT		
Thur	4.5	TUESDAY	A.M. IN OUT		
Fri	8.25		NOON IN OUT		
			P.M. IN OUT		
Sat	~~8.75~~	WEDNESDAY	A.M. IN OUT		
From Sat. other time card	8		NOON IN OUT	Rd	4:45
			P.M. IN OUT		OH OCT 11e pm 4.00
8 reg					OH OCT 11e pm 11:59
		THURSDAY	A.M. IN OUT		
			NOON IN OUT		
			P.M. IN OUT		
Sat		FRIDAY	A.M. IN OUT		
			NOON IN OUT		
			P.M. IN OUT		
Total 47.25 reg & OT		SATURDAY	A.M. IN OUT		
			NOON IN OUT		
			P.M. IN OUT		
		SUNDAY	A.M. IN OUT		
			NOON IN OUT		
			P.M. IN OUT		
TOTAL			TOTAL		

Pay Period E[illegible]ng

No.

NAME [redacted]

EXTRA TIME					REGULAR TIME
Thur	9.5	MONDAY	A.M.	IN	[illegible]
			NOON	OUT	[illegible]
Sun	1.75			IN	[illegible]
			P.M.	OUT	[illegible]
Sun	8	TUESDAY	A.M.	IN	[illegible]
			NOON	OUT	[illegible]
Mon	13.5			IN	[illegible]
			P.M.	OUT	[illegible]
Tue	6	WEDNESDAY	A.M.	IN	04SEP21AM 8:00
			NOON	OUT	[illegible]
Wed	7.25			IN	[illegible]
			P.M.	OUT	04SEP22PM 3:15
Thur	8	THURSDAY	A.M.	IN	[illegible]
			NOON	OUT	
Sat	14			IN	[illegible]
			P.M.	OUT	[illegible]
Sun	5	FRIDAY	A.M.	IN	[illegible]
			NOON	OUT	[illegible]
Mon	9.5			IN	[illegible]
			P.M.	OUT	[illegible]
Tue	14.5	SATURDAY	A.M.	IN	[illegible]
			NOON	OUT	04SEP28PM 10:30
Wed	10			IN	[illegible]
			P.M.	OUT	[illegible]
Fri	8.5	SUNDAY	A.M.	IN	[illegible]
			NOON	OUT	[illegible]
				IN	
			P.M.	OUT	
TOTAL			TOTAL		

19.25 reg; 40 Reg 13.75 O.T.; 40 reg 2.80 OT; Total 99.25 Reg 6.25 O.T.

PLEASE DETATCH AND RETURN UPPER PORTION WITH YOUR REMITTANCE

To avoid finance charges of 1.5% please pay within 30 days of statement date. Finance charges will not be adjusted.
We must hear from you no later than 60 days after we sent you the first bill on which the error or problem appeared.

10 DATE	11 NEWSPAPER REFERENCE	12 13 14 DESCRIPTION-OTHER COMMENTS/CHARGES	15 18 SAU SIZE BILLED UNITS	17 TIMES RUN RATE	19 GROSS AMOUNT	20 NET AMOUNT
10/31		BALANCE FORWARD				434.80
11/26	2528	Payment on Account				-434.80
10/29	00136265	Rns / Don for small	1x.72I	30		172.08
	11/11	0255 00136265				
		BASEVIEW SUN SURCHAR				3.36
11/09	00136269	Rns / Don for small	1x2.5I	1		0.00
		0255 00136269	2.5I			

FOR BILLING QUESTIONS OR TO PAY BY CREDIT CARD CALL
HEATHER @(801) 344-2509 HAVE A SAFE AND HAPPY HOLIDAY

STATEMENT OF ACCOUNT AGING OF PAST DUE ACCOUNTS

SAI™

21 CURRENT NET AMOUNT DUE	22 30 DAYS	60 DAYS	OVER 90 DAYS	*UNAPPLIED AMOUNT	23 TOTAL AMOUNT DUE
175.44	.00	.00	.00		175.44

Utah Valley Group
of Newspapers
1555 North Freedom Boulevard P.O. Box 717, Provo, Utah, 84603
(801) 373-5050 fax (801) 373-5489

*UNAPPLIED AMOUNT ARE INCLUDED IN TOTAL AMOUNT DUE

24	25 BILLING PERIOD	6 BILLING ACCOUNT NUMBER	7 ADVERTISER/CLIENT NUMBER	2 ADVERTISER/CLIENT NAME
9900522	11/01/04 - 11/28/04	102846		HALES REST HOME

ATTACHMENT 10

To avoid finance charges of 1.5% please pay within 30 days of statement date. Finance charges will not be adjusted.
We must hear from you no later than 60 days after we sent you the first bill on which the error or problem appeared.

10 DATE	11 NEWSPAPER REFERENCE	12 13 14 DESCRIPT-ON-OTHER COMMENTS/CHARGES	15 16 SAU SIZE BILLED UNITS	17 18 TIMES RUN RATE	19 GROSS AMOUNT	20 NET AMOUNT
11/28		BALANCE FORWARD				175.44
12/26	9907401	Finance Charge				2.63
11/21	00140479	Rns / Don for small	1x.72I	64		316.40
	12/20	0255 00140479				
		BASEVIEW SUN SURCHAR				10.85
		TOP JOB INET				60.00
12/10	00143269	CNAs needed FT or on	1x.51I	21		186.50
	12/19	0255 00143269				
		BASEVIEW SUN SURCHAR				4.56
12/14	00143434	CNAs needed FT or on	1x2.5I	1		0.00
		0255 00143434	2.5I			
12/21	00143434	CNAs needed FT or on	1x2.5I	1		0.00
		0255 00143434	2.5I			

FOR BILLING QUESTIONS OR TO PAY BY CREDIT CARD CALL
HEATHER @(801) 344-2509 HAVE A SAFE AND HAPPY NEW YEAR

Just a friendly reminder that your account is now 30 days past due. Please remit outstanding balance. Thanks

STATEMENT OF ACCOUNT AGING OF PAST DUE ACCOUNTS

SAI™

21 CURRENT NET AMOUNT DUE	22 30 DAYS	60 DAYS	OVER 90 DAYS	*UNAPPLIED AMOUNT	23 TOTAL AMOUNT DUE
580.94	175.44	.00	.00		756.38

Utah Valley Group
of Newspapers

1555 North Freedom Boulevard P.O. Box 717, Provo Utah, 84603
(801) 373-5050 fax (801) 373-5489

*UNAPPLIED AMOUNT ARE INCLUDED IN TOTAL AMOUNT DUE

24	25 ADVERTISER INFORMATION			
	1 BILLING PERIOD	6 BILLING ACCOUNT NUMBER	7 ADVERTISER/CLIENT NUMBER	2 ADVERTISER/CLIENT NAME
99051168	11/29/04 - 12/26/04	102846		HALES REST HOME

PLEASE DETATCH AND RETURN UPPER PORTION WITH YOUR REMITTANCE

#2241

To avoid finance charges of 1.5% please pay within 30 days of statement date. Finance charges will not be adjusted.
We must hear from you no later than 60 days after we sent you the first bill on which the error or problem appeared.

10 DATE	11 NEWSPAPER REFERENCE	12 13 14 DESCRIPTION-OTHER COMMENTS/CHARGES	15 16 SAU SIZE BILLED UNITS	17 18 TIMES RUN RATE	19 GROSS AMOUNT	20 NET AMOUNT
08/29		BALANCE FORWARD				173.74
09/20	2211	Payment on Account				-173.74
09/03	00125692	Cook Needed - Full	2x.9I	30		339.42
	09/16	0235 00125692				
		BASEVIEW SUN SURCHAR				8.64
		TOP JOB INET				50.00
09/07	00125696	Cook Needed - Full	1x5.25I	1		0.00
		0235 00125696	5.25I			
09/21	00128171	LPN/ RN P/T Wknds, 8	1x2.5I	1		0.00
		0255 00128171	2.5I			

FOR BILLING QUESTIONS OR TO PAY BY CREDIT CARD CALL
HEATHER @(801) 344-2509 WE APPRECIATE YOUR BUSINESS

STATEMENT OF ACCOUNT AGING OF PAST DUE ACCOUNTS

SBI™

21 CURRENT NET AMOUNT DUE	22 30 DAYS	60 DAYS	OVER 90 DAYS	*UNAPPLIED AMOUNT	23 TOTAL AMOUNT DUE
398.06	.00	.00	.00		398.06

Utah Valley Group
of Newspapers

1555 North Freedom Boulevard P.O. Box 717 Provo Utah, 84603
(801) 373-5050 fax (801) 373-5489

*UNAPPLIED AMOUNT ARE INCLUDED IN TOTAL AMOUNT DUE

24	25 ADVERTISER INFORMATION			
	1 BILLING PERIOD	6 BILLING ACCOUNT NUMBER	7 ADVERTISER/CLIENT NUMBER	8 ADVERTISER/CLIENT NAME
9890161	08/30/04 - 09/26/04	102846		HALES REST HOME

Spanish Fork Nursing & Rehab

Plan of correction

F157

In talking to the staff, the dr. was notified on several occasions. However, as you have noted we have no documentation to substantiate. On 12-14-04 the nurse on duty called the dr's office stating that resident had three sores two which are getting worse. The dr's office faxed back the following note,subject 2 bed sores getting worse.What to do? Plan : using duoderm? (In the form of a question) wash soap and water keep dry. See attachment 1. No further orders were forthcoming, On 12-22-04, staff nurse faxed asking dr. to please come and see resident 2 . See attachment 2. No response from dr.

The don who gave regular insulin to the resident is no longer with us . I have no idea why she would use a house protocol for a sliding scale on a resident who does not take insulin. I have tried to contact her to no avail.. See attachment 3.

1A.
At the IDTmeeting 08-18-04, the resident had no skin problems nor a history of having been at risk for skin problems that would require any pressure relieving devices. First documentation of problems noted on 10-15. Staff states that dr.was notified however they neglected to document. Staff states that treatment began 10-05-04. Attachment 4.
Staff stated that since the dr. had not responded to their calls, they treated the woound with Papain Urea Chlorophyllin that we had in house which was the source of the green drainage.

We do have policies and procedures for ulcer care and prevention which includes charting requirements.(see attachment 5) . However, staff failed to follow and adhere to our own policies. To alleviate this problem, I have created and filled the position of Resident Care Coordinator who will under the direction of the DON and Administration review all areas of patient care and report any problems to supervisors for immediate remedy. She will report directly to Administration to ensure that there are no longer any lapses in documentation of treatment ,outcome and physician notification. The administrator and asst. admin, will monitor on a monthly basis at the IDT meetings to ensure that routine reviews of the patient record are bieng conducted. See attachment 6 for a thorough job description.

F252

The cord on the concentrator has been repaired . All repairs are done by the administrator in a timely manner as soon as he is made aware of the problem . Monthly maintainance checks are made for these kind of problems by the administrator.

F314

In talking to staff, they indicated that dressings were applied and changed as ordered . The problem does not lie in nursing procedures but in the lack of documentation of treatment and physician notification. The donut cushion mentioned was a Roho dry flotation cushion which adjusts to aid in blood flow. See attachment 7.The greenish colored drainage was from the papain urea chlorophyllin ointment as I mentioned in F157. In the IDT meeting on 08-18-04,resident 2 had no skin problems .The pressure ulcer rap triggered and was addressed in the IDT care plan review(see attachment 8) and filed under her name in the IDT-MDS book.

As was mentioned in F157, We have created the position of resident care coordinator to review all patient records to ensure that proper documentation is being done. She will report directly to the DON and administration who will monitor , giving us a three way check on all documentation.

F354:

In going through time cards, We had coverage in October for all days except 9-10-19-25-30-.(see attachment9).Our DON left us at the end of October and we have been advertising for an RN since that time in newspapers, bulletin boards at hospitals and at schools of nursing.
We offer a competitive wage and benefit program but have had a hard time filling a full time RN position. See attachment10. We have recently hired a full time RN and we currently have 2 part time RN's and will have another in February. Administration spends more time scheduling and hiring nurses than any other aspect of the business. We currently have sufficient RN's to staff and administration will monitor scheduling to ensure that the seven day eight hour rule is followed to the best of our ability.

F363;

Administration has met with the food service supervisor and had her inservice the cooking staff on the importance of following the menus as written . They try to sustitute as little as possible, however there are times when substituting is unavoidable. When they do substitute, they do use foods with equal nutritional value. The cook on duty did not know that corn was not a vegetable when substituting vegetable for vegetable nor did I. The food service supervisor will monitor at the first of each week to ensure that grocery items necessary for the week's meals are in house and will instruct the staff to stay within the menu's guidelines.

F494

In talking to staff , we found that both employee A & B had taken the CNA classes but had not taken the test. Both employees have been put on housekeeping duties until their tests are taken which will be within the next month. The ass't administrator works with the aides and will review each chart on new hires to ensure that the four month limit is met. This will be accomplished by placing a color coded tag on their personnel files with their date of hire and placed in the front of the file cabinet. The tag will be removed and their file placed in the cabinet upon their completing their CNA requirements.

F514:

Dressing changes were made as ordered however there was a breakdown in the documentation. Physicians were notified but not documented. The problem does not lie in a breakdown of care but a breakdown on documentation. We have created the position of Resident Care Coordinator to alleviate this problem. The RCC will review all resident records ,nurses notes and labs to ensure that all patient care regimens are being followed and properly documented See attachment 6.

A copy of this plan of correction has been placed in the IDT-QA book and has been integrated into our QA system.

SPANISH FORK NURSING & REHAB

ADDENDUM TO P.O.C. PAGE 1

0157: STAFF HAS BEEN THOROUGHLY INSERVICED ON DOCUMENTATION PROCEDURES AND ANOTHER INSERVICE IS SCHEDULED FOR THURSDAY 01-27-05 WITH OUR MEDICAL RECORDS CONSULTANT.

0314: NURSING STAFF HAS BEEN INSERVICED ON DOCUMENTATION PROCEDURES AND NURSING STAFF WILL MEET WITH OUR MEDICAL RECORDS CONSULTANT ON 01-27-05. AT OUR LAST IDT MEETING, ADMINISTRATION THOROUGHLY INSERVICED ALL NURSING STAFF. OUR RESIDENT CARE COORDINATOR WILL TAKE ALL RECOMMENDATIONS FROM THE IDT COMMITTEE AND UNDER DIRECTION FROM THE DON WILL INCORPORATE THEM INTO THE RESIDENTS PLAN OF CARE.

0354: THE ASST. ADMINISTRATOR WHO IS OVER HIRING WILL SCHEDULE AND MONITOR NURSING STAFF ON A DAILY BASIS TO ENSURE THAT NURSING STAFF IS WITHIN THE GUIDELINES OF REGULATIONS.

SPANISH FORK NURSING & REHAB

ADDENDUM TO P.O.C. PAGE 2

F494: THE ASST. ADMIN. WILL MONITOR FILES ON A MONTHLY BASIS TO ENSURE THAT ALL CNA'S ARE CERTIFIED WITHIN THE TIME LIMITS SET BY THE REGULATIONS.

F314 = ALL AT RISK RESIDENTS ARE TO BE MONITORED BY THE R.C.C. ON A WEEKLY BASIS AND THOSE WITH ANY BREAK IN SKIN INTEGRITY WILL BE MONITORED DAILY AS PER OUR POLICY.

0252 - THIS COMPLETION DATE WAS 01-16-05. ALL COMPLETION DATES ARE FOR THE YEAR 2005 - THE 2004 DATES WERE A MINOR ERROR.

STEVEN D. BOWN 01-23-05

Spanish Fork Nursing & Rehab

Plan of correction

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