DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465092	A. BUILDING _____ B. WING _____	10/19/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UINTAH CARE CENTER	510 S 500 W VERNAL, UT 84078

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F 324 SS=G	483.25(h)(2)QUALITY OF CARE The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined that for 1 of 13 sampled residents, the facility failed to ensure that a resident, who was assessed as a high risk for falls, received adequate supervision and assistance to prevent a fall which resulted in a hip fracture. (Resident 52.) Findings include: Resident 52 was readmitted to the facility on 10/3/00, following an acute care hospitalization for the repair of a left hip fracture. The resident was originally admitted on 5/3/00, with the diagnoses of a cerebrovascular accident, dementia, muscle spasms, osteopenia, and atrial fibrilation. The resident was transferred to an acute care hospital on 9/20/00, following a fall in the facilities dining room. Record Review: 1. A review of resident 52's medical record was done. On 9/20/00, at 12:00 PM, a nursing note documented, "Called into dining area. CNA [certified nursing assistant] reports 1) patient stood from sitting position 2) ambulate 3) fall [left] side. [No] skin impairment, [no] hip leg external rotation. Legs equal in length. Patient c/o [complaint of] pain. Unable to bear wt [weight]. Physician ---- called. N.O. [nursing order] 1) transport to [acute care hospital]. 2) Evaluation and 3) Xray [left] hip, [left] knee [and] pelvis, transport via ambulance."	F 324 11/30/00	Immediately following incident staff members involved received counseling and disciplinary action regarding supervision of residents at high risk. Staff continue to receive information pertaining to residents at risk and personalized treatment plans at daily report. IDT continues to asses needs and changes in patient condition. Patients are now identified as high risk for falls with orange dot on name tag. This allows staff to immediately identify at risk individuals. DNS will be responsible for continued inservices and monitoring at at risk patients. NOV 20 2000 11/17/00 HT	~~1/17/01~~ 12/17/00 As per telephone interview with D.C. on 11/30/00

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Dom | 11/17/2000

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 324	Continued From page 1 2. On 9/20/00, a staff nurse completed an, "Incident/Accident Report" for resident 52. The incident report documented, "Pt. [patient] taken to dining room, ambulated to reg [regular] chair, pt sat in chair, Aide ---- pushed pt [and] chair up to table, aide walked away, pt pushed chair out [and] took a few steps [without] assist [and] fell on floor." The form documented that the incident occurred at 12:00 PM. 3. Facility staff completed a full Minimum Data Set (MDS) assessment on 5/16/00. The resident was assessed as having both long and short term memory deficits, and moderately impaired cognitive skills for daily decision making. The resident was also assessed as requiring extensive assistance with bed mobility, transfers, walking and locomotion off of the unit. Facility staff assessed that the resident had a recent history of falls, within the previous 31 to 180 days, and that the resident had a fracture within the past 180 days. The resident was assessed as being restrained with full bed rails and a trunk restraint on a daily basis. 4. Resident Assessment Protocals (RAPs) documentation for resident 52's MDS assessment, dated 5/16/00, included the following: a. Falls - "[Resident 52] is a high fall risk due to her poor standing balance, poor safety awareness, and poor eyesight...." b. Physical restraints - "[Resident 52] had a fall at home apparntly [sic] when she had her CVA [cerebrovascular accident]. She has a Dx [diagnosis] of T9 compression Fx [fracture]. Her static sitting balance is mildly impaired and her dynamic sitting balance is moderately impaired. Standing balance is severely impaired with impace [sic] on functional activity hight [sic] risk for falling unsupported. On	F 324		

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admission she wore an orthotic support for her fracture - it has since been dc'd [discontinued]. Her equilibrium and eyesight are impaired. She is confused as to situation, time and place...."

5. On 6/14/00, facility staff completed a "Significant change in status" MDS assessment for resident 52. The resident was assessed as having both long and short term memory deficits, and moderately impaired cognitive skills for daily decision making. The resident was also assessed as requiring extensive assistance with bed mobility, transferring, and walking. The resident required limited assistance with locomotion both on and off of the unit. Facility staff assessed that the resident had a recent history of falls, within the previous 31 to 180 days, and that the resident had a fracture within the past 180 days. The resident was assessed as being restrained with full bed rails on a daily basis. No trunk restraint was assessed as being utilized.

6. Resident Assessment Protocals (RAPs) documentation for resident 52's MDS assessment, dated 6/14/00, included the following:

Falls - "[Resident 52] is at high risk for falls related to impaired mobility, pain, Fx of T9 and [right] sided weakness as a result of [left] CVA..."

7. On 9/11/00, facility staff completed a quarterly MDS assessment for resident 52. The resident was assessed as having both long and short term memory deficits, and moderately impaired cognitive skills for daily decision making. The resident was also assessed as requiring extensive assistance with bed mobility, transferring, and walking. The resident required limited assistance with locomotion both on and off of the unit. Facility staff documented that the resident

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had a recent history of falls, within the previous 31 to 180 days and that the resident was restrained with a trunk restraint and a chair that prevents rising on a daily basis.

8. A review of resident 52's care plan was done. On 5/3/00, facility staff identified a problem of, "Mobility impaired, related to pain 2nd to T9 Fx, and R sided weakness r/t [related to] stroke." The goal for this identified problem was, "Will have no falls/injuries and will continue to ambulate with FWW [front wheel walker] and assist TNR [through next review]." Approaches for this identified problem included, "Ambulate with 1 assist with FWW minimal assist x1-2. Do not leave unrestrained while in any chair."

Interviews:

1. An interview with CNA 1 was held on 10/18/00 at 3:00 PM. CNA 1 was the nurse aide assigned to provide care to resident 52 on 9/20/00, the date the resident fell in the dining room. CNA 1 stated that as part of resident 52's plan of care, staff would ambulate her to the dining room for meals. She stated that the resident ate her meals while seated in a geri-chair with a lap tray. She stated that the lap tray was to prevent the resident from leaving during meals.

In addition to the interview with CNA 1, she provided a written statement about the events leading up to resident 52 falling in the dining room on 9/20/00. The interview was consistent with the written statement. The statement is as follows: "I ambulated pt to dining room from lobby. I had difficulty getting pt to stand up, but once standing, pt ambulated well with gait belt and one assist. When approaching dining room, pt began to resist. I asked [CNA 2] for assistance and we continued on with ambulation with 2 assists. Pt

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began complaining of pain, so we stopped ambulation to seat her at feeder table approximately 10 feet from geri chair. At that time pt reached for table, sat on it and grabbed her leg, still complaining of pain. We then lowered her to stationary chair and set her at table. Due to her resistance and complaint of pain, we did not continue ambulation. I needed to leave the dining room so I alerted [CNA 3] and asked if she intended on staying in dining room. She stated she did. I then told her pt was seated in stationary chair. [CNA 3] acknowledged pt and myself, and I left the dining room."

During the interview with CNA 1, she stated that soon after she left the dining room, she was informed that resident 52 had fallen.

2. A telephone interview with CNA 2 was held on 10/23/00 at 9:35 AM. CNA 2 stated that she recalled the day that resident 52 fell in the dining room. She stated that CNA 1 asked her to assist with ambulating resident 52 to the dining room. She stated that resident 52 was limping and rubbing her leg. She stated that she had ambulated resident 52 before and had never noticed the resident limp. CNA 2 stated that she stopped assisting CNA 1 at the door leading into the dining room. CNA 2 stated that she then went to assist other residents into the dining room. CNA 2 stated that when she returned to the dining room, she began getting ready to serve lunch trays. She stated that she was putting an apron on when she heard a resident yell out. At that time, CNA 2 stated resident 52 was on the ground.

3. A telephone interview was held with CNA 3 on 9/23/00 at 9:25 AM. CNA 3 stated that she recalled the day that resident 52 fell in the dining room. CNA 3 stated that she ambulated another resident into the

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F 324	Continued From page 5 dining room for the lunch meal. At that time, resident 52 and CNA 1 were already in the dining room. She stated that resident 52 was at an assistive feeding table but not in the geri-chair where she usually ate her meals. She stated that she told CNA 1 that resident 52 needed to be in the geri-chair. She stated that CNA 1 responded by saying resident 52 was agitated and could not get her to the geri-chair. CNA 3 stated that while CNA 1 was still in the dining room, resident 52 stood up at the table. CNA 3 stated that CNA 1 assisted the resident back to a regular chair then left the dining room. CNA 3 stated that there were three to four nurse aides in the dining room, but unsure how close they were to resident 52 when CNA 1 left the dining room. CNA 3 stated that she and another nurse aide were attending to two residents having a conflict at the dining room door, when she heard a resident yell. CNA 3 stated she turned around and resident 52 was on the floor. CNA 3 stated that resident 52 was a high risk for falling and that she needed close supervision. 4. A telephone interview with CNA 4 was held on 10/23/00 at 3:30 PM. CNA 4 stated that she recalled the day that resident 52 fell in the dining room. CNA 4 stated that, at the time of the fall, she had been in the dining room about one to two minutes and had not noticed resident 52. She stated that she was getting coffee for a resident and turned to see resident 52 falling. She stated that there was another nurse aide running toward resident 52 but that the other aide was too far away. CNA 4 stated that resident 52 had been sitting in a regular chair at the assistive feeding table and was supposed to be in a geri-chair. 5. An interview with the facility's physical therapist was held on 10/18/00 at 2:40 PM. The physical therapist stated that prior to resident 52's fall on	F 324		

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F 324	Continued From page 6 9/20/00, the resident was at high risk for falls. He stated the resident had no safety awareness and that she needed to be restrained at all times. He stated that if the resident were to be unrestrained, staff would need to be within arms length distance because of the resident's lack of safety awareness and quick movements. The physical therapist stated that a fall would have been a predictable outcome when the resident was left unrestrained in the dining room on 9/20/00. 6. An interview with the charge nurse on duty the day resident 52 fell in the dining room was held on 10/18/00 at 3:30 PM. The charge nurse stated that prior to resident 52 falling on 9/20/00, the resident was at high risk for falls. She stated that the resident had no awareness of her own safety needs and that she should not have been left unrestrained in the dining room. The charge nurse stated that the resident's fall on 9/20/00 was a likely outcome when left unrestrained. 7. A telephone interview with the orthopedic surgeon who repaired resident 52's hip fracture was held on 10/18/00 at 4:00 PM. The surgeon was asked if he had a professional opinion as to whether resident 52's hip fracture occurred before or after her fall. The surgeon stated that almost always hip fractures occur as a result of a fall and not the cause of a fall. He stated that he would only be guessing if he were to state when resident 52's hip fracture actually occurred.	F 324		
F 371 SS=E	483.35(h)(2)DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by:	F 371 JHB 11/20/00	Continued on page 8	

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F 371	Continued From page 7 Based on observation, the facility did not prepare, distribute and serve food under sanitary conditions as evidenced by two dietary staff handling food items with contaminated gloves during meal preparation on 10/17/00 and 10/18/00. Findings include: 1. During breakfast preparation on 10/17/00, at 7:15 AM, the cook was observed preparing toast for residents. She placed the toast in a container in a tray heater by opening the door by the handle with her gloved hands, contaminating her gloves. She then returned to the the food preparation table and removed saran wrap from a box with the same contaminated gloves. She was observed to touch a stack of toast as she placed them into a container and placed the saran wrap over the top of the container with the same contaminated gloves. The cook then removed her gloves, washed her hands and regloved. The cook was observed to lift two lids, which were used to cover cooked food, from the steam table with her gloved hands. She then returned to the food preparation table and removed a wisk by touching the preparation end of the wisk with the contaminated gloves. She then used the wisk to scramble eggs. She placed the scrambled eggs in the heating tray with the contaminated gloves. The cook was then observed to remove a container from above the food preparation table with the same gloves. She used that container to remove hot water from the steam table. The cook then returned to the food preparation table and placed the scrambled eggs in the tray heater by opening the door to the tray heater with the same gloves. When the cook began to prepare the resident plates, she placed her previously contaminated gloved left	F 371	Staff involved have received disciplinary action, counseled on 11/13/00. Observation of tray line 1 meal per day for 1 month, by FSS. Begin on 11/22/00 and end 12/22/00 Observation of Tray line for cross-contamination for 3 meals per week by FSS, begin 11/22/00 and end 12/22/00 Cross Contamination for 6 months will be highlighted subject of information in training with dietary staff taught by FSS, began 10/25/00. Continue Cross-Contamination training where Dietary Staff Employee will record, observation of possible Cross-contamination, begin 11/29/00, log will be kept. Include Cross-Contamination training with new Employee's hired into Dietary, by FSS for 3 day's, to educate. Continue process of obtaining training information and materials Tong's will be used to serve all Garnish's, Rolls, Bread, etc. Shoulder length hair will be contained. Will use proper handling of all Plates, glasses, etc.	11/17/00

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F 371	Continued From page 8 thumb over the top edge of the plate to hold it. She was observed to use her contaminated gloved hands to handle both oranges slices and toast, which she placed on the plate. The cook held each resident's hot cereal bowl with her left thumb positioned over the top edge of the bowl with the same gloves. With She then was observed to brush spilled egg from saran wrap that was partially covering the hashbrowns. The egg fell into the hashbrowns. The cook then was observed to slice bananas into a resident's hot cereal bowl with the same gloves. The cook was observed on several occasions to move from a dirty area to a clean area without washing her hands or regloving. 2. During observation of breakfast preparation on 10/17/00, at 7:15 AM, the dietary aide was observed to have no hair net on throughout the time that she assisted the cook with tray and meal preparation. She was not observed to wash her hands or glove until she began preparation of resident trays. The dietary aide was observed to remove two tray carts from the walk-in refridgerator with her gloved hands. She was not observed to wash her hands or reglove. The dietary aide then was observed to touch the top rim of each resident glass containing fluid with previously contaminated gloves. She then opened the door to the walk-in refridgerator, further contaminating her gloves, and returned to the tray preparation line. The dietary aide identified each resident by turning the resident identification card around with her gloved hands. The dietary aide then touched the handle of the scoop in the Promod (protein supplement) to place measured supplement in hot cereal bowls. She then placed the scoop back into the Promod container, allowing the scoop handle to slide into the supplement. The dietary aide was observed to move from a dirty area to a clean area without washing her hands or gloving.	F 371	Continued from page 8 Cook shall be stationary at tray line, if removed from station will wash and re-glove. Scoop, Pro-Mod thru dishwasher, after each use. All staff inserviced on 10/25/00	~~1/17/01~~ 12/17/00 AS PER TELEPHONE INTERVIEW WITH DON ON 11/30/00 JBB

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F 371	Continued From page 9 3. During breakfast preparation on 10/18/00, at 7:20 AM, the cook was observed to spray sanitizing foam on her gloved hands and return to the food preparation line. She was observed to handle both ham and waffles as she placed them on eight residents' trays with her gloved hands. The cook held each resident plate and hot cereal bowl with her left thumb positioned over the top edge and rim. She was not observed to wash her hands or reglove. The cook was observed to hold one resident's hot cereal bowl with her left thumb positioned over the top edge and rim of the bowl, while sweeping spilled cereal up and over the outer edge back into the bowl with the right contaminated gloved hand. The cook was observed to move from a dirty area to a clean area without washing her hands or regloving. 4. During observation of breakfast preparation on 10/18/00, at 7:20 AM, the dietary aide was observed to open the tray heater door with her gloved hands, contaminating her gloves. She returned to the food preparation area and removed toast and placed them in a container with the same gloves. The dietary aide placed a scoop in the cereal container after filling cereal bowls with contents, allowing the scoop to slide down into the cereal. She walked away from the tray line and opened the walk-in refridgerator, further contaminating her gloves. The dietary aide then returned to the tray line and touched the edge and rim of each resident glass containing fluid as she placed them on the trays with the same gloves. The dietary aide was observed to turn on the water faucet with her left gloved hand and return to the tray line. She did not wash her hands or reglove. The dietary aid was observed to move from a dirty area to a clean area without washing her hands or regloving.	F 371		

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