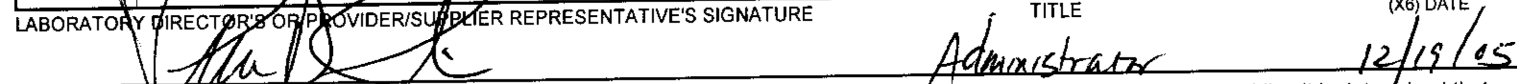
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. BUILDING ______ B. WING ______	C 11/29/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SIDE COMMUNITY NURSING CENTER	876 WEST 700 SOUTH SALT LAKE CITY, UT 84104

(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 CHANGES 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 o483.12(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 o483.15(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 medical record review, it was determined that for 1 of 7 sample residents (resident 4), the facility did not consult with the resident's physician when there was a need to	F 157 12/20/05 POC acceptable Completion date 12/1/05 [handwritten signature] RN	F 157 483.10 (b)(11) NOTIFICATION OF CHANGES This facility will continue to immediately inform the resident; consult with resident's physician; and if known notify the resident's legal representative or an interested family member of need to alter treatment significantly. The licensed nursing staff was inserviced on physician notification on December 1, 2005 with emphasis on the need for documented physician notification of all changes in resident condition. Compliance will be monitored by the Director of Nursing through on-going weekly reviews of the medical records of all residents, and with daily review of the medical records of residents with known changes of condition. The Director of Nursing will identify residents with known changes in condition and need for physician notification daily, through the licensed nurses' 24 Hour Report. This intervention will be followed as a QA issue in quarterly facility Quality Assurance meetings.	12/1/05



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	12/19/05

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Utah Department of Health
DEC 21 2005
2060790
Bureau of Health Facility Licensing, Certification and Resident Assessment

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. BUILDING ______ B. WING ______	C 11/29/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SIDE COMMUNITY NURSING CENTER	876 WEST 700 SOUTH SALT LAKE CITY, UT 84104

(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	Continued From page 1 alter treatment. Specifically, one resident had drainage from open wounds on his leg and the physician was not consulted to obtain orders to treat the wounds. Findings included: 1. Resident 4 was admitted to the facility on 6/5/03, with diagnoses which included right leg cellulitis, pulmonary embolism, congestive heart failure and hypothyroidism. On 11/13/05, a facility nurse documented the following on a Nurse's Note", "Has been c/o (complaining of) pain in knee & oozing from site although not willing to let it be dressed...Both legs are red & swollen [and] tender to touch. Will cont. (continue) to monitor." On 11/17/05, a facility nurse documented the following on a "Nurse's Note", "Pt (patient) pointed out H2O (water) blisters on [left] leg that started [after] he woken today...[at] mdnt (midnight) stated if leg doesn't quit hurting he wants to go to the hosp tonoc (tonight)." On 11/18/05, a facility nurse documented the following on a "Nurse's Note", "[left] leg oozing clear fl (fluid) Has saturated several towels throughout the evening & c/o (complaining of) a lot of pain. 3 AM requested to go to ER (emergency room)...Nurse suggested he hold off on going to ER until RN (registered nurse) comes on shift to assess condition..." On 11/19/05, a facility nurse documented the following on a "Nurse's Note", "Left leg continues to drain due to anasarca [with] several open areas, drainage is yellow, no odor, saturated prior	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. BUILDING ______ B. WING ______	C 11/29/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SIDE COMMUNITY NURSING CENTER	876 WEST 700 SOUTH SALT LAKE CITY, UT 84104

(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	Continued From page 2 drsg (dressing)...pt (patient) c/o (complaining of) swelling in [right] foot and is unable to put on shoe RN (registered nurse) instructed pt to elevate extrems (extremities)..." On 11/20/05, a facility nurse documented the following on a "Nurse's Note", "...Pt (patient) anxious re (regarding) swelling in legs. RN (registered nurse) assess 4+ pitting edema [right] foot and 3+ pitting [left] foot...Leg has 4 openings that are draining yellow, non-odor fluid continuously...Pt asked if ER (emergency room) was warranted and stated he didn't want to be admitted to hospital. RN to notify DON (director of nurses) for possible f/u (follow up) [with] MD (medical doctor)..." On 11/21/05, a facility nurse documented the following on a "Nurse's Note", "Pt (patient) [with] LE's (lower extremities) edema- legs dk (dark) purple- warm to touch. [left] leg [with] open areas draining clear liquid, [right] foot [with] 3+ pitting edema c/o's (complains of) pain when walking...Call placed to [medical doctor] on call for [resident's attending physician]. Pt sent to [local hospital] ER (emergency room) for evaluation." A review of the hospital discharge record dated 11/22/05, provided documented evidence that resident 4 had cellulitis with a MRSA infection. There was no documentation in the medical record of resident 4 to evidence that the physician was notified of the "oozing wounds" identified on 11/13/05, 11/17/05, 11/18/05, 11/19/05 and 11/20/05. On 11/29/05 at 3:15 PM, the director of nurses	F 157		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. BUILDING ______ B. WING ______	C 11/29/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SIDE COMMUNITY NURSING CENTER	**876 WEST 700 SOUTH SALT LAKE CITY, UT 84104**

(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	Continued From page 3 (DON) was interviewed. The DON stated that she was aware that resident 4 had open wounds and he had a diagnoses of anasarca. She further stated that she was not informed of the yellow drainage from the wounds. The DON stated that she did not contact resident 4's physician and did not know if anyone else contacted resident 4's physician. In a later interview, the DON stated, that resident 4's physician was difficult to reach. It should be noted that a physician was not notified of the "oozing wounds" until 8 days after they were identified.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	F 225 483.13(c) (1) (ii)-(iii) STAFF TREATMENT OF RESIDENTS This facility will continue to ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The licensed nursing staff was inserviced on immediate reporting of injuries of unknown origin on December 1, 2005. An identical inservice on injury reporting was held during general staff meeting on December 7, 2005. Reports of injuries of unknown origin will be reported to the State survey agency by the Administrator, Director of Nursing or Social Services Worker as soon as they are received. Reports	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. BUILDING ______ B. WING ______	C 11/29/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SIDE COMMUNITY NURSING CENTER	876 WEST 700 SOUTH SALT LAKE CITY, UT 84104

(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 225	Continued From page 4 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined that the facility failed to report an injury of unknown origin to the State Survey Agency. Resident identifier: 1 Findings Included: 1. Resident 1 was admitted to the facility on 4/25/03 with diagnoses which included dementia with psychotic and depressive features, alcohol abuse and grand mal seizures. On 11/29/05, a review of resident 4's medical record, including review of all documented nurses' notes was completed. On 11/24/05 , a facility nurse documented the following in a progress note, "...aid noted bruising on [left] hand, side of hand [and] small finger (pinky)- etiology unknown." On 11/25/05, the facility social worker documented the following in a progress note, "Resident's mother [and] sister in to visit, are	F 225	of injuries of unknown origin will be investigated by facility administration, and the results of all investigations will be submitted by the facility Social Services Worker to the State survey agency within 5 working days pursuant to Federal Long-Term care regulations. All reportable injuries will be entered into the reportable incidents tracking log by the Social Services Worker at the time they are reported to the State survey agency. The Social Services Worker will review the reportable incidents tracking log weekly and compare it to injury reports received, to ensure that all events are being investigated and reported. This will be followed as a QA issue in quarterly facility Quality Assurance meetings.	12/7/05

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. BUILDING ______ B. WING ______	C 11/29/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SIDE COMMUNITY NURSING CENTER	876 WEST 700 SOUTH SALT LAKE CITY, UT 84104

(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 225	Continued From page 5 concerned about bruises on hands- looked at bruises. Spoke [with] nurse about same- bruises were noted yesterday [with] no known cause, discussed possible advisability of getting x-rays due to bruising [and] swelling..." A facility "Incident Report" regarding the bruising of unknown origin could not be found. On 11/29/05 at 1:40 PM, the facility director of nurses (DON) was interviewed. The DON stated that the facility social worker follows-up and reports on the injuries of unknown origin. On 11/29/05 at 1:50 PM, the facility social worker was interviewed. The social worker stated that she did not report resident 4's injury of unknown origin because the x-ray did not show a fracture. The social worker was then asked for an investigation regarding resident 4's injury of unknown origin. At 2:15 PM, the social worker stated she was not able to find the investigation. On 11/29/05 at 3:45 PM, the facility nurse who worked with resident 4 on 11/24/05 was interviewed. She stated she has no idea how the bruising of unknown origin occurred. She stated she reported the injury to the nurse who came onto shift and that nurse reported the injury to the DON. Resident 4's bruising of unknown origin should have been immediately reported to the State Survey Agency, an investigation conducted and the results submitted to this agency within 5 working days pursuant to Federal Long-Term care Regulations.	F 225		
F 226	483.13(c) STAFF TREATMENT OF RESIDENTS	F 226		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. BUILDING ________ B. WING ________	C 11/29/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SIDE COMMUNITY NURSING CENTER	**876 WEST 700 SOUTH SALT LAKE CITY, UT 84104**

(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 226 SS=D	Continued From page 6 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and review of the facility's abuse policies and procedures, the facility did not establish effective abuse prevention and protection policies and procedures to ensure that the residents of the facility were free from actual and potential abuse. Additionally, based on interview and record review, the facility did not thoroughly investigate allegations of abuse (including injuries of unknown origin), the facility did not protect residents from further abuse and the facility did not report to the State Survey Agency.. During a complaint survey on 11/29/05, it was determined through record review and staff interviews an incident of resident to resident abuse (resident 1 and 2) where the facility did not protect resident 1 from further altercations with resident 2. In addition, resident 1 had an injury of unknown origin in which the facility did not investigate or report. Findings Included: 1. INVESTIGATION: a. A review of the facility's policy and procedures relating to investigation was completed on 11/29/05. The policies and procedures directed	F 226	F 226 483.13(c) STAFF TREATMENT OF RESIDENTS This facility will continue to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of resident and misappropriation of resident property. The licensed nursing staff was inserviced on immediate reporting of injuries of unknown origin on December 1, 2005. An identical inservice on injury reporting was held during general staff meeting on December 7, 2005. Reports of injuries of unknown origin will be reported to the State survey agency by facility Administrator, Director of Nursing or Social Services Worker as soon as they are received. Reports of injuries of unknown origin will be investigated by facility administration, and the results of all investigations will be submitted by the	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. BUILDING ______ B. WING ______	C 11/29/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SIDE COMMUNITY NURSING CENTER	876 WEST 700 SOUTH SALT LAKE CITY, UT 84104

(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 226	Continued From page 7 the following: "INVESTIGATION ...Once reported, the Director Of Nursing and/or Administrator will conduct their own investigation..." b. On 11/24/05, a nurse's note in resident 1's medical record documented the following entry: "...aid noted bruising on [left] hand, side of hand [and] small finger (pinky)- etiology unknown." On 11/25/05, the facility social worker documented the following in a progress note, "Resident's mother [and] sister in to visit, are concerned about bruises on hands- looked at bruises. Spoke [with] nurse about same- bruises were noted yesterday [with] no known cause, discussed possible advisability of getting x-rays due to bruising [and] swelling..." The facility administration was not able to provide any documented evidence that the bruising found on resident 1's hand on 11/24/05, had been investigated. 2. PROTECTION: a. A review of the facility's policy and procedures relating to protection was completed on 11/29/05. The policies and procedures directed the following: "PROTECTION OF RESIDENT During the investigation, corrective actions will be taken to ensure the protection of the resident, wither by suspension, termination, or other methods."	F 226	facility Social Services Worker to the State survey agency within 5 working days pursuant to Federal Long-Term care regulations. All reportable injuries will be entered into the reportable incidents tracking log by the Social Services Worker at the time they are reported to the State survey agency. The Social Services Worker will review the reportable incidents tracking log weekly and compare it to injury reports received, to ensure that all events are being investigated and reported. This will be followed as a QA issue in quarterly facility Quality Assurance meetings. Resident #2 was moved to Room 103 on December 2, 2005, after he and his responsible party were consulted about the need for the change and both had agreed to the change.	12-7-05

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. BUILDING ______ B. WING ______	C 11/29/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SIDE COMMUNITY NURSING CENTER	876 WEST 700 SOUTH SALT LAKE CITY, UT 84104

(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 226	Continued From page 8	F 226		

b. On 11/19/05, a nurse's note in resident 1's medical record documented the following, "[Resident 1] was in rm (room) moaning & nurse hear other resident yell at him to "Shut up", [resident 1] continued to groan & hear louder for [him] to "shut up" & CNA (certified nursing assistant) went to see what was going on. Brought him out to nurses station & he had bright red mark to forehead. Asked residents rm (room) mates who hit him & new resident said it was him..."

On 11/19/05, a nurse's note in resident 2's medical record documented the following, "Heard resident yelling at rm (room) mate to "shut up" resident repeated several time for moaning & groaning resident to shut up. CNA (certified nursing assistant) went in & brought res. (resident) out to nursing station. Nurse went off to rm to question what was happening. Asked [resident 2] if hit resident & at first would not admit that he hit him but resident had lg [large) red spot on forehead & nurse knew he couldn't have done self injuries. [resident 2] finally confessed he hit him on head & he did care if he had killed him at least he wouldn't be moaning & groaning anymore. Worried about resident being harmed so DON (director of nurses) notified of situation & residents will remain in same room for time being..."

On 11/23/05, the facility social worker completed an incident report regarding resident 1 and resident 2. The facility social worker documented the following, "...Date and time of incident: 11-19-05 evening shift...Both involved resident are roommates. Both were in room when staff heard resident [1] making "moaning and groaning" noises volume increased and heard

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. BUILDING ___ B. WING ___	C 11/29/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SIDE COMMUNITY NURSING CENTER	876 WEST 700 SOUTH SALT LAKE CITY, UT 84104

(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 226	Continued From page 9 resident [2] yelling at resident [1] so staff checked room. CNA (certified nursing assistant) brought resident [1] to nurses station where found small red mark on forehead. Nurse went to room to question resident [2] on events - he admitted to striking resident [1] on head...Discussed appropriate behaviors [with] resident [2], involving [2] in more out of room programs [and] activities. Room change under consideration if no improvement within week..." On 11/29/05 at 1:55 PM, the DON (director of nurses) was interviewed. The DON stated that resident 1 and resident 2 still continue to share a room. She stated that they are watched closely and they may need to move them because resident 1 annoys resident 2 and resident 2 gets all "worked up". She further stated that resident 1 and resident 2 had not had any further altercations. After the interview with the DON the following nursing note in resident 2's medical record was found. The nurse's note was dated 11/29/05 and documented the following, "CNA (certified nursing assistant) found resident standing over [resident 1] (roommate) Roommates gown/bed wet. [right] ear [with] what appears to be spit (I heard male pt (patient) spit approx (approximately) 1/2 [hour] before incident)..." On 11/29/05 at 2:20 PM, the DON stated that she was made aware of the incident involving resident 1 and resident 2 that morning. She further stated that resident 1 was removed from the room. The DON stated that the facility social worker and administrator have not been in the building this AM therefore they had not discussed what they will be doing with resident 1 and resident 2. The	F 226		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. BUILDING ______ B. WING ______	C 11/29/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SIDE COMMUNITY NURSING CENTER	**876 WEST 700 SOUTH SALT LAKE CITY, UT 84104**

(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 226	Continued From page 10 DON further stated that both resident had been monitored closely. On 11/29/05 at 3:55 PM, resident 1 and resident 2 were observed to be in their room together with no staff present or monitoring them. c. Resident 1 had an injury of unknown origin identified on 11/24/05. Facility staff were not able to provide any documentation regarding the investigation and what steps were taken to protect the resident. 3. REPORTING: a. A review of the facility's policy and procedures relating to reporting was completed on 11/29/05. The policies and procedures directed the following: "REPORTING ABUSE The investigation will be completed and findings reported to Adult Protective Services, Ombudsman, and Resident Assessment...All incidents of Unknown origin will be reported directly to the State Health Dept along with Adult Protective Services with the appropriate documentation as soon as completed within the five days." b. On 11/29/05, surveyors reviewed records maintained by the State Survey Agency, which related to the facility. Incidents of facility self reported allegations of abuse, neglect, misappropriation of resident property, and injuries of unknown origin were among the records reviewed. Since April 2004, the facility had not reported any of these incidents.	F 226		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. BUILDING ___ B. WING ___	C 11/29/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SIDE COMMUNITY NURSING CENTER	876 WEST 700 SOUTH SALT LAKE CITY, UT 84104

(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 226	Continued From page 11 c. Resident 1 had an injury of unknown origin identified on 11/24/05. Facility staff were not able to provide any documented evidence that the injury of unknown origin was reported to the State Survey Agency.	F 226		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview it was determined that the facility did not provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being for 1 of 7 sample residents (resident 4). Specifically, resident 4 did not receive prompt assessment and services when he presented with wounds which were draining. Findings included: 1. Resident 4 was admitted to the facility on 6/5/03, with diagnoses which included right leg cellulitis, pulmonary embolism, congestive heart failure and hypothyroidism. Resident 4's medical record was reviewed on 11/29/05.	F 309	F 309 483.25 QUALITY OF CARE This facility will continue to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. At the time of this survey, Resident #4 had been discharged to SNF. The licensed nursing staff was inserviced on physician notification on December 1, 2005, and the need for documented physician notification of all changes in resident condition was reinforced. Compliance will be monitored by the Director of Nursing through on-going weekly reviews of the medical records of all residents, and with daily review of the medical records of residents with known changes of condition. This will be	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. BUILDING ______ B. WING ______	C 11/29/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SIDE COMMUNITY NURSING CENTER	876 WEST 700 SOUTH SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 On 11/13/05, a facility nurse documented the following on a Nurse's Note", "Has been c/o (complaining of) pain in knee & oozing from site although not willing to let it be dressed...Both legs are red & swollen [and] tender to touch. Will cont. (continue) to monitor." On 11/17/05, a facility nurse documented the following on a "Nurse's Note", "Pt (patient) pointed out H2O (water) blisters on [left] leg that started [after] he woken today...[at] mdnt (midnight) stated if leg doesn't quit hurting he wants to go to the hosp tonoc (tonight)." On 11/18/05, a facility nurse documented the following on a "Nurse's Note", "[left] leg oozing clear fl (fluid) Has saturated several towels throughout the evening & c/o (complaining of) a lot of pain. 3 AM requested to go to ER (emergency room)...Nurse suggested he hold off on going to ER until RN (registered nurse) comes on shift to assess condition..." On 11/19/05, a facility nurse documented the following on a "Nurse's Note", "Left leg continues to drain due to anasarca [with] several open areas, drainage is yellow, no odor, saturated prior drsg (dressing)...pt (patient) c/o (complaining of) swelling in [right] foot and is unable to put on shoe RN (registered nurse) instructed pt to elevate extrems (extremities)..." On 11/20/05, a facility nurse documented the following on a "Nurse's Note", "...Pt (patient) anxious re (regarding) swelling in legs. RN (registered nurse) assess 4+ pitting edema [right] foot and 3+ pitting [left] foot...Leg has 4 openings that are draining yellow, non-odor fluid continuously...Pt asked if ER (emergency room)	F 309	followed as a QA issue in quarterly facility Quality Assurance meetings. The licensed nursing staff was inserviced on wound evaluation on December 1, 2005, and provided with procedure for documentation of new and existing wounds that specifies the conditions for physician notification. Compliance with this procedure will be monitored by the Director of Nursing through on-going daily reviews of the medical records of residents with known new or existing wounds. This will be followed as a QA issue in quarterly facility Quality Assurance meetings.	12/1/05

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. BUILDING ____ B. WING ____	C 11/29/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SIDE COMMUNITY NURSING CENTER	876 WEST 700 SOUTH SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 13 was warranted and stated he didn't want to be admitted to hospital. RN to notify DON (director of nurses) for possible f/u (follow up) [with] MD (medical doctor)..." On 11/21/05, a facility nurse documented the following on a "Nurse's Note", "Pt (patient) [with] LE's (lower extremities) edema- legs dk (dark) purple- warm to touch. [left] leg [with] open areas draining clear liquid, [right] foot [with] 3+ pitting edema c/o's (complains of) pain when walking...Call placed to [medical doctor] on call for [resident's attending physician]. Pt sent to [local hospital] ER (emergency room) for evaluation." A review of the hospital discharge record, dated 11/22/05, provided documented evidence that resident 4 had cellulitis with a MRSA infection. On 11/29/05 at 3:15 PM, the director of nurses (DON) was interviewed. The DON stated that she was aware that resident 4 had open wounds and he had a diagnoses of anasarca. She further stated that she was not informed of the yellow drainage from the wounds. The DON stated during that time period there was agency staff at the facility. It should be noted that a physician was not notified of the "oozing wounds" until 8 days after they were identified.	F 309		

INSERVICE TRAINING REPORT

Westside Community Nursing Center
876 West 700 South
Salt Lake City, Utah 84104

DATE: 12/7/05 SUBJECT PRESENTED Resident to Resident incidents unexplained injuries and

OUTLINE OF MATERIAL: bruising - reporting requirements

METHOD OF PRESENTATION: Lecture
(FILM, DEMONSTRATION, LECTURE, ETC.)

1.
EVALUATION OF GROUP RESPONSE:

TIME: 2:00pm SIGNATURE OF INSTRUCTOR Dian Hovey

SIGNATURE OF STAFF ATTENDING:

[illegible] - Administrator	Virginia Schutt TRT
[illegible]	Dian Hovey SSD
[illegible]	Phillip Cloe
Marie Matting CNA	Gloria Moe[illegible]
Susan Wood	Veronica Morales O
Jose Cruz	Celia Vega
Yolanda Garza	
Carmen S Cook	
[illegible]	
Nicole Ferguson	
Ruth C Mathis T.R.T	
[illegible]	

IN-SERVICE TRAINING REPORT

WESTSIDE COMMUNITY NURSING CENTER

DATE: 12/1/05 **SUBJECT PRESENTED** Results of Complaint
OUTLINE OF MATERIAL: Deficiency – Actual Harm findings

METHOD OF PRESENTATION: (FILM, DEMONSTRATION, LECTURE, ETC.

EVALUATION OF GROUP RESPONSE

TIME: 1430 **SIGNATURE OF INSTRUCTOR** [illegible] RN

SIGNATURE OF STAFF ATTENDING:

S. Wood LPN
N. Ferguson RN
[illegible] LPN

Licensed Nurses Meeting – December 1, 2005 2:00 PM

Complaint Survey Nov. 29, 2005

- failure to report injuries of unknown origin
- failure to adequately monitor and insure resident's safety
- failure to report changes in resident's condition to MD

Incomplete documentation, poor wound descriptions in charting

Charting that resident "wants MD called" or "wants to go to ER," but no follow through– resident's vacillation not documented, conversations with resident not documented, attempts at intervention and problem solving not documented…

Document everything! Use complete detail!

Call MDs whenever there is a change in resident condition, whether the resident wants you to or not: MD will decide to treat or not to treat and resident can decide whether or not to comply, but your job will have been done responsibly regardless.

Document completely that the physician has been notified.

Report injuries/bruising of unknown origin immediately: notify DON, Aministrator or Social Worker, write complete chart notes.

Follow the same procedure for injuries/bruising reported to you by family/visitors.

Nursing Documentation in Wound Management

Principles of documentation:

"If it wasn't documented, it wasn't done."

Wound Documentation: Why document?

Initially, to

- *record the client's history*
- *identify causitive factors*
- *identify intrinsic and extrinsic factors that may affect wound healing*
- *obtain a baseline for future comparison*

Principles of documentation:

- *timely*
- *accurate and objective*
- *concise*
- *comprehensive*
- *legible*
- *Include signature and printed name*
- *use only approved terminology*

Documenting Wound Appearance

Factors to document regularly:

- *new or pre-existing wound*
- *wound stage*
- *dimensions (including sinuses and undermining)*
- *tissue type(s) involved, presence or absence of new (pink or shiny white) tissue*
- *exudate color, opacity, and amount*
- *odor*
- *treatment(s) being used*
- *Wound Clinic involvement*
- *condition of surrounding skin*
- *signs of infection*
- *pain*
- *physician notification if there is a change or staff/family/resident concerns*

Documentation of a <u>New wound</u> includes:

- *wound location*
- *date wound sustained (if known)- if not known, document "unknown."*
- *how the wound was sustained (if known)- if not known, document "unknown."*
- *wound classification (acute / chronic, pressure, stasis, stage, recurring, etc.)*
- *physician and family notification for every new wound*

Stages of Wounds

NPUAP Report (National Pressure Ulcer Advisory Panel)

This is an updated definition, dated November 2003, from the National Pressure Ulcer Advisory Panel (NPUAP) web site http://www.npuap.org/positn6.htm and the change is primarily for the definition of a stage one pressure ulcer.

In the current literature, the National Pressure Ulcer Advisory Panel (NPUAP) staging system from the 1989 Consensus Development Conference is cited more frequently than others. This staging system has been adopted by the AHCPR Pressure Ulcer Guideline Panels and is published in both sets of AHCPR (now AHRQ) Pressure Ulcer Clinical Practice Guidelines (1992, 1994). It is described as follows:

Stage 1

Pressure ulcer is an observable pressure-related alteration of intact skin whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel), and/or sensation (pain, itching).
The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

Stage 2

Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.

Stage 3

Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

Stage 4

Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint, capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

11/03 http://www.npuap.org/positn6.htm

Notation from LDHP Medical Review Services Corp.
STAGE 5- This is an older classification and not now used. It appears in some older literature. A stage V wound is a wound that is extremely deep, having gone through the muscle layers and now involves underlying organs and bone. It is difficult to heal. Surgical removal of the necrotic or decayed tissue is the usual treatment. Amputation may be necessary is some situations. Death usually occurs from sepsis.

Notation- This replaces the previous page reflecting the older definitions of wound stages from NPUAP provided on the L D H P Medical Review Services Corp. web site.