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

PRINTED: 11/02/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465094	A. BUILDING ______ B. WING ______	C 10/20/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND PARK CARE CENTER	3855 SOUTH 700 EAST SALT LAKE CITY, UT 84106

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F 240 SS=G	483.15 QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, it was determined that the facility did not care for one of eight sample residents (Resident 1) in a manner and in an environment that promoted maintenance or enhancement of R1's quality of life. Specifically, Resident 1 was sent to a local dialysis center without being clothed which resulted in Resident 1 feeling "ashamed". Findings include: Resident 1 (R1) was most recently admitted to the facility on 10/12/05 after hospitalization for a GI (Gastrointestinal) bleed with diagnoses included the following: atrial fibrillation, pain, Gastroesophageal Reflux Disease, Osteoporosis, End Stage Renal Disease, Diabetes Mellitus, Gastrointestinal bleed, Congestive Heart Disease, Coronary Artery Disease, recurrent Methicillin Resistant Staphylococcus Aureus infections, and liver cirrhosis. R1 routinely goes to a local dialysis center every Monday, Wednesday and Friday for his/her hemodialysis treatment for End Stage Renal Disease. The morning of 10/14/05 R1 was picked up via contract transportation from the facility and transported to the dialysis center.	F 240	**F240** Resident #1 easssessed and care plan updated. Resident council will be conducted by the Administrator/Designee with alert and oriented residents to identify potential concerns r/t quality of life/dignity and follow-up completed as appropriate. The Director of Nursing/ Designee will over see that the residents in the facility are cared for in a manner that maintains the enhancement of each resident's quality of life. The Unit Manager/Designee will complete focus rounds weekly to ensure care is provided with observance of resident dignity and quality of life. An in-service was provided to all staff on October 28, 2005 regarding quality of life. In-service training will be provided annually, upon hire with all new employees and as needed for this process. Identified trends will be reviewed/reported monthly and as needed to facility Quality Assurance Team until a lesser frequency is deemed appropriate. Corrective action will be completed by November 28, 2005.	11/28/05

11/15/05 POC acceptable completion date 11/28/05 [signature]

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] NHA
TITLE: ADMINISTRATOR
(X6) DATE

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
NOV 14 2005 2440765 Reciept
Bureau of Health Facility Licensing, Certification and Resident Assessment

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F 240	Continued From page 1 Upon arrival at the dialysis center, R1 was found by a dialysis RN (registered nurse) to have no clothing on. On 10/19/05 an interview was conducted with dialysis RN 1 at 12:15 PM. She reported that on 10/14/05, R1 was brought into the center in his/her dialysis chair with a pink incontinence pad underneath him, a thin blanket around his trunk and a sheet around his legs. When asked about R1's orientation, RN 1 reported that R1 is alert and oriented. She further stated that R1 reported " I am embarrassed...they picked me up out of bed and put me in the chair..", and that she was embarrassed for R1. During the interview RN 1 was observed to be crying while discussing the incident on 10/14/05. On 10/19/05 at 12:40 PM an interview was conducted with dialysis RN 2. She reported that R1 being sent naked to an open clinic where R1 would not have any privacy was "not acceptable". RN 2 stated when asked about R1's orientation, that R1 is able to identify staff members by name at the dialysis center, and oriented to person, place and time. She further reported that R1 was angry about being sent to dialysis wrapped in nothing but a sheet. On 10/19/05 at 12:55 PM, an interview was conducted with R1. R1 reported, "I can't even move so I have to depend on what they (the facility staff) do...". When asked how R1 felt about being brought to the dialysis center covered in just a sheet, R1 stated that " I didn't like it...it made me feel bad...I feel ashamed...". R1 further stated that no one from the facility had come to talk with R1 about the incident in the 5 days since the incident occurred.	F 240	**F281** Resident #2's medication records were updated, physician orders reviewed, allergy list updated, and care plan reviewed/updated. The Director of Nursing Services/Designee will complete a facility chart audit of all resident records for appropriate documentation of allergies. The Unit Managers will complete focused rounds weekly on all new admission charts to ensure proper documentation of Resident's records is maintained. An in-service was provided to all licensed staff October 28, 2005 regarding admissions process and physicians orders regarding allergies. In-service training will be provided annually, upon hire with all new employees and as needed for this process. Identified trends will be reviewed/reported monthly and as needed to facility Quality Assurance Team until a lesser frequency is deemed appropriate. Corrective action will be completed by November 28, 2005.	11/28/05

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F 240	Continued From page 2 A review of R1's clinical record from 10/19/05 to 10/20/05 revealed the following: A care plan for Alteration in ADL's (activities of daily living) dated 10/12/05 was reviewed and copied on 10/19/05 at 2:30 PM. The following areas of concern were listed: 1. Mobility impaired due to: weakness 2. Requires set-up assist 3. Requires physical assist 4. Impaired vision/other sensory impairment The following approaches were listed in order for R1 to meet the goals of ADL needs being met everyday and accepting assistance with ADL's everyday: 1. provide assistance as needed with ADL's every day 2. explain tasks/procedures before beginning 3. encourage resident participation and independence as tolerated, praise all efforts 4. encourage/provide rest periods as needed 5. do not rush resident during cares 6. provide task segmentation, verbal cues, and set-up assist as needed during cares 7. provide assistance as needed with transfers 8. encourage resident to use call light and await assistance as needed 9. therapies as ordered... 10. ... 11. if resident becomes angry or combative during cares, ensure his/her safety and attempt again at a later time. Praise compliance. 12. Social services interventions as needed 13. Medications as ordered. On 10/19/05 the Director of Nursing (DON) and facility RN 1 were interviewed regarding R1 being	F 240		

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F 240	Continued From page 3 sent to dialysis with no clothes on, and wrapped in a sheet. Both nurses stated that R1 refused to get dressed on the morning of 10/14/05. Neither nurse mentioned during interview that R1 was approached again at a later time to get dressed or that social services was notified of the refusal to get dressed, or that R1 requested to go to dialysis without clothing on. On 10/19/05 at 5:30 PM facility RN 2, the nurse assigned to the room that R1 occupied on 10/14/05 was interviewed via telephone. RN 2 stated that she had gone into R1's room to give R1 his medications and noticed " he wasn't wearing a gown...". RN 2 further stated that upon seeing the individual who transports R1 to dialysis, she "grabbed an aide...told her that they're here to get (R1)...". RN 2 explained that she had not seen R1 again prior to his being transported, she then received a call from the unit manager who informed her that R1 was taken to the dialysis center "naked". RN 2 stated " I would never ever have let him leave like that...I don't know how in the world anyone could go to his bed, pick him up and transfer him without knowing he was naked...". When questioned about R1 refusing to get dressed, RN 2 stated " I've never heard of him not getting dressed for dialysis...it's not a problem...". RN 2 did not mention during interview that R1 requested to go to dialysis after refusing to get dressed. It was documented on a nursing assessment note dated 10/19/05: Late entry for 10/14/05 7am-7pm "...asked pt ...about 0800 why he didn't have a gown on, pt stated because it was too hot in here, disconnected pt feeding about 1030 and he still didn't want a gown on because of being hot, ...transport was here to pick up pt and this nurse	F 240		

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F 240	Continued From page 4 informed aides, pt again refused to get dressed, pt still wanted to go to dialysis...". A confidential interview was conducted on 10/20/05 at 6:20 AM with a facility staff member who is familiar with R1's habits and behaviors. He/she stated that " (R1) has had no refusals to get dressed...the situation was handled poorly...the dialysis center should have been called as well as the daughter to see if she could talk him into getting dressed, ...he should not have left the facility.".	F 240		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and family interview, it was determined that for 1 of eight sampled residents the facility did not provide services that meet professional standards of quality. Specifically, Resident 2 received a medication that had been documented as an allergy on the physicians orders and facility admission orders. Findings Include: On 10/19/2005 Resident 2's medical record was reviewed. Resident 2 was admitted to the facility on 8/6/05 with diagnosis including, hypotension, diabetes mellitus, dehydration, dementia, depression,	F 281		

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F 281	Continued From page 5 congestive heart failure and atrial fibrillation. Facility Admission orders and discharge orders from the hospital dated 8/6/05 list Resident 2 as having an allergy to" Amiodarone, lorazepam (Ativan), Sulfonamides, codeine, penicillins, and phenytoin extended dilantin." Physician recertification orders for October 2005 list Resident 2 as having an allergy to "Amiodorone, Ativan, Sulfonamides, Codeine, PCN (penicillin), Dilantin (phenytoin). On 10/9/05 at 4:30 AM it was documented on a physician's order for Resident 2 to receive, "Ativan 1 mg (milligram) SL (sublingual) now." On 10/8/05 it was documented on a nursing assessment note, ".....Order obtained for Ativan x1 obtained and given at 0430 (4:30 AM) at 0500 (5:00 AM) pt. (patient) calmer no longer yelling out.".... On 10/9/05 it was documented on a nursing assessment note,....."Daughter also upset about Ativan given to her. "It was listed on her allergies." Nurse explained it was the NOC (night) nurse who got the one time order"...... On 10/19/2005 Resident 2's daughter was interviewed regarding Resident 2's medication allergies. Resident 2's daughter stated that Resident 2 was given ativan after having surgery in 1993 and went into cardiac arrest after receiving the ativan. On 10/9/05 it was documented on a nursing assessment note, ..."Res (resident) given a Benadryl 25 mg per Dr (Doctor) order for	F 281		

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F 281	Continued From page 6 prevention of allergic reaction"..... References: Fundamentals of Nursing Concepts, Process, and Practice Sixth Edition, Barbara Kozier, RN, MSN; Glenora Erb, RN, BSN; Audrey Jean Berman, PhD, RN, AOCN; Karen Burke, RN, MS page 763 states under administering medication safely, "The nurse should always assess a client's health status and obtain a medication history prior to giving any medication. ...... An important part of the history is clients' knowledge of their drug allergies." Textbook of Basic Nursing Seventh Edition, Caroline Bunker Rosdahl, RN-C, BSN, MA page 703 under nursing considerations, "As a nurse, you must be knowledgeable about the medications you administer. Before administering any medication, know its classification, use, recommended dosage, desired effects, possible adverse or untoward effects, and route of administration. Confirm that the client has not had a previous adverse or allergic reaction to a medication before administering it. If you fail to determine previous untoward effects the client has experienced, you are not practicing safe nursing care. Your negligence may jeopardize the client's well-being."	F 281		