| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 465094 | A. BUILDING _____ B. WING _____ | C 01/07/2008 |

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

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| F 000 | INITIAL COMMENTS<br><br>This complaint survey was conducted on 1/3/08 - 1/7/08. Regulatory non-compliance identified. Deficiencies cited.<br><br>See 2567 | F 000 | | |
| F 329 SS=G | 483.25(l) UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review it was determined that for 1 of 14 sample residents the facility did not adequately monitor a resident's | F 329 | | 2/13/08 |

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

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laboratory levels, specifically for a resident on Coumadin (an anticoagulant -- blood thinning medication). Resident identifier: 1.

Findings include:

Resident 1 was an 86 year old female admitted to the facility on 10/1/07 with diagnoses that included right femoral neck fracture, chronic renal failure, diabetes mellitus, depression, anxiety, hypertension, Parkinson's tremor, and anemia.

On 1/3/08 resident 1's medical record was reviewed.

A document entitled "Physician's Order Sheet" dated 10/1/07 was located for resident 1. On 10/1/07 the physician medication and lab orders included the following:

a. Coumadin 1 milligram by mouth every evening.

b. Coumadin 2.5 milligrams by mouth every evening to be given with the 1 milligram dose. [Note: The resident received 2 pills to equal a total ordered dose of 3.5 mg of Coumadin each day].

c. Aspirin 81 milligrams by mouth every day.

d. Levaquin 250 milligrams by mouth every 48 hours, and discontinue on 10/07.

e. Collect baseline labs, CBC (complete blood count), CMP (comprehensive metabolic panel), TSH (thyroid stimulating hormone), PT/INR (prothrombin time/international normalized ratio) on 10/2/07.

("The international normalized ratio (INR) was devised to monitor more correctly anticoagulant therapy for clients receiving Coumadin therapy. The World Health Organization (WHO)

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| F 329 | Continued From page 2 | F 329 | | |

recommends the use of INR for a more consistent reporting of prothrombin time results. The INR is calculated by the use of nomogram demonstrating the relationship between the INR and the prothrombin time (PT) ratio. Usually both PT and INR values are reported for monitoring Coumadin therapy." Laboratory and Diagnostic Tests with Nursing Implications, Seventh Edition. Prentice Hall Publisher. Pg 263.)

On 10/2/07 a PT/INR was drawn per the doctor order given on 10/1/07 with results of PT: 24.7 and INR: 2.5. [Note: The normal reference range given on the lab results was PT: 10.6 to 13.0 and INR 0.9 to 1.1].

In a written statement received by the Director of Nursing (DON) on 1/8/08, Registered nurse (RN) 1 stated that on 10/3/07 she contacted the facility medical director by phone to report resident 1's lab values. RN 1 stated that the medical director gave her an order for "1/2 NS (normal saline) @ (at) 125 ml/hr (milliliters/hour) IV (intravenously) x 4 liters to correct out of range results from the CPM. No other orders were given." No orders for a follow up PT/INR were located.

On 10/15/07 resident 1 visited a physician outside of the facility who prescribed an antibiotic for resident 1. The order was transcribed onto a facility physician telephone order sheet and stamped by resident 1's attending physician on 10/18/07. The order read as follows: "Bactrim DS (double strength) (one) po bid (twice a day) x 2 weeks." According to resident 1's Medication Administration Record (MAR) resident 1 started the antibiotic on 10/15/07, and received 28 doses over the course of 15 days.

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| F 329 | Continued From page 3 | F 329 | | |

A telephone order dated 10/27/07 was located that read "PT/INR due 11/29", which is 58 days between scheduled PT/INR draws (10/2/07 to 11/29/07).

On 1/7/08 an interview was held with the facility Medical Director (MD) regarding resident 1. The MD stated that he was familiar with resident 1's chart and had seen her twice during the month she was at the facility. He stated that he did not believe resident 1 was on Coumadin prior to admission/surgery. The MD also stated that the results of the PT/INR results on 10/2/07 were what he considered within a normal range. When asked how often he checks PT/INRs for residents on Coumadin, he stated that he checks them a "minimum of once a week." When asked about Coumadin therapy, the MD stated that as a rule he checks the PT/INR when the resident is admitted and then in a couple of days or in a week, depending on the results; then the PT/INRs should be checked at least once a week. The MD stated that resident 1 should have had her PT/INR checked at least one more time within a week after the first draw on 10/2/07. The MD further stated that the antibiotic prescribed on 10/15/07 probably increased the PT/INR.

(NOTE: In the Nursing 2007 Drug Handbook published by Lippincott, Williams and Wilkins the following guidance is given:

a. Page 132: Bactrim: "May increase anticoagulant effect. Monitor patient for bleeding; monitor PT and INR."

b. Page 145: Levaquin: "May increase effect of oral anticoagulant. Monitor PT and INR."

c. Page 370-371: Aspirin: Interactions--"Anticoagulants: May increase risk of bleeding. Use with extreme caution if must be

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| F 329 | Continued From page 4<br>used together.")<br><br>On 1/3/8 at 10:50 AM the facility Director of Nursing (DON) was interviewed regarding resident 1. The DON stated that approximately 2 weeks after admission to the facility resident 1 was experiencing diarrhea, and after doing a stool culture, the facility administered an antibiotic to treat resident 1's diarrhea. The DON stated that on 10/29/07 resident 1 developed a bruise on her leg. The DON stated that the facility immediately called the lab to have resident 1's PT/INR checked in case the resident had developed a "drug to drug reaction." The DON further stated that when the results of the PT/INR were received the doctor was informed, a Vitamin K shot was ordered and administered, and the resident was sent to the hospital. [Note: Vitamin K reverses effects of Coumadin].<br><br>On 10/29/07 a PT/INR was drawn with results of PT: 120 and INR: 17.3. [Note: The normal reference range given on the lab results was PT: 10.6 to 13.0 and INR 0.9 to 1.1]. An order was written 10/29/07 to hold Coumadin, administer 10 milligrams of Vitamin K, and recheck PT/INR level on 10/30/07.<br><br>Nurses notes dated 10/30/07 reveal the following: "Pt (patient) up to bathroom (with) staff. Pt (with) severe weakness. Unable to stand. (Increased) fatigue. Dark tarry stool avg (average) size. C/O (complains of) nausea. . . 2 person assist back to bed. (Increased) bruising (with) several new areas of bruising on biLE (bilateral lower extremities). Dr [name] paged. Pt sent to [name of hospital] ER (emergency room). . ." No other documentation in Certified Nursing Aide (CNA) or nurses notes of diarrhea or dark tarry stools could | F 329 | | |

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| F 329 | Continued From page 5<br>be located.<br><br>An Emergency Room report was obtained for resident 1 regarding her visit on 10/30/07. In a document entitled "[Name of Hospital] Emergency Department Record" a physician documented that resident 1 "reports she started taking Coumadin (after) her hip surgery." In the Emergency Department Triage Assessment , the hospital staff documented that resident 1 reported she had had nausea, vomiting and diarrhea with "dark, tarry" stools over several days. The assessment also documented that resident 1 had increased bruising on her body as well."<br><br>Hospital labs drawn revealed a hematocrit of 16.4. [Note: The normal reference range is 36 to 46%. Laboratory and Diagnostic Tests with Nursing Implications, Seventh Edition. Prentice Hall Publisher. Pg 217.]. In the hospital progress notes it was documented that at 8:16 AM resident 1 received two units of packed red blood cells. The Emergency Department Physician Record documented in the Differential Diagnosis section that the diagnoses for resident 1 included both an upper and lower gastrointestinal bleed. | F 329 | | |
| F 333 SS=D | 483.25(m)(2) MEDICATION ERRORS<br><br>The facility must ensure that residents are free of any significant medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review it was determined that the facility did not ensure that 1 of 14 sample residents was not free of significant medication errors. Specifically, a resident was given a medication she was allergic to. Resident | F 333 | | 2/13/08 |

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| F 333 | Continued From page 6 | F 333 | | |

identifier: 1.

Findings include:

Resident 1 was an 86 year old female admitted to the facility on 10/1/07 with diagnoses that included right femoral neck fracture, chronic renal failure, diabetes mellitus, depression, anxiety, hypertension, Parkinson's tremor, and anemia.

On 1/3/08 resident 1's medical record was reviewed.

The October 2007 MAR listed resident 1 was allergic to penicillin and sulfonamides. A document entitled "Physician's Order Sheet" dated 10/1/07, and signed by the physician, listed resident 1's allergies to penicillin and sulfonamides as well.

On 10/15/07 resident 1 visited a physician outside of the facility who prescribed an antibiotic for resident 1. The order was transcribed onto a facility physician telephone order sheet and stamped by the facility medical director on 10/18/07. The order read as follows: "Bactrim (a sulfonamide) DS (double strength) (one) po bid (twice a day) x 2 weeks." According to resident 1's Medication Administration Record (MAR) resident 1 started the antibiotic on 10/15/07, and received 28 doses over the course of 15 days.

A faxed statement from the staff pharmacist manager on duty of the facility's provider of pharmacy services was received on 1/7/08. The fax was regarding why resident 1 received a sulfonamide drug even though she is allergic. It read: "At our facility we have 2 programs that we use. The first program is our paperless program

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| F 333 | Continued From page 7<br>that is used as the MAR and also what the nurses send their orders over to us. When the orders are received at the pharmacy via the paperless system, they are printed out and inputted (sic) into the AS400 dispensing program. When a new patient is admitted to one of our facilities their personal information is added to the AS400 system by our regional billing office using the patient's face sheet. This is the step where the patient's allergies are added. In this instance the paperless program lists both allergies, but the AS400 system only had the PCN (penicillin) allergy input and it appears that the other allergy was overlooked. When the order later was received, it was not flagged by the AS400 system as being a conflict for the patient." | F 333 | | |
| F 441 SS=D | 483.65(a) INFECTION CONTROL<br><br>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on multiple observations of three residents, it was determined that the facility did not maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and | F 441 | | 2/13/08 |

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| F 441 | Continued From page 8 | F 441 | | |

infection. Specifically, observations were made of resident's catheter bags lying on the floor. Resident identifiers: 2, 3, and 4.

Findings include:

1. Resident 3 was admitted to the facility on 10/17/02, with diagnoses which included pulmonary congestion, femur fracture, hypertension, and multiple sclerosis.

On 1/7/08 at 07:40 AM resident 3 was observed to be in her bed. Resident 3 had a Foley catheter bag in place. The down drain bag was observed to be lying on the floor.

2. Resident 2 was admitted to the facility on 7/13/07, with diagnoses which included cerebral vascular accident, bladder malignancy, depression, and chronic airway obstruction.

On 1/7/08 at 12:55 PM resident 2 was observed to be in her bed. Resident 2 had a urostomy bag in place, with a urine down drain bag in place. A facility CNA was in the room emptying the urine from the down drain bag. The facility CNA stated she was in the process of emptying the urine from the bag. The Down drain bag was noted to be lying on the floor during the process of the urine being emptied from the down drain bag. at 1:00 PM, the urine down drain bag was in a blue protective bag and was not observed to be on the floor.

Resident 4 was admitted to the facility on 11/9/07, with diagnoses which included paraplegia, depression, and self inflicted gunshot wound to the abdomen.

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| F 441 | Continued From page 9<br>On 1/3/07 at 1:46 PM, resident 4 was observed to be in her bed. Resident 4 had a Foley catheter down drain bag in place. The Foley catheter bag was observed to be lying on the floor.<br><br>On 1/3/07 at 4:00 PM, resident 4 was observed to be in her bed. Resident 4's Foley catheter down drain bag was attached to the lower side rail. The lower side rail was observed to be in the down position, and resident 3's catheter bag was touching the floor.<br><br>On 1/7/08 at 07:55 AM, resident 4 was observed to be in her bed. Resident 4's Foley catheter down drain bag was observed to be lying on the floor.<br><br>On 1/7/08 at 1:00 PM, resident 4 was observed to be in her bed. Resident 4's Foley catheter down drain bag was observed to be lying on the floor. | F 441 | | |