DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

POC accepted 7/27/00 mDawson RN

f/u

ATG
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTI	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 252				
SS=E	483.15(h)(1) Requirement ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This Requirement is not met as evidenced by: Based on observation on 6/15/00, and the confidential resident group interview on 6/13/00, it was determined that the facility did not provide a comfortable and homelike environment for the residents. Findings include: 1. During the confidential resident group interview on 6/13/00, at 1:45 PM, one of 11 residents present stated that there were "strong odors outside room 105." 2. There was a strong urine odor outside rooms 107, 108, and 109, at 6:40 AM, 9:00 AM, 1:25 PM, and 2:00 PM on 6/15/00. 3. During the confidential resident group on 6/13/00, at 1:45 PM, 1 of 11 residents present stated that frequently the water was cold during showers. 4. On 6/15/00, hot water temperatures were taken of the two communal shower rooms that all residents use: First floor shower room Time — Temperature 6:42 to 6:47 AM — 80 degrees 9:00 to 9:05 AM — 70 degrees 1:25 to 1:30 PM — 70 degrees		This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Salt Lake Nursing & Rehabilitation Center does not admit that the deficiencies listed on the HCFA form exist, nor does the facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts, and conclusions that form the basis for the deficiency. F252 mDawson 7/27/00 **F252 E Environment** **Corrective action for concern identified.** Specific residents were not identified. Rooms 105, 107, 108, and 109 will be deep cleaned by housekeeping by 7/14/00. The soiled utility room located directly across from rooms 105, 107, 108, and 109 will be deep cleaned by housekeeping by 7/14/00. The facility has enlisted the assistance of a professional plumber to determine the cause of the low water temperature in the shower rooms. **Identification of residents who potentially could be affected.** All residents could be affected by strong urine odors and by cool showers.	

#104524 H7

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/10/2000

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTI	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 252	Continued From page 1 2:00 to 2:05 PM 70 degrees Second floor shower room 6:50 to 6:55 AM 70 degrees 9:07 to 9:13 AM 65 degrees 1:32 to 1:37 PM 76 degrees 2:05 to 2:11 PM 70 degrees From 6:42 AM to 2:11 PM, the highest hot water temperature reached in the facility showers was 80 degrees. This water was cool for resident bathing and did not promote a homelike environment. As a reference point, the Health Facility Licensure Rules state that hot water must be delivered at a minimum of 105 degrees.	F 252	**Measures to Prevent Recurrence.** Resident rooms will be put on a schedule by the Housekeeping Supervisor to ensure periodic deep cleaning, this schedule will be devised by 7/12/00 by Housekeeping Supervisor and approved by the Administrator. Nursing staff will be inserviced by the Director of Nursing or designee by 7/13/00 on a) Importance of reporting any lingering strong urine odors or any other lingering unpleasant odors in the facility. The certified nursing assistants are to report to the charge nurse and if the charge nurse is unsuccessful in finding the source of the odor and removing the odor then the nurse is to enlist the assistance of the Director of Nursing. Persistent odor problems are to be referred to the Performance Improvement Committee. b) Possible sources of persistent strong urine odors and ways to correct these odors. **The shower rooms are to have the water temperature checked prior to giving a resident a shower by the Nursing Assistants. Temperature of water is to be at a minimum of 105 degrees.** **Monitoring / Quality Assurance** The Administrator will be responsible for continued compliance with odor control and comfortable water temperature for showers. The Director of Nursing or designee will do rounds at least four times a week to assess the facility for persistent strong urine odors and will report to the	
F 258 SS=B	483.15(h)(7) Requirement ENVIRONMENT The facility must provide for the maintenance of comfortable sound levels. This Requirement is not met as evidenced by: Based on confidential resident group interview and review of resident council minutes it was determined that the facility was not providing for the maintenance of comfortable sound levels. Findings include: 1. During the confidential resident group on 6/13/00, at 1:45 PM, 3 of 11 residents stated that there was noise at night. One resident stated that "staff was laughing and talking and we have a hard time sleeping because of the noise". 2. Review of the resident council minutes revealed that 7 times in last 10 months resident council members had discussed noise in the facility at night.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTI	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 258	Continued From page 2 Remarks were: on 8/17/99, "Aides are too noisy at night", on 8/26/99,"Aides are too noisy at night", on 2/24/00, "Needs improvement on night time noise", on 2/25/00, "Want more quiet at night, no loud laughing", on 3/24/00, "Noise on night shift, still an issue", on 4/28/00,"Noise on night shift", on 6/9/00, "Noise on night shift up and down".		administration weekly starting 7/17/00 for six weeks. The Administrator or Director of Nursing will report the results to the Performance Improvement Committee in July and August. Then continued monitoring and reporting will be done as directed by the Performance Improvement Committee. Water temperatures will be taken before each shower to ensure proper temperature levels with logs reported to the administrator at least 3 times a week with reports to the Performance Improvement Committee by the Administrator and then as directed by the Performance Improvement Committee.	8/15/00
F 281 SS=E	483.20(d)(3)(i) Requirement RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality. This Requirement is not met as evidenced by: Based on observation, and review of medical records, it was determined that the facility failed to provide services that met professional standards of quality for 2 supplemental sample residents. (Residents 3 and 11) Findings include: The textbook of Infection Control for the Health Care Worker, second edition, William and Wilkes, 1995; Leigh G. Donowitz, M.D., page 6, states "Gloves reduce the incidence of hand contamination with infective material, which in turn reduces the opportunity for personnel to become infected and /or the organisms to spread to other personnel. Gloves should never replace handwashing which actually eliminates the pathogens. Hands should be washed whenever gloves are changed. Gloves should be changed between care of patients and between care of different body parts of the same patient." Resident 3 Resident 3 was admitted to the facility on 6/9/00 with	F258	**F258 B Environment** **Corrective action for identified residents.** No specific residents were identified. **Identification to residents who could be affected.** All residents could be affected by uncomfortable sound levels at night. **Measures to prevent recurrence.** The nursing staff will be inserviced by Director of Nursing or designee by 7/13/00 on maintaining comfortable sound levels in the facility in the late evening and night. The licensed nurses will be charged with the responsibility of monitoring staff and residents on their shifts to maintain comfortable sound levels.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENT	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 281	Continued From page 3 diagnoses of upper GI bleed, cirrhosis, seizure disorder, aspiration pneumonia, anemia and hypokalemia. The resident was admitted with a generalized skin rash. Review of the resident's medical record revealed a physician's order dated 6/9/00, for the resident to have a treatment of 1% hydrocortisone ointment to the generalized body rash BID (2 times daily) and PRN (as needed). On 6/13/00 at 10:40 AM, the treatment nurse was observed to provide a treatment for resident 3. The nurse was observed to enter the resident's room and place an ointment container of 1% hydrocortisone cream on the resident's bedside table. The resident was positioned on her left side in the bed. The nurse donned clean gloves, and positioned the resident's clothing to expose the resident's buttocks and back. By touching the resident's clothing, the nurse contaminated her gloves. The nurse did not change gloves and was observed to open the container of hydrocortisone cream, dip her gloved fingers into the ointment and apply the ointment to resident 3's buttock area. The nurse then placed her gloved fingers (which were contaminated from touching the resident's buttock area) into the ointment container and applied the ointment to resident 3's back. The nurse then had the resident turn to her back and without changing gloves, placed her fingers into the ointment container and applied the ointment to the resident's chest. The nurse was not observed to wash her hands before or after providing resident 3's treatment. Each time the nurse dipped her contaminated gloved fingers into the hydrocortisone ointment container, this caused the ointment to be contaminated.	F281 smaurer 7/27/00	**Monitoring / Quality Assurance** The Director of Nursing will be responsible for continued compliance. The Director of Nursing or designee will do weekly audits for six weeks through resident interviews to assess compliance. The Director of Nursing will report progress to the Performance Improvement Committee in July and August and then as directed by the Performance Improvement Committee. **F281 E Resident Assessment** **Corrective action for identified residents.** The nurse identified as the treating nursing applying the hydrocortisone ointment to the rash of resident #3 will be inserviced by the Director of Nursing or designee by 7/13/00 on how to apply ointment using clean technique including proper handwashing and use of clean gloves. This nurse will also be observed by the director of Nursing or designee by 7/20/00 on a return demonstration to assess for satisfactory learning and use of clean technique. The nurse identified as the treating nurse doing the dressing change on Resident #11 will be inserviced by the director of nursing or designee by 7/13/2000 on the proper clean technique for dressing changes, for the application of medicated ointments and prevention of cross contamination. This nurse will	8/15/00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENT	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 281	Continued From page 4 Application of contaminated hydrocortisone ointment to resident 3's rash increased the possibility for the resident's skin to become infected. Resident 11 Resident 11 was admitted to the facility on 4/10/00 with diagnoses of cerebrovascular accident, hypopotassemia, hemiplegia, osteoarthritis, hypertension and folate deficiency. Review of the medical record revealed a physician's order, dated 5/19/00, for resident 11 to receive a daily treatment to multiple skin tears with an application of bactroban antibiotic ointment, and adaptic dressing. The treatment nurse was observed to provide a dressing change treatment to resident 11's multiple skin tears on 6/13/00 at 10:55 AM. The resident was positioned sitting in a wheelchair in her room. The resident stated "My skin is so thin, it tears when I barely touch it." The nurse was observed to bring the dressing supplies (tape, gloves, bactroban ointment tube, scissors and gauze dressings) to resident 11's room and place them on the resident's bed. The resident's bed is considered contaminated rather than a clean or sanitary surface. By placing the dressing supplies on the resident's bed, instead of on a clean surface, the dressing supplies would be considered to be contaminated before the dressing change was performed. The nurse was observed to don clean gloves and use scissors with sharp pointed ends (instead of nursing bandage scissors with the safety blunted ends) to		also be observed by the Director of Nursing or designee by 7/20/00 on a return demonstration to assess for satisfactory learning and use of clean technique. Identification of residents who potentially could be affected: All residents in need of clean technique for application of medicated ointments and dressing changes are at risk to be potentially affected by improper technique. **Measures to prevent recurrence** Facility licensed nurses will be inserviced by the Director of Nursing or designee by 7/27/2000 on proper clean technique for application of ointments and dressing changes. The Director of Nursing or designee will observe each licensed nurse by 8/4/2000 either do an ointment application or dressing change in the clinical setting or in a classroom setting to assess for satisfactory skills and understanding of clean technique. **Monitoring / Quality Assurance** The Director of Nursing will be responsible for continued compliance. The Director of Nursing will report monthly to the Performance Improvement Committee for three months on continued compliance through use of spot checks, on a weekly basis, of licensed nurses after the initial inservice and return demonstrations is completed. After three months the Director of Nursing will report as directed by the Performance Improvement Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTE	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 281	Continued From page 5	F 281		

remove the old dressings from resident 11's right forearm and left upper arm. The nurse was not observed to change her gloves after removing the soiled dressings. The scissors were not observed to be cleaned before or after they were used by the nurse. The resident was observed to have very frail, tissue paper thin skin. Two open skin tears were noted on the resident's right forearm and one open skin tear was noted on the resident's left upper arm. The nurse was observed to open the bactroban antibiotic ointment tube and place the ointment on her gloved fingers. The nurse was observed to apply the ointment with her gloved hand directly to the first skin tear on resident 11's right forearm and then, without changing gloves, the nurse used the same gloved hand to apply the ointment directly to the second skin tear on the right forearm and then directly to the open skin tear on the resident's left upper arm.
By directly touching each of resident 11's skin tears while applying the ointment, this caused direct contamination of the wounds and increased the possibility of cross contamination and wound infection for resident 11.

When the nurse completed the dressing change, the lid for the bactroban antibiotic ointment was dropped on the floor of resident 11's room. The nurse was then observed to pick up the lid, which was now contaminated, and place it directly back on the tube of bactroban ointment. This increased the possibility of cross contamination and wound infection for resident 11.

The treatment nurse was then observed to place the contaminated scissors back into the general use area of the treatment cart. The treatment nurse was also observed to place the contaminated tube of bactroban

After three months the Director of Nursing will report as directed by the Performance Improvement Committee. 8/15/00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENT	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 281	Continued From page 6 ointment back into the treatment cart.	F 281		
F 314 SS=G	483.25(c) Requirement QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This Requirement is not met as evidenced by: Based on observation, interviews, review of resident medical records and review of the facility's policies and procedures, it was determined that for 1 of 12 sample residents, the facility did not ensure that a resident who entered the facility without pressure sores did not develop pressure sores and did not provide necessary treatment and services to promote healing of the pressure sores. The facility did not assess, appropriately care plan, implement treatment or notify the consulting dietitian of the resident's prssure sores. Resident identifier: 44. Findings include: Resident 44 was a 95 year old male who was readmitted to the facility on 2/15/00 with the diagnoses of emphysema, chronic obstructive pulmonary disease, rectal prolapse, cardiac dysrythmias, hypertension, angina pectoris, constipation, deafness, arthritis, colon cancer and colectomy.	F 314	mourse 7/27/00 F314 G Quality of Care Corrective action for identified residents Pressure reducing devices were placed in the bed and wheelchair of resident #44 on 6/15/00. Resident #44's care plan was updated on 6/15/00, related to actual pressure ulcer care and related to potential for skin breakdown. Resident #44's stage II pressure ulcer was healed as of 6/21/00 and measures in place. Identification of residents who potentially could be affected. All residents at high risk for skin breakdown and those with actual breakdown could potentially be affected. Level of risk for skin breakdown will be identified by either Braden or Norton Scale (Skin risk assessment). The skin risk assessments will be done in conjunction with the MDS on admission, quarterly, annually and on a significant change of condition. Measures to prevent recurrence. The Director of Nursing or designee will audit present facility residents for a current skin risk assessment and will update assessments as may be indicated by 7/14/00.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTI	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 314	Continued From page 7 The readmission nurse's assessment, dated 2/15/00, did not document the presence of any pressure sores on resident 44. Observation of resident 44 during survey revealed that he could transfer himself from his wheelchair to his bed, but that the resident appeared unsteady when doing so. Observation also revealed that he spent his time either in his wheelchair or lying on his back in bed. From 6/12/00-6/14/00, neither the bed or the wheelchair of resident 44 were observed to have pressure relieving devices on them. Pressure relieving devices were first observed on 6/15/00, the day after facility staff were notified by the registered nurse surveyor of a stage 2 pressure sore to the right buttock of resident 44. The first pressure sore was recorded on 3/1/00 as "skin warm, dry, et (and then) spots of breakdown noted on coccyx." The nurse's notes documented on 3/24/00, "skin warm, dry, coloplast changed. Sore no longer open, wet scab, no drainage or s/s (signs,symptoms) of infection." The size and appearance of the pressure sore(s) were not described in the medical record of resident 44. The care plan problem, dated 3/1/00, read, "Breakdown on coccyx", the goal read, "pt. (patient) coccyx will heal within 1 mo (month) or time allowed", the approach read, "coloplast to site and left in place for 12 days." The facility's policy regarding care plan requirements states: "a. Add the pressure wound to the problem list. Specify the location, size and classification of wound type. b. Document interdisciplinary approaches, which	F 314	Facility residents will have a visual skin check done and documented by the Director of Nursing or designee by 7/12/00. Residents at high risk for skin breakdown will have their care plans updated to reflect preventive interventions and will be audited by the Director of Nursing or designee to confirm that preventive measures are in effect. Residents found to have a pressure ulcer on visual facility sweep will be care planned by 7/21/2000 , for care of an actual pressure ulcer. The residents' physician and the consultant registered dietitian will be notified. The facility wound care team will be reestablished by the Director of Nursing by 7/5/00, and will follow facility policy regarding the wound care teams. The wound team will meet weekly and do weekly measurements and staging of pressure ulcer as is specified in the facility policy. The licensed nurses will be inserviced by 7/13/00, by the Director of Nursing or designee on facility expectations related to skin care and treatment. These inservices will include at a minimum: 1) Scheduled skin risk assessments.2) Sizing and staging of pressure ulcers. 3) Role of wound care team.4) Appropriate care planning for "potential for skin breakdown" for high risk residents and for actual skin breakdown, updating of care plan as status changes.5) Notification of physician and registered	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTI	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 314	Continued From page 8 may include some or all of the following: - wound care specifics - preventive measures for further breakdown - specialty bed - pressure reducing surfaces - nutritional needs - restorative nursing techniques - PT (physical therapy) or OT (occupational therapy) involvement - hydration status - contributing medical diagnoses c. Interventions described in the care plan must be measurable and have a defined time frame. d. Ongoing evaluation of the effectiveness of care plan interventions and resident needs will determine when revisions are necessary. Update the Care Plan for a change in status of the wound and/or new physician orders." The facility's policy regarding Wound Documentation, "Routine Documentation" read: "1. Daily a. Initial the pressure reducing device being used on the resident's treatment record or on other designated form." There was no documentation on the March, April, May or June 2000 Treatment Sheets to evidence that pressure reducing devices were implemented with the first pressure sore which developed on 3/1/00 or with either of the 2 subsequent pressure sores which developed 3/31/00 to the left lower back and 5/14/00 to the right buttock. The care plan for resident 44 did not document the use of pressure reducing devices.	F 314	dietitian regarding residents with pressure ulcer. Also notification of registered dietitian of residents at high risk for breakdown.6) Elements of proper documentation of pressure ulcers. The certified nursing assistants will be inserviced by 7/13/00, by the Director of Nursing or designee on 1) their role in preventive measures related to risk of residents' development of pressure ulcers. 2) Their role in observing resident skin as they give daily care and as they assist residents with their showers. 3) Their role in reporting any reddened or broken skin areas to the licensed nurse. **Monitoring / Quality Assurance** The Director of Nursing will be responsible for continued compliance. The Director of Nursing or designee will do monthly audits for four months and will report for each of these four months to the Performance Improvement Committee and then at the conclusion of these four months will continue audits and reports as directed by the Performance Improvement Committee. The audits to be done and reported include percent of compliance with: 1) Skin Risk Assessments 2) Visual skin checks 3) Care planning of residents at high risk for development of pressure ulcers and updating of care plans. 4) Compliance of wound teams with facility policy and procedure.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTI	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 314	Continued From page 9 Observation of the bed and wheelchair of resident 44 on 6/12/00, 6/13/00 and 6/14/00, revealed that there were no pressure relieving devices. During interview with resident 44 on 6/12/00, the resident stated that he had not been offered a cushion or softer mattress for his bed. The resident stated, "You can feel the springs through this mattress. They're all hard. I would like a softer mattress, maybe a pad for my chair." The second pressure sore was recorded on 3/31/00 as "breakdown found on L (left) lower back. #1 1(one) cm (centimeters) circumference #2 1/2 (half) cm circumference - stage II - choloplast applied." The nurse filled out a "change of condition" form, but it did not include documentation that the physician was notified. The care plan was not updated to reflect a stage 2 pressure sore to the resident's left lower back. The third pressure sore, located on the resident's right buttock, was documented as first being observed by the ADON (assistant director of nurses) on 5/14/00. On 6/14/00 at 7:15 AM, the registered nurse surveyor observed the buttocks area of resident 44 with a facility staff person. Observation of the right buttocks of resident 44 revealed an area approximately 5 cm by 5 cm which was purplish red in color. Within this area was an open stage 2 pressure sore measuring approximately .25 cm by .5 cm with minimal depth. The pressure sore was not covered with a dressing. As of 6/14/00 at 7:15 AM, there was no documentation either on the May or June 2000 Treatment Sheets or in the nurse's notes to evidence that the current pressure sore, located on the resident's right buttock, had received treatment. The current care plan for resident 44, dated as being printed on 5/26/00, did not contain concerns related	F 314	5) Timely notification of physician and registered dietitian of presence of pressure ulcers. 6) Proper documentation of location, size, stage, and intervention for residents with pressure ulcers and intervention for high risk residents.	8/15/00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTE	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 314	Continued From page 10	F 314		

to pressure sores and did not reflect the presence of the pressure sore on the resident's right buttock. During interview with the ADON on 6/14/00 at 7:22 AM, he stated he was aware of the pressure sore to the right buttock of resident 44.

A form the facility uses called "Pressure Sore Record", documents that resident 44 was first observed with a stage 2 pressure sore to his right buttock on 5/14/00 measuring 2 cm by 1 cm. Neither the Pressure Sore Record or the nurse's notes document that either the dietitian or the physician were notified of this new pressure sore to the resident's right buttock until 6/13/00 and 6/14/00 respectively. The one nurse's note between 5/14/00 and 6/13/00 which discusses the resident's buttocks is dated 5/19/00 and documents, "dressing on buttocks dry intact." This nurse's note did not contain a description of the pressure sore, of its exact location, size, color, odor or drainage. There are four other nurse's notes between 5/14/00 and 6/13/00 which refer to the skin of resident 44. Each of those four notes document that the resident's skin is warm, dry and intact or "skin fragile but intact."

Review of the medical record for resident 44 revealed that although the resident had developed three pressure sores, one on 3/1/00, a second on 3/31/00 and the third on 5/14/00, there was no pressure ulcer skin risk assessment in the resident's clinical record. This was confirmed by a search of the medical record of resident 44 by both the DON (Director of Nurses) and the registered nurse surveyor.

The facility's Pressure Wound Prevention Program policy states that "All residents will be assessed on admission and routinely thereafter for risk of skin breakdown. Prevention interventions will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENT	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 314	Continued From page 11 identified and implemented to prevent the development of pressure wounds." During interview with the facility's consultant dietitian on 6/13/00 at 11:55 AM, she stated that she was not aware that resident 44 had a current pressure sore and that she had not been aware of the pressure sores in March, April or May of 2000. She stated that she was there at the facility for the "NIT meeting" (nutritional intervention team). The dietitian was asked if the facility had a committee which addressed the issue of skin breakdown. The dietitian stated that she had just recently started at the facility "a few months ago", was not sure about the facility having a skin committee, but was "going to press that issue." During interview with the DON (director of nurses) on 6/14/00 at 9:30 AM, the DON shared with the surveyor some of her expectations of skin care and treatment. The DON was asked if the facility nurses had been inserviced regarding her expectations of skin care and treatment. The DON stated, "no". The DON was then asked if the facility had a skin team or skin committee. The DON stated, "no". The facility's policy regarding the Wound Care Team is as follows: "1. The Wound Care Team will meet weekly." "2. Documentation of the meeting will be maintained." "3. An agenda will be developed for each meeting." "4. Team members will be multi-disciplinary." "5. The meeting will include discussion of the following a. Review of minutes from last meeting with follow-up discussion. b. Identify and review those residents identified as	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENT	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 314	Continued From page 12 "at risk" to assure that aggressive preventive measures are in place. c. Assess and evaluate residents with pressure or other wounds. d. Review current treatment modalities. e. Review results of previous interventions and resident response. f. Review progress toward care plan goals."	F 314		
F 323 SS=E	483.25(h)(1) Requirement QUALITY OF CARE The facility must ensure that the resident environment remains as free of accident hazards as is possible. This Requirement is not met as evidenced by: Based on observation on 6/12/00, it was determined that the facility had wooden hand rails which were cracked, nicked, and jagged creating an accident hazard in the resident environment. Findings include: 1. On the lobby floor there was a large, jagged gouge in the handrail by the soiled linen room. 2. On the first floor there were damaged handrails: A. a cracked and jagged handrail across from room 119 B. a large crack in the handrail outside social services C. a rough, chipped handrail outside room 103 D. a sharp, jagged handrail between rooms 109-110 E. a sharp, jagged surface on the handrail between rooms 110-111 F. a jagged, sharp handrail from storage room 3 to room 115	F 323 mAuisler 7/27/00	**F323 Quality of Care** **Correction action for identified concern** The following handrails will be repaired by 8/1/00. 1) Handrail near soiled linen room on lobby floor. 2) Handrails on first floor: a) across form room 119 b) outside social services c) outside room 103 d) between rooms 109 – 110 e) between rooms 110 – 111 f) from storage room 3 to room 115 g) between rooms 121 – 122 3) Handrails on second floor a) outside room 220 b) between rooms 203 - 204 c) by rehabilitation to 201 The following other damage identified will be repaired by 8/1/00. a) Sharp nick in wooden door on Second floor, storage room 4. b) First floor loose molding by Storage room 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTI	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 323	Continued From page 13 G. a rough edge on the handrail between rooms 121 -122 3. On the second floor there were damaged handrails: A. a deep gouge leaving the handrail with a sharp edge outside room 220 B. sharp nicks in the handrail between rooms 203-204 C. sharp nicks in the handrail by rehabilitation to room 201 4. Other damage: A. Second floor, storage room 4 had a sharp nick in the wooden door. B. First floor: loose moulding by storage room 3 Residents holding or touching these handrails, moulding or doors could injure their skin.	F 323	**Identification of residents who potentially cou be affected** All residents could potentially be affected by damaged handrails, doors and loose molding. **Measures to Prevent Recurrence** The Maintenance Supervisor or designee will do weekly rounds for four weeks and then monthly or as directed by the Performance Improvement Committee to monitor for damaged handrails, loose molding and damaged doors. The Maintenance Supervisor will make indicated repairs on a timely manner. Facility staff will be inserviced by the Administrator or designee by 7/13/00 on importance of reporting any needed repairs including repairs needed to handrails and doors to the Maintenance Supervisor for follow through and on use of maintenance request log. A maintenance request log will be maintained on each nursing unit where any staff member may log in needed repairs including those needed to handrails and doors. The Maintenance Supervisor will check this log daily, Monday through Friday, and make indicated repairs in a timely manner. **Monitoring / Quality Assurance** The Maintenance Supervisor will be responsible for continued compliance. The Maintenance Supervisor or designee will do an audit sheet on	
F 332 SS=E	483.25(m)(1) Requirement QUALITY OF CARE The facility must ensure that it is free of medication error rates of five percent or greater. This Requirement is not met as evidenced by: Based on 2 observations of medication pass, interviews with staff, review of the medication administration record (MAR), and review of the physician's orders, it was determined that for 88 opportunities, 6 medication errors occurred. This represented a 6.8% error rate. The facility failed to ensure that it was free of medication error rates of five percent or greater for 4 supplemental residents. (Residents 1, 17, 39, 49) In addition to the medication error rate of 6.8%, the facility also failed to ensure that residents were free from any significant medication errors for 4 supplemental sample residents. (Residents 1, 17, 39, and 49).			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENT	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 332	Continued From page 14 (Cross reference F-333) Resident 1 On 6/13/00, the medication nurse was observed to start to administer Lanoxin 0.125 mg. (milligram) 1/2 tablet to resident 1 without first assessing the resident's apical pulse for 1 minute. This is not in accordance with an accepted professional standard of quality. On 6/13/00, the medication nurse administered resident 1's AM insulin, 70/30, 36 units and sliding scale insulin, Regular 2 units at 8:30 AM. This was 1 hour after the insulin was scheduled to be administered and 1 hour after the resident had been observed to eat breakfast. Resident 17 On 6/13/00, resident 17 was observed to receive his AM insulin dose of Regular 4 units and NPH 8 units administered at 9:15 AM. This was 1 hour and 45 minutes after the resident ate breakfast and 1 hour and 45 minutes after the AM insulin was scheduled to be administered. On 6/14/00, resident 17 was observed to receive his AM insulin dose of Regular 4 units and NPH 8 units administered at 10:35 AM. This was 3 hours and 5 minutes after the insulin was scheduled to be administered. Resident 39 On 6/14/00, resident 39 was observed to receive her AM insulin dose of Regular 5 units and NPH 15	F332 mows pr 7/27/00	rounds to monitor for damaged handrails loose molding and damaged doors. The Maintenance Supervisor or designee will submit a report on audits and status of any needed repairs monthly to the Safety Committee. The chairperson of the Safety Committee or designee will report on Maintenance Supervisor's audits and status of indicated repairs to the Performance Improvement Committee monthly for three months and the as directed by the Performance Improvement Committee. F332 Quality of Care Corrective Action for Concern Identified The nurse administrating the lanoxin to Resident #1 on 6/13/2000 will be identified and will be inserviced by the Director of Nursing or designee on how to administer lanoxin in accordance with acceptable standards of practice of checking the Apical pulse for a full minute and withholding the medication if the Apical pulse is below 60 and notifying the physician for any further instructions. The nurse administering insulin for residents #17, 39 and 49 on 6/13/2000 and 6/14/2000 for times cited will be identified and will be inserviced by 7/27/2000 by the Director of Nursing or designee on proper administration of insulin in accordance with acceptable standards of practice of administering insulin ½ hour prior to meal times or as ordered by the physician.	8/15/00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTI	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 332	Continued From page 15 units plus a sliding scale insulin Regular 2 units administered at 10:15 AM. This was 2 hours and 45 minutes after the insulin was scheduled to be administered and 2 hours and 45 minutes after the resident ate breakfast. Resident 49 On 6/14/00, resident 49 was observed to receive his AM insulin dose of 70/30, 22 units administered at 8:30 AM. This was 1 hour after the insulin was scheduled to be administered and 1 hour after the resident had eaten breakfast. The facility failed to administer insulin for 4 residents in accordance with acceptable standards of practice and in accordance with MD orders. This was evidenced by observations on 6/13/00 and 6/14/00 that 4 residents did not receive their AM insulin from 1 to 3 hours and 5 minutes after the medication was scheduled to be administered and 1 hour to 3 hours and 5 minutes after the 4 residents had eaten breakfast.	F 332	**Identification of residents who Potentially Could be Affected** All residents currently living in the facility with orders for lanoxin and insulin could potentially be affected by nurses not following acceptable standards of practice for administration of these medications. **Measures to Prevent Recurrence** Licensed nurses will be inserviced by 7/13/00 by the Director of Nurses on how to properly administer lanoxin and insulin according to acceptable standards of practice. **Monitoring / Quality Assurance** The Director of Nursing or designee will be responsible for continued compliance. The Director of Nursing will audit insulin and lanoxin administration for compliance with acceptable standards of practice, as defined above, weekly for four weeks and then bi-monthly for two months and then as directed by the Performance Improvement Committee. The Director of Nursing and/or Staff Development Coordinator with Assistance from the Pharmacy Consultant will audit medication pass	
F 333 SS=E	483.25(m)(2) Requirement QUALITY OF CARE The facility must ensure that residents are free of any significant medication errors. This Requirement is not met as evidenced by: Based on observations, staff interviews, and review of medical records, it was determined that the facility failed to ensure that residents were free of any significant medication errors for 4 supplemental sample residents. (Residents 1, 17, 39, 49) Findings include:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTI	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 333	Continued From page 16 1. Resident 1 a. Lanoxin: Medication pass in the facility dining room was observed on 6/13/00 at 7:30 AM. Resident 1 was observed to be eating breakfast in the dining room at 7:30 AM. The medication nurse was observed to prepare resident 1's medications. The medication nurse placed the medication Lanoxin 0.125 mg (milligrams) 1/2 tablet into the medication cup with the resident's other oral medications. The nurse was not observed to check resident 1's apical pulse before beginning to administer the Lanoxin. The nurse was stopped by the surveyor before the Lanoxin was administered to the resident. The nurse stated she did not have a stethoscope to check resident 1's apical pulse and was then observed to check the resident's radial pulse for 30 seconds. The nurse stated resident 1's radial pulse was 68. The nurse then administered the Lanoxin to resident 1. Mosby's Nursing Drug Reference, 1998; page 358, states for administration of Lanoxin: "Nursing Considerations, Assess: Apical pulse for 1 minute before giving the drug: if pulse (less than) 60 (beats per minute) in adult...take again in 1 hr. (hour); if (less than) 60 in adult, call prescriber..." b. Insulin Review of the physician's orders and the MAR revealed resident 1 was to receive insulin "70/30, 36 units sq q AM (subcutaneously each AM)." The MAR documented the scheduled time for resident 1's AM insulin administration was 7:30 AM. The MAR documentation on 6/13/00 also revealed the resident was to receive sliding scale insulin Regular 2 units in	F 333	at least once per week for six weeks for compliance with acceptable standards of practice. The Director of Nursing will report to the Performance Improvement Committee on compliance for two Months and then as directed by the Performance Improvement Committee. 8/15/00 F 333 Quality of Care See Plan of Correction for F 332 8/15/00	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTI	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 333	Continued From page 17	F 333		

the AM, based on documentation of a blood glucose result of 241.

In an interview with the medication nurse on 6/13/00 at 7:35 AM, the nurse stated that because resident 1 was in the dining room, the nurse would not administer the resident's insulin until after the resident finished breakfast and returned to her room. When asked what the facility's policy was for insulin administration, the medication nurse stated she would use her nursing judgement regarding when to administer insulin.

The medication nurse was interviewed again at 9:00 AM and stated she had administered resident 1's AM insulin at approximately 8:30 AM, when the resident left the dining room. This was 1 hour after the AM insulin was scheduled to be administered and 1 hour after the resident was observed to be eating breakfast.

2. Three other insulin dependant diabetic residents were observed to receive their insulin administration during the AM medication pass on 6/13/00 and 6/14/00.

In the Textbook of Basic Nursing, sixth edition, Caroline Bunker Rosdahl, RN-C, BSN, MA, copyright 1995, page 1067, states "Regular insulin and semilente insulin are quick acting and are given 15 to 30 minutes before a meal so they will reach the bloodstream at about the same time as the glucose from the meal....Intermediate-acting insulins are usually given 30 minutes before breakfast...Their action will handle the glucose from meals during the day. Regular insulin is often combined with intermediate and long acting insulin for the best glucose management."
Page 1069 states "Nursing Skill Guidelines: Giving

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTE	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 333	Continued From page 19	F 333		

On 6/13/00, resident 17 was observed to be eating breakfast in the dining room at 7:30 AM.
On 6/13/00 at 9:15 AM, the medication nurse was observed to administer resident 17's insulin Regular 4 units and NPH 8 units. This was 1 hour and 45 minutes after the resident's meal and 1 hour and 45 minutes after the AM insulin was scheduled to be administered.

On 6/14/00, the medication nurse was observed to start passing medications at 7:30 AM. When asked what time she would administer the diabetic residents their insulin, she stated she would not administer insulin until after the residents had finished breakfast.

At 10:25 AM, the medication nurse was informed by a nurse assistant that resident 17 had not eaten his breakfast. The resident was observed to be in his room at this time. The medication nurse was observed to recheck the resident's blood glucose and reported it was 103. The nurse stated she would ask her supervisor how to proceed regarding insulin administration, because the resident had not eaten his breakfast. The medication nurse stated she was told by her supervisor to give the resident some juice and administer the AM insulin. At 10:35 AM the medication nurse was observed to administer resident 17's prescribed insulin Regular 4 units and NPH 8 units. This was 3 hours and 5 minutes after the insulin had been scheduled to be administered.

b. Resident 39

On 6/14/00 at 7:30 AM resident 39 was observed to be sitting in the assisted dining room. The medication nurse was observed to pour and administer resident 39's AM oral medications. Review of the MAR and physician's orders revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTI	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 333	Continued From page 20	F 333		

documentation that the resident was to receive insulin Regular 5 units and NPH 15 units sq q AM at 7:30 AM. The MAR also documented that the resident was on a sliding scale Regular insulin schedule. Documentation on the MAR for 6/14/00 revealed the resident's AM blood glucose result was 155. This triggered the order for administration of the sliding scale Regular insulin of 2 units. The medication nurse was not observed to administer the AM dose or sliding scale insulin dose to resident 39 at this time.

At 10:10 AM, the medication nurse had not been observed to administer resident 39's AM and sliding scale insulin. When asked regarding what was the scheduled time for resident 39's insulin, the nurse stated "I need to give it right now." At 10:15 AM, the medication nurse was observed to draw up and administer resident 39's insulin Regular 5 units and NPH 15 units, plus the sliding scale insulin Regular 2 units. This was 2 hours and 45 minutes after the AM insulin was scheduled and after the resident was observed to eat breakfast.

c. Resident 49

On 6/14/00 at 7:30 AM, resident 49 was observed to be eating breakfast. At 8:30 AM, the resident was observed to be in his room.

Review of resident 49's MAR and physician's orders revealed documentation that he was to receive insulin 70/30, 22 units sq each AM, scheduled at 7:30 AM.

The medication nurse was observed on 6/14/00 at 8:30 AM to draw up and administer resident 49's insulin 70/30, 22 units sq.

Administration of the AM insulin was 1 hour later

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTI	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 333	Continued From page 21 than it was scheduled and 1 hour after the resident was observed to eat breakfast. The facility failed to administer Lanoxin for 1 resident in accordance with acceptable standards of practice and in accordance with physician's orders. This was evidenced by an observation on 6/13/00 that staff did not assess an apical pulse for 1 resident before the administration of Lanoxin. The facility failed to administer insulin for 4 residents in accordance with acceptable standards of practice and in accordance with physician's orders. This was evidenced by observations on 6/13/00 and 6/14/00 which revealed 4 residents did not receive their AM insulin from 1 to 3 hours and 5 minutes after the medication was scheduled to be administered and 1 hour to 3 hours and 5 minutes after the residents had eaten breakfast.	F 333		
F 368 SS=B	483.35(f)(1)-(3) Requirement DIETARY SERVICES Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in (4) below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.	F 368	**F368B Dietary Services** **Corrective Action for Identified Residents** No specific residents were identified. **Identification of residents who potentially could be affected** All residents currently living in the facility have the potential to be affected by not being offered Bedtime snacks. **Measures to prevent recurrence** Licensed nurses and certified nursing assistants will be inserviced by the Director of Nursing or designee by 7/20/00 on: 1. Importance of timely offering of bedtime snacks to every resident 2. Importance of proper documentation of bedtime snack offering. 3. Bedtime snack flowsheets and how to properly document results.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTI	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 368	Continued From page 22 This Requirement is not met as evidenced by: Based on observation and the confidential interview with the resident group, it was determined that facility staff did not offer snacks at bedtime daily to all residents. Findings include: During the confidential group interview on 6/13/00, 4 of the 10 residents said they didn't receive a snack after dinner or prior to bedtime. One of the 10 residents stated that he/she "sometimes" received a bedtime snack. During further discussion with the group, the residents stated that you had to be "on the list" to get a snack at bedtime or that you had to tell dietary you wanted "to get on the list" for those who received a snack before bedtime. During observation within the facility on 6/15/00 between 7:00 PM and 8:35 PM, it was noted that the kitchen brought several snacks to each nurses station labeled with the names of residents on the snacks. Those snacks were passed to the residents identified on the label. The kitchen also brought several bananas and many packages of graham crackers to each nurses station. These other snacks were not offered to residents. When observed at 8:35 PM, the still full snack containers had been removed from the nurse's station. They were observed back in another room and next to the refrigerator. No non-labeled snacks were observed to be offered to residents on either the first or second floors.	F 368	**Monitoring / Quality Assurance** Audit tools will be developed by the Director of Nursing or designee to reflect a percentage compliance of bedtime snack offering to all residents through the use of resident satisfaction surveys and audits of bedtime snack flowsheet documentation. The Director of Nursing or designee will monitor weekly for six weeks and will report monthly to the Performance Improvement for July and August. Then as directed by the Performance Improvement Committee. The Director of Nursing is responsible for continued compliance.	8/15/00
F 371 SS=E	483.35(h)(2) Requirement DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This Requirement is not met as evidenced by:	F371 MQuirles 7/27/00	**F371 E Dietary Services** **Corrective action for concern identified** A vacuum breaker was placed on the spigot and hose in question on 6/15/00. The dishwasher kitchen helper was inserviced on 6/14/00 by Dietary Service Manager on proper handwashing / infection control techniques. **Identification of residents who potentially could be affected** All residents currently living in the facility have the potential to be affected by staff who do not follow infection control policies and procedures. **Measures to prevent recurrence** Dietary staff will be inserviced on proper handwashing / infection control	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENT	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 371	Continued From page 23 Based on observation on 6/16/00, it was determined that the facility is not serving food under sanitary conditions. Findings include: 1. During the kitchen inspection at 9:15 AM: A. There was a long hose attached to a plumbing spigot adjacent to the steam table. This hose was used to clean the steam table between meals. There was no vacuum breaker attached to the spigot and hose to prevent back flow of dirty water into the culinary and drinking water system. Back flow of dirty water into the clean water system could contaminate the clean water supply. B. The dishwasher kitchen helper was observed on 6/16/00 between 9:25 AM and 9:37 AM to alternate approximately 6 times between loading dirty dishes into the dishwasher and unloading/putting away clean dishes without washing his hands with soap and water or using a hand sanitizer in between. Hand washing or sanitizing needs to be done between the dirty and clean sides of the dishwasher so that bacteria from the dirty dishes is not contaminating the clean dishes.	F 371	techniques related to handling dirty and clean dishes during dishwashing process by the Dietary Service Manager or designee by 6/30/00. Monitoring / Quality Assurance The vacuum breaker will be checked weekly for six weeks by the Maintenance Supervisor who will report results to the Performance Improvement Committee monthly for two months and then as directed by the Performance Improvement Committee. Continued compliance will be the responsibility of the Maintenance Supervisor. Dietary Service Manager will be responsible for continued compliance with proper handwashing by dietary staff. Random weekly checks will be done for six weeks with results being reported to the Performance Improvement Committee for two months then as directed by the Performance Improvement Committee.	8/15/00
F 465 SS=B	483.70(h) Requirement PHYSICAL ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This Requirement is not met as evidenced by: Based on observation at 4:15 PM on 6/12/00, it was determined that the facility did not provide a sanitary environment for residents, staff and the public in the first floor dayroom.	F 465	**F465 B Physical Environment** Corrective action for concern identified The facility will reupholster or replace the sofas in question located in the first floor dayroom by 8/15/00. The carpet in the first floor dayroom will be removed and replaced if stains cannot be removed by 8/15/00.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTI	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 465	Continued From page 24 Findings include: 1. In the first floor dayroom, two sofas and the northeast corner of the carpet were stained and the northeast sofa in the dayroom smelled like urine. This day room was not supportive of a sanitary environment.	F 465	**Identification of residents who potentially could be affected** All residents currently living in the facility have the potential to be affected by stained sofas or carpet. **Measures to prevent recurrence** Housekeeper will do daily cleaning as assigned by Housekeeping Supervisor. **Monitoring / Quality Assurance** Housekeeping supervisor will do rounds three times a week for six weeks and report results to the Performance Improvement Committee for July and August. Continued compliance will be the responsibility of the Administrator and Housekeeping Supervisor.	8/15/00
F 502 SS=E	483.75(j) Requirement ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This Requirement is not met as evidenced by: Based on review of the medical record, review of the facility's laboratory log book, and staff interview it was determined that the facility failed to provide laboratory services that were timely for 2 of 12 sample residents and 1 closed record sample resident. (Residents 4, 19, and CR1) Findings include: Resident 4 Resident 4 was admitted to the facility on 5/23/00 with diagnoses of urosepsis, dehydration, malnutrition, blindness, delusions (paranoid type), and B12 deficiency. The resident expired 6/10/00. Review of the medical record revealed a physicians order dated 5/23/00 for a CBC and Chem 7 to be drawn on 5/26/00. Review of the lab results in resident 4's medical record revealed no lab reports for these orders.	F 502 mQuorum 7/27/00	F 502 Administration Corrective Action for Concern Identified Resident #4 had a CBC and Chem 7 reordered on 6/14/00 and drawn on 6/16/00. Results were reported to the doctor on 6/16/00. Resident #19 had a protime and fasting blood sugar reordered on 6/15/00 and drawn on 6/16/00. Results were reported to the doctor on 6/19/00. The order for monthly protimes and fasting blood sugar was entered on the MAR (Medical Administration Record) with dates for draw clearly identified. Resident #CR1, was discharged so no corrective action could be instituted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTI	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 502	Continued From page 25 In an interview with the ADON on 6/15/00, he stated that when labs are ordered for residents, the night nurse confirms the order, writes the order on the MAR, and writes a lab slip requisition for the laboratory services to draw the lab. The lab then draws the labs and faxes the results to the facility. The nurse on duty is responsible to review and act on the lab results. The labs are then given to medical records to file in the resident's chart. When asked if resident 4's labs had been drawn, the ADON and nurse checked the lab requisition log and called the laboratory services office and found there was no indication that the lab had been drawn. The nurse stated the physician was notified and another order was given to draw the CBC and Chem 7 on 6/16/00. Resident 19 Resident 19 was admitted to the facility on 1/31/00 with diagnoses of diabetes mellitus, hypothyroidism, atrial fibrillation, peptic ulcer disease, and dementia. Resident 19's medical record was reviewed on 6/15/00. Review of the physician's orders revealed an order dated 6/7/00 for a protime and fasting blood sugar to be drawn in the AM (6/8/00) and every month. Protimes are routinely ordered to assess the effectiveness of anticoagulant medication. Documentation on the MAR indicated resident 19 was currently taking the anticoagulant medication Coumadin 2 mg daily. Fasting blood sugars are routinely ordered to assess the stability and control of diabetes. Review of the laboratory results for resident 19 revealed no results for these ordered labs.	F 502	**Identification of residents who Potentially Could be Affected** All residents currently living in the Facility with lab orders have the Potential to be affected. **Measures to Prevent Recurrence** The Director of Nurses or designee will review each resident's chart including residents # 4 and #19 by 8/1/2000 for MD orders, for lab draws, and current lab report in chart to ensure continuity between what labs are ordered and what labs are being done. The system for tracking labs will be reviewed by the Director of Nursing by 8/1/2000 to show patients name, lab ordered, whether lab was done, when it was reviewed by facility, when MD was notified. **Monitoring / Quality Assurance** The Director of Nursing will be responsible for continued compliance. The Director of Nursing or designee will conduct audits weekly for six weeks and then as directed by the Performance Improvement Committee to assess compliance with timely drawing of ordered labs. The Director of Nursing will report compliance to the Performance Improvement Committee for two months and then as directed by the Performance Improvement Committee.	8/15/00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENT	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 502	Continued From page 26 The nurse providing care for resident 19 was asked if she could find documentation that the labs had been drawn on 6/8/00 and if the results had been returned to the facility. The nurse stated that she had contacted the laboratory services and there was no indication that the labs had been drawn on 6/8/00. The nurse stated she had notified the physician and had received a new order to have the labs drawn on 6/16/00. Resident CR1 Resident CR1's record was reviewed as a closed record. Resident CR1 was admitted to the facility on 5/26/00 with diagnoses of myocardial infarction, urethral stricture with a suprapubic catheter, and congestive heart failure. Review of resident CR1's medical record revealed that on admission the resident was assessed as having hematuria (blood in the urine). Review of the physician's progress notes dated 6/7/00 revealed the following: "Hematuria - Send UA (urine for a urinalysis). Review of the lab results in resident CR1's chart revealed no documentation that the UA had been collected or processed per laboratory services.	F 502		
F 520 SS=B	483.75(o)(1) Requirement ADMINISTRATION A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. This Requirement is not met as evidenced by:	F 520	**F520 B Administration** **Corrective action for concern identified** The Administrator will supply the Medical Director with a calendar of Scheduled Performance Improvement Committee Meetings by 8/1/2000. Administrator will also discuss with the Medical Director the importance of his Attendance at least quarterly at the Performance Improvement Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTI	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 520	Continued From page 27 Based on interview with the Administrator and the person in charge of medical records, it was determined that the facility did not have a physician involved in their quality assessment and assurance committee on at least a quarterly basis. Findings include: Upon interview with the Administrator and person in charge of medical records on 6/15/00 at 1:00 PM, they both stated that a physician had not been involved in the quality assessment and assurance committee since December of 1999. When asked if their physician had reviewed the committee's minutes and provided input, the Administrator stated, "no".	F 520	**Identification of residents who Potentially Could be Affected** All residents currently living in facility have the potential to be affected by lack of Medical Director involvement in the facility Performance Improvement Program. **Measures to Prevent Recurrence** The facility Administrator will invite And ensure that the Medical Director is involved at least quarterly in the Performance Improvement Committee Meetings and consulted on issues Identified by the Performance Improvement Committee regarding the Quality of service related to residents. **Monitoring / Quality Assurance** Continued compliance will be the responsibility of the Administrator who will document at least quarterly the Medical Director's involvement.	8/15/00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING _____ B. WING _____	06/16/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALT LAKE NURSING & REHABILITATION CENTI	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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) COMPLETE DATE
F 520	Continued From page 28	F 520		