Acceptable POC - 5/21/03 Lynnette RN

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

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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 241 SS=B | 483.15(a) QUALITY OF LIFE<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on a confidential individual interview and review of resident council meetings notes, it was determined that the facility did not provide care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality.<br><br>Findings include:<br><br>Review of resident council meeting notes dated 2/18/03, it was documented that CNA's (certified nurses assistants) are not speaking English at all times to the residents.<br><br>Further review of resident council meeting notes dated 3/4/03, it was documented that the English was "not clear, thick accents", "[staff]does not understand what residents are trying to say".<br><br>During a confidential interview on 4/8/03 at 2:55 PM the resident stated that the Spanish speaking staff would speak Spanish when caring for her. The resident stated that she did not like this and it made her feel uncomfortable because she did not know if they were talking about her. | F 241<br>OK 5/21/03 | **F 241 483.15(a) QUALITY OF LIFE**<br><br>Corrective Action for Identified Residents<br>In-services were held with the facility staff during the month of April about speaking foreign language during the care of residents.<br><br>Identification of Residents with Potential to be Affected<br>Any resident has the potential to be affected by this issue.<br><br>Measures to Prevent Reoccurrence<br>The general orientation for all new employees will include a discussion of this issue as part of resident rights.<br><br>Continued Monitoring/ Quality Assurance<br>A random weekly monitoring of the care provided by Spanish speaking C.N.A.'s will be preformed for 3 weeks beginning the week of 5/12/03. See attached form "Monitor – Use of Foreign Language While Caring for Residents". On going quality assurance will consist of monitoring 2 times per month for three months. The findings will be reported to the Performance Improvement Committee for analysis and recommendations for any further action needed.<br>507584<br>MAY 21 2003 | 6/5/2003 |
| F 242 SS=E | 483.15(b) QUALITY OF LIFE<br><br>The resident has the right to choose activities, schedules, and health care consistent with his or her | F 242 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paul T. Ogilvie — TITLE: ADMINISTRATOR — (X6) DATE: 5-14-03

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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 242 | Continued From page 1<br>interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, individual interviews and a confidential interview with a group of alert and oriented residents, it was determined that for 1 of 18 sample residents and 4 additional residents the facility did not allow the residents the right to make choices about aspects of their life in the facility that was significant to them. Specifically, residents were served foods that the residents had informed the facility that they did not like. Resident identifiers: 6, 25, 30, 42, and 45.<br><br>Findings include:<br><br>Resident 6 was an 82 year- old readmitted to the facility on 1/7/03. Diagnoses included nausea, constipation, cerebral vascular accident, hypertension, non- insulin dependent diabetes mellitus, anorexia, back pain, depression and Hodgkin's disease.<br><br>The summary of nutritional findings documented on 1/8/03 that resident 6 "...Wants extra margarine/ butter with meals to increase kcals. (calories) Monitor weights, skin, labs, intake, blood sugars."<br><br>Observations of resident's 6's breakfast meal on 4/7/03 revealed french toast and hot cereal served with 1 pat of butter and a packet of syrup<br><br>Resident 6 did not receive extra butter on breakfast and lunch meals observed on 4/7/03, 4/8/03, 4/09/03 and 4/10/03. | F 242 | **F 242 483.15(b) QUALITY OF LIFE**<br><br>Corrective Action for Identified Residents<br>The likes and dislikes for Residents 25, 30, 42, and 45 have been reviewed and diet cards updated by 5/13/03. Resident 6 has been discharged.<br><br>Identification of Residents with Potential to be Affected<br>Any resident with the ability to take nutrition by mouth has the potential to be affected.<br><br>Measures to Prevent Reoccurrence<br>An in-service was held on 5/12/03 with all dietary staff to review tray line accuracy for resident likes and dislikes. This in-service was given by the consultant Registered Dietition (RD) and the Dietary Manager.<br><br>Continued Monitoring/ Quality Assurance<br>As follow-up to this in-service, the Dietary Manager has audited 1 meal each day (5 days per week) for 3 weeks to ensure that the dietary staff is adhering to resident preferences (form 526). As ongoing quality assurance, the tray line is audited by the Dietary Manager 1 meal per week to ensure accuracy (form 526). The Consulting RD also monitors tray line accuracy during a monthly visit and reviews findings with the Dietary Manager and Administrator during the exit interview. The Dietary Manager is responsible to perform the audits and report her findings to the Administrator on a weekly | 6/5/2003 |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 242 | Continued From page 2<br><br>Resident 6 was interviewed on 4/8/03 at 7:00 AM. Resident 6 stated that she was supposed to get all the butter she wants but was not receiving it with her meal trays. She also stated that she "regularly" receives fish on her tray and she has specifically requested not to get fish. She stated that when she gets it she will not eat it and if she asks for a substitute she will get peanut butter and jelly which she does not eat either.<br><br>Observations her lunch tray card on 4/8/03 documented fish under the dislikes section.<br><br>Resident 25 was observed on 4/9/03 to receive rice with his lunch meal. Observations of his lunch tray card documented rice under the dislikes section.<br><br>In an interview with resident 25 on 4/9/03 he ststed that he "always" gets rice and he does not eat it. He stated that he has complained but nothing has changed.<br><br>In an interview with resident 45 on 4/8/03 she stated that she dislikes fish and gets it every time they serve it. She stated that she will ask for some thing else every time and receives an "awful" sandwich in its place.<br><br>In a confidential interview held on 4/8/03 with a group of alert and oriented residents 7 out of ten residents stated that they receive food that they have requested not to get. During this meeting the following residents were more specific:<br><br>Resident 30 stated that he has requested not to get meatloaf or any thing that resembles it and always gets ground beef patties that he cannot eat. He stated that the substitutes are always "a lousy sandwich" | F 242 | basis. The Meal Inspection (form 526) is being used to monitor tray line. Findings will be reported to the Performance Improvement Committee for analysis and recommendations. | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 242 | Continued From page 3<br><br>Resident 42 stated that the kitchen sends food that he is allergic to or foods he does not like. He stated that he has told them many times and nothing changes. | F 242 | **F 325 483.25(i) (1) QUALITY OF CARE**<br><br>Corrective Action for Identified Residents<br>A consulting firm with an excellent track record, was hired on 4/10/03 to provide consultant dietitian services.<br><br>Resident 5 was assessed by the RD on 4/11/03 regarding depleted albumin, multiple pressure sores, tube feeding, and significant weight loss. Form 103 was used for this assessment. Recommendations were made to nursing for nutritional interventions (form 107).<br><br>Resident 31 was assessed by the RD on 4/10/03 regarding mildly depleted albumin, multiple pressure sores (2), and significant weight losses. Form 103 was used for this assessment. Recommendations were made to nursing for nutritional interventions (form 107).<br><br>Resident 56 was assessed by the RD on 5/1/03 regarding severely depleted albumin, multiple pressure sores (3), and significant weight losses. Form 103 was used for this assessment. Recommendations were made to nursing for nutritional interventions (form 107).<br><br>Resident 3 was assessed by the RD on 4/11/03 regarding severely depleted albumin, malnutrition, and significant | 6/5/2003 |
| F 325 SS=H | 483.25(i)(1) QUALITY OF CARE<br><br>Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review and staff interviews, it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by 5 of 18 sampled residents who experienced significant weight loss and did not have adequate dietary interventions implemented to prevent further weight decline. Resident identifiers: 3, 5, 6, 31, and 56. Additionally, 3 of 18 sampled residents with pressure sores and/or low albumin (a protein and indicator of nutritional status) levels did not receive adequate dietary interventions implemented to increase protein in their diets to help improve the albumin levels and prevent further protein depletion. Resident identifiers: 8, 17, and CR2.<br><br>Calculating weight loss percentages is done by subtracting the current weight from the previous weight, dividing the difference by the previous weight and multiplying by 100. Significant weight losses are as follows: 5% in one month, 7.5% in 3 months and 10% in 6 months. (Reference guidance: Manual of | F 325<br>OK 5/21/03 AM | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 325 | Continued From page 4<br>Clinical Dietetics, American Dietetic Association, 6th edition, 2000).<br><br>An albumin level of 3.0 g/dl-3.5 g/dl is considered a mild visceral protein deficit and an albumin level of 2.4 g/dl-2.9 g/dl is considered a moderate visceral protein deficit; any level below 2.4 g/dl is considered a severe deficit. Reference Guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000, page 22.<br><br>The facility was found to be providing sub-standard quality of care (a pattern of actual harm) in this area.<br><br>Findings include:<br><br>1. Resident 5 was re-admitted to the facility from the hospital on 2/26/03 with diagnoses which included, insulin dependent diabetes mellitus, congestive heart failure, renal failure, hypertension, B-complex deficiency, urinary tract infection and gastritis.<br><br>Resident 5 had a gastrostomy tube (G-tube) in place and received all of her nutrition via this tube. She was NPO (receiving nothing by mouth).<br><br>Resident 21's medical record was reviewed on 4/7/03.<br><br>The following albumin (a protein and indicator of nutritional status) level was documented:<br><br>2/28/03 2.1 g/dl (grams per deciliter)<br><br>Resident 5's albumin level indicated a severe depletion of the visceral protein stores. The normal reference range, according to the lab use by the facility, was 3.3-4.8 g/dl.<br><br>Resident 5's admission assessment, dated 2/26/03, | F 325 | weight loss. Resident 3 was no longer receiving TPN at the time of this assessment. Form 103 was used for this assessment. Recommendations were made to nursing for nutritional interventions (form 107).<br><br>Resident 8 was assessed by the RD on 4/21/03 regarding significant weight losses and vegetarian diet. Form 103 was used for this assessment. Recommendations were made to nursing for nutritional interventions (form 107). Likes and dislikes were reviewed with resident 8 on 5/9/03.<br><br>Resident 17 was assessed by the RD on 4/15/03 regarding multiple pressure sores, fracture, and significant weight losses. Form 103 was used for this assessment. Recommendations were made to nursing for nutritional interventions (form 107).<br><br>Resident 6 was assessed by the RD on 4/10/03 regarding mildly depleted albumin, pressure sore, and significant weight loss. Form 103 was used for this assessment. Recommendations were made to nursing for nutritional interventions (form 107). Supplements administered by nursing are now recorded in cc's in the Medication Administration Record (MAR). The Special Nutrition Program has been implemented in the facility and is recorded as part of the total meal percentage. Resident 6 has now been discharged. | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 325 | Continued From page 5<br>completed by facility nursing staff, was reviewed on 4/7/03. A facility nurse documented that resident 5 had six pressure sores which included unstageable pressure sores to coccyx area, a left groin wound, a right flank wound, bilateral heel pressure sores with bilateral wounds to the feet. In addition, it was documented that resident 5 had two surgical wounds.<br><br>On 4/7/03, resident 5's weight record was reviewed. The following weights were recorded:<br><br>2/28/03 157.0 lbs. (pounds)<br>3/17/03 143.4 lbs.<br>3/24/03 148.7 lbs.<br>4/1/03 148.3 lbs.<br><br>Between 2/28/03 and 3/17/03 (17 days) resident 5 had a weight loss of 14 lbs., or 8.66%.<br><br>On 2/26/03, the dietician (RD) completed an initial assessment, which estimated resident 5's caloric needs to be 1699 calories a day and her protein needs to be 57-71 gms (grams) daily. Resident 5's nutritional needs were calculated by multiplying her weight in kilograms, 71.4 kg, by a 1.1 injury factor for her calories and a 0.8-1.0 protein factor for her protein needs. The nutrition assessment form used by the facility recommended that a 1.2 injury factor be used when a resident has undergone minor surgery and a 1.6 injury factor be used when the resident has major sepsis. It should be noted that resident 5 had a urinary tract infection. The nutrition assessment form used by the facility recommended that a 1.2-1.5 gram protein factor be used to calculate protein requirements when the resident had a decubitus ulcer. Using the factors from the assessment sheet a caloric range of 1853-2471with a protein range of 86-107gms. should have been used for her energy needs. | F 325 | Identification of Potential Residents to be Affected and Measures to Prevent Reoccurrence<br><br>Every resident in the facility was assessed by a clinical registered dietitian using the Nutritional Risk Review (form 103). This was complete 5/6/03. Recommendations were made to nursing for nutritional interventions (form 107). All nutritional assessments are completed using the consulting firm's Clinical Charting Handbook and Best Practice Guidelines, which follows ADA Guidelines and new policies and procedures.<br><br>Per the facility's new policy and procedures, all nutritionally high risk residents (significant weight changes, pressure sores, abnormal nutritionally related labs, dialysis and tube fed residents) are assessed at least monthly by the RD (form 109). Nutritional interventions for weekly significant weight changes are completed by the dietary manager and cosigned by the RD. All nutritionally high risk residents are also reviewed at least once per month in the facility's weekly skin and weight meeting. Minutes are kept using form 105.<br><br>Initial, annual and change-of-condition nutritional reviews (form 103) are completed by the dietary manager and cosigned by the RD. Quarterly progress notes are completed by the dietary manager and are cosigned by the RD when a high risk condition exists | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 325 | Continued From page 6<br><br>The ADA(American Dietetic Association) suggested nutrition interventions for older adults recommends a minimum protein intake of 1.2-1.5 g/kg or up to 2g/kg with multiple or highly exudative ulcers and an energy intake of 30-35 kcal/kg. Reference Guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000, page 151.<br><br>The nutritional recommendations made by the facility dietitian for resident 5's condition were not adequate to meet her energy or protein needs.<br><br>A nutrition progress note, dated 3/20/03, documented resident 5's weight at 143 lbs. The RD documented that resident 5 required 1825 calories to gain weight. She determined resident 5's calorie needs by multiplying her weight in kilograms, which was 65.2 by 28 calories per kilogram. She further documented that resident 5 was receiving Nepro (a tube feeding formula designed for people with kidney disease) at 45 cc (cubic centimeters) an hour for 21 hours. She documented that this would provide 948 cc daily and provided 1896 calories. There was no documented evidence that the RD completed a new nutrition assessment to determine the protein needs for resident 5 despite the fact that she was admitted to the facility with 6 pressure sores and two surgical wounds and had a significant weight loss since admission. Nepro at 45 cc an hour for 21 hours provides 945 cc, 1870 calories and 65.3 grams of protein.<br><br>2. Resident 31 was an 85 year-old male admitted to the facility on 12/18/00 his diagnoses included constipation, dementia, anemia, angina, hypothyroidism, hyperlipidemia and peptic ulcer.<br><br>A review of resident 31's medical record revealed the following weights: | F 325 | (all significant weight changes, pressure sores, abnormal nutritionally related labs, dialysis and tube fed residents). Best Practice Guidelines are followed for all nutritional assessments to ensure that adequate calorie, protein and fluid factors are used in the calculations. These guidelines also specify appropriate recommendations for various conditions. Recommendations are made to nursing for nutritional interventions (form 107).<br><br>Continued Monitoring/ Quality Assurance<br>As part of the monthly consultant RD visit, the RD reviews Nutrition At Risk (NAR) minutes to ensure that the weekly NAR (skin and weight) meetings are being conducted appropriately. The Consultant Dietitian reviews her findings with the Dietary Manager and Administrator during the exit interview.<br><br>Findings will be reported to the Performance Improvement Committee for analysis and recommendations. | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 325 | Continued From page 7<br><br>10/7/02 119 lbs.<br>10/14/02 117.0 lbs.<br>10/21/02 114.0 lbs.<br>10/28/02 114.0 lbs.<br>11/4/02 115.0 lbs.<br>11/11/02 114.5 lbs.<br>11/18/02 115.0 lbs.<br>11/25/02 108.0 lbs.<br>12/9/02 104.0 lbs.<br><br>Between the months of October 2002 and December 2002 (2 months) resident 31 lost 15 lbs. (12.60%) which was significant.<br><br>Between 11/18/02 and 12/9/02 (22 days) resident 31 lost 11 pounds (9.56%) which was significant.<br><br>A review of resident 31's weights revealed a weight of 104.0 lbs documented on 12/9/03. Resident 31 was 74% of the low end of his ideal body weight which according to the American Dietetic Association is an indicator of severe malnutrition. Reference Guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000, page 15.<br><br>A lab dated 11/5/02 documented an albumin level of 3.3g/dl. A normal level documented by the lab is 3.4-4.8g/dl.<br><br>A nutritional assessment dated 12/30/02, documented the weight for resident 31 was 106 lbs and that the ideal body weight was 142 lbs (74% of his ideal body weight ). The registered dietitian calculated his energy needs using an injury factor of 1.2 and a protein factor of 1.0. There was no documentation of the low albumin lab level or the significant weight loss in the factoring of his nutritional needs. | F 325 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 325 | Continued From page 8<br>A review of resident 31's medical record revealed a pressure ulcer record dated 1/30/03. A stage II pressure sore on resident 31's left hip was documented on 1/30/03. A stage I pressure sore on resident 31's back was documented on 2/1/03.<br><br>A physician telephone order dated 2/6/03, documented to add shakes with lunch and dinner.<br><br>Observations of resident 31's lunch meal on 4/8/03 and 4/9/03 revealed no shakes served with his meal.<br><br>3. Resident 56 was a 78 year-old male re-admitted to the facility from the hospital on 12/11/02 with diagnoses of urinary tract infection, pneumonia, hypertension, constipation, seizures and angina.<br><br>A review of resident 56's medical record was done on<br><br>A review of resident 56's weight reveled:<br>11/25/02 187.0 lbs<br>12/2/02 179.0<br>12/16/02 170.0<br>12/23/02 176.0<br>1/6/03 174.0<br>1/13/03 172.0<br>1/27/03 175.0<br>2/11/03 172.0<br>2/18/03 162.0<br>2/25/03 160.3<br>3/5/03 158.0<br>3/10/03 156.0<br>3/17/03 155.4<br><br>Resident 56 lost 31.6 lbs. (17.11%) in 4 months, which was significant.<br><br>A review of his discharge notes from the hospital | F 325 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 325 | Continued From page 9<br>revealed a nutritional assessment dated 12/10/02. The documentation revealed an albumin level of 2.6 g/dl. The protein needs of resident 56 were estimated at 94-104 gms, and kcal needs estimated at 1866-2239. These needs were based on a protein factor of 1.2-1.4 due to a moderately depleted albumin and an energy factor of 1.2 for mild infection.<br><br>A review of resident 56's dietary notes revealed a nutritional assessment dated 12/12/02. The documentation did not evidence that the facility dietitian re-assessed his nutritional needs based on his significant weight loss. There was no documented evidence that dietary interventions were implemented to increase calories in resident 56's diet. Resident 56's weight had been on a downward trend since November 2002.<br><br>A review of resident 56's January 2003 physician re-certification orders documented a diet order ordered on 12/11/02 for a regular diet.<br><br>A review of resident 56's weight and skin review dated 2/7/03, documented a pressure ulcer on the buttocks and the right heel. The weight and skin review dated 2/26/03, documented a stage II on the left heel and made recommendations to add promod .<br><br>A physician's order dated 3/5/03 documented an enriched diet for resident 56. This was 26 days after the development of the first pressure sore.<br><br>A review of resident 56's breakfast and lunch tray ticket documented no evidence that resident 56 was receiving promod with his meals.<br><br>The dietitian did not reassess his calorie or protein needs with the development of the pressure sores. | F 325 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 325 | Continued From page 10 | F 325 | | |

4. Resident 3 was admitted to the facility on 1/27/03 with the diagnoses of perforation of the intestine, abdominal sepsis, nutritional marasmos, and surgical convalescence.

Resident 3's medical record was reviewed on 4/7/03.

Resident 3 was admitted to the facility on total parenteral nutrition (TPN). The American Dietetic Association defines parenteral nutrition as the administration of nutrients intravenously either by means of a large central vein or a peripheral vein.

An admission minimum data set (MDS) completed on 1/27/03, documented that resident 3's weight was 128 pounds.

A review of resident 3's weights revealed the following:

| | |
|---|---|
| January 27, 2003 | 128.0 |
| February 4, 2003 | 113.0 |
| February 11, 2003 | 116.5 |
| February 25, 2003 | 109.5 |
| March 10, 2003 | 108.0 |
| April 1, 2003 | 104.5 |
| April 7, 2003 | 103.0 |
| April 10, 2003 | 102.0 |

Between the months of January 2003 and February 2003, resident 3 lost 18.5 lbs (14.4%), which was significant.

Between the months of January 2003 and April 2003, resident 3 lost 26 lbs (20.3%), which was significant.

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 325 | Continued From page 11<br>On 1/29/03, the RD documented resident 3 needed 65 grams of protein. The RD calculated resident 3's weight at 130 lbs, times a protein factor of 1.1 and that equaled 65 grams of protein. The range of resident 3's protein needs were, 59.1 - 118.2 grams of protein. Resident 3 was on the lower end of her protein needs. The RD estimated resident 3's calorie needs as 1905. The RD then documented resident 3 was receiving 1750 kcal per TPN 100cc/hr (X) 24 (hours). Documented in the nutritional findings section, the RD recommended to monitor weight, skin, labs, and intake of TPN. No protein or fat content of the TPN was documented. The TPN calculated out to be 155 calories short of her estimated needs. No recommendations were documented to increase her TPN.<br><br>An albumin level of 3.0g/dl was documented for resident 3 on 1/26/03, which indicated a mild protein depletion.<br><br>A physician's telephone order date 1/30/03, documented to have the "RD follow TPN."<br><br>A physician's note dated 1/30/03, documented "severe malnutrition - on TPN. RD consult."<br><br>It is the position of The American Dietetic Association that a RD with competency in nutrition support is qualified to assume responsibility for the assessment, planning, implementing, and monitoring of enteral, parenteral, and specialized oral therapies in patient care.<br><br>The RD did not make documentation until 2/12/03, which stated, resident 3 was "starting to take a few bites of soft food each meal - also puree food." There was no documentation of the TPN and no assessment of food intake. | F 325 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 325 | Continued From page 12<br><br>On 1/31/03, a nurse's note documented an order from the physician to "[decrease] the TPN rate to 80cc/24 [hour]."<br><br>There was no documentation from the RD to recalculate resident 3's calorie and protein needs when the TPN was decreased from 100cc/24hrs to 80cc/24hrs.<br><br>Resident 3 had an albumin level drawn on 2/3/03. The albumin level was 2.9g/dl, which indicated a moderate protein depletion.<br><br>A physicians order dated 2/16/03, documented to "start a soft diet."<br><br>A nurse's note dated 2/8/03, documented that resident was "c/o (complains of) nausea d/t (due to) starting po (by mouth) diet today."<br><br>Resident 3 had an albumin level drawn on 2/8/03. The albumin level was 2.8g/dl, which indicated a severe protein depletion.<br><br>Resident 3 had an albumin level drawn on 2/11/03. The albumin level was 2.6g/dl, which indicated a severe protein depletion.<br><br>Resident 3 had an albumin level drawn on 2/18/03. The albumin level was 2.5g/dl, which indicated a severe protein depletion.<br><br>A physician note dated 2/20/03, documented "severe malnutrition - TPN reduced to 40cc/hr. Diet advanced to reg. (regular) diet. When pt. Reaches 1600cal/day will DC TPN."<br><br>A nurse's note for resident 3 dated 2/20/03, | F 325 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 325 | Continued From page 13<br>documented, "regular diet, calorie count. Follow up - 2wk (week) [decrease] TPN to 40 cc/[hour] when eating 1600cal/day may D/C (discontinue) TPN)."<br><br>No calorie count was found in the medical record for resident 3.<br><br>There was no documentation from the RD to calculate resident 3's calorie and protein needs when she was put on a regular diet and when the TPN was decreased from 80cc/[hour] to 40cc/[hour].<br><br>A diet order and nurses note for resident 3 dated 2/22/03, documented "return to a clear liquid diet until further notice."<br><br>A nurse's note for resident 3 on 2/25/03, documented "for TPN to be [increased] to 80cc/hr X 24 hrs. Also NPO (nothing by mouth) except sips of clear liquids for comfort only."<br><br>A diet order and nurses note for resident 3 dated 2/27/03, documented a "clear liquid diet."<br><br>A nurse's note for resident 3 dated 3/19/03, documented off "TPN. On soft diet."<br><br>There was no documentation from the RD to calculate resident 3's calorie and protein needs when she was changed to a soft diet and taken off of the TPN.<br><br>A Clinical Update, written by the DON dated 3/20/03, documented that resident 3 "had a very poor appetite and we are trying to encourage her. If after several days to a week on the soft diet she has not improved in her intake, she may need tube feedings."<br><br>Resident 3 had an albumin level drawn on 3/20/03. The albumin level was 2.4g/dl, which indicated a | F 325 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 325 | Continued From page 14<br>severe protein depletion.<br><br>A diet order for resident 3 dated 3/28/03, documented a "soft diet."<br><br>On the meal monitor sheet for resident 3 for March 2003, there were 20 days not documented for breakfast, 21 days not documented for lunch, and 13 days not documented for dinner.<br><br>A daily nurses note for resident 3 dated 4/1/03, documented under the nutrition section; "decreased - Pt. (patient) cont. (continues) to pick [at] her food. States she gets full fast."<br><br>A daily nurses note for resident 3 dated 4/3/03, documented "eating 50%. C/O of diarrhea today."<br><br>There was no documentation from the RD to calculate resident 3's calorie and protein needs while on a soft diet and "picking at her food."<br><br>An observation of resident 3's lunch on 4/7/03, revealed that she ate about 15%.<br><br>An observation of resident 3's breakfast on 4/8/03, revealed that she ate about 15%.<br><br>The last dietary note for resident 3 was 2/12/03.<br><br>Resident 3 had lost 14 lbs (12%) from 2/12/03 to 4/10/03. Resident had lost a total of 26 lbs (20.3%) since admit.<br><br>5. Resident 8 was admitted to the facility on 3/31/97 with diagnoses including congestive heart failure, emphysema, anemia, hypothyroidism, peptic ulcer, post menopausal hormone replacement, senile depression, hypertension, airway obstruction, and | F 325 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 325 | Continued From page 15<br>history or alcoholism.<br><br>Review of resident 8's medical record was done on 4/9/03.<br><br>A review of resident 8's weights revealed the following:<br><br>December 2, 2002 105 lbs<br>December 9, 2002 100 lbs<br>December 23, 2002 97 lbs<br>January 6, 2003 93 lbs<br>January 20, 2003 91.5 lbs<br>February 11, 2003 84 lbs<br><br>A physicians recertification order for resident 8 dated 12/27/02, documented "RD consult, add protein supplement TID (three times a day)."<br><br>The RD note for resident 8 dated 12/27/02, documented "today her tray was untouched and she stated she wasn't hungry, yet had coffee and chocolates. Med pass TID had been ordered, stated she always drinks her milk."<br><br>The RD note for resident 8 dated 1/15/03, documented "had 1/2 carton of whole milk left from breakfast. We do med pass TID, mechanical soft, whole milk."<br><br>There was no documentation of resident 8's weight loss in the RD notes until February 6, 2003.<br><br>The Nutrition Quarterly Assessment dated 2/6/03, documented "weight loss, pt is on enriched diet, mighty shakes TID." On 2/12/03 the RD documented "weight 84# (pounds). Is drinking mighty shakes, takes 60 cc of med pass TID." | F 325 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 325 | Continued From page 16<br>Nursing notes dated 2/12/03, documented that the "dietary supervisor discussed dietary preferences with resident 8." Resident 8 "requested a vegetarian diet."<br><br>There was no documentation that the RD had assessed resident 8's protein or calorie needs with the change to a vegetarian diet. No other documentation had been made concerning her diet, weight, or her refusing to eat. There also was no other documentation of food that resident 8 liked, that had been added to her diet.<br><br>6. Resident 17 was admitted to the facility on 3/8/03 with diagnoses of fractured hip, congestive heart failure, hypertension, physical therapy, and occupational therapy.<br><br>Resident 17's medical record was reviewed on 4/9/03.<br><br>A review of resident 17's weights revealed the following:<br><br>March 10, 2003 120 lbs<br>March 17, 2003 100.5 lbs<br>March 24, 2003 112 lbs<br><br>A skin and weight review sheet dated 3/19/03, documented resident 17's "previous weight was 120.8 on admit." Resident 17's current weight stated "recheck wt. (weight)." There was no evidence that a re-weight was done.<br><br>The Initial Nutritional History/Assessment dated 3/12/03, documented the protein needs at 65 grams and the protein factor at 1.0. The protein needs for resident 17, who had a fracture and a pressure ulcer on admit, should have been between 65 and 129 grams of protein. The RD calculated him at the low end of his protein needs. | F 325 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 325 | Continued From page 17<br><br>There was no documentation of any assessments or interventions from the RD for resident 17 during his weight loss and the finding of another pressure ulcer on 3/17/03.<br><br>7. Resident CR 2 was admitted on 8/23/02 and re-admitted on 10/21/02, with diagnoses of diabetes type I, diarrhea, diabetic ulcer-foot, general symptoms, pruritus, hypertension, chronic airway obstruction, and edema.<br><br>Resident CR 2's medical record was reviewed on 4/9/03.<br><br>Resident CR 2 had an Initial Nutritional History /Assessment done on 10/31/02. Resident CR 2's weight on admit was 191. His calories were calculated at a weight of 176, 15 lbs lighter than his admit weight. His total calorie needs were calculated at 2327 calories, with an injury factor of 1.1. With a diabetic ulcer, his calories should have ranged from 2538 to 3172 calories/day. Resident CR 2's protein needs were calculated at a normal level. With a diabetic ulcer, his protein needs should have been calculated at 1.2 - 1.5/kg. At the lower weight, his protein should have ranged from 96 to 120 grams of protein. At his admit weight, his protein should have ranged from 104 to 130.<br><br>Resident CR 2 had a laboratory test dated 10/21/02. His albumin level was 2.6, which was below normal.<br><br>A physician note dated 11/21/02, documented protein malnutrition.<br><br>A Nutrition Quarterly Assessment dated 1/15/03, documented "7% wt. loss in 3 months, which was significant. Pt. stable at this time." | F 325 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 325 | Continued From page 18<br><br>A physician note dated 1/30/03, documented "wt. loss - RD consult. Calorie count."<br><br>A telephone order dated 1/30/03, documented to have "RD consult, weight loss, calorie count."<br><br>There was no documentation made by the RD until 2/4/03 in which she stated, "recent weight 176, but unable to determine if weight was with wheelchair. Pt. would like milk (2%) every meal which is excellent choice for wound healing."<br><br>There was no documentation of a calorie count being done after the order from the physician on 1/30/03.<br>8. Resident 6 was a 82 year old re-admitted to the facility on 1/7/03. Diagnoses included nausea, constipation, cerebral vascular accident, hypertension, non insulin dependent diabetes mellitus, anorexia, back pain, depression and Hodgkin's disease.<br><br>Resident 6's medical record was reviewed on 4/7/03.<br><br>The physician's recertification orders dated April 2003 documented the following orders for resident 6:<br>1/7/03 Regular reduced concentrated sweet diet.<br>1/7/03 Med plus supplement 60 cc with med pass tid.<br>2/4/03 Enriched diet and ground meat .<br><br>Resident 6's diet order dated 2/5/03, documented that she was to have shakes with lunch and dinner trays.<br><br>The facility's "Vital Signs and Weight Record" documented the following weights for resident 6:<br><br>1/7/03 124 lbs<br>1/20/03 110 lbs<br>1/27/03 102 lbs<br>2/4/03 110.8 lbs | F 325 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 325 | Continued From page 19<br>2/7/03 102 lbs<br>2/18/03 109.6 lbs<br>2/25/03 108.5 lbs<br>3/10/03 102.0 lbs<br>3/17/03 105 lbs<br>3/30/03 109.5 lbs<br><br>On 4/10/03, a facility staff member was observed to weigh resident 6. Resident 6 weighed 101 lbs.<br><br>Between 1/7/03 and 2/7/03 (1 month) resident 6 lost 22 pounds (17.7%) which was significant.<br><br>Between 1/7/03 and 4/10/03 (3 months) resident 6 lost 23 pounds (18.5%) which was significant.<br><br>The following laboratory albumin level was documented for resident 6:<br><br>3/22/03 3.1 g/dl<br><br>Resident 6's albumin level indicated a mild visceral protein deficit. The normal reference range, according to the lab used by the facility, was 3.3-4.8 g/dl.<br><br>The facility's "Initial Nutritional History/Assessment Data Collection Form" dated 1/8/03, documented resident 6's calorie needs at 1696 and her protein needs at 56 grams. This calculation was determined using a 1.3 activity factor and 1.2 injury factor and an 1.0 protein factor for her protein needs.<br><br>The summary of nutritional findings documented on 1/8/03, that resident 6 "...Wants extra margarine/ butter with meals to increase kcals. Monitor weights, skin, labs, intake, blood sugars." There were no calculations made by the dietitian as to how much extra kcal the extra butter or margarine would | F 325 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 325 | Continued From page 20<br>provide.<br><br>The facility's "Pressure Ulcer Report" documented on 1/30/03, that resident 6 had a stage II pressure sore on her coccyx that measured 2cm width and length by .5 in depth<br><br>The facility's "Weight/Skin Review" dated 2/12/03, 2/19/03, 2/26/03, 3/5/03, 3/12/03, 3/19/03 and 3/26/03 documented that resident 6's average meal intake was 25-50%.<br><br>The ADA suggest a "high calorie and high protein diet may be used for individuals with conditions that increase calorie and or protein requirements or to maximize calorie and protein consumption in persons with poor intake. The diet may be indicated for patients with one or more the following conditions: cancer...." Reference Guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000, page 719<br><br>The facility "Pressure Ulcer Report" documented on 4/6/03, that the pressure sore measured .25 cm by .25cm by .25 cm.<br><br>On 4/8/03 at 2:45 PM, a facility nurse was observed to perform a skin check on resident 6. Resident 6 had a stage II pressure sore on her coccyx.<br><br>The last nutritional progress note dated 2/4/03, documented that "....We discussed ways to add kcal."<br><br>The dietitian did not reassess resident 6's increased calorie and protein needs with the development of the pressure sore.<br><br>Resident 6's MAR (Medication Administration Record) was reviewed for the months of January | F 325 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 325 | Continued From page 21<br>2003, February 2003, March 2003 and April 2003. Resident 6's MAR's did not document how much of the med pass was consumed.<br><br>Observations of resident 6's lunch meal on 4/7/03, 4/8/03, 4/9/03 and 4/10/03, revealed that she did not drink her milk shake.<br><br>Resident 6 did not receive extra butter on breakfast and lunch meals observed on 4/7/03, 4/8/03, 4/09/03 and 4/10/03.<br><br>Resident 6 was interviewed on 4/8/03 at 7:00 AM. Resident 6 stated that she was suppose to get all the butter she wants but was not receiving it with her meal trays.<br><br>Resident 6's nurse was interviewed on 4/8/03 at 8:45 AM. She stated that she does not monitor the shakes that are being provided on resident 6's meal tray.<br><br>Two other nurses were interviewed on 4/8/03 at 12:30 PM. Both nurses stated that they did not monitor the shake supplements that were being provided on resident 6's meal tray.<br><br>A review of the nutritional notes completed since resident 6's re-admission did not have evidence that the dietitian re-assessed her nutritional needs based on her significant weight loss, low albumin, pressure sore, or low meal intake. There was no calculation of how many calories and protein was being provided by the med plus supplement and the shakes that were on the meal trays. There was no documented evidence that alternative dietary interventions were attempted to increase resident 6's calories or protein after she refused the milk shakes. Resident 6's weight had been on a downward trend since January 2003. | F 325 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 326 SS=H | 483.25(i)(2) QUALITY OF CARE<br><br>Based on a resident's comprehensive assessment, the facility must ensure that a resident receives a therapeutic diet when there is a nutritional problem.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, it was determined that for 5 of 18 sampled residents, and an additional 13 residents, the facility did not ensure that each resident received a therapeutic diet when there was a nutritional problem.<br>Resident identifiers: 3, 5, 6, 31, 56.<br><br>Findings include:<br>1. Resident 3 was admitted to the facility on 1/27/03 with diagnoses of perforation of the intestine, abdominal sepsis, nutritional marasmos, and surgical convalescence.<br><br>Resident 3's medical record was reviewed on 4/7/03.<br><br>Resident 3 was admitted to the facility on total parenteral nutrition (TPN). The American Dietetic Association defines parenteral nutrition as the administration of nutrients intravenously either by means of a large central vein or a peripheral vein.<br><br>Between the months of January 2003 and February 2003, resident 3 lost 18.5 lbs (14.4%), which was significant.<br><br>Between the months of January 2003 and April 2003, resident 3 lost 26 lbs (20.3%), which was significant.<br><br>On 1/29/03 the RD documented resident 3 needed 65 grams of protein. The RD calculated resident 3's weight at 130 lbs, times a protein factor of 1.1 and | F 326<br>OK 5/21/03 DM | **F 326 483.25(i)(2) QUALITY OF CARE**<br><br>Corrective Action for Identified Residents<br>On 4/10/03, a reputable consulting firm was hired to provide consultant dietitian services.<br><br>Resident 6 was assessed by the RD on 4/10/03 regarding mildly depleted albumin, pressure sore, and significant weight losses. Form 103 was used for this assessment. Recommendations were made to nursing for nutritional interventions (form 107). Supplements administered by nursing are now recorded in cc's in the MAR (Medication Administration Record). Resident 6 has now been discharged.<br><br>Resident 3 was assessed by the RD on 4/11/03 regarding severely depleted albumin, malnutrition, and significant weight losses. Resident 3 was no longer receiving TPN at the time of this assessment. Form 103 was used for this assessment. Recommendations were made to nursing for nutritional interventions (form 107).<br><br>Resident 5 was assessed by the RD on 4/11/03 regarding severely depleted albumin, multiple pressure sores, tube feeding, and significant weight losses. Form 103 was used for this assessment. Recommendations were made to nursing for nutritional interventions (form 107). | 6/5/2003 |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 326 | Continued From page 23<br>that equaled 65 grams of protein. The range of resident 3's protein needs were, 59.1 - 118.2 grams of protein. Resident 3 was on the lower end of her protein needs. The RD estimated resident 3's calorie needs as 1905. The RD then documented resident 3 as receiving 1750 kcal per TPN 100cc/hr (X) 24 (hours). Documented in the nutritional findings section, the RD recommended to monitor weight, skin, labs, and intake of TPN. No protein or fat content of the TPN was documented. The TPN calculated out to be 155 calories short of her estimated needs. No recommendations were documented to increase her TPN.<br><br>An albumin level of 3.0g/dl was documented for resident 3 on 1/26/03, which indicated a mild protein depletion.<br><br>A physician's telephone order date 1/30/03, documented to have the 'RD follow TPN."<br><br>A physician's note dated 1/30/03, documented "severe malnutrition - on TPN. RD consult."<br><br>It is the position of The American Dietetic Association that a registered dietitian (RD) with competency in nutrition support is qualified to assume responsibility for the assessment, planning, implementing, and monitoring of enteral, parenteral, and specialized oral therapies in patient care.<br><br>The RD did not make documentation until 2/12/03, which stated, resident 3 was "starting to take a few bites of soft food each meal - also puree food." There was no documentation of the TPN and no assessment of food intake.<br><br>On 1/31/03 a nurse's note documented an order from the physician to "[decrease] the TPN rate to 80cc/24 | F 326 | Resident 56 was assessed by the RD on 5/1/03 regarding severely depleted albumin, multiple pressure sores (3), and significant weight losses. Form 103 was used for this assessment. Recommendations were made to nursing for nutritional interventions (form 107).<br><br>Resident 31 was assessed by the RD on 4/10/03 regarding mildly depleted albumin, multiple pressure sores (2), and significant weight losses. Form 103 was used for this assessment. Recommendations were made to nursing for nutritional interventions (form 107).<br><br>Identification of Residents with Potential to be Affected<br>All residents have the potential for nutritional problems. To identify potential with the current population, all residents were assessed by a clinical Registered Dietitian using the Nutritional Risk Review (form 103). This was completed by 5/6/03. Recommendations were made to nursing for nutritional interventions (form 107). All nutritional assessments are completed using the Consulting firm's Clinical Charting Handbook and Best Practice Guidelines, which follows ADA Guidelines and Clinical policies and procedures.<br><br>Measures to Prevent Reoccurrence<br>Per new facility policies and procedures, all nutritionally high risk residents (significant weight changes, pressure | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 326 | Continued From page 24<br>[hour]."<br><br>There was no documentation from the RD to recalculate resident 3's caloric and protein needs when the TPN was decreased from 100cc/24hrs to 80cc/24hrs.<br><br>Resident 3 had an albumin level drawn on 2/3/03. The albumin level was 2.9g/dl, which indicated a moderate protein depletion.<br><br>A physicians order was documented on 2/6/03, to start a "soft diet."<br><br>A nurse's note on 2/8/03, stated that resident was "c/o (complains of) nausea d/t (due to) starting po (by mouth) diet today."<br><br>Resident 3 had an albumin level drawn on 2/8/03. The albumin level was 2.8g/dl, which indicated a severe protein depletion.<br><br>Resident 3 had an albumin level drawn on 2/11/03. The albumin level was 2.6g/dl, which indicated a severe protein depletion.<br><br>Resident 3 had an albumin level drawn on 2/18/03. The albumin level was 2.5g/dl, which indicated a severe protein depletion.<br><br>A physician note dated 2/20/03, documented "severe malnutrition - TPN reduced to 40cc/hr. Diet advanced to reg. (regular) diet. When pt. Reaches 1600cal/day will DC TPN."<br><br>A nurse's note for resident 3 dated 2/20/03, documented "regular diet, calorie count. Follow up - 2wk (week) [decrease] TPN to 40 cc/[hour] when eating 1600cal/day may D/C (discontinue) TPN)." | F 326 | sores, abnormal nutritionally related labs, and tube fed residents) are assessed at least monthly by the RD (form 109). Nutritional interventions for weekly significant weight changes are completed by the dietary manager and cosigned by the RD. All nutritionally high risk residents are also reviewed at least once per month in the facility's weekly skin and weight meeting. Minutes are kept using form 105.<br><br>As part of the monthly consultant dietitian visit, the RD reviews Nutrition At Risk (NAR) minutes to ensure that the weekly NAR (skin and weight) meetings are being conducted appropriately. The Consultant Dietitian reviews her findings with the Dietary Manager, Director of Nursing, and Administrator during the exit interview. These results will be presented to the performance improvement committee for analysis and recommendations.<br><br>The "Enriched" diet has been changed to the Special Nutrition Program (SNP). This program was initiated facility-wide on 04/16/03. It includes 8 oz super cereal, 4 oz high calorie/high protein pudding or cookie, 8 oz whole milk T.I.D. Recipes were provided to dietary and instructions given for preparation on 04/16/03. This program provides approximately 1000 calories and 40 grams of protein in addition to the diets served by dietary. | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 326 | Continued From page 25<br><br>No calorie count was found in the medical record for resident 3.<br><br>There was no documentation from the RD to calculate resident 3's calorie and protein needs when she was put on a regular diet and when the TPN was decreased from 80cc/[hour] to 40cc/[hour].<br><br>A diet order and nurses note for resident 3 dated 2/22/03, documented "return to a clear liquid diet until further notice."<br><br>A nurse's note for resident 3 dated 2/25/03, documented for "TPN to be [increased] to 80cc/hr X 24 hrs. Also NPO (nothing by mouth) except sips of clear liquids for comfort only."<br><br>A diet order and nurses note for resident 3 dated 2/27/03, documented a "clear liquid diet."<br><br>A nurse's note for resident 3 dated 3/19/03, documented "off TPN. On soft diet."<br><br>There was no documentation from the RD to calculate resident 3's calorie and protein needs when she was changed to a soft diet and taken off of the TPN.<br><br>A Clinical Update, written by the DON dated 3/20/03, documented that resident 3 "has a very poor appetite and we are trying to encourage her. If after several days to a week on the soft diet she has not improved in her intake, she may need tube feedings."<br><br>Resident 3 had an albumin level drawn on 3/20/03. The albumin level was 2.4g/dl, which indicated a severe protein depletion.<br><br>A diet order for resident 3 dated 3/28/03 documented | F 326 | Continued Monitoring/ Quality Assurance<br>To monitor the implementation of this new program, the Dietary Manager audits 1 meal each day (5 days per week) for 3 weeks to ensure that the dietary staff is providing SNP as ordered. As ongoing quality assurance, the tray line is audited by the dietary manager 1 meal per week to ensure accuracy. The Consultant Dietitian also monitors tray line accuracy during her monthly visit and reviews her findings with the Dietary Manager and Administrator during the exit interview. Findings will be reported to the Performance Improvement Committee for analysis and recommendations. | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 326 | Continued From page 26<br>a "soft diet."<br><br>On the meal monitor sheet for resident 3, for March 2003, there were 20 days not documented for breakfast, 21 days not documented for lunch, and 13 days not documented for dinner.<br><br>A daily nurses note for resident 3 dated 4/1/03, documented under the nutrition section; "decreased - Pt. (patient) cont. (continues) to pick [at] her food. States she gets full fast."<br><br>A daily nurses note for resident 3 on 4/3/03 documented "eating 50%. C/O of diarrhea today."<br><br>There was no documentation from the RD to calculate resident 3's calorie and protein needs while on a soft diet and "picking at her food."<br><br>An observation of resident 3's lunch on 4/7/03 revealed that she ate about 15%.<br><br>An observation of resident 3's breakfast on 4/8/03 revealed that she ate about 15%.<br><br>The last dietary note for resident 3 was 2/12/03.<br><br>Resident 3 has lost 14 lbs (12%) from 2/12/03 to 4/10/03. Resident had lost a total of 26 lbs (20.3%) since admit.<br><br>2. Resident 5 was a 72 year-old re-admitted to the facility from the hospital on 2/26/03. Resident 5's diagnoses included insulin dependent diabetes mellitus, congestive heart failure, renal failure, hypertension, B-complex deficiency, urinary tract infection and gastritis. Resident 5 had a gastrostomy tube (G-tube) in place and received all of her nutrition | F 326 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 326 | Continued From page 27<br>via this tube. She was to receiving nothing by mouth.<br><br>Resident 5's medical record was reviewed on 4/7/03. On 2/28/03, resident 5's albumin level was 2.1 g/dl (grams per deciliter). The normal albumin reference range, per the laboratory utilized by the facility, was 3.4 to 4.8 g/dl. Resident 5's level of 2.1 g/dl indicated a depletion of visceral protein stores.<br><br>Resident 5's admission assessment, dated 2/26/03, completed by facility nursing staff, was reviewed on 4/7/03. A facility nurse documented that resident 5 had six areas of skin impairment, which included unstageable pressure sores to her coccyx area, a left groin wound, a right flank wound, bilateral heel pressure sores with bilateral wounds to the feet. In addition, it was documented that resident 5 had two surgical wounds.<br><br>A review of resident 5's weights was done on 4/7/03. Facility staff documented the following weights for resident 5's:<br>a. 2/28/03 - 157.0 lbs. (pounds)<br>b. 3/17/03 - 143.4 lbs.<br>c. 3/24/03 - 148.7 lbs.<br>d. 4/1/03 - 148.3 lbs.<br><br>Between 2/28/03 and 3/17/03 (17 days) resident 5 had a weight loss of 14 lbs., or 8.66 %.<br><br>On 2/26/03, the registered dietician (RD) completed an initial nutritional history and assessment for resident 5. The RD estimated resident 5's caloric needs to be 1699 calories a day and her protein needs to be 57-71 gms (grams) daily. Resident 5's total caloric needs were calculated using a 1.1 injury factor. Her estimated protein needs were calculated using a 0.8 to 1.0 protein factor. The nutrition assessment form used by the facility recommended | F 326 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 326 | Continued From page 28<br>calculating a 1.2 injury factor when a resident has undergone minor surgery and a 1.6 injury factor when the resident has major sepsis. The assessment form did not identify the use of a 1.1 injury factor. One of resident 5's admitting diagnoses was a urinary tract infection. The nutrition assessment form used by the facility recommended calculating a 1.2 to 1.5 protein factor when the resident had a decubitus ulcer. Using the factors identified on the assessment, resident 5 had a total caloric needs range of 1853 to 2471, with a protein range of 86-107gms.<br>On 2/26/03, the RD documented that resident 5 was receiving Nepro (an enteral formula) at 35 cc (cubic centimeters) per hour, 24 hours a day. The RD documented that this would provide resident 5 with 1680 calories and 58 grams of protein per day. This enteral feeding order fell short of the RD's assessed total caloric need of 1699 and fell at the low level of protein needs assessed at 57 to 71. In comparison, had resident 5's injury factor and protein factor been adjusted to the resident's condition upon admission, the admission enteral feeding order would not have fallen within the resident's calorie and protein needs.<br>On 3/4/03, the RD documented that resident 5's enteral feeding was changed to Nepro at 40 cc per hour for 21 hours. This did not change the calories or protein provided to resident 5.<br>On 3/20/03, the RD documented that resident 5's enteral feeding was changed to Nepro at 45 cc per hour for 21 hours. The RD documented this would provide resident 5 with 1896 calories. There was no documented evidence that the RD completed a new nutrition assessment to determine the protein needs for resident 5 despite the fact that she was admitted to the facility with 6 pressure sores and two surgical wounds and had a significant weight loss since admission. Nepro at 45 cc an hour for 21 hours provides 945 cc, 1870 calories and 65.3 grams of protein. | F 326 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 326 | Continued From page 29<br><br>The ADA (American Dietetic Association) suggested nutrition interventions for older adults recommends a minimum protein intake of 1.2-1.5 g/kg or up to 2g/kg with multiple or highly exudative ulcers and an energy intake of 30-35 kcal/kg. Reference Guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000, page 151.<br><br>A review of dietary notes completed upon resident 5's admission did not evidence that the dietitian assessed her nutritional needs based on her high risk diagnoses to prevent further weight loss and to aide in the healing of her pressure sores.<br><br>3. Resident 6 was a 82 year old re-admitted to the facility on 1/7/03. Diagnoses included nausea, constipation, cerebral vascular accident, hypertension, non insulin dependent diabetes mellitus, anorexia, back pain, depression and Hodgkin's disease.<br><br>Resident 6's medical record was reviewed on 4/7/03.<br><br>The physician's recertification orders dated April 2003, documented the following orders for resident 6:<br>1/7/03 Regular reduced concentrated sweet diet.<br>1/7/03 Med plus supplement 60 cc with med pass tid.<br>2/4/03 Enriched diet and ground meat .<br><br>Resident 6's diet order dated 2/5/03, documented that she was to have shakes with lunch and dinner trays.<br><br>Observations of resident 6's lunch meal on 4/7/03, 4/8/03, 4/9/03 and 4/10/03 revealed that she did not drink her milk shake.<br><br>Resident 6 did not receive extra butter on breakfast and lunch meals observed on 4/7/03, 4/8/03, 4/09/03 and 4/10/03. | F 326 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 326 | Continued From page 30<br><br>The facility's "Vital Signs and Weight Record" documented the following weights for resident 6:<br><br>1/7/03 124 lbs<br>1/20/03 110 lbs<br>1/27/03 102 lbs<br>2/4/03 110.8 lbs<br>2/7/03 102 lbs<br>2/18/03 109.6 lbs<br>2/25/03 108.5 lbs<br>3/10/03 102.0 lbs<br>3/17/03 105 lbs<br>3/30/03 109.5 lbs<br><br>On 4/10/03, a facility staff member was observed to weigh resident 6. Resident 6 weighed 101 lbs.<br><br>Between 1/7/03 and 2/7/03 (1 month) resident 6 lost 22 pounds (17.7%), which was significant.<br><br>Between 1/7/03 and 4/10/03 (3 months) resident 6 lost pounds(18.5%), which was significant.<br><br>The following laboratory albumin level was documented for resident 6:<br><br>3/22/03 3.1 g/dl<br><br>Resident 6's albumin level indicated a mild visceral protein deficit. The normal reference range according to the lab used by the facility was 3.3-4.8 g/dl.<br><br>The facility's "Pressure Ulcer Report" documented on 1/30/03, that resident 6 had a stage II pressure sore on her coccyx.<br><br>The facility's "Initial Nutritional History/Assessment Data Collection Form" dated 1/8/03, documented | F 326 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 326 | Continued From page 31<br>resident 6's calorie needs at 1696 and her protein needs at 56 grams. This calculation was determined using a 1.3 activity factor and 1.2 injury factor and an 1.0 protein factor for her protein needs.<br><br>A review of the nutritional notes completed since resident 6's re-admission did not have evidence that the dietitian re-assessed her nutritional needs based on her significant weight loss, low albumin or pressure sore. There was no calculation of how many calories and protein was being provided by the med plus supplement, the ensure, and the shakes that were on the meal trays. There was no documented evidence that alternative dietary interventions were attempted to increase resident 6's calories or protein after she refused the milk shakes. There was no monitoring of resident 6's intake of ensure that was being provided by the family. Resident 6's weight had been on a downward trend since January 2003.<br><br>4. Resident 56 was a 78 year-old male re-admitted to the facility from the hospital on 12/11/02. His diagnoses included urinary tract infection, pneumonia, hypertension, seizures and angina.<br><br>Review of resident 56's medical record documented that resident 56 had been discharged to the hospital on 11/24/02 for treatment of pseudomonas urinary tract infection and re-admitted to the facility on 11/27/02.<br><br>There were no nutritional assessments documented upon readmission (11/27/02) for resident 56 to address the treatment for an infection and to address the weight loss.<br><br>Review of resident 56's medical record was done on 4/8/03. Between 11/25/02 and 3/17/03, resident 56 | F 326 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 326 | Continued From page 32<br>lost 31.6 pounds, or 17.11%, from 187 to 155.4 pounds. The following weights were documented for resident 56:<br>a. 11/25/02 - 187.0 lbs<br>b. 12/2/02 - 179.0<br>c. 12/16/02 - 170.0<br>d. 12/23/02 - 176.0<br>e. 1/6/03 - 174.0<br>f. 1/13/03 - 172.0<br>g. 1/27/03 - 175.0<br>h. 2/11/03 - 172.0<br>i. 2/18/03 - 162.0<br>j. 2/25/03 - 160.3<br>k. 3/5/03 - 158.0<br>l. 3/10/03 - 156.0<br>m. 3/17/03 - 155.4<br><br>Review of resident 56's medical record documented that resident 56 had been discharged to the hospital on 12/9/02 for treated of pneumonia and re-admitted to the facility on 12/11/02.<br><br>A review of his discharge notes from the hospital revealed a nutritional assessment dated 12/10/02. The documentation revealed an albumin level of 2.6 g/dl. The protein needs of resident 56 were estimated at 94-104 gms, and kcal needs estimated at 1866-2239. These needs were based on a protein factor of 1.2-1.4 due to a moderately depleted albumin and an energy factor of 1.2 for mild infection.<br><br>A review of resident 56's dietary notes revealed a nutritional assessment dated 12/12/02. The dietitian re-assessed his needs using an injury factor of 1 for his calorie needs and a protein factor of 1. The nutrition assessment sheet recommenced injury factors between 1.2-1.6 for major sepsis and protein factors of 1.2-1.5/kg. for pressure sores. The documentation did not evidence that the facility | F 326 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 326 | Continued From page 33<br>dietitian re-assessed his nutritional needs based on the recommended factors for his diagnoses.<br><br>A review of resident 56's January physician re-certification orders documented a diet order ordered on 12/11/02 for a regular diet.<br><br>A review of resident 56's weight and skin review dated 2/7/03, documented a pressure ulcer on the buttocks and the right heel. The weight and skin review dated 2/26/03, documented a stage two on the left heel and made recommendations to add promod .<br><br>A physician's order dated 3/5/03 documented an enriched diet for resident 56. This was 26 days after the development of the first pressure sore.<br><br>The weight and skin committee notes dated 2/12/03 and 2/19/03 document that resident 56 was consuming approximately 25-50% of his meals. The skin and weight committee notes dated 3/12/03 ,3/19/03 and 3/26/03 document that resident 56 was consuming approximately 50-75% of his meals.<br><br>A review of the meal monitoring record dated march 2003 documented 43 out of 93 meals with no percentage of the meal recorded.<br><br>The dietitian did not reassess his calorie or protein needs with the development of the pressure sores, the significant weight loss and with his low meal intake.<br><br>The facility did not ensure that resident 56 recieved the therepeutic diet necessary to prevent the develpoment of the pressure sores and to prevent further weight loss.<br><br>4. Resident 31 was an 85 year-old male admitted to the facility on 12/18/00, with diagnoses including | F 326 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 326 | Continued From page 34<br>constipation, dementia, anemia, angina, hypothyroidism, hyperlipidemia and peptic ulcer.<br><br>A review of resident 31's medical record was done on 4/8/03. Per documentation on weight records, resident 31 lost 15 pounds between 10/7/02 and 12/9/02, from 119 to 104 pounds. This was a 12.60% weight loss. Between 11/18/02 and 12/9/02, resident 31 lost 11 pounds, from 115 to 104 pounds. This was a 9.56 % weight loss.<br><br>On 11/5/02, resident 31's albumin level was 3.3 g/dl (grams per deciliter). The normal albumin reference range, per the laboratory utilized by the facility, was 3.4 to 4.8 g/dl.<br><br>A nutritional assessment, dated 12/30/02, documented the weight for resident 31 as 106 lbs and that the resident's ideal body weight was 142 lbs. On 12/30/02, resident 31 was 74% of his ideal body weight. The RD calculated resident 31's energy needs using an injury factor of 1.2 and a protein factor of 1.0. There was no documentation of the low albumin lab level or the significant weight loss in the factoring of his nutritional needs.<br><br>According to the American Dietetic Association, 74% of ideal body weight was an indicator of severe malnutrition. Reference Guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000, page 15.<br><br>A review of A review of resident 31's medical record revealed a pressure ulcer record dated 1/30/03. A stage II pressure sore on resident 31's left hip was documented on 1/30/03. A stage I pressure sore on resident 31's back was documented on 2/1/03.<br><br>A physician telephone order dated 2/6/03, | F 326 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 326 | Continued From page 35<br>documented to add shakes with lunch and dinner. There were no physician orders to discontinue the shakes after 2/6/03.<br><br>Observations of resident 31's lunch meal on 4/8/03 and 4/9/03 revealed no shakes served with his meal.<br><br>Observations of the breakfast tray line service on 4/8/03 revealed everyone receiving the same cereal, no additions to the cereal were observed. Observations of the lunch tray line service on 4/9/03 revealed everyone receiving the same entrée, starch and vegetable, no additions of extra butter were observed to any dish.<br><br>In an interview with the dietary manager on 4/9/03 she stated that she follows the HPSI (Health Procurement Services Incorporated) menu plan. She stated that she enriched the meals by adding butter and whole milk to the cereal of residents who were to receive an eriched diet. She further stated that she placed extra butter on the lunch and dinner trays. She stated that she did not have a recipe for the enriched cereal and that the dietitian had approved the additions of the milk and butter to the meals. She could not provide evidence regarding the amount of butter or milk which dietary staff added to the trays of those residents receiving enriched diets.She stated that if additional protein was added to the meal a milk shake would be added to the tray and no other foods on the tray contained any protein supplement. She stated that the milk shakes contained 1 scoop of ice cream, 8 oz. of whole milk and one scoop of Promod(a protein dietary supplement). She stated that Promod was only added to the puree cereals if ordered. She could not provide the calories or protein this shake contained and stated that the dietitian and | F 326 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 326 | Continued From page 36<br>director of nursing had made the recipe.<br><br>In an interview with the dietary manager and the dietitian on 4/10/03 the dietitian stated that the regular diet for HPSI supplied approximately 2400 calories per day and by adding extra butter and whole milk to the trays an additional 800 calories would enrich the diets.<br><br>In a review of the HPSI diet manual (page 1) documentation revealed that the regular diet contained approximately 2000-2200 calories, and 75-85 gms of protein.<br><br>In the menu/recipe notebook on the enhanced/enriched information page it states that the enhanced diet is "based on the regular diet with enhanced recipes providing 15-20 grams of additional protein and 250-300 additional calories per day. This diet should provide an average of 98 grams of protein and an average of 2550 calories per day. A recipe for super cereal on page 61 of the recipe notebook documented the additions of nonfat milk, margarine, evaporated milk, white sugar and brown sugar to any hot cereal to increase the calories and the protein content.<br><br>A taste test of the morning cereal on 4/9/03 revealed a non-sweet tasting cereal being served to all the residents. By following the approved recipe for the enriched cereal, the cereal would have a defined sweet taste.<br><br>The master diet list provided to the surveyors on 4/7/03 documented that 13 residents in the facility were currently ordered to receive enriched diets.<br><br>The dietary manager was not following the recommended recipes of the approved menu plan to | F 326 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 326 | Continued From page 37<br>provide the enriched diets that were ordered for the residents in the facility. | F 326 | **F 328 483.25(k) QUALITY OF CARE**<br><br>Corrective Action for Identified Residents<br>Resident 28 is receiving oxygen via a concentrator while in his room and when he will be in another room for a long period of time. When he is being transported or when he will be in another room for short periods of time, a portable oxygen tank is being used. When the resident is found without his oxygen on, the staff are reminding and assisting him with placing the oxygen tubing back on.<br><br>Identification of Residents with Potential to be Affected<br>Any resident using oxygen has the potential to be affected.<br><br>Measures to Prevent Reoccurrence<br>In-services were held with staff during the month of April regarding the use of portable oxygen when transporting patients requiring oxygen.<br><br>Continued Monitoring/ Quality Assurance<br>A random weekly monitoring of patients requiring oxygen who are being transported will be performed for 3 weeks starting during the week of 5/12/03. See form "Monitoring - Use of Portable Oxygen During Transport for Patients Requiring Oxygen." On –going quality assurance will consist of 2 times per month monitoring for three months. Findings will be reported to the Performance Improvement Committee for analysis and recommendations. | 6/5/2003 |
| F 328 SS=D | 483.25(k) QUALITY OF CARE<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br><br>Injections<br><br>Parenteral and enteral fluids;<br><br>Colostomy, ureterostomy, or ileostomy care;<br><br>Tracheostomy care;<br><br>Tracheal suctioning;<br><br>Respiratory care;<br><br>Foot care;<br><br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, and record review it was determined that the facility did not provide the proper care and treatment for 1 of 18 sampled residents who had a physician's order to receive oxygen therapy. Resident identifier: 28<br><br>Finding included:<br><br>1. Resident 28 was re-admitted to the facility on 2/18/03 with diagnoses of diabetes mellitus, neuropathy, aspiration pneumonia, chronic obstructive heart failure, schizophrenia, seizure | F 328 | ok 5/21/03 AM | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 328 | Continued From page 38<br>disorder, gastroesophageal reflux disease, hypertension, asthma and dysphagia.<br><br>A. The following observations were made during the recertification survey.<br><br>i. Resident 28 was observed in the hallway on 4/7/03 at 6:55 AM. Resident 28 was observed speaking with a facility nurse 5 feet away from his room without his oxygen on. His oxygen tubing was on the floor by the doorway of his room to the hallway. Resident 28 was observed to be diaphoric and pale. At 7:00 AM, resident 28 wheeled himself to the nursing station and another facility nurse was observed to place resident 28 's oxygen mask on him. At 7:02 AM, the surveyor asked a facility staff nurse to take resident 28's oxygen saturation. Resident 28's oxygen saturations was 82%.<br><br>ii. .Resident 28 was observed in his doorway to his room on 4/8/03 at 7:00 AM with his oxygen on. At 7:24 AM, a facility aide was observed to walk into resident 28's room and disconnect the oxygen concentrator from the electrical outlet. The aide was then observed to carry resident 28 's oxygen concentrator while resident 26 wheeled himself to the elevator. The aide was observed to take resident 28 onto the elevator to the second floor dining room, while the resident was disconnected from his oxygen. At 7:26 AM, the facility aide was observed to connect resident 26's oxygen concentrator in the electrical outlet and place resident 28 's nasal cannula in his nose.<br><br>iii. Resident 28 was observed in the dining room on 4/8/03. At 8:35 AM, a different facility aide was observed to disconnect resident 28's oxygen concentrator from the electrical outlet in the dining room. The aide was observed to take resident 28 from | F 328 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 328 | Continued From page 39<br>the elevator to his room. Resident 28 was observed to have wheezing breath sounds while being in the elevator. At 8:37 AM, the facility aide connected resident 28's oxygen concentrator to the electrical outlet. The surveyor asked the facility aide to take resident 28's oxygen saturations. The facility aide stated that he/she could not find the pulse oximeter to take resident 28's oxygen saturations.<br><br>iv. Resident 28 was observed in the doorway to his room on 4/9/03 at 7:20 AM with his oxygen on at 5 liters. A facility staff member was asked to take resident 26's oxygen saturations. Resident 28's oxygen saturations were 92% on 5 liters of oxygen. A facility staff member disconnected resident 28's oxygen concentrator from the electrical outlet at 7:30 AM. The facility staff member took resident 28 and his oxygen concentrator to the elevator, to the upstairs dining room. At 7:32 AM, resident 28's saturations was 86% without any oxygen. At 7:35 AM resident 28's oxygen saturations were 90% after being connected to his oxygen concentrator for approximately two minutes.<br><br>B. The following interviews were conducted during the recertification survey.<br><br>A facility nurse taking care of resident 28 was interviewed on 4/7/03 at 7:00 AM. She stated resident 28 was currently being treated for pneumonia.<br><br>A facility aide was interviewed on 4/7/03 at 1:00 PM. The facility aide stated that the aides could take the oxygen off for a short time. She/he also stated that was how the aides transported the residents while in the elevator.<br><br>A facility nurse taking care of resident 28 was | F 328 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 328 | Continued From page 40<br>interviewed on 4/7/03 at 1:05 PM. The facility nurse stated that resident 28 should always have his oxygen on.<br><br>C. Resident 28's medical record was reviewed on 4/7/03.<br><br>i. The admission nurse's note, dated 2/8/03 documented "resident brought to facility from hospital stay for respiratory distress.....O2 4 liters per NC (nasal cannula)...."<br><br>ii. A physician's order, dated 2/18/03 documented oxygen via nasal cannula, titrate oxygen to keep saturation above 90% and to check oxygen saturations every day.<br><br>iii. A care plan, dated 2/27/03 documented that resident 26 to keep "O2 (oxygen) on at all times- pt (patient) needs frequent reminders to keep O2 on."<br><br>iv. A nurse's note, dated 4/5/03 at 10:00 PM documented "T(temperature) 100.3 O2 sats 80%. Coughing [increased] brown colored phlem. [physician] called. Chest Xray ordered stat done at 2030..... A second nurses note, dated 4/5/03 at 10:00 PM documented that resident 28 was diagnosed with pneumonia "<br><br>v. A nurse's note, dated 4/6/03 documented that resident lungs sounds were congested and coarse and in both lungs. The nurse's note also documented that resident 26's oxygen is on 5 liters and his oxygen saturations fluctuate 85-90%.<br><br>vi. A nurse's note, dated 4/6/03 at 1:00 PM documented that "adventitious breath sounds in all fields. Patient has increase in confusion and agitation, calmer when he will have O2 NC on." | F 328 | | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 328 | Continued From page 41 | F 328 | **F 363 483.35(c)(1)-(3) DIETARY SERVICES** | 6/5/2003 |
| F 363 SS=E | 483.35(c)(1)-(3) DIETARY SERVICES<br><br>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, it was determined that the facility did not follow the approved menus. Specifically, all residents were served foods different than those listed on the menu, on 4/7/03 during the lunch meal, which would alter the calories, protein and other nutrients provided. This had the potential to affect all residents in the facility.<br>During observation of the breakfast meals on 4/8/03, 4/9/03 and 4/10/03 6 of 15 sample residents receiving enriched diets (residents 6, 8,13, 31, 51, and 56) and 1 additional resident receiving a high fiber diet (resident 23) were not served therapeutic diets per the written menu.<br><br>Findings include:<br><br>Observations of the lunch meal on 4/7/03 revealed the following menu:<br><br>Breaded pork patty with gravy<br>Mashed potatoes<br>Oriental mixed vegetables<br>Cherry dessert<br>White dinner roll<br><br>The posted menu listed a pork steak and squash | F 363 | Corrective Action for Identified Residents<br>See section below, "Measures to Prevent Reoccurrence" as it also applies to identified residents.<br><br>Identification of Residents with Potential to be Affected<br>All residents have the potential to be affected by this deficiency.<br><br>Measures to Prevent Reoccurrence<br>On 4/10/03, a consulting firm was hired to provide consultant dietitian services. An in-service was held on 4/24/03 with the dietary manager and dietary staff. The following items were reviewed and a sign-in sheet with minutes was completed:<br><br>▪ Menu adherence – reading spreadsheets to ensure appropriate diets were provided as ordered.<br>▪ Menu substitutions – Form 411 was reviewed and posted in the kitchen. All menu substitutions are recorded on Form 410. It was emphasized that the maximum allowable substitutions are 2 individual items per week (a resident's choice/manager's special meal is not considered a substitution).<br><br>An in-service was held on 5/12/03 with the dietary manager and dietary staff. | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 363 | Continued From page 42<br>medley as the entrée and vegetable.<br>The recipe for the entrée listed a roasted pork loin sliced into 2 oz. portions as the only ingredient. No breading was on the ingredient list for this entrée. The recipe for the squash medley listed the vegetables in this recipe as yellow and zucchini squash along with some onions.<br><br>Altering the menu would change the calories, protein and other nutrients for this meal.<br><br>Observations of the breakfast meal on 4/8/03 revealed a yellowish juice being served with the breakfast. The surveyor requested resident 6 to taste the juice on her tray to see what it was. She stated that it was a "watery orange juice that tasted terrible." This same juice was observed to be served to several resident during the meal.<br><br>In an interview with the dietary manager on 4/8/03 the surveyor requested to sample the juice. A cup was poured from the fountain. The consistency and taste of the juice was not altered and not watery. The dietary manager stated that she knew the juice was watery because she pours it into a pitcher full of ice to cool it down every morning. By pouring the juice over the ice the juice was diluted and altered the taste as well as the vitamin content. This had the potential to affect all the residents in the facility<br><br>Observations of the breakfast tray line service on 4/8/03, 4/9/03 and 4/10/03 revealed everyone receiving the same cereal, no additions to the cereal were observed.<br><br>Observations of the lunch tray line service on 4/9/03 revealed everyone receiving the same entrée, starch and vegetable, no additions of extra butter were observed to any dish. | F 363 | The following items were reviewed and a sign-in sheet with minutes was completed:<br>▪ Pitchers of juice are to be prepared at the end of each meal for the next meal and placed in the refrigerator to cool. An ice bath may also be used to facilitate the cooling process. Juice is not to be poured over ice as it dilutes the juice, thus affecting the palatability and reducing the calorie and vitamin content.<br>▪ The Special Nutrition Program (SNP) was reviewed again as follows: 8 oz super cereal, 4 oz high calorie/high protein pudding or cookie, 8 oz whole milk T.I.D (three times daily). This program adds approximately 1000 calories and 40 grams of protein per day.<br>▪ High fiber diets include wheat bread 3 times per day with meals, 1 TB bran in the breakfast cereal each day. 4 oz prune juice may also be used per resident preference.<br><br><u>Continued Monitoring/ Quality Assurance</u><br>To monitor the implementation of this new program, the Dietary Manager will audit 1 meal each day (5 days per week) for 3 weeks to ensure that the dietary staff is following the spreadsheets for therapeutic diets and providing SNP as ordered. The Dietary Manager will review daily the menu and | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 363 | Continued From page 43<br><br>In an interview with the dietary manager on 4/9/03 she stated that she follows the HPSI (Health Procurement Services Incorporated) menu plan. She stated that she enriched the meals by adding butter and whole milk to the cereal of residents who were to receive an eriched diet. She further stated that she placed extra butter on the lunch and dinner trays. She stated that she did not have a recipe for the enriched cereal and that the dietitian had approved the additions of the milk and butter to the meals. She could not provide evidence regarding the amount of butter or milk which dietary staff added to the trays of those residents receiving enriched diets.She stated that if additional protein was added to the meal a milk shake would be added to the tray and no other foods on the tray contained any protein supplement.<br><br>In an interview with the dietary manager and the dietitian on 4/10/03 the dietitian stated that the regular diet supplied approximately 2400 calories per day and by adding extra butter and whole milk to the trays an additional 800 calories would enrich the diets.<br><br>In a review of the HPSI diet manual (page 1) documentation revealed that the regular diet contained approximately 2000-2200 calories, and 75-85 gms of protein.<br><br>In the menu/recipe notebook on the enhanced/enriched information page it states that the enhanced diet is "based on the regular diet with enhanced recipes providing 15-20 grams of additional protein and 250-300 additional calories per day. This diet should provide an average of 98 grams of protein and an average of 2550 calories per day." A recipe for super cereal on page 61 of the recipe notebook | F 363 | substitution list to ensure that the menu is followed correctly. As ongoing quality assurance, the tray line will be audited by the Dietary Manager 1 meal per week to ensure accuracy. The Consulting RD also will monitor tray line accuracy and menu substitutions during her monthly visit and reviews her findings with the Dietary Manager and Administrator during the exit interview.<br><br>Continued Monitoring/ Quality Assurance<br>To monitor the implementation of this new program, the Dietary Manager audits 1 meal each day (5 days per week) for 3 weeks to ensure that the dietary staff is providing SNP as ordered. As ongoing quality assurance, the tray line is audited by the dietary manager 1 meal per week to ensure accuracy. The Consultant Dietitian also monitors tray line accuracy during her monthly visit and reviews her findings with the Dietary Manager and Administrator during the exit interview.<br>Findings will be reported to the Performance Improvement Committee for analysis and recommendations. | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 363 | Continued From page 44<br>documented the additions of nonfat milk, margarine, evaporated milk, white sugar and brown sugar to any hot cereal to increase the calories and the protein content.<br><br>A taste test of the morning cereal on 4/9/03 revealed a non-sweet tasting cereal being served to all the residents. By following the approved recipe for the enriched cereal, the cereal would have a defined sweet taste.<br><br>The master diet list provided to the surveyors on 4/7/03 documented that 13 residents in the facility were currently ordered to receive enriched diets.<br><br>Observations of resident 23's tray card during the breakfast meal on 4/8/03 and 4/9/03 and the lunch meals on 4/7/03 and 4/9/03 revealed documentation of a high fiber diet.<br><br>White bread was observed to be served to resident 23 during the breakfast and lunch meals.<br><br>In a review of the HPSI diet manual (page 25 and 26) documentation revealed that the high fiber diet would provide 25-35 grams of fiber per day. Recommendations included the use of whole grain breads and to limit the use of refined breads<br><br>The dietary manager was not following the recommended recipes of the approved menu plan to provide the diets that were ordered for the residents in the facility. | F 363 | | |
| F 364 SS=F | 483.35(d)(1)&(2) DIETARY SERVICES<br><br>Each resident receives and the facility provides food | F 364 | See next page — | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 364 | Continued From page 45<br>prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on the confidential group interview, it was determined that the facility did not provide food that was palatable to the residents.<br><br>Findings include:<br><br>During the confidential group interview on 4/8/03, 7 of the 10 residents stated that the food they were served was "tasteless". When asked if it was a particular meal or time of day, the residents stated that it was "most of the time". The residents stated that they had brought this concern to the attention of the facility staff and that they had been told the kitchen staff would be in-serviced. The residents continued to state the problem of the "flavorless" had not been solved. The residents stated that this was an "on-going" problem.<br><br>During 3 seperate confidential individual interviews on 4/7/03 and 4/8/03, it was said that the "food was bland", "too many breaded meats", "could stand an improvement", "I don't really like it (the food)", and "sometimes it is cold". | F 364 | **F 364 483.35(d)(1)&(2) DIETARY SERVICES**<br><br>Corrective Action for Identified Residents<br>Residents affected by this deficiency were not specifically identified in the survey.<br><br>Identification of Residents with Potential to be Affected<br>All residents except those on tube feedings have the potential to be affected.<br><br>Measures to Prevent Reoccurrence<br>On 4/10/03, a consulting firm was hired to provide consultant dietitian services. An in-service was held on 4/24/03 with the dietary manager and dietary staff. The following items were reviewed and a sign-in sheet with minutes was completed:<br><br>▪ Menu adherence – reading spreadsheets to ensure appropriate diets were provided as ordered.<br>▪ Following recipes to ensure a palatable and consistent product. | 6/5/2003 |
| F 366 SS=E | 483.35(d)(4) DIETARY SERVICES<br><br>Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on comments from 7 of 10 residents attending | F 366 | An in-service was held on 5/12/03 with the dietary manager and dietary staff. The following items were reviewed and a sign-in sheet with minutes was completed:<br>▪ Maintaining appropriate tray line temperatures to ensure that product is delivered to residents | |

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 366 | Continued From page 46<br>the confidential group meeting held on 4/8/03 and one additional resident interview, it was determined that the facility does not always offer substitutes of similar nutritive value to residents who refuse food served.<br><br>Findings include:<br><br>1. During the confidential group meeting held on 4/8/03, 7 of the10 residents actively participating in the meeting stated that substitutes have not been offered when they are served foods they do not like.<br><br>2. During the confidential meeting held on 4/8/03, 7 of the 10 residents stated that the only substitutes they receive for their meals are peanut butter and jelly and bologna and cheese sandwiches.<br><br>3. On 4/8/03, when asked about food substitutes, a resident stated during a confidential interview that when she was served something she didn't like she would ask for something else but the staff would tell her they didn't have anything else to serve. She said she has asked for ice cream on several occasions and was told that they did not have any.<br><br>4. An observation of the lunch meal on 4/8/03 revealed that the substitute listed for the pork steak was a peanut butter and jelly sandwich. | F 366 | Temperatures are recorded at the beginning of tray line and in the middle to ensure appropriate temperatures. (>140°F for hot foods, <41°F for cold foods)<br>Continued Monitoring/ Quality Assurance<br>To ensure tray line accuracy, the Dietary Manager will audit 1 meal each day (5 days per week) for 3 weeks to ensure that the dietary staff is following the spreadsheets. As ongoing quality assurance, the tray line will be audited by the dietary manager 1 meal per week to ensure accuracy. The Consultant Dietitian also will monitor tray line accuracy and menu substitutions during her monthly visit and reviews her findings with the Dietary Manager and Administrator during the exit interview. These findings will be presented to the Performance Improvement Committee on an on-going basis.<br><br>The Dietary Manager will also review a test tray (Form 526) on a weekly basis to ensure appropriate temperatures and palatability. The Consultant Dietitian will review the records of the test trays and samples the food for palatability during the monthly visit. This information is discussed during the monthly exit interview with the Dietary Manager and Administrator and will be presented to the Performance Improvement Committee. | |
| F 371 SS=E | 483.35(h)(2) DIETARY SERVICES<br><br>The facility must store, prepare, distribute, and serve food under sanitary conditions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations in 1 of 1 kitchens, it was | F 371 | | |

**ATTACHMENT #1**

OK 5/21/03 AD

**F 366 483.35(d)(4) DIETARY SERVICES**

Corrective Action for Identified Residents
Residents affected by this deficiency were not specifically identified in the survey.

Identification of Residents with Potential to be Affected
All residents have the potential to be affected by this deficiency.

Measures to Prevent Reoccurrence
On 4/10/03, a consulting firm was hired to provide consultant dietitian services. An in-service was held on 4/24/03 with the dietary manager and dietary staff. The following items were reviewed and a sign-in sheet with minutes was completed:

- Menu substitutions – Form 411 was reviewed and posted in the kitchen. All menu substitutions are recorded on Form 410. It was emphasized that the maximum allowable substitutions are 2 individual items per week (a resident's choice/manager's special meal is not considered a substitution).
- Menu Alternates are to include an alternate meat/protein and vegetable. These are to be posted daily with the regular menu. These alternates are to include 3 oz meat/protein, ½ c cooked or 1 c raw vegetable.

Continued Monitoring/ Quality Assurance
The Dietary Manager is responsible to ensure that the alternates are of comparable nutritional value based on the above guidelines.
The facility has an agreement with the consulting RD to monitor menu alternates as part of the monthly visit and review the findings with the Administrator and Dietary Manager during an exit interview. These results will be presented to the Performance Improvement committee as part of on-going quality assurance.

Completion Date
The date of completion is June 5, 2003.

| 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 _____ | 4/10/2003 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ARLINGTON HILLS CARE CENTER LL | 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 47<br>determined that the facility did not store, serve and distribute food under sanitary conditions as evidenced by a dietary staff member observed to cross contaminate between the dirty and clean side of the dish room.<br><br>Findings include:<br><br>During an observation of the kitchen on 4/8/03 at 8:40 AM a dietary employee was observed to place dirty plates and utensils into the dish machine. The dietary aide was observed to be wearing gloves. After the pans and utensils were washed, the dietary employee was observed to take the clean items and put them away without having changed his gloves or washing his hands between handling dirty and clean dishes.<br>This was observed after four different wash cycles. | F 371 OK 5/21/03 DS | **F 371 483.35(h)(2) DIETARY SERVICES**<br><br>Corrective Action for Identified Residents<br>Residents affected by this deficiency were not specifically identified in the survey.<br><br>Identification of Residents with Potential to be Affected<br>All residents have the potential to be affected by this deficiency.<br><br>Measures to Prevent Reoccurrence<br>An in-service was held on 4/11/03 and 4/15/03 with the Dietary Manager and dietary staff. The sign-in sheet/minutes are filed in the dietary in-service manual. The in-service was given by the Consultant RD and Dietary Manager and reviewed the following items:<br>• Proper procedures for cleansing hands when moving between the dirty and clean areas of the dish room.<br><br>Continued Monitoring/ Quality Assurance<br>The Dietary Manager observes staff in the dish room during a weekly Sanitation Check (Form 610) to ensure that proper procedures are being followed for cleansing hands in the dish room.<br>The Consulting RD reviews the weekly sanitation checks conducted by the Dietary Manager during the monthly visit and performs another sanitation check in the kitchen at least monthly. Part of the sanitation check involves monitoring the staff to ensure proper cleansing of hands when moving between the dirty and clean areas of the dish room. This sanitation check will be reviewed during the monthly exit interview with the Administrator and Dietary Manager.<br><br>Findings will be reported to the Performance Improvement Committee for analysis and recommendations. | 6/5/2003 |

ATTACHMENT #2

# MEAL INSPECTION

Date: _____

Time meal served: _____

Time last meal served to resident: _____

Meal inspected: _____

Cook: _____

Aides: _____

Note: Meal Inspection to be done 1 breakfast / 1 lunch / 1 dinner per month

| | S = 3 pts U = 0 pts | | | | | S = 6 pts U = 0 pts | |
|---|---|---|---|---|---|---|---|
| Foods | Serving Temps | Bedside Temps | Taste | Appearance (Garnish) | Diet Card | Accuracy with Diet Card | Diet Card Agrees with Di |
| 1. One regular cold food | | | | | 1. | | |
| 2. One vegetable hot food | | | | | 2. | | |
| 3. One ground hot food | | | | | 3. | | |
| 4. One pureed hot food | | | | | 4. | | |
| 5. One entrée hot food | | | | | 5. | | |
| TOTAL POINTS | | | | | TOTAL POINTS | | |

(minus 2 points if no garnish)

1. Proper handling of foods (plastic gloves)? Yes No
2. Proper scoops and portions of meat? Yes No
3. Double / Large / Small portions accurate? Yes No
4. Dislikes and allergies adhered to? Yes No
5. Proper amounts of milk given to diabetics, low sodium and renals? Yes No
6. Correct condiments given? Yes No
7. Did you observe each area of meal served? Yes No
8. Did you interview (5) patients during meal service? Yes No

Observations:

Total Points Available: _____

Percentage of Compliance: _____

Dietary Manager: _____

Administrator: _____

Dietitian: _____

Form 526 (06/01)

Attachments to form 2567-L

# ATTACHMENT #3

# PRE SURVEY SANITATION REVIEW

## AREAS REVIEWED

(☑ areas of concern and circle specifics)

Completed by: _____

| | SANITATION | S 3 | S- 2 | U 0 | R -1 |
|---|---|---|---|---|---|
| | *General Work Area:* | | | | |
| | ☐ Sanitizing buckets available with correct amount of sanitizer | | | | |
| | ☐ Ceilings/walls/lights/floors/baseboards/drains clean | | | | |
| | ☐ Shelves / drawers / cabinets / windows / doors / fans clean | | | | |
| | ☐ Trash containers clean/ covered/ disposed of properly; dumpster clean / closed | | | | |
| H | ☐ Pest control in place with no sign of rodents or insects | | | | |
| | *Food Preparation Areas:* | | | | |
| | ☐ Food purchased from approved sources, with first in first out rotation | | | | |
| | ☐ Emergency water provided for; Emergency menu posted with food on hand | | | | |
| H | ☐ Current *Food Code for Cooking & Reheating* posted / followed | | | | |
| H | ☐ Pasteurized eggs used / eggs cooked per current *Food Code* | | | | |
| H | ☐ All food (i.e. roasts, salads, puddings) cooled to 41° within 6 hours / *Cooling Monitor* Form used correctly | | | | |
| | ☐ Cereal dispensers clean / Food preparation sink clean | | | | |
| | ☐ Milk left in container after pouring marked "for cooking only" and dehydrated milk used per state regulations | | | | |
| | *Dry Storage:* | | | | |
| | ☐ Food once opened is sealed / labeled / dated | | | | |
| | ☐ Food stored off floor 6" / 18" from sprinkler head / Pallets santizable | | | | |
| | ☐ Cans free of dust / dented cans removed | | | | |
| | ☐ Food bins clean/ free of scoops/ labeled/ dated/ in good repair | | | | |
| H | ☐ Quality of food good / no spoilage / delivery temp appropriate/ recorded on invoice | | | | |
| | ☐ Food shelves clean / rust free / well organized | | | | |
| | *Cold Storage:* | | | | |
| H | ☐ Freezer clean / frost free / 0° / Refrigerators clean / ≤ 41° / Food off floor (Check nursing unit) | | | | |
| | ☐ No freezer burnt food, reseal once opened, date | | | | |
| H | ☐ Internal thermometers in all units in warmest area | | | | |
| H | ☐ Refrigerator / Freezer temperatures recorded daily / action plan noted when not working (Check nursing unit) | | | | |
| H | ☐ Food covered/ labeled/ dated/ leftover policy posted/ followed | | | | |
| H | ☐ Produce of good quality / stored separate from ready to eat food | | | | |
| H | ☐ Meat thawed (under refrigeration ≤ 41°) on tray on bottom shelf | | | | |
| H | ☐ Eggs stored on bottom shelf | | | | |
| H | ☐ No outdated milk products or outdated leftovers | | | | |
| H | ☐ Refrigerated potentially hazardous foods are at 41° or below when received / frozen at 0° or less (note temps on invoice) | | | | |

| | SANITATION | S 3 | S- 2 | U 0 | R -1 |
|---|---|---|---|---|---|
| | *Utility Room:* | | | | |
| | ☐ Mops and brooms clean / stored off the floor / floor clean | | | | |
| | ☐ Chemicals stored off the floor/separate from food/MSDS posted | | | | |
| | ☐ Fire extinguisher in kitchen | | | | |
| | *Personnel:* | | | | |
| | ☐ Hygiene good / hair restraints worn / uniforms clean and neat | | | | |
| H | ☐ Hand washing sink with sanitizing soap / hot water / towel / step on trash containers / plastic gloves worn when needed/ non dietary personnel not in kitchen / ready to eat food not touched by hands | | | | |
| | ☐ Nails clean and free of polish unless gloves worn | | | | |
| H | ☐ Personal hygiene good / Food Handler Cards current where needed / one individual with food safety certification | | | | |
| | ☐ Annual TB test documented in personnel file | | | | |
| | ☐ Cleaning schedule followed | | | | |
| | *Dishwashing Area:* | | | | |
| | ☐ Dishwasher area clean / dishwasher free of scale | | | | |
| | ☐ Sanitizer labeled in appropriate area | | | | |
| H | ☐ No contamination from dirty to clean areas | | | | |
| H | ☐ Dish machine temps and ppm per posted requirements | | | | |
| H | ☐ Dish machine temps recorded daily / corrective action noted | | | | |
| H | ☐ Kitchen has a flow pattern for clean and soiled items | | | | |
| | *Pot and Pan Washing Area:* | | | | |
| H | ☐ Pot sinks clean / amount of sanitizer and procedure posted / ppm recorded on form | | | | |
| | ☐ Pots and pans clean / dry / inverted / in good condition | | | | |
| | *Equipment:* | | | | |
| | ☐ Dishes clean / dry / free of chips / cracks / lowerators clean / silverware clean / rust free / inverted / covered | | | | |
| | ☐ Blender and food processor clean / Can opener clean / Cutting boards clean / Coffee urn clean / Beverage dispenser clean | | | | |
| | ☐ Knife rack clean with no knife chipped or rusted | | | | |
| | ☐ Microwave clean / Mixer clean / Ovens clean / Range and grease trap clean | | | | |
| | ☐ Slicer clean with steel mitt / steamer clean / steam table clean and free of scale / toaster clean / tray cards clean and legible / tray carts clean | | | | |
| | ☐ Equipment is in working order | | | | |
| | ☐ Filter, vents, and hood clean with suppression system working | | | | |
| | ☐ Food thermometers work and alcohol wipes available – be sure to calibrate | | | | |
| | ☐ No scoop in ice machine / clean / rust free / no leaks / scoop in container | | | | |
| | **Totals** | | | | |
| | GRAND TOTAL FOR SANITATION (TOTAL POINTS AVAILABLE = 162) Formula: S + S- + U – R = | | | | |

H = Hazardous (could cause an immediate jeopardy)

S = Satisfactory

S- = Needs Improvement

U = Unsatisfactory

R = Repeated Problem

Date(s) of visit: _____

Facility: _____

Form 510 (07/02)

Arlington Hills Care Center Annual Survey completed 4-10-03

ATTACHMENT #4

Attachments to form 2567-L

# DINING ROOM MONITOR

| | | | | | | | | | COMMENTS: |
|---|---|---|---|---|---|---|---|---|---|
| Date Observed: | | | | | | | | | |
| Meal Observed: | | | | | | | | | |
| DR Observed: | | | | | | | | | |

Code: Mark Y = Yes, N = No **[give 1 point for each yes (25 available) – divide # yes by 25 to get compliance score]**

| Compliance Score: # yes / % | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Residents in dining room on time | | | | | | | | |
| Hands and faces washed before meals | | | | | | | | |
| Clothes protectors provided | | | | | | | | |
| Tray out on time | | | | | | | | |
| Residents offered drink of choice and ice water poured | | | | | | | | |
| Nurse to dining room on time | | | | | | | | |
| Tablecloths/centerpieces/ DR quiet with soft music | | | | | | | | |
| Menu/alternate posted | | | | | | | | |
| Adaptive devices used properly | | | | | | | | |
| Entire table served at same time | | | | | | | | |
| Food removed from trays where appropriate | | | | | | | | |
| Residents promptly assisted with eating – adequate staff | | | | | | | | |
| Condiments offered, bread buttered, milk opened, etc. | | | | | | | | |
| Residents offered alternatives/meal replacement | | | | | | | | |
| Table correct height | | | | | | | | |
| Portion correct | | | | | | | | |
| Liquids thickened appropriately | | | | | | | | |
| Meal % recorded | | | | | | | | |
| Dishes, warmer cover, and silverware clean | | | | | | | | |
| Residents received correct diet, consistency, likes and dislikes adhered to | | | | | | | | |
| Resident positioned appropriately | | | | | | | | |
| Aides sitting while feeding inside table | | | | | | | | |
| Hands and faces washed after meals | | | | | | | | |
| Clothes protectors removed after meals | | | | | | | | |
| Check Care Plan on 4 High Risk Residents for correct implementation. | | | | | | | | |
| Monitor's Initials | | | | | | | | |

Form 522 (06/01)

Arlington Hills Care Center Annual Survey completed 4-10-03
Attachments to form 2567-L

ATTACHMENT #5

# TRAYLINE CHECKLIST

- ☐ Food prepared appropriately / vegetables cooked last / garnish available
- ☐ Food on steam table ~~½~~ 15 mins hour prior to service
- ☐ Temperature taken / correct / recorded
- ☐ Scoops and ladle sizes correct
- ☐ Cold food on ice
- ☐ Alternate meat and vegetable on trayline
- ☐ SF / LF food available, if needed
- ☐ Puree / Mechanical Soft consistency appropriate
- ☐ Plate heated or chilled
- ☐ Menu posted on both sides of trayline
- ☐ Brief menu conference held