MB

PRINTED: 06/29/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING ______ B. WING ______	06/16/2005

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

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F 157 SS=G	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and review of resident medical records, it was determined that for 1 of the 15 sample residents, the facility did not immediately consult with the resident's physician	F 157 7/21/05 POC acceptable Completion date 7/28/05 [illegible]	This Plan of Correction is being submitted pursuant to applicable federal and state regulations. Nothing contained herein shall be construed as an admission that the facility violated any federal or state regulation, or failed to follow any applicable standard of care. The facility will immediately inform the resident, consult with resident's physician, and if known, notify the resident's legal representative or interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention. Resident #1 was admitted to the hospital and then returned to the facility where she currently resides. Licensed nurses will consult with the MD/NP within thirty minutes of receiving critical lab reports. If the licensed nurse is unable to contact the MD/NP, the DON will be notified immediately for follow up. Licensed nurses will be in-serviced on critical lab reports and MD/NP notification.	07/28/05

Utah Department of Health
0318604 HD
JUL 20 2005
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE (X6) DATE 7-9-05

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

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F 157	Continued From page 1 when there was a significant change in the resident's physical status. Specifically, a facility employee was notified (via telephone) by the facility's contracted laboratory service of critical laboratory results on 4/18/05 at 2:16PM. The facility did not notify the resident's physician (also the medical director) of the critical laboratory results until 6:30 PM, four hours and 16 minutes later, when the resident was noted to be "pale" and "lethargic". The resident's physician then ordered staff to send the resident to the emergency room. Resident 1 was transferred to the hospital via ambulance and admitted. Resident identifier: 1. Findings include: The medical record of resident 1 was reviewed on 6/14/05 and 6/15/05. During the review of the medical record, it was noted by the registered nurse surveyor that on 4/18/05, resident 1 experienced critical laboratory results. Those results which were listed by the laboratory as "CRITICAL" include: Potassium - 6.7 - "CRITICAL HIGH" CO2 - 12 - "CRITICAL LOW" BUN - 57 - "CRITICAL HIGH" The laboratory director of the contracted laboratory used by the facility was interviewed by telephone on 6/23/05 at approximately 3:00PM. He stated that an employee of the facility (giving a specific name) was notified by telephone of the critical laboratory results on 4/18/05 at 2:16PM. The laboratory director also stated that they documented next to the laboratory results "RRB" meaning that they had the facility employee read the results back to the lab to ensure that the	F 157	The DON will audit all labs each month for timely MD/NP notification. All discrepancies will be corrected and the licensed nurse will receive one-on-one counseling. Findings and trends will be reported every month in the QA meetings for follow up and further corrective action. The laboratory will conduct its own quarterly internal audit. All significant discrepancies will be immediately reported to the DON. All residents' labs will be reviewed to determine if any further follow up by the MD is necessary. The Lab will be contacted to check if any other critical labs need further intervention.	

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

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F 157	Continued From page 2 employee had taken the correct information. Nurse's notes in the medical record of resident 1 include an entry dated 4/18/05 which read "at 1830 (6:30 p.m.) pt. (patient) pale, lethargic. VS (Vital Signs)= 96.2 degrees, P (pulse) 69, R (Respirations) 20, 96/47, SaO2 (Oxygen Saturation)= 95% RA (room air). BMP (Basic Metabolic Panel) results K+ (Potassium) = 6.7, M.D. (Doctor) ordered pt. to LDS ER (Emergency Room) to evaluate. Left facility via ambulance at 7:20 p.m. Pt. reported admitted to 8 West at this time." Facility staff did not consult with resident 1's physician regarding the critical laboratory results for four hours and 16 minutes. Resident 1 did not leave the facility via ambulance until 7:20 PM, an additional 50 minutes after staff received the order from the physician to send the resident to the emergency room. Laboratory and Diagnostic Tests with Nursing Implications, Sixth Edition, Joyce LeFever Kee, 2002, page 348, discusses increased potassium levels and states, "Report serum potassium levels >5.3 mEq/l. High serum-potassium levels can cause cardiac arrest.	F 157		
F 163 SS=E	483.10(d)(1) FREE CHOICE The resident has the right to choose a personal attending physician. This REQUIREMENT is not met as evidenced by: Based on confidential interview and record	F 163	The facility will ensure that the residents have the right to choose a personal attending physician. A letter will be sent to all families and residents explaining that they have choice of physician, and that the	07/28/05

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F 163	Continued From page 3 review, it was determined that the facility did not ensure that residents had the right to choose a personal attending physician. Findings included: On 6/14/05 at 9:30 AM, a confidential group interview was held at the facility. It was revealed at the meeting that 8 of 8 residents attending felt they had no choice of a personal attending physician. The 8 residents stated that they knew a new physician would be assuming their care. They had been notified of this in a letter dated 3/30/05. Seven of the 8 residents attending the group meeting said that they had not seen the new physician. One of the 8 residents in the group stated she had seen someone in the facility lobby who she thought might be the new physician, but was not sure. None of the eight residents were given a choice to change to the new physician or not to change. Comments voiced in the confidential group of residents included, "Who the h*** is the new physician?", "I haven't seen the new physician" and "I don't know who he is." On 6/15/05, surveyors reviewed the letter that had been given to facility residents concerning the change in medical directors. The letter was an announcement that the facility would have a new Medical Director effective 3/30/05. The letter stated that the new physician "will assume care for all patients/residents in the facility who have been under the care of our outgoing Medical Director..." The letter did not include information regarding any other physician options available to the residents. Admission paperwork contained a form titled	F 163	facility will be happy to assist them in choosing their own personal physician. The facility will then survey the residents and families each quarter thereafter if they are satisfied with their choice of physician. If not, the facility will offer assistance in choosing another personal physician. All staff will be in-serviced on resident rights. Resident satisfaction surveys will be completed and will be monitored by Social Services. All problems and trends identified on the survey will be compiled and brought to the attention of the QA committee for follow up and further corrective action. Medical Records will obtain a new notification and consent form. This will then be mailed to and signed by the resident/responsible party identifying choice of physician.	

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F 163	Continued From page 4 "Notification and Consent" which included the following statement, "I [the resident] have designated the physician identified below as my personal attending physician. If he/she fails to fulfill a given requirement, the facility will have the right, after consulting with me, to seek another physician to assure that I am appropriately and adequately cared for and treated." Review of seven resident medical records, whose care had been assumed by the current facility medical director, revealed that the above mentioned form titled "Notification and Consent" still contained the name of the previous medical director as the physician designee. The facility did not have any documentation to evidence that residents had been "consulted" prior to the change in their physician. Information given to residents upon admission regarding their right while in the facility included a statement under "Free Choice" stating "You may choose your own personal physician."	F 163		
F 164 SS=E	483.10(d)(3) FREE CHOICE The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the	F 164	The residents will have the right to personal privacy and confidentiality of his/her medical records. 1. All staff will be in-serviced on privacy–specifically knocking on residents' doors and closing doors and/or pulling curtains during personal care. 2. Licensed nurses will be in-serviced on providing procedures and injections in resident rooms.	07/28/05

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F 164	Continued From page 5 release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not ensure personal privacy during treatment from staff. Specifically, 5 of the 8 residents in the confidential group interview stated that staff did not knock on their doors prior to entering; 3 of the 8 residents stated that staff did not close their room door or pull the privacy curtain prior to administering personal cares. Additionally, two observations were made in which residents were exposed in public areas. Resident identifier: 24 and 25. Findings include: 1. A confidential group interview was held with eight residents on 6/14/05. Three of the 8 residents stated that staff did not close doors or pull privacy curtains when providing care to them. Five of the 8 residents stated that staff did not knock on their doors prior to entering their personal rooms. 2. On 6/15/05 at 7:30 AM, a staff nurse was observed to administer insulin into the abdomen of resident 24 in the main hallway with other residents in the vicinity. The abdomen of resident	F 164	3. Drapes will be added to the bottom of the shower chairs and staff will be in-serviced on not pulling the resident backwards down the hall. Observation rounds will be completed three to five times per week and documented on a quality observation sheet to monitor privacy and staff knocking on resident doors. All trends identified from the quality observation rounds will be reported to the QA committee for further corrective action. The QA committee will monitor monthly.	

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F 164	Continued From page 6 24 was exposed while the nurse was performing this injection. 3. On 6/14/05 at 7:22 AM, resident 25 was observed sitting in a shower chair, covered by a bath blanket and being pulled down the hallway backwards by a nurse aide. As resident 25 was being transported, her buttocks were visible through the hole in the bottom of the shower chair.	F 164		
F 240 SS=G	483.15 QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. This REQUIREMENT is not met as evidenced by: Based on information gathered from residents in the facility during the course of the survey, including confidential interviews in group and confidential interviews with individuals, it was determined that the facility did not care for its residents in a manner and an environment that promoted enhancement of each resident's quality of life. Residents: 5, 10, 11, and 13. Findings included: 1. Resident 5 was dependent upon the staff to create and sustain an environment that humanized and individualized each resident. An interview was conducted with resident 5 on 6/14/05 at 1:30 PM. The resident stated, "When I push the call light, it takes a long time.	F 240	The facility will care for its residents in a manner which promotes and enhances each resident's quality of life. Residents #5, 10, 11, and 13–as well as all other residents–will have their call lights answered in a timely manner. Timely manner will be determined by the residents in resident council and satisfaction surveys. Observation rounds will occur three to five times per week by the Director of Staff Development to observe that this is being done, as well as call lights being within the resident's reach. Resident satisfaction surveys will be competed. Resident council concerns will be addressed until resolved by the resident council, and will be brought to the attention of the QA committee.	07/28/05

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F 240	Continued From page 7 Sometimes when I have had a bowel movement it takes two to three hours before an aid comes to change my brief." The resident said, "It makes me feel bad. That is not good for my skin." The resident also stated, "I feel lousy when my brief is soiled and I have to wait to be changed. I do not like it." 2. During a confidential interview conducted on 6/14/2005 with Resjdent 10, he/she stated that he/she had felt "embarassed" when he/she had become incontinent while waiting for the call light to be answered. When asked how frequently this had occurred, Resident 10 stated, "It has happened a couple of times." Review of Resident 10's Minimum Data Set regarding incontinence and transfers shows Resident 10 is continent of bowel and requires extensive assistance with transfers. 3. On 6/14/2005 a confidential interview was conducted with Resident 11. Resident 11 stated that he/she had felt "belittled" by staff when he/she became incontinent of bowel awaiting the call light and he/she had also felt "lowly." Resident 11 confided that he/she had become incontinent four times waiting for a call light to be answered. Review of Resident 11's Minimum Data Set regarding incontinence and transfers shows Resident 11 is continent of bowel and bladder and requires supervision while transferring. 4. Resident 13 was continent of bowel and bladder, but dependent upon staff for assistance to the bathroom. During interview with resident	F 240		

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F 240	Continued From page 8 13 on 6/14/05, he/she stated that he/she had become incontinent of bowel while waiting for the call light to be answered. The resident stated that this made him/her "embarrassed". All four residents stated that they needed assistance from staff to remain continent. All four residents stated that there were times when they had to wait extended periods for their call lights to be answered.	F 240		
F 281 SS=D	483.20(k)(3)(i) RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that services provided by the facility did not meet professional standards of quality. Findings include: 1. During observation of 8:00 AM medication pass on 6/14/05, a facility nurse was observed to administer insulin to resident 16. The nurse obtained the bottle of Humalog insulin from within her medication cart. After the insulin was administered, the registered nurse surveyor noted that the bottle of insulin did not have on it the date on which the bottle had been opened. The surveyor then asked the facility nurse when the bottle of insulin had been opened. The facility nurse looked at the bottle and stated that she did not know when the bottle had been opened. The 2005 Physician's Desk Reference, page	F 281	The services provided or arranged by the facility will meet professional standards of quality. 1. The insulin bottle in question was discarded. Another was ordered and dated when opened. 2. Inhalers are administered per MD order. Pharmacy consultant will in-service licensed nurses on proper handling, storage, and administration of insulin and inhalers. Med pass evaluations and med cart assessments will be completed one to three times per week by the DON. Trends, discrepancies, and concerns will be reported to the QA committee each month. The QA committee and DON will monitor for further follow up and corrective action	07/28/05

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F 281	Continued From page 9 1854, states "Humalog should be stored in the refrigerator (36 - 46 degrees F), but not in the freezer. If refrigeration is impossible, the vial or cartridge of Humalog in use can be unrefrigerated for up to 28 days, as long as it is kept as cool as possible (not greater than 86 degrees F) and away from direct heat and light. Unrefrigerated vials and cartridges must be used within this time period or be discarded." Facility staff could not verify that the unrefrigerated bottle of Humalog insulin used for resident 16 had been in use less than 28 days. 2. On 6/15/2005, LPN 3 was observed administering 8:00 a.m. medications to Resident 17. LPN 3 was observed administering a Flovent 110 milliequivalant inhaler to Resident 17. The order was for four puffs to be administered. LPN 3 was observed administering two puffs via Resident 17's mouth, then a fifteen second pause followed by two more puffs via the mouth. According to Basic Nursing Theory and Practice Second Edition, Patricia A. Potter, RN, MSN; Anne G. Perry, RN, MSN, ANP, EdD, page 600-601 under using Metered Dose Inhalers, the correct way to administer inhaled medications are: a. " Exhale fully, then grasp mouthpiece with teeth and lips while holding inhaler with thumb at mouthpiece and index and middle fingers at top. b. While inhaling slowly and deeply through mouth, fully depress medication canister once. c. Hold breath for approximately 10 sec. d. Exhale through pursed lips. e. Instruct client to wait 5 to 10 min. between inhalations or as ordered by physician."	F 281	Pharmacy consultant will review the med carts once per month to check for outdated insulin bottles.	
F 309	483.25 QUALITY OF CARE	F 309		

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F 309 SS=G	Continued From page 10 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on interviews and review of resident clinical records, it was determined that the facility did not provide the necessary care and services to attain or maintain the highest physical, mental and psychosocial well-being in accordance with the resident's comprehensive assessment and plan of care. Specifically, one resident (8) complained of having to wait 40 minutes for his call light to be answered during which time he reports having chest pain. Another resident (4) was not treated timely for a urinary tract infection. No antibiotics were started until 6 days after staff were aware of abnormal urinalysis results. An additional three residents (10, 11 and 13) complained of having to wait up to 30 minutes for their call lights to be answered, during which time they became incontinent of bowel. Another resident (5) complained of having to wait over an hour to have a soiled brief changed. Each of the residents expressed feeling "embarrassed", "lowly" or "lousy" as a result of their bowel incontinence. One of these four residents also expressed that he/she "felt belittled" by staff after they became aware of his/her bowel incontinence.	F 309	Each resident must receive, and the facility will provide, the necessary care and services to attain and/or maintain the highest practical physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. 1. The call light of Resident #8 will be answered in a timely manner. 2. Resident #4 was treated for a UTI. Licensed nurses will consult with the MD/NP within thirty minutes of receiving an abnormal UA report. If the licensed nurse is unable to contact the MD/NP, the DON will be notified immediately for follow up. Licensed nurses will be in-serviced on reporting abnormal UAs and timely follow up. The DON will audit all labs each month for timely MD notification. Any discrepancies will be corrected and the licensed nurse will receive one-on-one counseling. Findings and trends will be reported every month in the QA meetings for follow up and further corrective action. All resident labs will be reviewed to determine if any abnormal UAs and/or other labs are missing. Corrective	07/28/05

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F 309	Continued From page 11	F 309		

F 309 — Summary statement of deficiencies:

Findings include:

1. Resident 8 was a 54 year old bedfast male with diagnoses which included multiple sclerosis, congestive heart failure, coronary artery disease and chest pain. Current physician's orders (June 2005) for resident 8 included the use of Nitro tablets 0.4mg/hr sublingual every 5 minutes times three for chest pain.

Resident 8 was interviewed by a registered nurse surveyor at approximately 10:00 AM on 6/14/05. When asked about his life in the facility, resident 8 stated that the food was "a slice of heaven" and that the staff were always very courteous and kind to him. Resident 8 stated that his only complaint was that he had been having more frequent chest pain and that staff were taking longer to answer his call light to help him. Resident 8 stated that there had been a time when he had significant chest pain and he had had to wait 40 minutes for his call light to be answered and another 5 minutes for the nurse to bring him a Nitro tablet. When asked when this had happened, he stated that it had been within the last week or so. He also stated that this had happened several times and that because of that, he had spoken with the director of nurses and asked her to keep a close eye on his light as he only put it on when he "really needed it".

2. Resident 4 was admitted to the facility on 5/26/2004 with diagnosis including, Calcium deficiency, Nutritional deficiency, Hypertension, Dementia, Diabetes Mellitus, and chronic back pain.

On 5/4/2005 an entry in the Nurses' notes states,

F 309 — Provider's plan of correction:

follow-up action will be taken if any labs and/or UAs have been missed or need further intervention. All residents have been interviewed on call light timeliness. Call light audits have revealed that call lights have been answered on all residents within three to five minutes.

3. Residents #5, 10, 11, and 13 will have their call lights answered within a timely manner.

Observation rounds will occur three to five times per week by the DSD to observe that this is being done, as well as call lights being within the resident's reach. Resident satisfaction surveys will be completed. Resident council concerns will be addressed until resolved by the resident council, and will be brought to the attention of the QA committee.

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	465072	A. BUILDING ____ B. WING ____	06/16/2005

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) COMPLETION DATE
F 309	Continued From page 12	F 309		

"Resident has increasing confusion, wandering hall and asking if we've seen her mother, blood sugars elevated, urine foul odor and cloudy. UA (urinalysis) with culture and sensitivity if indicated collected for laboratory per order."

Review of the medication administration record shows the UA was collected on 5/5/2005.

Review of Resident 4's laboratory paperwork revealed the specimen was received on 5/5/2005 at 9:55 p.m. and reported on 5/5/2005 at 11:36 a.m. with the following results.

Color	Yellow
Clarity	Slt. Cloudy
Spec. Gravity	1.005
ph	6
protein	neg
glucose	neg
ketones	neg
urobilinogen	norm
bilirubin	neg
blood	+
nitrite	neg
Leukocytes	500
WBC	30-50
RBC	0-5
Epithelial cell	none seen
Bacteria	1+
Mucous	1+
Yeast	none seen
Crystals	none seen

On 5/10/2005 the nurses' notes have an entry stating, "New order for Bactrim DS one by mouth twice daily for seven days for UTI (urinary tract infection)."

Review of the medication administration record

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F 309	Continued From page 13 for May 2005 revealed that the Bactrim was not started until 5/11/2005, the day after it had been ordered. During an interview on 6/16/2005 with the DON, when asked if she had any additional information regarding the lab results and the timeliness of treatment for resident 4, the DON stated she had no additional information, that it just looked like the staff did not start treatment until 5/11/2005. Facility staff were aware of Resident 4's abnormal urinalysis result on 5/5/2005 and treatment was not started until 5/11/2005, six days after the initial (abnormal) results were faxed to the facility. 3. On 6/14/05, a confidential interview was conducted with Resident 5. Resident 5 stated that he/she had to wait for the call light to be answered after being incontinent of bowel for approximately two to three hours. He/she rang the call light to request an aid to change the soiled brief. He/she knew that the soiled brief was bad for the skin. He/she felt bad about waiting such a long time for having the brief changed. 4. On 6/14/2005 a confidential interview was conducted with Resident 10. Resident 10 stated that he/she had to wait on two to three occasions for the call light to be answered and receive assistance with using the bathroom. Resident 10 confided that he/she had become incontinent while waiting for the call light to be answered and receive assistance in the bathroom. Resident 10 stated that he/she had felt "embarrassed" after becoming incontinent. Review of Resident 10's Minimum Data Set	F 309		

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F 309	Continued From page 14 indicates Resident 10 is continent of bowel and requires extensive assistance with transfers and hygiene/bathing. 5. A confidential interview was conducted on 6/14/2005 with Resident 11. During the interview Resident 11 stated that he/she had to wait on four separate occasions for the call light to be answered by the facility staff. Resident 11 confided that while waiting for the call light to be answered he/she had become incontinent and felt "lowly and belittled" due to the incontinence. Resident 11 stated he/she is continent of bowel and bladder but needs assistance with transfers on occasion. Review of Resident 11's Minimum Data Set revealed that Resident 11 is continent of bowel and bladder and requires supervision while transferring. 6. Resident 13 was continent of bowel and bladder, but dependent upon staff for assistance to the bathroom. During interview with resident 13 on 6/14/05, he/she stated that he/she had become incontinent of bowel while waiting for the call light to be answered. The resident stated that this made him/her "embarrassed".	F 309		
F 312 SS=G	483.25(a)(3) QUALITY OF CARE A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312	The facility will ensure that residents that are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal/oral hygiene. Residents #5, 10, 11, and 13–as well as all other residents–will have their call	07/28/05

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F 312	Continued From page 15 Based on interviews, it was determined that residents who were unable to carry out activities of daily living did not receive the necessary services to maintain personal hygiene. Residents: 5, 10, 11, 13 Findings included: 1. Resident 5 was admitted to the facility with needs including assistance with activities of daily living. The resident needed assistance with toileting and with personal hygiene. In interviews on 6/14/05 and 6/15/05, the resident said that after ringing the call light to have a soiled brief changed, staff waited approximately two to three hours to have an aide change the soiled brief. The resident stated that staying in a soiled brief is bad for the skin. The resident said they "felt bad" waiting a long time in a soiled brief. 2. On 6/16/2005 Resident 10's medical record was reviewed. Resident 10 had an active careplan for self-care deficit. Resident 10 was to have all ADL's (Activities of Daily Living) met TNR ('Til Next Review). The approach listed for Resident 10 was for he/she to use toilet and receive extensive assistance while transferring. Review of Resident 10's Minimum Data Set revealed that Resident 10 was continent of bowel and required extensive assistance with transfers and hygiene/bathing. During a confidential interview with Resident 10 on 6/14/2005 he/she stated that on several occasions while waiting for the call light to be answered to receive assistance with using the toilet he/she had become incontinent. Resident further confided that he/she felt "embarrassed"	F 312	lights answered in a timely manner. Timely manner will be determined by the residents in resident council and satisfaction surveys. Observation rounds will occur three to five times per week by the Director of Staff Development to observe that this is being done, as well as call lights being within the resident's reach. Resident satisfaction surveys will be completed. Resident council concerns will be addressed until resolved by the resident council, and will be brought to the attention of the QA committee. The facility has consulted with various mental health providers to address psycho-social issues, resident concerns related to perceptions of reality, and other psychological disorders.	

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F 312	Continued From page 16 on these occasions. 3. On 6/16/2005 Resident 11's medical record was reviewed. Resident 11 had an active careplan for self-care deficit. Resident 11 was to have all ADL's performed each day and encouraged to do ADL's for self within physical limitation. One approach listed for Resident 11 was for he/she to receive assistance as needed with activities unable to perform independently. Review of Resident 11's Minimum Data Set revealed that Resident 11 was continent of bowel and bladder and supervision was required with transfers. During a confidential interview with Resident 11 on 6/14/2005 he/she stated that on four different occasions he/she had become incontinent while waiting for the call light to be answered so he/she could receive assistance while using the toilet and transferring. Resident further confided that he/she had felt "belittled" and "lowly" when the incontinence had occurred. 4. Resident 13 was continent of bowel and bladder, but dependent upon staff for assistance to the bathroom. During interview with resident 13 on 6/14/05, he/she stated that he/she had become incontinent of bowel while waiting for the call light to be answered. The resident stated that this made him/her "embarrassed". All four residents stated that they needed assistance from staff to remain continent. All four residents stated that there were times when they had to wait extended periods for their call lights to be answered.	F 312		

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F 332	Continued From page 17	F 332		
F 332 SS=E	483.25(m)(1) QUALITY OF CARE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations of four nurses, staff interview, and medical record review it was determined the facility did not ensure that it was free of medication error rates of five percent or greater. Observation of 76 medication opportunities revealed 4 medication errors resulting in a 5.2 percent medication error rate. (Residents 10, 16, 17 and 18) Findings include: 1. On 6/14/2005, LPN 1 (Licensed Practical Nurse) was observed during the morning medication pass. LPN 1 was observed administering all 8:00 a.m. medications to Resident 16 except Senna 8 mg. Upon review of Resident 16's medical record, an order was written on 6/13/2005 for Resident 16 to receive Senna 8 mg, one tablet by mouth every day. This is considered an error of omission. 2. On 6/14/2005, LPN 1 was observed administering 8:00 a.m. medications to Resident 10. Resident 10 received all 8:00 AM medications including Aspirin 325 mg by mouth. Upon review of Resident 10's medical record, the Physician Orders for April, May and June 2005 indicated that Aspirin 325mg one tablet by mouth every day was on HOLD. Further review of the medical record revealed that according to the medication administration records for April, May, and June 2005, Resident 10 had been receiving	F 332	The facility will ensure that it is free of medication error rates of five percent or greater. 1. Resident #16 is receiving Senna per physician order. 2. A physician's order has been written for the resumption of Resident 10's aspirin. 3. Resident #17's Flovent is being given per MD order. 4. Resident #18 now has order for acetaminophen. Random checks of the medication pass will occur one to three times per week by the DON. MARs will be audited once per month by the DON. All MARs will be audited for holes by Medical Records staff. PRN medications will be documented on the PRN sheet indicating use and response of medication. Pharmacy consultant reports will be reviewed once per month in the QA meeting for all trends and followed up with corrective action. Random audits of monthly physician orders will be completed by the DON to ensure that triple check is being performed by licensed nurses on all charts. The nurse consultant will do a four-way med check once per quarter on 25% of the residents.	07/28/05

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F 332	Continued From page 18 325 mg of Aspirin daily. This medication was given when it should have been held. 3. On 6/15/2005, LPN 3 was observed administering 8:00 a.m. medications to Resident 17. LPN 3 was observed administering a Flovent 110 milliequivalant inhaler to Resident 17. The order was for four puffs to be administered. LPN 3 was observed administering two puffs via Resident 17's mouth then a fifteen second pause followed by two more puffs via the mouth. According to Basic Nursing Theory and Practice Second Edition, Patricia A. Potter, RN, MSN; Anne G. Perry, RN, MSN, ANP, EdD, page 600-601 under using Metered Dose Inhalers, the correct way to administer inhaled medications are: a. " Exhale fully, then grasp mouthpiece with teeth and lips while holding inhaler with thumb at mouthpiece and index and middle fingers at top. b. While inhaling slowly and deeply through mouth, fully depress medication canister once. c. Hold breath for approximately 10 sec. d. Exhale through pursed lips. e. Instruct client to wait 5 to 10 min. between inhalations or as ordered by physician." This was an error of administration. Resident 17 did not receive the correct dosage of the inhaler because of the way in which the nurse administered the Flovent. 4. On 6/15/2005, LPN 4 was observed administering 8:00 a.m. medications to Resident 18. LPN 4 was observed dispensing Tylenol 650mg into a white paper envelope for Resident 18 to take out of the facility. Upon review of the medical record for resident 18, it was noted that an order was signed by the physician on	F 332	All medications placed on hold will have a reevaluate date indicated on the MAR for follow up. The DON will monitor to ensure that audits have been completed. Consultant reports will be reviewed in the QA meetings.	

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F 332	Continued From page 19 5/12/2005 to discontinue the Tylenol. This medication was given although it had been discontinued for over a month.	F 332		
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility did not store, prepare and serve food under sanitary conditions. Findings included: On 6/13/05 at 12:40 PM, observations were made in the kitchen. 1. Four packages of seafood in original plastic wrap covering were observed to be sitting in a container of hot water with hot water running over them. The seafood was observed to be in the hot water for 20 minutes from 12:40 to 1:00 PM. At 1:00 PM, the surveyor shared the observation with the Dietary Manager. Then the Dietary Manager turned off the hot water and turned on the cold water. This same deficient practice (improper thawing of frozen foods) was cited during the recertification survey last year (5/6/04). 2. At 1:05 PM, the sanitizing solution in the red kitchen bucket was tested by the dietary manager. The dietary manager got a test strip for quaternary ammonium compound and the	F 371	The facility will store, prepare, distribute, and serve food under sanitary conditions. 1. All dietary staff will be in-serviced once per month for the next three months on proper thawing of meats. The meat will be removed from the freezer three days in advance and thawed in the refrigerator. 2. The sanitizing solution will be changed per standard procedure to read the proper quaternary ammonium compound. It will be documented and available for review for the QA committee. The Dietary manager will ensure that in-services have been completed, and all trends will be brought to the attention of the QA committee for further corrective actions. Dietary Services Consultant will monitor monthly for proper storage, preparing, distributing, and serving of food under sanitary conditions.	07/28/05

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F 371	Continued From page 20 sanitizing solution tested 100 parts per million (ppm) Quaternary solution. The US Food Code states the following guideline for sanitizing solutions: 200 ppm Quaternary solution.	F 371	Consultant reports will be reviewed monthly. All trends identified will have follow-up corrective action.	
F 385 SS=G	483.40(a)(1)&(2) PHYSICIAN SERVICES A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one of fifteen sampled residents and eight out of eight residents in the confidential group interview, the facility did not ensure that the medical care of each resident was supervised by a physician or that another physician supervised the medical care of residents when their attending physician was unavailable. Specifically, Resident 1 had diarrhea and a positive culture for Clostridium Difficile and was not treated until she was sent to the hospital 27.5 hours after the results were called to the facility. Additionally, all eight residents in the group interview voiced complaints about not being seen by the new facility physician. Findings included:	F 385	The facility will ensure that the medical care of each resident is supervised by a physician. 1. Resident #1 has been treated for C-dif and currently resides at the facility. 2. Refer to Plan of Correction for F163. In addition, residents had been seen by the Nurse Practitioner. Medicare does not pay for "preventative" exams. The Medical Director has been in the facility once per week, and the Nurse Practitioner one to two times per week, and will continue to do so. The facility has scheduled a Meet & Greet BBQ for residents and family members. Licensed nurses will consult with the MD/NP within 30 minutes of receiving critical lab reports. If the licensed nurse is unable to contact the MD/NP, the DON will be notified immediately for follow up. Licensed nurses will be	07/28/05

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F 385	Continued From page 21	F 385	in-serviced on critical lab reporting and follow through with the MD.	

1. Resident 1 was originally admitted to the facility on 10/13/2004 with diagnosis including Diabetes Mellitus Type II, Urosepsis, Peripheral Neuropathy, Osteomyelitis, Peripheral Vascular Disease, and Hypertension.

The medical record for resident 1 was reviewed 6/14/05 - 6/16/05.

A history and physical report documented that Resident 1 was admitted to a local hospital on 2/01/2005 with diagnosis including "Acute Renal Failure Secondary to dehydration from diarrhea..."and "Hyperkalemia secondary to renal tubular acidosis..... worsened by renal function." Resident 1 had both diarrhea and hyperkalemia in the hospital on 2/01/2005 and was subsequently treated for both. Ten weeks later Resident 1 again experienced diarrhea and hyperkalemia at the facility. A facility nurse left a message for the resident's physician (medical director) of the diarrhea and positive C-diff culture on 4/17/2005 at 3:00PM. The physician did not respond back to the facility regarding resident 1.

It was not until facility staff received critical laboratory results, which initiated another call to the resident's physician on 4/18/05 at 6:30 PM, that the physician ordered to send resident 1 to the emergency room. (Please also see tag F - 157.)

On 4/16/05 at 3:00 p.m. a nurse's note entry states, "Weak and pale. Liquid BM (bowel movement) at breakfast. Stool sample obtained for C-Dif toxin (Clostridium Difficile). Collected by lab at 11:50 a.m. Continue to hold KCL (Potassium). No cardiac arrhythmias noted.........."

Provider's plan of correction (continued):

The DON will audit all labs each month for timely MD notification. All discrepancies will be corrected and the licensed nurse will receive one-on-one counseling. Findings and trends will be reported every month in the QA meetings for follow up and further corrective action.

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F 385	Continued From page 22 Upon review of the medical record, lab results show the lab received the specimen at 1:28 p.m. on 4/16/2005 and called the results to Arlington Hills on 4/17/2005 at 2:35 p.m. The results according to the lab were that Resident 1 was positive for Clostridium Difficile Toxin. A Nursing note dated 4/17/05 at 3:00 p.m. states, " Physician notified-left message pt. positive for C-diff. The next entry in the nursing notes is dated 4/18/05 at 4:00 a.m. and states, "...... Resident does however have redness on coccyx area also awaiting call concerning resident C-diff. Will also inform treatment nurse and physician about redness on coccyx area when he calls concerning C-diff lab......." Medical Record review revealed that no medication or treatment was started for Resident 1 during the time frame of 4/17/2005 at 3:00 p.m. through 4/18/2005 at 6:30 p.m. Nursing note entry dated 4/18/05 at 10:00 p.m. states, "at 1830 (6:30 p.m.) pt. (patient) pale, lethargic. VS (Vital Signs)= 96.2 degrees, P (pulse) 69, R (Respirations) 20, 96/47, SaO2 (Oxygen Saturation)= 95% RA (room air). BMP (Basic Metabolic Panel) results K+ (Potassium) = 6.7, M.D. (Doctor) ordered pt. to LDS ER (Emergency Room) to evaluate. Left facility via ambulance at 7:20 p.m. Pt. reported admitted to 8 West at this time." Lab results from the BMP reported on 4/18/05 at 1:33 p.m. were as follows; Sodium 133	F 385		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 385	Continued From page 23	F 385		

Potassium 6.70
Chloride 111
CO2 12
Glucose 142
BUN 57
Creatinine, Serum 2.2
Calcium 10.3

Medical Record review revealed no other nursing entries stating the doctor had returned the facilities call regarding the lab results of the Clostridium Difficile and that treatment had been started. Facility staff were aware of positive c-diff results and the hyperkalemia. Facility staff notified the physician of abnormal lab values. Evaluation of the above issues did not occur until 4/18/05 at 6:30 PM. This was 27.5 hours after the first abnormal laboratory results were returned to the facility and the first call was placed to the physician.

2. Residents of the facility received a letter dated March 30, 2005 stating the new Medical Director would be assuming care of residents under the previous Medical Director starting March 30, 2005.
During the confidential resident group interview all eight residents attending the group interview voiced concerns that they had not been seen by the new Medical Director. When asked about preventative medical examinations, three of eight residents expressed that they had asked for preventative exams and had not received those services. Upon inquiry if they had asked the new Medical Director about preventative exams, one resident stated, "Who the h*** is the new Doctor?"

PRINTED: 06/29/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING ______ B. WING ______	06/16/2005

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F 426	Continued From page 24	F 426		
F 426 SS=D	483.60(a) PHARMACY SERVICES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observation and medical record review, it was determined that for 1 of 15 sampled residents the facility did not provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of each resident. Specifically, Resident 10 received 325mg of Aspirin daily for two and one half months after the medication had been put on HOLD. Findings Include: Resident 10 was admitted to the facility on 5/20/2004 with diagnosis including cellulitis, asthma, hypertension, hyperlipidemia,hypothyroidism,obesity, and depression. On 6/14/2005 LPN (Licensed Practical Nurse) 1 was observed administering all 8:00 a.m. medications to Resident 10. Resident 10 received 325mg of Aspirin by mouth. Medical record review for Resident 10 revealed that per physician orders signed by the current medical director on 5/29/2005, the Aspirin 325mg one tablet by mouth every day was on HOLD.	F 426	The facility will provide pharmaceutical services to meet the needs of each resident. Resident 10's physician has been contacted and an order has been received and written for the resumption of the resident's aspirin. Random checks of the med pass will occur one to three times per week. MARs will be audited once per month by the DON. One hundred percent of the current MARs will be audited for holes. PRN medications will be documented on the PRN sheet indicating use and response of medication. Pharmacy consultant reports will be reviewed once per month in the QA meeting for all trends and followed up with corrective action. Fifty percent of monthly physician orders will be audited to ensure that triple check is being performed. The nurse consultant will do a four-way med check once per quarter on 25% of the residents. All resident charts have been reviewed and we have not found any other residents with medications on hold. The DON will monitor to ensure that audits have been completed and charts	07/28/05

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F 426	Continued From page 25 Further review of the medical record revealed that the 325mg of Aspirin was on HOLD for the months of April and May 2005 as well. Review of the medication administration records for the months of April, May and June 2005 revealed that Aspirin 325mg had been given daily to Resident 10. This medication had been placed on HOLD per the March medication administration record as of March 4th 2005.	F 426	have been reviewed. Consultant reports will be reviewed in the QA meetings.	
F 492 SS=D	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility incident reports, it was determined that the facility was not in compliance with all applicable State laws. Findings include: Utah State Licensure Rule R432-150-11(3)(B) reads "Incident and accident reports shall be numbered and logged in a manner to account for all reports." On 6/14/05, the facility's March, April, May and June 2005 incident reports were reviewed, a total of 28 documented incidents. The reports were not numbered or logged in a way to account for all reports.	F 492	The facility will operate and provide services in compliance with all applicable federal, state, and local laws, regulations, and codes. All Incident Reports have been numbered and logged. Incident Reports are brought to the daily morning meeting for review. All logging will be completed within 72 hours, and all Incident Report logs will be reviewed monthly in the QA meeting to identify trends for follow up and any further corrective action.	07/28/05

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F 492	Continued From page 26 During interview with the Director of Nurses on 6/14/05, she confirmed that the facility had not numbered their incident reports.	F 492		