STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

POC accepted 8-1-02 ETL

(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 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined that the facility was using side rails on 1 of 10 sampled residents without a current physicians order or proper assessment and care planning. Resident Identifier: 26 1. Resident 26 was admitted to the facility on 1/26/02 with diagnoses of chronic obstructive pulmonary disease, bronchitis, dementia with aggressive features, hypertension and diabetes. Observation of resident 26 on 7/2/02 at 4:30 PM, 5:20 PM and 5:50 PM then on 7/3/02 at 6:55 AM, 8:50 AM, 9:55 AM and 10:30 AM revealed him to be in bed resting with both side rails up. Review of resident 26's active medical record on 7/2/02, revealed no current doctor recertification order, no signed family consent form, no restraint evaluation, no bed entrapment assessment and no care plan that addressed the use of side rails. An interview with a facility floor nurse on 7/3/02 at 10:35 AM, revealed that no additional information concerning orders, consents, assessments or care plans could be provided. She stated that resident 26 uses the side rails for mobility. Further review of resident 26's care plans on 7/3/02, revealed no documentation that side rails were used for mobility.	F 221	The facility has physician orders for the use of side rails, of any type for resident 26, and all residents. It is the goal of Art City Nursing & Rehabilitation to remain restraint free. In the event that a resident is determined to need a restraint or the use of side rails, the restraint assessment form will be completed a recommendation will be made to the physician and orders given will be followed. When an order for side rails is given the Director of Nursing will complete the Entrapment Risk Assessment form. The Director of Nursing will report to the Quality Assurance Committee any findings. The Quality Assurance Committee will set into action any necessary steps to continue to ensure the protection of all residents at Art City Nursing & Rehabilitation Center. We Allege compliance August 21, 2002. All changes made to the plan of correction were done with the permission of the Administrator during a telephone conversation on 8-1-02.	8/21/02

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

C. Todd Brandt | Administrator | July 31, 2002

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
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 221	Continued From page 1	F 221	1. The March 2002 quarterly assessments for resident 1 was removed from the chart and placed into a "working file" by the nurse. The assessments have been returned to the patient chart. All nursing staff were in-serviced that no patient information is to be removed from the patient chart on July 25, 2002 and August 9, 2002. The Director of Nursing will monitor that assessments are done within the appropriate time frame and report to the Quality Assurance Committee. The Quality Assurance Committee will take appropriate action as necessary. We allege compliance August 21, 2002.	
F 276 SS=B	483.20(c) RESIDENT ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by HCFA not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility did not ensure that the active medical records for 6 of 10 sampled residents contained quarterly Minimum Data Set (MDS) assessments completed at least once every 3 months. Residents 1, 9, 17, 19, 26, and 29. Findings include: An interview was conducted with a RN (registered nurse) working at the facility on 7/3/02 . She stated that she had recently been doing MDS's for the facility and that she had taken some of them home to work on them. She stated she wasn't sure which resident's MDS's she had at home, but that she had left them at home, and forgot to bring them back to the facility today. 1. Resident 1 was admitted to the facility on 4/13/01 with diagnoses of total knee replacement, diabetes, hypertension, congestive heart failure, arthritis, rheumatoid arthritis, and depression. A complete review of resident 1's active medical record was done on 7/3/02. The medical record contained an annual MDS assessment dated 6/28/01, and a quarterly MDS dated 3/26/2002. A quarterly MDS should have been completed 6/2002. The active medical record did not contain any assessments that had been completed after 3/26/2002.	F 276	2. The nurse assigned to work on the MDS had removed the March 2002 quarterly assessments for resident 17 and placed it with the June 2, 2002 quarterly assessment and placed into a "working file." The assessments have been returned to the patient chart and all nursing staff were in-serviced that no patient information is to be removed from the patient chart on July 25, 2002 and August 9, 2002. The Director of Nursing will monitor that assessments are done within the appropriate time frame and report to the Quality Assurance Committee. The Quality Assurance Committee will take appropriate action as necessary. We allege compliance August 21, 2002. 3. The nurse assigned to work on the MDS had removed the March 2002 quarterly assessments for resident 19 and placed it with the June 2, 2002 quarterly assessment into a "working file." The assessments have been returned to the patient chart and all nursing staff were in-serviced that no patient information is to be removed from the patient chart on July 25, 2002 and August 9, 2002. The Director of Nursing will monitor that assessments are done within the appropriate time frame and report to the Quality Assurance Committee. The Quality Assurance Committee will take appropriate action as necessary. We allege compliance August 21, 2002. CONT.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 276	Continued From page 2 2. Resident 17 was admitted to the facility on 11/30/96 with diagnoses of colitis, hypertension, polio, insomnia, and major recurrent depression. A complete review of resident 17's active medical record was done on 7/2/02. The medical record contained an annual MDS assessment dated 12/6/01. A quarterly MDS should have been completed 3/2002, and 6/2002. The active medical record did not contain any assessments that had been completed after 12/6/01. 3. Resident 19 was admitted to the facility 8/28/79. The most recent MDS in his medical record was dated 12/6/01. Two MDSs should have been completed and stored in the medical record for resident 19 since the one completed 12/6/01. 4. Resident 9 was admitted to the facility 12/1/98 with diagnoses of pneumonia, arthopathies, hypothyroidism, congestive heart failure, hypertension, esophageal reflux, urinary tract infection and hysterectomy. A complete review of resident 9's active medical record was done on 7/2/02. The medical record contained six quarterly MDS's dated 6/8/00, 9/8/00, 3/25/01, 6/22/01, 1/29/02 and 4/30/02 and one annual MDS dated 12/23/00. A quarterly MDS should have been completed on or around 9/22/02. 5. Resident 26 was admitted to the facility on 1/26/02 with diagnoses of chronic obstructive pulmonary disease, bronchitis, dementia with aggressive features, hypertension and diabetes. A complete review of resident 26's active medical record was done on 7/2/02. The medical record contained an admission MDS dated 2/8/02. A	F 276	4. The nurse completed a change of condition MDS on July 31, 2001 and submitted to the state via electronic submission. The assessment was printed from the computer and placed into the chart. The October 2002 quarterly assessment was completed and submitted to the state via electronic submission and has been placed in the chart. The Director of Nursing will monitor resident #9 and all residents to make certain that all required MDS assessments are done within the appropriate time frames. The Director of Nursing will report to the Quality Assurance Team. The Quality Assurance Committee will take appropriate action as necessary. We allege compliance August 21, 2002. 5. The nurse assigned to work on the MDS had removed the quarterly assessments for residents 26 dated May 28, 2002 and placed it into a "working file." The assessment has been returned to the patient chart and all nursing staff were in-serviced that no patient information is to be removed from the patient chart on July 25, 2002 and August 9, 2002. The Director of Nursing will monitor that assessments are done within the appropriate time and report to the Quality Assurance Team. The Quality Assurance Committee will take appropriate action as necessary. We allege compliance August 21, 2002. 6. The nurse assigned to work on the MDS had the quarterly assessments for residents 29, removed the March 2002 and June 26, 2002 quarterly assessment from the chart and placed into a "working file." The assessments have been returned to the patient chart and all nursing staff were in-serviced that no patient information is to be removed from the patient chart on July 25, 2002 and August 9, 2002. The Director of Nursing will monitor that assessments are done within the appropriate time frame and report to the Quality Assurance Committee. The Quality Assurance Committee will take appropriate action as necessary. We allege compliance August 21, 2002	

Medical records will monitor compliance monthly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 276	Continued From page 3 quarterly MDS should have been completed on or around 5/8/02. 6. Resident 29 was admitted to the facility on 12/13/01 with diagnoses of fractured hip, hypertension, severe headaches, arthritis and anxiety. A complete review of resident 29's active medical record was done on 7/2/02. The medical record contained an admission MDS dated 12/26/01 and one quarterly dated 4/11/02. Two quarterly MDS should have been completed on or around 3/26/02 and 6/26/02.	F 276		
F 281 SS=E	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 the facility did not provide services that met professional standards of quality in the area of medication administration for 6 of 34 residents at the facility. The facility nurse did not refer to the medication administration book on 6 of the 6 residents. On 1 of 6 residents the medication administration book was not on the medication cart. Resident identifiers: 3, 17, 19, 23, 27 and 28. Observation of the facility nurse during the morning medication pass on 7/2/02 revealed the following: 1. At 7:20 AM, the facility nurse was observed to administer the following medications to resident 23 without referring to the medication schedule valproic 10cc, Seroquel 75 mg, calcium 650 mg, and prevacid 30 mg. The surveyor had to ask the facility nurse to	F 281	An in-service was held with the licensed nurses on August 9, 2002. Instruction was given on proper administration of medication. The Director of nursing will monitor each nurse administer one medication pass for residents 3, 17, 19, 23, 27 and 28 to assure that the nurse refers to the Medical Administration Record prior to administering any medication to a resident and instruct any nurse should any problem be noted. The Director of nursing will further report to the Quality Assurance Team any errors or incorrect procedures performed by the nurse. The Quality Assurance Committee will take appropriate action if necessary. We allege compliance August 21, 2002. The Don will monitor compliance periodically, but at least every 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 281	Continued From page 4 open the medication administration book. The facility nurse did not initial the line indicating she administered the medication. 2. At 7:30 AM, the facility nurse was observed to administer the following medications to resident 19 without referring to the medication schedule metamucil 15 ml, potassium 10 meq, furosemide 80 mg, daily vitamin 1 tab, plavix 75 mg, singular 10 mg, celebrex 200 mg, spironolactone 25 mg, foltx 2 mg, Paxil 20 mg, and Tylenol 1000 mg. The surveyor had to ask the facility nurse to open the medication administration book. The facility nurse did not initial the line indicating she administered the medication. 3. At 7:35 AM, the facility nurse was observed to administer the following medications to resident 28 without referring to the medication schedule Lasix 40 mg and potassium 20 meq. The surveyor had to ask the facility nurse to open the medication administration book. The facility nurse did not initial the line indicating she administered the medication. 4. At 7:38 AM, the facility nurse was observed to administer the following medications to resident 17 without referring to the medication schedule Levothroid 0.05 mg, Zoloft 100 mg, ranitidine 300 mg, Tylenol 650 mg, DSS (colace) 250 mg and milk of magnesium 15 cc. The surveyor had to ask the facility nurse to open the medication administration book. The facility nurse did not initial the line indicating she administered the medication. 5. At 7:40 AM, the facility nurse was observed to administer the following medications to resident 3 without referring to the medication schedule vitamin E 800 iu, Zestril 10 mg, Clozaril 100 mg, Levothroid 0.2 mg, glucotrol 10 mg, fluoxetine HCL 20 mg, premarin 0.625/5mg and plavix 75 mg. The surveyor had to ask	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 281	Continued From page 5 the facility nurse to open the medication administration book. The facility nurse did not initial the line indicating she administered the medication. 6. At 7:45 AM, the facility nurse was observed to administer the following medications to resident 27 without referring to the medication schedule vitamin E 800 iu, singular 10 mg, avandia 2 mg, prevacid 30 mg, fluoxetine 40 mg, hydrocodone 5/500 mg and Zestril 5 mg. The surveyor had to ask the facility nurse to open the medication administration book, which was not on the medication cart the facility nurse had to obtain it from the nurse's desk The facility nurse did not initial the line indicating she administered the medication. During an interview with the administrator on 7/2/02, he stated they had just done an in service about referring to the medication administration book while administering medications. Rosdahl's Textbook of Basic Nursing, 7th edition: "Check the medication order with the medication administration record (MAR). Make certain that the MAR and physician's orders are identical...." p. 746. "...5. Proceed from the top to bottom of the MAR when preparing medications. 6...Compare the label to the medication order on the MAR...7. Recheck each medication with the MAR. 8. When you have prepared all medications, compare each one again to the medication order..."p.752 "Record medication administration on the appropriate form: Sign after you have given the medication..." p.753.	F 281	Art City Nursing & Rehabilitation has hired a new company to consult for our Dietary Supervisor. The new Registered Dietician completed an audit of all patients charts including a nutritional assessments, weight, skin integrity and laboratory tests on July 8th and 9th, recommendations were given to the physician, who reviewed and gave orders according to his knowledge of the patients on July 11, 2002. All new orders were followed and any recommendation not followed by the physician were reported to the Registered Dietician who discussed the recommendations with the nurse and physician and appropriate interventions have been made. Art City Nursing & Rehabilitation has further adopted new dietary Policy & Procedure for the Dietary Department. The Dietary Supervisor attended an in-service held by the Registered Dietician on July 12, 2002. The Registered Dietician has further held in-services with the administrator on July 12, 2002. Another Dietary Supervisor in-service was given August 5, 2002 with the Registered Dietician. The Dietary Supervisor has also spent the month of July becoming familiar with the new Policy & Procedures. The Registered Dietician will continue to make recommendations and follow-up with the dietary supervisor within three days of consultant visit to assure follow-through with recommendations from the dietary supervisor and the physician and make further recommendations as necessary, The Registered Dietician gives a written report to the administrator the ability of the dietary and nursing department to follow through with recommendations and physician orders after each visit. The Administrator and Dietary Supervisor report to the Quality Assurance Team all findings related to patients who have had weight loss or gain outside established parameters. We allege compliance August 21, 2002.	
F 325 SS=H	483.25(i)(1) QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as	F 325	8/1/02 Cont.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by 3 of 10 sampled residents experienced significant weight loss with either no dietary interventions or inadequate dietary interventions implemented to prevent further weight decline. Resident identifiers: 9, 26 and 29. An additional 2 residents (16, 17) had laboratory values reflecting malnutrition and were not adequately assessed by the facility's dietitian. 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 Clinical Dietetics, American Dietetic Association, 6th edition, 2000). Findings include: 1. Resident 9, a 92 year- old female, was admitted to the facility on 12/01/98 with diagnoses of pneumonia, arthopathies, hypothyroidism, congestive heart failure, hypertension, esophageal reflux, urinary tract infection, hysterectomy. A review of resident 9 weight revealed the following: December 2001 153 lbs. (Pounds) January 2002 No weight documented February 2002 147 lbs.	F 325	The facility will assure the protection of resident 9, 26, 29, 16, 17 and all residents by review of weight loss and gain in the bi-monthly skin and weight meeting. The Registered Dietician will review lab values ordered by the physician and calculate protein parameters. The Registered Dietician will include these calculations in the assessments they perform. The assessments are reviewed by the Dietary Supervisor and reported to the Director of Nursing. Any recommendations will be relayed to the physician who will give orders according to their knowledge of the patient and all orders will be followed. The Dietary Supervisor and Director of Nursing will report to the Quality Assurance Committee any irregularities and appropriate action will be taken. We allege compliance August 21, 2002. The Dietary Supervisor will assure that recommendations for laboratory tests made by the Registered are given to the Director of Nursing and the recommendations are further given to the physician. The physician will give orders appropriate to their understanding of the patient. The recommendations made by the Registered Dietician will be acted upon within 72 hours of being given. The Dietary Supervisor will report to the Quality Assurance Committee and appropriate actions will be taken to ensure the nutritional needs are met for residents 9, 26, 29, 16, 17 and all residents. We allege compliance August 21, 2002. See attached Policy & Procedures with assessment forms. At the end of the 2567L.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 March 2002 138 lbs Between the months of December and March resident 9 lost 15 lbs. (9.8%) which was significant. A lab (laboratory) value taken at the facility and dated 7/3/01 showed an albumin (protein) level of 2.7. The normal reference range, according to the lab used by the facility, was 3.3- 4.8 g/dl. An albumin level of less than 2.4 g/dl is considered a severe visceral protein deficit, an albumin level of 2.4- 2.9 g/dl is considered a moderate visceral protein deficit and an albumin level of 3.0- 3.5 g/dl is considered a mild visceral protein deficit. (Reference guidance: Manual of Clinical dietetics, American Dietetic Association, 6th edition, 2000, page 22). The albumin of 2.7g/dl dated 7/3/01 was the most current in resident 9's medical record and was acknowledged by the RD (registered dietitian) on her yearly Nutritional Assessment and Care Plan dated 11/6/01. A review of resident 9's medical record dietary notes revealed that no RD assessment addressing the weight loss had been completed for resident 9. Resident 9 had a nutritional assessment and care plan completed on 11/20/00. The dietitian recommended a regular diet with one ounce of extra protein to address an albumin level of 2.8 g/dl. The nutritional assessment and care plan dated 11/6/01, documented a 2.7 g/dl albumin which was a decrease from the previous year. The assessment also documented a healing DQ (pressure sore). The RD's documented goals for resident 9 were to continue with 1 ounce of extra protein TID, eat 75-100% at each meal and no weight loss or gain greater than 5 lbs/30days. The dietitian had not calculated an estimation of protein requirements for resident 9 although her most recent albumin reflected malnutrition. Which had worsened	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 during the previous months despite the "one ounce of extra protein." Without a calculation of protein requirements, it would not be possible for facility staff to know whether or not the diet would meet the protein needs of this resident. On 2/4/02 the RD, DON (director of nursing) and FSS (food service supervisor) documented on their Weight/Skin Condition Review that resident 9 had a weight of 147 a 5 lb weight change, regular diet and the weight loss is desirable. On 3/5/02 the weight skin team documented "138 lbs decrease 9 [pounds]/30 days. The loss may be related to the edema." A care plan could not be found in resident 9's clinical record or provided by the facility addressing a desired weight loss program. On 3/5/02 the FSS documented the following, "wt 138 lbs (97-115) [decrease] 9/30 days. The loss may be related to edema to intake 70-80%..." Review of resident 9's diet card on 7/3/02, revealed she was on a regular diet/cut meats/1 ounce extra protein. It did not indicate that resident 9 was on any desired weight loss program. In an interview with the FSS on 7/3/02 she stated they add extra protein to the diet by using eggs, meat and nestle additions. She stated there is no program in place providing follow up to dietary interventions. On 7/3/02 resident 9's breakfast and lunch were observed. For breakfast resident 9 was served 1 muffin, fruit, hot cereal with one ounce of nestle additions added to it, orange juice, hot chocolate and milk. Resident 9 was observed to eat 100% of the hot cereal, 100% of the fruit, 200 cc of the hot chocolate and 180 cc of milk. Resident 9 was not served eggs like the other resident were served that day.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 resident 9 was receiving adequate protein for her needs. The RD did not identify or address the significant weight loss. Staff did not identify or acknowledge during the months of significant weight loss, nursing staff was documenting that resident 9 had no edema. 2. Resident 26, a 76 year- old male, was admitted to the facility on 1/26/02 with diagnoses of chronic obstructive pulmonary disease, bronchitis, dementia with aggressive features, hypertension, heart/renal disease, malignant, no congestive heart failure or renal failure and diabetes. A review of resident 26's weights revealed the following: February 11, 2002 162 lbs. (Pounds) March 11, 2002 155 lbs April, 8, 2002 148 lbs. May 13, 2002 148 lbs Between February 11, 2002 and May 13, 2002 resident 26 lost 14 lbs. (8.6%) which is significant. A lab (laboratory) value taken at the facility and dated 6/6/02 showed an albumin (protein) level of 3.0. A review of resident 26's medical record dietary notes revealed that no RD assessment addressing the weight loss had been completed for resident 26. A nutritional assessment and care plan for resident 26 was completed on 1/29/02. The dietitian recommended a reduced concentrated sweet diet. The RD's documented goals for resident 26 were "eat 75-100% at each meal, will drink adequate fluids (at least 1500 cc) and monthly wts."	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 On 2/5/02, the RD documented on her weekly notes ..."[decrease] 3 lbs/1 week. His appetite seems to be improving." On 3/3/02 the FSS documented the following on resident 26's dietary progress notes, "wt 154 [decrease] 3 lbs in 2 weeks...leaves dining room if he isn't served right away." On 3/5/02 the RD documented on her weekly notes, "...[decrease] 2/1 week." On 5/25/02 the FSS documented the following on resident 26's dietary progress notes, "wt 150 [decrease] 4 lbs in 60 days [decrease] 15 lbs in 4 months this is way to much will SF (sugar free) instant breakfast TID to promote less wt loss." On 5/28/02 the RD, and FSS (food service supervisor) documented on their Weight/Skin Condition Review that resident 26 had a weight of "145 a 15 lb weight change, [decrease] 15 # in 4 months this is way to much, give SF (sugar free) instant breakfast TID." On 6/6/02 resident 26's physician wrote the following order, "D/T (due to) lack of appetite SF instant breakfast QAM (every morning)." Review of resident 26's diet card on 7/3/02, revealed he was on a regular reduced concentrated sweets diet and he was to have SF instant breakfast TID. On 7/3/02 resident 26's breakfast and lunch were observed. For breakfast resident 26 was served eggs with salsa, fruit, hot cereal, toast, water, coffee, milk and 120 cc health shake (no sugar added). Resident 26 was observed to eat 100% of the eggs and salsa, 100 % of the fruit, 240 cc coffee, 180 cc of the milk and 120 cc of the health shake. For lunch resident 26 was	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 served meat with gravy, green beans, cheesy potatoes, salsa, pie, milk, pink supplement in a glass, orange punch. Resident 26 was observed to eat 100% of the meat and gravy, 100% of the cheesy potatoes, 100% of the salsa, 100% of the pie and 100% of the pink supplement. A review of resident 26's care plan dated 1/26/02 and updated 2/18/02 and 5/28/02, documented the following approaches, "1. Diet as ordered. 2. Assist resident as needed. 3. Monitor and record intake. 4. Monitor and record weight." Further review of resident 26's care plans revealed a 2nd care plan addressing nutrition dated 2/8/02, it documented the following approaches, "Diet as ordered by MD. Document % (percentage) eaten on ADL form every meal. Monitor if < (less than) 50% average every day. Weight every week- document on VS (vital sign) form." A review of resident 26's Nursing Monthly Summary dated 2/17/02 documented, "Appetite- poor-fair, Skin Condition- red, scaley areas on face. Intact, fair turgor, Edema- +(plus) one [lower] extremities." A review of resident 26's Nursing Monthly Summary dated 3/17/02 documented, "Appetite- fair, Skin condition- reddened scaley areas, Edema- dependent edema face, arms and hands." A review of resident 26's Nursing Monthly Summary dated 4/17/02 documented, "Appetite- fair-good, Skin condition- intact- same reddened areas, Edema- dependent edema, face, arm, hand." A review of resident 26's Nursing Monthly Summary dated 5/17/02 documented, "Appetite- usually good, Skin condition- clean, dry, intact, Edema- 0 (none)	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 noted." A review of resident 26's Nursing Monthly Summary dated 6/16/02 documented, "Appetite- fair, Skin condition- [left] foot DQ, otherwise intact, Edema- bilat (bilateral) le's (lower extremities) 3+ - 4+." A review of resident 26's ADL (activities of daily living) sheet from 2/11/02to 5/13/02 revealed resident 26 consumed less than 75% of his meals 101 times out of 276 meals. The RD did not follow up on her goal for resident 26 to ensure he was eating 75-100% at each meal. Dietary staff did not make dietary recommendations to change the diet of resident 26 until 5/25/02, almost two weeks after resident 26 suffered significant weight loss. The RD did not calculate protein requirements for resident 26 to address the mild visceral protein depletion to ensure that his diet met his protein needs. 3. Resident 29, a 72 year- old female, was admitted to the facility on 12/13/01 with diagnoses of fractured hip, hypertension, severe headaches, arthritis and anxiety. A review of resident 29 weight revealed the following: January 2002 144 lbs. (Pounds) February 2002 133 lbs. Between the months of January and February resident 29 lost 11 lbs. (7.6%) which was significant. A lab (laboratory) value taken at the facility and dated 3/21/02 showed an albumin (protein) level of 3.2. A review of the dietary notes revealed that no RD (registered dietitian) assessment addressing the weight loss had been completed for resident 29.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 On 1/14/02 the RD and FSS (food service supervisor) documented on their Weight/Skin Condition Review that resident 29 had an "11 lb weight change, weights are done weekly, regular diet and they recommended supplement TID (three times a day) [with] meals." No documentation could be found in the clinical record or provided by the facility that resident 29 had weekly weights or was receiving supplements TID with meals as recommended by the weight skin team. On 1/30/02 the FSS documented the following, "Reg (regular) diet wt (weight) 133 11 # (pounds) wt loss 2 weeks asked for diet order for supplement with meals TID intake 50-75%... Continue to monitor intake & (and) wt weekly." 1. The FSS did not document any further progress notes until 4/11/02, 71 days after she initially identified weight loss issues. 2. Review of resident 29's clinical medical record revealed only monthly weights. 3. Review of resident 29's clinical medical record revealed no order for a TID supplement. 4. Review of resident 29's diet card revealed she was on a mech (mechanical) soft diet. The card did not indicate resident 29 was to receive TID supplements. In an interview with the FSS on 7/3/02 she stated that all of her dietary recommendation are looked at by the dietitian who comes into the facility weekly. A review of resident 29's care plan dated 12/13/01 and updated 1/9/02 and 4/4/02, documented the following approaches, "1. Diet as ordered. 2. Monitor and record intake. 3. Monitor and record wt. 4. Monitor for edema." A review of resident 29's Nursing Monthly Summary dated 1/11/02 documented, "Appetite- good, Edema- 0	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 (none)." A review of resident 29's Nursing Monthly Summary dated 2/11/02 documented, "Appetite- fair, Edema- 0 (none)." A review of resident 29's Nurse's Notes dated 1/11/02-2/11/02 documented that resident 29's appetite was fair 4 times and good 9 times. A review of resident 29's ADL (activities of daily living) sheet from 1/11/02- 2/11/02 revealed resident 29 consumed 100% of 72 out of 96 meals. The facility's policy and procedures for Residents at Nutritional Risk was reviewed on 7/3/02. It was documented in the policy that "Any resident identified as being at nutritional risk will have a problem of 'Alteration in Nutrition' identified on the care plan and the physician will be informed and a Dietary consultation requested." "The following criteria will be used to help identify nutritionally at risk residents:... 6. Undesirable weight loss or gain of 3 lbs (under 100 lbs) and 5 lbs (over 100 lbs) or more in one month..." It was documented in the procedures that: "1. Identify any resident at nutritional risk using Policy for resident at Risk. 2. Nursing will enter date, room, name and brief description of problem on Dietitian Referral form that is kept at the nurses station. 3. Dietitian will date and initial same form when resident has been reviewed. 4. When making a recommendation, the Dietitian will enter recommendation in the clinical record and fill our Dietary Recommendation Sheet.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 5. Dietary Recommendation Sheet will be given to the Charge Nurse. 6. Nursing will review recommendation and follow through as appropriate." In an interview with a facility charge nurse on 7/3/02, she stated she had never seen the Dietitian Referral for Resident at Nutritional Risk Form nor had she seen the Dietary Recommendation Form. In an interview on 7/3/02 with the FSS she stated when she has a concern about a resident she calls the RD and she does not keep any documentation of those calls. She further stated she does not use the Dietitian Referral for Resident at Nutritional Risk Form. 4. Resident 16 was an 87 year old female who was admitted to the facility on 7/23/01 with the diagnoses of left detached retina, right false eye and dementia with delusions. The medical record of resident 16 was reviewed 7/1/01 through 7/3/02. A review of laboratory results revealed the following stages of mild to moderate visceral protein depletion: 8/2/01 - albumin 3.3g/dL 12/27/01 - albumin 2.9g/dL 1/23/02 - albumin 3.2g/dL 5/2/02 - albumin 2.8g/dL A review of the dietary notes in the record of resident 16 revealed that the facility's dietitian had not documented an entry in the resident's chart since the day after admission, 7/24/01. (All other entries had been performed by the food service supervisor.) The initial assessment of resident 16, performed by the registered dietitian on 7/24/01 did not include a calculation of the estimated protein requirements for	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 this resident. The dietitian documented that she would "review labs when done". This was not performed. On 10/2/01, the food service supervisor recommended "snack and supp (supplement) TID (three times daily)" to address concerns regarding weight loss for resident 16. On 11/5/01, the food service supervisor noted that resident 16 "will drink supplements 50% of the time with meals refuses entirely to drink 2 Cal with med pass..." There was no documentation that the dietitian was aware of this situation or made suggestions to improve the nutritional status of resident 16. It would not be possible for the staff to know whether or not the diet and the supplement for resident 16 would meet her needs since her protein requirements had not been calculated. 5. Resident 17 was an 87 year old female who was admitted to the facility on 11/30/96 with the diagnoses of colitis, hypertension, a history of polio, insomnia, major recurrent depression and a urinary tract infection. The medical record for resident 17 was reviewed 7/1/02 through 7/3/02. The most current albumin level for resident 17, dated 11/22/01, was 2.7g/dL which reflected moderate visceral protein depletion. On 12/11/01, the facility dietitian performed a nutritional assessment and documented the following as her "goals and plans" for resident 17: "1. Get a lab to check alb (albumin)." "2. Cont (continue) suppl (supplement) - still under	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 IWR (ideal weight range)". "3. Encourage and assist as needed." "4. Monthly wts (weights)". There was no documentation to evidence that staff obtained an albumin as requested by the dietitian on 12/11/01. On 12/31/01, the food service supervisor documented in the dietary notes that resident 17 "refuses supplements, doesn't like them." On 5/28/02, the food service supervisor notes that resident 17 has been drinking Ensure (another type of supplement). There was no documentation to evidence that the facility dietitian was aware of the change in the type of supplement being given to resident 17. Until 5/28/02, there was no documentation to evidence that alternative methods of dietary supplement had been attempted to increase the nutritional status of resident 17. There was no documentation to evidence that the facility's dietitian had calculated an estimation of the protein requirements for resident 17. Without this calculation, staff would not know whether or not the diet, supplement or other intake would meet the protein needs for resident 17.	F 325	The food in the kitchen will be stored, prepared and served in a sanitary manner. Kitchen personnel were in-serviced on 7-25-02 and August 9, 2002, on the proper labeling and dating of all food stored in the kitchen area, both inside the fridge, freezer and outside. The dietary supervisor will continue to in-service all dietary personnel upon hire and at in-services where a problem is identified. The Dietary Department will hold regular monthly in-services with dietary personnel to continue to assure understanding and knowledge related to the performance of their job. The Dietary Supervisor will report to the Quality Assurance Team any discrepancies or non-compliance by any employee. The dietary supervisor has also removed all utensils that were in need of replacement and reported to the Administrator upon replacement of utensils. The registered dietician met with the administrator and dietary supervisor and in-serviced on the proper chilling of potato salad for distribution at any outside event such as the barbecue held during survey. The Dietary Supervisor will test food temperatures and report to the Quality Assurance Committee any problems. Any food not stored, prepared or distributed in the proper manner will be reported, reviewed and corrections made as necessary, to and by the Quality Assurance Committee. We allege compliance August 21, 2002. Food temperatures will be tested daily.	
F 371 SS=D	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 observations in the kitchen, and checking food temperatures, it was determined that the facility did not store, prepare, distribute and serve food under	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 19 sanitary conditions, as evidenced by: 1. Food was not properly labeled and dated. 2. The facility served potato salad which contained mayonnaise (salad dressing) at an improper temperature. 3. The facility was using utensils which were worn and needed replacement. Findings include: The refrigerator/freezer located upstairs in the cooking area, near the 3 compartment sink contained: - cheese slices which were not dated. - meat patties in the freezer side which were not labeled, and not dated. The large refrigerator, upstairs, in the tray line area contained: - grapes that were not dated. - watermelon and cantaloupe (individual resident's) that were not dated. - Mighty shakes which were not dated. These shakes should be dated the day they are taken out to thaw. - hot dogs which which were not dated. - hash browns which were not dated. The utensil drawer contained: - 2 rubber spatulas which were worn and in need of replacement. On 7/2/02 at 1:00 PM, the facility provided the residents with an outside barbecue, which included potato salad. The food temperatures were taken on a test tray, and the potato salad temperature was 62 degrees. Cold foods must be maintained at a temperature of 45 degrees or below.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 426	Continued From page 20	F 426		
F 426 SS=E	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 review of medical records during the annual recertification survey from 7/1/02 through 7/3/02, it was determined that 4 of the 10 residents on the sample were insulin dependent diabetics. For 3 of those 4 diabetic residents (1, 21 and 26), the facility did not ensure that pharmaceutical services, including procedures to assure the accurate dispensing and administering of all drugs, were met. One of the diabetic residents (1) also did not receive antibiotics as ordered by the physician to treat an infection. Findings include: 1. Resident 1 was admitted to the facility on 4/3/01 with diagnoses of total knee replacement, diabetes, hypertension, congestive heart failure, arthritis, rheumatoid arthritis, and depression. Resident 1's medical record was reviewed on 7/2/02 and 7/3/02. Resident 1 was seen by the facility physician on 2/19/02. The physician ordered a UA (urinalysis), and culture if indicated. The results of the the UA report, dated 2/31/02, was signed off by facility nurse. The results showed 4+ bacteria, positive for nitrites, and large amount of leukocytes, indicating that the resident had a urinary tract infection. There was an order for resident 1 to start on Levaquin (an antibiotic), on 2/26/02. The order read: "Levaquin 250 mg every day for 5 days for urinary tract infection." Resident 1's MAR	F 426	Resident 1, 21, 26 will be cared for as outlined in the policy and procedure manual, as will all other residents with a similar diagnosis. The facility policy states "medications shall be administered as prescribed by the attending physician." The licensed nurses were in-serviced on August 9, 2002 that the dosage of insulin to be administered on a sliding scale is based on the blood glucose reading, as outlined in the physician order, as follows: $\geq$ 150 = 3 units of regular insulin; $\geq$ 200 = 6 units of regular insulin; $\geq$ 250 = 8 units of regular insulin; $\geq$ 300 = 10 units of regular insulin; $\geq$ 350 = 15 units of insulin. The Director of Nursing conducted the in-service with all of the licensed nurses. The nurses understand that they are to administer regular insulin according to the scale outlined by the physician. The Director of Nursing will monitor all residents receiving regular insulin on a sliding scale on a weekly basis for August and September and report to the Quality Assurance Committee the results of the findings. After September 2002, if there are no errors noted the Director of Nursing will review the medications of residents receiving regular insulin on a monthly basis and report to the Quality Assurance Committee in the quarterly meeting. If no errors are noted then the Director of Nursing will monitor on a quarterly basis and report to the Quality Assurance Committee. If errors are noted a medication error form will be filled out and the physician will be notified. The source of the error will be identified and appropriate action will be taken to assure that no further errors occur. We allege compliance August 21, 2002.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 426	Continued From page 21 (medication administration record) for February 2002 was reviewed. Resident 1 received the ordered Levaquin for 3 days, and not the full 5 days as ordered. She received the medication on 2/26, 2/27, and 2/28. There was no documentation in the nurses notes as to why the medication was discontinued two days early. Resident 1's diabetic record, and MAR was reviewed on 7/2/02, and 7/3/02. There were two days in the month of June 2002, that resident 1 did not receive her sliding scale insulin as ordered. A physician's recertification orders for June 2002, stated to monitor residents blood glucose level by finger stick two times a day, and to administer SS (sliding scale) regular insulin for resident as follows: BS (blood sugar) greater than 150 give 2 units regular sliding scale insulin. BS greater than 200 give 3 units regular sliding scale insulin. BS greater than 250 give 4 units regular sliding scale insulin. BS greater than 300 give 6 units regular sliding scale insulin. Glucose below 70 or greater than 350 call Doctor for orders. On 6/2/02, resident 1's AM glucose prior to breakfast was 157. Resident 1 should have received 2 units of SS regular insulin. There was no documentation to show that resident 1 received any insulin. On 6/20/02, resident 1's PM glucose prior to dinner was 152. Resident 1 should have received 2 units of SS regular insulin. There was no documentation to show that resident 1 received any insulin. 2. Resident 21 was admitted to the facility on	F 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 426	Continued From page 22 12/17/01 with diagnoses of diabetes, cerebral vascular accident, dementia, pneumonia, hiatal hernia depression, hip fracture, congestive heart failure, and pneumonia. Resident 21's medical record was reviewed over the course of 3 days, 7/1/02, 7/2/02, and 7/3/02. Resident 21's diabetic record and MAR were reviewed for the months of May and June 2002. A physician's recertification order for June 2002, stated that blood glucose levels should be checked 4 times a day, and that "Humalog sliding scale sub Q (subcutaneous) QID (four times a day) one unit per 25 points over 200." On 5/1/02 at lunchtime, resident 21 had a BS of 279. Resident 21 received no regular SS insulin, but should have received 3 units. On 5/4/02 at lunchtime, resident 21 had a BS of 240. Resident 21 received no regular SS insulin, but should have received 1 unit. On 5/10/02 at lunchtime, resident 21 had a BS of 295. Resident 21 received 4 units of regular SS insulin, but should have received 3 units. On 5/10/02 at dinnertime, resident 21 had a BS of 270. Resident 21 received 4 units of regular SS insulin, but should have received 2 units. On 5/11/02 at dinnertime, resident 21 had a BS of 245. Resident 21 received 4 units of regular SS insulin, but should have received 1 unit. On 5/28/02 at dinnertime, resident 21 had a BS of 227. Resident 21 received no SS insulin, but should have received 1 unit.	F 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 426	Continued From page 23 On 5/28/02 at HS, resident 21 had a BS of 156. Resident 1 received 21 unit of SS insulin, but should have received no insulin. On 6/4/02, at lunchtime, resident 21 had a BS of 246. Resident 21 received 2 units of SS insulin, but should have received only 1 units of insulin. On 6/7/02, at HS, resident 21 had a BS of 219. Resident 21 received 1 unit of SS insulin, but should have received no insulin. On 6/14/02, at HS, resident 21 had a BS of 272. Resident 21 received no SS insulin, but should have received 2 units. On 6/17/02, at lunchtime, resident 21 had a BS of 230. Resident 21 received no SS insulin, but should have received 1 unit. On 6/24/02, at HS, resident 21 had a BS of 243. Resident 21 received no SS insulin, but should have received 1 unit. On 6/28/02, at HS, resident 21 had a BS of 248. Resident 21 received 2 units SS insulin, but should have received 1 unit. On 6/29/02, at HS, resident 21 had a BS of 220. Resident 21 received 1 unit of SS insulin, but should have received no insulin. On 6/30/02, at lunchtime, resident 21 had a BS of 214. Resident 21 received 1 unit of SS insulin, but should have received no insulin. 3. Resident 26 was admitted to the facility on 1/26/02, with diagnoses which include chronic obstructive	F 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 426	Continued From page 24 airway disease, bronchitis, acute dementia with aggressive features, hypertension, heart and renal disease, and diabetes. Resident 26's medical record was reviewed on 7/1/02, 7/2/02, and 7/3/02. The physicians order for resident 26's sliding scale insulin was as follows: Blood glucose level 150-200 give 2 units SS regular insulin. Blood glucose level 201-250 give 4 units SS regular insulin. Blood glucose level 251-300 give 6 units SS regular insulin. Blood glucose level 301-450 give 10 units SS regular insulin. Blood glucose level greater than 450, give 12 units SS regular insulin. Resident 26's MAR was reviewed for April, May and June 2002. On the following days, there was no documentation to show that resident 26's blood glucose levels were checked. On 6/2/02 at HS On 6/13/02 at dinnertime On 6/18/02 at HS On 6/25/02 at HS On 5/22/02 at lunchtime On 5/24/02 at lunchtime On 5/28/02 at lunchtime No insulin was given on the following dates and times for resident 26. On 6/3/02, at HS, resident 26's glucose was 181.	F 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 426	Continued From page 25 Facility nurses should have provided 2 units of regular insulin, but instead gave none. On 6/23/02 at lunchtime, resident 26's glucose was 163. Facility nurses should have provided 2 units of regular insulin, but instead gave none. On 5/2/02, at HS, resident 26's glucose level was 162. Facility nurses should have provided 2 units of regular insulin, but instead gave none. On 5/4/02, at breakfast, resident 26's glucose level was 166. Facility nurses should have provided 2 units of regular insulin, but instead gave none. On 5/5/02, at dinnertime, resident 26's glucose level was 161. Facility nurses should have provided 2 units of regular insulin, but instead gave none. On 5/11/02, at dinnertime, resident 26's glucose level was 170. Facility nurses should have provided 2 units of regular insulin, but instead gave none. On 5/13/02, at dinnertime, resident 26's glucose level was 187. Facility nurses should have provided 2 units of regular insulin, but instead gave none. On 5/16/02 at dinnertime, resident 26's glucose level was 185. Facility nurses should have provided 2 units of regular insulin, but instead gave none. On 5/23/02 at lunchtime, resident 26's glucose level was 159. Facility nurses should have provided 2 units of regular insulin, but instead gave none. On 5/25/02 at dinnertime, resident 26's glucose level was 153. Facility nurses should have provided 2 units of regular insulin, but instead gave none.	F 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 426	Continued From page 26 On 4/4/02 at HS, resident 26's glucose level was 260. Facility nurses should have provided 6 units of regular insulin, but instead gave none. On 4/27/02 at dinnertime, resident 26's glucose level was 219. Facility nurses should have provided 4 units of regular insulin, but instead gave none. The wrong insulin dose was given to resident 26 on the following dates at times: On 5/11/02 at lunchtime, resident 26 had a blood glucose level of 204. Resident 26 received 2 units of regular sliding scale insulin, but should have received 4 units. On 5/12/02 at dinnertime, resident 26 had a blood glucose level of 226. Resident 26 received 2 units of regular sliding scale insulin, but should have received 4 units. On 5/17/02 at dinnertime, resident 26 had a blood glucose level of 141. Resident 26 received 2 units of regular sliding scale insulin, but should not have received any insulin. On 4/7/02 at breakfast, resident 26 had a blood glucose level of 198. Resident 26 received no insulin, and should have received 2 units. On 4/9/02 at lunchtime, resident 26 had a blood glucose level of 252. Resident 26 received 4 units of regular sliding scale insulin, but should have received 6 units. On 4/10/02 at breakfast, resident 26 had a blood glucose level of 221. Resident 26 received no insulin, and should have received 4 units.	F 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 426	Continued From page 27 On 4/13/02 at dinnertime, resident 26 had a blood glucose level of 146. Resident 26 received 2 units of regular sliding scale insulin but should have received no insulin.	F 426	Resident 9, 26 and 29 will be protected by the administrator as well as all patients at Art City Nursing & Rehabilitation in the following manner. The administrator has hired a new company to consult for our Dietary Department. The new Registered Dietician completed an audit of all patients charts on July 8th and 9th, has made recommendations to the physician which were reviewed and orders given by the physician, on July 11, 2002. All new orders were followed. Art City Nursing & Rehabilitation has further adopted new Dietary Policy & Procedure manuals and held an in-services with the Dietary Supervisor on July 12, 2002, The Registered Dietician gave this in-service. The Registered Dietician has further held in-services with the administrator on July 12, 2002. Another Dietary Supervisor in-service will be held on August 5, 2002 with the Registered Dietician who is contracted, to review patient charts, patient assessments, care planning and recommendations. Nutritional parameters will further be calculated by the Registered Dietician and reports will be given to the Administrator and Dietary Supervisor who will also consult with the Director of Nursing to assure the physician is notified and appropriate actions are taken as warranted. The Registered Dietician will further follow-up with the Dietary Supervisor within three days of consultant visit to assure follow-through with recommendations was completed. The Registered Dietician will inform the Administrator of any problems. The Administrator will then report to the Quality Assurance Team and appropriate action will be taken. If the physician does not follow the recommendations of the Registered Dietician the Registered Dietician will be notified and further recommendations will be made to the physician, as necessary. The Registered Dietician will report to the administrator the ability of the dietary and nursing department to follow through with recommendations and physician orders. (Cont).	
F 490 SS=H	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of resident medical records, facility policies and procedures, and Quality Assurance Committee meeting minutes during the annual survey from 7/1/02 through 7/3/02, it was determined that the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical well-being for each resident in the area of weight loss with nutritional assessment and intervention. The facility was found to be providing Sub-Standard Quality of Care (a pattern of actual harm) in this area. The facility was cited in a total of 10 areas, not including this deficiency. Findings include: 1. On July 3, 2002, a Standard Extended survey was completed which resulted in the determination of Sub-Standard Quality of Care. The determination of Sub-Standard Quality of Care was based on the lack of dietary assessment and intervention for 3 residents who had significant weight loss and laboratory values	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 490	Continued From page 28 reflecting malnutrition. [CFR 483.25 (i) Tag F - 325]. Weight loss/Nutritional Assessment and Intervention: Please see F - 325. A pattern of actual harm was identified for 3 residents (9, 26, 29) who experienced significant weight loss and whose laboratory values reflected malnutrition but did not receive adequate nutritional assessment or intervention. An additional 2 residents (16, 17) had laboratory values reflecting malnutrition and were not adequately assessed by the facility's dietitian. Resident 26 experienced an 8.6% unplanned weight loss in 3 months, from February 11, 2002 to May 13, 2002. This weight loss was not addressed until almost 2 weeks after it happened when on 5/25/02, the food service supervisor suggested adding a supplement to resident 26's diet. A complete metabolic panel was ordered by the physician for resident 26 on 6/6/02 and reflected an albumin level of 3.0g/dL. The laboratory the facility uses set the normal levels of an albumin at 3.3 to 4.8g/dL. The facility's dietitian had not calculated an estimation of protein required by resident 26 although he had experienced significant weight loss, his albumin level was below normal and the nurses monthly summary, dated 6/16/02, had referred to a pressure sore to the resident's left foot. Without a calculation of protein requirements, it would not be possible for facility staff to know whether or not the diet and supplements would meet the protein needs of this resident. Resident 9 experienced a 9.8% unplanned weight loss in 3 months, from December 2001 to March 2002. On 11/20/2000, the dietitian recommended a regular diet with one ounce of extra protein for resident 9 to address an albumin level of 2.8. Resident 9 continued to remain on this same diet although the most current	F 490	The Administrator and Dietary Supervisor report to the Quality Assurance Team all findings related to patients who have had weight loss or gain outside of established parameters, lab values that may be out of line and any tests that may not have been administered. A. The Administrator has met with nursing personnel and in-serviced that at no time shall any patient charting information be removed from the chart for any "working" reason. Reference Plan of Correction F-276. B. The necessary in-service and training have been given to licensed personnel and continued monitoring and reporting will occur. Reference Plan of Correction F-281. C. The administrator has delegated the responsibility of monitoring the licensed nursing personnel and reporting to the Director of Nursing any lack of professionalism and training to the Director of Nursing. The Director of Nursing will inform the Administrator of any problems and the Quality Assurance Team will assure compliance. Reference Plan of Correction F-282.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 490	Continued From page 29 albumin, dated 7/3/01, reflected a level of 2.7g/dL, a decrease from the previous year. No further dietary interventions were implemented to address either the abnormal albumin of 2.7 or the significant weight loss. The dietitian had not calculated an estimation of protein requirements for resident 9 although her most recent albumin reflected malnutrition and the fact that she had experienced a significant weight loss. Without a calculation of protein requirements, it would not be possible for facility staff to know whether or not the diet would meet the protein needs of this resident. Resident 29 experienced a 7.6% unplanned weight loss in 1 month, from January 2002 to February 2002. Resident 29 continued to receive a regular diet although she had experienced significant weight loss and the fact that her albumin after the weight loss (3/21/02) was 3.2, below normal. The dietitian had not calculated an estimation of resident 29's protein requirements. Without a calculation of protein requirements, it would not be possible for facility staff to know whether or not the diet would meet the protein needs of this resident. Resident 17 had an albumin result on 11/22/01 of 2.7g/dL. The facility dietitian had not calculated an estimation of resident 17's protein needs. Without a calculation of protein requirements, it would not be possible for facility staff to know whether or not the diet and supplements would meet the protein needs of this resident. Resident 16 had an albumin result on 5/2/02 of 2.8g/dL. The facility dietitian had not calculated an estimation of resident 16's protein needs. Without a calculation of protein requirements, it would not be possible for facility staff to know whether or not the diet and supplements would meet the protein needs of this resident.	F 490	D. All residents who may be in need of a restraint will be evaluated to assure that alternatives were attempted and failed prior to the use of a restraint. If it is determined that a restraint may be necessary the Social Service Director will contact the resident and resident family member and inform them of the intent to use a restraint. The Director of Nursing will contact the physician and receive orders before the use of a restraint is incorporated. The Director of Nursing will complete an Entrapment Risk Assessment to for anyone who has orders for side rails to assure resident safety. The Social Service Director and Director of Nursing will make certain that any resident requiring a restraint will be care planned for in the patient medical record, and report to the Quality Assurance Committee. Reference Plan of Correction F-221. E. The appropriate action has been taken to protect all residents at Art City Nursing & Rehabilitation and the administrator will further ensure that dietary personnel follow guideline as outlined in the federal register. Reference Plan of Correction F-371. F. The administrator will have the Director of Nursing report to the Quality Assurance Team any related problems with obtaining laboratory services to assure that the residents are care for according to standards of practice and physicians orders. Reference Plan of Correction F-502. G. The Administrator has instructed the Medical Records Consultant to complete audits of patient charts and report any noted problems to the Medical Records Clerk and Administrator. The Consultant will further train and instruct the Medical Records Clerk on current standards of practice. The Director of Nursing will supervise the Medical Records Clerk and report to the Quality Assurance Team any noted problems and appropriate actions will be taken to assure compliance. Reference Plan of Correction F-520.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 490	Continued From page 30 Nutritional Policies and Procedures: The facility's policy and procedures for Residents at Nutritional Risk was reviewed on 7/3/02. It was documented in the policy that "Any resident identified as being at nutritional risk will have a problem of 'Alteration in Nutrition' identified on the care plan and the physician will be informed and a Dietary consultation requested. The following criteria will be used to help identify nutritionally at risk residents:... 6. Undesirable weight loss or gain of 3 lbs (under 100 lbs) and 5 lbs (over 100 lbs) or more in one month..." It was documented in the procedures that: "1. Identify any resident at nutritional risk using Policy for resident at Risk. 2. Nursing will enter date, room, name and brief description of problem on Dietitian Referral form that is kept at the nurses station. 3. Dietitian will date and initial same form when resident has been reviewed. 4. When making a recommendation, the Dietitian will enter recommendation in the clinical record and fill our Dietary Recommendation Sheet. 5. Dietary Recommendation Sheet will be given to the Charge Nurse. 6. Nursing will review recommendation and follow through as appropriate." In an interview with a facility charge nurse, on 7/3/02, she stated she had never seen the Dietitian Referral for Resident at Nutritional Risk Form nor had she seen the Dietary Recommendation Form. In an interview with the food service supervisor on 7/3/02, she stated when she has a concern about a resident she calls the registered dietitian and she does not keep any documentation of those calls. She further	F 490	H. The Administrator will invite the physician to attend the Quality Assurance Committee Meetings. In the event that the Physician is unable to attend the meetings, a copy of the minutes will be given the physician for review by the administrator and a signature will be obtained to verify that the information was reviewed or attendance was complied with. This will be monitored by the Administrator. Reference Plan of Correction F-520. I. The Administrator will further in-service all Department Heads on the importance of following federal guidelines and will incorporate into the Quality Assurance Committee Meetings the training and in-servicing of the federal guideline for the increased knowledge of all parties controlling the resident care. We allege compliance August 21, 2002.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 490	Continued From page 31 stated she does not use the Dietitian Referral for Resident at Nutritional Risk Form. The facility was not following its own policies and procedures. Quality Assurance: The facility's Quality Assurance (QA) Committee met on 1/15/02, 2/13/02, 4/23/02, and 6/19/02. The QA minutes were reviewed on 7/3/02 after the implementation of an extended survey. A review of the QA minutes revealed the following: The QA minutes contained a section titled "Dietary Report" - "Weight loss Residents". Resident 26 should have triggered for significant unplanned weight loss of 8.6% on or around 5/13/02. QA minutes for June 2002 did not address resident 26 under the section "Dietary Report" - "Weight loss Residents". Resident 9 should have triggered for significant unplanned weight loss of 9.8% in March 2002. A review of the QA minutes for April 2002 revealed the statement "(resident 9) down 5# (pounds) edema okay." The QA notes did not address the total significant unplanned weight loss (9.8%) from 153 pounds to 138 pounds, a total of 15 pounds in 3 months. Resident 29 should have triggered for significant unplanned weight loss of 7.6% in February 2002. A review of the QA minutes revealed that resident 29 was not addressed in either the February 2002 or April 2002 facility minutes. The QA minutes did not reveal that facility staff had	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 490	Continued From page 32 identified the lack of protein requirement estimations for residents with weight loss or abnormal protein/albumin levels. In addition to the Sub-Standard Quality of Care stated above, the facility's administration did not effectively and efficiently use its resources to ensure that each resident attained or maintain their highest practicable physical, mental and psychosocial well-being in the following areas of deficient practice cited during the survey completed 7/3/02. a. Facility administration did not ensure that quarterly minimum data sets were completed and submitted as required. (Refer to Tag F- 276) b. Facility administration did not ensure that nursing staff met professional standards of practice. (Refer to Tag F- 281) c. Facility administration did not ensure that physician's orders were followed. (Refer to Tag F- 282) d. Facility administration did not ensure that the use of restraints were evaluated, ordered and care planned. (Refer to Tag F- 221) e. Facility administration did not ensure that dietary staff stored, prepared and served food under sanitary conditions. (Refer to Tag F- 371) f. Facility administration did not ensure that the facility provided laboratory services to meet the needs of the residents. (Refer to Tag F - 502) g. Facility administration did not ensure that medical records were complete and accurately documented. (Refer to Tag F - 514)	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 490	Continued From page 33 h. Facility administration did not ensure that the physician attended Quality Assurance meetings at least quarterly. (Refer to Tag F - 520) i. Facility administration did not ensure that the QA committee identified quality deficiencies and then developed a plan of action to correct identified deficiencies. (Refer to Tag F - 521)	F 490		
F 502 SS=E	483.75(j) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review, it was determined that the facility did not obtain laboratory services to meet the needs of 4 of 10 sample residents. Resident identifiers: 9, 16, 26 and 29. Findings include: 1. Resident 16 was an 87 year old female who was admitted to the facility on 7/23/01. A physician's progress note, dated 4/16/02, documented "acute behavioral change" regarding resident 16. The same day, 4/16/02, the physician ordered a urinalysis to be performed with a culture and sensitivity if indicated. There was no documentation in the medical record of resident 16 to evidence that staff had performed this as ordered. Approximately two weeks later, on 5/2/02, the physician ordered another urinalysis. Again, there was	F 502	Residents 9, 16, 26 and 29 along with all residents will be given laboratory services when ordered by the physician. The Medical Records Clerk will review all patient charts and make certain all ordered labs were drawn as ordered by the physician.* In the event an individual is identified as not having labs drawn the patient name will be given to the Director of Nursing who will then contact the resident physician and inform them of the missing lab. The director of nursing will obtain the date and time of the failure and give it to the Office Manager who will then identify who the nurse was working at the time and inform the Administrator. Appropriate disciplinary action will be taken at that time. The licensed nurses were in-serviced on August 9, 2002 on the Policy & Procedure related to physician orders. All physician orders will be followed. The Medical Records Clerk will audit charts after the initial audit in connection with the quarterly assessment period. The Medical Records Clerk will report to the Director of Nursing any identified problems will then be brought to the Quality Assurance Committee Meeting and appropriate action will be taken. We allege compliance August 21, 2002. * Medical records will monitor at least 2 times a month.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 502	Continued From page 34 no documentation to evidence that this lab had been performed as ordered. 2. Resident 9 was a 92 year old female who was admitted to the facility on 12/01/98 with diagnoses of pneumonia, arthopathies, hypothyroidism, congestive heart failure, hypertension, esophageal reflux, urinary tract infection, hysterectomy. On 3/5/02, the physician ordered a CMP (complete metabolic panel), a CBC (complete blood count), a TSH (thyroid stimulating hormone), and a lipid profile. There was no documentation in the medical record for resident 9 to evidence that these labs were performed as ordered. Also, there was no documentation to evidence that resident 9 refused to let the staff obtain samples for these labs. On 4/9/02, the physician ordered a TSH. There was no documentation in the medical record for resident 9 to evidence that this lab was performed as ordered. Also, there was no documentation to evidence that resident 9 refused to let the staff obtain a sample for this lab. On 4/23/02, the physician ordered a urinalysis and a TSH. There was no documentation in the medical record for resident 9 to evidence that these labs were performed as ordered. Also, there was no documentation to evidence that resident 9 refused to let the staff obtain samples for these labs. 3. Resident 26 was a 76 year old male who was admitted to the facility on 1/26/02 with diagnoses of chronic obstructive pulmonary disease, bronchitis, dementia with aggressive features, hypertension, heart/renal disease, malignant, no congestive heart failure or renal failure and diabetes.	F 502		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 502	Continued From page 35 On 4/9/02, the physician ordered a BMP (basic metabolic panel) to be performed "next week". There was no documentation in the medical record of resident 26 to evidence that this lab was performed as ordered by the physician. 4. Resident 29 was a 72 year- old female who was admitted to the facility on 12/13/01 with diagnoses of fractured hip, hypertension, severe headaches, arthritis and anxiety. On 6/25/02, the physician ordered a BMP to be performed for resident 29. There was no documentation in the medical record of resident 29 to evidence that this lab was performed as ordered by the physician. On 1/29/02, the physician ordered a mammogram screening for resident 29. There was no documentation in the medical record of resident 29 to evidence that this screening had been performed as ordered.	F 502	Art City Nursing & Rehabilitation will protect residents 6 and 29 by ensuring that proper documentation of residents daily happenings are recorded in accordance with current standards of practice. The licensed nurses were in-serviced, by the Director of Nursing on Aug 9, 2002 and instructed on documenting resident incident reports and making sure any incident is recorded in the patient chart not just on an incident report form. The nurses were further in-serviced that any trip to the hospital or physicians office must be documented in the clinical records for review. The Director of Nursing will audit incident reports for August and September and assure that nurses are making appropriate entries into the patient clinical record. Any failure to chart appropriately will result in further one to one training by the Director of Nursing. The Director of Nursing will report findings to the Quality Assurance Committee and any further action will be taken as necessary. We allege compliance August 21, 2002.	
F 514 SS=E	483.75(l)(1) ADMINISTRATION The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. This REQUIREMENT is not met as evidenced by: Based on observation and medical record review, it was determined that the facility did not maintain clinical records on each resident in accordance with accepted professional standards and practices that were complete, accurately documented and readily accessible as evidenced by: 2 of 10 sampled residents	F 514		

The DON will perform random audits at least QUARTERLY, to ensure Compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 514	Continued From page 36 had medical records that did not accurately reflect the residents status. Resident identifiers: 29, and 6. Findings include: 1. Resident 29 was admitted to the facility on 12/13/01, with diagnoses of hip fracture, hypertension, severe headaches, arthritis, and anxiety. A review of resident 29's medical record was completed on 7/1/02 through 7/3/02. Resident 29 suffered a fall on 6/29/02, according to facility incident report. Nurses notes dated 6/29/02 (No time) document the following: " Resident has been hunched over cannot stand up straight, is dropping things from her mouth confusion - I am trying to get a hold of (family) to see if they want to take her to the hospital. Nurse practitioner has ordered an evaluation at the hospital. " It is difficult to determine if this note is associated with the fall the resident suffered. The nurses note does not mention any injury, or bruising. Nurses notes dated 6/29/02 at 17:30 PM says the following: " Resident returned from hospital with grand daughter, right eye severely bruised and swollen. Resident denies pain but wincing at giver touching of eye noted. Tylenol given @ HS (hour of sleep). Orders from hospital state that physician has been notified and will call with dietary and medication changes. Swallowing study next week. Awaiting call from physician. Resident with increased confusion will monitor." This Nurses note entry follows the above nurses note entry, and makes it appear that an injury happened at	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 514	Continued From page 37 the hospital, because she returned from the hospital with her right eye "severely bruised and swollen." There is not previous documentation concerning bruising or how it happened. On 7/1/02, during tour, facility staff nurse stated that resident's injury occurred one week ago. 2. Resident 6 was admitted to the facility on 6/22/99, with diagnoses of cerebral vascular accident, dysarthria, hypertension, hypothyroidism, arthritis, constipation, diarrhea, brain tumor resection, hiatal hernia, nausea and lethargy. A review of resident 6's medical record was completed on 7/1/02 through 7/3/02. During review of resident 6's activity of daily living sheets, specifically the section where bowel movements are to be recorded, it was noted that resident 6 would go from 5 to 9 days without a bowel movement. The documentation reflected the following about resident 6's bowel movements: October, 2001, 9 days without a bowel movement December, 2001, 5 days without a bowel movement January, 2002, 5 days without a bowel movement February, 2002, 5 days without a bowel movement March, 2002, 8 days without a bowel movement April, 2002, 9 days without a bowel movement During an interview with CNA (certified nurses aides) on 7/1/02, two CNA's reported that this resident never went 6 shifts, (48 hours) without having this reported to the charge nurse. They also stated that she frequently had loose stools. The CNA were not aware of any time when resident had not gone 9 days without a bowel movement.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 514	Continued From page 38 During an interview with facility LPN (licensed practical nurse), on 7/1/02, I asked this nurse if resident 6 actually went 9 days without a bowel movement for the month of April, 2002, she said "No, this flowsheet is not accurate." 3. Please refer also to tag F - 276 to reveal the details of minimum data sets which were not in the facility at the time of survey and not available for review.	F 514		
F 520 SS=D	483.75(o)(1) ADMINISTRATION A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. This REQUIREMENT is not met as evidenced by: Based on interview with the Administrator and review of Quality Assurance Committee minutes, it was determined that the facility did not involve the physician in the QA meetings at least quarterly. Findings include: The facility's Quality Assurance (QA) Committee met on 1/15/02, 2/13/02, 4/23/02, and 6/19/02. The QA minutes were reviewed on 7/3/02 after the implementation of an extended survey. During review of the QA minutes, it was noted the facility's physician (or any physician) did not attend the QA meetings at least quarterly. During interview with the Administrator on 7/3/02, he stated that it was "sometimes hard" to get the physician to the meetings.	F 520	The Administrator will invite the physician to attend the Quality Assurance Team Meetings. In the event that the Physician is unable to attend the meetings, a copy of the minutes will be given the physician for review and a signature will be attained to certify that the physician was involved in the Quality Assurance process as outlined in the federal guideline. The Administrator will report to the Quality Assurance Committee when the physician is unable to attend and when the minutes were given to the physician for review. We allege compliance August 21, 2002.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 520	Continued From page 39	F 520		
F 521 SS=H	483.75(o)(2)&(3) ADMINISTRATION The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, and review of the facility's policies and procedures and the facility's Quality Assurance (QA) Committee minutes (dated 1/15/02, 2/13/02, 4/23/02, and 6/19/02), it was determined that the facility's QA committee did not identify quality deficiencies regarding identification, assessment, intervention and re-evaluation for residents with significant unplanned weight loss and malnutrition, resulting in actual harm for 3 of 10 sample residents (9, 26 and 29). In addition to the area of weight loss and lack of nutritional intervention (F - 325) cited at a Sub-Standard level, the facility's QA Committee also did not identify, establish and implement corrective action plans for the following areas: a. Professional Standards of Practice (F281) b. Following plan of care (physician's orders) (F282) c. Food Service and Sanitation (F371) d. Lack of physician at QA meetings (F520) e. Administrative services (F490)	F 521	The Quality Assurance Team will meet monthly for the next six months beginning in August 2002, and review items identified in standard and extended survey and assure that standards of practice are being met by employees of Art City Nursing & Rehabilitation. The Quality Assurance Team will further assure that employees are trained and understand their job as outline in their job descriptions. Each employee will be given a copy of their job description in the month of August and review their responsibilities, sign that they have reviewed them and place the signed document in their personnel file. The Office Manager will report to the Quality Assurance Committee when all employees are given a copy of their job description and that they have signed the acknowledgement of receipt. We allege compliance August 21, 2002.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 521	Continued From page 40 f. Medical record completion and accuracy (F514) g. Quarterly Assessments - MDS (Minimum Data Sets) (F276) h. Laboratory services i. Restraints Findings include: 1. The facility's Quality Assurance (QA) Committee met on 1/15/02, 2/13/02, 4/23/02, and 6/19/02. The QA minutes were reviewed on 7/3/02 after the implementation of an extended survey. A review of the QA minutes revealed the following: The QA minutes contained a section titled "Dietary Report" - "Weight loss Residents". a. Resident 26 should have triggered for significant unplanned weight loss of 8.6% on or around 5/13/02. QA minutes for June 2002 did not address resident 26 under the section "Dietary Report" - "Weight loss Residents". b. Resident 9 should have triggered for significant unplanned weight loss of 9.8% in March 2002. A review of the QA minutes for April 2002 revealed the statement "(resident 9) down 5# (pounds) edema okay." The QA notes did not address the total significant unplanned weight loss (9.8%) from 153 pounds to 138 pounds, a total of 15 pounds in 3 months. c. Resident 29 should have triggered for significant unplanned weight loss of 7.6% in February 2002. A review of the QA minutes revealed that resident 29 was not addressed in either the February 2002 or April 2002 facility minutes. The QA minutes did not reveal that facility staff had	F 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 521	Continued From page 41 identified significant weight loss for these residents or the lack of protein requirement estimations for residents with weight loss or abnormal protein/albumin levels. 2. The facility's policy and procedures for "Residents at Nutritional Risk" was reviewed on 7/3/02. It was documented in the policy that "Any resident identified as being at nutritional risk will have a problem of 'Alteration in Nutrition' identified on the care plan and the physician will be informed and a Dietary consultation requested. The following criteria will be used to help identify nutritionally at risk residents:... 6. Undesirable weight loss or gain of 3 lbs (under 100 lbs) and 5 lbs (over 100 lbs) or more in one month..." It was documented in the procedures that: "1. Identify any resident at nutritional risk using Policy for resident at Risk. 2. Nursing will enter date, room, name and brief description of problem on Dietitian Referral form that is kept at the nurses station. 3. Dietitian will date and initial same form when resident has been reviewed. 4. When making a recommendation, the Dietitian will enter recommendation in the clinical record and fill our Dietary Recommendation Sheet. 5. Dietary Recommendation Sheet will be given to the Charge Nurse. 6. Nursing will review recommendation and follow through as appropriate." In an interview on 7/3/02, with a facility charge nurse she stated she had never seen the Dietitian Referral for Resident at Nutritional Risk Form nor had she seen the Dietary Recommendation Form. In an interview on 7/3/02 with the food service supervisor, she stated when she has a concern about a	F 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 521	Continued From page 42 resident she calls the RD and she does not keep any documentation of those calls. She further stated she does not use the Dietitian Referral for Resident at Nutritional Risk Form. The facility was not following its own policies and procedures regarding weight loss and nutritional risk. 3. The facility's QA committee did identify concerns with the MDSs, labs and restraints, but the QA minutes did not contain any documentation to evidence that these concerns had been addressed through any type of corrective action plan. 4. The facility's QA committee did not identify and establish a corrective action plan to ensure that the facility was administered in a manner that enabled it to use it's resources efficiently or effectively to ensure that residents were provided the opportunity to attain or maintain their highest practicable well-being. 5. The facility's QA committee did not identify and establish a corrective action plan to ensure that resident medical records were complete and accurate. 6. The facility's QA committee did not identify and establish a corrective action plan to ensure that professional standards of practice were followed. 7. The facility's QA committee did not identify and establish a corrective action plan to ensure that facility staff were following physician orders. 8. The facility's QA committee did not identify and establish a corrective action plan to ensure that the facility stored, prepared and distributed food under sanitary conditions. 9. The facility's QA committee did not identify and	F 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	7/3/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHAB	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 521	Continued From page 43 establish a corrective action plan to ensure that a physician attended the QA meetings at least quarterly.	F 521		