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

PRINTED: 06/21/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465162	A. BUILDING ____ B. WING ____	06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN PARK REHABILITATION	1430 EAST 4500 SOUTH SALT LAKE CITY, UT 84117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167 SS=B	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined that the facility did not ensure that the most recent survey results were posted in a place that was readily accessible to residents, without having to ask a staff member. Findings include: An on-site recertification survey was conducted on 6/07/06 to 6/08/06. The facility is a locked unit and only accessible by punching in a number code on a keypad upon entering or exiting. On 6/0706 during the initial tour of the unit, the last survey results could not be found posted on the unit, nor could a posting of it's availability be found. On 6/0706 at 10:50 AM, an interview was conducted with RN1 (Registered nurse) charge nurse, regarding where the unit's survey results were posted. She stated that, "It's kept in the administrators office".	F 167	7/27/06 POC acceptable completion date 7/14/06 [illegible] Survey results will be posted at the nurses station and the desk where residents, family members and prospective residents must sign in. It will be integrated into our July Q.A meeting 7-14-06. Utah Department of Health 755926 JUL 17 2006 Bureau of Health Facility Licensing, Certification and Resident Assessment	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 7/2/06

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

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F 167	Continued From page 1 On 6/08/06 at 9:30 AM, an interview was conducted with resident 5. When asked if she was aware of where the unit's survey results were posted, she stated that she didn't know that they needed to be posted. On 6/08/06 at 10:35 AM, an interview was conducted with the facilities administrator, regarding where the unit's survey results were posted. She stated that, "To be honest with you, I didn't know that the first survey counted....so I made a copy after yesterday and put it out in the front".	F 167		

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F 279 SS=E	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under o483.25; and any services that would otherwise be required under o483.25 but are not provided due to the resident's exercise of rights under o483.10, including the right to refuse treatment under o483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that for 3 of 8 sampled residents (Residents 3,4, and CL8), the facility did not develop, and revise comprehensive care plans for each resident based on their individual needs identified by the facility staff. Specifically, the facility did not revise careplans for residents: 3,4, and 8, to ensure that their continence was accurately reflected on their careplans. Findings include: A. Resident 3 was admitted to the facility on	F 279	1) Interim care plans are placed in each residents chart upon admission and replaced when the computerized care plan is generated from the 5 day MDS Assessment 2) The Licensed Nurse is responsible for updating the care plan with information that accurately reflects changes in condition and changes in treatment. This information shall include the actual change the date and the licensed Nurses initials 3) The unit mngr shall incorporate into the audit of the residents record a review of the care plan to ensure updates are occurring timely and that the information contained therein is current 4) New care plans have been developed to add to the plan of care when an infection, a fall, or altered skin integrity occur, this is to be initiated by licensed nurse. Effective 7/1/06 Tag F279 will be reviewed in QA. meeting on 7/1[illegible]/06	

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F 279	Continued From page 3	F 279		

5/05/06 with the following diagnoses: congestive heart failure, hypertension, pace maker, depression, hip fracture, osteoporosis, and anemia.

On 6/07/06, resident 3's medical record was reviewed.

Resident 3's careplan dated 5/18/06, addressed the problem area of incontinence as follows:

"Potential for incontinent episodes secondary to debility"

Goals were documented as:
"Will be clean, dry and free from odors by next review date".....
"Will have no skin breakdown as a result of B&B (Bowel and Bladder) incontinence by next review".....

Interventions were documented as:
"Reduce stress as much as possible to decrease incontinence".....
"Peri-care with each incontinence episode".....

Documentation was found in resident 8's admission nursing assessment that she was admitted with a Foley catheter.
No documentation was found that resident 8's careplan accurately refected resident 8's continence upon admission to the facility.

Also addressed in the careplan dated 5/18/06 was the following problem area:

"Potential for infection related to debility, Foley cath use".

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F 279	Continued From page 4 Resident 3's medical record had documentation that resident 3's Foley catheter had been discontinued on 5/24/06. No documentation could be found that resident 3's careplan had been updated to reflect that her Foley catheter had been discontinued as of 5/24/06, B. Resident 4 was admitted to the facility on 4/24/06 with the following diagnoses: fractured femur, joint/hip replacement, Alzheimer, and hypertension. On 6/07/06, resident 4's medical record was reviewed. Resident 4's careplan dated 5/05/06, addressed the following problem area as follows: "Potential for infection related to Foley cath use, and debility". Resident 4's physician telephone orders documented a order dated 5/24/06 to discontinue resident 4's Foley catheter. Review of resident 4's nurse's notes dated 5/24/06, revealed that resident 4's Foley catheter had been discontinued. No documentation could be found that resident 4's careplan had been updated to reflect that her Foley catheter had been discontinued as of 5/24/06, C. Resident CL8 was admitted to the facility on	F 279		

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F 279	Continued From page 5	F 279		

12/14/05 with the following diagnoses: congestive heart failure, dementia, closed fracture of the femoral condyle, hypertension, diabetes mellitus, atrial fibrillation, senile depression, and urinary tract infection.

Resident 8's closed medical record was reviewed on 6/08/06.

Resident 8's careplan dated 12/14/05, addressed the following problem area as follows:

"Potential for incontinent episodes secondary to debility in mobility, increased confusion."

Goals were documented as:
"Will be clean, dry and free from odors by next review date".....
"Will have no skin breakdown as a result of urinary incontinence by ...."

Interventions were documented as:
"Perineal care AM and PM and after each incontinence...."
"Reduce stress as much as possible to decrease incontinence".....

Documentation was found in resident 8's admission nursing assessment that she was admitted with a Foley catheter.
No documentation was found that resident 8's careplan accurately refected resident 8's continence upon admission to the facility.

Also addressed in the careplan dated 12/14/05 was the following problem area:

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F 279	Continued From page 6 "Potential for infection related to debility, deconditioned, has Foley cath to dd (direct drainage)".... The careplan also documented that resident 8's Foley was discontinued on 1/03/06. No documentation could be found that resident 8's care planning interventions had been revised to reflect that her Foley catheter had been discontinued as of 1/03/06.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, it was determined that for 1 of 8 sampled residents (Resident 1), the facility did not ensure that the resident received the care and services to maintain the highest practicable in accordance with the comprehensive plan of care. Specifically, when resident 1's oxygen saturation decreased, there was no documentation in the medical record that any interventions had been implemented. Findings include:	F 309		

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F 309	Continued From page 7 A. Resident 1 was admitted to the facility on 4/06/06 with diagnoses that included, cardiovascular accident, hypertension, arthritis, stomach dysfunction disorder, dementia, anemia, and duodenal ulcers. On 6/07/06, resident 1's medical record was reviewed. Review of resident 1's "Resident Weight/VS Record'" revealed that for the following days, resident 1's oxygen saturation was below 90%: 4/20/06 was 82% room air 5/14/06 was 87% room air 5/16/06 was 88% room air 5/20/06 was 88% room air 5/25/06 was 86% room air No documentation could be found that any interventions had taken place to increase resident 1's oxygen level for any of the days which resident 1's oxygen fell below 90%. On 6/08/06 at 9:30 AM, an interview was conducted with the DON (Director of Nursing) in regards to why there wasn't any documentation of any interventions when resident 1's oxygen saturations fell below 90%. The DON stated that there is supposed to be documentation in the nurse's notes... If saturations decrease below 90%, put resident on oxygen and re-check sats (saturations), according to the policies. Review of the facilities "Protocol For Hypoxia", revealed the following:	F 309	1) Protocol for hypoxia has been established and is available to the licensed Nurses in written format 2) Licensed Nurses have been and will continue to be inserviced on this protocol 3) The licensed nurse is responsible for following this protocol and ensuring documentation accurately reflects the hypoxia episode, the physical assessment, the intervention, MD notification, and the results of the intervention 4) The unit manager will audit the oxygen saturations to ensure that any saturation below 90% has had adequate intervention and documentation to support the occurrence Effective 7/1/06 Tag F309 will be reviewed in our QA. meeting 7/19/06	

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F 309	Continued From page 8 "1. Any oxygen saturation that falls below 90% requires nursing intervention." "2. If there is a physician order for oxygen to keep sats over 90%, place oxygen on patient, notify MD and recheck sats in 10-15 minutes to ensure adequate oxygenation." "3. If there is no physician order for oxygen, contact MD....." "4......" "5. Documentation should reflect in the Nurses Notes as to what the original oxygen saturation was, what intervention was performed, that MD was notified, and evidence of the physical assessment. "6....." No documentation could be found in the nurses notes that interventions were implemented on the days that resident 1's oxygen saturations fell below 90%.	F 309		
F 371 SS=B	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by:	F 371		

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F 371	Continued From page 9 Based on observation and interview, it was determined that the facility did not store, distribute and serve food under sanitary conditions. Findings included: The following observations were made during the initial kitchen observation on 6/07/06 at 8:45 AM. 1. A staff member was observed to be sitting on a food crate at the counter, eating and drinking. 2. The sugar bin was uncovered. Walk in refrigerator: 1. A plate of turkey legs not labeled or dated. 2. A plate of sliced tomatoes not dated. 3. A 5 pound container of garlic not dated. 4. 1/2 of a 5 pound block of cheese not dated. 5. A large section of white sliced cheese not labeled or dated. 6. A large section of yellow sliced cheese not labeled or dated. Freezer: 1. A container of bread dough not dated. 2. Two packages of waffles (6 waffles in each package), not labeled or dated.	F 371	On 6/7/06 while survey was in the building staffs were in serviced on making sure all foods were labeled and dated. Dietary Manager is in serviced on staff on 6/25/06 about making sure all food items are dated and labeled. Dietary Manager will audit to make sure staff is labeling and dating all foods items on a weekly basis Effective 7/1/06 Tag F371 will be reviewed in our QA meeting on 9/14/06	

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F 371	Continued From page 10 3. A large plastic bag of bread dough (rolls) not labeled or dated. 4. A plastic bag of potato smiles, not labeled or dated. 5. A large plastic bag of breadstick dough, not labeled or dated. 6. A bag of cinnamon rolls not dated.	F 371		
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS 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. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, it was determined that for 3 of 8 sampled residents (Resident 1,5,and 6), the facility did not maintain clinical records that were complete or accurately documented for. Specifically, the facility did not ensure that residents 1 and 6's clinical record contained their initial MDS's, and also did not ensure that	F 514		

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F 514	Continued From page 11 resident 5's clinical record allergy sticker accurately reflected her allergies, and that her Resident Assessment Protocol was incomplete. Findings include: A. Resident 1 was admitted to the facility on 4/06/06 with the following diagnoses: cardiovascular accident, hypertension, arthritis, stomach dysfunction disorder, dementia, anemia, and duodenal ulcers. On 6/07/06, resident 1's medical record was reviewed. 1. Resident 1's admission MDS (Minimum Data Set) dated 5/02/06 documented the following RAP (Resident Assessment Protocol) problem areas which were triggered: Delirium Cognitive loss Communication Activities of daily living Urinary incontinence Psychosocial well-being Mood state Falls Nutrition Pressure ulcers Psychotropics Documented under "Care Planning Decision" the problem areas which were triggered were not checked to be careplanned. There was no documentation under "Location and Date of RAP Assessment Documentation" as to where documentation could be found to support the	F 514	*Initial MDS assessment not found in record: 1) MDS coordinator maintains a calender of when MDS assessments are due, this calendar will be followed and the MDS assessments completed timely 2) If the MDS coordinator determines there is potential for not meeting the completion schedule, for whatever reason he/she is to ask for assistance from the DHS to maintain the schedule 3) The DHS to perform a weekly audit with the MDS coordinator to ensure compliance *Missing Allergy from resident record: 1) The licensed nurse is responsible for asking the resident and the responsible party of admission of any known allergies and record the responses in the resident record 2) The unit manager shall review the review the resident record in its entirety and list all known allergies with admission 3) The social worker will review the POLST form when reviewing Advanced Directives and notify nursing of any items that may have been errantly listed on these forms within 3 days of admit *Incomplete Resident Assessment Protocol 1) The MDS coordinator is responsible for data collection and entry of the MDS assessment. The RAP guide is generated from the initial MDS assessment. The MDS coordinator is responsible for completing the RAP guide in its entirety 2) The MDS coordinator has [illegible] system when an assessment has been completed as well as when the RAP guide has been completed to place in the resident record 4) The unit manager will audit the resident record for the completed RAP guide by day 14 after admission 5) The DHS will meet with the MDS coordinator on weekly basis to review adherence to MDS schedule and completion of RAP guides Effective 7/1/06	

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F 514	Continued From page 12 decision-making. Documentation on the RAP summary also revealed that there was no RN (Registered Nurse) Coordinator signature. Documentation revealed that the admission MDS dated 5/02/06, had no RN signature as to the assessment being completed. 2. Resident 1's POLST (Physician Order For Life-Sustaining Treatment), revealed documentation under "Antibiotics" that resident 1 was "allergic to sulfa" Resident 1's allergy sticker which was posted on the inside of resident 1's clinical record revealed that her allergy to Sulfa was not documented on the sticker. B. Resident 5 was admitted to the facility on 5/11/06 with the following diagnoses: right hip fracture, status-post replacement, left hip revision, left lower lobe pneumonia, aortic stenosis, aortic fibrillation, pulmonary embolism, recent right ankle fracture, cardiopulmonary disease, and hypertension. On 6/07/06 resident 5's medical record was reviewed. Upon review of resident 5's medical record, no initial MDS (Minimum Data Set) assessment could be found in the record. Resident 5's June 2006 re-certification orders documented the following psychotropic medication orders: Xanax 0.25 milligrams Remeron 15 milligrams	F 514	Tag F514 will be reviewed in our QA meeting 7/14/06	

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F 514	Continued From page 13 Temazepam 15 milligrams Review of resident 5's careplans revealed that there was no psychotropic careplan. On 6/08/06 at 11:30 AM an interview was conducted with the MDS Coordinator in regards to where resident 5's initial MDS and psychotropic careplan were. The MDS Coordinator stated that "they are late"...and she is "working on them now...and that they will be done today". C. Resident 6 was admitted to the facility on 5/16/06 with the following diagnoses: Dementia, atrial fibrillation, and degenerative joint disease. On 6/07/06 resident 6's medical record was reviewed. Upon review of resident 6's medical record, no initial MDS (Minimum Data Set) assessment could be found in the record. On 6/08/06 at 3:25 PM, ann interview was conducted with the MDS Coordinator in regards to where resident 6's initial MDS was. The MDS Coordinator stated that "I don't have it...."it's late...I'm behind...".	F 514		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SE[illegible]CES

"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 465162	MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	DATE SURVEY COMPLETE: 6/8/2006
NAME OF PROVIDER OR SUPPLIER **ASPEN PARK REHABILITATION**	STREET ADDRESS, CITY, STATE, ZIP CODE **1430 EAST 4500 SOUTH SALT LAKE CITY, UT**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) RESIDENT ASSESSMENT

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on clinical record review, it was determined that for 1 of 8 sampled residents (Resident 1), the facility did not ensure that a registered nurse signed and certified that an inital Minimum Data Set assessment was complete.

A. Resident 1 was admitted to the facility on 4/06/06 with diagnoses that included: cardiovascular accident, hypertension,arthritis,stomach dysfunction disorder, dementia, anemia, and duodenal ulcers.

On 6/07/06, resident 1's medical record was reviewed.

Documentation revealed that the admission MDS dated 5/02/06, had no RN signature as to the assessment being completed.

Plan of Correction
1) The MDS coordinator must review the MDS for the signature prior to filing the assessment in the resident record
2) Medical Records will routinely audit active and closed records for the RN signature for each MDS assessment
3) The Unit Manager will routinely audit the MDS assessment for the RN signature with review of the resident records
Effective 7/1/06 QA. Meeting on 7/19/06 will review tag.

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

The above isolated deficiencies pose no actual harm to the residents

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	465162	A. BUILDING ______ B. WING ______	06/08/2006

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ASPEN PARK REHABILITATION	**1430 EAST 4500 SOUTH SALT LAKE CITY, UT 84117**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167 SS=B	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined that the facility did not ensure that the most recent survey results were posted in a place that was readily accessible to residents, without having to ask a staff member. Findings include: An on-site recertification survey was conducted on 6/07/06 to 6/08/06. The facility is a locked unit and only accessible by punching in a number code on a keypad upon entering or exiting. On 6/0706 during the initial tour of the unit, the last survey results could not be found posted on the unit, nor could a posting of it's availability be found. On 6/0706 at 10:50 AM, an interview was conducted with RN1 (Registered nurse) charge nurse, regarding where the unit's survey results were posted. She stated that, "It's kept in the administrators office".	F 167	7/6/06 POC NOT acceptable Unacceptable [handwritten] Utah Department of Health 761304 JUL 05 2006 Bureau of Health Facility Licensing, Certification and Resident Assessment	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 7/2/06

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

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F 167	Continued From page 1 On 6/08/06 at 9:30 AM, an interview was conducted with resident 5. When asked if she was aware of where the unit's survey results were posted, she stated that she didn't know that they needed to be posted. On 6/08/06 at 10:35 AM, an interview was conducted with the facilities administrator, regarding where the unit's survey results were posted. She stated that, "To be honest with you, I didn't know that the first survey counted....so I made a copy after yesterday and put it out in the front".	F 167		

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F 279 SS=E	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under o483.25; and any services that would otherwise be required under o483.25 but are not provided due to the resident's exercise of rights under o483.10, including the right to refuse treatment under o483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that for 3 of 8 sampled residents (Residents 3,4, and CL8), the facility did not develop, and revise comprehensive care plans for each resident based on their individual needs identified by the facility staff. Specifically, the facility did not revise careplans for residents: 3,4, and 8, to ensure that their continence was accurately reflected on their careplans. Findings include: A. Resident 3 was admitted to the facility on	F 279		

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F 279	Continued From page 3 5/05/06 with the following diagnoses: congestive heart failure, hypertension, pace maker, depression, hip fracture, osteoporosis, and anemia. On 6/07/06, resident 3's medical record was reviewed. Resident 3's careplan dated 5/18/06, addressed the problem area of incontinence as follows: "Potential for incontinent episodes secondary to debility" Goals were documented as: "Will be clean, dry and free from odors by next review date"..... "Will have no skin breakdown as a result of B&B (Bowel and Bladder) incontinence by next review"..... Interventions were documented as: "Reduce stress as much as possible to decrease incontinence"..... "Peri-care with each incontinence episode"..... Documentation was found in resident 8's admission nursing assessment that she was admitted with a Foley catheter. No documentation was found that resident 8's careplan accurately refected resident 8's continence upon admission to the facility. Also addressed in the careplan dated 5/18/06 was the following problem area: "Potential for infection related to debility, Foley cath use".	F 279		

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F 279	Continued From page 4 Resident 3's medical record had documentation that resident 3's Foley catheter had been discontinued on 5/24/06. No documentation could be found that resident 3's careplan had been updated to reflect that her Foley catheter had been discontinued as of 5/24/06, B. Resident 4 was admitted to the facility on 4/24/06 with the following diagnoses: fractured femur, joint/hip replacement, Alzheimer, and hypertension. On 6/07/06, resident 4's medical record was reviewed. Resident 4's careplan dated 5/05/06, addressed the following problem area as follows: "Potential for infection related to Foley cath use, and debility". Resident 4's physician telephone orders documented a order dated 5/24/06 to discontinue resident 4's Foley catheter. Review of resident 4's nurse's notes dated 5/24/06, revealed that resident 4's Foley catheter had been discontinued. No documentation could be found that resident 4's careplan had been updated to reflect that her Foley catheter had been discontinued as of 5/24/06, C. Resident CL8 was admitted to the facility on	F 279		

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F 279	Continued From page 5	F 279		

12/14/05 with the following diagnoses: congestive heart failure, dementia, closed fracture of the femoral condyle, hypertension, diabetes mellitus, atrial fibrillation, senile depression, and urinary tract infection.

Resident 8's closed medical record was reviewed on 6/08/06.

Resident 8's careplan dated 12/14/05, addressed the following problem area as follows:

"Potential for incontinent episodes secondary to debility in mobility, increased confusion."

Goals were documented as:
"Will be clean, dry and free from odors by next review date".....
"Will have no skin breakdown as a result of urinary incontinence by ...."

Interventions were documented as:
"Perineal care AM and PM and after each incontinence...."
"Reduce stress as much as possible to decrease incontinence".....

Documentation was found in resident 8's admission nursing assessment that she was admitted with a Foley catheter.
No documentation was found that resident 8's careplan accurately refected resident 8's continence upon admission to the facility.

Also addressed in the careplan dated 12/14/05 was the following problem area:

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F 279	Continued From page 6 "Potential for infection related to debility, deconditioned, has Foley cath to dd (direct drainage)".... The careplan also documented that resident 8's Foley was discontinued on 1/03/06. No documentation could be found that resident 8's care planning interventions had been revised to reflect that her Foley catheter had been discontinued as of 1/03/06.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, it was determined that for 1 of 8 sampled residents (Resident 1), the facility did not ensure that the resident received the care and services to maintain the highest practicable in accordance with the comprehensive plan of care. Specifically, when resident 1's oxygen saturation decreased, there was no documentation in the medical record that any interventions had been implemented. Findings include:	F 309		

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F 309	Continued From page 7 A. Resident 1 was admitted to the facility on 4/06/06 with diagnoses that included, cardiovascular accident, hypertension, arthritis, stomach dysfunction disorder, dementia, anemia, and duodenal ulcers. On 6/07/06, resident 1's medical record was reviewed. Review of resident 1's "Resident Weight/VS Record'" revealed that for the following days, resident 1's oxygen saturation was below 90%: 4/20/06 was 82% room air 5/14/06 was 87% room air 5/16/06 was 88% room air 5/20/06 was 88% room air 5/25/06 was 86% room air No documentation could be found that any interventions had taken place to increase resident 1's oxygen level for any of the days which resident 1's oxygen fell below 90%. On 6/08/06 at 9:30 AM, an interview was conducted with the DON (Director of Nursing) in regards to why there wasn't any documentation of any interventions when resident 1's oxygen saturations fell below 90%. The DON stated that there is supposed to be documentation in the nurse's notes... If saturations decrease below 90%, put resident on oxygen and re-check sats (saturations), according to the policies. Review of the facilities "Protocol For Hypoxia", revealed the following:	F 309		

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F 309	Continued From page 8 "1. Any oxygen saturation that falls below 90% requires nursing intervention." "2. If there is a physician order for oxygen to keep sats over 90%, place oxygen on patient, notify MD and recheck sats in 10-15 minutes to ensure adequate oxygenation." "3. If there is no physician order for oxygen, contact MD....." "4......" "5. Documentation should reflect in the Nurses Notes as to what the original oxygen saturation was, what intervention was performed, that MD was notified, and evidence of the physical assessment. "6....." No documentation could be found in the nurses notes that interventions were implemented on the days that resident 1's oxygen saturations fell below 90%.	F 309		
F 371 SS=B	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by:	F 371		

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F 371	Continued From page 9 Based on observation and interview, it was determined that the facility did not store, distribute and serve food under sanitary conditions. Findings included: The following observations were made during the initial kitchen observation on 6/07/06 at 8:45 AM. 1. A staff member was observed to be sitting on a food crate at the counter, eating and drinking. 2. The sugar bin was uncovered. Walk in refrigerator: 1. A plate of turkey legs not labeled or dated. 2. A plate of sliced tomatoes not dated. 3. A 5 pound container of garlic not dated. 4. 1/2 of a 5 pound block of cheese not dated. 5. A large section of white sliced cheese not labeled or dated. 6. A large section of yellow sliced cheese not labeled or dated. Freezer: 1. A container of bread dough not dated. 2. Two packages of waffles (6 waffles in each package), not labeled or dated.	F 371		

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F 371	Continued From page 10 3. A large plastic bag of bread dough (rolls) not labeled or dated. 4. A plastic bag of potato smiles, not labeled or dated. 5. A large plastic bag of breadstick dough, not labeled or dated. 6. A bag of cinnamon rolls not dated.	F 371		
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS 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. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, it was determined that for 3 of 8 sampled residents (Resident 1,5,and 6), the facility did not maintain clinical records that were complete or accurately documented for. Specifically, the facility did not ensure that residents 1 and 6's clinical record contained their initial MDS's, and also did not ensure that	F 514		

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resident 5's clinical record allergy sticker accurately reflected her allergies, and that her Resident Assessment Protocol was incomplete.

Findings include:

A. Resident 1 was admitted to the facility on 4/06/06 with the following diagnoses: cardiovascular accident, hypertension, arthritis, stomach dysfunction disorder, dementia, anemia, and duodenal ulcers.

On 6/07/06, resident 1's medical record was reviewed.

1. Resident 1's admission MDS (Minimum Data Set) dated 5/02/06 documented the following RAP (Resident Assessment Protocol) problem areas which were triggered:

Delirium
Cognitive loss
Communication
Activities of daily living
Urinary incontinence
Psychosocial well-being
Mood state
Falls
Nutrition
Pressure ulcers
Psychotropics

Documented under "Care Planning Decision" the problem areas which were triggered were not checked to be careplanned. There was no documentation under "Location and Date of RAP Assessment Documentation" as to where documentation could be found to support the

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F 514	Continued From page 12	F 514		

decision-making.

Documentation on the RAP summary also revealed that there was no RN (Registered Nurse) Coordinator signature.

Documentation revealed that the admission MDS dated 5/02/06, had no RN signature as to the assessment being completed.

2. Resident 1's POLST (Physician Order For Life-Sustaining Treatment), revealed documentation under "Antibiotics" that resident 1 was "allergic to sulfa". Resident 1's allergy sticker which was posted on the inside of resident 1's clinical record revealed that her allergy to Sulfa was not documented on the sticker.

B. Resident 5 was admitted to the facility on 5/11/06 with the following diagnoses: right hip fracture, status-post replacement, left hip revision, left lower lobe pneumonia, aortic stenosis, aortic fibrillation, pulmonary embolism, recent right ankle fracture, cardiopulmonary disease, and hypertension.

On 6/07/06 resident 5's medical record was reviewed.

Upon review of resident 5's medical record, no initial MDS (Minimum Data Set) assessment could be found in the record.

Resident 5's June 2006 re-certification orders documented the following psychotropic medication orders:
Xanax 0.25 milligrams
Remeron 15 milligrams

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN PARK REHABILITATION	1430 EAST 4500 SOUTH SALT LAKE CITY, UT 84117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 13 Temazepam 15 milligrams Review of resident 5's careplans revealed that there was no psychotropic careplan. On 6/08/06 at 11:30 AM an interview was conducted with the MDS Coordinator in regards to where resident 5's initial MDS and psychotropic careplan were. The MDS Coordinator stated that "they are late"...and she is "working on them now...and that they will be done today". C. Resident 6 was admitted to the facility on 5/16/06 with the following diagnoses: Dementia, atrial fibrillation, and degenerative joint disease. On 6/07/06 resident 6's medical record was reviewed. Upon review of resident 6's medical record, no initial MDS (Minimum Data Set) assessment could be found in the record. On 6/08/06 at 3:25 PM, ann interview was conducted with the MDS Coordinator in regards to where resident 6's initial MDS was. The MDS Coordinator stated that "I don't have it...."it's late...I'm behind...".	F 514		

REFERENCE TAGE F 483.10(g) (1)

Survey results are posted in a binder in the nurse's station. Administrator will audit to Make sure survey results are always readily available to all staff.

effective 7/1/04

REFERENCE TAG F 278

RN signature is required on each MDS. The MDS Coordinator is responsible for the data collection, entry and signature upon completion. Compliance will be enforced through the following means:

1) The MDS Coordinator must review the MDS for the signature prior to filing the assessment in the resident record.
2) Medical Records will routinely audit active and closed records for the RN signature for each MDS Assessment.
3) The Unit Manager will routinely audit the MDS Assessment for the RN signature with review of the resident records.

EFFECTIVE 7/1/06

REFERENCE TAG F 279

Comprehensive Care Plans must be maintained on each resident and updated timely with any changes throughout their stay. This requirement will be met through the following:

1) Interim Care Plans are placed in each resident record upon admission and replaced when the computerized Care Plan is generated from the 5-Day MDS Assessment.
2) The Licensed Nurse is responsible for updating the Care Plan with information that accurately reflects changes in condition and changes in treatment. This information shall include the actual change, the date and the Licensed Nurse's initials.
3) The Unit Manager shall incorporate into the audit of the resident records, a review of the Care Plan, to ensure updates are occurring timely and that the information contained therein is current.
4) New Care Plans have been developed to add to the plan of care when an infection, a fall, or altered skin integrity occur. This is to be initiated by the Licensed Nurse.

EFFECTIVE 7/1/06

REFERENCE TAG F 309

To maintain the highest well-being of the resident, documentation must reflect necessary care and services that are provided in accordance with the comprehensive assessment and plan of care. This will be evidenced by the following:

1) Protocol for hypoxia has been established and is available to the Licensed Nurses in written format.
2) Licensed Nurses have been and will continue to be in-serviced on this protocol.
3) The Licensed Nurse is responsible for following this protocol and ensuring documentation accurately reflects the hypoxic episode, the physical assessment, the intervention, MD notification and the results of the intervention.
4) The Unit Manager will audit the oxygen saturations to ensure that any saturation below 90% has had adequate intervention and documentation to support the occurrence.

EFFECTIVE 7/1/06

REFERENCE TAG F371

On 6/7/06 while survey was in the building staffs were in serviced on making sure all foods were labeled and dated. Dietary Manager in serviced on staff on 6/25/06 about making sure all food items are dated and labeled. Dietary Manager will audit to make sure staff is labeling and dating all food items on a weekly basis.

effective 7/1/06

REFERENCE TAG F 514

Maintenance of clinical records. The areas of deficiencies have been corrected in the following manner:

Initial MDS Assessment not found in resident record:

1) The MDS Coordinator maintains a calendar of when MDS Assessments are due. This calendar will be followed and the MDS Assessments completed timely.
2) If the MDS Coordinator determines there is potential for not meeting the completion schedule, for whatever reason, he/she is to ask for assistance from the Director of Health Services to maintain the schedule.
3) The Director of Health Services to perform a weekly audit with the MDS Coordinator to ensure compliance.

Missing allergy from resident record: The responsible party had written an allergy (of the resident's) on the POLST form which is not a typical place to list an allergy. The allergy had not been transferred to the allergy list.

1) The Licensed Nurse is responsible for asking the resident and the responsible party on admission of any known allergies and record the responses in the resident record.
2) The Unit Manager shall review the resident record in its entirety and list all known allergies with admission.
3) The Social Worker will review the POSLT form when reviewing Advanced Directives and notify nursing of any items that may have been errantly listed on these forms.

Incomplete Resident Assessment Protocol:

1) The MDS Coordinator is responsible for data collection and entry of the MDS Assessment. The RAP Guide is generated from the initial MDS Assessment. The MDS Coordinator is responsible for completing the RAP Guide in its entirety.
2) The MDS Coordinator has a calendar system in place for MDS due dates. The RAP Guides have been added to this calendar system to ensure its timely completion.
3) The MDS Coordinator will initial on her calendar when an assessment has been completed as well as when the RAP Guide has been completed to place in the resident record.
4) The Unit Manager will audit the resident record for the completed RAP Guide by Day 14 after admission.
5) The Director of Health Services will meet with the MDS Coordinator on a weekly basis to review adherence to MDS schedule and completion of RAP Guides.

EFFECTIVE 7/1/06

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 465162	MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	DATE SURVEY COMPLETE: 6/8/2006
NAME OF PROVIDER OR SUPPLIER **ASPEN PARK REHABILITATION**	STREET ADDRESS, CITY, STATE, ZIP CODE **1430 EAST 4500 SOUTH SALT LAKE CITY, UT**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) RESIDENT ASSESSMENT

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on clinical record review, it was determined that for 1 of 8 sampled residents (Resident 1), the facility did not ensure that a registered nurse signed and certified that an inital Minimum Data Set assessment was complete.

A. Resident 1 was admitted to the facility on 4/06/06 with diagnoses that included: cardiovascular accident, hypertension,arthritis,stomach dysfunction disorder, dementia, anemia, and duodenal ulcers.

On 6/07/06, resident 1's medical record was reviewed.

Documentation revealed that the admission MDS dated 5/02/06, had no RN signature as to the assessment being completed.

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

The above isolated deficiencies pose no actual harm to the residents