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

PRINTED: 07/13/2006
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
	46A043	A. BUILDING ______ B. WING ______	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAR RIVER VALLEY NURSING HOME	460 WEST 600 NORTH TREMONTON, UT 84337

(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 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation of medication administration, interview, and record review, it was determined the facility did not immediately notify the physician when there was a significant	F 157 7/27/06 POC acceptable completion date 8/18/06 [signature] RN	F 157 Physicians and resident's legal representative or an interested family member will be notified on medication changes. Nursing staff will circle medication on MAR when medication is not given then they will document in back of MAR why medication was held. Shift Coordinators will review MAR on a weekly basis and if they find any medication that has been held three or more times during the week they will report it in clinical review and recommendations from pharmacist and medical director will be taken to residents primary physician. Process will be monitored by the ADON and reported each month to the administrator and quality committee through the submission of the monthly quality monitor performance report. Refer to Exhibit A & Exhibit B	8/1/06

Utah Department of Health
Cert# 70060100000040797 3497
JUL 25 2006
AM 7/21/06
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 21 July 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 157	Continued From page 1 change in the resident's physical condition (i.e., a deterioration in health status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment for 2 of 10 sample residents. The physician was not notified that one resident began to experience frequent episodes of diarrhea and continued to receive laxative therapy. One resident was experiencing slow heart rates and medication was being withheld without notifying the physician. Residents 9 and 14. Findings included: 1. On 6/27/06 at 8:10 AM, observation was made of the morning medication pass to resident 9. The resident's drug regimen included daily doses of colace, a stool softener, Senna-S, a stimulant laxative combined with colace, and Milk of Magnesia (MOM), a stool softener. The medication nurse administered the other laxatives, but did not give resident 9 the MOM. The medication nurse stated that the MOM was being held because resident 9 had been having diarrhea. The June 2006 Medication Administration Record (MAR) for resident 9 was reviewed. The MAR revealed MOM had been held six times in June, on 6/4/06, 6/15/06, 6/23/06, 6/25/06, 6/26/06 and 6/27/06. The MAR revealed colace had been held 6/25/06 and 6/26/06. There was no documentation on the MAR to reveal the reason the medication was being held or that the physician had been notified.	F 157		

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F 157	Continued From page 2	F 157		

On 6/27/06 at 2:30 PM, a brief interview was conducted with the medication nurse. The medication nurse was asked how it had been communicated to her that resident 9 was having diarrhea. The medication nurse stated that the CNAs (Certified Nursing Assistants) caring for resident 9 documented it in a separate log as "loose stool".

The CNA documentation revealed resident 9 had loose stool 17 of 26 days in June 2006, 6/2/06, 6/7/06, 6/8/06, 6/9/06, 6/10/06, 6/11/06, 6/13/06, 6/14/06, 6/16/06, 6/17/06 6/19/06 6/20/06, 6/21/06, 6/22/06, 6/23/06, 6/24/06 and 6/26/06.

The medication nurse stated she had not contacted the physician. She was unaware if anyone else had notified the physician of the change in resident 9's condition or the nurses' decisions to adjust the resident's medication regimen.

Resident 9's interdisciplinary progress notes, dated June 2006, did not mention that medication was being held. A weekly nursing summary, dated 6/15/06, revealed resident 9 had complained of feeling sick to her stomach and had a large loose bowel movement. There was no additional documentation that the resident's diarrhea had continued, that the physician had been notified, or that part of the resident's laxative medication was being held.

2. On 6/27/06 at 8:00 AM, observation was made of the morning medication pass to resident 14. The resident's drug regimen included a daily dose of Toprol and of Dilacor XR. Both medications

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F 157	Continued From page 3	F 157		

are antihypertensives that can have the side effect of bradycardia (slow heart rate) according to Nursing 2006 Drug Handbook. The medication nurse withheld resident 14's dose of Toprol because the resident's heart rate was slow, 54 beats per minute (bpm).

The June 2006 Medication Administration Record (MAR) for resident 14 was reviewed. The MAR revealed Toprol had been held sixteen times in June, 6/2/06, 6/3/06, 6/4/06, 6/6/06, 6/8/06, 6/11/06, 6/12/06, 6/13/06, 6/15/06 6/17/06 6/18/06, 6/20/06, 6/22/06, 6/23/06, 6/25/06, and 6/27/06. Resident 14's heart rate ranged from 51 to 54 bpm, with one exception. Resident 14's heart rate was documented as 80 bpm on 6/13/06.

There was no documentation that the physician was notified that the prescribed medication was being withheld or that resident 14's heart rate was frequently less than 60 bpm.

On 6/27/06, the Director of Nursing (DON) was interviewed. The DON stated they did not have a specific policy for when to withhold medications or parameters specifying when to notify the physician that medications were being withheld. The DON stated that they referred to recommendations in the medication reference books for parameters,

Nursing 2006 Drug Handbook, 26th edition, revealed nursing considerations for administration of Toprol included, "Always check patient's apical pulse rate before giving drug. If it's slower than 60 beats/minute, withhold drug and call prescriber immediately."

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F 161 SS=B	483.10(c)(7) ASSURANCE OF FINANCIAL SECURITY The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's current surety bond, it was determined that the facility did not have a surety bond which would assure the security of all personal funds of residents deposited with the facility. Findings included: The Director of Nursing was asked to provide to surveyors a copy of the facility's current surety bond. Review of the facility's surety bond as of 6/26/06, revealed it to be for $5,000. The Director of Nursing was asked for a copy of the resident trust account. On 6/29/06, the business office provided documentation that the resident trust account total was $5,991.67 The facility's surety bond was not sufficient to ensure the security of all personal funds of residents deposited with the facility.	F 161	F 161 We had three residents that when their balances were totaled it came to $3,600.65. We talked to the families of these residents and they transferred or spent down these accounts. The unit secretary will balance the personal needs account each month and verify that the total is $500 below our $5,000 surety bond. The administrator and quality committee through the submission of the monthly quality monitor performance report will review this process. Refer to Exhibit A.	8/1/06

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225	F 225 An educational in-service regarding mistreatment, neglect and abuse was held on June 15, 2006. Supporting documentation is provided in Exhibit C. The ADON will submit the number of alleged abuse investigations held each month to the administrator and quality committee. This information will be provided through the submission of the monthly quality monitor performance report. This will allow us to monitor how many investigations have been performed through the year and also raise questions if no allegations are being presented.	7/21/06

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F 225	Continued From page 6	F 225		

by:
Based on interviews and records review, it was determined the facility did not ensure that resident was protected from potential abuse during the investigation of alleged abuse for 1 of 10 sample residents. Resident 7.

Findings included:

Resident 7's medical record was reviewed 6/29/06.

Resident 7 had been admitted to the facility In 2004 with diagnoses that included anxiety disorder with depression and muscle spasms.

Resident 7's Minimum Data Set (MDS) assessment, dated 5/9/06, revealed the resident had no memory deficit, she had moderately impaired decision making. The IDT documented, further, that resident 7 had no behavior bilateral physical limitations and required extensive assistance of staff for all activities of daily living.

Resident 7 was interviewed in her room on 6/29/06 at 8:20 AM. Resident 7 stated that the facility staff were all nice except staff A. Resident 7 stated that staff A didn't like the resident, was disrespectful to the resident, and treated the resident and another resident mean. Specifically, resident 7 stated that during the previous shift, staff A:

1. Was "mean" to her. Resident 7 stated staff A refused to allow other staff to provide cares resident 7 had required. Resident 7 stated she often needed a shoulder massage to help her relax so that she could get to sleep. The resident

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F 225	Continued From page 7 stated staff A had refused to massage resident 7's shoulder. 2. Entered the resident's room to care for the resident's roommate and turned on all the lights to wake up both residents. 3. Was noisy at night and shouted at a resident in another room loud enough to keep resident 7 awake. At 8:55 AM on 6/29/06, the Director of Nursing (DON) was interviewed. The DON was asked if she had received any complaints from any residents regarding their treatment by staff. The DON stated that the previous afternoon (6/28/06), resident 7 had stated that staff A "was mean to her, not mean to her exactly, but not nice." The DON was asked if there had been any further investigation into the allegation or if she had reported to the State officials. The DON stated she had twenty-four hours (after the allegation to begin an investigation). The DON stated she had intended to discuss the allegation with her assistant (ADON) when the ADON arrived that morning (6/29/06) and then begin an investigation. The DON stated she had talked to staff B who "didn't think there was anything." On 6/28/06 at approximately 2:40 PM, the surveyor had met staff A who had arrived to work through the night shift. The DON was observed sitting in the visiting area talking with resident 7. At 10:10 AM on 6/29/06, the DON stated that she had talked with resident 7 on 6/28/06 in the visiting area. The DON stated that resident 7 was crying and told the DON that there was a problem with staff A. The DON stated again that resident	F 225		

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F 225	Continued From page 8	F 225		

7 had stated staff A was "mean, or not nice".

The DON was asked if she had done anything to protect resident 7 until the resident's concerns had been investigated, considering that staff A had been scheduled to work through the night with resident 7 after the allegation had been made on 6/28/06.

The DON stated she thought the resident was just concerned about not getting her medications. The DON stated that she could not see that any medications had been missed.

During the discussion with the DON, at 10:20 AM, the ADON joined the interview. The ADON stated she had not been aware of resident 7's allegation. The ADON stated that they would investigate all allegations, even though resident 7 complained a lot. The ADON stated that resident 7 had made a similar complaint about another staff during a survey two years ago. The ADON stated the pervious allegations were not substantiated.

Following discussions with the facility, but prior to survey exit, the DON stated she, the ADON, the ombudsman (who had been called to the facility by the surveyor per normal survey routine), and another staff had visited resident 7 in her room to begin the investigation.

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F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility did not promote care for residents in a manner and environment that maintained or enhanced each resident's dignity and respect, for 6 of 10 sampled residents and 4 additional residents. Resident identifiers 1, 2, 3, 5, 8, 9, 10, 11, 12 and 13. Findings included: During the annual survey on 6/26/06, the noon meal was observed from approximately 1:05 PM until 1:30 PM. Resident 8 was observed to require a total assist to eat her meal. During the meal, resident 8 was observed to have food residue around her mouth and on her upper lip. Resident 8 was observed to be taken from the dining room without her face being wiped clean of food residue. Resident 8 was taken to the activities day room and placed into a recliner chair where she was observed to remain with food residue on her face until 2:15 PM. During the annual survey on 6/27/06 at approximately 8:10 AM, several residents were observed to be sitting in the main hallway near the nurse's station. Resident 13 was approached by the facility medication nurse who administered resident 13's insulin injection to resident 13's left abdomen in full view of several other residents	F 241	F 241 The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Residents face will be wiped clean before leaving dining room after meals. Nursing staff will give injections in the resident's rooms for privacy unless the resident requests otherwise. 1. When assisting residents with meals the staff will sit down to feed residents. 2. When feeding residents, staff will feed them at their pace and they will allow time for resident to chew and swallow food. 3. Staff will engage in conversations with residents as able to during meal times.	8/4/06

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F 241	Continued From page 10 and anyone in the nurse's station area. At approximately 9:00 AM on 6/27/06, the facility medication nurse was observed to discuss resident 2's insulin dosage and administer resident 2's insulin injection to him in the hallway near the activities room within full view of other residents and others passing by in the hallway. At approximately 8:20 AM on 6/29/06, the facility medication nurse was observed to administer resident 1's insulin injection in the hallway near the dining room entrance within full view of other residents and others passing by in the hallway. During the annual survey on 6/28/06 from approximately 9:00 AM to approximately 9:30 AM, observations were made of the residents who were being assisted with eating at a full assist table nearest the folding doors to the activities day room. A facility Certified Nursing Assistant (CNA) was observed to be assisting resident 8 while the CNA was standing. The CNA was feeding resident 8 at a rate faster than resident 8 could chew and swallow the food. The CNA appeared not to notice that resident 8 was having difficulty swallowing the food and had a distressed look on her face. During the dining the two facility CNAs at the full assist table engaged in conversation about their activities outside the facility and did not include three residents who were seated at the table in their conversations, resident identifiers 8, 11 and 12. On 6/27/06 at 10:55 AM, a male resident was	F 241	All residents will be shaved in the beauty shop or in their room. Discussions with female residents regarding their need to shave facial hair will take place in privacy. ADON will monitor this process. The dietary manager will monitor and make changes in the dining room as needed in a manner that allows staff to freely bring in all residents without having to move any residents once they are seated if possible patient will ambulate to dining room. The dietary manager will hold an in-service on 7/25/06 for kitchen staff about serving residents. All residents on a table will be served prior to going onto another resident's table, unless a resident makes a special order request that requires an extended amount of preparation time. In this case, the resident will be told the amount of time that will be required to meet their request.	

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F 241	Continued From page 11 being shaved in the beauty shop near the nurses' station. When the beautician finished with the male resident, she left the beauty shop and approached a female, resident 10. Resident 10 was sitting in the visiting area across from the nurses' station. The beautician told resident 10 that she needed to have her chin shaved. The beautician proceeded to shave resident 10, while the resident sat in the visiting area. On 6/27/06 at 8:20 AM, resident 9 was observed to be seated in her wheelchair at the dining table. Resident 9 was eating breakfast independently. A CNA entered the dining room with a female resident who was seated in a wheelchair. The CNA told resident 9 she had to be moved for just a moment to let the other resident pass by. Three minutes later, another CNA entered the dining room with a male resident who was seated in a wheelchair. The CNA told resident 9 she had to be moved for just a moment to let the other resident pass by. Resident 9 was moved away from the table and left out of reach of her meal until the male resident was situated at a table. While she waited to be assisted back to the table, resident 9 expressed annoyance. Resident 9 asked twice to be assisted back to the table before the CNA returned to help reposition resident 9 at the table. On 6/28/06 at 12:45 PM, resident 5 was observed sitting at the dining room table with seven other residents. The residents' trays had been preset with beverages and a fruit cup. Resident 5 had refused her pureed fruit cup and it had been taken away. After five minutes, resident 5 was given another fruit cup and she promptly ate the two banana chunks. The seven other residents	F 241	The Dietitian and Dietary manager will monitor all dining room activity. A monthly report will be submitted to the ADON and Administrator.	

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F 241	Continued From page 12 at resident 5's table were eating their entrees, but resident 5 had not been served hers. Resident 5 watched the other residents eating, but looked up at the serving staff occasionally. Resident 5 watched her tablemates eat until she was served her meal at 12:59 PM, fourteen minutes after the last resident at the table had been served.	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility did not provide maintenance services to maintain a sanitary, orderly and comfortable interior for 10 of 10 sampled residents. Resident identifiers 1-10 Findings included: During the annual survey of the facility conducted on 6/26/06 at 12:45 PM, a floor drain in the facility kitchen was observed to be backed up with an inch of water covering approximately 32 inches by 42 inches of floor surface surrounding the drain. The puddle of water was observed to be located within three feet of the steam table, where lunch was being served. The dietary manager stated that she had notified the facility maintenance staff. The dietary manager stated grease needed to be cleaned out of the drain and maintenance was going to take	F 253	F 253- The dietary floor drain has been added to the monthly PM list. The facility safety committee monitors PM list completion. Refer to Exhibit I.	7/17/06

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	46A043	A. BUILDING ______ B. WING ______	06/29/2006

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F 253	Continued From page 13 care of it. An interview with the facility maintenance supervisor was held on 6/27/06. During the interview the facility maintenance supervisor stated that the kitchen floor drain has to be periodically treated with chemical to keep it open and draining.	F 253		
F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility did not complete a comprehensive Minimum Data Set (MDS) assessment of a resident after the Interdisciplinary Team (IDT) documented the resident had experienced a significant change in physical and mental condition. Resident 1.	F 274	F 274 7/19/2006 an educational meeting was held to review the MDS & the importance of documentation and gathering of accurate data. See Exhibit H. An MDS specialist has been contacted and will provide training in completing and utilizing the MDS. This training is scheduled for August 1, 2006. The MDS for resident 1 was filled out incompletely as resident 1 was on hospice at the time in question. A modification will be completed. Appropriate corrective action will be education on accurately completing the MDS. A	8/18/06

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F 274	Continued From page 14 Findings included: Resident 1 had been admitted to the facility October 2005 with diagnoses that included diabetes and depression. The medical records for resident 1 were reviewed on 6/26/06. The facility IDT completed an initial comprehensive assessment, dated 11/8/05, of resident 1's physical, mental and psychosocial condition. The IDT completed a quarterly MDS assessment of resident 1, dated 1/31/06. The quarterly MDS included data that indicated resident 1 had experienced a significant change of condition that had an impact on more than one area of the resident's health status. Changes from November 2005 through January 2006 included: B4, Cognitive Skills for Daily Decision Making, from "1" some difficulty in new situations only, to "2" decisions poor, cues supervision required. C4, Communication, from "0" understood, to "1" sometimes understood. G1c, Walk in Room, from "8" did not happen, to "3" resident performed part of activity with staff support. G1g, Dressing, from "2" limited assistance,	F 274	consultant will review the facility in three months to ascertain the effectiveness of our education and then will review the facility Bi-annually. This will allow us to monitor the thoroughness and completeness of our MDS's and the performance of our MDS coordinator. A report will be provided to ADON and Administrator.	

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F 274	Continued From page 15 to "3" extensive assistance. G1j, Personal Hygiene, from "2" limited assistance, to "3" extensive assistance. H1a, Bowel Continence, from "3" frequently incontinent, to "0" complete control. K2b, Nutritional Status, from a weight of 107 pounds, to a weight of 94 pounds. A significant loss of 12% over less than 90 days. K3a, Weight change, from "0" no significant change, to "1" significant weight loss. P1, Special Treatments and Procedures, from P1s "0" none, to P1o "X" Hospice care.	F 274		

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F 278 SS=E	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 observation, interview, and medical record review, it was determined the facility Interdisciplinary Team (IDT) did not complete accurate Minimum Data Set (MDS) assessments for 3 of 10 sample residents, to include accurate assessment and staging of pressure ulcers. Residents 1, 4, 5	F 278	F 278 7/19/2006 an educational meeting was held to review MDS & the importance of documentation and gathering of accurate data. See Exhibit H MDS coordinator will review MDS for accuracy, prior to signing completion of all MDS's. A consultant will review the facility in three months to ascertain the effectiveness of our education and then will review the facility Bi-annually. This will allow us to monitor the thoroughness and completeness of our MDS's and the performance of our MDS coordinator. A report will be provided to ADON and Administrator. An MDS specialist has been contacted and will provide training in completing and utilizing the MDS. This training is scheduled for August 1, 2006	8/18/06

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F 278	Continued From page 17 Criteria for staging an ulcer on the MDS assessment: Stage I. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Stage II. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. Stage III. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue. Stage IV. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone. The presence of necrotic eschar is to be coded as Stage IV. Findings included: Resident 4 was admitted to the facility March 2006. The IDT documented an initial comprehensive MDS assessment, dated 3/14/06, that resident 4 had previously had a pressure ulcer which was healed. The documentation on resident 4's quarterly MDS assessment, dated 6/7/06, revealed the resident had two Stage II pressure ulcers. A significant change MDS assessment, dated 6/20/06, revealed resident 4 had one Stage I pressure ulcer and one pressure ulcer had been healed. A physician's order, dated 6/22/06, revealed resident 4's left heel was to be debrided and evaluated by the physical therapist.	F 278	Wound specialist came into facility July 12th 2006 and educated shift coordinator on treatment of wounds. Wound specialist made recommendations and recommendations where taken to families and primary physicians. Resident #1 was seen at wound clinic. Resident #1 and family declined treatment at the wound clinic. An educational In-service was held on July 13th 2006. The treatment of wounds was discussed. Documentation is provided in Exhibit D.	

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F 278	Continued From page 18 Resident 4's pressure ulcer was observed on 6/26/06 at 4:40 PM as it was being debrided by the physical therapist. The pressure ulcer appeared to be approximately 4.5 cm (centimeters) by 4 cm with a 0.5 cm rolled white/yellow edge. The bed of the wound was a moist yellow slough prior to being debrided. The pressure ulcer was a Stage III when observed on 6/26/06. On 6/21/06, a facility Registered Nurse (RN) had completed wound documentation that revealed the wound to be Stage II. Photo documentation of the pressure ulcer on resident 4's left ankle, dated 6/21/06, revealed the pressure ulcer on resident 4's left ankle had been Stage III. Resident 1 was admitted to the facility October 2005 with a Stage I pressure ulcer on her right buttock and and a blister (Stage II) on her right heel. The IDT completed an MDS assessment, dated 4/25/06, with documentation that the resident's right heel had a Stage II ulcer. Wound documentation revealed resident 1's right heel had an ulcer with white/gray rolled edges with pink/beefy red tissue in the wound bed. Additional errors documented on resident MDS assessments included: The facility IDT documented resident 4's initial MDS, dated, 3/14/06, that the resident was divorced (section A5). On 6/26/06, resident 4's care giver stated the resident was married and had been married over 40 years. The facility IDT completed an MDS assessment	F 278		

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F 278	Continued From page 19 for resident 1, dated 1/31/06, that documented the resident's height as 61 inches. The facility IDT completed an MDS assessment for resident 1, dated 4/25/06, that documented the resident's height as 62 inches.	F 278		
F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on observation of medication administration, interview, and record review, it was determined the facility did not ensure a resident's drug regimen was free from unnecessary drugs for 1 of 10 sample residents. One resident continued to receive duplicate laxative therapy after the resident began to experience frequent episodes of diarrhea. Resident 9. Findings included: On 6/27/06 at 8:10 AM, observation was made of the morning medication pass to resident 9. Resident 9 received three medications for constipation. The resident's drug regimen	F 329	F 329 Pharmacist will review Medication records monthly. Recommendations of unnecessary drugs will be reviewed monthly by IDT members and recommendations will be taken to residents primary physician, orders will be followed as per primary physician. As a tool to assist with the laxative issue, the following form has been established. See Exhibit E.	7/21/06

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F 329	Continued From page 20	F 329		

included daily doses of colace, a stool softener, Senna-S, a stimulant laxative combined with colace and Milk of Magnesia (MOM), a stool softener. The medication nurse administered did not give resident 9 the MOM. The medication nurse stated that she was not going to give the prescribed dose of MOM because resident 9 had been having diarrhea.

On 6/27/06 at 2:30 PM, a brief interview was conducted with the medication nurse. The medication nurse stated she realized, after giving the medications to resident 9, that it didn't make sense to hold MOM but give colace and Senna-S to a resident with diarrhea.

The June 2006 Medication Administration Record (MAR) for resident 9 was reviewed. Nurses signed the MAR for each medication administered to the resident. When a medication was held, the nurses drew a circle around their initials. The MAR revealed MOM had been held six times in June, on 6/4/06, 6/15/06, 6/23/06, 6/25/06, 6/26/06 and 6/27/06. The MAR revealed colace had been held 6/25/06 and 6/26/06 and Senna-S had not been held. There was no documentation on the MAR to reveal the reason medication was being held.

Resident 9's interdisciplinary progress notes, dated June 2006, did not mention that medication was being held. A weekly nursing summary, dated 6/15/06, revealed resident 9 had complained of feeling sick to her stomach and had a large loose bowel movement.

The medication nurse was asked how it had been communicated that resident 9 was having

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F 329	Continued From page 21 diarrhea. The medication nurse stated that the CNAs (Certified Nursing Assistants) caring for resident 9 documented the incidents in a separate log. The nurse revealed that CNAs had documented it as "loose stool". The CNA documentation revealed resident 9 had loose stool 16 of 26 days in June 2006. A faxed communication from the facility, dated 7/5/06, revealed resident 9's laxatives had been held 6 days and the resident's "diarrhea persists."	F 329	F 514 Facility will maintain clinical records on each resident in accordance with acceptable professional standards and practices that are complete. #1-When physicians orders are received, the nurse will write the order on medication record. When recerts are up-dated nurse will check original physicians orders and revise recert as per physician. ADON will give a copy of the recert to unit clerk to reconcile against MAR. ADON will monitor and report monthly to administrator and quality committee through the monthly quality monitor performance report. See Exhibit F & A. #2- Social Worker went through residents chart and corrected any misspelling. Staff was informed and asked to pay close attention to the spelling of resident names. MDS coordinator will perform a quarterly audit of resident charts. Any	7/21/06
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 observation, interview and record review, it was determined the facility did not maintain clinical records on each resident that were accurately documented for 4 of 10 sample residents. Residents 4, 5, 7, and 9. Findings included:	F 514		

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F 514	Continued From page 22 1. During observation of medication administration on 6/27/06, resident 9 was observed to receive Celebrex 200 milligrams. Resident 9's medical record was reviewed on 6/27/06. The recertification of physician's orders, signed by resident 9's physician on 6/7/06, 4/7/06, 2/7/06 and 12/7/05, did not include an order for Celebrex to be administered to resident 9. A physician's order for Celebrex for resident 9, dated 4/11/05, was located in the resident's overflow records. No physician's order to discontinue the Celebrex was located in resident 9's medial record. 2. Resident 7's medical record was reviewed on 6/28/06. Resident 7's name was spelled four different ways in various parts of the resident's record. 3. Resident 5's medical record was reviewed on 6/27/06. Resident 5 was admitted to the facility March 2005. Resident 5's medical record was reviewed on 6/27/06. Resident 5's date of birth was documented as 1917 on her care plans and advanced directives. Resident 5's date of birth was documented as 1918 on her admission record Minimum Data Set (MDS) assessments and nutritional assessments. 4. A certified nursing assistant (CNA) was interviewed on 6/27/06. The CNA stated she worked for a hospice company to help provide	F 514	inconsistencies or problems will be corrected and MDS coordinator will educate person creating error. ADON will monitor and report monthly to administrator and quality committee through the monthly quality monitor performance report. See Exhibit F & A. #3 On admission resident's daughter wrote the wrong birth year of 1918 on our contract. When the blue stamp was printed from data on file in our computer it was 1917. This was investigated with daughter and resident and the blue stamp was correct. Corrections were made in the chart and modifications were made to the MDS and sent to the state. The unit secretary will reconcile information from the family to the information available in our system database to assure consistency. ADON will monitor this process. See Exhibit J.	

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F 514	Continued From page 23 cares for resident 4, in conjunction with the facility staff. The Director of Nursing was requested to provide the surveyors with a list of resident's who were receiving hospice care. Resident 4 was not included in the list.	F 514	#4 Issue arouse with the first legacy hospice resident at the care center. Legacy Hospice Nurse was unaware of the importance of placing admit order in physicians orders in residents chart. Hospice list is generated from physician orders. Legacy hospice nurse was informed and shown where to put it. Hospice nurse indicated she was following hospice protocol and was under the understanding that they had 8 calendar days. See Exhibit G. Resident was put on hospice service June 21st 2006, 5 days before survey team presented to the care center. ADON will provide orientation to new Hospice agencies to verify they understand our required processes. ADON will report completed orientation for all new Hospice agencies to administrator.	

EXHIBIT A

Bear River Valley Care Center performance report 2006

GOALS	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	AVE
Personal needs accounts balanced and surety bond $4500.00													
Missed narcotic counts													
Narcotic Waste/2 signatures missed													
Mortalities													
Total Falls													
Restraints Used													
Pressure Ulcers													
# of residents on antidepressants													
Infections reported													
Medication Errors													
Abuse Investigations													

Number of residents with meds held													
Quarterly audits completed													

Bear River Valley Care Center
Date____________________

EXhibit B

The following residents medication profiles have been reviewed for the following:

1. Each medication has a documented indication.
2. Regimen has been evaluated for duplication of medications or medication classes.
3. PRN medications have been reviewed for duplication and non use.
4. Psycoactive medications have been evaluated for appropriate use.
5. If anticonvulsants ordered for seizure disorder, seizures are controlled.
6. Patients on thyroid medication have lab documentation of thyroid function.
7. Patients on anticoagulants have appropriate labs present.
8. Patients on insulin or oral hypoglycemics have appropriate labs.
9. If patient on iron, vit B6, B12 or folate has RBC assessment in first month of treatment.
10. If patient is on urinary anti-infective or being catheterized, labs are present.
11. Patients on antihypertensives or other cardiac medications have BP and pulses recorded weekly.
12. When medications are held for 3 or more days in 7 day period pharmacist and physician are notified.
13. Patients on digoxin or diuretics have appropriate labs in place.
14. Drug allergies are documented and checked against medication profile.
15. Estimated CrCL is in place and dosage ranges for medications are appropriate for patients renal function.
16. Physician certification is current.
17. Unnecessary medications.

Patient:	Labs	Notes/Recommendations

Exhibit K

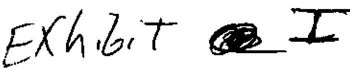
DINING ROOM SERVICE
WEEKLY TRENDING

Date_____________ Number of residents in sample_________________

Reviewer_________

Item	1st	2nd	3rd	4th
Staff talks with resident, not other staff, during meal service and feeding assistance				
Staff are alert and responsive to residents needs during meal time				
Staff cannot change seating arrangements in dining room. Notify Dietary Manager of changes needed				
Staff is efficient with delivery of meal				
Comments:				

Dietitian will monitor weekly and report on findings monthly on QA report.



Intermountain Healthcare
Preventative Maintenance Work Page

PM ID Number: 1405044	**Condition:** Poor	**ECRI Product Category:** Drains, Floor		
Assigned To: Burnhope, Roger		**Equipment ID:** 295256	**Prefix:** BRCC10	**Facility Location:** Bear River Valley Hospital Care Unit Care Unit
Completed By:		**Serial Number:** na		
PM Date: 8/1/2006	**Date Completed:**	**Manufacturer:** VARIOUS		**Schedule Type:** Monthly
PM Begin Date: 7/17/2006	**PM Due Date:** 8/16/2006	**Model:** DRAINS		**Control Number:** BRCC100

PM Comment:

Work Steps:

Estimated Time to Perform: 0

Perform General Maintenance Procedures, As Applicable

1. Add enzymes.
2. Auger lines as required.
3. Clean all x-ray film processor drains, or call outside service as required.
4. Clean all soft drink dispenser drains.
5. Treat areas with root killer as needed.
6. Check water flow and keep open.

Results:

Technician Name	Minutes

Part Number	Description	Quantity	Cost

Comments:

This information is for the exclusive use of Intermountain Healthcare employees, who may use this information on a need-to-know basis only.

Exhibit D

July 2006
Staff Meeting/Inservice

Nursing Staff

Medication Management Update

- See attachment Medication Management update-Interpreting Medication Orders
- Handout to the nurses given

Labs-Amy T.

- Amy discussed how to mark and track when labs have been done for each month.
- She places the lab tracking sheet in the plastic folder at the nurses desk with each monthly lab listed with the patients names and we just need to mark them when they are sent back to the care center from the lab

Insulins

- When you open a new insulin box please tear of the lid so that we know that it has been opened and we don't have out dated insulins left in the fridge because we think that it has not been opened.

Care Plans

- With each new problem or new diagnosis you need to start updating the care plans there are 3 examples in a manila folder that you can refer to. They will be located in the back of the south care plan folder.

Digoxin Policy & Procedure

- When we have a patient whose heart rate is below 60 you must hold the medication.
- If it is below 50 then we need to contact the physician immediately
- Also if we are holding meds for 3 or more times in a week MD must be notified

All Staff

Eye Infections

- Hand out of the eye infection inservice by PAM and pharmacy student

State Survey Results

- Irene discussed the state survey results see attached paper.

Wounds

- Wound specialist into BRVCC for wound consultation. Two residents referred to clinic for treatment by wound specialist.
- Staff reminded to notify nurse stat of any changes in the residents skin.
- Repositioning, Nutrition, Hydration, et protective creams reviewed.

Wound Care Specialist Consultation
July 13, 2006

She gave us the IHC protocols they follow at LRH. They can be found in the wound binder. She then evaluated our current wounds and gave recommendations. These are the following recommendations made for our residents at the Bear River Valley Care Center.

- Wet to moist dressings for those that are hard to heel. (Poor nutrition & diabetic)
- DO NOT USE HEELBOS FOR PRESSURE RELIEVING
- Wounds with eschar they are unstagable- they must be debrided so we can stage them. If they have poor circulation or diabetes be careful with debridement.
- With wounds in acute care they do not back stage. Example: If the wound is a stage III and it heals to a stage II would would not stage it a stage II at that time you would document a healed Stage III-The wound specialist was not sure if this would be the same for LTC Regulations. Refer to old book pg 12 & 13.
- Wounds that are stage III or IV then we need to send them to an acute care facility unless we get special permission from the state to keep them here.
- Waffle boots were recommended for all high risk immobile residents. They are cheap only 25$.
- Multidex Boots better for those with chronic long term wounds these are more expensive.
- Just make note skin tear dressings should only be changed every 3 days and small ones up to a week. This will help prevent infection.
- Blisters when popped or removed should be dressed with the wet to moist dressing.
- Xenaderm ointment is recommended for scrotum wounds-This encourages circulation. (Order form Health Point)

Type of Wound	Drainage	Treatment and/or Dressing	Frequency of Dressing Change
Skin Tear **Linear skin tear or flap tear. Partial thickness. Completely approximated or1 ml of dermal exposure**	Absent to Moderate	➢ Call Wound Care team **(if available)** & follow wound care protocol ➢ Re-approximate tissue and secure with Steri-strips ➢ 3M foam dressing non-bordered secured with rolled gauze ➢ Non-adherent contact layer	Every 3 days and/or PRN
Skin Tear **Partial thickness skin loss. 25% of the epidermal flap is lost or 75% of the dermis is covered by the flap.**	Small to Moderate	➢ Call Wound Care team **(if available)** & follow wound care protocol ➢ Re-approximate tissue and secure with Steri-strips ➢ Protect surrounding with 3M™Cavilon No Sting Barrier Film ➢ 3M foam dressing ➢ Adaptic non-adherent contact layer	Weekly and/or PRN
Skin Tear **Partial thickness wound with no flap present.**	Small to Moderate	➢ Call Wound Care team **(if available)** & follow wound care protocol ➢ Protect surrounding skin with 3M™Cavilon No Sting Barrier Film ➢ 3M foam dressing ➢ Adaptic non-adherent contact layer	Every 3 days for foam Weekly for non-adherent

Use IHC Wound Care Formulary products, consult your local wound care specialist Phone#________________ or materials management for questions, treatment and best products to use

Formulary available http://ihcweb.co.ihc.com/enterprise/shared_services/MMWeb/WoundCare/WCProductFormulary.cfm

3M Skin Health Web site: http://www.3m.com/us/healthcare/professionals/skinhealth/jhtml/pressure_ulcers.jhtml

Exhibit E

LAX LIST

Date	Resident Name	Last BM	Consistency	Size	Medication Given	Initial

EXHIBIT F

QUARTERLY AUDIT			
Name:	Date of Audit	Initials	Comments
Signed & dated recerts / all meds on recert			
Telephone orders signed & dated by M.D.			
M.D. progress notes 60 days			
Nurses notes as per facility policy			
Nurses monthly summary			
Weights, monthly or as ordered			
Vital signs, monthly or as ordered			
Monthly pharmacy review			
Dietary progress notes every 90 days			
Social history & evaluation annual update			
Social services notes every 90 days			
Discharge plan updated every 90 days			
Activity plan updated every 90 days			
Activity assessment annual update			
Patient care plan - date of review			
Resident - family participation in IDT			
Annual MDS			
Quarterly MDS			
check spelling and dates throughout chart			

Exhibit G

Sec. 418.20 Eligibility requirements.

In order to be eligible to elect hospice care under Medicare, an individual must be--

(a) Entitled to Part A of Medicare; and

(b) Certified as being terminally ill in accordance with Sec. 418.22.

[Page 693-694]

Sec. 418.21 Duration of hospice care coverage--Election periods.

(a) Subject to the conditions set forth in this part, an individual may elect to receive hospice care during one

[[Page 694]]

or more of the following election periods:

(1) An initial 90-day period.

(2) A subsequent 90-day period.

(3) A subsequent 30-day period.

(4) A subsequent extension period of unlimited duration during the individual's lifetime.

(b) The periods of care are available in the order listed and may be elected separately at different times.

[55 FR 50834, Dec. 11, 1990, as amended at 57 FR 36017, Aug. 12, 1992]
[Page 694]

Sec. 418.22 Certification of terminal illness.

(a) Timing of certification--(1) General rule. The hospice must obtain written certification of terminal illness for each of the periods listed in Sec. 418.21, even if a single election continues in effect for two, three, or four periods, as provided in Sec. 418.24(c).

(2) Basic requirement. Except as provided in paragraph (a)(3) of this section, the hospice must obtain the written certification no later than two calendar days after the period begins.

(3) Exception. For the initial 90-day period, if the hospice cannot obtain the written certifications within two calendar days, it must obtain oral certifications within two calendar days, and written certifications no later than eight calendar days after the period begins.

(b) Content of certification. The certification must specify that the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course.

(c) Sources of certification. (1) For the initial 90-day period, the hospice must obtain written certification statements (and oral certification statements if required under paragraph (a)(3) of this section) from--

(i) The medical director of the hospice or the physician member of the hospice interdisciplinary group; and

(ii) The individual's attending physician if the individual has an attending physician.

(2) For subsequent periods, the only requirement is certification by one of the physicians listed in paragraph (c)(1)(i) of this section.

BEAR RIVER VALLEY CARE CENTER

EXhibit J

NURSING CHECK LIST

PRIOR TO ADMITTANCE:

- ____**Preadmission meeting with family**
- ____**Admittance packet completed**
- ____**PASRR prescreening done**

UPON ADMITTANCE:

- ____**Physician History and Physical** signed by MD
- ____**Orders verified,** noted. Orders to include DX/reason for each med and treatment
- ____**Take vitals, height, weight**
- ____**Do full body assessment**
- ____**Admission Nursing History and Assessment**
- ____**Personal Belongings List**
- ____**Label clothing**
- ____**Admission Progress Notes written**
- ____**Call business office ex 4340 to inform about new admit/check stamper information with information given by the family for any discrepancies**
- ____**Prepare and fax Medicaid form 10A to 801-536-0948 (Use bare minimum info if necessary--see sample form)**

PAPERWORK CHECKLIST:

- ____**Flow sheet** stamped and placed in List Book
- ____**Allergies/DNR stickers** posted on outside of chart
- ____**MDS** Completed within 14 days
- ____**Lab work** sent as applicable
- ____**Braden Scale** completed on flow sheet
- ____**Dietary orders** on flow sheet
- ____**Pressure Sore Assessment** on flow sheet
- ____**Fall Risk Assessment** on flow sheet
- ____**Side Rail/Restraint Form** completed if needed
- ____**Psychotropic Medications Consent Form** completed if needed
- ____**Initial psychotropic medication rap** completed if needed

UPON DISCHARGE OR TRANSFER

- ____**Complete Discharge Tracking form**
- ____**Call business office ex 4340 to inform of discharge or transfer**

UPON REENTRY

- ____**Complete Reentry Tracking form**
- ____**Call business office ex 4340 to inform of reentry**