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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465066	A. BUILDING _____ B. WING _____	3/27/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE BENNION CARE CENTER	6246 SOUTH REDWOOD ROAD SALT LAKE CITY, UT 84123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 157 SS=D	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES 5/8/03 A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and review of medical records, it was determined that for 1 of 19 sample residents, the facility did not immediately inform the resident's physician or family when there was a significant change in the resident's physical and mental status. Resident identifier: 10.	F 157	POC accepted/ c addendum Completion date for all tags 5/26/03 [signature] RN **F 157** Resident 10 was admitted to Hospice services 10/31/02 with the last Quarterly MDS assessment dated 1/29/03 indicating end stage disease, 6 or fewer months to live and Overall Change In Care Needs marked as deteriorated. The facility did notify the physician of resident 10's condition that included lethargy, left eye droop, drooling etc. at 12:00 noon on 1/3/03. Additionally the resident's family was notified of her condition. Per 1/3/03 nursing note the family response was "No heroic measures." Therefore, this resident's inability to take her medications and unresponsiveness to stimulation noted 1/3/03 at 1900 was not a change from the previous assessment and did not warrant further physician notification as directives had previously been received regarding the resident's status. The episode sited on 3/8/03 was transient lasting approximately 30 seconds. The resident's vital signs remained within normal limits and the resident continued to be monitored over the course of an hour at the end of which the resident's condition had returned to baseline. Per guidelines for F157, "immediate" family and physician notification is required when an accident involving the resident results in injury, and has the potential for requiring physician intervention; a significant change in physical, mental or psychosocial status in either life threatening conditions or clinical complications. A need to alter treatment significantly or a decision to transfer or discharge the resident from the facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 4/25/03

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

APR 28 2003
04/24/03 MT

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F 157	Continued From page 1 Findings include: Resident 10 was an 84 year old female who was admitted to the facility on 12/21/99 with a gastrointestinal bleed, iron deficiency, chronic blood loss, anemia, senile dementia, esophageal reflux and constipation. Resident 10's medical record was reviewed on 3/26/03 and 3/27/03. On 1/3/03, a nurse documented the following regarding resident 10: "Resident unresponsive, unable to take meds (medications) at 1900 (7:00 PM). Later at 2030 (8:30 PM) responded slightly to loud verbal stimulation." The medical record did not contain any documentation to evidence that the resident's physician had been notified of this "unresponsive" episode. The nurse who wrote this note (1/3/03) was interviewed on 3/27/03 at 1:50 PM. The nurse was asked if she had notified resident 10's physician or family of the above "unresponsive" episode. The nurse stated that she had not called either the resident's physician or family, but "should have". Resident 10 experienced another unresponsive episode on 3/8/03. The nurse's note recorded the following: "Resident suddenly jerked and clumped over. Her eyelids were jerking rapidly and she was unresponsive to loud noise and whaking for approximately 30 seconds. When she came around resident was much	F 157	The resident's Medical Treatment Plan completed November 2000 specifies; DNR (Do Not Resuscitate), DNI (Do Not Intubate), No CPR, No I.V., No Tube Feeding, No I.V. antibiotics, No hospitalization without family consent, Comfort Measures Only. The transient episode lasting 30 seconds on 3/8/03 does not represent a significant change in condition as the resident's status returned to baseline within one hour. This transient episode did not require physician intervention due to a need to alter treatment, discontinue treatment, or a decision to transfer or discharge from the facility. As specified in the Medical Treatment Plan which addressed each of these issues. The resident's Hospice status further supported the family's wish for "Comfort Measures only" as specified on the Medical Treatment Plan. Resident 10 has been reassessed. Condition and plan of care remain the same. Licensed Nurses will continue to be educated on physician notification of significant changes in resident condition as part of new hire orientation and this education will be repeated PRN. An inservice will be conducted 5/7/03 for nursing staff pertaining to physician notification of resident change in condition. Director of Nursing/Designee will continue to review 24 hour reports 3 times per week and PRN. Any identified trends will be reported to the QA committee Q month or as needed.	

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F 157	Continued From page 2 calmer and very confused..." The medical record did not contain any documentation to evidence that the resident's physician had been notified of this "unresponsive" episode. The nurse who wrote this note (3/8/03) was interviewed on 3/27/03 at 1:50 PM. The nurse was asked if she had notified resident 10's physician or family of the above "unresponsive" episode. The nurse stated that she had not called either the resident's physician or family, but "should have".	F 157		
F 164 SS=D	483.10(d)(3) FREE CHOICE The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164	**F 164** The staff members "dressed in nursing attire" were in fact a licensed nurse in the facility as a C.N.A. certification instructor along with her students. Upon interview conducted by the facility Administrator with the licensed nurse instructor she reported that upon passing room 306 she and her students were called into the room by resident 82. Upon entering the room the resident raised her shirt and asked the nurse to assess her ostomy. The instructor attempted to reassure her and told the resident she would get the nurse on duty to assist her. Resident 82 exposed her abdomen for approximately 30 seconds.	

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F 164	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that for one resident, the facility did not ensure personal privacy. Resident 82. Findings include: On 3/26/03 at 4:31 PM, a surveyor was passing room 306. The surveyor observed resident 82 (in bed A of room 306) sitting on the side of the bed. The resident was observed to have her stomach and lower half exposed while 3 individuals (dressed in nursing attire) were looking at her abdomen. The resident's privacy curtain had not been pulled to provide privacy nor had the room's door been shut. Anyone passing by the room could see the resident exposed. A few moments later, the surveyor again passed by room 306. The resident continued to be exposed. The 3 individuals dressed in nursing attire made no effort to close the door to the room or pull the privacy curtain.	F 164 OK LB	The resident's Quarterly MDS assessment dated 3/19/03 is marked indicating Socially inappropriate/Disruptive behavioral symptoms (made disruptive sounds, noisiness, screaming, self abusive acts, sexual behavior or disrobing in public.) Behavior of this type occurred 1-3 days in last 7 days and behavior is not easily altered. The Quarterly MDS assessment dated 3/19/01 also indicates the following behaviors are exhibited daily or almost daily. Repetitive questions, Repetitive verbalizations, Repetitive health complaints, Persistently seeks medical attention, Obsessive concern with body functions. The resident also has a diagnosis of Generalized Anxiety Disorder (Psych. Diagnosis) for which she is being followed by Wasatch Mental Health for psychotherapy. Additional diagnoses include Dementia with Psychotic Features and COPD with Anxious Features. At the time of the occurrence the resident was being treated for pneumonia. Her illness was increasing her shortness of breath and subsequently was impacting her level of anxiety and restlessness. The resident has the cognitive ability necessary to understand that her door and privacy curtain was open when she made the free choice to lift her gown to show the licensed nurse instructor and her students her abdomen.	
F 241 SS=E	483.15(a) QUALITY OF LIFE 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, confidential individual interviews and the confidential group interview, it was determined that the facility did not provide care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality.	F 241 OK Tadlender LB		

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F 241	Continued From page 4 Residents: 46, 75, 76, 78 Findings include: 1.During an observation of the breakfast meal on 3/24/03 in the Brass cafe Certified Nursing Assistant (CNA) #1 was observed speaking roughly to another aide. She was then observed to spill the eggs off the plate of a resident on to the table. She scooped the eggs up with her bare hand and replaced them on the residents plate she then proceeded to feed the eggs to the resident. 2. In a confidential interview with a group of alert and oriented residents 4 out of 15 residents stated that when they turn on their call lights an aide will come and turn the light off and say they will come back and never do. Five out of 15 residents stated that they have waited in excess of 20 minutes for their call light to be answered on week-ends. 3. On 3/24/03 at 8:50 AM, resident 75 was observed to be in her wheelchair, with her day gown pulled up around her waist, with a lap blanket covering the top of her legs. Resident 75 was observed to have the side of her buttocks and the side of her upper thighs exposed while being wheeled from the dining room, down the hall and into her room. 4. A confidential interview was held with a resident on 3/24/03 at 1:40 PM. When asked about call lights, the resident stated that he had to wait from 15 minutes to 1 hour for his call light to be answered. When probed for more specifics, he stated that 50% of the time its up to one hour and 50% of the time its up to 15 minutes. He further stated that when he is in pain he has waited up to 2 hours for a nurse to return with pain medication. 5. On 3/26/03 at 8:05 AM, resident 75 was observed	F 241	The resident exposure did not occur during the provision of care and was not a failure by involved staff members to protect resident privacy. Resident 82 will continue to be assessed and care plan updated as needed. All facility staff will continue to be educated regarding resident's free choice upon hire and as needed. Administrator/Designee will continue to complete walking rounds weekly to ensure resident free choice being observed by facility staff. Any trends identified will be brought monthly as needed to the QA committee. **F 241** C.N.A. #1 is no longer employed by the facility. Resident 75 who is above her ideal body weight, alert and oriented to person, place and surroundings and able to make her wants and needs known. Resident 75 did not request intervention by staff members who were in close proximity during the meal time, to assist her to adjust her clothing or to remove her clothing protector after the meal. Resident 75 has a history of noncompliance with physician ordered diet texture and fluid consistency. Resident 75 has previously been assessed by Speech Therapy and has been educated regarding the risks of noncompliance with ordered diet texture and fluid consistency. Resident 75 has been reassessed and care plan updated as indicated.	

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F 241	Continued From page 5 in the dining room to gag and spit up her food on her clothing protector. Resident 75's table mate called an aide over who wiped her mouth with her clothing protector and walked away. The aide went and got a nurse, while the nurse was walking over to the resident, resident 75 proceeded to spit up more of her food onto her clothing protector. Another aide took resident 75 out of the dining room, with the soiled clothing protector still in place. At 8:12 AM, resident 75 was observed to be alone in her room, by the door, with the soiled clothing protector still in place. 6. On 3/26/03 at 8:40 AM, resident 76 had his call light on, the maintenance supervisor answered his call light. Upon entering resident 76's room, he was observed to be up in his wheelchair next to a bedside commode. The resident stated he was upset because he has needed to use the bedside commode for the past 20-25 minutes. When asked if he had the call light on that whole time, he replied that it had been on the whole time. 7. On 3/26/03 at 12:15 PM, two facility aides were in the dining room talking loudly. CNA #1 was observed and heard to be talking with profanity loud enough for 12 residents to hear her. 8. On 3/27/03 at 8:15 AM, resident 78 was observed to be in the dining room and was over heard to say that "she wished she sat at a table where people would talk to her." Nurse #1 was heard to reply, they do talk to you. The resident was observed to sit at the table with two table mates who did not engage into conversation with resident 78, the staff was also not observed to engage resident 78 into conversation. At 8:17 AM, the resident wheeled herself out of the dining room. At 8:18 AM a facility CNA brought resident 78 back into the dining room and sat her at another table with 1 table mate. From 8:18 AM until	F 241	Resident 76 is currently being followed by Advanced Behavioral Care for Psychotherapy for symptoms of Depression and Anxiety. Resident 76 has been reassessed and care plan updated as indicated. When observed during survey, resident 78 was seated at a table with three other facility residents. Seating arrangement includes 3 residents who alert, oriented and able to communicate. Resident 78, who is hard of hearing and has Dementia, has a long history of repetitive, anxious statements. Social Service assessment dated 9/19/02 indicates resident 78 "can not express wants and needs effectively. Expressive and receptive communication skills are poor." Since the time of the survey, resident 78 has been moved to another dining room for meals where increased supervision may be provided. This was deemed necessary due to anxiety and repetitive attempts to leave the dining room. Resident forgets that she has not eaten/ why she is in the dining room. Monthly weight review completed 4/5/03 indicates a 4.2 lb. weight gain for that month. Current weight is 131.4 lbs. Ideal Body Weight is 110 lbs. Resident 78 was reassessed and care plan updated as applicable. Resident 46 was assessed regarding slippers labeled "313A MELE". The slippers in question were removed.	

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F 241	Continued From page 6 8:30 AM, resident 78 was observed to sit at the table and not be engaged in any conversation with the table mate or the facility staff. At 8:30 AM, resident 78 was observed to wheel herself out of the dining room. 9. Two observations of resident 46 were made on 3/27/03. The resident was observed to be wearing pink slippers which were marked with big, bold black permanent marker to read, "313A MERF".	F 241	Facility staff will continue to be educated regarding quality of life issues such as resident dignity and privacy, as part of new employee general orientation and as needed thereafter. An inservice will be provided to facility staff regarding quality of life issues to include proper meal service, resident dignity and privacy on 5/9/03.	
F 272 SS=B	483.20(b) RESIDENT ASSESSMENT A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status;	F 272 Ok KB	Focused dining rounds will be completed by the facility Administrator/Designee 5xweek to ensure proper service of meals, staff observance of resident dignity and privacy. Trends will be presented monthly to the facility QA, until a lesser frequency is deemed appropriate. **F 272** Resident 48 MDS, RAPs and dates corrected as applicable. Resident 61MDS, RAP's and dates corrected as applicable. All facility nurse managers and the facility dietary manager have attended MDS training and education programs provided by Resident Assessment in the last two months. Facility staff who participate in the MDS process were inserviced on 4/29/03 regarding individuals responsibility for ensuring RAP Trigger sheet indicates the dates and location of information used to complete the MDS. The R.N. Coordinator is responsible for ensuring the RAP trigger sheet is complete and includes this information upon her signature.	

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F 272	Continued From page 7 Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility did not complete comprehensive Minimum Data Set (MDS) assessments which included documentation of summary information regarding as additional assessment performed through the Resident Assessment Protocols (RAP) for 2 of 19 sample residents. Resident Identifiers: 48, 61 Findings include: The Raps (section VA a and b) of the Resident Assessment Instrument (RAI- the combined MDS and Rap Assessment) are used to identify areas of a resident's care, which have been triggered from the MDS assessment and require further assessment in order to provide an individualized care plan for the resident. Documentation relevant to the assessment information regarding the resident's status should include a description of the nature of the resident's condition, complications and risk factors to use in	F 272	The Medical Records department will monitor weekly all completed MDS assessments for proper completion of RAP Trigger sheets if required, prior to submission. The Medical Records department will alert the D.O.N./Designee of needed follow up of identified discrepancies/omitted information pertaining to RAP Trigger sheets. Identified trends will be presented monthly and as needed to the facility QA Committee until a lesser frequency is deemed appropriate.	

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F 272	Continued From page 8 deciding to proceed with care planning and factors that must be considered in developing individualized care plan interventions, as well as the possible need for further evaluation by appropriate health professionals. The care planning decision-making column must be completed within 7 days of completing the RAI. Potential problem areas that may trigger on a RAP from an MDS include: 1. Delirium 2. Cognitive Loss 3. Visual Function 4. Communication 5. ADL (activities of daily living) functional/rehabilitation potential 6. Urinary Incontinence and Indwelling Catheter 7. Psychosocial Well-being 8. Mood State 9. Behavioral Symptoms 10. Activities 11. Falls 12. Nutritional Status 13. Feeding Tubes 14. Dehydration/Fluid Maintenance 15. Oral/Dental Care 16. Pressure Ulcers 17. Psychotropic Drug Use 18. Physical Restraints 1. Resident 48 was originally admitted to the facility on 12/13/99, discharged on 10/21/02 and re-admitted on 10/14/02 with the diagnoses of osteoporosis, vertebra fracture, congestive heart failure, acute rheumatic endocarditic, depressive disorder, cellulites, hypertension, chronic ischemic heart, neoplasm, diabetes mellitus, atrial fibrillation and edema.	F 272		

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F 272	Continued From page 9 Review of the medical records for resident 48 documented an incomplete RAI assessment, dated 10/21/02, which did not include the dates of RAP assessment documentation. Problem areas 2, 5, 6, 8, 9, 11, 12, 14 and 16 identified where the RAP documentation could be located but no date was documented to reference any particular note. Further review of the resident's medical record revealed no documentation during the assessment period that provided any summary information regarding the resident's cognitive status, ADLs, continence, mood state, behaviors, falls, nutritional status, hydration status or pressure sores. 2. Resident 61 was admitted to the facility on 1/14/03 with diagnoses of edema, atrial fibrillation, chronic ischemic heart, depressive disorder, anemia, renal failure, hypertension, cellulites and thyrotoxicosis. Review of the medical record for resident 61 documented an incomplete RAI assessment, dated 1/21/03, which did not include the dates of RAP assessment documentation. Problem areas 1, 2, 4, 5, 6, 7, 8, 9, 11, 12, 14, 16 and 17 identified where the RAP documentation could be located but no date was documented to reference any particular note. Further review of the resident's medical record revealed no documentation during the assessment period that provided any summary information regarding the resident's delirium, cognitive status, communication, ADLs, continence, psychosocial well being, mood state, behaviors, falls, nutritional status, hydration status, pressure sores or psychotropic drug use.	F 272		

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F 278 F 278 SS=C	Continued From page 10 483.20(g) - (h) 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 Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or 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 record review, it was determined that the facility did not have a registered nurse (RN) sign the Minimum Data Set (MDS) assessments as being complete and acurate, signatures on the face sheet were incomplete and/or the MDS assessments did not accurately reflect the resident at the time of the assessment for 5 of 19 sample residents reviewed. Resident Identifiers: 7, 38, 59, 61, 76	F 278 F 278 Ok KB	**F 278** Resident 59 MDS/ RAP assessment completed corrected and signatures/dates obtained as applicable. Resident 61 MDS assessment dated 1/21/03 corrected with accurate weight. Resident 76 MDS assessment dated 2/19/03 signatures/dates obtained as applicable under section AA9 and Section K2-b and K3-a corrected to reflect accurate weight and significant weight loss 5% or more in last 30 days. Resident 38 MDS dated 2/27/03 section P1 corrected to reflect oxygen therapy. Resident 7 MDS dated 5/22/02 signature dates obtained as applicable. All facility nurse managers have attended MDS training and education programs provided by Resident Assessment in the last two months. Facility staff who participate in the MDS process were inserviced on 4/29/03 regarding individuals responsibility for ensuring MDS accuracy, requirements for signatures and dates where indicated and identification of sections completed/date completed.	

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F 278	Continued From page 11 Findings include: 1. Resident 59 was admitted to the facility on 1/26/02. Resident 59's medical record contained an annual MDS dated 12/19/02. Under section R2, the RN assessment coordinator had not signed the assessment as being completed. Under section VB1, the RN coordinator had not signed the RAP (Resident Assessment Protocol) as being completed. Under section VB2, a facility staff person had not signed the care planning decision as being completed. 2. Resident 61 was admitted to the facility on 1/14/03. Resident 61's medical record contained an admission MDS dated 1/21/03. Under section AA9 the certified dietary manager documented that they had completed Section K on 1/19/03. Under section K2-b the weight was documented as "152" lbs (pounds). Medical record review of resident 61's weight revealed he weighed 147.8 lbs on 1/19/03. 3. Resident 76 was admitted to the facility on 11/13/02. Resident 76's medical record contained a quarterly MDS dated 2/19/03. Under section AA9 facility staff members signed that they had completed the assessment on 2/19/03, the facility staff did not indicate which sections they had completed. Under section K2-b the weight was documented as "256" lbs. Under section K3-a "no" significant weight loss of 5% or more in last 30 days or 10% or more in last 180 days was documented. Medical record review of resident 76's weight revealed he weighed 256.8 lbs on 1/19/03 and 234.6 lbs on 2/18/03. Resident 76 had an 8.6% weight loss in one month.	F 278	The R.N. Coordinator will be responsible for ensuring the completion of all required assessment information upon her signature. The Medical Records department will monitor weekly to ensure the completion of required information prior to submission and will report identified omissions to the D.O.N./Designee for appropriate follow up. Identified trends will be presented monthly and as needed to the facility QA Committee until a lesser frequency is deemed appropriate.	

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F 278	Continued From page 12 4. Resident 38 was re-admitted to the facility on 12/27/02. Resident 38's medical record contained a 60 day MDS dated 2/27/03. Under section P1, Special Treatments Procedures and Programs, oxygen therapy was not documented. Medical record review of resident 38's recertification orders was done. Resident 38 had physician orders for oxygen since 12/31/02. Resident 38 was interviewed on 3/24/03. Resident 38 stated that she has needed the oxygen on a daily basis especially at night. On 3/24/03 and 3/25/03 resident 38 was observed in bed with her oxygen. 5. Resident 7 was admitted to the facility on 9/25/97. Resident 7's annual MDS assessment dated 5/22/02 did not have dates accompanying the signatures on the face sheet	F 278		
F 286 SS=B	483.20(d) Resident Assessment A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility did not maintain Minimum Data Set (MDS) assessments completed within the previous 15 months in the resident's active record for 2 of 19 sample residents. Resident Identifiers: 38, 48	F 286 Ok 48	**F 286** Resident 48- 15 months of MDS assessments have been placed in active chart. Resident 38- 15 months of MDS assessments have been placed in active chart. Medical Records department inserviced regarding the required 15 months of MDS assessments to be present in all active charts as applicable.	

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F 286	Continued From page 13 Findings include: 1. Resident 48 was originally admitted to the facility on 12/13/99, discharged on 10/21/02 and re-admitted on 10/14/02 with the diagnoses of osteoporosis, vertebra fracture, congestive heart failure, acute rheumatic endocarditis, depressive disorder, cellulites, hypertension, chronic ischemic heart, neoplasm, diabetes mellitus, atrial fibrillation and edema. A complete review of resident 48's active medical record was done on 3/25/03. The medical record contained two significant change MDS's dated 6/6/02 and 10/21/02 and two quarterly MDS's dated 9/4/02 and 1/6/03. The active medical record did not contain any assessments that had been completed after 1/6/03. The active medical record did not contain any assessments that had been completed before 6/6/02. The active medical record only contained 7 months of MDS's. On 3/25/03 at 9:20 AM, a facility unit manager stated that they keep all the MDS's for each resident in the resident's active medical record. 2. Resident 38 was ordinally admitted to the facility on 9/14/01, discharged on 12/27/02 and re-admitted on 12/27/02 with the diagnoses of bronchitis, cerebral vascular accident, hypertension, asthma, multiple sclerosis, osteoarthrosis, diabetes mellitus, polio, kidney and ureter disorder. A complete review of resident 38's active medical record was done on 3/24/03. The medical record contained a fourteen day MDS dated 1/13/03, a thirty day MDS dated 1/28/03 and other MDS dated 1/31/03 and a 60 day MDS dated 2/27/03. The active	F 286	All active resident charts audited to ensure the presence of 15 months of MDS assessments as applicable. The facility Administrator/Designee will audit 5% of active charts weekly and identified trends presented monthly to the QA committee until a lesser frequency is deemed appropriate.	

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F 286	Continued From page 14 medical record did not contain any assessments that had been completed before 9/14/01. The active medical record only contained 3 months of MDS's.	F 286		
F 325 SS=G	483.25(i)(1) QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by 2 of 19 sampled residents experienced significant weight loss with either no dietary interventions or inadequate dietary interventions implemented to prevent further weight decline. Resident identifiers: 75 and 76 . Calculating weight loss percentages is done by subtracting the current weight from the previous weight, dividing the difference by the previous weight and multiplying by 100. Significant weight losses are as follows: 5% in one month, 7.5% in 3 months and 10% in 6 months. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000). Findings include: 1. Resident 75 was an 89 year old female admitted to the facility on 4/22/99 diagnose include hypertension, osteoporosis, gastro esophageal reflux disorder,	F 325	**F 325** Resident 75 current weight as of 4/20/03 is 136.8 lbs. Resident 75 is 5 ft. tall and has an Ideal Body Weight of 100 lbs. She is currently 136% of her Ideal Body Weight and has a Body Mass Index of 26.0. A BMI of 24.0 to 29.0 is a healthy weight for most elderly. (*Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000 page 13 Table 1.3 and page 15 Table 1.6)* Monthly weights for resident 75 were obtained the first week of May 2002 and June 2002. July's monthly weight, however, was obtained at the end of the month. This resulted in 55 days from the last obtained weight rather than 30 days. Resident 75 experienced a significant weight loss of 6.7 % from 6/3/02 to 7/28/02. (55 days) Resident 75's monthly weight for the month of July was delayed due to the facility changing the monthly weight schedule for the entire building. Significant weight loss of 6.7% in 55 days and 7.9% in 84 days was identified on 7/28/02. At this time interventions of weekly weights and assessments were implemented.	

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F 325	Continued From page 15 dementia, constipation and hypothyroidism. A review of resident 75's weight monitoring sheets for 2002 and 2003 revealed the following weights: 5/5/02 155.8 pounds (lbs) 6/3/02 153.8 lbs. 7/28/02 143.4 lbs. 8/7/02 144.8 lbs. 9/8/02 140.4 lbs. 10/6/02 138.2 lbs. 11/6/02 135.8 lbs. 12/2/02 138.6 lbs. 1/25/03 136.4 lbs 2/12/03 131.0 lbs. 3/19/03 134.6 lbs. Between May 2002 and July 2002 (84 days) resident 75 lost 12.4 lbs., a 7.95% weight loss, which is significant. Between June 2002 and September 2002 (97 days) resident 75 lost 13.4 lbs., an 8.71% weight loss, which is significant. Between May 2002 and November 2002 (185 days) resident 75 lost 20 lbs., a 12.84% weight loss, which is significant. A review of the nutritional progress notes dated 8/13/02 documented a late entry stating the weights as 6/3/02 (153.8) 7/28/03 (143.4) 8/7/03 (144.8) with a 7.9% weight loss times 90 days. There were no nutritional recommendations or interventions documented by a registered dietitian. A nutritional progress note dated 9/02/02 documented resident 75's weight as 140.4 and a 3.13% weight loss times one month.	F 325	Resident 75 was seen or evaluated by a Registered Dietitian (Including a review of body weights and protein needs) 16 times in a period of 11 months. On 7/28/02, upon identification of the trend toward significant weight loss for the 3-month/ 90-day period, the intervention of weekly weights and assessments was implemented for resident 75. The wound identified to resident 75's right posterior ankle was related to poorly fitting shoes. The blister to the left buttock identified on 2/11/03 was later identified as related to a blister caused by plastic briefs. Resident 75 will continue to be assessed at the weekly Skin and Weight meeting as applicable and her plan of care updated as needed. Resident 76 current weight is 209 lbs. His Ideal Body Weight is 148 lbs. Resident 76 is 141% of his Ideal Body Weight. Resident 76 has a Body Mass Index of 32. A Body Mass Index of 24 to 29 is a healthy weight for most elderly. A Body Mass Index greater than 29 may be associated with health problems in some elderly. (*Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000 page 13 Table 1.3 and page 15 Table 1.6)* Resident 76's Albumin upon admission was likely elevated due to dehydration secondary to treatment for an Upper Respiratory Infection prior to his admission.	

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F 325	Continued From page 16 A physician's telephone order dated 9/3/02 and signed by the physician documented a high calorie, high protein restricted concentrated sugar diet due to weight loss. A diet clarification dated 9/17/02 and signed by the physician documented a high calorie, high protein diet as being ordered. A review of the physician's recertification orders dated 10/02, 11/02,12/02, 1/03 documented dietary orders of a regular diet with honey thick liquids. A physician telephone order dated 1/16/03 and signed by the physician documented a high protein puree diet secondary to wound as being ordered. The physician recertification order dated 2/03 documented a high calorie, high protein diet. This was six months after the original order dated 9/17/02. A lab (laboratory) value done at the facility, dated 1/16/03, was reviewed and revealed a serum albumin (protein) level of 3.2. A lab value taken at the facility and dated 3/24/03 showed an albumin level of 3.2. The reference range, according to the lab used by the facility, was 3.3-4.8 g/dl. An albumin level of less than 2.4 g/dl is considered a severe visceral protein deficit, an albumin level of 2.4 g/dl- 2.9 g/dl is considered a moderate visceral protein deficit and an albumin level of 3.0 g/dl-3.5 g/dl is considered a mild visceral protein deficit. . (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000, page 22). A nurse's note dated 1/03/03 documented "small but appears necrotic sore, right posterior ankle." A nurse's note dated 1/22/03 documented " Rt. (right) ankle wound- eschar has come off wound. Now able to asset, stage III. no odor, no drainage, no other	F 325	Resident 76 calculations completed on 11/14/02, by the facility Registered Dietitian, are correct. The surveyor did not include Injury and Activity Factors that were noted on the Registered Dietitian's 11/14/02 assessment. The assessment completed on resident 76 by the facility Registered Dietitian, on 11/14/02, was one day after admission to the facility. The resident was not on a weight loss program at this time. Resident 76's weight loss program began in February 2003. The approach of a weight loss program was determined to be appropriate by the Skin and Weight committee, including the Registered Dietitian, the resident and the resident's family in February 2003. Assessment information noted by the surveyor from the medication administration record as "AM" and "PM" assessments of edema, by nursing staff, are highly variable. The MAR (medication administration record) "AM" assessment of edema could reflect an assessment occurring any time from 6:00 AM to 11:55 AM. The evening or "PM" assessment of edema could reflect an assessment occurring any time from 6:00 PM to midnight.	

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F 325	Continued From page 17 signs/symptoms of infection. Measures 1.8 cm (centimeters) times 1.1 cm depth .2 cm...." A nurses shift charting report dated 2/11/03 documents an open blister area on the left buttocks approximately .3cm (centimeters) by 1 cm in size. There is no documentation in the medical record between the months of 5/02 and 1/03 that a nutrition assessment by a registered dietitian had been completed to assess the calorie and protein needs and to address the adequacy of the supplements provided to ensure they were appropriate to prevent further weight loss and skin break down. 2. Resident 76, was a 76 year old male, admitted to th facility on 11/13/02, with the diagnoses of congestive heart failure, ischemic heart disease, diabetes, coronary artery disease, atrial fibrillation, asthma, chronic obstructive pulmonary disease, depression and pain. A review of resident 77's weight monitoring sheets for 2002 and 2003 revealed the following weights: 11/20/02 265.2 lbs. 11/26/02 266.8 lbs. 12/3/02 265.8 lbs. 12/10/02 263 lbs. 12/31/02 262 lbs 1/8/03 257.8 lbs. 1/15/03 Refused 1/19/03 256.8 lbs. 1/25/03 255.6 lbs 2/5/03 251.0 lbs. 2/12/03 Refused 2/18/03 234.6 lbs. 2/23/03 231.6 lbs. 3/2/03 232.0 lbs 3/9/03 226.4 lbs.	F 325	Weekly Skin and Weight Committee meeting is conducted from approximately 8:00 AM to 5:00 PM. Therefor, the "AM" assessment of edema and the evening of "PM" assessment of edema, by the nurse caring for the resident, will likely differ from the hands on, physical assessment taking place as part of the skin and weight meeting. Additionally, the information documented on the Skin and Weight meeting form is often gathered prior to the date on the Skin and Weight meeting form. Pertaining to the weight assessment for resident 76 completed on 2/19/03. Due to a significant weight discrepancy from the last weight for resident 76, a reweigh was completed as well as a hands on assessment of resident 76's lung sounds and lower extremity edema by the Skin and Weight team, as is protocol when such discrepancies occur. Great lengths were taken to discover the cause of the weight discrepancy. It was identified that the staff who normally weigh resident 76 were not in the building when the weight in questioned was obtained. The staff member who obtained the weight in question was not available for interview on 2/19/03. It was also determined that the RNA staff who normally obtained weights for resident 76 had different techniques. Therefore, a good faith effort was made by the Skin and Weight team, on 2/19/03, to re-establish baseline and to develop specific guidelines for staff to follow to ensure the accuracy of future weights for resident 76.	

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F 325	Continued From page 18 3/15/03 225.8 lbs. 3/23/03 225.2 lbs. Between 11/20/02 and 3/23/03 (124 days) resident 76 lost 40 lbs., a 15.08% weight loss, which is significant. Between 11/20/03 and 2/18/03 (91 days) resident 76 lost 30.6 lbs., a 11.5% weight loss, which is significant. Between 12/31/02 and 3/23/03 (83 days) resident 76 lost 36.8 lbs., a 14.04 % weight loss, which is significant. Between 1/25/03 and 2/23/03 (30 days) resident 76 lost 19.6 lbs., a 9.38% weight loss, which is significant. Between 2/5/03 and 3/2/03 (26 days) resident 76 lost 19 lbs., a 7.56% weight loss, which is significant. Between 2/5/03 and 3/9/03 (33 days) resident 76 lost 24.6 lbs., a 9.8% weight loss, which is significant. A laboratory (lab) value taken at the facility and dated 11/15/02 showed an albumin of 4.2 g/dl. Another lab taken at the facility on 1/13/03 showed and albumin of 3.4 g/dl. The albumin of 3.4 g/dl, dated 1/13/03, was the most current in resident 76's medical record. While resident 76's albumin was still within the normal low range, resident 76's albumin level dropped significantly from November 2002 to January 2003. A "Nursing Admission Assessment" documented, "...RLE (right lower extremity)...Bilateral 1+ pedal edema...	F 325	The staff does follow through with recommendations made by Registered Dietitian #1 on 1/11/03 for 8 ounces of milk every meal. There is a Dietary Communication present for 1/11/03 which requests 8 ounces milk be provided with every meal. Registered Dietitian #2 on 1/15/03 assessed the stage 3 vascular ulcer and her note goes on to reference recommendations made by Registered Dietitian #1 on 1/11/03. Resident 76 allowed facility staff to weigh him on 4 of 6 requests. The two documented refusals of resident 76 do not account for all refusals made/verbalized prior to staff succeeding in obtaining weights. A Nursing note dated 2/20/03 is present which summarizes the Inter-Disciplinary Team Meeting held with the resident and his family on this date. The note documents that resident 76 and his family agrees with the goal of working toward independent living. On a physician visit progress noted dated 3/27/03, resident 76 states he is happy he has lost weight and feels he needs to lose an additional 20 lbs. The physician further states the resident has had a desire to lose weight and that the physician and resident goal for weight loss has improved the health status of resident 76. Per interview with resident 76's daughter on 4/23/03, she states that her dad had been trying to lose weight when he had lived with her prior to his nursing home placement.	

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F 325	Continued From page 19 An initial nutritional assessment for resident 76 was completed by RD#2 on 11/14/02. RD#2 noted that resident 76 had breakdown on his buttocks and a 3.2 g/dl albumin dated 9/30 (prior to admit). RD#2 calculated resident 76's protein requirement at 76 grams of protein per day. She got this protein requirement by calculating his ideal body weight times "1.2 grams of protein for pressure sores." RD#2 calculated his caloric need as "1734" calories per day. RD#2 got this calculation by using the following formula: "BEE (basal energy expenditure) = 66 + (13.7 x 120) + (5 x 170) - (6.8 x 75) = 1734 calories." According to this calculation and the number RD#2 plugged into the calculation the correct calories per day should have been 1984. RD#2 also documented a dietary clarification to change the no concentrated sweet diet to a reduced concentrated sweet diet with no added salt. She documented that the resident had right lower extremity edema on admit. RD#2 did not take into consideration protein or caloric needs due to resident 76's obesity. RD#2 did not document that resident 76 was on a planned weight loss program. A physician order, dated 11/14/02, documented, "1. Diet order clarification RCS (reduced concentrated sweets). 2. Add NAS (no added salt) to current D.O. (diet order). 3. Add [increased] pro (protein) to current D.O. (diet order)." The "Weight/Skin Condition Review" on 11/26/02, documented, "...Current weight 266.8... P.U. (pressure ulcer) [left] buttocks...stg (stage) II...3+ pitting edema..." On 11/26/02, a facility nurse documented on the MAR (medication administration record) resident 76's edema as a +1 in the morning and in the	F 325	Circling of approaches to indicate which are to be implemented, is not the protocol of the facility. All interventions appearing on the care plan for resident 76 are applicable. Per facility menu spread sheet dated 3/25/03, residents on a large portion entrée should have received 2 ounces of sausage. Therefore, when resident 76 was observed to have received 2 sausages for breakfast on 3/25/03, he had the correct amount of protein. Resident 76 was expecting a visit from his daughter who was to bring him a "Whopper" for lunch on 3/26/03, and he did not want a lunch tray. The Registered Dietitian convinced resident 76 to accept a tray just in case his daughter did not bring him a "Whopper", to which he agreed. When the lunch tray was delivered to resident 76, he stated to Registered Dietitian #2 that he did not like Turkey and would not eat it. Resident 76 proceeded to request from Registered Dietitian #2 very specifically what he wanted brought to him. Resident 76 was provided what he had requested. Resident 76's skin is clear and without impairment at this time. Resident 76's Albumin level as of 4/4/03 is 3.5 g/dl which is within normal limits. The facility will continue to review resident 76 weekly at the Skin and Weight committee meeting as applicable and will update the care plan for resident 76 as needed.	

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HERITAGE BENNION CARE CENTER	6246 SOUTH REDWOOD ROAD SALT LAKE CITY, UT 84123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 325	Continued From page 20 evening. The assessment of resident 76's edema on 11/26/02, by the weight/skin team and facility nurse caring for resident 76 does not match. The "Weight/Skin Condition Review" on 01/07/03, documented, "...Bilat (bilateral) LE's (lower extremities) 3+...Stage III [right] heel [right] forearm skin tear Breakdown to buttocks Skin..." On 1/7/03, a facility nurse documented on the MAR that resident 76's edema was +2 at 8:00 AM and +1 at 12:00 PM. The assessment of resident 76's edema on 1/7/03, by the weight/skin team and facility nurse caring for resident 76 does not match. A "Monthly Nutrition ReAssessment of At Risk Resident" dated 1/11/03, was completed by RD#1. RD#1 documented, "...DQ (decubitus ulcer) on buttocks [with]...skin tear [right] LE (lower extremity)..." She also documented, "...pro (protein) calc (calculation) not adjusted for obesity 117 g (grams) pro (protein)..." She re-calculated the caloric needs to be at 2450 calories per day, due to his obesity. Under the summary RD#1 documented, "...1. Protein intake inadequate [at] this time...4. Suggest 8 oz (ounces) milk [every] meal and large portions of meat entree [every] meal..." The right heel stage III pressure ulcer was not addressed by the RD on the 1/11/03, nutrition re-assessment. A physician order, dated 1/11/03, documented, "1. give large portions meat entree [very] meal..." There was no physician order for the 8 ounces of milk with every meal. The facility staff did not follow through with RD#1 suggestion on 1/11/03, for 8 ounces of	F 325	The facility will continue to identify residents at risk for weight loss, through weekly and monthly weights. A Registered Dietitian will continue to assess body weights and protein needs as applicable. D.O.N./Designee will continue to monitor weekly, facility obtained weights to ensure the implementation of appropriate interventions/follow up. Identified trends will be brought monthly to the facility Quality Assurance team for review until a lesser frequency is deemed appropriate.	

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F 325	Continued From page 21 milk with every meal. The "Weight/Skin Condition Review" on 1/15/03, documented, "...Current weight R (refused)...[right] heel stage III [left] heel stage I...Stage II on buttocks...Buttocks [with] redness/excoriation...LE's (lower extremities) very edematous..." On 1/15/03, a facility nurse documented on the MAR that resident 76's edema was +1 at 8:00 AM and at 12:00 PM. The assessment of resident 76's edema on 1/15/03, by the weight/skin team and facility nurse caring for resident 76 does not match. The "Weight/Skin Condition Review" on 1/22/03, documented, "...Current weight 256.8...Edema BLE (bilateral lower extremities) 1+- 2+..." On 1/22/03, a facility nurse documented on the MAR that resident 76's edema was +2 at 8:00 AM and at 12:00 PM. The "Weight/Skin Condition Review" on 1/30/03, documented, "...Current weight 255.6....Edema BLE (bilateral lower extremities) 2+...Weight fluctuates [with] edema" The "Weight/Skin Condition Review" on 2/5/03, documented, "...Current weight 251.0...Edema bilat LE's (bilateral lower extremities) 1+ - 2+..." The facility marked to continue with "Plan-Anticipated/Planned wt (weight) loss" The facility documented, "...Gradual wt (weight) loss likely associated [with] increasing activity level and improved general condition. Wt does fluctuate R/T (related to) edema...Slow gradual wt (weight) loss desirable. However will speak [with] resident	F 325		

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F 325	Continued From page 22 concerning desire for further wt loss. Will cont (continue) [with] wts r/t impaired skin [and] to ensure wt loss continues to be gradual." On 2/5/03, a facility nurse documented on the MAR that resident 76's edema was +2. The "Weight/Skin Condition Review" on 2/12/03, documented, "...Current weight R (refused)...Edema BLE (bilateral lower extremities) +2..." The facility marked to continue with "Plan-Anticipated/Planned wt (weight) loss" On 2/12/03, a facility nurse documented on the MAR that resident 76's edema was +1. The assessment of resident 76's edema on 2/12/03, by the weight/skin team and the facility nurses caring for resident 76 does not match. The "Weight/Skin Condition Review" on 2/19/03, documented, "...Current weight 234.6...Wt (weight) has been historically weighed with full O2 (oxygen) tank on his W/C wheel chair todays wt was with an empty O2 tank...Discrepancy of wt likely r/t (related to) staff from who normally weighs pt is not present [and] did not obtain current wt unable to determine how previus wts obtained...Resident has had [zero] change in PO (by mouth) intake. However edema to LE's (lower extremities) has gone from 3+ to 0...Clothing cont (continue) to fit the same..." On 2/19/03, a facility nurse documented on the MAR that resident 76's edema was +1. The assessment of resident 76's edema on 2/19/03, by the weight/skin team and the facility nurses caring for resident 76 does not match.	F 325		

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F 325	Continued From page 23 In an interview, on 3/26/03 at 6:15 AM, with the unit manager for the 400 hall, she stated that the restorative aides weigh the residents every Sunday and that they weigh the same people every week. She further stated that she has realized resident 76 has lost some weight because his clothing are fitting differently. She went on to state that she thought his admit weight of 265 lbs was correct. In an interview, on 3/26/03, with the two restorative aides who do the weights in the facility, they stated that resident 76 was standing for his weights when he first came into the facility and then some time around the first of January he started not wanting to stand up so they weighed him in his wheelchair. They further stated that they weigh him in the wheelchair and then they weigh the wheelchair without him in it. In an interview, with a corporate nurse, on 3/26/03 at 2:40 PM, she stated that she had been attending the weight/skin meetings for the past month to month and a half and that she was present for the weight of 2/19/03, where they had a weight discrepancy. Stated there was a gray area as to who was doing resident 76's weight prior to 2/19/03 and the first time she had weighed the resident was on 2/19/03. She further stated that she had understood that resident 76 was in a wheelchair since admit and that he has had a lot of edema. She stated that on 2/19/03 they had assessed the resident as a team assessing the edema and listening to his lungs, she continued to say that they were able to tell the resident had not lost weight because of the way his clothing fit. A "Monthly Nutrition ReAssessment of At Risk Resident" dated 2/20/03, was completed by RD#2. RD#2 documented that the resident "frequently [refuses] to be weighed...stage III...[right] heel...alb (albumin) 3.4...protein not met...current wt (weight)	F 325		

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F 325	Continued From page 24 234.6 [decreased] 2 wks (weeks)...fort (fortified) skim milk [with] meals to meet protein needs D/T (due to) DQ (decubitus ulcer)...3+ BLE (bilateral lower edema) ...Edema flux (fluctuates)." It should be noted that the "Weight Monitoring" sheet provided documented evidence that resident 76 had only refused a weekly weight twice, once on 1/15/03 and again on 2/12/03. At the time of this dietary assessment RD#2 documented a weight of 234.6 lbs, which is a 11.5% weight loss in 3 months, which is significant. This significant weight loss should have been addressed on this 2/20/03 assessment. She also documented that resident 76 had 3 plus edema, this should have shown a weight increase not decrease. On 2/20/03, a facility nurse documented on the MAR that resident 76's edema was+1. The assessment of resident 76's edema on 2/20/03, by RD#2 and the facility nurses caring for resident 76 does not match. The "Weight/Skin Condition Review" on 2/26/03, documented, "... Current weight 231.6...Edema LE (lower extremities) +1...[zero] wt (weight) [decline] edema [increased] slightly from last week...Wt loss desired. Per nurse Rt (resident) wants supplements, nurse will discuss [with] Rt receiving adequate calories to promote gradual wt [decline]. After discuss if Rt still desires supplement will complete risk Vs benefit." The facility marked to continue with "Plan-Anticipated/Planned wt (weight) loss" On 2/26/03, a facility nurse documented on the MAR that resident 76's edema was+1. The "Weight/Skin Condition Review" on 3/5/03, documented, "...Current weight 232.0...Edema No...Unit manager spoke [with] Rt (resident)	F 325		

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F 325	Continued From page 25 regarding wanting supplement. She shared [with] him that if he wants to go to Legacy (an assisted living facility) wt [decline] desired..." The facility marked to continue with "Plan-Anticipated/Planned wt (weight) loss" The documentation did not provide evidence that the resident desired a planned weight loss. On 3/5/03, a facility nurse documented on the MAR that resident 76's edema was +1. The assessment of resident 76's edema on 3/5/03, by the weight/skin team and the facility nurses caring for resident 76 does not match. In an interview, with the resident on 3/26/03 at 12:35 PM, he stated he has lost weight and it has not been a planned thing, says if he eats a few bites he is full and the weight has just been coming off. A "Monthly Nutrition ReAssessment of At Risk Resident" dated 3/6/03, was completed by by a dietary student and co-signed by RD#2. The assessment documented, ".01% loss in 1 mo (month) weight stable...protein needs met...nutritional needs met, wt (weight) stable..." It should be noted that on 2/5/03 resident 76 weighed 251.0 lbs and on 3/2/03 he weighed 232.0 lbs. This represents a 7.56% weight loss in one month, which is significant. This significant weight loss should have been addressed on this 3/6/03 assessment. According to the weekly weights the resident's weight was not stable and his nutritional needs were not being met. The "Weight/Skin Condition Review" on 3/12/03, documented, "...Current weight 226.4...Edema No...Desired wt (weight) [decline] Rt (resident) is more active and out of room more..." The facility marked to continue with "Plan-Anticipated/Planned	F 325		

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F 325	Continued From page 26 wt (weight) loss" On 3/12/03, a facility nurse documented on the MAR that resident 76's edema was+1. The assessment of resident 76's edema on 3/12/03, by the weight/skin team and the facility nurses caring for resident 76 does not match. Observations of resident 76, on 3/24/03 through 3/27/03, provided evidence that the resident was usually in bed in his room, on a few occasions he was observed to be up in his wheel chair in his room. The resident was observed during those days to take his meals in his room. The resident was not observed to be up and active in the facility during the state survey. The "Weight/Skin Condition Review" on 3/19/03, documented, "...Current weight 225.8...Edema No..." The facility marked to continue with "Plan-Anticipated/Planned wt (weight) loss" There was no documentation on the MAR to provide information as to what resident 76's edema was on 3/19/03. A review of resident 76's care plan, dated 1/11/03 and reviewed 3/19/03, the facility documented by circling the following problem, "Resident is at nutritional risk D/T (due to) obesity. On a therapeutic diet. Leaves 25% or more uneaten. Eats in dining room" The goal circled by the facility documented, "Weight will remain stable plus or minus 5% in 30 days..." The facility does not indicate with circles any approaches they were taking with resident 76. There was not a care plan for resident 76 that addressed a planned weight loss. There was not a care plan that addressed a significant weight loss for	F 325		

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F 325	Continued From page 27 resident 76, nor was there a care plan that addressed any approaches the facility was taking to ensure that the resident did not have a further significant weight decline. On 3/25/03 at 9:03 AM, review of resident 76's dietary card revealed that resident 78 was on a reduced concentrated sweet diet with no added salt. The dietary card further documented that resident 76 was to receive large portions of protein, as well as 4 oz (ounces) of juice and 8 oz of fortified skim milk. It should be noted that the dietary card did not match the physician order, dated 1/11/03. Resident 76 should have been receiving a larger portion of meat not a larger potion of protein. Observation of resident 76 at breakfast on 3/25/03, revealed he was served 2 sausage links, an orange, 1 slice of french toast, 1 bowl of cream of wheat and 240 cc of milk. Observation of resident 76's tray after he had finished eating revealed there was still plastic wrap over his milk and cereal. The resident had eaten 25% of his french toast and 1 bite of his sausage, the rest of the meal was not touched. Observation of resident 76 at lunch on 3/25/03, revealed he was served a green salad with ranch dressing, 240 cc cup of ham and bean soup, 120 cc apple juice, 240 cc of milk and fried potatoes. According to the facility menu resident 76 should have also received a dessert and cornbread. Observation of the tray after resident 76 had finished eating revealed he had eaten a few bites of the green salad with ranch dressing. On 3/25/03 at 1:10 PM, the registered dietitian (RD) stated that diabetics would be served cornbread and the dessert.	F 325		

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F 325	Continued From page 28 On 3/25/03 at 1:20 PM, a facility CNA who picked up resident 76's lunch tray, stated that he had not been eating well and stated that he had eaten about 25% of his lunch. When asked how she came up with that amount she stated he had eaten about 50% of his salad and that would be 25% of his meal. On 3/25/03 at 4:00 PM, the "Resident Meal Consumption Record" was reviewed. On 3/25/03, for lunch, the facility staff documented that resident 76 had consumed 75% of his meal and 120cc of fluid. By not accurately documenting the correct meal intake the facility weight/skin team and registered dietitians can not adequately address resident 76's caloric and protein intake to ensure his nutritional needs are being met. Observation of resident 76 at lunch on 3/26/03, revealed he was served Salisbury steak, 1 piece of bread, mixed vegetables, masked potatoes with gravy, vanilla ice cream and 240 cc of apple juice. There was no milk observed to be served to the resident during this meal. Observation of the tray after resident 76 had finished eating revealed he had eaten 25% of his steak, 2 bites of the potatoes and gravy and 100% of the vanilla ice cream. In an interview, on 3/27/03 at 8:40 AM, with the Food Service Supervisor (FSS), she stated that for breakfast on 3/25/03 a resident on a large portions of protein diet would have received 4 sausages in stead of 2, for lunch on 3/25/03, a resident on a large portions of protein diet would have received a bowl of cottage cheese or yogurt and for lunch on 3/26/03, a resident on a large portions of protein diet would have received a bowl of cottage cheese. She further stated that she does not serve large portions of meat because	F 325		

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F 325	Continued From page 29 that can overwhelm an elderly person, so she increases the protein in other ways. By not ensuring that resident 76 received the therapeutic diet ordered for him, the facility did not adequately address his nutritional problem and did not follow physician orders. A review of resident 76's "Resident Meal Consumption Record" from November to March revealed the following: In November 2002, resident 76 consumed less than 50% of his meal 4 times out of 52. In December 2002, resident 76 consumed less than 50% of his meal 20 times out of 93. In January 2003, resident 76 consumed less than 50% of his meal 18 times out of 93. In February 2003, resident 76 consumed less than 50% of his meal 28 times out of 84. In March 2003, resident 76 consumed less than 50% of his meal 26 times out of 74.	F 325		
F 326 SS=G	483.25(i)(2) QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and medical record review, it was determined that for 3 of 19 sampled residents, the facility did not ensure that each resident received a therapeutic diet when there was a nutritional problem as evidenced by: the facility did not follow resident 76's dietary orders, which resulted in severe weight loss; the facility did not follow the	F 326	**F 326** For resident 76, the amount of protein is the same in both a large portion protein and a large portion meat diet since the majority of protein is found in meat products. Therefore resident 76 did receive the correct diet. Per menu the facility menu spreadsheet dated 3/25/03, residents on a large portion entrée should have received 2 ounces of sausage. Therefore, when resident 76 was observed to have received 2 sausages on 3/25/03, he had received the correct amount of protein.	

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F 326	Continued From page 30 registered dietitian recommendations for resident 61 which resulted in elevated laboratory values and the facility did not follow resident 38's dietary orders which had a potential for further skin breakdown and/or weight loss and/or decreased albumin levels. Resident Identifiers: 38, 76 and 61 Findings include: 1. Resident 76 was admitted to the facility on 11/13/02 with the diagnoses of congestive heart failure, ischemic heart disease, diabetes, coronary artery disease, atrial fibrillation, asthma, chronic obstructive pulmonary disease, depression and pain. On 3/25/03, resident 76's medical record was reviewed. A physician order, dated 1/11/03, documented, "1. give large portions meat entree [every] meal..." It also revealed a physician's order dated 2/20/03, which documented, "Fort (fortified) skim milk [with] meals TID (three times a day..." On 3/25/03 at 9:03 AM, review of resident 76's dietary card revealed that resident 78 was on a reduced concentrated sweet diet with no added salt. The dietary card further documented that resident 76 was to receive large portions of protein, as well as 4 oz (ounces) of juice and 8 oz of fortified skim milk. It should be noted that the dietary card did not match the physician order, dated 1/11/03. Resident 76 should have been receiving a larger portion of meat not a larger potion of protein. Observation of resident 76 at breakfast on 3/25/03, revealed he was served 2 sausage links, an orange, 1 slice of french toast, 1 bowl of cream of wheat and 240 cc of milk.	F 326	Resident 76 was expecting a visit from his daughter who was to bring him a "Whopper" for lunch on 3/26/03, and he did not want a lunch tray. The Registered Dietitian convinced resident 76 to accept a tray just in case his daughter did not bring him a "Whopper", to which he agreed. When the lunch tray was delivered to resident 76, he stated to Registered Dietitian #2 that he did not like Turkey and would not eat it. Resident 76 proceeded to request from Registered Dietitian #2 very specifically what he wanted brought to him. Resident 76 was provided what he had requested. Resident 76's Albumin upon admission was likely elevated due to dehydration secondary to treatment for an Upper Respiratory infection prior to his admission. The current albumin level for resident 76 as of 4/4/03, is 3.5 g/dl. This is within normal limits. Resident 76's skin is intact and without impairment. Resident 76 did receive diet as ordered with assessments weekly in Skin and Weight meeting and interventions as applicable. Resident 61 had elevated BUN and Creatinine levels prior to admission: 12/29/02: BUN: 57(H) Creatinine: 3.0 (H) Resident 61 was admitted to the facility 1/14/03. Two days following admission labs were obtained with the following results: 1/16/03: BUN: 59(H) Creatinine: 2.3(H)	

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F 326	Continued From page 31 Observation of resident 76 at lunch on 3/25/03, revealed he was served a green salad with ranch dressing, 240 cc cup of ham and bean soup, 120 cc apple juice, 240 cc of milk and fried potatoes. According to the facility menu resident 76 should have also received a dessert and cornbread. On 3/25/03 at 1:10 PM, the registered dietitian (RD) stated that diabetics would be served cornbread and the dessert. Observation of resident 76 at lunch on 3/26/03, revealed he was served Salisbury steak, 1 piece of bread, mixed vegetables, masked potatoes with gravy, vanilla ice cream and 240 cc of apple juice. There was no milk observed to be served to the resident during this meal. In an interview, on 3/27/03 at 8:40 AM, with the Food Service Supervisor (FSS), she stated that for breakfast on 3/25/03 a resident on a large portions of protein diet would have received 4 sausages in stead of 2, for lunch on 3/25/03, a resident on a large portions of protein diet would have received a bowl of cottage cheese or yogurt and for lunch on 3/26/03, a resident on a large portions of protein diet would have received a bowl of cottage cheese. She further stated that she does not serve large portions of meat because that can overwhelm an elderly person, so she increases the protein in other ways. A review of the weight charts for resident 76 revealed the following: 11/20/02 265.2 lbs (pounds) 12/31/02 262 lbs 1/25/03 255.6 lbs 2/23/03 231.6 lbs 3/23/03 225.2 lbs	F 326	Additional lab values obtained following admission include the following values: 1/20/03 BUN: 44(H) Creatinine: 2.0(H) 2/6/03 BUN: 54(H) Creatinine: 2.2(H) BUN and Creatinine levels for resident 61 were elevated prior to admission. Elevated BUN and Creatinine levels were anticipated due to disease processes of progressive Cardiac disease and Prostate Cancer. Resident 76's physician was aware of these lab values. Resident 38 per facility menu spreadsheet dated 3/25/03, residents on a large portion entrée should have received 2 ounces of sausage. Therefore, when resident 38 was observed to have received 2 sausages on 3/25/03, she had received the correct diet and the correct amount of protein. Salisbury steak was served for lunch on 3/24/03. It is unclear as to the reference made regarding "pork" served to resident 38 for the lunch meal on this date. The menu for 3/24/03 reflects no changes to the menu were made on this date. The dietary "change book" reflects no changes to the menu were made on this date. Per interview with dietary staff, staff report no recollection of any changes made to the lunch menu on this date. Resident 38 has always eaten her meals in her room Her room is located at the end of the hall and is not located near a dining room. Resident 38's bed is located away from the doorway next to the window in her room. It is unclear how resident 38 would have observed the meals received by other facility residents for her comparison.	

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F 326	Continued From page 32 Between 11/20/02 and 3/23/03 there was a 40 lb weight loss, which represents a 15.08% weight loss in 4 months, which in accordance with the State Operations Manual (SOM) is considered to be severe. Between 12/31/02 and 3/23/03 there was a 36.8 lb weight loss, which represents a 14.04% weight loss in 3 months, which in accordance with the SOM is considered to be severe. Between 1/25/03 and 2/23/03 there was a 19.6 lb weight loss, which represents 9.38% weight loss in 1 month, which in accordance with the SOM is considered to be severe. A laboratory (lab) value taken at the facility and dated 11/15/02, showed an albumin of 4.2 g/dl. Another lab taken at the facility on 1/13/03 showed and albumin of 3.4 g/dl. The normal reference range, according to the lab used by the facility was 3.3 - 4.8 g/dl. An albumin level of less than 2.4 g/dl is considered a severe visceral protein deficit, an albumin level of 2.4- 2.9 g/dl is considered a moderate visceral protein deficit and an albumin of 3.0- 3.5 g/dl is considered a mild visceral protein deficit. (Reference guidance: Manual of clinical dietetics, American Dietetic Association, 6th edition, 2000, page 22.) The albumin of 3.4 g/dl dated 1/13/03 was the most current in resident 76's medical record and the decreased albumin was acknowledged by the RD on her "Monthly Nutrition ReAssessment of At Risk Residents" note dated 1/16/03. On 3/6/03, the RD co-signed a "Monthly Nutrition ReAssessment of At Risk Residents" note dated 3/6/03 which documented, (.01% loss in 1 mo (month) weight stable...Nutritional needs met, wt (weight) stable..."	F 326	The diets and supplements for resident 76, 61 and 38 were re-assessed to ensure accuracy per physician's order. An inservice will be provided to the dietary staff pertaining to therapeutic diets provided by the facility. This will be held 5/7/03. An inservice will be provided to applicable staff on recording meal % /consumption, therapeutic diets and snack and supplement orders. The dietary manager/designee will continue to complete monthly audits to include review of all diet, snack and supplement orders to ensure provision per physician orders. Trends identified will be presented to the facility Quality Assurance team monthly until a lesser frequency is deemed appropriate.	

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F 326	Continued From page 33 Review of the weekly weights, the month prior to the RD note dated 3/6/03, revealed the following: 1/25/03 255.6 lbs 2/5/03 251.0 lbs 2/12/02 Refused 2/18/03 234.6 lbs 2/23/03 231.6 lbs 3/2/03 232.0 lbs 3/9/03 226.4 lbs Between 2/5/03 and 3/2/03 there was a 19 lb weight loss, which represents a 7.56% weight loss in 1 month, which in accordance with the SOM is considered to be severe. The weights from 2/5/03 through 3/2/03 are the weights one month prior to the RD co-signed note written on 3/6/03. According to the weekly weights the resident's weight was not stable and his nutritional needs were not being met. While resident 76's albumin was still within the normal low range, resident 76's albumin level dropped significantly from November 2002 to January 2003. By not ensuring that resident 76 received the therapeutic diet ordered for him, the facility did not adequately address his nutritional problem and did not follow physician orders. 2. Resident 61 was admitted to the facility on 1/14/03 with the diagnoses of renal failure, edema, atrial fibrillation, chronic ischemic heart, depressive disorder, anemia, hypertension, cellulitis and thyrotoxicosis. On 3/26/03, resident 61's medical record was reviewed. Admit orders documented that resident 61 was to be on a regular decreased sodium and decreased cholesterol diet.	F 326		

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F 326	Continued From page 34 A "Nursing- Dietary Communication" slip dated 1/14/03, documented that resident 61 was on a regular no added salt low fat diet. A Registered Dietitian #1 (RD#1) assessment note dated 1/20/03 documented, that resident 61's albumin was severely depleted, that he does accept 100% of his 2.0, 120cc med pass, four times a day but due to his renal insufficiency the med pass would need to be stopped due to excessive protein. RD#1 also documented that the renal labs were increased. She also changed his diet to a no added salt with snacks three times a day. A physician order on 1/20/03 documented, "1. D/C (stop) Med Pass 2.0 (120 cc) QID (four times a day) [with] meds (medications). 2. [change] diet to: NAS (no added salt) [with] TID (three times a day) snacks." Review of laboratory results, dated 1/16/03, documented that resident 61's BUN (blood urea nitrogen) was 59mg/dl, his creatinine was 2.3 mg/dl and his BUN/Creatinine Ratio was 25.7. The laboratory results on 1/20/03 documented that resident's BUN had decreased to 44 mg/dl, his creatine decreased to 2.0 mg/dl and his BUN/Creatine Ratio decreased to 22. On 1/30/03 on a "Weight/Skin Condition Review" RD#2 documented, "...needs are not being met. Add med pass 60cc TID (three times a day) to provide extra protein needed" The skin/weight team also documented, "...Change snacks to high cal (calorie) high protein TID (three times a day)." A physician order on 1/30/03, documented, "med pass 60 cc TID (three times a day)..." Another physician	F 326		

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F 326	Continued From page 35 order dated 1/30/03, documented "[change] snacks to [increased] cal (calories) [increased] pro (protein) TID (three times a day)..." On 2/5/03 on the skin/weight team documented on a "Weight/Skin Condition Review" form to change diet to "...[increased] cal/pro (calories and protein)..." They also documented, "...med pass [increased] to 120 cc TID (three times a day) [with] meals." A physician order on 2/5/03, documented, "[increase] med pass to 120 cc TID (three times a day)." Another physician order dated 2/5/03, documented, "1. D/C (stop) [decreased] fat diet...4. Add [increased] cal (calories) [increased] pro (protein) diet..." Review of the laboratory results dated 2/6/03 documented that resident 61's BUN increased to 54 mg/dl, creatinine increased to 2.2 mg/dl and his BUN/Creatinine Ratio increased to 24.5. The BUN level rises steadily at a rate dependent on the degree of breakdown of protein, renal perfusion and protein intake. Serum creatinine rises in conjunction with glomerular damage. Serum creatinine levels are useful in monitoring kidney function and disease progression. (Reference guidance:Textbook of Medical- Surgical Nursing 9th edition, 2000, page 1149.) A physician order on 2/12/03, documented, "D/C (stop) all nutricion [sic] orders..." Another physician order dated 2/12/03, documented, "NAS (no added salt) diet TID (three times a day) snack..." The January and February MAR (medication administration record) were reviewed and med pass 2.0 120cc was documented as being given four times a day from 1/15/03 through 1/21/03 and then restarted on 1/29/03 through 2/26/03.	F 326		

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F 326	Continued From page 36 A physician order to start the med pass 2.0, 120cc four times a day, on 1/15/03, was not in resident 61's medical record. A physician order to restart the med pass 2.0, 120cc, four times a day, on 1/29/03, was not in resident 61's medical record. It should be noted from 1/15/02 through 1/21/03 and on 1/29/03, there was not a physician order to give resident 61 med pass four times a day. It should also be noted, that from 1/30/03 through 2/5/03, resident 61, according to physician orders should have been getting 60 cc of med pass three times a day instead of 120 cc four times a day. In addition, from 2/5/03 through 2/12/03, resident 61, should have been receiving 120cc of med pass three times a day instead of four times a day. On 2/12/03, resident 61, should have not been receiving any med pass due to the physician order which documented to stop all nutrition orders. Based on nutritional information, the med pass 2.0, 120cc, four times a day, was providing an additional 40 grams of protein per day to this resident in renal failure. Facility staff did not heed the recommendation of RD#1 on 1/20/03, when she wrote to stop the med pass containing excessive protein because of renal insufficiency. There is a direct correlation between the time resident 61 began again to receive the protein supplement and the increased BUN, Creatinine and BUN/Creatinine ratio. It should also be noted, that RD#1 stopped the med pass due to the excessive protein, yet on 1/30/03 the facility staff began an increased calorie, increased protein snacks, three times a day and on 2/5/03 they added an increased calorie, increased protein diet.	F 326		

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F 326	Continued From page 37 The most current renal lab values in resident 61's medical record, dated 2/6/03 showed an increase in his BUN, Creatinine and Bun/Creatinine Ratio. There were no other lab values in resident 61's medical record to provide evidence that the facility had monitored the increased BUN, Creatinine and BUN/Creatinine ratio to ensure that they were decreasing rather than continuing to increase. 3. Resident 38 was originally admitted to the facility on 9/14/01, discharged on 12/27/02 and re-admitted on 12/31/02 with the diagnoses of bronchitis, cerebral vascular accident, hypertension, asthma, multiple sclerosis, osteoarthrosis, diabetes mellitus, polio, kidney and ureter disorder. Resident 38's medical record was reviewed on 3/24/03. Resident 38 had a history of skin breakdown. Resident 38 had stage II pressure sore that developed on 2/14/03 and was resolved by 2/25/03. The physician's re-certification orders dated March 2003 documented that resident 36's was to be given "large portions- meat entrée q (every) meal 12/31/02." Resident 36's meal ticket was observed on 3/24/03. Resident 36's meal ticket stated large portions of meat. Resident 38's lunch meal was observed on 3/24/03 at 12:15 AM. Resident 36 was served coffee, water, rice, two rolls, green beans, pork, juice, and cherry pie for lunch. Resident 38's meat portion size was compared to several other resident's meat portion sizes and there was no difference between regular and large portion of meats. Resident 38's breakfast meal was observed on 3/25/03	F 326		

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F 326	Continued From page 38 at 7:55 AM. Resident 36 was served 4 ounces of orange juice, 1 piece of French toast, 2 sausages, 1 bowl of cereal and 8 ounces milk. Resident 38's was interviewed on 3/27/03 at approximately 11:00 AM. Resident 36 stated that she never received more meat on her tray than other residents. The food supervisor was interviewed on 3/27/03 at approximately 10:30 AM. The food supervisor stated that on 3/24/03 resident 36 should have received an extra serving of pork for lunch and on 3/25/03 resident 36 should have received 4 sausages.	F 326		
F 502 SS=E	483.75(j) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, it was determined that the facility did not obtain laboratory services for 3 of 19 sampled residents, as ordered by the physician. Resident identifers: 10, 16 and 75 Findings include: 1. Resident 75 was an 89 year old female admitted to the facility on 4/22/99 diagnose include hypertension, osteoporosis, gastro esophageal reflux disorder, dementia, constipation and hypothyroidism. A review of the medical record revealed a physician telelphone order dated 1/10/03, signed by the	F 502		

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

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F 502	Continued From page 39 physician requesting a CMP (comprehensive metabolic panel) secondary to a pressure ulcer and weight loss. In an interview with a staff nurse on 3/27/03 she stated that the CMP lab was not done but an albumin level was drawn instead. 2. Resident 10 had a comprehensive metabolic panel performed, as per physician's orders, on 10/16/02. The results of this lab came back reflecting a low potassium level (3.1 mEq). Continued review of the medical record revealed a physician's order to obtain a basic metabolic panel on 10/18/02, two days after the comprehensive metabolic panel. The basic metabolic panel would have included a new potassium level, among other results. There was no documentation to reveal that this lab was obtained as ordered by the physician. Facility staff were asked both on 3/26/03 and 3/27/03 to provide documentation to evidence that this lab was performed as ordered. Facility staff could not provide this documentation. 3. Resident 16 was admitted to the facility on 2/19/03 with diagnoses hypertension, hypercholesterolemia, glaucoma, congestive heart failure, fracture femur, constipation, gastroesophageal reflux disease, and open reduction internal fixation. Resident 16's medical record was reviewed on 3/24/03. A physician order dated 3/5/03 documented that resident 16 was to guaiac his stools three times. The nurses notes dated 3/10/03 and 3/12/03 documented that resident 16's stools were guaiac and the results were negative. There was no additional	F 502	**F 502** Resident 75 telephone order dated 1/10/03 for a CMP (Complete Metabolic Panel) was clarified on the same date with a second order signed by the same nurse, requesting a BMP (Basic Metabolic Panel) be obtained every October and January. Nursing staff had already obtained the January lab requested, on 1/7/03. Nursing staff, feeling that this was a clarification of the first order obtained, did not draw the Complete Metabolic Panel requested in the first order. On 1/15/03 (5 days later), a telephone order was received for to obtain an Albumin level only. This lab was obtained as ordered. For resident 10 the first order obtained on 10/15/02 requests a CMP (Complete Metabolic Panel), and a Depakote level. These labs were obtained as ordered. The next order written 10/17/02 (2 days later) for a BMP (Basic Metabolic Panel) and Depakote level, is in fact a frequency clarification of currently existing routine lab orders. This is not a new order. A Complete Metabolic Level consists of all lab values contained in a Basic Metabolic Panel plus additional lab values. Lab results included slightly low potassium level; however; the physician upon his notification of the lab results including the pofassium level made no changes pertaining to this. In fact the physician actually discontinued the resident's potassium supplement on 11-14-02 which further supports that he did not view the slightly low potassium level on 10/16/02 as reason for concern.	

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

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F 502	Continued From page 40 nurses note documenting that resident 16's stools was guaiac for the third time. An interview with a a nurse was done on 3/25/03 at 4:30 PM. The nurse stated that because the first two stools were negative that it was unnecessary to guaiac the third.	F 502	There is no documentation in the resident chart to support the personal opinion cited in the 2567 as to the physician's intent regarding the duplicate lab orders. The physician was in the building during survey and was asked by facility nursing staff, to explain his intent. The physician indicated that the CMP (Complete Metabolic Panel) completed on 10/16/02 satisfied his request for a routine BMP (Basic Metabolic Panel) to be completed in the month of October. Additionally he stated that had he been concerned about the potassium level he would have requested a potassium level only and not an entire Metabolic Panel as all other values on the 10/16/02 lab test were normal. For resident 16 stools were guaiac x3 as per the 3/5/03 order. Nursing notes 3/10/03 and 3/12/03 present as well as a late entry completed for 3/11/03 by the nurse who had by her account completed the guaiac but had failed to document the negative result. The late entry was reported to the surveyor during the survey process. Additionally the physician assessed the resident on 3/20/03 and assessed the resident's GI status with no abnormal findings identified and no new orders given. The facility will continue to provide and obtain laboratory services to meet the need of facility residents. Nurse managers will review new lab orders received 3x week to ensure lab orders are requisitioned and obtained as ordered. Nurse managers, as part of triple check will review routine lab orders monthly. Nurse managers will ensure routine lab orders are scheduled and requisitioned for completion, at that time. The D.O.N. /Designee will perform an audit of 5% of facility residents monthly to ensure labs obtained as ordered. Any identified trends will be reported to the QA committee monthly, until a lesser frequency is deemed appropriate.	

HM
HERITAGE BENNION CARE CENTER

A member of the Heritage Management Family. Caring professionals serving western communities.

May 7, 2003

[redacted]
Resident Assessment
PO Box 144103
Salt Lake City, Utah, 84114

Dear [redacted]

As follow up to our conversation on Monday May 5, and in response to the fax that I received from you, I am submitting the following information:

Addendum to the Plan of Correction for F 241 for Heritage Bennion's Annual Survey.

On May 9, 2003 an all staff inservice will be conducted and part of the agenda will include a review on expectations as to responding to resident requests when they use their call light.

Focused rounds will be conducted at least x3 week by administrator/ designee to monitor the staff are responding to resident call lights appropriately. Rounds will be recorded in written form assessing a random number of call lights for proper function, timeliness of response and that service is rendered when light answered or reasonable return time set and followed through. Immediate training of staff will occur per out come of rounds as required.

Administrator will monitor plan for compliance and identified trends brought monthly to QA committee.

In addition, you brought to my attention that on the original POC that was submitted that the dates for compliance for all outstanding tags were omitted. May 26, 2003 is the date that we have set for the compliance of all outstanding tags.

This letter will be attached to the existing POC as outlined on the 2567.

If you have any further questions please feel free to give me a call at 969-1420.

Respectfully,

Matt Thompson, Administrator
Bennion Care Center

6246 South Redwood Road Salt Lake City, Utah 84123 (801) 969-1420 FAX (801) 969-1850