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 _____	05/25/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 APPROPPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility did not provide housekeeping and or maintenance services to maintain a sanitary, or comfortable home for its residents. Findings include: The following observations were made between 5/22/06 and 5/25/06. There were multiple areas where the walls in the facility were observed to be noticeably dirty, or where the paint was gouged or scratched off. The handrails which the residents use to stabilize themselves felt sticky in many areas. There were two upholstered chairs in the Day room which were very soiled, and observed to be in use by residents on 5/22/06. There was an area approximately 4 feet by 4.5 inches on the west wall in the Day room where the baseboard was falling off, and 2 nails were left exposed. This area was not attended to during 5/22/06 through 5/25/06. On 5/22/06, 5 of 8 tablecloths in the dining room were noted to be very soiled. The top of the tablecloths are covered with glass; however, the skirt area which rests in the residents lap was	F 253	6/19/06 POC acceptable with addendum completion date 7/7/06 UBrownbank RN Tag F253 Walls, handrails and chair upholstery cleanliness: Housekeeping services/designee and administrator will inspect all wall and handrails in facility for cleanliness on 6/14/06. All walls, handrails and upholstered chairs found to be dirty will be cleaned on or before 7/7/06. Monthly environmental audits by housekeeping services/designee and administrator/designee will include random audits of walls, handrails and upholstered chairs for cleanliness. Trends identified by this monthly audit will be discussed at the monthly QA meeting. The monthly audits will continue until the QA committee deems a lesser frequency is appropriate. (Two upholstered chairs: These two chairs were removed from the day room during survey, as other upholstered chairs had been obtained the week prior to survey arrival. One of the upholstered chairs was disposed of; one was given to a resident that wanted it in her room. This chair has been cleaned for the resident.) Dayroom base board was reattached; main dining room entrance threshold was replaced; hole in room 404 has been repaired. All walls found to have gouges/scratches will be repaired on or before 7/7/06.	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 6/15/06

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

Utah Department of Health

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JUN 15 2006

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F 253	Continued From page 1 soiled. The entrance threshold to the main dining room was missing. The wall to the left of the door in room 404 had a hole approximately 3 inches by 1.5 inches. During the initial walk-through of the facility, there was an oxygen cannister (emergency tank) propped up against the wall on a loveseat couch in room 405. On 5/24/06, observations were made of residents wheelchairs during and after breakfast. The following wheelchairs were observed to be very dirty with food and other substances dried onto the surface: 1. Resident 9's wheelchair 2. Resident 10's wheelchair 3. Resident 20's wheelchair 4. Resident 21's wheelchair 5. Resident 22's wheelchair was also observed to have sharp edges on the left armrest where the plastic had broken leaving an area approximately 3 inches by 1.5 inches in diameter.	F 253	Environmental audits by maintenance manager and administrator/designee will be completed monthly. Trends identified by this monthly audit will be discussed at the monthly QA meeting. The monthly audits will continue until the QA committee deems a lesser frequency is appropriate. Tablecloths: Starting 6/16/06, Each tablecloth will be checked for cleanliness before setting tables before each meal. A random weekly audit will be completed by the dietary manager/designee. This weekly audit will be conducted each week starting 6/16/06. Trends identified by this weekly audit will be discussed at the monthly QA meeting. This weekly audits will continue until the QA committee deems a lesser frequency is appropriate. Oxygen canister not in stand, and wheelchairs cleanliness: Oxygen canister in question was put in a stand the same day it was found out of the stand by survey team. An initial complete facility audit of oxygen tanks and wheelchair cleanliness/repair will be completed 6/16/06 by maintenance/administrator/designee.	

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F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS	F 279		

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

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 care plan services to be furnished to attain or maintain the resident's highest practicable physical well-being. Resident identifier: 9

Findings include:

Resident 9 was admitted to the facility on 3/13/06 after being discharged from a local hospital. Resident 9 had been treated for a left tibia/fibula fracture.

CNA coordinator/ ADON/designee will insure any dirty wheelchairs will be cleaned by 6/16/06.

Any oxygen tanks found out of stand will be put into a stand immediately.

Resident #22's wheelchair armrest has already been repaired.

An in-service to aides and nurses will be conducted on or before 6/30/06 to remind/education aides/nurses about duty to keep oxygen canister in a stand at all times.

This in-service will also address the cleanliness of the wheelchairs which is done on the graveyard shift.

A weekly room check will be completed by the CNA coordinator and ADON/designee to check that all oxygen canisters are in a stand and all wheelchairs are clean/in good repair.

Trends identified by this weekly audit will be discussed at the monthly QA meeting.

The weekly audits will continue until the QA committee deems a lesser frequency is appropriate.

Tag F279

Staff had not established a care plan for anticoagulant use. Resident #9's care plan was updated to include anticoagulant use, a measurable goal, and the intervention to monitor for signs and symptoms of bleeding.

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F 279	Continued From page 3	F 279	A care plan audit of all residents with anticoagulant use will be conducted by the DON/designee. This audit will be done by 6/30/06 and then monthly. Trends identified by this monthly audit will be discussed at the monthly QA meeting. This monthly audits will continue until the QA committee deems a lesser frequency is appropriate. 6/19/06 - Addendum - Per telephone call with administrator - Completion dates for all tags is 7/7/06 - Added to POC With permission. L. Bauernbank RN	

Two of the drugs resident 9 was receiving upon admission to the facility were Lovenox (an anticoagulant) and aspirin (which is also known as acetylsalicylic acid).

Physician discharge orders from the hospital, dated 3/13/06, stated the following:

"CBC (complete blood count) q (every) 5 days on Lovenox, notify house physician platelet count less than < 150,000."

Between the time of admission on 3/13/06 and the day the medical record was reviewed during the survey process on 5/23/06, the facility obtained two complete blood counts. (During this time, resident 9 remained on Lovenox and aspirin.)

The first CBC was obtained the day after admission (3/14/06). The platelet count was 313, with normal values falling between 150 to 400 K/uL.

The second CBC was not performed until 5/11/06, 59 days after the first CBC. The platelet count for this second CBC was 136, which is abnormally low.

The information provided by Aventis, the maker of Lovenox, included the following regarding Lovenox:

"Laboratory Tests:
Periodic complete blood counts, including platelet count, and stool occult blood tests are recommended during the course of treatment with

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Lovenox Injection..."
"Drug Interactions:
Unless really needed, agents which may enhance the risk of hemorrhage should be discontinued prior to initiation of Lovenox Injection therapy. These agents include medications such as: anticoagulants, platelet inhibitors including acetylsalicylic acid, salicylates, NSAIDs (including ketorolac tromethamine), dipyridamole, or sulfinpyrazone. If co-administration is essential, conduct close clinical and laboratory monitoring."

There was no documentation in the medical record for resident 9 to evidence that staff had obtained the CBCs as ordered by the physician upon discharge from the hospital. There was no documentation to evidence that staff had obtained an order to discontinue the monitoring of the CBCs.

Staff had not established a care plan to address the use of an anticoagulant or its co-administration with acetylsalicylic acid.

The medical record of resident 9 did not contain documentation that staff had monitored resident 9 for signs and symptoms of bleeding after the platelet count was discovered to be abnormally low.

The director of nurses was interviewed in the presence of three registered nurse surveyors on 5/24/06 regarding the order to obtain CBCs to monitor the Lovenox. The director of nurses stated, "I didn't know you needed to monitor Lovenox."

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F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility did not provided services according to professional standards for 1 of 19 sample residents who required daily dressing changes to pressure ulcers on her heels, one of which was infected. Resident 3. Findings included: On 5/24/06 at 10:30 AM, resident 3 was observed to have medication infusing into an IV (intravenous) port in her left arm. A facility nurse stated she had just finished connecting resident 3's dose of Vancomycin to her IV cannula. When the nurse was asked what type of infection resident 3 was being treated for, the nurse stated, " She doesn't have MRSA. " The nurse stated that resident 3 was on Vancomycin IV because they had tried several other antibiotics that were not effective in clearing the infection in the resident ' s left heel. The nurse stated that no culture or sensitivity had been tested from the wound site. The nurse was then observed to change the dressings on the Stage IV (4) pressure sores on resident 3 ' s right and left heels. The nurse had set the dressing change supplies on one end of resident 3 ' s tray table. She spread a dry wash cloth at the other end. The nurse donned gloves to remove the outer wrap around resident 3 ' s left	F 281	Tag F281 Treatment change according to facility policy: An in-service, on or before 6/30/06, will address treatment dressing changes and normal saline storage/contamination rules The in-service will be conducted by DON/designee. All nurses will sign off treatment skills test, on or before 6/30/06, and then nurses' skills tests will continue yearly. Trends identified by these skills tests will be discussed at the monthly QA meeting. Any further skills tests needed will continue until the QA committee deems a lesser frequency is appropriate.	

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ankle. The nurse attempted to remove the gauze dressing that was against resident 3 ' s open wound but the dressing had adhered to the wound. The nurse took a single use vial of normal saline from the table to moisten and remove the dressing. The dressing had a light tan stain on it. The nurse discarded the contaminated dressings and her gloves into the clear plastic bag in a waste basket between the resident's and her roommate's beds.

The nurse donned new gloves. The nurse dipped a syringe into a container of normal saline and drew the liquid into the syringe. The nurse irrigated resident 3 ' s wound with the saline. She rinsed a dime sized area of yellow tissue which was distal to resident 3 ' s ankle and above the red tissue, then the red tissue which was around the heel, then the blackened area at the bottom of resident 3 ' s heel and back up to the top of the wound. The nurse set the syringe on resident 3 ' s tray table. The nurse dabbed at the wound with a clean gauze pad to dry the wound. Without washing or changing gloves, the nurse applied a clean dressing to resident 3 ' s heel and ankle. The nurse discarded her gloves into the waste basket.

The nurse washed and donned clean gloves to change the dressing on resident 3 ' s right heel. The nurse removed the old dressings and discarded them into the waste basket. Without washing or changing her gloves, the nurse dipped the syringe into the same container of normal saline and drew the liquid into the syringe. The nurse rinsed the wound on resident 3 ' s right foot and applied a clean dressing. The nurse discarded her gloves into the waste basket and

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washed her hands. The nurse removed the rest of the dressing change items from resident 3 ' s tray table and left the room. The nurse left the contaminated dressings and gloves in the waste basket in resident 3 ' s room. At 12:15 PM, 75 minutes later, the waste basket with the contaminated dressings and gloves was observed to be in resident 3 ' s room, between the resident ' s and her roommate ' s beds. The clear plastic bag that lined the waste basket remained open at the top throughout the procedure and after the nurse left resident 3 ' s room.

" Fundamentals of Standard Precautions
Handwashing
1. Handwashing is the single most important measure to reduce the risks of transmitting microorganisms.
2. Washing hands as promptly and thoroughly as possible between patient contacts; after contact with blood, body fluids, secretions, excretions and contaminated equipment or articles; and after gloves are removed is vital for infection control.
3. It may be necessary to wash hands between tasks on the same patient to prevent cross-contamination of different body sites.
Gloves
1. Gloves are worn to provide a protective barrier and prevent gross contamination of the hands of health care workers and to reduce the transmission of microorganisms to patients.
2. Wearing gloves does not replace the need for handwashing because gloves may have small, inapparent defects or may be torn during the use, and hands can become contaminated during removal of gloves. "

The Lipincott Manual of Nursing Practice - 7th

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edition (2001), pg 958.

" What body fluids are included in Standard Precautions?

All fluids, secretions, excretions and non-intact skin of the body. This includes blood, saliva, sputum, feces, urine, open lesions, non-intact skin (including broken skin, rashes, skin irritation), secretions from wounds, vomitus, breast milk and all other fluids, secretions and excretions except sweat.

Do Standard Precautions just mean using protective equipment such as gloves?

Standard Precautions don't stop with protective equipment. They also include proper disposal of contaminated equipment and good handwashing practices. They include disposing sharps in a rigid container, putting dirty linen in the proper receptacle and putting infectious waste in a biohazard container ... "

Utah Department of Health, Division of Community Health Services, Bureau of Epidemiology, A Resource for Infection Control in Long-Term Care Facilities (1997)

The following day, the nurse was asked where resident 3's container of normal saline had been stored. The nurse produced the container from the cabinet in the nurse's alcove where other treatment supplies were being kept. The nurse stated that it was the same container she had used in resident 3's room the previous day. The surveyor had marked the container during the dressing change. The surveyor observed that the

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container the nurse held had the surveyor's mark on it. The bottle had not been dated as to when it had been opened.

The facility's Policy and Procedure for Non-sterile Dressing changes included:

"5. Gather necessary supplies. Ointments, creams, etc., should be placed in a medication cup rather than the bottle/tube being brought into the resident's room. A tongue blade or sterile Q-tip can be used for application. Cleansing agents will be single use unless otherwise specified. Cleansing agents such as normal saline will be provided by the facility in single use containers. Unused portions will be discarded following each treatment. If a cleansing agent is multi-use, each will be labelled with the resident's name and used for that resident only.
10. . . . The nurse will ensure that all bagged soiled dressings are disposed of in a biohazard container and trash can liners are replaced if used.
11. Remove soiled dressing and dispose of in bag. Remove gloves. Wash hands.
12. Apply clean gloves.
13. Clean wound . . .
14. Dispose of cleaning supplies in bag.
15. Remove gloves and wash hands.
18. Dispose of unused items in bag.
21. Remove bag containing soiled items from room and dispose of in biohazard container."

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F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of resident medical records, it was determined that for 2 of 19 sample residents, the facility did not provide the necessary care and services to attain or maintain the residents highest practicable physical well-being. Resident identifiers: 5 and 9. Findings included: 1. Resident 5 was an 82 year old male who was admitted to the facility on 4/3/04. Resident 5 had a foley catheter with a down drainage bag. The medical record of resident 5 was reviewed on 5/22/06 and 5/23/06. The care plan for resident 5 included the following: "Potential for Infection R/T (related to) Hx (history) of infection...uti (urinary tract infection)..." The goal for this concern was that resident 5 would "have no untreated infections through the next review." The approached for this concern and goal were	F 309	Tag F309 A complete facility chart check of all residents with a urinalysis ordered will be completed by DON/designee, by 6/30/06, to ensure MD/NP notification, orders received and follow-up in a timely manner. Weekly focus rounds will be completed by DON/designee. An in-service, on or before 6/30/06, will be held on proper documentation and notification to MD/NP on all labs by DON/designee. Trends identified by these audits will be discussed at the monthly QA meeting. The weekly audits will continue until the QA committee deems a lesser frequency is appropriate. Physician visit scheduling: A corporate form, "Interdisciplinary Memo/Communication", has been initiated by the nursing department to alert the scheduler about visits that need to be scheduled; this will be a double check as the scheduler looks at all new admission paperwork to schedule appointments for new residents. This communication form has three copies, one will go to the scheduler and one will remain in the chart, one will be used by DON/Unit Manager.	

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that nursing staff would "monitor resident for s/sx (signs and symptoms infection include: ...foul smelling urine dark cloudy urine", and to perform "labs as ordered." The last date this care plan was updated was 3/13/06.

Review of the nurse's notes revealed the following:

5/10/06 - "dayshift"

"Pt (patient) has a dark and foul urine called MD and family and hospice UA C&S (culture and sensitivity) if ind (indicated) tomorrow will follow"

The laboratory received a sample of resident 5's urine on 5/10/06. The following laboratory results were found in the resident's chart:

The urine tested positive for nitrites, blood and leukocyte esterase. The normals listed for each of these would be a negative, not a positive result.

The urine showed 11 to 20 white blood cells per high power field. The normal is 3 - 4 per high power field.

The urine also showed many bacteria per high power field. This would not be a normal finding.

The bottom of this report stated that the culture of the urine was "pending".

The medical record of resident 5 did not contain any documentation to evidence that staff were aware of or had addressed these abnormal laboratory results. As of 5/23/06, there were no culture results in the medical record of resident 5.

A weekly chart audit by the DON/designee will include whether the resident has a communication form in the chart. The schedule will be checked to see if the new appointment has been made in the time period ordered.

Trends identified by this weekly audit will be discussed at the monthly QA meeting.

This monthly audits will continue until the QA committee deems a lesser frequency is appropriate.

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There was no documentaion in the medical record of resident 5 to evidence that staff were aware of or had pursued the results of the culture.

The surveyor called the laboratory on 5/23/06 at approximately 10 AM. The lab representative stated that urine sample had appeared to have been "contaminated" and that a "repeat collection with clean catch protocol was advised."

The lab representative was asked if a copy of the culture results (the fact that the sample appeared contaminated and a second specimen was advised) was sent to the facility. The lab representative stated that it had been sent.

The director of nurses (DON) was then asked if he could assist in locating the culture results for the urinalysis performed 5/10/06. The DON could not locate the results of the culture and ended up having to have the lab fax the results on 5/23/06 at 1:27 PM.

At the bottom of the urinalysys report, the lab noted that the specimen source that would be used to perform the culture contained mixed contaminating flora and that no further workup would be performed. The lab also noted "Repeat collection following clean catch protocol is advised."

As of the review date by the surveyor on 5/23/06, there was no documentation in the medical record of resident 5 to evidence that staff obtained a second urine specimen (by clean catch) to send to the lab. There was no documentation that staff had addressed the abnormal lab results, or that they had reassessed

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the status of resident 5, or updated the care plan.

Visual and olfactory assessments were performed on resident 5 by a nurse aide, a nurse manager and the nurse surveyor on 5/23/06. Visual inspection of the urine within the foley drainage bag revealed it to be cloudy with large bits of sediment. The smell around the drainage bag was foul. The aide, who was squatting on her knees while holding the drainage bag commented, "It smells foul, really foul."

Later this same day (5/23/06) at 3:10 PM, two nurse aides who had taken care of resident 5 on multiple occasions were interviewed. They stated that the urine of resident 5 did "not always smell foul and strong like today."

Facility nurse notes and hospice nurse notes were reviewed back through January of 2006. There was no documentation in those notes to establish that the characteristics of dark and foul urine were a normal or routine finding in resident 5.

2. Resident 9 was admitted to the facility on 3/13/06 after being discharged from a local hospital. Resident 9 had been treated for a left tibia/fibula fracture.

Physician discharge orders from the hospital, dated 3/13/06, stated that resident 9 was to follow-up with her orthopedic physician in 4 weeks and that staff were to obtain "repeat x-ray prior to f/u (follow-up) L (left) knee."

Review of the medical record of resident 5 revealed that the follow-up with the orthopedic

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physician did not take place until 5/11/06, approximately 30 days late. The follow-up should have been done on or about 4/10/06.

During interview with the DON on 5/24/06, he suggested that the delay in having resident 9 see her physician may have been a scheduling issue.

The orthopedic physician's scheduling person was interviewed by telephone on 5/30/06 at 10:07 AM. She stated that if the doctor had ordered the resident to be seen in 4 weeks, "we would have gotten her in, no questions asked." When asked about scheduling problems, she stated that the worst case scenario would have been to see the resident in the 5th week, but no later.

During review of the orthopedic physician's note of 5/11/06, he documented and underlined the following: "Needs x-rays..." He then added "Please get x-rays AP and lat L knee and send to my office for review."

During telephone interview with the assistant to the orthopedic physician on 5/30/06, he stated that the x-rays which had been ordered to be brought with the resident to the visit had not been sent.

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F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on interview and review of medical records, it was determined that for 1 of 19 sample residents, the facility did not ensure that the resident's drug regimen was free from unnecessary drugs. An unnecessary drug is any drug when used without adequate monitoring. Resident identifier: 9. Findings include: Resident 9 was admitted to the facility on 3/13/06 after being discharged from a local hospital. Resident 9 had been treated for a left tibia/fibula fracture. Two of the drugs resident 9 was receiving upon admission to the facility were Lovenox (an anticoagulant) and aspirin (which is also known as acetylsalicylic acid). Physician discharge orders from the hospital, dated 3/13/06, stated the following: "CBC (complete blood count) q (every) 5 days on Lovenox, notify house physician platelet count	F 329	Tag F329 Lovenox was ordered by discharging MD at the hospital for resident #9. He continued ASA as ordered. House MD changed CBC order to initially and then as ordered which was obtained as ordered. Again ASA was continued as ordered. DON/designee will audit all charts that have Lovenox ordered, if ASA is also ordered the MD/NP will be notified to ensure that the ASA was meant to continue and document this. This audit will be completed by 6/30/06 and will continue monthly. Trends identified by this audit will be discussed at the monthly QA meeting. The monthly audits will continue until the QA committee deems a lesser frequency is appropriate.	

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less than < 150,000."

Between the time of admission on 3/13/06 and the day the medical record was reviewed during the survey process on 5/23/06, the facility obtained two complete blood counts. (During this time, resident 9 remained on Lovenox and aspirin.)

The first CBC was obtained the day after admission (3/14/06). The platelet count was 313, with normal values falling between 150 to 400 K/uL.

The second CBC was not performed until 5/11/06, 59 days after the first CBC. The platelet count for this second CBC was 136, which is abnormally low.

The information provided by Aventis, the maker of Lovenox, included the following regarding Lovenox:

"Laboratory Tests:
Periodic complete blood counts, including platelet count, and stool occult blood tests are recommended during the course of treatment with Lovenox Injection..."
"Drug Interactions:
Unless really needed, agents which may enhance the risk of hemorrhage should be discontinued prior to initiation of Lovenox Injection therapy. These agents include medications such as: anticoagulants, platelet inhibitors including acetylsalicylic acid, salicylates, NSAIDs (including ketorolac tromethamine), dipyridamole, or sulfinpyrazone. If co-administration is essential, conduct close clinical and laboratory monitoring."

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There was no documentation in the medical record for resident 9 to evidence that staff had obtained the CBCs as ordered by the physician upon discharge from the hospital. There was no documentation to evidence that staff had obtained an order to discontinue the monitoring of the CBCs.

Staff had not established a care plan to address the use of an anticoagulant or its co-administration with acetylsalicylic acid.

The medical record of resident 9 did not contain documentation that staff had monitored resident 9 for signs and symptoms of bleeding after the platelet count was discovered to be abnormally low.

The director of nurses was interviewed in the presence of three registered nurse surveyors on 5/24/06 at 10:55 AM regarding the order to obtain CBCs to monitor the Lovenox. The director of nurses stated, "I didn't know you needed to monitor Lovenox."

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F 496 SS=D	483.75(e)(5)-(7) REQUIRED TRAINING OF NURSING AIDES	F 496		

Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.

Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.

If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.

This REQUIREMENT is not met as evidenced by:

Based on interview with the facility human resources director, and review of facility personnel files, it was determined that the facility did not seek information from the nurse aide

Tag F496
Aide hired from out of state.

Human Resources was in-serviced on how to check other State registries on the internet, and will seek information from every State registry that the facility believes will include information on an aide.

Human Resources will audit the charts, by 6/30/06, of the aides that still work here, that have been hired in the last four months.

An audit will be completed monthly by administrator/designee.

Trends identified by this audit will be discussed at the monthly QA meeting.

The monthly audits will continue until the QA committee deems a lesser frequency is appropriate.

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registry prior to allowing 1 of 5 CNA's (Certified Nursing Assistants) to perform cares on facility residents. The nurse aide registry provides information on current aide certification and whether or not an aide has a history of abuse.

Findings include:

Employee A was hired 3/9/06, and was permitted to work in the facility as a CNA with direct patient contact. Employee A's personnel file contained a nurse aid registry check for Utah which showed "no matches found". Employee A specified on her application to work, that she was certified as a CNA in Idaho. The facility did not make an attempt to check the Idaho CNA registry prior to allowing employee A to provide resident care.

During an interview with the human resource member who conducts the Nurse Aide registry checks on 5/24/06 at approximately 3:50 PM, she stated that she did not know how to check the Nurse Aide registry in other states. She further stated that she only contacts the nurse aide registry for Utah.

F 502 SS=E 483.75(j)(1) LABORATORY SERVICES

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 observation, medical record review,

F 502

Tag F502

Laboratory Services

DON/designee will audit charts, by 6/30/06, for May to see that all labs were drawn in a timely manner. All labs including stool cultures with no

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and interviews it determined that the facility did not meet the needs of 3 of 19 sample residents for laboratory services as ordered. Resident Identifiers: 10, 15 and 9.

Findings Include:

1. Resident 10 was admitted to the facility on 3/24/05 with the following diagnoses: gastrointestinal hemorrhage, dementia with behaviors, hypertension, Senile depressive disorder, and weight loss.

Resident 10's Physician orders dated 3/9/06 indicate that resident 10 was to have a Comprehensive Metabolic Panel (CMP). The facility did not obtain that lab value until 4 days later on 3/13/06.

Meetings with facility's department heads including the Administrator, DON (Director of Nursing), and corporate staff revealed that no explanation could be given as to why the lab test was performed 4 days after the physician ordered it.

2. Resident 15 was admitted to the facility September 2002. Resident 15 had diagnoses that included history of pulmonary embolism.

Resident 15 an anticoagulant medication for his history of pulmonary embolism. A physician's telephone order, dated 4/1/06, clarified that resident 15 had been prescribed Coumadin 4 milligrams to be given at 4:00 PM daily.

The physician ordered blood testing, PT - prothrombin time / INR - international ratio, to

F 502

indication of date due will be audited to insure they were drawn the next day. Orders written for "this week", "monthly" or "quarterly" will be audited to insure lab was drawn within order window.

DON/designee will give in-service, by 6/30/06, to nurses to document reason why a lab/stool culture is not obtained and that the physician is notified and if there are any new orders.

Weekly focused rounds will be completed to ensure all labs are being completed in a timely manner and documented, by DON/designee.

Trends identified by this audit will be discussed at the monthly QA meeting.

The weekly audits will continue until the QA committee deems a lesser frequency is appropriate.

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monitor the efficacy of resident 15's anticoagulant medication.

When they were received from the laboratory, resident 15's laboratory results were called to the physician and noted by the nurse. Resident 15's PT/INR was checked on 4/6/06 and the results were called to the physician the same day. The laboratory result sheet was noted that the nurse had notified the physician and received a new order to have the test repeated in two weeks. A nurse's note in resident 15's medical record, dated 4/6/06, revealed that new orders had been received for the resident to have another PT/INR on 4/20/06.

The laboratory result for resident 15, dated 4/20/06, was noted by the nurse that it had been faxed to the physician and an order had been received to repeat the test in two weeks. The next PT/INR would have been due 5/4/06. The laboratory test was not done for resident 15 until 5/24/06, three weeks after it was due.

A nurse documented the nurse's notes, on 5/22/06, "PT/INR monthly due (May) 5/23/06."

Resident 15's PT/INR was tested 5/24/06. A nurse noted the 5/24/06 laboratory result and wrote a nurse's note and a telephone order, on 5/24/06, that the physician had been notified of the test results and had ordered the test to be repeated in two weeks.

On 5/24/06 at 4:10 PM, the Director of Nursing was notified there was no laboratory report indicating the test for resident 15, that was due 5/4/06, had been done. The DON was asked to

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provide any laboratory report to document resident 15's PT/INR had been tested on or near 5/4/06. No test results were provided.
3. Laboratory results received on 4/3/06 for resident 9 revealed that she tested positive for the clostridium difficile toxin.

On 4/19/06, the physician ordered "Stool culture X (times) 2 to r/o (rule out) cont (continuous) c-diff (clostridium difficile)."

There was no documentation in the medical record to evidence that these two labs had been performed. There was no documentation to explain why they had not been performed.

During interview with the director of nurses on 5/24/06, he stated that there was some "miscommunication between them (the nurses and nurse aides) about getting the sample."

F 502

F 507 SS=D 483.75(j)(2)(iv) LABORATORY SERVICES

The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.

This REQUIREMENT is not met as evidenced by:

Based on interview and review of resident medical records, it was determined that for 1 of 19 sample residents, the facility did not file in the resident's clinical record laboratory reports that were dated and contained the name and address of the testing laboratory. Resident identifier: 5.

F 507

Tag F507
Resident #5: Since survey, a second UA was ordered and drawn with results back. The patient was still asymptomatic and the family and MD decided not to treat the patient. This is documented in the chart.

DON/designee will audit all charts, by 6/30/06, to see that all labs ordered for May are in the chart with documentation of no order or new order, date and nurses signature.

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F 507	Continued From page 23	F 507	DON/designee will give an in-service, by 6/30/06, to nurses including unit managers that lab is to be in chart, with documentation of no order or new order, and nurses signature and date. Weekly focused rounds will be completed by DON/designee to ensure proper documentation is in residents chart. Trends identified by this audit will be discussed at the monthly QA meeting. The weekly audits will continue until the QA committee deems a lesser frequency is appropriate.	

Findings include:

1. Resident 5 was an 82 year old male who was admitted to the facility on 4/3/04. Resident 5 had a foley catheter with a down drainage bag.

The medical record of resident 5 was reviewed on 5/22/06 and 5/23/06.

Review of the nurse's notes revealed the following:

5/10/06 - "dayshift"

"Pt (patient) has a dark and foul urine called MD and family and hospice UA C&S (culture and sensitivity) if ind (indicated) tomorrow will follow"

The laboratory received a sample of resident 5's urine on 5/10/06. The following laboratory results were found in the resident's chart:

The urine tested positive for nitrites, blood and leukocyte esterase. The normals listed for each of these would be a negative, not a positive result.

The urine showed 11 to 20 white blood cells per high power field. The normal is 3 - 4 per high power field.

The urine also showed many bacteria per high power field. This would not be a normal finding.

The bottom of this report stated that the culture of the urine was "pending".

The medical record of resident 5 did not contain

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any documentation to evidence that staff were aware of or had addressed these abnormal laboratory results. As of 5/23/06, there were no culture results in the medical record of resident 5. There was no documentaion in the medical record of resident 5 to evidence that staff were aware of or had pursued the results of the culture.

The surveyor called the laboratory on 5/23/06 at approximately 10 AM. The lab representative stated that urine sample had appeared to have been "contaminated" and that a "repeat collection with clean catch protocol was advised."

The lab representative was asked if a copy of the culture results (the fact that the sample appeared contaminated and a second specimen was advised) was sent to the facility. The lab representative stated that it had been sent.

The director of nurses (DON) was then asked if he could assist in locating the culture results for the urinalysis performed 5/10/06. The DON could not locate the results of the culture and ended up having to have the lab fax the results on 5/23/06 at 1:27 PM.

At the bottom of the urinalysys report, the lab noted that the specimen source that would be used to perform the culture contained mixed contaminating flora and that no further workup would be performed. The lab also noted "Repeat collection following clean catch protocol is advised."

As of the review date by the surveyor on 5/23/06, there was no documentation in the medical record of resident 5 to evidence that staff

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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) COMPLETION DATE
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obtained a second urine specimen (by clean catch) to send to the lab. There was no documentation that staff had addressed the abnormal lab results, or that they had reassessed the status of resident 5, or updated the care plan.