STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465093	A. BUILDING _____ B. WING _____	2/28/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHAM CITY NURSING & REHAB	775 N 200 E POB 518 BRIGHAM CITY, UT 84302

(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 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 and interviews, it was detemined the facility did not respond to resident call lights in a timely manner. Call lights were observed to signal, unanswered, for up to 15 minutes. In addition, one confidential resident interview and 7 of 16, in a confidential group interview, stated that call lights were not answered in a timely manner. Findings include: 1. Observations of staff response to resident call lights were made on 2/25, 2/26 and 2/27/01. The following observations were made: a. On 2/25/01 at 8:50 AM, the call light to room 10 was observed to be signalling. At 9:03 AM, the call light remained signalling. b. On 2/25/01 at 9:50 AM, the call light for room 36 was observed to be signalling. At 10:02 AM, a staff member responded to the call light. c. On 2/25/01 at 11:25 AM, the call light for room 27 was observed to be signalling. At 11:38 AM, a staff member responded to the call light. d. On 2/25/01 at 2:35 PM, the call light for room 39 was observed to be signalling. At 2:43 PM, a staff member responded to the call light. e. On 2/26/01 at 10:25 AM, the call light for room 3	F 241	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction Brigham City Nursing and Rehabilitation Center does not admit that the deficiencies listed on the HCFA 2567 exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal and/or regulatory or administrative proceedings all deficiencies, statements, facts, and conclusions that form the basis for each deficiency." F 241 Quality of Life JB 3/29/01 1. The staff (CNA's, Nurses and administrative staff) that cares for rooms 3, 10, 36, 27, and 39 were inserviced on the importance of answering call lights. Observation was conducted by administrative staff on these rooms to make certain the lights were answered in a timely manner. 2. Observation of the entire building was conducted to identify any other lights that are not being answered in a timely manner. Any lights identified as not being answered appropriately the staff were counseled on the importance of promptly answering call lights.	3-28-01 4-6-01

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3-23-01

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 made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 was observed to be signalling. There was a nurse passing medications two doors away from room 3. Another nurse and two nurse aides passed by the signalling call light at the north nursing station. At 10:40 AM, a staff member responded to the call light. f. On 2/27/01 at 8:06 AM, the call light to room 10 was observed to be signalling. At that time, a nurse was observed with a medication cart between rooms 10 and 9. The nurse remained in this area until 8:12 AM, at which time she moved the medication cart down the hallway. At no time did the nurse enter room 10 to determine the resident's needs. At 8:15 AM, the resident residing in room 10 propelled himself from room 10 to the dining room. In the dining room, the resident requested staff assistance. A nurse aide followed the resident to room 10. g. On 2/27/01 at 9:40 AM, the call light to room 10 was observed to be signalling. At 9:51 AM, a staff member responded to the call light. 2. A confidential resident interview was on 2/26/01. The resident stated that staff response to his/her call light was variable. This resident stated that approximately two to three weeks prior, he/she had to wait in excess of three hours for staff to respond to the call light. This resident stated that it took staff long periods of time to answer the call light during meal times, in the morning and in the evening. 3. On 2/27/01 at 1:30 PM, a confidential group interview was conducted. Sixteen (16) residents participated in the group interview. Seven (7) of the 16 residents stated their call lights were not answered in a timely manner. Two residents stated they had waited longer than 30 minutes for their call lights to be answered. Seven residents stated they had waited	F 241	3. One on One inservice was conducted to all staff on the importance of answering call lights. Staff was instructed on how to respond to call lights and make certain needs are prioritized and met. All employees were inserviced on the system that everyone is responsible for answering call lights. Weekly the Administrator will assign a department head to monitor the call lights for ½ hour at different times of the day and in different areas of the building. Rewards will be given to staff that answer call lights in a prompt manner and instruction will be given if the call lights were not answered promptly. Documentation will be completed each time call lights are monitored which will include area of the building monitored, time the call light went off and the time the call light was answered. 4. Monthly the Quality Assurance Committee will review documentation on call light monitoring in an effort to monitor the system. If the call lights are still not being answered timely then the QA committee will discuss changes to the system.	4-9-01 4-6-01 4-12-01

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F 241	Continued From page 2 longer than 20 minutes for their call lights to be answered.	F 241		
F 309 SS=G	483.25QUALITY 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. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that for 1 of 15 sampled residents, facility staff failed to identify, and to provide treatment, when a resident presented with signs and symptoms of a urinary tract infection. (Resident 26.) Findings include: Resident 26 was readmitted to the facility on 11/2/00 following a surgical repair of a fractured ankle. Upon readmission to the facility, the resident had an indwelling catheter. Resident 26 was discharged from the facility on 1/6/01, at which time she was diagnosed as having urosepsis. A review of resident 26's medical records was done. Facility staff completed an admission Minimum Data Set (MDS) assessment for resident 26 on 11/15/00 and a significant change MDS on 12/5/00. Both MDS assessments included documentation that the	F 309 JSB 3/24/01	F 309 Quality of Care 1. Resident 26 identified as having Urosepsis from a UTI came back from the Hospital with prescribed antibiotics which cleared the Citrobactor Frendii bactieria. Nurses who work with resident 26 were instructed that if Resident 26 develops signs or symptoms of UTI that they are to obtain Physician intervention in order to identify and to provide appropriate treatment for it. If signs or symptoms occur and Physician intervention is not happening then the nurses were instructed to notify the Medical Director of the symptoms and gain appropriate interventions through him so that resident 26 receives the necessary care and services to attain her highest practicable physical, mental, and psychosocial well being. A review of all labs ordered for resident 26 was done to make certain all labs ordered were collected, results were received and appropriate intervention occurs with any significant abnormalities.	3-23-01 3-23-01

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F 309	Continued From page 3 resident had an indwelling catheter and that the resident had not experienced a urinary tract infection in the previous 30 days. A review of resident 26's care plan was done. Facility staff identified a problem of, "Altered urinary elimination, indwelling catheter utilized." The goal for this identified problem was, "Will have adequate urinary output and be free from UTI [urinary tract infection] while foley cath indwelling." Approaches for this identified problem included monitoring for signs and symptoms of infections such as sediment, blood, cloudy appearance and foul odor. Another approach was to notify the resident's attending physician if signs and symptoms of a urinary tract infection or decreased urinary output were noted. Brunner and Suddarth's Textbook of Medical-Surgical Nursing, eigth edition, 1996, page 1182 documented, "Elderly patients often lack the typical symptoms of UTI and sepsis. Although frequency, urgency, and dysuria may occur, nonspecific symptoms such as altered sensorium, lethargy, anorexia, hyperventilation, and low-grade fever may be the only clues to the presence of a UTI. Frequent reinfections are common in the elderly." A review of nursing notes was done. There were several entries made by nursing staff to document possible signs and symptoms of a urinary tract infection. The following documentation was noted: a. 11/29/00 at 2:00 PM - "Pt [patient] c/o [complaint of] stomach upset this AM, poor appetite [at] meal..." b. 12/2/00 at 11:00 AM - "pt c/o stomach upset, refused breakfast..." c. 12/3/00 at 10:30 PM - "...foley cath draining [without] problem, urine is dark [and] foul smelling,	F 309	2. All residents in the facility were assessed by nursing for any signs or symptoms of infection especially UTI's. Any resident identified as having signs or symptoms had the Physician notified and appropriate interventions were implemented. A review of all lab orders was completed to make sure all labs that were drawn or specimens taken had results in the chart and appropriate treatments were in place for any result which indicated the need. 3. All nursing staff inserviced on identification and treatment of infections especially atypical symptoms. Quarterly inservices will be done to make certain our staff is well trained on the assessment and appropriate treatments to make sure each resident receives necessary care and services. If signs and symptoms are present and physician intervention does not take place nurses are to notify our Medical Director and get intervention through him.	4-6-01 4-12-01 4-2-01 3-23-01

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F 309	Continued From page 4 will report to MD in AM d. 12/4/00 at 2:00 PM - "...orders for UA [urinalysis] to [rule out] UTI..." e. 12/4/00 at 9:30 PM - "...[Changed] catheter 16 [french and] down drain bag..." f. 12/6/00 at 1:30 PM - "Pt c/o 'not feeling well', [No] specific complaint except fatigue. [Vital signs within normal limits] appetite poor..." g. 12/8/00 at 2:00 PM - "Pt [decreased] appetite [times] two meals..." h. 12/11/00 at 11:00 PM - "[Attending physician] called regarding infection in [right] great toe. Orders given for Augmentin [antibiotic]..." i. 12/12/00 at 10:30 AM - "...MD called inquiring of UA order given 12/4/00 ordered the lab Dc'd [discontinued]..." j. 12/29/00 at 10:00 PM - "Pt has very bloody urine this shift. Pt denies pulling on cath. Will pass to day nurse to notify M.D. in am." (There was no documentation that resident 26's physician was notified.) k. 12/30/00 at 11:15 PM - "...urine more clear...." l. 12/31/00 at 2:00 PM - "...poor appetite today, urine more yellow today..." m. 12/31/00 at 9:30 PM - "urine has blood in it, c/o pain in [left] thigh area, [no] prob [problem] noted in this area. Passed info onto charge nurse to call Dr. in am..." (There was no documentation that resident 26's physician was notified.) n. 1/1/01 at 2:00 PM - "...poor appetite...urine appears more clear..." o. 1/3/01 at 6:00 AM - "...Has foley to DD [down drain]. Urine clear [with] foul odor. Appears concentrated...." p. 1/5/01 Monthly Summary - "...12. QS [quantity sufficient]. [No] s/s UTI...." q. 1/5/01 at 11:30 PM - "Pt dry heaving [and] extremely lethargic all shift. Pt refused supper.	F 309	Treatment nurse will track all labs by use of a lab book. She will make sure all labs ordered are collected, results are received, physician is notified and treatments are in place for issues identified. 24 hour report will be done to communicate any signs or symptoms of infection. Daily the DON will review the 24 hour report and follow up with nurses to make sure any issues are identified and treated appropriately. 4. Monthly the QA committee will review 7 days of the 24 hour report and look specifically for communication of signs/symptoms of infection and physician involvement with treatment of issues identified. The QA committee will also review the lab books to make certain the labs are being tracked and followed up with. Quarterly the medical records consultant will audit 10% of our charts to see that the system is working and give a report to QA committee on results of her audit.	3-23-01 3-23-01 4-12-01

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F 309	Continued From page 5 Refused HS [hour of sleep] care - started dry heaving again [and] moaning. Daughter notified of condition. Urine is clear tonight." r. 1/6/01 at 2:30 PM - "Res. lethargic - opens eyes to name. [Vital signs] [at] 1000 [temperature] 101.5, [pulse] 108, [respirations] 24, [blood pressure] 262/90 [oxygen saturation] 85-87% [room air]. Skin hot, dry, turgor poor. [Attending physician] called and stated, 'I will be over to see'...labs sent..." s. 1/6/00 at 6:00 PM - "...Orders to send pt. to ER [emergency room] via ambulance..." A review of physician orders for resident 26 was done. Upon admission, 11/3/00, resident 26 had orders for an indwelling catheter. On 12/4/00, a telephone order was written to obtain a urinalysis with culture and sensitivities to rule out a urinary tract infection. On 12/11/00, a telephone order was written to begin Augmentin, two times a day for seven days. On 12/12/00, a telephone order was written to discontinue the urinalysis with culture and sensitivities. On 1/6/01, at telephone order was written to transport the resident to the hospital via ambulance. A review of laboratory test results for resident 26 was done. A urinalysis with culture and sensitivities was performed on 12/4/00. The urinalysis identified that resident 26 had four plus bacteria in her urine, the identified infecting organism was Citrobacter Freundii. This organism was identified as being resistant to Augmentin (the antibiotic prescribed on 12/11/00, for a wound infection.) On 1/6/01, another urinalysis with culture and sensitivities test was performed on resident 26. Citrobacter Freundii was again identified in the resident's urine. Also on 1/6/01, a complete blood count was completed. Resident 26's white blood cells were elevated to 22.4	F 309		

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F 309	Continued From page 6 (normal range was 4.0 to 11.2).	F 309	F 314 Quality of Care	
F 314 SS=D	483.25(c)QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for 1 of 15 sampled residents, the facility did not ensure that a resident with a pressure sore received treatment and services in accordance with physician orders, in order to promote wound healing. (Resident 47.) Findings include: Resident 47 was admitted to the facility on 6/26/00. His diagnoses include a stage III pressure sore to his right outer ankle. A review of resident 47's medical record was done. Facility staff completed an admission Minimum Data Set (MDS) assessment for resident 47 on 7/9/00, and quarterly MDS assessments on 9/27/00, and 12/13/00. Facility staff assessed resident 47 as having a stage III pressure sore. A review of resident 47's plan of care was done. On	F 314 JB 3/24/01	1. Nurses who worked with resident 47 were instructed on the imperativeness of dressing wounds according to physician orders. 2. All residents may be affected by this. All residents who are receiving wound care were assessed by DON for appropriate treatments according to Physicians orders. Any resident identified as having similar issues had dressing changes changed according to physician orders and instruction given to nurses on appropriate treatment according to physician orders. 3. Treatment nurse will obtain specific M.D. orders for all dressing changes and put the specific order in the Treatment Book so all nursing staff will know what dressing is to be used.	3-23-01 4-6-01 4-2-01

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F 314	Continued From page 7 11/17/00, facility staff identified a problem of, "Stage III pressure ulcer on outer aspect [right] ankle". The goal for this identified problem was, "Will heal [without] [signs/symptoms] infection ongoing until healed". Approaches for this identified problem included, "[Treatment] to pressure sore as ordered per [attending physician]." A review of physician orders was done. On 1/29/01, a telephone order was written to, "[Discontinue] physical therapy wound care. Nursing to do dressing changes. Clean [with] wound cleanser, apply hydrogel to wound, cover [with] Duoderm. (Ankle [and] toes.) Wrap foot [and] ankle [with] Kerlex to protect." A review of the March, 2001, treatment record for resident 47 was done. Per documentation, facility staff were to cleanse resident 47's right ankle pressure sore with wound cleanser, apply hydrogel, cover with Duoderm and wrap with Kerlex. An observation of resident 47's right ankle pressure sore was made on 2/26/01 at 1:30 PM. The observation was made during a dressing change to the pressure sore. The nurse removed the old dressing. The dressing removed was two, 4 x 4 gauze pads wrapped with a gauze (Kerlex) roll. The outer portion of the dressing was observed to have a two centimeter (cm) area of sanguineous (bloody) drainage. Upon removal of the dressing, the pressure sore was observed to have no necrotic tissue. The wound bed was bright red. The nurse cleansed the pressure sore with wound cleanser, applied a wound gel, applied a Duoderm dressing and wrapped the ankle with a gauze roll. The nurse who performed the dressing change was	F 314	Treatment Nurse was recently sent to California to a Smith and Nephew training on the latest wound care technique. Treatment Nurse will help inservice and instruct all nursing staff on the imperativeness of dressing wounds according to physician orders and where to look for the Physicians orders when it is necessary to do a dressing change. Treatment Nurse will change dressings according to orders. If a patient is identified, by the treatment nurse, that the dressing has been changed and it is not the right treatment according to Physician orders then she is to provide a written report of this to the DON. Follow up training and consultation will be given by DON as needed. Weekly an assessment of wounds will be done by the DON to make sure dressings on the wounds are according to the physician orders. 4. Monthly a member of the QA committee will be assigned to do rounds with the treatment nurse and assess each dressing to make certain it is according to Physician orders. A report of the rounds will be given to the QA committee on a monthly basis.	4-2-01 4-2-01 4-6-01 4-12-01

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F 314	Continued From page 8 interviewed on 2/26/01 at 1:45 PM. She also stated the dressing was not the type dressing that was currently ordered for resident 47. The nurse was asked if the pressure sore appeared to need debridement to remove necrotic tissue. The nurse stated the pressure sore did not have necrotic tissue and did not need debridement. The nurse stated the dressing she had removed was not the correct type dressing for the resident's pressure sore. The U.S. Department of Health and Human Services, Clinical Practice Guideline, Pressure Ulcer Treatment, 1994, page 16, documented, "Pressure ulcers require dressings to maintain their physiologic integrity. An ideal dressing should protect the wound, be biocompatible, and provide ideal hydration. The condition of the ulcer bed and the desired dressing function determine the type of dressing needed. The cardinal rule is to keep the ulcer tissue moist and the surrounding intact skin dry."	F 314		
F 371 SS=E	483.35(h)(2)DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations of the kitchen and the north dining room, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Findings include: 1. Observations were made in the kitchen on 2/25/01,	F 371 JJB 3/12/01	F 371 Sanitation 1. Resource Juices, cottage cheese, sour cream, deli turkey, salami, buttermilk, icing and chocolate tart that was either outdated or not dated were removed from the walk in refrigerator, north dining room and tray line refrigerator. Plumbing that caused the water to back up which resulted in staff placing towels on the floor was fixed and staff was instructed not to leave dirty linen on the floor.	3-2-01 4-21-01

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F 371	Continued From page 9 between 8:20 AM to 9:00 AM. The following was observed: a. In the walk-in refrigerator, there were five Resource juice drinks with an expiration date of 12/98, two containers of cottage cheese with an expiration date of 2/12/01, and one container of sour cream with an expiration date of 2/24/01. There was an opened package of deli-turkey, dated 2/2/01, and an opened package of salami, dated 2/5/01. b. On the floor, under the beverage counter, there was a pile of wet brown stained towels. c. In the tray line refrigerator, there was a quart of buttermilk with an expiration date of 2/22/01. d. There were no chlorine test strips available to determine if necessary levels of chlorine were maintained in the sanitation fluid which held the kitchen cleaning towels. e. In the walk-in refrigerator, there were four thawed Resource drinks with no dates indicating what date it was thawed. The product information documented the product expired 14 days from thawing. f. Stuck to the bottom of the reach in freezer were five bags of unidentified brown sauce and eight bags of unidentified green shredded vegetable with no dates. g. There were no temperatures taken for the breakfast meal on 2/21, 2/22, 2/23, 2/24 and 2/25/01. There were no temperatures taken for the lunch meal on 2/20, 2/21 and 2/22/01. There were no temperatures for the dinner meal on 2/24/01.	F 371	Chlorine Test strips were obtained in order to make sure our bleach water was within proper ppms. Unidentified and unnecessary items left in the walk in freezer on the floor were removed. Staff that failed to take temps on the days identified were instructed to take temps on every meal. 2. Walk through of the complete kitchen and food storage areas was completed by dietary manager and administrator in order to identify any other similar issues with regards to sanitation. Any problems we identified were fixed as needed. 3. 5 times weekly the dietary manager will review the temperature log after meals and follow up with staff if the temps are lacking. Cleaning schedules were implemented for the cooks and the diet aides to include all areas of the kitchen.	3-2-01 3-2-01 3-2-01 3-26-01 3-26-01 3-2-01

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BRIGHAM CITY NURSING & REHAB	775 N 200 E POB 518 BRIGHAM CITY, UT 84302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 371	Continued From page 10 2. Observations of the kitchen were made on 2/27/01 at 8:20 AM. In the walk-in refrigerator, there were five Resource juice drinks with an expiration date of 12/98, and four thawed Resource drinks with no dates of thawing. 3. On 2/25/01, in the north dinning room refrigerator, there was one can of icing with no date, one cup of soup with no name or date and a chocolate tart that was uncovered with no date.	F 371	Inservice/instruction given to kitchen staff on what to look for in cleaning food storage areas and the importance of covering, dating and throwing out food that is old and outdated. Weekly dietary manager perform sanitation rounds looking for any outdated or unlabeled food items in all food storage area's and any other sanitation issues that may be present.	4-2-01 4-12-01
F 426 SS=D	483.60(a)PHARMACY SERVICES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for 1 of 15 sampled residents, the facility did not ensure that a resident received medications in accordance with physician orders. (Resident 50.) Findings include: On 2/26/01, beginning at 8:12 AM, observations of a licensed nurse administering medications was done. The nurse prepared medications for resident 50. Among the medications poured into a medication cup were two 10 milliequivalent (mEq) capsules of potassium chloride. Potassium chloride was identified on resident 50's medication administration record (MAR) as being discontinued on 1/3/01. The	F 426	4. Monthly the Administrator and Registered Dietician will walk through the kitchen and storage areas looking for sanitation concerns and report any findings to the Quality Assurance Committee. If the walk through indicates sanitation concerns then the QA committee will make adjustments to the system. F 426 1. Resident 50's Physician was called and a clarification order was received and the Potassium chloride was d/c'd and the MAR was changed to reflect this order.	4-12-01 2-29-01

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465093	A. BUILDING _____ B. WING _____	2/28/01

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F 426	Continued From page 11 nurse walked away with resident 50's medications and stated she was going to give the medication to resident 50. The surveyor requested the nurse review resident 50's MAR prior to administering the medications. The nurse reviewed resident 50's MAR. The nurse removed the potassium chloride and stated the medication had been discontinued. The nurse then administered resident 50 the medications without the potassium chloride. An interview with the medication nurse was held on 2/26/01 at 8:30 AM. The nurse stated that she had been unaware resident 50's potassium chloride had been discontinued. A review of resident 50's medical record was done. On 12/30/00, a physician's telephone order was written for resident 50 to receive Lasix 80 milligrams (mg) everyday and potassium chloride 20 mEq every day. On 1/3/01, a telephone order was written to decrease the Lasix to 40 mg. There was no order to adjust or to discontinue the potassium chloride. A review of resident 50's MARs for the months of 12/00, 1/01, and 2/01 was done. The following was documented on the MARs: a. December, 2000 - Potassium chloride 20 mEq everyday, with a beginning date of 12/30/00. Per documentation, the medication was administered on 12/30 and 12/31/00. b. January, 2001 - Potassium chloride 20 mEq everyday. Per documentation, the medication was administered on 1/1, 1/2, 1/3, and 1/4/01. c. February, 2001 - Potassium chloride 20 mEq everyday. Per documentation, the medication had not	F 426	The Nurse who almost gave the Potassium Chloride without reviewing the MAR was inserviced on the imperativeness of reviewing the MAR prior to administration of medications. 2. All residents MAR's and orders were checked to make sure that the MAR reflects the orders. Any MAR's found to be different from the Dr.'s orders were changed to reflect the order. All nurses were inserviced on the appropriate methods to administer medications. 3. Night Shift Nurse will receive and review all new Dr.'s orders for each day and compare them to the MAR to double check that the order was transcribed correctly. Monthly the DON will triple check the Medication Administration Record with the Dr.'s orders and check the drugs in the cart.	2-29-01 4-12-01 4-2-01 4-12-01 4-12-01

ST ATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 426	Continued From page 12 been administered on any day during the month of February. The potassium chloride had been yellowed out and "Dc'd [discontinued] 1/3/01" was written to the side of the potassium chloride. Resident 50's medications were dispensed from pharmacy A. On 2/26/01 at 10:40 AM, a telephone interview was held with a pharmcist at pharmacy A. The pharmacist stated that 60, 10 meq capsules of potassium chloride had been dispensed for resident 50 on 12/30/00. The pharmacist stated that pharmacy A had not received documentation that resident 50's potassium chloride had been discontinued. The facility utilized a blister package to dispense potassium chloride to resident 50. On 2/26/01 at 10:30 AM, the potassium chloride blister package was observed. The label documented 60, 10 mEq capsules of potassium chloride had been dispensed for resident 50 on 12/30/00. There was one, 10 mEq capsule remaining in the blister package; 59, 10 mEq capsules had been previously punched through the blister package.	F 426	4. Pharmacy Consultant will review 5 residents MAR, Dr.'s orders and medications in the nurses carts to monitor the system. The pharmacy consultant will give a report to the QA committee on a monthly basis and the QA committee will make changes to the system as needed.	2-12-01