STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465095	A. BUILDING ______ B. WING ______	C 05/01/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTUS ST JOSEPH VILLA	451 BISHOP FEDERAL LANE SALT LAKE CITY, UT 84115 Revised per IDR

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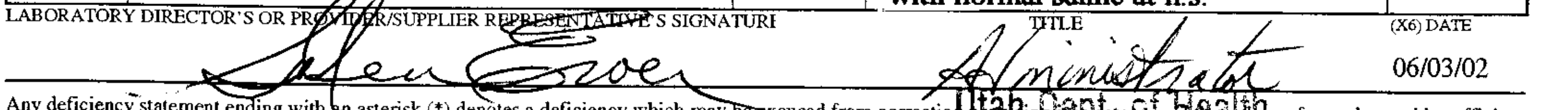
F 157 SS=H	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in 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 staff interview and review of resident medical records, it was determined that the facility did not notify resident physicians when residents experienced a significant change in medical condition. Specifically, the physician was not notified when three residents developed pressure sores	F 157	**F157** **Resident 56:** **Multi-vitamins** **Arginade** **Geomat to bed** **Geomat to wheelchair** **Tegasorb dressing** **Resource** **Weekly weights** **Rule out restorative feeding due to late stage Alzheimer's Disease** **Head of bed not more than 30°** **Resident 116:** **Nylex mattress/electric bed** **House supplement three times daily** **Multi-vitamins** **Arginade twice daily** **Tegasorb dressing to coccyx/change every three days and PRN** **Spence boots** **Weekly weights** **Cushion pad to wheelchair** **Resident 165:** **CMP** **Boost (240 cc three times daily) or Resource (120 cc three times daily)** **Dressing change to buttocks twice daily** **Irrigate with acetic acid in a.m. and with normal saline at h.s.**	5/31/02

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 06/03/02



Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correcting 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.

Utah Dept. of Health

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F 157	Continued From page 1 (Resident 56, 116 and 165). The physician was not notified when resident blood sugars were out of ranges that were set by the physician. (Residents 29 and 42) The physician was not notified that a registered dietitian had not been consulted, as ordered, in assessing and making changes to a resident's tube feeding regimen. (Resident 53) Findings include: Residents with pressure sores: 1. Resident 56 was a 79 year old female who was admitted to the facility on 12/5/01 with diagnoses of organic brain dysfunction, vertebral fracture, and bipolar disorder. A review of the resident 56's medical record was done on 4/25/02 and revealed the following: The "Weekly Nursing Summary", dated 1/27/02, documented that resident 56 had a stage II pressure sore on her coccyx. The facility nurse documented that the pressure sore was treated with "Hydrcol/ tegraden" and response to treatment was "? started 1/27/02." The "Interdisciplinary Notes" dated 1/28/02 at 4:00 AM documented that resident 56 had a stage II pressure sore on her right inner buttock fold that measured 1 x 1 cm (centimeter). The interdisciplinary note also documented, "placed Tegaderm with PolyMem to cover. Will have AM nurse call MD (physician) for orders." The "Interdisciplinary Notes" dated 1/28/02 at 1:40 PM documented that physician's nurse practitioner saw resident 56.	F 157	Reweigh Arginine, 500 mg twice daily Multi-vitamin each day Air mattress Change diet to high protein mechanical soft, small portions A change will be made to the internal reporting format. Each nursing unit will receive a resident roster each day. The roster will be used in conjunction with the current 24-hour report form as a quick reminder of all the residents who live on that unit. The current 24-hour report form does not list all residents on the unit. The Charge Nurses are required to document on those residents who have had a change in condition. By having a daily roster at the nurses' station, the nurses are finding that it helps them to remember at a glance who they need to document on each day. This should help agency nurses as well. The new form was developed and the nursing staff was informed of how to utilize it during their Charge Nurse Meeting on Wednesday, May 22, 2002. Following initial implementation on Thursday, May 23, 2002, the Charge Nurses had	

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F 157	Continued From page 2 A review of the physician's progress notes documented that the nurse practitioner had assessed resident 56 on 1/28/02. The nurse practitioner did not document in her assessment that she was aware of resident 56's pressure sore. A physician's order dated 2/4/02 documented the treatment for resident 56's pressure sore was to "cleanse with NS (normal saline) apply skin prep around area. Apply tegasorb change dressing q (every) 3 to 5 days and prn (as needed)." An interview with the treatment nurse was done on 4/29/02 at 2:50 PM. The treatment nurse stated that the physician had not been notified of resident 56's pressure sore until 2/4/02. The facility did not notify the physician until 9 days after the pressure sore on resident 56 was first identified by the facility nurses. 2. Resident 116, a 66-year-old male was admitted to the facility, on 6/13/01, with diagnoses of quadriplegia, intraspinal abscess, esophageal reflux, and hypothyroidism. Review of the nursing notes, dated 4/19/02, documented resident 116 had a stage III DQ on his coccyx. A review of the decubitus/pressure ulcer report, dated 4/19/02, documented a stage III pressure ulcer on resident 116's coccyx, 1 cm, 1/8 in depth. On 4/22/02 the documentation stated "coccyx, stage II, 1cm, pink in color, small slit, more from friction than actual breakdown." A review of the nurses notes revealed no documentation of the physician being notified. In an interview with the physician on 05/01/02, she stated that she had not been notified of the pressure	F 157	made suggestions for change that would make the document work better for them. Final revisions were made, and the Form was implemented following discussion of the process at the Charge Nurse Meeting on Friday, May 31, 2002. It was implemented on Friday, May 31, 2002. The Ward Clerks will print out the daily rosters and check to see that the 24-hour reports indicate notification of appropriate individuals when changes in resident condition do occur. The new Pressure Ulcer Treatment Guideline and Notification form has been completed and added to the medical records of residents 56, 116 and 165. This form requires the nurse to initial the dates on which the physician, family, dietitian and Wound Care Nurse were notified of any observation of a skin condition.. This same form was in development during the time that Resident 53 was discharged, so it was never entered into that medical record. The Ward Clerks have reorganized the medication sheets so that the insulin administration and documentation of blood sugars is	

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F 157	Continued From page 3 sore when it developed on 4/19/02. She had not been informed until 4/25/02, when she gave orders for nursing staff to treat the pressure sore. This was 6 days after the development of the pressure sore. The physician also stated that she had identified a previous pressure sore on resident 116 prior to being notified by the facility. 3. Resident 165 was admitted to the facility, on 2/9/01, with diagnoses which included dementia, transient ischemic attacks, lumbago, renal insufficiency, degenerative joint disease, pancreatic mass and digestive neoplasm. Resident 165 was re-admitted to the facility, on 9/24/01, following a temporary discharge for surgical repair of a fracture to her left hip. In the interdisciplinary progress notes, dated 10/3/01, the charge nurse documented that resident 165 was given a tub bath and her TED hose (antiembolism stockings) were removed. The charge nurse documented that resident 165 had been found to have dry, black scabs measuring two centimeters on both of the resident's heels. On 10/10/01, the wound team nurse documented she had notified the resident's family of the pressure ulcers on resident 165's heels, and would notify the physician. The wound nurse documented that resident 165's physician had been notified of the heel wounds on 10/11/01, 8 days after the wounds had first been observed. Residents with Sliding Scale Insulin: 1. Resident 29, a 81 year- old male, was admitted on 3/19/01, with diagnoses of diabetes mellitus, osteoporosis, renal/ureter disorder, anemia, hypertension, Alzheimer's and polymyalgia. Review of resident 29's current physician's orders,	F 157	all on the same page. They have changed entries in the computer so that it prints out directions indicating where to chart the time, what the blood sugar was, the number of units given, the site and the nurse's initials. It also has a space to initial if the physician was notified of certain parameters as ordered. When the Nursing Supervisors do their daily checks and they discover an item which needed to be reported and it was not, they will intervene by reminding the nurse to call the family, the doctor, the dietitian or the Wound Care Nurse right away if the nurse is on duty at the time. If the Charge Nurse who made the omission is not on duty, the Nursing Supervisor will assume the task herself. Intervention should take place immediately. The Nursing Supervisors will report to the Director of Nursing the number of times interventions were required each month and action taken. The Director of Nursing will report the information to the Quality Committee.	

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dated 4/3/02, documented the physician was to be notified if resident 29's blood sugar (BS) went above 400 mg/dl or below 80 mg/dl.

The Medication and Treatment Record (MAR) for March 2002 and April 2002 was reviewed for resident 29, on 4/24/02. The MAR documented that the blood sugar had been out of range 7 times in March and 6 times in April as follows;

DATE:	TIME:	BLOOD SUGARS:
3/8/02	0630	BS 57 mg.dl
3/14/02	1130	BS 75 mg/dl
3/15/02	0630	BS 74 mg/dl
3/16/02	0630	BS 71 mg/dl
3/17/02	0630	BS 58 mg/dl
3/17/02	1130	BS 59 mg/dl
4/4/02	0630	BS 49 mg/dl
4/4/02	1130	BS 40 mg/dl
4/5/02	0630	BS 75 mg/dl
4/19/02	1130	BS 75 mg/dl
4/20/02	1130	BS 70 mg/dl
4/24/02	0630	BS 63 mg/dl

Review of the Interdisciplinary Progress Notes from 3/1/02 to 4/25/02 reflected the physician had not been called to report out of range BS's as ordered.

In an interview with a facility charge nurse, on 4/25/02, it was confirmed there was no documentation the physician had been called to report low BS levels for resident 29.

2. Resident 42 was an 82-year-old male who was admitted to the facility, on 1/10/99, with the diagnosis of diabetes mellitus.

Review of resident 42's clinical record on 4/23/02 revealed a physician's order, dated 12/05/01, that

F 157

A sliding scale protocol has been developed and was approved by the Medical Director in April 2002. It was not implemented prior to the arrival of the survey team, but has been presented to the Charge Nurses, and implementation will be overseen by the Director of Nursing. The new protocol will begin May 31, 2002.

This plan of correction is to be implemented by the Director of Nursing by May 23, 2002.

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F 157	See below	F 157		

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documented to notify the physician if resident 42's blood sugars went below 90 or above 400mg/dl

The April 2002 "Medication and Treatment Record" for resident 42 was reviewed on 4/23/02 and 5/1/02. It was noted that during April 2002, the blood sugars of resident 42 had been found by the facility nurses to be out of the accepted ranges, as set by the physician, on 24 occasions. The out of range blood sugars were as follows:

DATE:	TIME:	BLOOD SUGARS:
4/1/02	1700	59 mg/dl
4/4/02	0600	71mg/dl
4/4/02	1700	79mg/dl
4/7/02	0600	80mg/dl
4/7/02	1700	77mg/dl
4/7/02	2000	89mg/dl
4/8/02	1200	80mg/dl
4/10/02	1700	84mg/dl
4/11/02	1700	80mg/dl
4/12/02	1700	80mg/dl
4/13/02	1700	39mg/dl
4/14/02	1700	54mg/dl
4/15/02	0600	77mg/dl
4/16/02	1700	52mg/dl
4/19/02	1700	74mg/dl
4/20/02	0600	58mg/dl
4/20/02	1700	84mg/dl
4/23/02	1700	81mg/dl
4/24/02	1700	45mg/dl
4/25/02	1700	56mg/dl
4/26/02	1700	42mg/dl
4/28/02	1700	75mg/dl
4/29/02	1700	53mg/dl
4/30/02	2000	85mg/dl

A nurse's note, dated 4/4/02, in the medical record of resident 42, documented that the physician had been

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notified once of an out of range blood sugar of 79 on 4/4/02.

A review of the facility's hypoglycemia protocol on 4/25/02 revealed that if a resident had a blood sugar of 60mg/dl or below the physician should be notified. Resident 42 had nine out of twenty-eight blood sugars during the month of April 2002 that were below 60mg/dl. The facility could not provide any documentation that the facility nurses had followed the facility protocol.

During an interview with resident 42's physician on 5/1/02, the physician stated she had only been notified once during April 2002 regarding the resident's blood sugar. The physician also stated that resident 42 was a brittle diabetic and when nursing had notified her in the past about low blood sugars she had made changes to resident 42's insulin doses.

Residents with Nutritional Changes:

Resident 53, an 82-year-old female was admitted to the facility, on 3/18/02, with diagnoses including cachexia, pancreatic mass causing obstructive jaundice, history of weight loss, right middle cerebrovascular accident with left sided weakness, gastrostomy (G-tube) tube placement secondary to dysphagia and diabetes mellitus.

A review of resident 53's physician admission orders, dated 3/18/02, and physician progress notes, dated 3/23/02 and 4/18/02, revealed that a dietary consult was ordered on 3/18/02 and again on 3/23/02.

On 4/29/02, a review of the dietary section of the chart was done. There was no documented evidence that the registered dietitian had completed a dietary

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F 157	Continued From page 7 assessment, assessing resident 53's nutritional needs, or the adequacy of the physician ordered tube feedings. On 3/19/02, the facility nutrition aide completed an "Initial Nutrition Screening". The form listed a series of questions, which would provide each resident with a total score depending on the answers received. Residents receiving a score of 5 or more, per the form, were considered at high nutritional risk and a copy of the form was to be given to the registered dietitian. Resident 53 received a total score of 6 and would have been considered at high nutritional risk. A care plan, initiated 3/18/02, documented that resident 53 was in a state of ill health, malnutrition and wasting secondary to a pancreatic mass causing biliary obstruction. The goal addressing this care plan problem was that resident 53's health; weight and stamina may improve while on the transitional care unit. Approaches to the problem included, nutritionist/dietitian to evaluate the diet. A nutritional care plan, initiated 3/18/02, documented that resident 53 was at risk for decreased nutritional status related to dysphagia secondary to a cerebrovascular accident and would be monitored. The goal addressing this care plan problem was that the resident would have no weight loss greater than 5 % and consume greater than 75% of meals daily. Approaches to the problem included, make referral to nutritionist if needed. A tube feeding care plan, initiated 3/18/02, and updated 4/17/02, documented that resident 53 had a tube feeding placed related to a cerebrovascular accident and dysphagia and would be monitored through her stay at the facility. The goal addressing this care plan problem was that the resident would maintain adequate caloric intake daily through her	F 157		

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F 157	Continued From page 8 stay on the transitional care unit. Approaches to the problem included, have dietitian monitor for adequate caloric intake. On 4/25/02, at 4:43 PM, the consultant dietitian was interviewed. She stated that she was unaware that tube feeding changes were being made. She further stated that she had not made recommendations regarding tube feeding changes. On 4/29/02, at 11:00 AM, the consultant dietitian was interviewed for a second time. She stated that she was not made aware of resident 53's changes made in her tube feeding regimen. The dietitian also stated she was not contacted for any dietary consults and was not aware of any physician ordered consults for resident 53. On 05/01/02, in an interview with the physician she stated that she was not aware that the dietitian had not been contacted for dietary consults as ordered and she was not aware that a nutritional assessment had not been done.	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	F 164	F164 CNA staff on all units have received in-service training focusing on privacy and dignity of the residents. Specifically, staff members caring for residents 95 and 98 have been alerted to these residents' inability to utilize the commode independently or to close the door themselves. "Staff attention to privacy while toileting	5/24/02

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F 164	Continued From page 9 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. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that for 1 of 26 sample residents and 1 additional resident, the facility did not provide personal privacy during times of personal hygiene. Specifically, 2 residents were observed in their separate rooms sitting on bedside commodes while the doors to their rooms were open. Resident identifiers: 95 and 98. Findings include: 1. On 4/23/02, from 9:05 AM to 9:15 AM, resident 95 was observed to be in her room with the door open. Resident 95 was sitting on a bedside commode which was in plain view from the hallway. Resident 95's undergarments were observed around her calves. There was no curtain or other device to provide privacy to resident 95 while she was sitting on the commode. Staff were observed to walk past her bedroom door at least twice during this time and did not intervene to provide privacy. 2. On 4/23/02, from 9:10 AM to 9:20 AM, resident 98 was observed to be in her room with the door open. Resident 98 was sitting on a bedside commode and could be viewed from the hallway. There was no	F 164	resident" has been added to the care plan of residents 95 and 98. To ensure that the privacy and dignity of all residents is protected, the service delivery monitor is conducted monthly by the CNA Educator and the Nursing Supervisors. The CNA Educator will monitor this tag and will report findings of the service delivery monitor to the Quality Committee each month. Corrective action will be completed by May 24, 2002.	

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F 164	Continued From page 10 curtain or other device to provide privacy to resident 98 while she was sitting on the commode. Staff were observed to walk past her bedroom door at least twice during this time and did not intervene to provide privacy. Both of these residents needed staff assistance to get onto the bedside commode. Neither resident was able to get up and close the bedroom door themselves.	F 164		
F 282 SS=E	483.20(k)(3)(ii) RESIDENT ASSESSMENT The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of resident medical records, it was determined the facility did not provide services in accordance with each resident's written plan of care for 2 of 26 sampled residents. Specifically as per the residents plan of care, blood sugars were not monitored and anti-hypertensive medication was given when the resident's blood pressure reading indicated the medication should be held. (Residents 42 and 57) Findings include: 1. Resident 42 was an 82-year-old male who was admitted to the facility on 1/10/99 with the diagnosis of diabetes mellitus. Review of resident 42's care plan, dated 1/30/99, revealed that the "staff will check and record blood sugars as ordered."	F 282	F282 Physician orders for frequency of blood sugars on resident 42 have been changed to twice daily (at 0600 and 1700). Physician orders for frequency of blood pressures with certain parameters for administration of lisinopril have been changed (Resident 57). The new order is based on stable blood pressures and it reads "D/C all Rx for daily BPs with parameters. Continue weekly BPs." The Ward Clerks will audit monthly recertification orders as well as telephone orders. The MDS Nurse Assessors will monitor to ensure that plans of care are implemented as ordered. While assessing residents and completing MDS's, these nurses check to see if the appropriate care plans have been completed and what interventions for care are taking place. They assess residents when there is a change of status, upon admission and quarterly throughout	5/23/02

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F 282	Continued From page 11	F 282		

A physician's order, dated 12/5/01, documented to monitor resident 42's blood sugars 4 times per day.

Resident 42's medical records for February 2002, March 2002, and April 2002 were reviewed on 4/23/02 and 5/1/02. The following blood sugars that were not documented were as follows:

DATE	TIME
2/6/02	1200
2/21/02	1200
2/29/02	2000
3/1/02	1200
3/8/02	1200
3/8/02	2000
3/27/02	1700
3/27/02	2000
4/3/02	0600
4/5/02	1200
4/8/02	0600
4/10/02	2000
4/18/02	1200
4/21/02	1200
4/21/02	2000

There was no documentation in the medical record of resident 42 providing reasons for the missed blood sugars.

2. Resident 57 was an 82 year old female who was admitted to the facility, on 10/24/01, with the diagnoses of macular degeneration, hypertension, lung disease, hyponatremia and fluid retention.

A review of resident 57's medical record was done, on 4/22/02, and revealed the following:

A physician order for resident 57, dated 10/25/01, documented that vitals were to be done every Sunday and to record the vital results.

the year. They also educate the Charge Nurses when they discover that a plan of care needs to be completed or a treatment has been missed. The Nursing Supervisors also conduct one-to-one training of the Charge Nurses when plans of care are not being implemented appropriately.

The Ward Clerks will conduct a quality check at least five times per week of every nursing unit for physician's orders. The orders will be checked for sign-off by a nurse and whether they have been entered into medication or treatment sheet. If any steps are missing, the orders will be returned to the Charge Nurse `for correction.

The Charge Nurses will be informed of this additional step at the Charge Nurse Meeting held Wednesday, May 23, 2002. The reviews will begin Thursday, May 23, 2002.

The Ward Clerks will generate a report of their quality checks showing the number of orders and the number of orders with missing steps along with information regarding action taken at the time of

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F 282	Continued From page 12 A physician order, dated 11/13/01, documented resident 57 was to receive a medication, called lisinopril for her hypertension. The order stated, "lisinopril 10 mg (milligrams) every day by mouth ½ tab (tablet) hold if SBP<100 (systolic blood pressure was less than 100). A review of resident 57's recertification of physician orders dated April 2002 was done. The physician orders documented that resident 57 should have her vitals signs taken every Sunday between the hours of 3:00 PM to 11:00 PM. Resident 57's physician had ordered to monitor, record and call if systolic blood pressure was less than 90 or if patient has signs and symptoms of hypotension. The care plan for resident 57, dated 11/12/01, included the problem decreased cardiac output due to resident 57 was taking a medication for hypertension. One of the care plan intervention stated "BP(blood pressure) has been <100 (systolic) recently-holding lisinopril until needed. Continue to monitor BP on daily basis." A review of resident 57's Medication Administration Record (MAR) was done. The months of November 2001, December 2001, January 2002, February 2002, March 2002 and April 2002 MARs did not document any blood pressures. A review of resident 57's treatment record was done. Resident 57's treatment record dated November 2001 stated to perform "vital signs every Sunday monitor and record". The treatment record for December 2001, January 2002 and February 2002 documented that resident 57 was to have "vitals signs every Sunday monitor and record call if SBP < 90 or if patient has s/s (signs and symptoms) of	F 282	the quality check. This will be reported to the Director of Nursing who will present the information to the Quality Assurance Team each month. The person responsible for overseeing the implementation of this will be the Director of Nursing. Completion date is May 23, 2002.	

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F 282	Continued From page 13 hypotension/dizziness." The treatment record for March 2002 and April 2002 documented, "vital signs monitor and record call if SBP<90 or if patient has s/s of hypotension/dizziness very Sunday." Resident 57's treatment records for the months of November 2001, December 2001, January 2002, February 2002, March 2002 and April 2002 did not document daily blood pressure as ordered by the physician on 11/13/02. A review of the treatment record, medication record, interdisciplinary progress notes, and monthly nursing summary's was done. Resident 57 had low systolic blood pressures for the following days: On 12/23/01 resident 57's systolic blood pressure was 100. Lisinopril was documented as given at 8:00 AM. On 12/30/01 resident 57's systolic blood pressure was 84. Lisinopril was documented as given at 8:00 AM. On 1/6/02 resident 57's systolic blood pressure was 100. Lisinopril was documented as given at 8:00 AM. On 1/7/02 resident 57's systolic blood pressure was 100. Lisinopril was documented as given at 8:00 AM. On 1/12/02 resident 57's systolic blood pressure was 98. Lisinopril was documented as given at 8:00 AM. On 1/14/02 resident 57's systolic blood pressure was 98. Lisinopril was documented as given at 8:00 AM. On 1/17/02 resident 57's systolic blood pressure was 100. Lisinopril was documented as given at 8:00 AM. On 1/18/02 resident 57's systolic blood pressure was 100. Lisinopril was documented as given at 8:00 AM.	F 282		

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F 282	Continued From page 14 On 1/20/02 resident 57's systolic blood pressure was 98. Lisinopril was documented as given at 8:00 AM. On 1/21/02 resident 57's systolic blood pressure was 80 Lisinopril was documented as given at 8:00 AM. On 1/22/02 resident 57's systolic blood pressure was 90. Lisinopril was documented as given at 8:00 AM. On 1/23/02 resident 57's systolic blood pressure was 98. Lisinopril was documented as given at 8:00 AM. On 1/27/02 resident 57's systolic blood pressure was 90. Lisinopril was documented as given at 8:00 AM. On 1/28/02 resident 57's systolic blood pressure was 100. Lisinopril was documented as given at 8:00 AM. On 2/3/02 resident 57's systolic blood pressure was 88. Lisinopril was documented as given at 8:00 AM. On 2/17/02 resident 57's systolic blood pressure was 80. Lisinopril was documented as given at 8:00 AM. Resident 57's nurse was interviewed on 4/22/02 at 9:30 AM. The nurse stated that the she did not check resident 57's blood pressures on a daily basis.	F 282		
F 309 SS=G	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.	F 309		5/24/02

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F 309	Continued From page 15 Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interviews, it was determined that for 3 of 27 sample residents and 1 additional resident, the facility staff did not ensure that residents received the necessary care and services to attain or maintain the highest practicable physical well-being by providing nutritional assessments and appropriate interventions based on those assessments. Resident identifiers: 109, 53, 163 and 45. Findings include: System breakdown: The facility had one consultant dietitian providing services for the facility. Her contract with the facility allowed her 10 to 12 hours a week in the facility. During those 10 to 12 hours in the facility, the consultant dietitian was responsible for the 173 residents in the facility, as well as all the residents in the facility's assisted living section (at least 80 additional individuals) and was also assigned to attend the weekly skin/weight team meeting. Actual harm was identified for residents 109 and 53 whose laboratory values reflected malnutrition (based on American Dietetic Association guidelines) These same residents received either late, inadequate or no dietary intervention. During interview with the consultant dietitian, on 4/25/02 at approximately 2:00PM, she stated that the person performing the Dietary Risk Assessments	F 309	F309 Resident 53 was discharged on May 15, 2002. She moved to California to be closer to her son. Our staff had assisted in arrangements for hospice care in California prior to her discharge. The remaining residents (109, 163, 45) have all been reviewed by the Weight/Skin Team. The membership of this team includes a Wound Care Nurse, a Registered Dietitian, a Nursing Supervisor or delegate, the Nutrition Care Aide and the Nurse Educator. The Weight/Skin Team meets at least once per week until it is determined by the Quality Steering Committee that meetings can be held twice per month. The first meeting of the Weight/Skin Team was held May 21, 2002. A height and weight policy has been adopted facility wide, which include the form for standardized monthly weights and another form for weekly weights on those individuals identified at risk. The weekly weights will be taken for those individuals who are recommended by the Weight/Skin Team.	05/24/02

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F 309	Continued From page 16 "works in the kitchen, but has no formal training." She further stated that the assessments completed by this person from the kitchen were "not always accurate". The consultant dietitian indicated that she was not being informed of residents who scored as "high risk" on the Dietary Risk Assessments although the form directed the evaluator to notify the dietitian. Based on record review performed throughout the survey, 3 of the 7 residents (109, 53, 45) who were scored at high nutrition risk and/or had laboratory values reflecting malnutrition (low albumin) had not been evaluated by the registered dietitian. During an interview with the 2 individuals on the skin/weight team on 4/25/02 at approximately 2:00 PM, it was revealed that the skin/weight committee consisted of 1 registered nurse and the consultant dietitian. These two individuals stated that they met weekly. When asked if they had a written description of the duties of the skin/weight committee, the team members stated "no". When asked if the skin/weight team kept minutes of it's weekly meetings to identify residents discussed, recommendations made and interventions implemented, the team responded that they kept no minutes. When asked how the team ensured follow-up on recommendations made during the meeting, both members indicated that it was the individual nurses responsibility to provide preventative measures. A review was conducted on 5/13/02 of the quarterly Quality Assurance (QA) Committee Meeting minutes (dated 10/17/01, 1/16/02, and 4/17/02). A review was conducted on 5/1/02 of the monthly Quality Steering Committee minutes from July 2001 to February 2002. None of the minutes reviewed contained references to nutritional intervention and assessment issues identified during the survey (refer to F 521 for additional information.)	F 309	An individualized weight/skin care plan will be initiated on every resident within 72 hours of admission to track weight/skin integrity issues during their stay. Two new cameras have been purchased to take photographs. The weight/skin care plan will be brought to each weight/skin team meeting for every resident being reviewed during the meeting. An additional registered dietitian was obtained through contract to begin May 18, 2002 to assist the current dietitian to evaluate the resident needs. All existing residents listed (residents 109, 163 and 145) were reviewed by a newly formed "Weight/Skin" Team May 21, 2002. The back of the Weight/Skin Care Plan contains signature lines to evidence which members attended the meetings. A photocopy of each resident's Weight/Skin Care Plan with the latest recommendations for intervention will serve as "minutes" of the Weight/Skin Team Meeting. The Wound Care Nurse will follow through on skin problems. The Registered Dietitian will track nutrition issues. The Nutrition Care Aide will check the weights and report back to the Weight/Skin Team at the next meeting.	

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F 309	Continued From page 17 Resident examples: 1. Resident 109, a 98 year-old female, was admitted to the facility on 12/12/01 with diagnoses of hypothyroidism, organic brain syndrome and edema. On 4/22/02, a review was conducted of resident 109's facility weight history and revealed the following: January 108.1 lbs. (pounds) February 103 lbs. March 98.1 lbs. April 98.3 lbs. Between the months of January and March, resident 109 lost 10 lbs or 9.26% of her total weight which is deemed "significant" by federal survey standards. On 1/30/02, resident 109 was re-admitted to the long term care facility from the hospital. A lab (laboratory) value done at the hospital (dated 1/27/02) was reviewed and revealed a serum albumin (protein) level of 2.8. A lab value taken at the facility dated 2/15/02, showed a albumin level of 2.4. According to the lab used by the facility, a normal albumin range was 3.3-4.8 g/dl (grams per deciliter). According to the Manual of Clinical Dietetics (American Dietetic Association, 6th edition, 2000, page 22), albumin levels are as follows: Severe visceral protein deficit = less than 2.4 g/dl Moderate visceral protein deficit = 2.4 g/dl- 2.9 g/dl Mild visceral protein deficit = 3.0g/dl-3.5 g/dl Using this as a guideline, resident 109's albumin level fell at the bottom range of the moderate protein deficit range.	F 309	**The Weight/Skin Care Plan will identify residents at risk for weight loss and malnutrition because it has columns for "current weight, last weight, amount gained or lost and lab work." It also indicates their risk for the development of pressure ulcers according to the Pressure Ulcer Risk Scale. Low protein or albumin levels will be addressed by the Charge Nurse with the physician upon receipt of the lab results.** **The Charge Nurse initials and dates the page of lab results upon notification of the physician.** **The Ward Clerks will be auditing physician orders to assure follow-up. If there are no lab results in the chart within 24 hours following an order for lab work, the Ward Clerks will call the lab and have them fax the information to the Villa.** **Those residents who have been identified as being at high risk for weight loss and/or malnutrition will be monitored closely by the Registered Dietitian and other members of the Weight/Skin Team. Specific orders will be written for**	

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F 309	Continued From page 18 A nursing admission history and evaluation form, dated 1/30/02, and the nurses notes, dated 1/31/02, documented "...an area on coccyx that is purplish-red- skin intact." A nurses note dated 2/05/02 documented " CNA reported to nurse that she discovered reddened area with tissue breakdown on patient. On assessment patient has stage II decub (decubitus) on inner top of right buttock approximately 2 cm- not draining- and a smaller stage II decub on coccyx." A physician's order, dated 03/01/02, documented a diet order for a mechanical soft NAS (no added salt). A review of the dietary notes revealed that no dietary assessment addressing the weight loss, skin breakdown or the low lab values had been completed for resident 109. There were no dietary recommendations for the increased protein and calories needed to promote healing for resident 109. In an interview with the dietitian, on 4/25/02, she stated that she had not been notified by nursing and was not aware of the weight loss, the low lab levels or the skin breakdown on resident 109. The facility's policy for Nutritional Status/Significance of Weight Loss were reviewed, on 4/25/02. It was documented in the procedure that " the Registered Dietitian is responsible for the provision of nutritional intervention to ensure the maintenance of acceptable parameters, such as body weight and protein levels... it is the responsibility of the Registered Dietitian to ensure that the resident receives an individualized therapeutic diet to correct nutritional problems." In an interview with the dietitian, on 4/25/02, she stated that she is contacted of nutritional changes "by	F 309	**interventions such as weekly weights, high protein diet, multi-vitamins, supplements to increase calorie intake, smaller and more frequent meals, enriched cereals for breakfast, and/or enteral feedings as appropriate for each resident at risk. Orders for albumin levels will be written more frequently for those residents found to be at risk for malnutrition.** **The Nutrition Care Aide will monitor all weights on a weekly basis. She is responsible for entering weights into a computerized tracking program. She will bring printouts of residents' weights to the Weight/Skin Team Meetings every week. She will also notify the Registered Dietitian of weight problems long before they would trigger as such on the MDS.** **The Wound Care Nurse may request a physician's order for an albumin level when she suspects that the resident may be at risk for weight loss/malnutrition or if the Registered Dietitian suggests that obtaining an albumin level would be a prudent intervention. All albumin level results will be called**	

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F 309	Continued From page 19 the wound nurse or by nurses pulling her aside in the halls." 2. Resident 53 was an 82 year old female with diagnoses including cachexia, pancreatic mass causing obstructive jaundice, history of weight loss, right middle cerebrovascular accident with left sided weakness, gastrostomy (G-tube) tube placement secondary to dysphagia and diabetes mellitus. Resident 53 was admitted to the facility's transitional care unit, on 3/18/02. She was discharged from the transitional care unit, on 4/19/02, and was admitted to the facility's long term care unit, on 4/19/02. On 4/29/02, resident 53's medical records from both the transitional care unit and the long term care unit were reviewed. A review of resident 53's admission weight, documented in the nursing staff notes dated 3/18/02, revealed that she weighed 82.5 pounds. A review of resident 53's weekly weights, documented on the resident's treatment records, were as follows: 3/18/02 82.5 pounds. 3/30/02 119.5 pounds. 4/6/02 120.4 pounds. 4/13/02c77 pounds. This represents a significant weight loss of 5.5 pounds, or 6.6% from 3/18/02 to 4/13/02 (26 days). 4/28/02 75.2 pounds. This represents a significant weight loss of 7.3 pounds, or 8.8 % from 3/18/02 to 4/28/02 (41 days). 4/30/02 74.2 pounds. This weight was obtained at the request of the survey team and represents a significant weight loss of 8.3 pounds, or 10% from 3/18/02 to 4/30/02 (43 days).	F 309	in to the Wound Care Nurse by the Ward Clerk. She will share the results with the Registered Dietitian so that appropriate interventions can be made. The following recommendations for intervention were made by the Weight/Skin Team for the residents listed below: <u>Resident 109</u>: Spence boots Weekly weight Boost three times daily (or Resource) Turn and position every two hours No restorative feeding due to dementia Pressure ulcer resolved	

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F 309	Continued From page 20 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, page 14). On 4/29/02, a review of resident 53's laboratory (lab) values was done. The following albumin (a protein) levels were documented: 3/20/02 2.3 g/dl 3/28/02 3.6 g/dl 4/4/02 2.7 g/dl 4/11/02 2.8 g/dl 4/18/02 3.0 g/dl 4/25/02 2.7 g/dl With the exception of the value obtained on 3/28/02, all of resident 53's albumin levels were low. 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). On 4/29/02, resident 53's physician admission orders, dated 3/18/02, were reviewed. It was documented that resident 53 was NPO (receiving nothing by mouth) and was to receive Diabetic Resource at 80 cc (cubic centimeters) per hour for 20 hours or 65 cc per hour for 24 hours via her G-tube.	F 309	Resident 45: High protein diet H.S. – snacks Clarify diet to regular as tolerated – high protein Track behavior of isolating self in room and throwing food away Physician appointment for three-month evaluation Mattress or geomat to bed Keep bed at less than 30° elevation Multi-vitamins with minerals Gets restorative feeding Resource (120 cc three times per day) or Boost (240 cc three times per day) Resperidol started Weight meeting in two weeks Resident 163: Nothing by mouth Oral care every two hours Planned weight change program for weight loss Geomat to bed Arginine twice daily Vitamin B (100 mg) daily Vitamin B12 each month Aquacel with stratosorb to wound on buttocks Turn every two hours and proper positioning Hydrocortisone cream Foley catheter	

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F 309	Continued From page 21 On 4/29/02, a review of resident 53's physician admission orders, dated 3/18/02, and all physician telephone orders from 3/18/02 through 4/29/02 was done. The following was documented: On 3/18/02, Diabetic Resource was ordered at 80 cc (cubic centimeters) per hour for 20 hours or 65 cc per hour for 24 hours via her G-tube. On 3/26/02, the facility speech therapist ordered a modified barium swallow study be completed. On 4/2/02, the facility speech therapist documented the following, " Ready to begin diet, gradually wean from G-tube feedings. Diet of soft [with] thins [thin liquids], supervised. Double swallow. Upgrade as tolerated. Oral tablets ok. See formal report." On 4/3/02, Diabetic Resource was ordered to begin every night for 12 hours at 75 cc per hour. On 4/11/02, Diabetic Resource feedings were discontinued. It was documented that this was because the resident was eating 75% of meals. A review of the physician admission orders, dated 3/18/02 and physician progress notes, dated 3/23/02 and 4/18/02, documented that a dietary consult was ordered on 3/18/02 and again on 3/23/02. On 4/29/02, a review of the dietary section of the chart was done. There was no documented evidence that a dietary assessment, assessing resident 53's nutritional needs, the resident's significant weight fluctuations or weight loss, the low albumin levels obtained or the adequacy of the physician ordered tube feedings, had been completed by the registered dietitian. On 3/19/02, an "Initial Nutrition Screening" was completed by the facility nutrition	F 309	Resident 53: This resident was discharged on May 15, 2002. She moved to California to be closer to her son. She had a terminal diagnosis of pancreatic cancer. Villa staff made arrangements for hospice in California to follow her. Nutrition Care Plan notes on resident 53 prior to discharge indicate: Mechanical soft diet with low concentrated sweets Impaired ability to feed self related to CVA April 25 – Reglan (5 mg PO TID GERD) April 26 – Diabetic Resource per G-tube or PO PRN QID. Chart cc's for weight loss Weekly weights Goal: adequate intake of 25% or more at most meals April 26 – sliding scale regular insulin Goal: April 30 diabetic Resource to 5 cartons per day Goal: May 2 refer to hospice (pancreatic cancer) The Director of Nursing is responsible for implementation of this plan. Corrective action will be completed by May 24, 2002.	

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F 309	Continued From page 22 aide. The form listed a series of questions, which would provide each resident with a total score depending on the answers received. Residents receiving a score of 5 or more, per the form, were considered at high nutritional risk and a copy of the form was to be given to the registered dietitian. Resident 53 received a total score of 6 so would have been considered at high nutritional risk. On the "Initial Nutrition Screening" form resident 53's height was documented as 60" (5 feet) and her weight was documented as 82.5 pounds. Resident 53's nutritional needs were not assessed on this form. A review of the "Nursing Staff Notes", from 3/18/02 through 4/2/02, documented that resident 53 was receiving Diabetic Resource at 65 cc an hour for 24 hours. There was no documentation in the nurses' notes, which addressed the large weight fluctuation from 82.5 pounds on 3/18/02 to 119.5 pounds on 3/30/02. A review of the "Nursing Staff Notes", from 4/3/02 through 4/10/02, documented that resident 53's tube feeding regimen had been changed to Diabetic Resource at 75 cc per hour for 12 hours at night per her physician. There was no documentation in the nurses' notes, which addressed the large weight fluctuation from 82.5 pounds on 3/18/02 to 120.4 pounds on 4/6/02. The following was also documented in the nursing notes: On 4/4/02, the nurse documented that resident 53 had a decreased appetite due to the tube feeding running at night. On 4/7/02, the nurse documented that resident 53 had a fair appetite.	F 309		

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F 309	Continued From page 23 On 4/9/02 and 4/10/02, the nurse documented that resident 53 had a good appetite. A review of the "Nursing Staff Notes", from 4/11/02 through 4/19/02, was done. On 4/11/02, the nurse documented that the Diabetic Resource had been discontinued and the G-tube was to be used for the administration of water and medications. During this time, the nurses documented that resident 53 had a good appetite and was consuming an average of 75% of meals. There was no documented evidence in the nurses' notes, which addressed the significant weight loss from 82.5 pounds on 3/18/02 to 77 pounds on 4/13/02 or the low albumin levels obtained on 4/4/02, 4/11/02 or 4/18/02. A review of resident 53's meal intakes, documented on the "CNA Care Sheet" for April 2002 from 4/1/02 through 4/19/02 was done. Out of a possible 19 breakfast meals reviewed, 1 was documented as 100%, 1 was documented at 75%, 1 was documented at 50%, 11 were documented as 25%, 1 was blank and 4 were documented as NPO. Out of a possible 19 lunch meals reviewed, 1 was documented at 100%, 2 were documented at 50%, 10 were documented as 25%, 1 was documented at 10%, 1 was blank and 4 were documented as NPO. Out of a possible 19 supper meals reviewed, 2 were documented at 75%, 2 were documented at 50%, 3 were documented at 30%, 3 were documented at 25%, 1 was documented at 10%, 5 were blank, and 3 were documented as NPO. On 4/19/02, resident 53 was moved from the facility's transitional care unit to a long term care unit. She was ordered a mechanical soft diet with low concentrated sweets. She was also receiving 300 cc of water through her G-tube every 8 hours. A review of nursing notes, from 4/27/02 through	F 309		

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F 309	Continued From page 24 4/29/02, was done. On 4/23/02 the nurse documented resident 53 had a fair appetite. On 4/24/02 and 4/26/02, the nurse documented resident poor appetite. On 4/27/02, the nurse documented that resident 53 was consuming an average of 50% of meals. On 4/28/02, the nurse documented that resident 53 was consuming an average of 0-25% of meals and that she refused meals when she had visitors. On 4/26/02, the physician ordered that resident 53 was to receive Diabetic Resource per her G-tube or by mouth 4 times per day and that the amount given was to be charted due to weight loss. The amount of Diabetic Resource to be given was not specified in the physician order. A review of resident 53's "Enteral Flow Sheet" was done. The nurses initialed that they had given Diabetic Resource. The amount given to the resident each day was not documented. On 4/29/02, at 8:58 AM, a nurse familiar with resident 53's care was interviewed. She was asked how much Diabetic Resource was given to resident 53 each day. She stated that she gave as much as the resident could tolerate. She was asked if the amount of Diabetic Resource given daily varied and she stated yes. On 4/29/02, at 9:48 AM, this nurse was interviewed a second time. She stated that she gave resident 53 four cartons, (240 cc each) of Resource Diabetic every day. She stated that if less than 240 cc four times daily was given, the nurse would circle their initials on the "Enteral Flow Sheet". A review of all documented physician assessments completed from resident 53's admission on 3/18/02 through 4/29/02 was done. The physician did recommend a dietary consult, on 3/23/02, to consider increasing resident 53's tube feeding regimen for weight loss and low albumin levels obtained. The weight recorded on the 3/23/02 physician assessment was 82.5. A follow up physician assessment, on	F 309		

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F 309	Continued From page 25 4/18/02, documented a weight of 77 pounds for resident 53 but did not address the significant weight loss of 5.5 pounds or 6.6%, which had occurred between the dates of 3/18/02 and 4/13/02. There was no documented evidence that the resident's low albumin levels obtained on 4/4/02, 4/11/02 and 4/18/02 were addressed in the 4/18/02 physician assessment. A review of all lab reports in the medical record documented that the physician had been notified of each abnormal lab value obtained by a nursing staff member. A care plan, initiated 3/18/02, documented that resident 53 was in a state of ill health, malnutrition and wasting secondary to a pancreatic mass causing biliary obstruction. The goal addressing this care plan problem was that resident 53's health, weight and stamina may improve while on the transitional care unit. Approaches to the problem included, nutritionist/dietitian to evaluate the diet. A nutritional care plan, initiated 3/18/02, documented that resident 53 was at risk for decreased nutritional status related to dysphagia secondary to a cerebrovascular accident and would be monitored. The goal addressing this care plan problem was that the resident would have no weight loss greater than 5 % and consume greater than 75% of meals daily. Approaches to the problem included, make referral to nutritionist if needed. A tube feeding care plan, initiated 3/18/02, and updated 4/17/02, documented that resident 53 had a tube feeding placed related to a cerebrovascular accident and dysphagia and would be monitored through her stay at the facility. The goal addressing this care plan problem was that the resident would	F 309		

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F 309	Continued From page 26 maintain adequate caloric intake daily through her stay on the transitional care unit. Approaches to the problem included, have dietitian monitor for adequate caloric intake, monitor weight as ordered by the physician and "pt [patient] eating fairly well. GT [gastrostomy tube] patent- [water] thru G-tube". On 4/25/02, at 2:25 PM, the facility nutrition aide was interviewed. She stated that she completes an "Initial Nutrition Screening" form for all newly admitted residents and for residents re-admitted to the facility. She stated that she usually gets answers to the questions asked on the form from the resident. She stated that if the resident could not answer the questions appropriately, she would gather information from the nurse, a certified nurses' aide or the chart. She stated that if the resident was admitted with a pressure sore she would document that information on the form, but she was not involved if the resident developed a pressure sore while in the facility. She further stated that she would document the resident's admit weight on the "Initial Nutrition Screening" form but did not address weight loss prior to admission or during the resident's admission. She stated that if a resident received a score of 5 or greater on the "Initial Nutrition Screening" form she would place a copy of the form in the consultant dietitian's box for her to follow up. On 4/25/02, at 4:43 PM, the consultant dietitian was interviewed. She stated that she was unaware that tube-feeding changes were being made for resident 53. She further stated that she had not made recommendations regarding tube-feeding changes or completed a nutritional assessment. On 4/29/02, at 11:00 AM, the consultant dietitian was interviewed for a second time. She stated that she was not made aware of resident 53's significant	F 309		

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F 309	Continued From page 27 weight loss, low albumin levels or the changes made in her tube-feeding regimen. ANN E. CHECK TO SEE IF THIS MAKES SENSE. U.S. Department of Health and Human Services, Number 15, olQuick Reference Guide for Clinicians Pressure Ulcer Treatment, December 1994 page 6-7. "The goal of nutritional assessment and management is to ensure that the diet of the individual with a pressure ulcer contains nutrients adequate to support healing.... Nutritional support: Encourage dietary support intake or supplementation if an individual with a pressure ulcer is malnourished. If the dietary intake continues to be inadequate, impracticable, or impossible, nutritional support should be used to place the patient into positive nitrogen balance (approximately 30 to 35 calories/kg/day/ and 1.25 to 1.50 grams of protein/kg/day) according to the goals of care. As much as 2.00 grams of protein/kg may be needed. " U.S. Department of Health and Human Services, Number 15, Treatment of Pressure Ulcers, December 1994, p. 21; states, "The initial assessment of patients with pressure ulcers has several dimensions: (a) Assessment of the pressure ulcer, (b) complete history and physical examination, (c) assessment for complications and comorbidities, (d) nutritional status assessment, (e) pain assessment, (f) psychosocial evaluation, and (g) assessment of risk for developing additional pressure ulcers." 3. Resident 163 was admitted to the facility, on 11/6/01, with diagnoses which included right sided hemiparesis secondary to cardiovascular accident, anemia, congestive heart failure, hypertension, pneumonia, aphasia, depression, and seizure disorder. Resident 163's medical record was reviewed, on 4/24/02. It was documented in the initial MDS (Minimum Data Set) assessment, dated 11/12/01, and	F 309		

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F 309	Continued From page 28 the nursing staff notes dated 11/6/01, that resident 163 was admitted to the facility with skin intact. No pressure ulcers and no redness were documented in the descriptive portion or in the body diagram portion of resident 163's skin and body assessment, dated 11/6/01. Daily nursing staff notes for resident 163, dated 11/7/01 through 11/16/01, documented the resident's skin was warm and dry with normal color and no wounds, rashes, or dressings. The nursing staff notes documented, on 11/17/01, the resident's buttocks were excoriated. The nursing staff notes, dated 11/18/01, documented, "Stage II [area of broken skin] DQ [decubitus ulcer] to [right] buttocks." The nursing staff notes, dated 12/6/01, documented, "Excoriation to buttocks, reddened, some open areas, improving." Observation by two nurse surveyors, of a dressing change performed on resident 163 by the charge nurse on 4/23/02, revealed an area approximately 18 x 15 cm of deep purple color over resident 163's right buttock and partially over his left buttock. Site A was an open, draining, reddened area on the resident's right buttock which the nurse measured as 1 1/2 x 4 cm at the proximal end, and 2 x 4 cm across the center of the wound. There were also scattered, bleeding, open areas around and distal to the wound on his right buttock and a narrow, bleeding, open area on his left buttock. Resident 163 was totally dependent upon enteral feedings for his nutrition and fluids. As documented on his enteral feeding records, the resident had been receiving Jevity (enteral feeding formula) at 94 cc (cubic centimeters) an hour. It was documented in the nursing staff notes for resident 163, dated 11/8/01 and 11/18/01, that he was tolerating the feeding without problems.	F 309		

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The initial nutrition screening, by the nutrition care aide, dated 11/7/01, documented resident 163 was NPO (to receive nothing by mouth) and was on a tube feeding program. The screening form was blank for the resident's height and weight, and it documented resident 163 was not admitted with a pressure ulcer. Resident 163's screening score totaled "6" where "5 or more" equaled "High Risk" and the dietician was to be notified.

Initial assessment by the registered dietitian, dated 11/9/01, documented the facility needed to obtain a height and weight for resident 163 and that there were no laboratory values for the resident. Without the information, the resident's caloric, fluid, or protein needs could not be determined. The registered dietitian documented resident 163 was NPO and had been receiving a tube feeding diet of Jevity (enteral feeding formula) at a rate of 94 cc (cubic centimeters) per hour. There was no further nutritional assessment for resident 163 until 3/12/02, four months later.

The dietitian's second nutritional assessment for resident 163, dated 3/12/02, documented the resident's estimated daily nutritional requirements included 109 to 149 grams of protein, 2398 to 3270 kcalories, and 2980 to 3070 cc of fluids. The dietitian documented that resident 163's tube feeding had been changed to Fibersource at 80 cc an hour for 23 hours out of every day. The dietitian documented that the feeding was providing resident 163 with 79 grams protein, 2208 calories, and with additional water the resident received, 2437 cc water. At that time, the protein in resident 163's enteral feedings provided him with 30 to 70 grams less than his nutritional requirements. The enteral feeding provided him 190 to 1062 calories less than his nutritional requirements. The dietitian documented that

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F 309	Continued From page 30 "nursing reports some weight increase recently, even though resident's not meeting his estimated needs." It was also documented that resident 163 had edema. The registered dietician documented that it had been suggested to reduce resident 163's enteral feeding rate to 70 cc an hour, 1610 cc daily, to help reduce his weight and diarrhea, and an arginine supplement be added to his diet. The revised rate of feeding provided 64 grams of protein which was 45 to 85 grams less than his daily requirements, and 1794 calories which was 604 to 1476 kcalories less than his daily requirements, and a total of 2212 cc water daily which was 768 to 1460 cc less than his daily requirements. A comprehensive metabolic panel result (CMP), dated 11/15/01, documented resident 163's albumin was moderately low at 2.7 (normal limit 3.3-4.8). Review of the nurses' enteral feeding documentation for March 2002 and April 2002, revealed that the amounts of enteral formula resident 163 received during any shift were not documented. Nurses initialed at the end of their shifts, that they had given the resident his enteral feedings. There was no specific documentation of the times the resident was not receiving his formula, which was to run 23 hours a day and stop for one hour a day. In an interview with the charge nurse for resident 163, on 4/24/02, the nurse stated she gave the resident two or three cans of formula on the first shift. The nurse stated she tried to stop the feedings for one hour each shift, but that sometimes she had to leave it off for nursing students or aides to provide cares for the resident. There was no documentation tracking the total cc of enteral feeding resident 163 received during any 24 hour period. 4. Resident 45 was admitted to the facility on 10/5/01	F 309		

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with the diagnoses of cerebrovascular accident, cerebrovascular disease, atrial fibrillation, constipation, edema, decubitus ulcer, right hip replacement, right hernia, and pneumonia.

A review of resident 45's medical record on 4/22/02 revealed the following:

The physicians progress notes from the hospital, dated 10/4/01, documented a stage 2 pressure sore on her right lateral malleolus (ankle). Resident 45 developed an additional stage 2 pressure sore on her left buttocks on 11/17/01.

A review of resident 45's recertification physician orders, dated 10/5/01, documented a mechanical soft low fat diet. The same day, 10/5/01, the facility's "Dietary Communication" form documented a regular diet.

Resident 45's laboratory results, dated 11/2/01, documented a low albumin of 2.4 g/dL (grams/deciliter). The facility's laboratory service states that the normal range is from 3.3-4.8 g/dL.

"Physicians Telephone Orders," dated 11/3/01, requested a high protein diet.

A review of the December 2001 "Treatment Record" documented that resident 45 began receiving 120 cc of supplement three times a day beginning 12/13/01.

During review of resident 45's medical record, it was revealed that there was no nutritional assessment performed by the dietitian. The nutritional assessment would be needed to determine whether the high protein diet and supplements were meeting her calorie and protein requirements.

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(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 309	Continued From page 32 Geriatric Nutrition, A Comprehensive Review, second edition, By Morley, Glick and Rubenstein pg.57, 335-338 states that, albumin is significant in regards to pressure sores, in that if an albumin level is low, visceral protein stores are low, and a high protein level is essential in the healing process.	F 309		
F 314 SS=H	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, review of resident medical records, Quality Steering Committee meeting minutes, Quality Assessment Committee minutes and review of facility policies and procedures, it was determined that for 6 of the 27 sample residents, the facility did not ensure that residents who entered the facility without pressure sores did not develop pressure sores. The facility also did not ensure that residents who had pressure sores received the necessary treatment and services to promote healing and prevent new sores from developing. 1. Treatments to pressure sores were not being performed as ordered by the physician for 3 of the 6 residents. (116, 95, 56) 2. Pressure relieving devices were not provided or were provided only after the development of pressure	F 314	F314 The following information identifies some of the interventions and recommendations that were made by the Weight/Skin Team for the residents identified in the deficiency: <u>Resident 56</u>: Multi-vitamins Arginade Geomat to bed Geomat to wheelchair Tegasorb dressing Resource Weekly weights Rule out restorative feeding due to late stage Alzheimer's Disease Head of bed not more than 30° <u>Resident 95</u>: Nylex mattress Comprehensive Metabolic Panel Arginade Calmoseptine to buttocks Offered Geomat in chair (resident refuses) Supplements offered twice daily (resident refuses frequently)	6/21/02

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F 314	Continued From page 33 sores for 1 of the 5 residents. (95) 3. The facility was not following it's own policy regarding skin risk assessments. 4. Skin risk assessments were not performed for 4 of the 6 residents. (116, 95, 56, 165) 5. Care plans addressing skin breakdown/pressure sores were not in place for 1 of the 6 residents. (95) The facility did not care plan a stage 1 pressure sore until it progressed into multiple stage II and III pressure sores. (165) 6. Four of the 6 residents developed pressure sores within the facility. For 3 of the 6 residents who developed pressure sores, the physician was not notified until 6 to 8 days after the identification of the pressure sores. (116, 56, 165) The physician stated that 1 of the 5 pressure sores (116) she identified herself prior to being informed by nursing staff. 7. The consultant dietitian confirmed that she was not aware of 2 of the 6 residents with pressure sores. (116, 95) There was no documentation to evidence that the consultant dietitian was aware of the fifth pressure sore (56) until 51 days after it was initially identified by nursing staff and was not aware of the sixth resident with pressure sores until 31 days after the pressure sores were identified. (165) 8. Two of the 6 residents did not have nutritional assessments by the consultant dietitian to calculate the protein and calorie needs to assist in the healing of the pressure sores. (116, 95) 9. The skin team, which consisted of one registered nurse and one consultant dietitian, stated they met weekly, but did not keep minutes of their meetings to identify which residents were discussed, what recommendations were made or what interventions were implemented. There was no method to ensure that staff had followed through with recommendations made by the skin team. The skin team had no written job description of its duties. 10. The February 2002 monthly pressure ulcer	F 314	<u>Resident 116</u>: Nylex mattress/electric bed House supplement three times daily Multi-vitamins Arginade twice daily Tegasorb dressing to coccyx/change every three days and PRN Spence boots Weekly weights Cushion pad to wheelchair <u>Resident 165</u>: Comprehensive Metabolic Panel Boost (240 cc three times daily) or Resource (120 cc three times daily) Dressing change to buttocks twice daily Irrigate with acetic acid in a.m. and with normal saline at h.s. Reweigh Arginine, 500 mg twice daily Multi-vitamin each day Air mattress Change diet to high protein mechanical soft, small portions A full-time R.N. who will focus solely on wound care has been hired as of May 29, 2002.	

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F 314	Continued From page 34 report, dated 2/21/02, documented the facility's nosocomial (house acquired) pressure sore rate to be 5.6%, an increase from the previous month (January 2002) of 2.8%. The facility did not have documentation to evidence that it had addressed this increase in the pressure sore rate. Resident identifiers: 95, 56, 116 and 165. Findings include: 1. System Breakdown - A pattern of actual harm was identified for 4 residents who developed an avoidable pressure sore and/or did not receive treatment and services to promote healing of a pressure sore. Residents 95, 56, 116 and 165. a. The February 2002 pressure ulcer report, dated 2/21/02, identified the facility's nosocomial pressure ulcer rate at 5.6% which was up from the January 2002 rate of 2.8%. On 4/30/02, the facility was requested to provide documentation that they had addressed the increase in the pressure sore rate. Facility administration was not able to provide any documentation to evidence that it had. When asked if the facility had addressed the increased rate of 5.6% in the next monthly Quality Steering Committee Meeting, the Director of Nurses stated that "For some reason, it (the meeting for March 2002) was cancelled." Further, the facility did not provide minutes to the April 2002 Quality Steering Committee Meeting. Based on a review conducted 5/13/02, there was no documentation in the quarterly Quality Assessment (QA) Committee minutes, dated 4/17/02, to evidence that the QA committee had addressed the increase in the nosocomial pressure ulcer rate.	F 314	Weight Skin Care Plans have also been completed and placed in their medical record (Residents 42, 56, 95, 116, 109, 165). A skin integrity procedure has been developed to ensure that residents are assessed for the development of pressure sores upon admission and at regular intervals, that timely notification of the physician, family, dietitian and wound care nurse occurs, that recommendations for appropriate intervention take place by specific interdisciplinary team members, and that routine monitoring and documentation of the healing process occurs. The Pressure Ulcer Risk Scale will be completed for all current residents within three weeks. This scoring tool has already been used to assess all residents whom the Survey Team identified as receiving substandard care. The plan for residents who score high risk is to: I. Implement the following: *Telephone orders will be obtained from the attending physicians and documented before the following interventions:	

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F 314	Continued From page 35 b. The facility had a skin/weight team which consisted of one registered nurse and one registered dietitian. When asked if there was a written job description for the duties assigned to the skin/weight team, the skin nurse replied, "no." During interview with this team on 4/25/02, they stated that they met weekly to discuss residents with skin and weight issues, but they did not keep any minutes of their meetings to detail what residents were reviewed or what recommendations and interventions were implemented. The registered dietitian confirmed that she was not aware of 4 of the 6 pressure sores with which survey had concerns. c. The facility was not following it's own policy for assessing residents at high risk for pressure sores. The policy stated that "Within the first 8 hours of admission to St. Joseph Villa, each resident will be evaluated to determined those who are at high risk for pressure sores or who have evidence of skin breakdown." During an interview with the skin team nurse on 4/25/02 at 2:35 PM, she was asked if the facility performed skin risk assessments. The skin team nurse replied, "We don't do them." When asked how individuals were assessed for the need of pressure relieving devices and other appropriate interventions, the skin team nurse replied, "If they (a resident) come in and they are non-ambulatory or can't turn in their bed or they're incontinent or can't relieve pressure on their own, then you (the charge nurse) provide pressure relieving devices to their bed and wheelchair." The skin team nurse continued to state that it was left up to "nursing judgement" as to whether an individual needed pressure relieving devices. The facility did not have a consistent method to initially and then periodically reassess residents who may have become at risk for skin breakdown. d. The facility did not have a consistent manner to	F 314	1. Pressure reducing mattress or geomat 2. Pressure relieving devices as indicated for care (i.e. elbow protectors, float heels, Spence boots) 3. Initiate Resource supplement II. The plan for residents who have low risk is to: 1. Turn and reposition every two hours if unable to reposition self 2. Head of bed less than 30° unless physician orders alternate 3. Assess level of pain weekly 4. Nutritional assessment by Registered Dietitian 5. Encourage activities and mobility 6. Monitor percentage of meals consumed and notify nurses if intake is poor 7. Complete skin assessment on a weekly basis by Charge Nurse. During bathing, CNA assesses skin and reports to Charge Nurse any skin problems 8. Scheduled bathing	

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ensure that the skin team was aware of resident's who developed skin breakdown and therefore received care for that breakdown. During the 4/25/02 interview with the skin team, they were asked how they became aware of skin breakdown. The skin team nurse replied that the nurses had been instructed to place that information on a 24 hour report and submit it to her. When she was informed that resident 116 had a Stage II pressure ulcer on his coccyx, she indicated that she was not aware that this had occurred. When asked if there were other ways she might have been informed, she stated that nurses would sometimes stop her in the hall and inform her of a skin problem.

e. Through record review completed throughout the survey and an interview conducted with the physician on 5/1/02, it was found that the physician was not notified regarding the development of pressure sores for three residents until 6 to 8 days after the nurse's initial identification. (Resident 116, 165 and 56.)

2. Effected Residents

a. Resident 95 was a 79 year old female who was admitted to the facility on 4/3/02 with the diagnoses of chronic obstructive pulmonary disease (COPD) exacerbation, insulin dependent diabetes mellitus, osteoporosis, depression with anxiety, coronary artery disease, gastroesophageal reflux disease and cor pulmonale.

A nurse's note, from resident 95's hospital discharge record, dated 4/3/02, documented, "Pt. (patient) has stage II decubitus on coccyx that is covered by duoderm." This hospital discharge note is contradicted by the facility's admission nurse's note, also dated 4/3/02, which documented, "Pt. does have redness on buttocks, looks like friction. No open area. Blanches well, placed tegasorb for protection."

Provider's Plan of Correction (F 314):

9. Peri-care after incontinent episodes
10. Toilet every two hours and as needed

Skin risk assessments will be performed by the Charge Nurse upon admission or by the MDS Nurse Assessor at quarterly intervals. Nursing Supervisors will check to see that admission skin risk assessments have been completed. The Wound Care Nurse will monitor monthly to assure that pressure relieving devices are in place and that dietary and other appropriate interventions have been and continue to be in place.

The Weight/skin Team will meet weekly until it is determined by the Quality Steering Committee that residents are being properly monitored and are receiving such high quality dietary and nursing care that meetings could be held twice per month. The membership of the Weight/Skin Team will include:

- Wound Care Nurse
- Registered Dietitian
- Nursing Supervisor or delegate
- Nutritional Care Aide

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F 314	Continued From page 37 The nurse who performed this resident's admission assessment was interviewed on 5/1/02. The nurse stated that she did a very thorough assessment of resident 95 and that there was no skin breakdown, only the redness which she described in her admission note of 4/3/02. A "Weekly Nursing Summary" for resident 95 was completed by a facility nurse on 4/6/02. The sections regarding "skin condition" and "preventative" measures were left blank. There was no documentation in the medical record of resident 95 to evidence that facility staff had addressed the resident's coccyx area again until 4/9/02, 6 days after the admission assessment. The nurse's note of 4/9/02 documented the following: "c/o (complaining of) buttocks being sore - has tegasorb over @ (at) buttock. Noted has - pressure sores - stage II superficial 1- 0.5, #2 - 1 cm (centimeter) and one very sm (small) one with escar - 0 (no) drainage. Tegasorb caused redness on side edges - stratasorb applied - geo pad - et (and then) geo mattress for bed ordered - ..." This note documented a total of 3 pressure sores where the admission assessment documented none. The facility did not perform a skin risk assessment of resident 95, as required by their own policies. The facility did not care plan the concern of pressure sores or any type of skin breakdown. The facility did not implement the use of pressure relieving devices until 4/9/02, the day resident 95 was identified with open pressure sores. This was a 6 day delay from the time the nurse had initially identified the "redness on buttocks". On 4/15/02, the physician changed the orders to treat the pressure sores to the following: "Calmoseptine q	F 314	• Nurse Education • Physical Therapist (by consultation) The Weight/Skin Team will review all residents who meet the MDS criteria for significant weight loss or gain. The Wound Care Nurse will bring a list of residents with wounds to each Weight/Skin Team Meeting for review. Actual skin checks will be performed on every resident at least weekly by the Charge Nurses who are completing their weekly summaries. With a new form called "Pressure Ulcer Treatment Guideline and Notification," the nurses will notify the physician, family, dietitian, and Wound Care Nurse for each condition, if any, that they observe. The Wound Care Nurse will audit to ensure that dressings have been applied and are being changed as ordered. The Wound Care Nurse or Registered Dietitian will report the progress of the Weight/Skin Team	

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F 314	Continued From page 38 (every) 3-4 X (times) a day til resolved." Review of the April 2002 Treatment sheet for resident 95 revealed the following: There was no documentation to evidence that the calmoseptine was applied at all on 4/15/02, 4/17/02, 4/18/02, 4/21/02 or 4/22/02. There was documentation to evidence that the calmoseptine was applied once on 4/16/02, once on 4/19/02 and twice on 4/20/02. Sixteen out of 20 scheduled treatments were not documented as being performed. During interview with the consultant dietitian on 4/25/02, she was asked if she was aware that resident 95 had developed pressure sores. The consultant dietitian stated, "no". There was no dietary/nutritional assessment of resident 95 by the dietitian to calculate protein requirements and calories needed to promote wound healing. b. Resident 56 was a 79 year old female who was admitted to the facility on 12/5/01 with diagnoses of organic brain dysfunction, vertebral fracture, and bipolar disorder. A review of the resident 56's medical record was done on 4/25/02 and revealed the following: The MDS (minimum data set), a mandatory comprehensive assessment of the resident completed by facility staff, dated 12/18/01 and 3/18/02, documented that the cognitive skills of resident 56 were severely impaired and that she needed extensive assistance when moving to and from a lying position, turning side to side, positioning her body in bed, and moving to or from a bed and wheelchair. Both MDS's documented that resident 56 was occasionally incontinent of bowel and bladder. The MDS, dated 12/18/01, documented that resident 56 had no prior	F 314	to the Quality Steering Committee each month. The Director of Nursing is responsible for implementing this plan. Corrective action for those residents whom the Survey Team identified as receiving substandard quality of care was implemented by May 23, 2002. The remaining current residents will have a Pressure Ulcer Risk Scale completed and placed in their medical record by June 21, 2002.	

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F 314	Continued From page 39 history of pressure sores or current pressure sores. Both MDS's documented that resident 56 needed a pressure-relieving device for her bed and that she should be placed on a turning and repositioning program. The care plan for resident 56, dated 12/9/01, included the problem skin integrity and urinary incontinence due to decrease mobility, fragile skin and incontinence. Resident 56 was further care planned on 2/4/02 for pressure sores due to impaired transfers mobility, Alzheimer's or other dementia and coronary artery disease. The care plan on 2/4/02 included the following interventions: 1. "Evaluate/assess/monitor/document/communicate with RN/MD/RD/resident/family prn (as needed) status." 2. "Provide/serve/monitor nutrition and hydration." 3. "Provide/monitor effectiveness and document treatment." The "Nursing Admission History and Evaluation" documented on 12/5/01 that resident 56 had redness on her buttock area. An interview with the nurse who cared for resident 56 was done on 4/23/02 at 11:00 AM. The nurse stated that residents weekly skin checks were documented on the weekly nursing summary. The nurse further stated that the "Nursing Admission History and Evaluation" was the form that helped the nurse determine that a resident was at risk for developing a pressure sore. She stated it was up to the individual nurse to determine the residents that were at risk for developing a pressure sore. The nurse stated it was the responsibility of the nurse to notify the physician,	F 314		

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F 314	Continued From page 40 the treatment nurse and dietary when a pressure sore had developed. She further stated that the nurse is responsible to initiate the use of pressure relieving devices for the bed and wheelchair. A review of resident 56's medical record was done. A risk assessment for skin breakdown could not be found. The "Weekly Nursing Summary", dated 1/3/02, stated that resident 56 had redness on her behind which was healing. The "Weekly Nursing Summary" dated 1/27/02 documented that resident 56 had a stage II pressure sore on her coccyx. The facility nurse documented that the pressure sore was treated with "Hydrcol/ tegraden" and response to treatment was " ? started 1/27/02." The "Interdisciplinary Notes" dated 1/28/02 at 4:00 AM documented that resident 56 had a stage II pressure sore on her right inner buttock fold that measured 1X1 cm (centimeter). The interdisciplinary progress note also documented, "placed Tegaderm with PolyMem to cover. Will have AM nurse call MD (physician) for orders." The "Interdisciplinary Notes" dated 1/28/02 at 1:40 AM documented that physician's nurse practitioner saw resident 56. A review of the physician's progress notes documented that the nurse practitioner had assessed resident 56 on 1/28/02. The nurse practitioner did not document in her assessment that resident 56 had a stage II pressure sore. A review of the physician orders revealed that 2/4/02	F 314		

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was the first time, since the pressure sore was discovered on 1/27/02, that there was documentation of the physician being made aware of resident 56's pressure sore. This was 8 days after the initial identification of the pressure sore by facility nurses.

The physician's orders, dated 2/4/02, documented the following orders for resident 56's pressure sore.

1."Cleanse with NS (normal saline) apply skin prep around area. Apply tegasorb change dressing q (every) 3 to 5 days and prn (as needed).
2. "Walk q 2 hours for 15 minutes. Reposition q 2 [hours] while in bed."
3. "Boost nutritional supplement TID (three times a day) record cc(cubic centimeters) for wound healing."
4. "Ariginaid BID (twice a day) mixed in 6 to 8 ounces for wound healing."
5. "Pressure reducing mattress on bed. "

An interview with the treatment nurse was done on 4/29/02 at 2:50 PM. The treatment nurse stated that the physician had not been notified of resident 56's pressure sore until 2/4/02.

A review of the treatment record for resident 56 documented that treatment started 2/6/02, two days after the physician had ordered to treat resident 56's pressure sore. For 10 days, from 1/27/02 through 2/5/02, the treatment for resident 56's pressure sores had not been documented as being performed.

An interview with the treatment nurse was done on 4/29/02 at 2:50 PM. The treatment nurse stated that she had measured the wound on 1/28/02 and it measured 1 X 1 cm. She further stated she had measured the wound again on 2/4/02 and the wound measured 1X1.5 cm. She stated she had done a dressing change on 2/4/02. When asked if the

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F 314	Continued From page 42 treatment nurse measured resident 56's pressure sore with a measuring device the treatment nurse stated "yes". A review of resident 56's laboratory results documented that a complete metabolic panel was collected on 12/6/01. Resident 56 had an albumin of 2.3 g/dl (grams per deciliter) which reflected a severe protein deficit. The normal range according to the facility's laboratory was 3.3 to 4.8 g/dl. A review of the dietary notes revealed that on 3/19/02, the first dietary note was written by the registered dietitian documenting the estimated resident protein needs. The dietary note documented that 61 to 84 g/dl of protein was needed for resident 56. This dietary assessment was completed 103 days after resident 56 was identified with severe malnutrition and 51 days after she was identified with a stage II pressure sore. An interview with the registered dietitian was done on 4/29/02 at 2:50 PM. The dietitian stated resident 56 received boost supplement three times a day. The boost supplement provided 15 grams of extra protein per day. The dietitian also stated that resident 56 received a mechanical soft diet that would provide 45 grams of protein a day. A review of "C.N.A. Care Sheet " documented the percentage of meal intake for resident 56. The "C.N.A. Care Sheet" for December 2001, January 2002, February 2002, March 2002, documented resident 56's meal intake. She ate approximately 50% of her meals. If resident 56 ate 100% of her meals and consumed 120 cc three times a day of her boost supplement she would receive 60 grams of a protein a day. The	F 314		

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F 314	Continued From page 43 dietitian's minimum recommendation was 61 grams of protein per day was needed for resident 56 per day. Resident 56 was not receiving the minimum amount of protein required to meet her needs or promote wound healing. A review of the facility's "Decubitus/ Pressure Ulcer Report", dated 4/24/02, documented that resident 56's pressure sore on her right inner buttock had resolved. On 4/25/02 at 2:00 PM, two registered nurse surveyors observed a nurse perform a skin check on resident 56. On resident 56's right inner buttock, there was a 1 cm by 1 cm partial thickness loss of the epidermis that was reddened and round in appearance. The nurse who performed the skin check on resident 57 stated "looks like she [resident 56] is broken down again." The nurse described the wound as being a stage two pressure sore. The treatment nurse was interviewed on 4/29/02 at 2:50 AM. The treatment nurse was not aware that resident 56 had current skin breakdown to her right inner buttock. On 4/30/02 at 7:45 AM, two registered nurse surveyors observed a facility nurse perform a skin check on resident 56 a second time. Resident 56 was observed to have a soiled incontinent brief with feces and urine without any dressing on her open sore. On resident 56's right inner buttock, there was a 1 cm by 1 cm partial thickness loss of the epidermis that was reddened and round in appearance. A review of the treatment record dated April 2002 documented that resident 56 was to have a tegasorb dressing be applied on her coccyx as necessary. There was no documentation that that resident 56 had a tegasorb dressing applied for the month of April	F 314		

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2002.

A review of "Weekly Summary" for April 2002 documented resident 56's weekly skin checks. Weekly skin checks were documented on 4/1/02, 4/8/02, and 4/28/02. Documentation of two skin checks were missing.

A review of resident 56's interdisciplinary notes, treatment record, and weekly summaries for April 2002 was done. From 4/8/02 to 4/24/02, there were 16 days where there was no documentation of the pressure sore.

c. Resident 116, a 66-year-old male, was admitted to the facility on 6/13/01 with diagnoses of quadriplegia, intraspinal abscess, esophageal reflux, and hypothyroidism.

Resident 116 was re-admitted to the long-term-care facility from the hospital on 8/16/01. A nursing admission assessment dated 8/16/01 was reviewed. It was documented on this assessment that resident 116's "skin [was] intact, coccyx area excoriated/reddened".
A weekly nursing summary dated 8/19/01 reported the skin condition as being "intact, very excoriated".

A lab report dated 8/31/01 documented an albumin (protein) level of 2.7 g/dl.

Further review of the weekly nursing summaries revealed the following skin conditions for resident 116:
10/5/01 stage II coccyx
10/19/01 stage II coccyx
11/5/01 stage II coccyx
11/12/01 pt. (patient) has small skin breakdown
11/19/01 stage II coccyx

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F 314	Continued From page 45 11/26/01 stage II coccyx 12/5/01 stage II coccyx 12/12/01 stage II coccyx ½ by ½ cm (centimeter) 12/19/01 stage II coccyx 12/26/01 stage II coccyx 1/05/02 stage II coccyx-resolved A diet order for regular mechanical soft was documented in the dietary notes on 7/31/01. Further review of the dietary section of the medical chart revealed no dietary evaluation from 8/01 to 1/02 addressing the low albumin value or the pressure ulcers. A weekly nursing report dated 1/19/02 documented a stage II on the coccyx. A review of the physician progress report dated 1/28/02 documented a "stage II coccyx decub." (decubitus) A care plan dated 1/30/02 documented Arginad supplement BID (twice a day), ten days after the discovery of the pressure sore. A review of the medical records revealed a dietary assessment completed on 02/14/02, six months after the low albumin level and four months after the first pressure sore was discovered. A physician progress note dated 3/27/02 stated, " DQ (decubitus) ulcer to coccyx- Arginaid BID- resolved per nursing." Review of the nursing notes, dated 4/19/02, documented a stage III DQ on coccyx. A review of the decubitus/pressure ulcer report, dated 4/19/02, documented a coccyx, stage III, 1 cm, 1/8 in depth. The pressure sore was not addressed again until 4/22/02.	F 314		

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NAME OF PROVIDER OR SUPPLIER: CHRISTUS ST JOSEPH VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE: 451 BISHOP FEDERAL LANE SALT LAKE CITY, UT 84115		

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F 314	Continued From page 46 On 4/22/02, the documentation stated coccyx, stage II, 1cm, pink in color, small slit, more from friction than actual breakdown. There was no documentation in the medical record of resident 116 to evidence that the physician was notified of this pressure sore until 4/25/02, when orders were obtained to treat it. This was 6 days after nursing staff had initially identified the pressure sore. On 4/25/02 at 9:40 AM, two registered nurse surveyors observed the pressure sore of resident 116 with a facility nurse manager. All three nurses who observed the pressure sore, located on his coccyx, agreed that it appeared to be a stage II which measured approximately 1 cm (centimeter) by 0.5 cm with a depth of 0.25 cm. The pressure sore was not covered by a dressing and had been exposed to fecal contamination. During interview with the resident on 4/25/02, he stated that the pressure sore was one which kept reoccurring and that "one nurse will change it one day and then it won't get touched for a week". Resident 116 continued to state that he felt his pressure sore was not healing because the treatment was not consistent. He also stated that the dressing "will fall off and not be replaced." During an additional interview with resident 116 on 4/30/02, he was asked regarding his occasional refusal to get out of bed for meals. He admitted this and stated "when you get the same thing day after day, you tend to lose your appetite." When asked if he refused to be turned from side to side, to relieve the pressure off his back, he stated that he did not refuse to be turned and was willing to do what he needed to get the pressure sore healed. The "Treatment Record" for March 2002 contained orders for the nurses to provide "wound care clean wound with ns (normal saline) and apply tegasorb	F 314		

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F 314	Continued From page 47 change Q (every) 3 days/ PRN (as necessary) until healed..." There were only two days in March 2002 that nurses documented as performing this treatment, 3/9/02 and 3/12/02. A nurse documented on the treatment sheet on 3/20/02, "appears resolved". There were no orders on the April 2002 treatment record for resident 116's pressure sore until 4/25/02. During interview with the physician on 5/1/02, she confirmed that she had not been notified of this pressure sore until 4/25/02. The physician added that in months prior to this new most recent pressure sore, she had identified a pressure sore on resident 116 herself. She stated that resident 116 had complained of a sore bottom and that she had observed the sore prior to being notified by nursing staff. In an interview with the dietitian on 4/25/02, she stated that she had not been notified and she was not aware of the recent skin breakdown on resident 116. d. Resident 165 was admitted to the facility, on 2/9/01, with diagnoses which included dementia, transient ischemic attacks, lumbago, renal insufficiency, degenerative joint disease, pancreatic mass and digestive neoplasm. Resident 165 was re-admitted to the facility, on 9/24/01, following a temporary discharge for surgical repair of a fracture to her left hip. Resident 165's medical record was reviewed on 4/24/02 and 4/30/02. A significant change MDS for resident 165, dated 10/7/01, documented that the resident was totally dependent upon the assistance of two staff members for her bed mobility (section G1a). Resident 165 was documented as being totally dependent upon staff for toileting (G1i) and for personal hygiene (G1j). There was no skin risk assessment in resident 165's record.	F 314		

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The admitting nurse documented, in the interdisciplinary progress notes dated 9/24/01, that resident 165 had a Foley catheter, a long support stocking on her left leg, and a dressing on her left hip. The admitting nurse also documented resident 165 "has a dark reddened area on her coccyx/buttocks that is not broken down" and that a protective dressing was applied.

There was no further mention in resident 165's medical record of any further concern's regarding resident 165's skin integrity until the physician saw the resident, the afternoon of 10/1/01, six days after her readmission. On 10/1/01, the physician documented that resident 165's coccyx had a "butterfly area of Stage II and III breakdown". At that time, the physician ordered that the dressing continue for the pressure ulcer but requested a wound consult. Documentation on the daily nursing shift report, for 10/1/01 afternoon shift, documented that resident 165's coccyx area "is now open", and a care plan was started for resident 165's "altered skin integrity." A care plan addressing skin integrity was not initiated on 9/24/01, when nursing staff first identified the dark red area on her coccyx/buttocks.

On 10/2/01, the wound team nurse assessed the pressure ulcer and began documenting on a decubitus/pressure ulcer report. The wound team nurse documented the pressure ulcer as measuring 8 cm x 4 cm x 9 cm, Stage III of superficial depth, and the wound nurse diagramed it as an inverted U shape with a round spot in the center of the U.

In the interdisciplinary progress notes, dated 10/3/01, the charge nurse documented that resident 165 was given a tub bath and her TED hose (antiembolism stockings) were removed. The charge nurse

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documented that resident 165 had been found to have dry, black scabs measuring two centimeters on both of the resident's heels. There was no documentation to evidence that the TED hose had been removed from 9/24/01 until 10/6/01, a total of 12 days.

In an interview, on 4/25/02, with the charge nurse for resident 165, the nurse stated that the resident's TED hose been on, but not removed for the week since the resident had been admitted. The nurse stated previous attempts to remove resident 165's TED hose had been too painful to the resident, so much so that the nurse stated she was unable to proceed. The nurse stated, that when the TED hose were removed, resident 165 had an additional open wound located on the anterior (top) portion of resident 165's left ankle, under the area of a wrinkle that had been in the resident's TED hose.

Lippincott, Textbook of Basic Nursing, seventh edition, pg 624-626:
Often elasticized bandages are wrapped around a client's limbs to provide muscular support and to increase circulation. Gentle pressure against the tissues stimulates blood return to the heart and prevents blood from pooling in the extremity. Application that is too tight, however, can squeeze the blood vessels and nerves (constriction), resulting in tissue damage. Carefully and frequently assess circulation and nerve function in the client's fingers or toes to make sure that a bandage is not too tight. You can do so by assessing the clients's skin color, finger or toe motion, and sensation."

"These stockings [TED socks] do not become loose; thus, you must check the client's CMS [color, motion, and sensation] at least once every 2 hours. Remove the stockings at least once every 8 hours and examine the leg carefully for redness, pitting edema, or skin

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discoloration. Document your findings. Wash the client's legs gently each day, apply lotion if the skin is dry, and apply clean stockings."

The steps for applying the TED socks, "Nursing Procedure 53-1" included:
Step 2. Use the tape measure to determine proper stocking size for the client.
Rationale "Stockings that are too tight may interfere with circulation."
Step 7. Grasp the stocking's heel and turn it inside out.
Rationale "Minimize bunching of the stocking on the client's foot."
Step 9. Support the client's ankle and ease the stocking smoothly over the calf and remainder of the leg.
Rationale "Prevent wrinkles from forming, which can impede circulation."
Step 11. Instruct the client to report any extreme discomfort.
Rationale "Prevent complications from occurring."
Step 13. Document the procedure on the client's record.
Rationale "Ensure continuity of care."

On 10/10/01, the wound team nurse documented she had notified the resident's family of the pressure ulcers on resident 165's heels, and would notify the physician. The wound nurse documented that resident 165's physician had been notified of the heel wounds on 10/11/01, eight days after the wounds had first been observed. There was no documentation in the decubitus/pressure ulcer report that tracked the pressure ulcer on resident 165's right ankle until 11/24/01. At that time, the nurse documented the wound was Stage III, 1 1/2 cm, superficial, with slight drainage.

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F 314	Continued From page 51 The Registered Dietician did not conduct an assessment of resident 165's nutritional needs until 11/2/01, 39 days after resident 165 was admitted as a post-surgical patient and 31 days after the resident had been identified with the "butterfly area of Stage II and Stage II breakdown." The following information concerning pressure sores was found in the facility's policy and procedures and indicated how pressure sores (decubitus ulcers) were to be treated in the facility: " 1. Pressure ulcers are caused by either compression of soft tissue between bony prominences and external surface, shearing, or friction combined with moisture. 2. Interventions that will be taken to prevent pressure ulcers are: A. Regular turning of immobilized residents at least every two hours. B. Reducing shear and friction by using draw sheet, not raising the head of the bed greater than 30 degrees for extended periods. C. Providing assistive devices to increase activity. D. Keeping incontinent resident clean and dry E. Providing adequate nutritional and fluid intake F. Using pressure relieving wheelchair pads and mattresses..." The facility's policy on wound care/decubitus ulcer states the following : "1. Assessment: A. Within the first 8 hours of admission to [the facility] , each resident will be evaluated to determine those who are at high risk for pressure sores or who have evidence of skin breakdown. Ongoing assessments of skin integrity will take place on each resident's bath days . . .	F 314		

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F 314	Continued From page 52 E. A nutritional assessment will be accomplished by the dietitian upon notification of the nursing staff. If the resident's nutritional needs are not met, appropriate supplemental measures will be initiated. Adequate protein and calorie intake will be assessed." F. Pressure ulcers will be staged using the National Pressure Ulcer Advisory Panel (NPUAP) guidelines: Stage I: Non-blanchable erythema of intact skin Stage II: Partial thickness skin loss involving epidermis and/or dermis Stage III: Full thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down but not through, underlying fascia. Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures . . . 2. Interventions: A. If the pressure sore occurs in an area of skin maceration, plans to alter the resident's nursing care to keep the resident clean and dry should be formulated. Use catheters or other devices to prevent soilage should be considered . . . D. Increased protein and calories will be added to the diet by the dietitian and/or nurse . . . 3. Documentation: All DQ"s [decubitus] will be charted on every day. Additionally, shift charting is required if dressing is changed . . . 5. The charge nurse will assess the skin. If a pressure sore is developing he or she will notify the supervisor, make a notation on the 24 hour report, make a notation in the progress notes, begin a decubitus ulcer	F 314		

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F 314	Continued From page 53 flow sheet, update the care plan establishing a short goal for the resolution of the pressure sore, notify the family, dietician and physician . . . 8. The decubitus ulcer flow sheet is updated by the charge nurse at least every seven days." The facility was not following its own policies and procedures. Preece, Rebecca	F 314		
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 interviews it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by 1 of 27 sampled residents (109) and 1 supplemental resident (53) who experienced significant weight loss with no dietary interventions implemented to prevent further weight decline. Resident identifiers: 109 and 53. 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,	F 325	**F325** **Resident 109 has been reviewed by the Weight/Skin Team. The following recommendations for interventions have been made:** **Resident 109:** **Spence boots** **Weekly weight** **Boost three times daily (or Resource)** **Turn and position every two hours** **No restorative feeding due to dementia** **Pressure ulcer resolved**	5/24/02

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F 325 (summary statement)

Continued From page 54
6th edition, 2000).

Findings include:

1. Resident 109, a 98 year- old female, was admitted to the facility on 4/22/02 with diagnoses of hypothyroidism, organic brain syndrome and edema.

A review of resident 109 weight revealed the following:

January 108.1 lbs. (pounds)
February 103 lbs.
March 98.1 lbs.
April 98.3 lbs.

Between the months of January and March resident 109 lost 10 lbs (9.26%) which is significant.

On 1/30/02 resident 109 was re-admitted to the long term care facility from the hospital. A lab (laboratory) value done at the hospital, dated 1/27/02, was reviewed and revealed a serum albumin (protein) level of 2.8. A lab value taken at the facility and dated 2/15/02 showed a albumin level of 2.4. 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 nursing admission history and evaluation form dated 1/30/02 and the nurses notes dated 1/31/02 documented a "...an area on coccyx that is purplish-red- skin intact." A nurses note dated

F 325 (provider's plan of correction)

<u>Resident 53</u>:
This resident was discharged on May 15, 2002. She moved to California to be closer to her son. She had a terminal diagnosis of pancreatic cancer. Villa staff made arrangements for hospice in California to follow her.
<u>Nutrition Care Plan notes on resident 53 prior to discharge indicate</u>:
Mechanical soft diet with low concentrated sweets
Impaired ability to feed self related to CVA
April 25 – Reglan (5 mg PO TID Gastric Esophageal Reflux Disease)
April 26 – Diabetic Resource per G-tube or PO PRN QID. Chart cc's for weight loss
Weekly weights
Goal: adequate intake of 25% or more at most meals
April 26 – sliding scale regular insulin
Goal: April 30 diabetic Resource to 5 cartons per day
Goal: May 2 refer to hospice (pancreatic cancer)

Each resident's nutritional status, including body weight and protein levels will be assessed by the Weight/Skin Team.

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F 325	Continued From page 55 2/05/02 documented " CNA reported to nurse that she discovered reddened area with tissue breakdown on patient. On assessment patient has stage II decub (decubitus) on inner top of right buttock approximately 2 cm- not draining- and a smaller stage II decub on coccyx." A review of the dietary notes revealed that no dietary assessment addressing the weight loss, skin breakdown or the low lab values had been completed for resident 109. In an interview with the dietitian on 4/25/02 she stated that she had not been notified by nursing and was not aware of the weight loss, the low lab levels or the skin breakdown on resident 109. The facility's policy for Resident's Nutritional Interview and Assessment were reviewed on 4/25/02. It was documented in the procedure that "all residents are contacted by the Registered Dietitian within seventy-two (72) hours after admission with follow-up within (7) days of admission, thirty (30) days post-admission, and sixty (60) days post-admission...but in no case exceeds ninety (90) days." In an interview with the dietitian on 4/25/02 she stated that she in the facility for approximately 10-12 hours a week. She stated that she was not aware of the policy for nutritional assessments. She stated that she is contacted of nutritional changes "by the wound nurse or by nurses pulling her aside in the halls." 2. Resident 53 was an 82 year old female with diagnoses including cachexia, pancreatic mass causing obstructive jaundice, history of weight loss, right middle cerebrovascular accident with left sided weakness, gastrostomy (G-tube) tube placement	F 325	**The membership of this team includes a Wound Care Nurse, a Registered Dietitian, a Nursing Supervisor or delegate, the Nutrition Care Aide and the Nurse Educator. The Weight/Skin Team will meet at least once per week until it is determined by the Quality Steering Committee that residents are being properly monitored and are receiving such high quality dietary and nursing care that meetings could be held twice a month.** **The back of the Weight/Skin Care Plan contains signature lines to evidence which members attended the meetings. A photocopy of each resident's Weight/Skin Care Plan with the latest recommendations for intervention will serve as "minutes" of the Weight/Skin Team Meeting.** **The Weight/Skin Care Plan will identify residents at risk for weight loss and malnutrition because it has columns for "current weight, last weight, amount gained or lost and lab work." Low protein or albumin levels will be addressed by the Charge Nurse with the physician upon receipt of the lab results.**	

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F 325	Continued From page 56 secondary to dysphagia and diabetes mellitus. Resident 53 was admitted to the facility's transitional care unit on 3/18/02. She was discharged from the transitional care unit on 4/19/02 and was admitted to the facility's long term care unit on 4/19/02. On 4/29/02, resident 53's medical records from both the transitional care unit and the long term care unit were reviewed. A review of resident 53's admission weight, documented in the nursing staff notes dated 3/18/02, revealed that she weighed 82.5 pounds. A review of resident 53's weekly weights, documented on the resident's treatment records, were as follows: 3/18/02 82.5 pounds. 3/30/02 119.5 pounds. 4/6/02 120.4 pounds. 4/13/02 77 pounds. This represents a significant weight loss of 5.5 pounds, or 6.6% from 3/18/02 to 4/13/02 (26 days). 4/28/02 75.2 pounds. This represents a significant weight loss of 7.3 pounds, or 8.8 % from 3/18/02 to 4/28/02 (41 days). 4/30/02 74.2 pounds. This weight was obtained at the request of the survey team and represents a significant weight loss of 8.3 pounds, or 10% from 3/18/02 to 4/30/02 (43 days). 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,	F 325	**The Charge Nurse initials and dates the page of lab results upon notification of the physician.** **The Ward Clerks will be auditing physician orders to assure follow-up. If there are no lab results in the chart within 24 hours following an order for lab work, the Ward Clerks will call the lab and have them fax the information to the Villa. The nursing staff will use a new tool called the Pressure Ulcer Risk Scale on admission and at every MDS.** **I. Those residents who have been identified as being at high risk for weight loss and/or malnutrition will be monitored closely by the Registered Dietitian and other members of the Weight/Skin Team:** ***Telephone orders need to be written per these interventions:** **1. *Pressure reducing mattress or geomat** **2. *Pressure relieving devices as indicated for care (i.e. elbow protectors, float heels, Spence boots)** **3. *Review with physician for possibility of getting labs (CMP, albumin)**	

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F 325		F 325		

Continued From page 57
American Dietetic Association, 6th edition, 2000, page 14).

On 4/29/02, a review of resident 53's laboratory (lab) values was done. The following albumin (a protein) levels were documented:

3/20/02 2.3 g/dl
3/28/02 3.6 g/dl
4/4/02 2.7 g/dl
4/11/02 2.8 g/dl
4/18/02 3.0 g/dl
4/25/02 2.7 g/dl

With the exception of the value obtained on 3/38/02, all of resident 263's albumin levels were low. 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).

On 4/29/02, resident 53's physician admission orders, dated 3/18/02, were reviewed. It was documented that resident 53 was NPO (receiving nothing by mouth) and was to receive Diabetic Resource at 80 cc (cubic centimeters) per hour for 20 hours or 65 cc per hour for 24 hours via her G-tube.

On 4/29/02, a review of resident 53's physician admission orders, dated 3/18/02, and all physician telephone orders from 3/18/02 through 4/29/02 was done. The following was documented:

Provider's plan of correction (F 325):

4. *Initiate Resource supplement
5. Turn and reposition every two hours if unable to reposition self
6. Head of bed less than 30° unless physician orders alternate
7. Assess level of pain weekly
8. Nutritional assessment by Registered Dietitian
9. Encourage activities and mobility
10. Monitor percentage of meals consumed and notify nurses if intake is poor
11. Complete skin assessment on a weekly basis by Charge Nurse. During bathing, CNA assesses skin and reports to Charge Nurse any skin problems.
12. Scheduled bathing
13. Peri-care after incontinent episodes
14. Toilet every two hours and as needed

II. Residents at low risk:

1. Monitor percentage of meals consumed and notify nurses if intake is poor
2. Complete skin assessment on a weekly basis by the

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F 325	Continued From page 58 On 3/18/02: Diabetic Resource was ordered at 80 cc (cubic centimeters) per hour for 20 hours or 65 cc per hour for 24 hours via her G-tube. On 3/26/02: the facility speech therapist ordered a modified barium swallow study be completed. On 4/2/02: the facility speech therapist documented the following, " Ready to begin diet, gradually wean from G-tube feedings. Diet of soft [with] thins [thin liquids], supervised. Double swallow. Upgrade as tolerated. Oral tablets ok. See formal report." On 4/3/02: Diabetic Resource was ordered to begin every night for 12 hours at 75 cc per hour. On 4/11/02: Diabetic Resource feedings were discontinued. It was documented that this was because the resident was eating 75% of meals. A review of the physician admission orders, dated 3/18/02 and physician progress notes, dated 3/23/02 and 4/18/02, documented that a dietary consult was ordered on 3/18/02 and again on 3/23/02. On 4/29/02, a review of the dietary section of the chart was done. There was no documented evidence that a dietary assessment, assessing resident 53's nutritional needs, the resident's significant weight fluctuations or weight loss, the low albumin levels obtained or the adequacy of the physician ordered tube feedings, had been completed by the registered dietitian. On 3/19/02, an "Initial Nutrition Screening" was completed by the facility nutrition aide. The form listed a series of questions, which would provide each resident with a total score depending on the answers received. Residents receiving a score of 5 or more, per the form, were considered at high nutritional risk and a copy of the	F 325	Charge Nurse 3. During bathing, CNA assesses skin and reports to Charge Nurse any skin problems 4. Scheduled bathing 5. Peri-care after incontinent episodes 6. Head of bed 30° or below unless ordered by physician 7. Toilet every two hours and as needed 8. Encourage activity (i.e. ambulation to bathroom, dining room) Specific orders will be written for interventions such as weekly weights, high protein diet, multi-vitamins, supplements to increase calorie intake, smaller and more frequent meals, enriched cereals for breakfast, and/or enteral feedings as appropriate for each resident at risk. Orders for albumin levels will be written more frequently for those residents found to be at risk for malnutrition. The Nutrition Care Aide will monitor all weights on a weekly basis. She is responsible for entering weights into a computerized tracking program. She will bring printouts of	

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F 325	Continued From page 59 form was to be given to the registered dietitian. Resident 53 received a total score of 6 so would have been considered at high nutritional risk. On the "Initial Nutrition Screening" form resident 53's height was documented as 60" (5 feet) and her weight was documented as 82.5 pounds. Resident 53's nutritional needs were not assessed on this form. A review of the "Nursing Staff Notes", from 3/18/02 through 4/2/02, documented that resident 53 was receiving Diabetic Resource at 65 cc an hour for 24 hours. There was no documentation in the nurses' notes, which addressed the large weight fluctuation from 82.5 pounds on 3/18/02 to 119.5 pounds on 3/30/02. A review of the "Nursing Staff Notes", from 4/3/02 through 4/10/02, documented that resident 53's tube feeding regimen had been changed to Diabetic Resource at 75 cc per hour for 12 hours at night per her physician. There was no documentation in the nurses' notes, which addressed the large weight fluctuation from 82.5 pounds on 3/18/02 to 120.4 pounds on 4/6/02. The following was also documented in the nursing notes: On 4/4/02: the nurse documented that resident 53 had a decreased appetite due to the tube feeding running at night. On 4/7/02: the nurse documented that resident 53 had a fair appetite. On 4/9/02 and 4/10/02: the nurse documented that resident 53 had a good appetite. A review of the "Nursing Staff Notes", from 4/11/02 through 4/19/02, was done. On 4/11/02, the nurse	F 325	residents' weights to the Weight/Skin Team Meetings every week. She will also notify the physician of weight problems long before they would trigger as such on the MDS. The Wound Care Nurse will request a physician's order for an albumin level when she suspects that the resident may be at risk for weight loss/malnutrition or if the Registered Dietitian suggests that obtaining an albumin level would be a prudent intervention. All albumin level results will be called in to the Wound Care Nurse by the Ward Clerk. She will share the results with the Registered Dietitian so that appropriate interventions can be made. The Nutrition Care Aide will be monitoring weights between the quarterly MDS's on a weekly basis. She will be entering and tracking all weights in a computerized program. The Nutrition Care Aide will bring this information to the Weight/Skin Team meetings. The Wound Care Nurse will assure that risk assessments are completed as required and that dietary interventions have been and continue to be implemented. This	

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F 325	Continued From page 60 documented that the Diabetic Resource had been discontinued and the G-tube was to be used for the administration of water and medications. During this time, the nurses documented that resident 53 had a good appetite and was consuming an average of 75% of meals. There was no documented evidence in the nurses' notes, which addressed the significant weight loss from 82.5 pounds on 3/18/02 to 77 pounds on 4/13/02 or the low albumin levels obtained on 4/4/02, 4/11/02 or 4/18/02. A review of resident 53's meal intakes, documented on the "CNA Care Sheet" for April 2002 from 4/1/02 through 4/19/02 was done. Out of a possible 19 breakfast meals reviewed, 1 was documented as 100%, 1 was documented at 75%, 1 was documented at 50%, 11 were documented as 25%, 1 was blank and 4 were documented as NPO. Out of a possible 19 lunch meals reviewed, 1 was documented at 100%, 2 were documented at 50%, 10 were documented as 25%, 1 was documented at 10%, 1 was blank and 4 were documented as NPO. Out of a possible 19 supper meals reviewed, 2 were documented at 75%, 2 were documented at 50%, 3 were documented at 30%, 3 were documented at 25%, 1 was documented at 10%, 5 were blank, and 3 were documented as NPO. On 4/19/02, resident 53 was moved from the facility's transitional care unit to a long term care unit. She was ordered a mechanical soft diet with low concentrated sweets. She was also receiving 300 cc of water through her G-tube every 8 hours. A review of nursing notes, from 4/27/02 through 4/29/02, was done. On 4/23/02 the nurse documented resident 53 had a fair appetite. On 4/24/02 and 4/26/02, the nurse documented resident poor appetite. On 4/27/02, the nurse documented that resident 53 was consuming an average of 50% of meals. On	F 325	**will be done on an ongoing basis as the Wound Care Nurse continues to make her rounds visiting new admissions and assisting the Charge Nurses with oversight of skin integrity for the residents who live at the facility.** **The Weight/Skin Team will produce a summary of pressure ulcer rates and interventions, plus weight loss rates and interventions. The Quality Nurse will report the results to the Quality Committee monthly, along with recommendations for corrective action.** **The Director of Nursing is responsible for implementation of this plan. Corrective action will be completed by May 24, 2002.**	

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F 325	Continued From page 61 4/28/02, the nurse documented that resident 53 was consuming an average of 0-25% of meals and that she refused meals when she had visitors. On 4/26/02, the physician ordered that resident 53 was to receive Diabetic Resource per her G-tube or by mouth 4 times per day and that the amount given was to be charted due to weight loss. The amount of Diabetic Resource to be given was not specified in the physician order. A review of resident 53's "Enteral Flow Sheet" was done. The nurses' initialed that they had given Diabetic Resource but the amount given to the resident each day was not documented. On 4/29/02, at 8:58 AM, a nurse familiar with resident 53's care was interviewed. She was asked how much Diabetic Resource was given to resident 53 each day. She stated that she gave as much as the resident could tolerate. She was asked if the amount of Diabetic Resource given daily varied and she stated, Yes." On 4/29/02, at 9:48 AM, this nurse was interviewed a second time. She stated that she gave resident 53 four cartons (240 cc each) of Resource Diabetic every day. She stated that if less than 240 cc four times daily was given, the nurse would circle their initials on the "Enteral Flow Sheet". A review of all documented physician assessments completed from resident 53's admission on 3/18/02 through 4/29/02 was done. The physician did recommend a dietary consult on 3/23/02 to consider increasing resident 53's tube feeding regimen for weight loss and low albumin levels obtained. This dietary consult was not completed. The weight recorded on the 3/23/02 physician assessment was 82.5 pounds. A follow up physician assessment on 4/18/02 documented a weight of 77 pounds for resident 53, but did not address the significant weight loss of 5.5 pounds or 6.6%, which had occurred between the dates of 3/18/02 and 4/13/02. There was	F 325		

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F 325	Continued From page 62 no documented evidence that the resident's low albumin levels, obtained on 4/4/02, 4/11/02 and 4/18/02, were addressed in the 4/18/02 physician assessment. A review of all lab reports in the medical record documented that the physician had been notified by a nursing staff member of each abnormal lab value obtained. A care plan, initiated 3/18/02, documented that resident 53 was in a state of ill health, malnutrition and wasting secondary to a pancreatic mass causing biliary obstruction. The goal addressing this care plan problem was that resident 53's health, weight and stamina may improve while on the transitional care unit. Approaches to the problem included: nutritionist/dietitian to evaluate the diet. A nutritional care plan, initiated 3/18/02, documented that resident 53 was at risk for decreased nutritional status related to dysphagia secondary to a cerebrovascular accident and would be monitored. The goal addressing this care plan problem was that the resident would have no weight loss greater than 5% and consume greater than 75% of meals daily. Approaches to the problem included, make referral to nutritionist if needed. A tube feeding care plan, initiated 3/18/02, and updated 4/17/02, documented that resident 53 had a feeding tube placed related to a cerebrovascular accident and dysphagia and would be monitored through her stay at the facility. The goal addressing this care plan problem was that the resident would maintain adequate caloric intake daily through her stay on the transitional care unit. Approaches to the problem included, have dietitian monitor for adequate caloric intake, monitor weight as ordered by the	F 325		

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F 325	Continued From page 63	F 325		

physician and "pt [patient] eating fairly well. GT [gastrostomy tube] patent- [water] thru G-tube".

On 4/25/02, at 2:25 PM, the facility nutrition aide was interviewed. She stated that she completes an "Initial Nutrition Screening" form for all newly admitted residents and for residents re-admitted to the facility. She stated that she will usually get answers to the questions asked on the form from the resident. She stated that if the resident could not answer the questions appropriately, she would gather information from the nurse, a certified nurses' aide or the chart. She stated that if the resident was admitted with a pressure sore she would document that information on the form but she was not involved if the resident developed a pressure sore while in the facility. She further stated that she would document the resident's admit weight on the "Initial Nutrition Screening" form but did not address weight loss prior to admission or during the resident's admission. She stated that if a resident received a score of 5 or greater on the "Initial Nutrition Screening" form, she would place a copy of the form in the consultant dietitian's box for her follow up.

On 4/25/02, at 4:43 PM, the consultant dietitian was interviewed. She stated that she was unaware that tube feeding changes were being made. She further stated that she had not made recommendations regarding tube feeding changes.

On 4/29/02, at 11:00 AM, the consultant dietitian was interviewed for a second time. She stated that she was not made aware of resident 53's significant weight loss, low albumin levels or the changes made in her tube feeding regimen.

On 4/25/02, resident 53 was interviewed. She stated that she had a poor appetite and was aware that she

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F 325	Continued From page 64 had lost weight. She stated that the nursing staff had been giving her a supplement via her G-tube and she was not taking it orally.	F 325		
F 329 SS=D	483.25(l)(1) QUALITY OF CARE 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 resident medical records, it was determined that for 2 of 26 sampled residents, the facility did not ensure that each resident's drug regimen was free from unnecessary drugs. Specifically, one resident was receiving an antipsychotic drug without adequate indications for its use as well as lack of adequate monitoring. A second resident was receiving an antihypertensive without adequate monitoring. Resident identifiers: 95 and 57. Findings include: 1. Resident 95 was a 79 year old female who was admitted to the facility on 4/3/02 with the diagnoses of chronic obstructive pulmonary disease (COPD) exacerbation, insulin dependent diabetes mellitus, osteoporosis, depression with anxiety, coronary artery disease, gastroesophageal reflux disease and cor pulmonale.	F 329	**F329** **Resident 95 was admitted with a long-time prescription of ambien for sleep. On May 1, in less than thirty days, the prescription was discontinued due to lack of identified behaviors.** **Resident 95 admitted with zyprexa due to anxiety, apparently in the hospital. No significant behaviors to justify continuation, therefore, dose reduction began May 1, 2002. Results are being monitored by the Psychotropic Committee.** **Responsibility for monitoring the use and related behaviors of psychotropic medications and reporting to the Psychotropic Committee is that of the Lead Social Worker.** **(Resident 57) Nursing staff spoke with the attending physician who felt that the resident's blood pressure was stable enough to give a new order which "D/C all Rx for daily BPs with parameters. Continue weekly BPs."**	5/1/02

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F 329	Continued From page 65 Resident 95 was admitted to the facility from the hospital with orders for Zyprexa (an antipsychotic) 5mg to be given twice a day. The 2001 Nursing Drug Handbook indicates that Zyprexa is used for psychotic disorders. During review of the nursing admission assessment, dated 4/3/02, the nurse documented that resident 95 was "alert, oriented X 3" (to person, place and time) and that her long term memory was intact. On 4/5/02, the facility social worker completed a psychosocial assessment which listed her diagnosis as "COPD with anxious features". Under the heading "Psychiatric history, DX (diagnosis) or medications" the social worker listed "xanax - anxiety r/t (related to) COPD" and "celexa - Dep (depression) r/t (related to) COPD". There was no documentation to evidence that the social worker was aware that resident 95 was receiving Zyprexa, an antipsychotic medication. The psychosocial assessment continued to document that resident 95 was pleasant and cooperative, alert and oriented to person, place and time, that both her long and short term memory were intact, that she was not verbally or physically abusive, she did not resist cares, she was not suspicious, fearful or angry. There was no documentation of any aberrant behaviors that would warrant the use of an antipsychotic medication. On 4/6/02, the Weekly Nursing Summary documented that resident 95 oriented to person, place and time and that she was cooperative. On 4/10/02, the social worker completed a progress note which listed the psychotropic medications that were being received by resident 95. Zyprexa was not listed as one of the psychotropic medications. The	F 329	**The results of the blood pressure checks have been changed to the Medication Record Sheet with the related medication.** **The Ward Clerks will audit Medication Record Sheets at least weekly to identify discrepancies between physician orders and documented activity. Discrepancies will be reported to the Nursing Supervisor the same day, and the action documented.** **Monthly, the Ward Clerk will provide the Director of Nursing a report of compliance with orders and actions taken. The Director of Nursing will report the results quarterly to the Quality Assessment Committee.** **The facility's current policy regarding the use of anti-psychotic medications states that the rationale for use of psychoactive drug intervention must favor the resident and is based on sound risk-benefit analysis of the resident's problem and potential adverse effects of the drug.** **The Psychotropic Team meets the first Wednesday of every month. The team consists of the Medical**	

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F 329	Continued From page 66 social worker documented that resident 95 "can be very demanding on staff and can become very anxious when her call light is not answered promptly." There was still no documentation that the social worker was aware that resident 95 was receiving an antipsychotic. On 4/13/02, the Weekly Nursing Summary documented that resident 95 was oriented to person, place and time and that she was cooperative and anxious. The nurse documented under the "Behavioral problems" section of the weekly nursing summary that resident 95 "cont. (continues) to be very anxious about several problems as they arrive, pt (patient) calms down when someone sits with her, she enjoys company." On 4/15/02, the consulting pharmacist reviewed the medications of resident 95 and made a recommendation to the facility to "Clarify DX (diagnosis) Zyprexa". On 4/23/02, the medical record and medications ordered for resident 95 were reviewed by the registered nurse surveyor. When the medication administration record was reviewed, it was noted that from April 3rd through the 18th, 2002, facility staff did not monitor resident 95 for any aberrant behaviors which would have warranted the use of Zyprexa. It was not until 4/19/02, sixteen days after admission, that facility staff began using a behavior tracking sheet to monitor for behaviors which would warrant the use of Zyprexa. The target behaviors listed on the tracking sheet included "combative with cares, talking with unseen others and accusing others of stealing." For April 19th through the 22nd, staff documented that none of these behaviors were exhibited by resident 95. Further review of the medical record revealed that there was no care plan to	F 329	Director, the Social Worker, two social work designees, the pharmacist and a charge nurse from each unit where the residents live. Each month, the team reviews about one fourth of all residents who are receiving anti-psychotic medications so that each resident is reviewed at least four times each year plus monthly if medications or behaviors change. Team members will include residents on the agenda that need to be discussed the month following medication changes or other issues that may arise. These are working meetings where notes and physician orders are reviewed; the team members all sign a form indicating their presence and participation in the meeting; behavior tracking is discussed, decisions are made for changes in the plan of care and new physician orders are written. This meeting is generally two to three hours long each month. The Lead Social Worker keeps minutes on behavior tracking sheets and reviews them to assure that they accurately depict the behaviors for which the anti-psychotic is being administered. The pharmacist assists with this task by performing	

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F 329	Continued From page 67 address the use of an antipsychotic medication. There was also no documentation to evidence that staff had performed a baseline exam to assess for abnormal involuntary movements (tardive dyskinesia) which can be caused by the use of Zyprexa. Review of the nurses notes in the medical record of resident 95 revealed no documentation to evidence that she was combative with cares, talked with unseen others or accused others of stealing. The charge nurse, who routinely cared for resident 95, was interviewed on 4/24/02. The nurse was asked why resident 95 was on Zyprexa. The charge nurse responded, "For the anxiety and for the psychosis." When asked to clarify what she meant by psychosis, the charge nurse stated that resident 95 "was afraid and brand new to the place and its scary." The charge nurse continued to say that resident 95 gets "panicky about not being able to breathe." The charge nurse denied that resident 95 was ever verbally or physically abusive. The charge nurse did not mention any problems with resident 95 talking to unseen others or accusing others of stealing. During interview with the aide caring for resident 95 on 4/23/02, she was asked if resident 95 was verbally or physically abusive. The aide denied any problems with this and stated that resident 95 was "calm." 2. Resident 57 was an 82 year old female who was admitted to the facility on 10/24/01 with the diagnoses of macular degeneration, hypertension, lung disease, hyponatremia and fluid retention. A review of resident 57's medical record was done on 4/22/02 and revealed the following: A physician order, dated 10/25/01 for resident 57, documented that vitals were to be done every Sunday	F 329	**monthly audits to ensure that anti-psychotics are being given for the appropriate reasons. The results are reported to the Director of Nursing monthly and to the Pharmacy Committee quarterly. The Pharmacy Committee recommendations are forwarded to the Quality Assurance Committee for approval and monitoring.** **The Director of Nursing has overall responsibility to ensure compliance with this regulation.**	

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

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F 329	Continued From page 68 and to record the vital results. A physician order dated 11/13/01 documented resident 57 was to receive a medication, called lisinopril for her hypertension. The order stated, "lisinopril 10 mg (milligrams) every day by mouth ½ tab (tablet) hold if SBP<100" (systolic blood pressure was less than 100). A review of resident 57's recertification of physician orders dated April 2002 was done. The physician orders documented that resident 57 should have her vitals signs taken every Sunday between the hours of 3:00 PM to 11:00 PM. Resident 57's physician ordered to monitor, record and call if systolic blood pressure was less than 90 or if patient has signs and symptoms of hypotension. The care plan for resident 57 dated 11/12/01, included the problem "Decrease cardiac output" due to resident 57 taking a medication for her hypertension. One of the care plan interventions stated "BP(blood pressure) has been <100 (systolic) recently-holding lisinopril until needed. Continue to monitor BP on daily basis." A review of resident 57's Medication Administration Record (MAR) was done. The months of November 2001, December 2001, January 2002, February 2002, March 2002 and April 2002 MARs did not document any blood pressures. A review of resident 57's treatment record was done. The treatment record of resident 57 dated November 2001 stated to perform "vital signs every Sunday monitor and record". The treatment record for December 2001, January 2002 and February 2002 documented that resident 57 was to have "vitals signs every Sunday monitor and record call if SBP < 90 or	F 329		

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F 329	Continued From page 69 if patient has s/s (signs and symptoms) of hypotension/dizziness." The treatment record for March 2002 and April 2002 documented "vital signs monitor and record call if SBP<90 or if patient has s/s of hypotension/dizziness very Sunday." Resident 57's treatment records for the months of November 2001, December 2001, January 2002, February 2002, March 2002 and April 2002 did not document daily blood pressure as ordered by the physician on 11/13/02. A review of resident 57's "Monthly Nursing Summary, Interdisciplinary Progress Notes, Medication Record, and Treatment Record" was reviewed and revealed the following: During the month of November 2001 facility staff had not monitored resident 57's blood pressures since the physician order, dated 11/17/01, 9 out of 14 days. During the month of December 2001 facility staff had not monitored resident 57's blood pressures 22 out of 31 days. During the month of January 2002 facility staff had not monitored resident 57's blood pressures 14 out of 31 days. During the month of February 2002 facility staff had not monitored resident 57's blood pressures 15 out of 28 days. During the month of March 2002 facility staff had not monitored resident 57's blood pressures 22 out of 31 days. During the month of April 2002 facility staff had not monitored resident 57's blood pressures 26 out of 30 days.	F 329		

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F 329	Continued From page 70 A review of the treatment record, medication record, interdisciplinary progress notes, and monthly nursing summary's was done. Resident 57 had low systolic blood pressures for the following days: On 12/23/01 resident 57's systolic blood pressure was 100. Lisinopril was documented as given at 8:00 AM. On 12/30/01 resident 57's systolic blood pressure was 84. Lisinopril was documented as given at 8:00 AM. On 1/6/02 resident 57's systolic blood pressure was 100. Lisinopril was documented as given at 8:00 AM. On 1/7/02 resident 57's systolic blood pressure was 100. Lisinopril was documented as given at 8:00 AM. On 1/12/02 resident 57's systolic blood pressure was 98. Lisinopril was documented as given at 8:00 AM. On 1/14/02 resident 57's systolic blood pressure was 98. Lisinopril was documented as given at 8:00 AM. On 1/17/02 resident 57's systolic blood pressure was 100. Lisinopril was documented as given at 8:00 AM. On 1/18/02 resident 57's systolic blood pressure was 100. Lisinopril was documented as given at 8:00 AM. On 1/20/02 resident 57's systolic blood pressure was 98. Lisinopril was documented as given at 8:00 AM. On 1/21/02 resident 57's systolic blood pressure was 80 Lisinopril was documented as given at 8:00 AM. On 1/22/02 resident 57's systolic blood pressure was 90. Lisinopril was documented as given at 8:00 AM.	F 329		

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F 329	Continued From page 71 On 1/23/02 resident 57's systolic blood pressure was 98. Lisinopril was documented as given at 8:00 AM. On 1/27/02 resident 57's systolic blood pressure was 90. Lisinopril was documented as given at 8:00 AM. On 1/28/02 resident 57's systolic blood pressure was 100. Lisinopril was documented as given at 8:00 AM. On 2/3/02 resident 57's systolic blood pressure was 88. Lisinopril was documented as given at 8:00 AM. On 2/17/02 resident 57's systolic blood pressure was 80. Lisinopril was documented as given at 8:00 AM. Resident 57's nurse was interviewed on 4/22/02 at 9:30 AM. The nurse stated that the she did not check resident 57's blood pressures on a daily basis.	F 329	F361 Resident 53 was discharged on May 15, 2002. She moved to California to be closer to her son. Our staff had assisted in arrangements for hospice care in California prior to her discharge.	
F 361 SS=H	483.35(a)(1)-(2) DIETARY SERVICES The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.	F 361	<u>Resident 56</u>: Multi-vitamins Arginade Geomat to bed Geomat to wheelchair Tegasorb dressing Resource Weekly weights Rule out restorative feeding due to late stage Alzheimer's Disease <u>Resident 109</u>: Spence boots Weekly weight Boost three times daily (or Resource) Turn and position every two hours No restorative feeding due to dementia Pressure ulcer resolved	5/24/02

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F 361	Continued From page 72 This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and observations, it was determined that the facility failed to utilize their part-time consultant dietitian in a manner which provided adequate supervision to the facility staff regarding: accurately monitoring and assessing residents at risk for weight loss, malnutrition (low albumin levels) and pressure sores. One of 27 sample residents and 1 additional resident experienced significant weight loss. (Residents 109 and 53). Per interview with the dietician on 4/25/02 and 4/29/02, the dietician had not been notified by the facility of the resident's weight loss. Please also refer to tag F-325. Five of 27 sample residents and 1 additional resident had labs reflecting low albumin (malnutrition) that had not been addressed by the dietician. (Residents 109, 116, 56, 53, 163, and 45). Please also refer to tag F-309. In the case of 4 of the 6 sample residents (residents 116, 109, 95, 42), with pressure sores, an interview on 4/25/02 with the dietician documented that she was not made aware by the facility that the residents had developed pressure sores while in the facility. In regards to resident 56, the dietician was not made aware of the pressure sore development for 51 days after development. In regards to resident 165, the dietician was not made aware of the pressure sore development for 31 days. Please also see F-314. Findings include: In an interview with the dietitian on 4/25/02, she stated that she was in the facility for approximately 10-12 hours a week in which she is responsible for	F 361	**Resident 45:** **High protein diet** **H.S. – snacks** **Clarify diet to regular as tolerated – high protein** **Track behavior of isolating self in room and throwing food away** **Physician appointment for three-month evaluation** **Mattress or geomat to bed** **Keep bed at less than 30° elevation** **Multi-vitamins with minerals** **Gets restorative feeding** **Resource (120 cc three times per day) or Boost (240 cc three times per day)** **Resperidol started** **Weight meeting in two weeks** **Resident 163:** **Nothing by mouth** **Oral care every two hours** **Planned weight change program for weight loss** **Geomat to bed** **Arginine twice daily** **Vitamin B (100 mg) daily** **Vitamin B12 each month** **Aquacel with stratosorb to wound on buttocks** **Turn every two hours and proper positioning** **Hydrocortisone cream** **Foley catheter**	

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F 361	Continued From page 73 assessments and follow-ups for up to 285 residents (173 residents in the facility and at least 80 additional individuals in the assisted living center). She further stated that some of the 10-12 hours a week is also used in the skin/weight meetings. When the dietitian was asked if this was sufficient time to complete the tasks assigned to her, she stated "No". When requested, the facility was unable to produce documentation which indicated the consultant dietitian was "promptly notified" after a significant change in the resident's physical condition, as directed by their own policy. (Refer to F-325 and F-314) Based on observation, interview and medical record, review the facility did not have proper individualized therapeutic diets for its residents to correct nutritional problems. (refer to F-309) The facility failed to provide dietetic supports and services, which maintained the body weights and low albumin levels for each resident as evidenced by: 1. Resident 109, a 98 year-old female, was admitted to the facility on 4/22/02 with diagnoses of hypothyroidism, organic brain syndrome and edema. Resident 109 had significant weight loss of 9.26% in 3 months, an albumin level of 2.4 on 2/15/02 and developed a pressure sore on 2/5/02. The dietitian had not been informed of any of these concerns. 2. Resident 53 was an 82 year old female with diagnoses including cachexia, pancreatic mass causing obstructive jaundice, history of weight loss, right middle cerebrovascular accident with left sided weakness, gastrostomy (G-tube) tube placement secondary to dysphagia and diabetes mellitus. Resident 53 had 2 physician orders, dated 3/18/02	F 361	The job description of the registered dietician was revised May 10, 2002. An additional contracted registered dietician began work May 18, 2002. The hours of the two individuals equate to approximately one full-time registered dietician. One of the two registered dieticians will attend the weekly weight/skin team meeting. They will review the information gathered regarding weight loss and pressure ulcer wounds as well as wounds from other sources. They will also be included in the new pressure ulcer treatment guideline and notification form, which will be implemented after education of the Charge Nurses on May 22, 2002. The role of the nutritional care aide has been revised. The nutritional care aide will gather weight and height information, enter weights into computerized databases which will be available to compare ideal body weight to that of the admitting body weight and weights shown on the weekly or monthly weight forms. These computerized reports will be brought to the weight/skin team meetings weekly.	

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F 361	Continued From page 74 and 3/23/02, to receive a dietary assessment. No dietary assessment was completed. Resident 53 had a significant weight loss of 10% which occurred from 3/18/02 to 4/30/02 (43 days) which was not addressed by the dietician. Based on facility laboratory tests, resident 53 had 5 of 6 albumin levels that were below therapeutic range, resulting in various levels of malnutrition which were not addressed by the dietician. 3. Resident 116, a 66-year-old male, was admitted to the facility on 6/13/01 with diagnoses of quadriplegia, intraspinal abscess, esophageal reflux, and hypothyroidism. Resident 116 developed a pressure sore in the facility and had a low albumin level of 2.7 (moderate low). The dietician was not aware that resident 116 had developed a pressure and there was no dietary intervention from 8/01 to 1/02 addressing the low albumin level or the pressure sores. The dietary assessment was completed 6 months after the first low albumin level was found and 4 months after the pressure sore developed. 4. Resident 56 was a 79 year old female who was admitted to the facility on 12/5/01 with diagnoses of organic brain dysfunction, vertebral fracture, and bipolar disorder. Resident 56 had developed a Stage II pressure sore on 1/27/02. An albumin level of 2.3 (severe) was found on 12/6/01. There was no assessment completed by the dietician until 3/19/02, at which time the dietician determined that the resident required 61 - 84 grams of protein to meet the resident's nutritional needs and promote healing of the pressure sore. Review of the medical record showed that if resident 56 consumed all her meals and drank all the dietary supplement given, the protein intake would have equaled 60 grams and was less than the dietician recommendation. Documentation of meals consumed indicated that	F 361	**The activities of the registered dietician will be reported to the Director of Nursing and the Administrator at least monthly with any recommendations.** **The Quality Assurance Committee will be informed through the activities of the weight/skin team when they provide their summary of weight loss rates and pressure sore rates along with the interventions to the Quality Assessment Committee quarterly.** **The Weight/Skin Care Plan will identify residents at risk for weight loss and malnutrition because it has columns for "current weight, last weight, amount gained or lost and lab work." The Charge Nurse will notify the physician of low protein or albumin levels upon receipt of the lab results.** **The Charge Nurse initials and dates the page of lab results upon notification of the physician.** **The Ward Clerks will be auditing physician orders to assure follow-up. If there are no lab results in the chart within 24 hours following an order for lab work, the Ward Clerks**	

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F 361	Continued From page 75 resident 56 averaged approximately 50% consumption. 5. Resident 45 was an 86 year old female admitted to the facility on 10/5/01 with the diagnoses of cerebrovascular accident, cerebrovascular disease, atrial fibrillation, constipation, edema, decubitus ulcer, right hip replacement, right hernia, and pneumonia. Resident 45 was admitted to the facility with a pressure sore and developed a second pressure sore on 11/17/01. A low albumin of 2.4 (severe) was found on 11/2/01. The medical record did not contain a dietary assessment to calculate calorie and protein needs for resident 45. 6. Resident 163 was and 81 year old male admitted to the facility on 11/6/01 with diagnoses which included right sided hemiparesis secondary to cardiovascular accident, anemia, congestive heart failure, hypertension, pneumonia, aphasia, depression, and seizure disorder. An initial nutrition screening was completed by the nutrition aide, on 11/7/01, which rated resident 163 as high nutrition risk. The initial assessment by the dietician was completed 11/9/01 and documented that the facility needed to obtain a weight and height and laboratory values were needed in order to determine caloric, fluid and protein needs of the resident.. A albumin level was obtained on 11/15/01 of 2.7 reflecting a moderate protein depletion. No further nutritional assessment was completed until 3/12/02, approximately 4 months after admission. 7. Resident 165 was 88 year old female admitted to the facility on 2/9/01 with diagnoses which included dementia, transient ischemic attacks, lumbago, renal insufficiency, degenerative joint disease, pancreatic mass and digestive neoplasm. Resident 165 was re-admitted to the facility, on 9/24/01, following a	F 361	**will call the lab and have them fax the information to the Villa.** **Those residents who have been identified as being at high risk for weight loss and/or malnutrition will be monitored closely by the Registered Dietitian and other members of the Weight/Skin Team.** **Orders for albumin levels will be written more frequently for those residents found to be at risk for malnutrition.** **The Wound Care Nurse will request a physician's order for an albumin level when she suspects that the resident may be at risk for weight loss/malnutrition or if the Registered Dietitian suggests that obtaining an albumin level would be a prudent intervention. All albumin level results will be called in to the Wound Care Nurse by the Ward Clerk. She will share the results with the Registered Dietitian so that appropriate interventions can be made.** **The Director of Nursing will be responsible for overseeing the implementation of the registered dietician's responsibilities and implementation of the added duties.**	

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F 361	Continued From page 76 temporary discharge for surgical repair of a fracture to her left hip. The resident developed "butterfly" area of stage II and III breakdown on her coccyx on 10/1/01. Two additional pressures with eschar were identified on resident 165 heel's on 10/3/01. The dietician did not conduct a dietary assessment of resident 165's nutritional needs until 11/2/01, 31 days after the resident was identified with pressure sores. 8. Resident 95 was a 79 year old female who was admitted to the facility on 4/3/02 with the diagnoses of chronic obstructive pulmonary disease (COPD) exacerbation, insulin dependent diabetes mellitus, osteoporosis, depression with anxiety, coronary artery disease, gastroesophageal reflux disease and cor pulmonale. Resident 95 was identified with no pressure sores upon admission to the facility. The resident was then identified with 3 pressures ulcers on 4/9/02. There was no dietary assessment to address her nutritional needs. When the dietician was interviewed concerning resident 95, she indicated that she was unaware that they had developed. 9. Resident 42 was an 82-year-old male who was admitted to the facility on 1/10/99 with the diagnosis of diabetes mellitus, Hypertension, glaucoma, atherosclerosis, obstructive ascending cholangitis with gallstones, pancreatitis, choledocholithiasis, chronic cholecystitis. Resident 42 was assessed by the podiatrist on 4/15/02 as having a stage III pressure sore on his left heal. The dietary aide assessed resident 42 on 4/16/02 but the assessment did not contain any information regarding the pressure sore or any potential increase in protein consumption to promote healing. The resident was last assessed by the dietician on 1/31/02. On 4/25/02 the dietician was interviewed and indicated that she was unaware that the resident had developed a pressure sore.	F 361		

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F 361	Continued From page 77	F 361		
F 371 SS=B	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 observation it was determined that the facility did not prepare food under sanitary conditions. Findings include: An inspection of the kitchen was made at 6:30 AM on 4/24/02. Four buckets with towels stored in them were tested with chlorine test strips supplied by a staff member. The test strips turned black in two of the buckets indicating a ppm (parts per million) exceeding 200. The other two buckets remained white when tested indicating a ppm below 10. In order for the sanitizing solution to be effective it must measure between 50 ppm and no more than 200 ppm.	F 371	F371 The Dietary Manager will begin doing daily checks of the solution and report the results monthly to the Quality Committee. The Quality Committee met May 16, 2002 and accepted the new procedure and noted that the new data collection has begun. Responsible party is the Director of Dietary Services.	5/16/02
F 426 SS=E	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 interview and review of resident medical records, it was determined that the facility did not provide pharmaceutical services (including the	F 426	F426 **Physician orders directed that the frequency of the blood sugar levels on resident 42 be taken only twice per day. Resident 29 discharged from the facility April 28, 2002.** **The Ward Clerks have reorganized the medication sheets so that the insulin administration and documentation of blood sugars is**	5/31/02

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F 426	Continued From page 78 accurate administration of all drugs) to meet the needs of its residents. Specifically, of the 26 sampled residents, 4 were insulin dependent diabetics. Two of these 4 residents and 1 additional resident with insulin dependent diabetes did not receive the correct amount of regular insulin based upon the sliding scale that was ordered by the physician. (Residents 95, 29 and 42) Additionally, one resident was not administered necessary medications as ordered by the physician on 4/22/02 at 8:00 AM. (Resident 8) Findings include: INSULIN ADMINISTRATION 1. Resident 95 was a 79 year old female who was admitted to the facility on 4/3/02 with the diagnoses of chronic obstructive pulmonary disease (COPD) exacerbation, insulin dependent diabetes mellitus, osteoporosis, depression with anxiety, coronary artery disease, gastroesophageal reflux disease and cor pulmonale. Upon admission to the facility, nurses had physician's orders to provide regular insulin based on the results of resident 95's blood sugars (BS). The sliding scale ordered was as follows: 160 - 200 = 3 U (units) 201 - 250 = 6 U 251 - 300 = 10 U 301 - 350 = 15 U greater than 351 = 20 U Nursing staff at the facility were obtaining resident 95's blood sugars (BS) three times a day (at 6:00 AM, 11:00 AM, and at 4:00 PM) from 4/3/02 through 4/10/02. On 4/11/02, the nurses also began to obtain an additional blood sugar at 8:00 PM.	F 426	all on the same page. They have changed entries in the computer so that it prints out directions indicating where to chart the time, what the blood sugar was, the number of units given, the site and the nurse's initials. It also has a space to initial if the physician was notified. Insulin and blood sugar orders were clarified and rewritten on one page for residents 95 and 42 to make things easier for the nurses to remember to chart the necessary components such as time, blood sugar, units given, site of injection, their initials and whether the physician was notified of certain parameters. The Charge Nurse caring for Resident 8 was spoken to by the Director of Nursing concerning the importance of the medications which were not given to Resident 8. The Nursing Supervisor will review the medication administration record on this unit closely for a two-week period to assure that this resident and others who are attending activities receive their daily routine medications.	

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F 426	Continued From page 79 On 4/4/02 at 11:00 AM, facility staff recorded a BS of 221. Based on the physician's orders, resident 95 should have received 6 units of regular insulin, but instead received 3 units. On 4/4/02 at 4:00 PM, facility staff recorded a BS of 142. Based on the physician's orders, resident 95 should have received no insulin, but instead received 6 units. On 4/4/02 at 11:00 AM, facility staff recorded a BS of 221. Based on the physician's orders, resident 95 should have received 6 units of regular insulin, but instead received 3 units. On 4/5/02 at 11:00 AM, facility staff recorded a BS of 198. Based on the physician's orders, resident 95 should have received 3 units of regular insulin, but instead received none. On 4/5/02 at 4:00 PM, facility staff recorded a BS of 231. Based on the physician's orders, resident 95 should have received 6 units of regular insulin, but instead received none. On 4/12/02 at 4:00 PM, facility staff recorded a BS of 222. Based on the physician's orders, resident 95 should have received 6 units of regular insulin, but instead received none. On 4/16/02 at 6:00 AM, facility staff recorded a BS of 201. Based on the physician's orders, resident 95 should have received 6 units of regular insulin, but instead received none. On 4/16/02 at 11:00 AM, facility staff did not record a BS for resident 95, yet they administered 6 units of regular insulin.	F 426	**The new resident roster being printed out by the Ward Clerks will be helpful in reminding nurses which residents they need to document on for the purposes of changes in condition and notification of the appropriate individuals.** **Ward Clerks will conduct a quality check at least weekly by completing a chart audit. The results of the chart audit will be reported by showing the number of sliding scales indicating a need for change in the dosage and the number not done. This report shall also show action taken at the time of the quality check. The information will be reported to the Director of Nursing, who, in turn, will report to the Quality Assurance Committee.** The form will be developed by May 22, 2002 and presented to the Charge Nurses at their meeting and, and implementation will begin May 23, 2002. A sliding scale protocol has been developed and was approved by the Medical Director in April 2002. It was not implemented prior to the arrival of the survey team, but has been presented to the Charge	

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F 426	Continued From page 80 On 4/17/02 at 4:00 PM, facility staff recorded a BS of 184. Based on the physician's orders, resident 95 should have received 3 units of regular insulin, but instead received none. On 4/18/02 at 11:00 AM, facility staff recorded a BS of 220. Based on the physician's orders, resident 95 should have received 6 units of regular insulin, but instead received none. There was no documentation to evidence that blood sugars were obtained as ordered on 4/21/02 at 11:00 AM and 4:00 PM. There was no documentation to evidence that a blood sugar was obtained as ordered on 4/22/02 at 11:00 AM. 2. Resident 42 was an 82-year-old male who was admitted to the facility on 1/10/99 with the diagnosis of diabetes mellitus. Resident 42's medical record was reviewed on 4/23/02 and 5/1/02. A physician's order dated 11/28/01 documented to administer regular insulin sliding scale PRN (whenever necessary) for resident 42 as follows: BS of 200-250 give 2 units (U) BS of 251-300 give 4 U BS of 301-350 give 6 U BS of 351-400 give 8 U. A physician order dated 12/5/01 documented to monitor resident 42's blood sugars (BS) 4 times a day. Review of resident 42's "Medication and Treatment	F 426	Nurses, and implementation will be overseen by the Director of Nursing. The new protocol will begin May 31, 2002. The Director of Nursing will be notified of sliding scale dosage errors by the Ward Clerks on a weekly basis. A letter is being written by the Director of Quality and Education to inform other physicians who frequently admit individuals to the facility about the sliding scale protocol that has been accepted by our Medical Director. If they also approve of the protocol for use with their residents, we will begin to utilize it when appropriate. For other residents who do not have the Medical Director for their physician, the nurse may inform the ordering physician about our standard protocol to see if he or she is interested in using it. If not, the physician will order whatever he/she feels is most beneficial for the resident. The Director of Nursing is responsible for implementation of this plan.	

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F 426	Continued From page 81 Record" for February 2002, March 2002 and April 2002 revealed the following: February 2002 The "Medication and Treatment Record" for February 2002, documented the insulin administration as follows: On 2/8/02 at 8:00 PM, BS of 224. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U. On 2/12/02 at 8:00 PM, BS of 277. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 4 U. On 2/15/02 at 6:00 AM, BS of 214. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U. On 2/15/02 at 8:00 PM, BS of 278. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 4 U. On 2/16/02 at 5:00 PM, BS of 278. There was documentation to show that 6U of SS insulin had been administered. Resident 42 should have received only 4 U. On 2/16/02 at 8:00 PM, BS of 251. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 4 U. On 2/17/02 at 12:00 PM, BS of 200. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U.	F 426		

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F 426	Continued From page 82 On 2/17/02 at 8:00 PM, BS of 228. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U. On 2/18/02 at 8:00 PM, BS of 241. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U. On 2/22/02 at 8:00 PM, BS of 237. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U. On 2/25/02 at 8:00 PM, BS of 318. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 6 U. On 2/26/02 at 12:00 PM, BS of 301. There was documentation to show that 4U of SS insulin had been administered. Resident 42 should have received 6 U. On 2/26/02 at 5:00 PM, BS of 274. There was documentation to show that 8U of SS insulin had been administered. Resident 42 should have received only 4 U. March 2002 The "Medication and Treatment Record" for March 2002, documented the insulin administration as follows: On 3/1/02 at 8:00 PM, BS of 255. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 4 U. On 3/2/02 at 6:00 AM, BS of 305. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 6 U.	F 426		

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F 426	Continued From page 83 On 3/2/02 at 8:00 PM, BS of 212. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U. On 3/4/02 at 12:00 PM, BS of 306. There was documentation to show that 2U of SS insulin had been administered. Resident 42 should have received 6 U. On 3/9/02 at 5:00 PM, BS of 239. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U. On 3/11/02 at 6:00 AM, BS of 215. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U. On 3/11/02 at 8:00 PM, BS of 217. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U. On 3/12/02 at 8:00 PM, BS of 235. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U. On 3/17/02 at 8:00 PM, BS of 285. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 4 U. On 3/18/02 at 8:00 PM, BS of 322. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 6 U. On 3/21/02 at 8:00 PM, BS of 231. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U. On 3/25/02 at 8:00 PM, BS of 225. There was no	F 426		

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F 426	Continued From page 84 documentation to show that SS insulin had been administered. Resident 42 should have received 2 U. On 3/28/02 at 8:00 PM, BS of 214. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U. On 3/31/02 at 8:00 PM, BS of 262. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 4 U. April 2002 The "Medication and Treatment Record" for April 2002, documented the insulin administration as follows: On 4/1/02 at 8:00 PM, BS of 224. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U of SS insulin. On 4/2/02 at 8:00 PM, BS of 261. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 4 U. On 4/4/02 at 8:00 PM, BS of 202. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U. On 4/5/02 at 8:00 PM, BS of 205. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U. On 4/8/02 at 8:00 PM, BS of 243. There was documentation to show resident 42 received 2U plus an additional 4U of SS insulin. Resident 42 should have received only 2 U.	F 426		

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F 426	Continued From page 85 On 4/9/02 at 8:00 PM, BS of 283. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 4 U. On 4/11/02 at 8:00 PM, BS of 222. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U. On 4/13/02 at 8:00 PM, BS of 212. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U. On 4/14/02 at 8:00 PM, BS of 218. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U. On 4/15/02 at 8:00 PM, BS of 200. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U. On 4/18/02 at 8:00 PM, BS of 271. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 4 U. On 4/22/02 at 8:00 PM, BS of 282. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 4 U. On 4/23/02 at 8:00 PM, BS of 280. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 4 U. On 4/24/02 at 8:00 PM, BS of 251. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 4 U. On 4/26/02 at 8:00 PM, BS of 215. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U.	F 426		

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On 4/27/02 at 8:00 PM, BS of 287. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 4 U.

On 4/28/02 at 8:00 PM, BS of 250. There was no documentation to show that SS insulin had been administered. Resident 42 should have received 2 U.
3. Resident 29, an 81 year old male, was admitted to the facility on 3/19/02 with diagnoses of diabetes mellitus, osteoporosis, renal/ureter disorder, anemia, hypertension, Alzheimer's disease and polymyalgia.

Review of resident 29's medical record on 4/29/02, revealed a nurse's note and a resident care plan dated 3/1/02 that documented the physician had ordered the BS to be monitored daily at 6:00 AM, 11:30 AM and 4:30 PM.

Review of resident 29's MAR for March 2002 and April 2002 indicated resident 29 was to have BS monitored at 6:00 AM. 11:30 AM and 4:30 PM. The MAR also documented resident 29 was to receive sliding scale insulin as follows:

BS of 150 – 200 give 2 units (U).
BS of 201 – 250 give 4 U.
BS of 251 – 300 give 6 U.
BS of 301 – 350 give 8 U.
BS of 351 – 400 give 10 U.
Call physician if BS is above 400 or below 80.

A review of resident 29's MAR for March 2002 and April 2002 revealed the following:

March 2002

On 3/1/02 at 6:30 AM, facility nursing staff documented a BS of 151. There was no

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CHRISTUS ST JOSEPH VILLA	**451 BISHOP FEDERAL LANE SALT LAKE CITY, UT 84115**

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F 426	Continued From page 87 documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/2/02 at 6:30 AM, facility nursing staff documented a BS of 197. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/2/02 at 4:30 PM, facility nursing staff documented a BS of 162. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/3/02 at 6:30 AM, facility nursing staff documented a BS of 152. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/3/02 at 4:30 PM, facility nursing staff documented a BS of 156. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/4/02 at 11:30 PM, facility nursing staff documented a BS of 156. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/5/02 at 4:30 PM, facility nursing staff documented a BS of 170. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/6/02 at 4:30 PM, facility nursing staff documented a BS of 166. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/7/02 at 11:30 AM, facility nursing staff	F 426		

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F 426	Continued From page 88 documented a BS of 163. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/9/02 at 11:30 AM, facility nursing staff documented a BS of 152. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/10/02 at 4:30 PM, facility nursing staff documented a BS of 168. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/11/01 at 11:30 AM, facility nursing staff documented a BS of 152. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/15/02 at 4:30 PM, facility nursing staff documented a BS of 175. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/16/02 at 11:30 AM. Facility nursing staff documented a BS of 163. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/18/02 at 6:30 AM, facility nursing staff documented a BS of 174. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/18/02 at 4:30 PM, facility nursing staff documented a BS of 170. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U.	F 426		

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F 426	Continued From page 89 On 3/19/02 at 4:30 PM, facility nursing staff documented a BS of 163. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/23/02 at 11:30 AM, facility nursing staff documented a BS of 150. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/23/02 at 4:30 PM, facility nursing staff documented a BS of 165. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/25/02 at 6:30 AM, facility nursing staff documented a BS of 208. There was no documentation resident 29 received SS insulin. Resident 29 should have received 4 U. On 3/25/02 at 4:30 PM, facility nursing staff documented a BS of 195. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/28/02 at 11:30 AM, facility nursing staff documented a BS of 179. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 3/29/02 at 11:30 AM, facility nursing staff documented a BS of 168. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. April 2002 On 4/1/02 at 4:30 PM, facility nursing staff documented a BS of 154. There was no	F 426		

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F 426	Continued From page 90 documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 4/5/02 at 11:30 AM, facility nursing staff documented a BS of 184. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 4/5/02 at 4:30 PM, facility nursing staff documented a BS of 176. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 4/7/02 at 4:30 PM, facility nursing staff documented a BS of 182. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 4/9/02 at 6:30 AM, facility nursing staff documented a BS of 171. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 4/9/02 at 4:30 PM, facility nursing staff documented a BS of 250. It was documented that resident 29 received 6U of SS insulin. Resident 29 should have received 4 U. On 4/10/02 at 4:30 PM, facility nursing staff documented a BS of 168. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 4/14/02 at 4:30 PM, facility nursing staff documented a BS of 151. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 4/16/02 at 4:30 PM, facility nursing staff	F 426		

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F 426	Continued From page 91 documented a BS of 156. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 4/20/02 at 6:30 AM, facility nursing staff documented a BS of 226. It was documented that resident 29 received 6 U of SS insulin. Resident 29 should have received 4 U. On 4/20/02 at 4:30 PM, facility nursing staff documented a BS of 272. There was no documentation resident 29 received SS insulin. Resident 29 should have received 6 U. On 4/22/02 at 6:30 AM, facility nursing staff documented a BS of 205. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 4/22/02 at 4:30 PM, facility nursing staff documented a BS of 188. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. On 4/23/02 at 6:30 AM, facility nursing staff documented a BS of 190. There was no documentation resident 29 received SS insulin. Resident 29 should have received 2 U. MORNING MEDICATIONS Resident 8, a 96 year old female, was admitted to the facility on 10/29/01 with diagnoses of congestive heart failure, hypertension, osteoporosis, atrial fibrillation, and esophageal reflux. A review of the physician recertification orders dated 4/3/02 was done on 4/23/02. The recertification orders documented that resident 8 was to receive the	F 426		

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F 426	Continued From page 92 following medications: Digoxin .125 mg every day at 8:00 AM. (heart medication) Imdur 30 mg every morning at 8:00 AM. (blood pressure medication) Lopressor 25 mg every day at 8:00 AM. (blood pressure medication) Calcium with vitamin D 500mg three times daily at 8:00 AM, 12:00 PM and 5:00 PM. (medication for osteoporosis) Prevacid 30 mg every day at 8:00 AM. (medication for esophageal reflux) A review of the medication administration record (MAR) for resident 8 was performed on 4/23/02. During this review, it was noted that there was no documentation to evidence that resident 8 had received her 8:00 AM medications on 4/22/02. These medications included Digoxin, Imdur, Prevacid, Lopressor and Calcium with vitamin D. During review of the Nurse's Medication Notes, a facility nurse documented that the reason resident 8 did not receive her 8:00 AM medications on 4/22/02 was "Resident at activities and got missed."	F 426		
F 490 SS=H	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of	F 490	**F490** **F157: Administrator has hired another full-time registered nurse who will specifically help to implement the plan of correction, and has also hired another registered dietitian so that the facility has two registered dietitians who together will give the facility**	6/1/02

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F 490	Continued From page 93 resident medical records, facility policies and procedures, Quality Steering Committee Minutes, quarterly Quality Assessment Committee minutes and monthly "Pressure Ulcer Reports" during the survey from 4/22/02 through 5/1/02, it was determined that the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical well-being for each resident in the areas of pressure sore treatment and prevention and nutritional asxessment and intervention. The facility was found to be providing Sub-Standard Quality of Care (a pattern of actual harm) in both of these areas. In addition to the finding of Sub-Standard Quality of Care in two areas, isolated instances of actual harm were identified in the ares of weight loss and lack of notification to the physician when there wa a ned to alter the plan of care. The facility was cited for deficient practice in a total of 14 areas, not including this deficiency. Findings include: 1. On May 1, 2002, a Standard Extended survey was completed which resulted in the determination of Sub-Standard Quality of Care. The determination of Sub-Standard Quality of Care was based on the lack of treatment and services to 6 residents with pressure sores [42 Code of Federal Regulation (CFR) 483.25 (c) Tag F314) and the lack of dietary assessment and itervention for 7 residents with laboratory values reflecting malnutrition and/or dietary risk asessments scoring residents at "high risk". [42 CFR 483.25 (a) - m , Tag F - 309]. Pressure Sores: Please see F-314. A pattern of actual harm was identified for 6 residents	F 490	**the equivalent of one FTE registered dietitian. The administrator will also oversee the Quality Steering Committee to which the new Weight/Skin Team will report. The Administrator will be responsible to supervise and discipline employees who do not follow through and correctly implement changes to improve quality care, including the timely notification of attending physicians and the medical director of skin conditions, labs and weight loss.** **<u>F164</u>: Administrator will schedule and require attendance at in-service of all nursing staff and personnel on sensitivity to patient privacy and dignity, particularly when toileting residents. In addition to this specific in-service, the administrator will order monthly orientation and annual in-service training meetings on patient dignity and privacy. Finally, the CNA Educator and the Nursing Supervisors all monitor the delivery of resident services monthly, using a checklist for privacy, dignity and other patient care services. The written results of this monitoring is given to the Quality Committee which the Administrator chairs. The Administrator will have**	

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F 490	Continued From page 94 who developed an avoidable pressure sore and/or did not receive treatment and services to promote healing of a pressure sore. The February 2002 pressure ulcer report, dated 2/21/02, identified the facility's nosocomial pressure ulcer rate at 5.6% which was up from January's rate of 2.8%. Facility administration could not provide any documentation to evidence that it had addressed the increase in the pressure sore rate. When asked if the facility had addressed the increased rate of 5.6% in the next monthly Quality Steering Committee Meeting, the Director of Nurses stated that "For some reason, it (the meeting for March 2002) was cancelled." The facility did not provide minutes to the April 2002 Quality Steering Committee Meeting. There was no documentation in the quarterly Quality Assessment (QA) Committee minutes, dated 4/17/02, to evidence that the QA committee had addressed the increase in the nosocomial pressure ulcer rate. The facility had a skin/weight team which consisted of one registered nurse and one registered dietitian. When asked if there was a written job description for the duties assigned to the skin/weight team, the skin nurse replied, "no." During interview with this team on 4/25/02, they stated that they met weekly to discuss residents with skin and weight issues, but they did not keep any minutes of their meetings to detail what residents were reviewed or what recommendations and interventions were implemented. There was no method to ensure follow-through of recommendations. Also, the registered dietitian confirmed that she was not aware of a number of residents with pressure sores with which survey had concerns.	F 490	**ultimate authority to enforce changes and to discipline staff who do not make necessary changes.** **<u>F282</u>: Administrator has assembled three teams to work on deficiencies, one of which is dedicated to inter-staff and inter-facility communication. The team came up with a new computer form that places all the information about each resident's medications in one place, making it easier for nurses to chart and see blood pressure levels and blood sugar levels and to document whether any medication is appropriate, and if so, how much was administered and whether a physician was contacted if need be. The Administrator is overseeing the DON who is implementing the use of the form and the oversight of medications with the charge nurses and ward clerks.** **<u>F309</u>: Administrator has hired an additional registered dietitian so that the facility now has two registered dietitian who together equal one full time dietitian. In addition, the Administrator has hired a full-time registered nurse whose entire job will be the prevention, assessment and treatment of skin conditions and**	

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F 490	Continued From page 95 The facility was not following its own policy for assessing residents at high risk for pressure sores. The policy stated that "Within the first 8 hours of admission to St. Joseph Villa, each resident will be evaluated to determined those who are at high risk for pressure sores or who have evidence of skin breakdown." During interview with the skin team nurse on 4/25/02 at 2:35 PM, she was asked if the facility performed skin risk assessments. The skin team nurse replied, "We don't do them." When asked how individuals were assessed for the need of pressure relieving devices and other appropriate interventions, the skin team nurse replied, "If they (a resident) come in and they are non-ambulatory or can't turn in their bed or they're incontinent or can't relieve pressure on their own, then you provide pressure relieving devices to their bed and wheelchair." The skin team nurse continued to state that it was left up to "nursing judgement" as to whether an individual needed pressure relieving devices. The facility did not have a formal method to periodically reassess residents who may have become at risk for skin breakdown. During continued interview with the skin team on 4/25/02, they were asked how they became aware of skin breakdown. The skin nurse replied that the nurses were to place that information on a 24 hour report and submit it to her or they sometimes stop her in the hall and inform her of a skin problem. The physician was not notified regarding the development of pressure sores for 3 residents until 6 to 8 days after the nurse's initial identification. Nutritional assessment and intervention: Please see F-309.	F 490	pressure ulcers. Her position will, in fact, be called the "Wound Care Nurse." The Administrator has also purchased two new cameras so that a camera is available in every part of the facility for staff to photograph skin conditions. Finally, the Administrator has changed the job description of a nutrition aide so that her sole responsibility is to monitor weekly and monthly weights of every resident and report to the Quality Committee which the Administrator chairs. Administrator will have the ultimate authority to supervise, hire, fire and discipline any employee who does not adequately follow through on implementing this plan of correction. F314: Administrator has hired an additional registered dietitian so that the facility now has two registered dietitian who together equal one full time dietitian. In addition, the Administrator has hired a full-time registered nurse whose entire job will be the prevention, assessment and treatment of skin conditions and pressure ulcers. Her position will, in fact, be called the "Wound Care Nurse." The dietitians, the wound care nurse, the director of education	

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F 490	Continued From page 96 The facility's consultant dietitian was the only dietitian providing services for the facility. Her contract with the facility allowed her 10 to 12 hours a week in the facility. During those 10 to 12 hours in the facility, the consultant dietitian was responsible for the 173 residents in the facility, as well as all the residents in the facility's assisted living section (at least 80 additional individuals) and was also assigned to attend the weekly skin/weight team meeting. A pattern of actual harm was identified for 7 residents whose laboratory values reflected malnutrition and/or residents with pressure sores who did not receive an evaluation of dietary needs by a dietitian. These same residents received either late, inadequate or no dietary intervention. During interview with the dietitian on 4/25/02, she stated that the person performing the Dietary Risk Assessments "works in the kitchen, but has no formal training." According to the dietician, the information on the assessments completed by this person from the kitchen "was not always accurate". The consultant dietitian stated she was not being informed of residents who scored as "high risk" on the Dietary Risk Assessments although the form directed the evaluator to notify the dietitian. Five of the 7 residents who were scored at a high nutrition risk and/or had laboratory values reflecting malnutrition had not been evaluated by the registered dietitian. One of the seven residents whose laboratory value, dated 12/6/01, reflected severe malnutrition, did not receive any nutritional interventions until 2/4/02, almost 2 months after the malnutrition had been identified. The dietitian did not evaluate this resident until 3/19/02, almost 3 and a half months after the malnutrition had been identified. It should also be noted that the nutritional interventions were	F 490	**and quality, and the daytime nursing supervisors, the nutrition aide, and the physical therapist (upon request) will all constitute the Skin/Weight Committee which will meet weekly and monitor every resident's weight and skin condition, including a new form for assessing skin conditions and notifying family and physicians. The Administrator and the Director of Nursing have developed a new form to be used for assessing skin conditions called "The Pressure Ulcer Risk Scale." It will be and is being used to assess residents at high risk of pressure sore development and dictates a protocol which involves many steps (see form attached). For those residents whom the tool identifies as low risk, a different protocol is implemented. The risk scale tool will be used at admission and with every MDS assessment for every resident. In addition, for those residents who do begin to develop a skin condition, a new Pressure Ulcer Treatment Guideline and Notification will be implemented which establishes treatment protocols and requires that nurses notify the physician, family, dietician and wound care nurse, and gives a place for the nurse to sign**	

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F 490	Continued From page 97 implemented by the skin team nurse, not the dietitian, and did not meet the minimal protein requirements recommended by the dietitian in her evaluation of 3/19/02. The skin/weight team did not keep minutes of its weekly meetings to identify which residents were discussed, what recommendations were made and what interventions were implemented. There was no method to ensure follow-through of recommendations. Neither the quarterly QA minutes (dated 10/17/01, 1/16/02, and 4/17/02) nor the monthly Quality Steering Committee minutes (from July 2001 to February 2002) contained any documentation to evidence that the facility had identified a concern with the lack of nutritional assessments and intervention. 2. In addition to the areas of Sub-Standard Quality of Care stated above, the facility's administration failed to effectively and efficiently use its resources to ensure that each resident attained or maintained their highest practicable physical, mental and psychosocial well-being in the following areas of deficient practice cited during the survey completed 5/1/02. a. Facility administration failed to ensure that the physician was immediately notified regarding significant changes in residents which required the plan of care to be altered. This was cited at an actual harm level. (Refer to F-157) b. Facility administration failed to ensure privacy during personal care for 2 residents. (Refer to F-164) c. Facility administration failed to ensure that residents were free from unnecessary medications.	F 490	**and date that he or she did so. The Skin/Weight Committee will report to the Director of Nurses who will, in turn, report to the Administrator. The Administrator has also purchased two new cameras so that a camera is available in every part of the facility for staff to photograph skin conditions.** **F325: The Administrator has changed the job description of a nutrition aide so that her sole responsibility is to oversee and monitor weekly and monthly weights of every resident and report to the Quality Committee which the Administrator chairs. She will also do on-site observation of meal consumption by the residents in the dining rooms during meals, and she will review CNA charting to ensure that it is coordinated with her observation of how much is consumed by each resident. The Administrator has also hired an additional registered dietitian to increase staffing hours for nutritional assessments. These two dietitians (who together will work one FTE dietitian position) will meet with the nutrition aide and the dietary manager to coordinate residents' nutritional needs.**	

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

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F 490	Continued From page 98 (Refer to F329) d. Facility administration failed to ensure that the Director of Food Service received frequently scheduled consultation from a registered dietitian to attain or maintain the highest practicable physical well-being for its residents. (Refer to F 361.) e. Facility administration failed to ensure the adequate administration of medications to its residents. (Refer to F-426) f. Facility administration failed to ensure that staff followed the plan of care (physician's orders) for its residents. (Refer to F-282) g. Facility administration failed to ensure that the State Nurse Aide Registry was called prior to hiring nurse aides. (Refer to F-496) h. Facility administration failed to ensure that laboratory services were met for its residents. (Refer to F-502) i. Facility administration failed to ensure that medical records were accurately documented and systematically organized. (Refer to F-514) j. Facility administration failed to ensure that residents maintained an acceptable level of nutritional status, specifically body weight. This was cited at an actual harm level. (Refer to F-325) k. Facility administration failed to ensure the Quality Assessment and Assurance Committee, referred to as the Quality Assessment Committee at this facility, developed and implemented appropriate plans of action to correct identified quality deficiencies. (Refer to F-521).	F 490	F329: The Psychotropic Committee meets once a month and consists of the Medical Director, the Pharmacist, the Lead Social Worker, two Social Service designees, and a charge nurse. They review the residents' behavioral tracking sheets, discuss side effects psychotropics may be causing, and talk about whether the drugs can be reduced and whether the family should be consulted. They try to determine whether other interventions which do not require psychotropic medications would be useful. This committee answers to the Administrator. For other medications, the ward clerks have been given an in-service together with the nurses on adequately tracking physician orders for medications and accurately administering them. The Administrator will have ultimate authority to discipline ward clerks and nurses who do not properly implement and document physician orders for medication times and doses.	

F490

F361: The Administrator has hired an additional registered dietitian to double the current hours, and both dietitians together will provide the facility residents with the equivalent of a full-time equivalent dietitian. In addition, the Administrator has changed the job description of the nutrition aide to oversee and monitor the nurses aides taking weekly and monthly weights of every resident. The aide will report to the Weight/Skin Committee. Finally, the Administrator is requiring that the dietary manager, dietitians, and nutritional aide meet on a regular basis to discuss the needs of residents and how to address them.

F371: The Administrator has installed a new dispensing system in the kitchen which ensures that the proper chemical concentration is maintained in the cleaning solution. The Dietary Manager has been instructed to begin doing daily checks on the solution and report the results monthly to the Quality Committee which the Administrator chairs.

F426: The Administrator will receive reports of how the new form is improving the need for and timely administration of drugs in the proper doses, the conformity with physician orders. Where one or more particular nurses fails to achieve the optimal level, the Administrator will order training or discipline as required.

F496: The Administrator directed that Human Resources change the internal policy and procedure to require that Human Resources calls the Nurse Registry each and every time an aide applicant applies. The Administrator also has changed the facility's practice to require that the Human Resources assistant documents the time and date the inquiry was made and who the assistant spoke to and the results of the call (whether the applicant was certified or not).

F502: The Administrator, together with the Director of Nursing, has implemented a new resident roster on which all medications are charted (See form attached). This new procedure will be reviewed by ward clerks to ensure that medications are given timely and exactly as ordered by the physicians.

F514: The Administrator has hired a Medical Records Consultant who will spend at least two days a month to train and consult with the nursing staff and to monitor medical records for completeness and accuracy. In addition, another registered nurse who has long years of experience in long term care has been hired by the Administrator to conduct mock surveys, train the nursing staff on accuracy and timeliness of compliance with physician orders and medical charting.

F521: The Administrator will implement all of the above changes, increase staffing for nutrition, nursing, and medical records consultants, and implement all of the new forms and protocols set out in more detail above.

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F 490	Continued From page 99	F 490		
F 496 SS=D	483.75(e)(5)-(7) ADMINISTRATION 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 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 review of 9 employee records on 4/24/02, and a telephone interview with an employee of the State Nurse Aide Registry, it was determined that the facility did not contact the State Registry on 4 of 9 employees prior to allowing them to serve as a nurse aide in the facility. Employee identifiers: E, F, G and I. Findings include: A review of 9 employee files, randomly selected, was completed on 4/24/02. No documentation could be	F 496	**F496** **The Human Resource procedure for contacting the Registry was changed April 29, 2002 to assure that the Registry is called for all nursing assistant applicants even though it is known that the person is in an approved Certified Nursing Assistant training program or had information requested from a previous state in which they were a Certified Nursing Assistant.** **The Human Resource staff will document the date the Registry was called, the person giving the information, and the results of the call.** **The person responsible for this implementation is the Director of Human Resource.** **The nurse aide registry was called for Employed 'F' on April 25, 2002. She was taking the CNA course at Pioneer Valley Hospital, therefore not certified. Debbie, at the CNA registry, stated that they did not have a record of abuse for her.**	5/21/02

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F 496	Continued From page 100 found in the employee files that the facility had contacted the State Registry on 4 of 9 individuals hired by the facility to work as nurse aides. On April 24, 2002 at approximately 2:00 P.M. a call was placed to the State Registry to inquire if the facility had contacted the registry on the 9 potential nurse aides before they were allowed to work in the facility. The employee of the State Registry stated that the registry had not been contacted by the facility on 4 of the 9 employees in question.	F 496	The nurse aide registry was called for Employee 'E' on April 25, 2002. She was not certified, pending completion of the tests. Debbie, at the registry, stated Employee 'E' does not have a record of abuse in their files. The nurse aide registry was called for Employee 'G' March 28, 2002 and re-verified May 21, 2002. According to Debbie, she was not listed as a CNA and was not shown on the list for abuse.	
F 502 SS=D	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 review of residents' medical records and facility staff interviews, it was determined that the facility did not provide timely laboratory services as ordered by the physician. Specifically, the facility did not obtain a TSH (Thyroid Stimulating Hormone) laboratory test for resident 56. The facility did not obtain a chest x-ray until 8 days after the x-ray was ordered by the physician for resident 57. Findings include: 1. Resident 56 was admitted to the facility on 12/5/01 with the diagnoses of organic brain dysfunction, vertebral fracture, and bipolar disorder. Review of resident 56's medical record, on 4/25/02, revealed a physician's telephone order dated 12/21/02,	F 502	F502 A change will be made to the internal reporting format. Each nursing unit will receive a resident roster each day. The roster will be used in conjunction with the current 24-hour report form as a quick reminder of all the residents who live on that unit. The current 24-hour report form does not list all residents on the unit. The Charge Nurses are required to document on those residents who have had a change in condition. By having a daily roster at the nurses' station, the nurses are finding that it helps them to remember at a glance who they need to document on each day. This should help agency nurses as well.	5/31/02

F496

The nurse aide registry was called for Employee 'I' on April 24, 2002. According to Debbie, she was not certified nor has a record of abuse. She had completed her CNA course work and was scheduled to take the tests.

The Human Resource Clerk is responsible for completing new hire forms that include a space for the date the registry is called, the person contacted and the results. The Human Resource Director is responsible for checking the form for total completion by conducting audits to determine how many of the new hires have had all the required items completed. He will report the results to the Quality Improvement Committee, along with action taken for any incomplete items found.

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F 502	Continued From page 101 which documented to obtain a TSH level. No documentation could be found in resident 56's medical record that the TSH had been done. During an interview with the DON (Director of Nursing) on 4/23/02 at 4:00 PM, it was stated that the facility could not provide the laboratory results for resident 56. 2. Resident 57 was admitted to the facility on 10/24/01 with the diagnoses that include macular degeneration, hypertension, lung disease, hyponatremia, and fluid retention. Review of resident 57's medical record, on 4/22/02, revealed a physician's telephone order dated 11/21/01, which documented to obtain a chest x-ray to rule out tuberculosis. Further review of the medical record for resident 57 revealed that the chest x-ray was performed on 11/29/01, 8 days after it was ordered by the physician.	F 502	The new form was developed and the nursing staff was informed of how to utilize it during their Charge Nurse Meeting on Wednesday, May 22, 2002. Following initial implementation on Thursday, May 23, 2002, the Charge Nurses had made suggestions for change that would make the document work better for them. Final revisions were made, and the Form was implemented following discussion of the process at the Charge Nurse Meeting on Friday, May 31, 2002. It was implemented on Friday, May 31, 2002. **The Ward Clerk will print out the daily rosters and check to see that the 24-hour reports indicate notification of appropriate individuals when changes in resident condition do occur.**	
F 514 SS=D	483.75(l)(1) ADMINISTRATION The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. This REQUIREMENT is not met as evidenced by: Based on interview and review of resident medical records, it was determined that for 1 of 26 sample residents, the facility did not maintain clinical records in accordance with accepted professional standards	F 514	**F514** **Insulin and blood sugar orders were clarified and rewritten on one page for residents 95 and 42 to make things easier for the nurses to remember to chart the necessary components such as time, blood sugar, units given, site of injection, their initials and whether the physician was notified of certain parameters.**	5/25/02

F502

The Ward Clerk will check each nurses station daily for the initiation of physician orders and requests for lab or x-rays. In addition, they will monitor if the lab or x-ray results are in the medical record and if the physician has been contacted with the results.

The Ward Clerk will conduct a quality check of the physician's orders at least weekly. They will report to the Quality Committee the number of orders reviewed, the number of incomplete implementation steps, and actions taken as a result.

The Nursing Supervisor was directed to call the laboratory by the Director of Nursing to see if they could locate a copy of Resident 56's TSH level. After a good deal of time searching, the lab called back and said they had found it in the computer under the first part of this resident's hyphenated last name. The lab sent a copy of the TSH level by fax, and the physician was notified of the results. The copy of the TSH level was placed ;into this resident's medical record.

Resident 57's ex-ray was ordered following a routine TB skin test which was positive. There were no clinical symptoms. The x-ray was obtained after the Thanksgiving holiday weekend. No orders for treatment were given by the physician.

The Director of Nursing will be responsible for overseeing the implementation of these changes.

Complete date: 5/25/02

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F 514	Continued From page 102 and practices that were accurately documented or systematically organized. Resident identifier: 95. Findings include: Resident 95 was a 79 year old female who was admitted to the facility on 4/3/02 with several diagnoses which included insulin dependent diabetes mellitus. Upon admission, the physician ordered the facility staff to obtain blood sugars four times a day and then to administer regular insulin based on the following sliding scale: 160 - 200 3 u (units) 201 - 250 6 u 251 - 300 10 u 301 - 350 15 u greater than 351, 20 u The April 2002 medication administration records (MAR) and treatment sheets for resident 95 were reviewed on 4/23/02. During review of these records, it was noted that the orders for the sliding scale were recorded on four different sheets. Blood sugars were being recorded on five different sheets. The administration of sliding scale regular insulin was documented on three different sheets. The blood sugar for 4/9/02 at 4:00 PM, was recorded as two different results. On page "3 of 4" of the April 2002 MAR, the blood sugar was documented as "132" which would have required no sliding scale insulin. Page "3 of 4" of the April 2002 treatment record documented the blood sugar for resident 95, on 4/9/02 at 4:00 PM, to be 182, which would have required the administration of 3 units of regular insulin. There was no documentation to show whether or not insulin	F 514	**The Ward Clerks have reorganized the medication sheets so that the insulin administration and documentation of blood sugars is all on the same page. They have changed entries in the computer so that it prints out directions indicating where to chart the time, what the blood sugar was, the number of units given, the site and the nurse's initials. It also has a space to initial if the physician was notified of certain parameters when ordered.** **The new computer program which prints out medication and treatment sheets will be visually inspected by the Night Supervisor at the end of each month to assure that physician orders are not duplicated on multiple pages for the next month and to detect any errors. Changes to the medication administration sheets are made at the time that errors are found by the night supervisor.** **Appropriate documentation was addressed at the Charge Nurse Meeting on May 22, 2002. A special educational session on documentation will be held at a Charge Nurse Meeting on May 31, 2002. The guest speaker will be**	

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F 514	Continued From page 103 was provided. The blood sugar for 4/20/02 at 6:00 AM, was recorded as two different results. On page "1 of 4" of the April 2002 Treatment Record, the blood sugar was recorded as 90. On page "2 of 4" of the April 2002 Treatment Record, the blood sugar was recorded as 94. Nurses were documenting several things in the tiny boxes on the MAR and treatment sheets. Some boxes appeared to contain a blood sugar result and units of insulin given. Some boxes appeared to contain staff initials and units of insulin given. Some boxes contained what appeared to be staff initials and a blood sugar result. Nurses were not consistent in what was documented in the boxes. The writing, in many cases, was not legible. After reviewing all of the medication and treatment sheets, it was very difficult, and in a few cases impossible, to determine the results of blood sugar checks and whether or not insulin had been given and it what amount. The third floor nurse supervisor was interviewed on 4/24/02. She was shown the April 2002 MAR and treatment sheets for resident 95. She agreed that it was difficult to determine blood sugar results and what insulin was given, if any.	F 514	**our Medical Records Consultant. Administration has requested that the consultant spend at least two days per month in the facility to help with the chart audits and to assure improvement in our notification, documentation and care delivery process.** **The Director of Nursing is responsible for implementation of this plan. Completion date May 25, 2002.**	
F 521 SS=H	483.75(o)(2)&(3) ADMINISTRATION The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 521	**F521** **The policy and procedure for the Quality Steering Committee and the quality assurance process was updated May 16, 2002. The quality improvement cycle was diagramed as well as a quality assessment and improvement quarterly report was developed to show not only information gathered and the results, but actions taken to improve care or service.**	6/7/02

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F 521	Continued From page 104 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of the facility's Quality Assessment Committee Minutes (dated 10/17/01, 1/16/02 and 4/17/02) and the facility's monthly Quality Steering Committee meeting minutes (dated from July 2001 through February 2002), it was determined that the facility's quality assessment and assurance program failed to identify quality deficiencies regarding the identification, assessment and intervention for residents with malnutrition, resulting in actual harm for 6 of 27 sample residents and 1 additional resident. The facility's quality assessment and assurance committee also failed to identify quality deficiencies regarding the identification, assessment, appropriate treatment and prevention of the development of pressure sores, resulting in actual harm for 6 of 27 sample residents. Both the facility's Quality Assessment (QA) Committee and Quality Steering Committee failed to intervene when members were notified by the skin team nurse, in a written memo dated 2/21/02, that the facility's nosocomial (house acquired) pressure sore rate had increased to 5.6% (an increase from the previous month of 2.8%). In addition to the areas of nutritional intervention (F309) and pressure sores (F314), cited at Substandard levels, the facility's Quality Assessment Committee also failed to identify, establish and implement corrective action plans for the following areas:	F 521	**The procedure for the quarterly Quality Assessment Committee was also updated and the duties of the Quality Assessment Committee outlined.** **The procedure change and the new quality assessment improvement report were adopted by the Quality Steering Committee May 16, 2002.** **The administrative/management team members were presented the new information May 20, 2002 at the monthly Management Meeting, and implementation is to begin immediately.** **The person responsible for overseeing implementation of the new procedures and plan is the Administrator.** **F157: The Director of Nursing will receive a monthly report from the Nursing Supervisors of the number of times interventions were required due to omissions of notification per policy and/or protocol. The Director of Nursing will report the information to the quality Committee along with the actions taken.**	

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F 521	Continued From page 105 a. Notifying the physician of a significant change in resident status (F157); b. Resident personal privacy (F164); c. Following the plan of care (F282); d. Unplanned weight loss (F325); e. Unnecessary medications (F329); f. Dietary staffing (F361); g. Accurate dispensing of insulin to diabetics (F426); h. Administrative services (F490); i. Aide registry (F496); j. Laboratory services (F502); and, k. Medical records (F514). Findings include: 1. The administrator was interviewed on 4/29/02 regarding the facility's Quality Assurance and assessment committee. He stated that the Quality Assessment meetings were held quarterly and were attended by himself, the medical director, the director of nurses, the skin team nurse, and other department heads. The director of nurses was also interviewed on 4/29/02. She stated that they also had a "Quality Steering Committee" which was held monthly and that concerns and issues within the facility were also addressed through those meeting as well as the quarterly QA meetings. 2. Pressure sores - A pattern of actual harm was identified for 6 residents who developed an avoidable pressure sore and/or did not receive treatment and services to promote healing of a pressure sore. The February 2002 pressure ulcer report, dated 2/21/02, identified the facility's nosocomial pressure ulcer rate at 5.6%, which was up from January's rate	F 521	F164: The quality monitor "service delivery" includes a section on privacy and dignity issues. Monthly, the Nursing Supervisors or CNA Educator will complete the monitor. The CNA Educator will report the findings, along with corrective actions, monthly to the Quality Committee. F282: The Ward Clerks will generate a report of their quality checks showing the number of orders and the number of orders with missing steps, along with information regarding action taken, at the time of the quality check. The report will be given to the Director of Nursing who will present the information to the Quality Committee each month. F325: The Weight/Skin Team will produce a summary of pressure ulcer rates and interventions, plus weight loss rates and interventions. The Quality Nurse will report to the Quality Committee monthly, along with recommendations for corrective action. F329: Psychotropic medication usage will be audited monthly by the consulting pharmacist. The results of the audit are reported to	

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F 521	Continued From page 106 of 2.8%. Facility administration could not provide any documentation to evidence that it had addressed the increase in the pressure sore rate. When asked if the facility had addressed the increased rate of 5.6% in the next monthly Quality Steering Committee Meeting, the Director of Nurses stated that "For some reason, it (the meeting for March 2002) was cancelled." The facility did not provide minutes to the April 2002 Quality Steering Committee Meeting. There was no documentation in the quarterly Quality Assessment (QA) Committee minutes, dated 4/17/02, to evidence that the QA committee had addressed the increase in the nosocomial pressure ulcer rate. Pressure sores had also not been addressed on either of the prior two QA meetings. The facility had a skin/weight team which consisted of one registered nurse and one registered dietitian. When asked if there was a written job description for the duties assigned to the skin/weight team, the skin nurse replied, "no." During interview with this team on 4/25/02, they stated that they met weekly to discuss residents with skin and weight issues, but they did not keep any minutes of their meetings to detail what residents were reviewed or what recommendations and interventions were implemented. There was no method to ensure follow-through of recommendations. Also, the registered dietitian confirmed that she was not aware of 4 of the 6 pressure sores with which survey had concerns. The facility was not following its own policy for assessing residents at high risk for pressure sores. The policy stated that "Within the first 8 hours of admission to St. Joseph Villa, each resident will be evaluated to determined those who are at high risk for pressure sores or who have evidence of skin	F 521	**the Director of Nursing monthly and to the Pharmacy Committee Quarterly. The Pharmacy Committee recommendations are forwarded to the Quality Assurance Committee for approval and monitoring.** **Physician orders will be audited on every long-term care resident by the Ward Clerks weekly to identify discrepancies between physician orders and documented activity. Discrepancies will be reported to the Nursing Supervisor the same day and action documented.** **Monthly, the Ward Clerks will provide a report of compliance with orders and action taken to the Director of Nursing. The Director of Nursing will report the information to the Quality Committee.** **F361: The Registered Dietitians will report their findings and activities to the Administrator and Director of Nursing at least monthly with any recommendations. The Quality Committee will be informed of the Registered Dietitians' recommendations by the Director of Nursing, and actions taken.**	

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

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F 521	Continued From page 107 breakdown." During interview with the skin team nurse on 4/25/02 at 2:35 PM, she was asked if the facility performed skin risk assessments. The skin team nurse replied, "We don't do them." When asked how individuals were assessed for the need of pressure relieving devices and other appropriate interventions, the skin team nurse replied, "If they (a resident) come in and they are non-ambulatory or can't turn in their bed or they're incontinent or can't relieve pressure on their own, then you provide pressure relieving devices to their bed and wheelchair." The skin team nurse continued to state that it was left up to "nursing judgement" as to whether an individual needed pressure relieving devices. The facility did not have a formal method to periodically reassess residents who may have become at risk for skin breakdown. During continued interview with the skin team on 4/25/02, they were asked how they became aware of skin breakdown. The skin nurse replied that the nurses were to place that information on a 24 hour report and submit it to her or they sometimes stop her in the hall and inform her of a skin problem. The physician was not notified regarding the development of pressure sores for 3 residents until 6 to 8 days after the nurse's initial identification. 3. Nutritional Assessment and Intervention - The facility's consultant dietitian was the only dietitian providing services for the facility. Her contract with the facility allowed her 10 to 12 hours a week in the facility. During those 10 to 12 hours in the facility, the consultant dietitian was responsible for the 173 residents in the facility, as well as all the residents in the facility's assisted living section (at least 80 additional individuals) and was also assigned to attend the weekly skin/weight team meeting.	F 521	**F426**: Dispensing of insulin will be included in the quality audit conducted by the Ward Clerks on every resident prescribed insulin at least weekly. The results of the audit will be reported by showing the number of sliding scales indicating a need for a change in the dosage and the number not done. Action taken will also be reported. The audit report will be presented to the Quality Committee by the Director of Nursing. **F490**: The Administrative services effectiveness and efficiency will be assessed by the Board of Directors through the reports of the Quality Assurance Committee. The Medical Director chairs the Quality Assurance Committee, plus one or more Board members are members of the Committee. The Committee evaluations and recommendations are reported to the Board of Directors. **F496**: Human Resource audits will be conducted by the Director of Human Resources to determine compliance with all required activities at the time a person is hired or begins work. She will	

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	465095	A. BUILDING ______ B. WING ______	C 05/01/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 521	Continued From page 108 A pattern of actual harm was identified for 7 residents whose laboratory values reflected malnutrition and/or residents with pressure sores who did not receive an evaluation of dietary needs by a dietitian. These same residents received either late, inadequate or no dietary intervention. During interview with the dietitian on 4/25/02, she stated that the person performing the Dietary Risk Assessments "works in the kitchen, but has no formal training." The dietician indicated that the assessments completed by the dietary aide "were not always accurate" and that she was not being informed of residents who scored as "high risk" on the Dietary Risk Assessments although the form directed the evaluator to notify the dietitian. Five of the 7 residents who were scored at a high nutrition risk and/or had laboratory values reflecting malnutrition had not been evaluated by the registered dietitian. One of the 7 residents whose laboratory value, dated 12/6/01, reflected severe malnutrition, did not receive any nutritional interventions until 2/4/02, almost 2 months after the malnutrition had been identified. The dietitian did not evaluate this resident until 3/19/02, almost 3 and a half months after the malnutrition had been identified. It should also be noted that the nutritional interventions were implemented by the skin team nurse, not the dietitian, and did not meet the minimal protein requirements recommended by the dietitian in her evaluation of 3/19/02. The skin/weight team did not keep minutes of its weekly meetings to identify which residents were discussed, what recommendations were made and what interventions were implemented. There was no method to ensure follow-through of any	F 521	**report the results to the Quality Committee, along with action taken for any incomplete items.** **F502: Laboratory and x-ray orders and results will be included in the daily quality check by the Ward Clerks. A weekly report will be generated to show the number of orders reviewed, the number of incomplete implementation steps and actions taken. The reports will be given monthly to the Quality Committee for assessment.** **F514: Dispensing of insulin will be included in the quality audit conducted by the Ward Clerks on every resident prescribed insulin at least weekly. The results of the audit will be reported by showing the number of sliding scales indicating a need for a change in the dosage and the number not done. Action taken will also be reported. The audit report will be presented to the Quality Committee by the Director of Nursing.**	

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F 521	Continued From page 109 recommendations. Neither the quarterly QA minutes (dated 10/17/01, 1/16/02, and 4/17/02) nor the monthly Quality Steering Committee minutes (from July 2001 to February 2002) contained any documentation to evidence that the facility had identified a concern with the lack of nutritional assessments and intervention. (The Quality Steering Committee did not meet in March of 2002.) 4. The facility's QA committee failed to identify and establish corrective action plans to ensure the facility was administered in a manner that enabled it to use it's resources either efficiently or effectively to ensure that residents were provided the opportunity to attain or maintain their highest practicable well-being. 5. The facility's QA committee failed to identify and establish corrective action plans to ensure the physician was notified of significant changes in resident status which would have required a change to the plan of care. This was cited at an actual harm level. 6. The facility's QA committee failed to identify and establish corrective action plans to ensure that unplanned weight loss was addressed. Two residents experienced harm due to the lack of facility intervention for significant weight loss. 7. The facility's QA committee failed to identify and establish corrective action plans to ensure accurate administration of insulin to diabetics. The facility had identified "medication errors", but referred only to "doses missed", not to inaccurate insulin administration. The facility did not provide the results of any follow-up audits for these concerns.	F 521		

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F 521	Continued From page 110 8. The facility's QA committee failed to identify and establish corrective action plans to ensure that physician's orders (plan of care) were being followed. 9. The facility's QA committee failed to identify and establish corrective action plans to ensure that residents did not receive unnecessary medications. 10. The facility's QA committee failed to identify and establish corrective action plans to ensure the nurse aide registry was called prior to the facility hiring nurse aides. 11. The facility's QA committee failed to identify and establish corrective action plans to ensure that laboratory services were provided as ordered by the physician. 12. The facility's QA committee failed to identify and establish corrective action plans to ensure that medical records were accurately documented and systematically organized. 13. The facility's QA committee failed to identify and establish corrective action plans to ensure the personal privacy of residents.	F 521		