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 _____	06/29/2006

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based upon interview and observation, it was determined that the facility did not promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Specifically, it was found that staff did not answer call bells in a timely fashion, did not speak a language understood by residents in their presence, and for one resident, did not ensure water was within reach, resulting in the resident having to ask for help for a task she could perform independently. (Resident Identifiers: 8, 12, 28) Findings included: 1. Resident 12 was admitted to the facility on March 16, 2006 with the diagnoses of fractured neck of femur, reactive psychosis and internal fixation device. On June 26, 2006, resident 12 was observed lying in bed, which was positioned along the west wall. Her water glass was approximately four feet away on her bedside table along the north wall of the room. On June 28, 2006, at 10:05 A.M, again the resident and her water were seen in the same position. At this time, CNA (Certified Nurses Aide) CNA 1 was interviewed. She stated that the resident could not get out of bed by herself, and	F 241	**F241: Quality of Life** This facility does and will continue to promote care of residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her ability. *Resident 12:* Drinking water made available to resident and within her reach while in her room. A smaller cup is provided to facilitate resident independence with drinking. Nursing staff will offer resident a drink with each contact. Resident care plan reviewed and updated to meet resident needs. Nursing associates providing care for resident 12 will be educated about updated care plan by August 18, 2006. Nursing associates will be educated in identifying resident hydration needs, placement of water and other liquids within a resident's reach, and offering of water and other liquids with each contact. An audit, by the nursing leadership, of each resident's treatment plan will be conducted to insure that hydration needs of residents are identified. A weekly random audit of 10 residents on each unit will be completed for one month to inspect placement of water in a resident room. Random audits of 10 residents on each unit will be completed monthly there after. The Director of Nursing or designee will present trends of the audits at least quarterly to the Quality Assurance Council for evaluation and further intervention if needed.	

7/27/06 POC acceptable Completion date 8/18/06 Bbuesenbarker RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Salem Lower — TITLE: Administrator — (X6) DATE: 7/21/06

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

Utah Department of Health
JUL 25 2006
pm 7/21/06
Bureau of Health Facility Licensing
Certification and Resident Assessment

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F 241	Continued From page 1 could not reach her water. On June 28, 2006, at 10:15, RN 1 (Registered Nurse) stated in an interview that, "Every time I come into the room, she asks for water." RN 1 further explained that the water could not be within reach of the resident, because the recliner was beside the bed, and the bedside table was across the room. Neither CNA 1 or RN 1 attempted to position the furniture in a way that would allow the resident access to her water. 2. An interview with resident 28 took place on 06/27/06 at 7:18 AM. Resident 28 who ambulated via wheelchair and needed staff assistance to transfer from bed to wheelchair, and from wheelchair to toilet, stated that she had had to wait from 15-20 minutes to have staff respond to call lights. Resident 28 stated that the problem occurred mostly during the evenings, but that the problem had been experienced on all shifts. It was also stated, by Resident 8, that urinary incontinence had been experienced due to slow response to call lights. 3. A confidential, resident group interview was conducted on 6/27/06. When residents were asked by surveyors if they had any additional concerns, ten out of ten residents stated that they were having trouble understanding staff members due to thick accents or speaking in another language. The residents stated that this made it very difficult for them participate in conversations relating to their cares. The residents also stated that this made them feel insecure or uneasy, as if the staff members were possibly speaking badly about them.	F 241	*Resident 8& 28:* Nursing associates will be educated to answer resident 8 & 28's call-light in a timely manner of five minutes or less by August 18, 2006. Nursing associates will be educated about the importance of timely answering of call lights. A random audit, by the nursing department, 3 times a week for 4 weeks to time response to call lights will be conducted on each unit. Each shift will have at least 4 audits in a 4 week period. Random audits will be conducted at least monthly on each unit thereafter. The Director of Nursing or designee will present trends of the audits at least quarterly to the Quality Assurance Council for evaluation and further intervention if needed. Associates will be in-serviced in the following areas by August 18, 2006 regarding use of foreign language and barriers to communication: • Associates are not to speak in a language other than English while providing cares to the resident unless the resident requires another language to communicate. • There will be at least one associate that has a fluent use of English, without a "thick" accent on each shift. If there is a communication barrier, a resident or associate will request assistance from that associate to insure that communication between resident and associate is adequate.	

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F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility did not ensure housekeeping and maintenance services to maintain a sanitary, orderly, and comfortable interior. Findings included: On 6/29/06 it was observed in the physical therapy room located on the second floor that 10 ceiling tiles were missing, and water stains were present in two locations on the ceiling. On 6/29/06 the physical therapist was interviewed. She stated that the ceiling had been that way all winter. She stated that the patio located outside of the solarium on the third floor had been leaking, and that the facility was unable to repair in during the winter. A resident was observed in the physical therapy room receiving ultra-sound therapy during the interview. The morning of 6/29/06, the following bathrooms were observed to have broken light covers and a missing light cover: 1. Room 3314 - bathroom (broken light cover) 2. Room 3309 - bathroom (broken light cover) 3. Room 3311- bathroom (missing light cover) The morning of 6/29/06, it was observed that 8	F 253	• Associates will be evaluated during the hiring process to insure they have the ability to communicate using the English language. • Plan of correction for concern about use of foreign language will be presented to the resident council before August 18, 2006. Compliance with this communication plan will be monitored through the monthly Resident Council. The Social Service Director or designee will report trends at least quarterly to the Quality Assurance Council for evaluation and further interventions. This plan of correction will be completed by August 18, 2006. F253 A contract was signed prior to the survey for the repair of the roof above the therapy room. The repairs are to be completed by August 1, and the stained ceiling tiles will be addressed by August 15th. Light fixtures and covers were ordered and are scheduled to arrive by 8/7/06. They will be installed by 8/18/06. The light fixtures will be included in a monthly maintenance survey by the Director of Facilities Management. He will present the monitoring tool to the Quality Council August 17th for approval and report the monthly findings and repairs completed to Council.	

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F 253	Continued From page 3 light covers in the entry halls were missing from rooms 3311, 2295, 2253, 2250, 2251, 2258, 2259, and 2261.	F 253		
F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278	**F278: Resident Assessment** This facility does and continues to provide accurate assessment of resident status. A registered nurse conducts and coordinates each assessment with the appropriate participation of health professionals. A registered nurse signs and certifies that the assessment is complete. Each individual that completes a portion of the assessment signs and certifies the accuracy of that portion of the assessment. *Resident 3, 7&21:* Height of resident verified. Significant correct of height for MDS will be completed before August 18, 2006. *Resident 3, 5, 7, 13&16:* The missing AD Face Sheet signatures will be completed by August 18, 2006. An audit, by nursing leadership or designee, of current resident's MDS, including the AD Face Sheet will be audited for certification signatures and corrected as needed. Associates, who participation in the completion of the MDS, will be in-serviced by August 18, 2006 in the following, verifying accuracy of information and certification signatures.	

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F 278	Continued From page 4 Based on record reviews the MDS did not accurately reflect the resident's status or was not certified for 6 of 29 sample residents. Residents: 3, 5, 7, 13, 16 and 21. Findings included: Resident 3 had an MDS inaccuracy for 6/2/06. The MDS documented that resident 3 had gained 5 inches in height as of 6/2/06. Resident 7 had an MDS inaccuracy for 6/15/06. The MDS documented that resident 7 had gained 1 inch in height as of 6/15/06. Resident 21 had an MDS inaccuracy for 6/13/06. The MDS documented that resident 21 had gained 3 inches in height as of 6/13/06. The MDS AD Face Sheet was missing certification signatures for three residents: Resident 3 was missing the AD Face Sheet certification signatures for MDS dated 6/2606. Resident 5 was missing the AD Face Sheet certification signatures for MDS dated 6/11/06. Resident 7 was missing the AD Face Sheet certification signatures for MDS' dated 5/8/06 and 5/26/06. Resident 13 was missing the AD face sheet certification signature for MDS dated 3/18/06. Resident 16 was missing the AD face sheet certification signature for MDS dated 7/27/05.	F 278	All MDS' for a 4 week period will be audited for accuracy of information and certification signatures. Random audits of 10 residents will be completed monthly thereafter. The Director of Nursing or designee will present trends of the audits at least quarterly to the Quality Assurance Council for evaluation and further intervention if needed. This plan of correction will be completed by August 18, 2006.	

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F 279 SS=B	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based upon record review and interview, it was determined that the facility did not use the results of the assessment to develop, review and revise the resident's comprehensive plan of care with measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the assessment or describe in the care plan the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 6 out of 29 sampled residents. (Resident identifiers: 2, 12, 13, 14, 16 and 26)	F 279	**F279: Comprehensive Care Plan** This facility does and will continue to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. *Resident 12& 2:* Care plan for psychotropic drug use has been added to the medical record. *Resident 14:* Care plans for cognitive loss, ADL function, urinary incontinence, psychotropic drug use, and falls has been added to the medical record. *Resident 26:* Care plans for ADL function and psychotropic drug use has been added to the medical record. *Resident 13:* Care plans for pressure ulcer risk, and ADL function has been added to the medical record. *Resident 16:* A Care plan for urinary incontinence has been added to the medical record. Current resident's care plans will be audited by nursing for completeness and corrected as needed. All resident care plans will be reviewed at least quarterly to insure care plans reflect the resident's needs and services. Associates who are responsible for the development and maintenance of the care plans will be in-serviced in timely completion and updating of care plans by August 18, 2006.	

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F 279	Continued From page 6 Findings included: 1. On March 16, 2006, resident 12 was admitted to the facility. A review of resident 12's medical chart was completed on 6/29/06. On April 17, 2006, Seroquel 50 milligrams was ordered by the physician to be given by mouth each evening at bedtime. The RAPs (Resident Assessment Protocols) triggered by the Significant Change Assessment completed on 5/12/06 included psychotropic drug use and had been checked indicating that it would be care planned. No plan of care for psychotropic drug use could be found on the medical record. On June 27, 2006 at 9:30 A.M., RN 2 (Registered Nurse) was interviewed. She stated that antipsychotic drugs prescribed for residents, such as the drug Seroquel, should be addressed in a care plan. 2. Resident 2 was admitted 12/28/05 with diagnoses that included urinary tract infection, morbid obesity, leg wounds, lymphadema, psychotic disorder related to medical condition and atrial fibrilation. A review of resident 2's medical record occurred 06/27/06-06/28/06. Resident 2 was receiving Seroquel 150 mg from 02/01/06-06/06/06.	F 279	All residents that have RAPs generated as part of their assessment will be audits to insure that necessary care plans are present in the medical record for a 4 week period. Random monthly audits of at least 4 residents who have RAPs generated as part of their assessment will be audited to insure necessary care plans are present in the medical record, thereafter. The Director of Nursing or designee will present trends of the audits at least quarterly to the Quality Assurance Council for evaluation and further intervention if needed. This plan of correction will be completed by August 18, 2006.	

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The RAPs (Resident Assessment Protocols) triggered by the Significant Change Assessment completed on 05/04/06 included psychotropic drug use and had been checked indicating that it would be care planned.

No plan of care for psychotropic drug use could be found on the medical record.
3. Resident 14 was admitted to the facility in April of 2006 with diagnoses that included a compound fracture, hypertension and atrial fibrillation.

A review of resident 14's medical record was completed on 6/29/06.

Resident 14 had the following RAPs (Resident Assessment Protocols) generated by her 5/1/06 initial MDS (minimum data set) assessment and checked as care planned:

Cognitive Loss
ADL (Activities of daily living) Function
Urinary Incontinence
Falls
Nutritional Status
Feeding tubes
Pressure Ulcers
Psychotropic Drug Use

Care plans for cognitive loss, ADL (Activities of daily living) function, urinary incontinence, psychotropic drug use and falls were not found on the chart.

4. Resident 26 was admitted to the facility in June of 2006 with diagnoses that included fractures hip, renal failure, hypertension, and depression.

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A review of resident 26's medical record was completed on 6/29/06.

Resident 26 had the following RAPs generated by her 6/15/06 initial MDS assessment and checked as care planned:

ADL (Activities of daily living) Function
Falls
Nutritional Status
Psychotropic Drug Use

Care plans for ADL (Activities of daily living) function, and psychotropic drug use were not found on the chart.

5. Resident 13 was admitted to the facility in March of 2005 with diagnoses that included congestive heart failure, hypertension, peripheral vascular disease, arthritis, seizure disorder, esophageal reflux, hyperlipidemia, personality disorder.

A review of resident 13 's medical record was completed on 6/29/06.

A significant change MDS assessment for resident 13 was completed by facility staff on 3/15/06. Pressure Ulcers were triggered in the problem area on the RAPs. The facility staff

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completed a RAP Assessment on 3/31/06 and determined that a care plan needed to be implemented for the prevention of pressure ulcers.

No plan of care for pressure ulcers could be found on resident 13's medical record.

On 6/27/06 at 3:00 PM., LPN 1 was interviewed. LPN 1 stated that he could not find a care plan for resident 13 for a pressure ulcer but that he would write one.

On 6/27/06 at 3:25 PM, an interview with RN 3 was conducted . RN 3 stated that resident 13 did not have a pressure ulcer so a pressure ulcer care plan was not needed. RN 3 reviewed the RAPs assessment and then said, maybe it is for prevention, we will do it today.

An annual MDS assessment dated 3/31/06 triggered Activities of Daily Living (ADLs) in the problem area on the RAPs. The facility staff completed a RAPs assessment on 3/31/05 and determined that a care plan would be implemented for ADLs needs.

No plan of care for ADLs could be found in resident 13's medical record.

On 6/27/06 at 3:00 PM, an interview with LPN 1 was conducted. LPN 1 stated that he could not find a care plan for resident 13 for ADLs, but that he would write one.

6. Resident 16 was admitted to the facility in July of 2005 with diagnoses that included diabetes, hypothyroidism, congestive heart failure,

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F 279	Continued From page 10 hypertension, arthritis, Parkinson disease, depression, obsessive compulsive disorder, esophageal reflux, and spinal stenosis. A review of resident 16 ' s medical record was completed on 6/29/06. An annual MDS assessment dated 8/9/06, for resident 16 triggered urinary incontinence in the problem area on the RAPs. The facility staff completed a RAPs assessment on 8/09/05 and determined that a care plan would be implemented for urinary incontinence. No plan of care for urinary incontinence could be found in resident 16's medical record. On 6/27/06 at 3:00 PM,. LPN 1 was interviewed. LPN 1 stated that he could not find a care plan for resident 16 for urinary incontinence but that he would write one.	F 279		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations it was determined that the facility did not store, prepare, distribute, and serve food under sanitary conditions.	F 371	**F 371** **1 & 8.** **Action**: In-service training of Cooks regarding the proper cleaning procedures will be completed by July 31, 2006 and conducted by the Food Services Production Manager. New cleaning brushes are being purchased and the training will include proper use of this tool. Both pieces of equipment will be placed on the Sanitation Inspection score sheet when used by the Registered Dietician. The frequency of these thorough inspections will be increased to two a month for the next six months and be reported to the Quality Improvement Council monthly for the same period of time.	

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F 371	Continued From page 11 Findings included: On 6/26/06 at 7:50 AM, observations were done in the kitchen. 1. The large Univex Mixer had dried food on the neck. The counter Kitchenaid Mixer had dried food on the neck. 2. There were two broken light covers and one missing light cover in the food preparation areas. 3. The walk in refrigerator had the following items with no thaw or pull (from freezer) dates: three 6.5 pound cartons previously frozen sliced strawberries, four 1 quart cartons liquid cholesterol free eggs and one unopened case of liquid cholesterol free eggs, three 15 pound boxes of bacon, two 10 pound boxes of pork sausages, one box of thawed waffles dated 10/15, one box of raw chopped clams. 4. Raw chopped clams were stored above "ready to serve" juice cartons. 5. Ground cooked pork and ham was dated 6/22/06. On 6/27/06 at 9:45 AM, observations were done in the kitchen. 6. The dish machine specifications for the final rinse were 180 degrees F (Farenheit) according to the hot temperature requirements attached to the machine. Observations of three time periods revealed that the final rinse did not reach 180 degrees F. At 9:55 AM the final rinse was 170 degrees F for three cycles. At 10:30 AM the final	F 371	**2.** **Action**: 7/18/06 the missing light cover was replaced and four damaged covers were replaced. Light covers will be inspected during Sanitation Inspections performed monthly. **3.** **Action**: A new labeling system which will require notation of 'received date, pull date and use-by-date' will be developed by July 24, 2006. A label will be placed on the item received and dated. A "Daily Check List" for monitoring will be implemented by the Food Services Department Managers beginning July 31, 2006 and posted by the freezer and each refrigerator door. Quarterly reporting of the outcome achieved will occur as a component of the quarterly 'Dietary' report to the Quality Improvement Council for the next two quarters. Continuing in-servicing of all the Food Services Department associates will be completed on August 12, 2006 **4,5 &7.** **Action**: The shelving in the walk-in refrigerator will be labeled by July 31, 2006 which will specifically designate what item(s) can be placed on each shelf. In-service training will be completed August 7, 2006 with Cooks and Dining Room Servers. The 'Daily Check List' being used of to verifying the presence of dates (number 3) will also be used for monitoring the proper storage of food. As with response three, the outcomes achieved will be reported quarterly to the Quality Improvement Council for the next two quarters.	

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 _____	06/29/2006

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 12 rinse was 175 degrees for two cycles. At 1:25 PM the final rinse was 170 degrees for four cycles. 7. Raw pork sausages were stored on a shelf above tortillas in the walk in refrigerator. 8. The large Univex Mixer had dried food on the neck. 9. Clean dishes and plate covers from the dish machine were observed to be stacked wet on solid tray surfaces or nested wet. This does not allow dishes to dry. Moist, warm surfaces are ideal for potential bacterial growth. 10. The Hobart reach in refrigerator had bent, disassembled metal sheeting around motors on top that was covered with black, greasy dust particles. Fan blowers were blowing black dust out to food preparation areas while food was being prepared. 11. An observation of the main floor dining area took place on 06/29/06. At 8:15 AM, a staff person was observed using a tray to serve a resident. The tray with dishes of food was placed in front of a resident. The resident was observed eating food from the dishes, which were still on the tray, for 3 minutes. Another facility staff person was then observed to remove the food dishes from the tray, placing the dishes on the table in front of the resident. The staff person then returned the tray the resident	F 371	**6.** **Action**: Additional in-servicing of associates performing dishwashing was conducted immediately, to demonstrate the appropriate approach when restarting the machine and the correct reading and recording of temperatures. Training will continue throughout the month of July until reliability can be achieved. The faucet and valve on the large soup kettle that allowed bleeding cold water into the hot will be replaced by July 31, 2006. In addition to the temperature readings and recordings conducted by the Dishwashers, random monitoring of the water temperature will be conducted by the Food Services Department Managers, beginning the week of July 31, 2006 and concluding October 31, 2006. **9.** **Action**: Dishwashers will continue to receive on-going training and feedback regarding the appropriate way of allowing the clean dishes to dry prior to stacking. In-service training will be provided by Food Services Department Managers, and Registered Dietician. Complete by July 31st. **10.** **Action**: Work order immediately initiated, sheet metal company contracted to develop and install the appropriate materials to surround the motors and fan blowers on top of the refrigerator. Task completed on July 18, 2006.	

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F 371	Continued From page 13 had been eating from to the tray line where it was used to serve other residents without being washed or sanitized.	F 371	**11.** **Action**: Additional in-service training to include demonstration and practice regarding the proper use of the tray to transport served meal to the resident will be provided to CNAs serving the residents and Dining Room Servers. CNAs will receive in-service training provided by the Chief Nurse Executive and Dining Room Servers will receive additional training provided by the Food Services Dept. Dietary Manager and the Registered Dietician. Both in-service trainings will be completed by August 15, 2006.	
F 426 SS=D	483.60(a) PHARMACY SERVICES - PROCEDURES 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 record review it was determined that for 1 of 29 sampled residents, the facility did not provide pharmaceutical services to meet the needs of 1 out of 29 sampled residents. (Resident identifier:16) Findings included: Resident 16 was admitted to the facility in July of 2005 with diagnoses that included diabetes, hypothyroidism, congestive heart failure, hypertension, arthritis, Parkinson, depression, obsessive compulsive disorder, esophageal reflux, and spinal stenosis. On 6/29/06, a review of resident 16's medical record was completed. Located in the history and physical section of resident 16's chart was a pink form completed by the the resident's physician dated 5/26/06. In the	F 426	**F426: Pharmacy Services Procedure** This facility does and will continue to 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. *Resident 16:* Resident 16 Glipizide order was clarified with the physician and written in the Medication Record June 28, 2006. The electronic medication record program was updated and the ability to split orders was removed. An audit of split orders was completed and found no other resident affected by this process. Nursing associated educated in the clarification and writing of orders, as well as inputting orders into the electronic medical record.	

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F 426	Continued From page 14 Assessment Plan section of the pink form was a listing of diagnoses and medications that were to be administered. One of the diagnoses listed was diabetes. "Glipizide 2.5 mg QAM." was documented. The Monthly Physician Orders, titled "Administrative Data" dated 5/26/06 for resident 16 listed Glipizide 2.5 mg and directly under that Glipizide 5 mg. The following was documented in resident 16's MAR for June of 2006: "*****SPLIT MEDICATION****** 0800 GLIPIZIDE 2.5 MG GLIPIZIDE 5 MG DAILY BEFORE BREAKFAST ORAL DX: Diabetes Start: 02/01/06 Stop: None Ord#000378 Give 30 minutes before meal, preferably breakfast. Do not crush or chew." On 6/26/06 at 4:45 PM, RN 4, who was resident 16's nurse, was interviewed. RN 4 stated that if the pharmacy sends the Glipizide pills in the 2.5 mg dosage, she administers 1 pill of the medication to resident 16. However, RN 4 stated that if the pharmacy sends the Glipizide pills in the 5.0 mg dosage, she splits the pill in half and administers 2.5 mg of the medication to resident 16. RN 4, then opened the medication cart to verify that resident 16 had a bubble pack card containing pills of Glipizide 2.5 mg. It was observed by the surveyor that directly behind the above mentioned card, was a bubble pack card containing pills of Glipizide 5.0 mg..	F 426	The pharmacy consultant or designee will audit resident orders for accuracy on a monthly basis. The pharmacy representative will report quarterly trends to the Quality Assurance Council for evaluation and further intervention as needed. This plan of correction will be completed by August 18, 2006	

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F 426	Continued From page 15 On 6/27/06 at 3:25 PM, RN 3, who was the Resident Care Coordinator for resident 16, was interviewed. RN 3 stated that resident 16's physician's orders documented Glipizide 7.5 mg was to be given daily not 2.5 mg..	F 426		
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based upon observation, it was determined that staff did not wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. Specifically, staff members were observed directly assisting residents without first washing or sanitizing their hands. Findings included: 1. On June 27, 2006, at the breakfast meal, CNA 2 (Certified Nurses Aide), was assisting residents in the 2nd East dining room. Resident 10 and Resident 27 were using their utensils to feed themselves. Resident 10 placed the handle end of her utensil in her mouth. CNA 2 helped her to obtain food onto her utensil and held the handle end of this same utensil to help resident 10 guide the utensil to her mouth. Within moments, and	F 444	**F444: Preventing Spread of Infection** The facility does and will continue to require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. *Resident 5, 10 & 27:* Nursing associates have been educated to use infection control techniques while assisting these residents with eating. Nursing associates will be educated about infection control measures while in the dining room setting. Education includes sanitation of hands while providing assistance of eating when assisting one or more residents at a time and handling of eating utensils, cups and plates to reduce the risk of cross contamination. Nursing will conduct audits of infection control compliance while in the dining room. The audit will occur daily at each meal for one week in each dining room. Random weekly audits of each dining room will occur for 3 months. Meal times will vary for the random audits, with at least one audit per meal time done each week. Audits will then occur monthly thereafter. The Director of Nursing or designee will report quarterly the trends of the audits to the Quality Assurance Council. This plan of correction will be completed by August 18, 2006.	

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F 444	Continued From page 16 without washing or sanitizing his hands, CNA 2 assisted Resident 27 with her utensils and beverage. After the assistance, resident 27 and resident 10 continued to use their utensils to feed themselves. On 6/27/06 at 8:45 AM, observations were done in the 3rd floor solarium/dining room. CNA 3 was observed assisting resident 5 and some other residents handling their spoons, forks, cups, assisting their hands around the coffee mugs, with no washing of hands between assisting different residents. The residents were handling their own utensils and mugs to feed themselves, but they needed assistance to complete the meal. This allowed the possibility of cross-contamination.	F 444		
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514	**F514: Clinical Records** This facility does and will continue to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete: accurately documented; readily accessible; and systemically organized. *Resident 15, 2, &23:* Medications for these residents has been clarified and documented on the medication record as ordered by the physician Nursing associated educated in the clarification and writing of orders, as well as inputting orders into the electronic medical record.	

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F 514	Continued From page 17 Based on record review and interview, it was determined that the facility did not maintain accurate clinical records for 3 out of 29 sampled residents. (Resident identifiers: 2, 15 and 23) Findings included: 1. Resident 15 was admitted to the facility in May of 2006 with diagnoses that included hypertension, Parkinson's diease, peripheral neuropathy and dementia. On 6/29/06 a review of resident 15's medical record was completed. It was documented in resident 15's MAR (medication administration record) that the resident was to be administered a "Lidocaine patch 5% 1 ea (each) prn (as needed) to right knee." A review of resident 15's physician's orders dated 5/18/06, documented that the resident was to be administered "Lidocaine 5% 5in X 6in (inch) 1/2 patch TRNDRML (transdermal)..." On the morning of 6/28/06 the unit secretary was interviewed. When shown the physicians's order, she stated that the Lidocaine order was transcribed incorrectly onto the MAR. 2. Resident 2 was admitted 12/28/05 with diagnoses that included urinary tract infection, morbid obesity, leg wounds, lymphedema, and atrial fibrillation. A review of resident 2's medical record occurred from 06/27/06- 06/28/06.	F 514	Nursing associates will audit all medication order transcription into the electronic medication record and compare with physician order for accuracy. Nursing associates will then audit all new medication order transcription into the electronic medication record and compare with physician order for accuracy daily for one month. Medication Administration Record will then be compared to the physician orders at least monthly thereafter to insure accuracy. The Director of Nursing or designee will report quarterly the trends of the audits to the Quality Assurance Council. This plan of correction will be completed by August 18, 2006	

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Resident 2's physician recertification order dated 06/14/06 listed the following order: "Feeding, Supplemental 120 ML (milliliters) BID (twice a day)/SCH (scheduled dose) PO (by mouth) 02/09."

The order, as transcribed to the MAR, showed the feeding supplement (Argenaid) originally written as 120 ML BID. The 120 ML had a line drawn through it, and 237 ML had been hand written above the crossed out amount.

An interview with a facility LPN 2 (licensed practical nurse) took place on 06/27/06 at 2:06 PM. LPN 2 stated that the order for Argenaid had been changed on the MAR because the supplement was provided in packages marked 237 ML, and that the order was in need of physician clarification.

A physician's order was noted on the residents chart on 06/28/06, dated/timed 06/28/06 11:30 AM, discontinuing the Argenaid supplement.

3. Resident 23 was admitted in June of 2006 with diagnoses that included left hip fracture, dementia, incontinence, and pneumonia.

On 6/29/06, a review of resident 23's medical record was completed.

A review of resident 23's physician's telephone orders dated 6/21/06 documented that the resident was to be administered Namenda 5 mg (milligrams) by mouth twice daily for dementia.

It was documented in resident 23's MAR dated June of 2006 that the resident was to be

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administered Namenda 5 mg daily for dementia.

The MAR was initialed on the 0800 line for Namenda on 6/22/06 through 6/28/06 but no other documentation was found for a second daily dose of Namenda as ordered.

On 6/28/06 at 9:25 AM, an interview with RN 5 was conducted . RN 5 stated that it looked like they messed up, the Namenda should have been on the MAR twice daily.

A review of resident 23's physician's telephone orders dated 6/21/06 documented that the resident was to be administered Levaquin 500 mg by mouth daily for10 days for pneumonia.

It was documented in resident 23's MAR dated June of 2006 that the resident was to be administered Levaquin 500 mg by mouth once a day .
The June 2006 MAR was initialed on the 0800 line for Levaquin for 6/22/06, 6/23/06 and 6/24/06 then an arrow and a stop was written in the inital boxes for 6/25/06, 6/26/06 and 6/27/06 and was blank for 6/28/06.

On 6/28/06 at 9:25 AM, an interview with RN 5 was conducted. RN 5 stated that it looked like they messed up, the Levaquin should have been administered on the MAR for 10 days.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 465095	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/29/2006
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 276	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on chart review and staff interview it was determined that the facility did not have a quarterly Minimum Data Set (MDS) assessment on file for 1 of 29 sampled residents. (Resident 2) Findings included: Resident 2 was admitted 12/28/05 with diagnoses that included urinary tract infection, morbid obesity, leg wounds, lymphedema, and atrial fibrillation. A review of resident 2's medical record occurred from 06/27/06- 06/28/06. Resident 2's medical record contained the following MDS assessments: 01/04/06 annual and 05/04/06 significant change. There should have been a quarterly MDS assessment completed on or about 04/04/06. A medicare 90 day assessment was on the chart, but was not coded as a quarterly assessment. An interview with the MDS coordinator was conducted on 06/29/06 at 9:05 AM. The coordinator stated that a 90 day assessment had been completed for billing purposes, but had not been coded as a quarterly assessment. It was stated that a request for change had been submitted on 06/28/06 to add the quarterly coding to the 90 day assessment. A request for change, adding the quarterly coding to the 90 day assessment, was noted on the medical record dated 06/28/06.
F 286	483.20(d) RESIDENT ASSESSMENT - USE A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review it was determined that 1 of 29 sample residents did not have the previous 15 months of assessments completed in the resident's active record. (Resident identifier: 7)

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 465095	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 6/29/2006
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F 286	Continued From Page 1

Findings included:

On 6/27/06 the medical record of resident 7 was reviewed.

Resident 7 was originally admitted to the facility on 2/13/06. She was discharged with "return anticipated." She was readmitted to the facility on 5/26/06. The Minimum Data Set (MDS) from the past admission was not in the current chart as required.