| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 465110 | A. BUILDING _____ B. WING _____ | 05/10/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 371 SS=E | 483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE<br><br>The facility must store, prepare, distribute, and serve food under sanitary conditions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility did not store, distribute, and serve food under sanitary conditions.<br><br>Findings included:<br><br>On 5/8/06 at 9:35 AM, observations were completed in the kitchen.<br><br>1. The walk-in refrigerator had three five pound rolls of thawed ground beef on a tray. There was no thaw date on any of the rolls of ground beef. On the same tray with the thawing raw ground beef, there was a plastic bag of cooked sliced turkey that had been pulled from the freezer and also had no thaw date.<br><br>2. There were two 32 ounce cartons of thawed Whip Topping labeled keep frozen. There was no thaw date on the cartons. The Whip Topping can be kept 21 days in the refrigerator after thawing.<br><br>3. A dietary worker was observed to take twelve clean blue plastic water pitchers from the dish machine. The pitchers were still wet. The worker stacked and nested the wet pitchers and placed them on a storage shelf in the kitchen. When nested, there was no possibility for the pitchers to dry. Dishes, trays and glasses stored wet allow | F 371 | The Plan of Correction is being submitted with specific requirements and should not be construed as an admission of guilt or agreement with any of the deficiencies cited on the CMMS 2567-L; nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings all conclusions that form the basis for the deficiency.<br><br>The plan of correction also serves as a credible allegation of compliance.<br><br>5/30/06 poc acceptable Compliance date 6/30/06 KBwombaugh KN<br><br>Utah Department of Health 26/258 MAY 25 2006<br><br>**Tag: F-371 Dietary Services** Bureau of Health Facility Licensing, Certification and Resident Assessment<br><br>**Corrective Action for Identified Resident:**<br>No resident identification in 2567<br><br>**Identification of Residents with Potential to be Affected:**<br>All residents have potential to be affected<br><br>**Corrective Action to Prevent Recurrence:**<br>1. Dietary Services Manager will inservice dietary staff on properly placing the thaw dates on food stored in the facility refrigerator. Dietary staff will also be inserviced on not placing raw meat on the same trey as cooked meat. In-services will be completed by 06/20/2006. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Jake Bauer | Executive Director | 5/25/06 |

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.

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 371 | Continued From page 1<br>the possibility for bacteria to multiply in a moist environment and cause possible cross contamination.<br><br>4. On the spice shelf, the white pepper lid was open allowing the possibility of contamination of the product.<br><br>On 5/9/06 at 6:50 AM, observations were completed in the kitchen.<br><br>5. Clean goblets were stored upside down on a tray above the dish machine area. There were water droplets inside the goblets. When wet items are stored upside down on a solid tray or shelf, there is no possibility for them to dry.<br><br>6. The flour bin lid had a 4 inch opening at the center exposing the flour.<br><br>7. On the spice shelf, the ground allspice lid and the white pepper lid were open.<br><br>8. Clean, wet trays were stacked on top of each other in the dish room. At approximately 7:40 AM, the wet trays were set next to the tray line and were used to hold the breakfast meals for the residents. The meal included a banana half that was set directly on the wet tray. The entire tray line service was observed from 7:40 AM to 8:45 AM. All the clean trays were wet.<br><br>9. At approximately 8:55 AM, an aid came into the kitchen and collected approximately 12 clean, wet, nested blue pitchers from a storage shelf in the kitchen. She took an ice chest and water and proceeded to pass the blue pitchers filled with water and ice to individual residents. | F 371 | The Plan of Correction is being submitted with specific requirements and should not be construed as an admission of guilt or agreement with any of the deficiencies cited on the CMMS 2567-L; nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings all conclusions that form the basis for the deficiency.<br><br>The plan of correction also serves as a credible allegation of compliance.<br><br>2. Dietary Services Manager will inservice dietary staff on properly placing the thaw dates on food stored in the facility refrigerator by 06/20/2006.<br>3. Dietary Services Manager will inservice dietary staff on properly placing water pitchers on trays. Pitchers will be placed individually, not stacked on top of one another, on bar-mat liner. This will allow the pitchers to dry, which will lower the risk of bacteria multiplying in a moist environment. Inservice will be completed by 06/20/06.<br>4. Dietary Services Manager will inservice dietary staff on properly closing the lids on open spice containers. This will lower the risk of contamination of the product. Inservice will be completed by 06/20/06. | |

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|---|---|---|---|---|
| F 371 | Continued From page 2<br><br>In interviews with the cook on 5/8/06 and the dietary manager on 5/9/06, they both said that the thawing ground beef should have had a thaw or pull date. There was no tag on the packages or the tray. The cook took a black marker and wrote directly on the plastic packages when this was pointed out to her. They also said that cooked turkey should not be on the same tray with raw ground beef. | F 371 | The Plan of Correction is being submitted with specific requirements and should not be construed as an admission of guilt or agreement with any of the deficiencies cited on the CMMS 2567-L; nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings all conclusions that form the basis for the deficiency.<br><br>The plan of correction also serves as a credible allegation of compliance. | |
| F 463 SS=D | 483.70(f) RESIDENT CALL SYSTEM<br><br>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview it was determined that the facility was not equipped with a functioning communication system from one resident room.<br><br>Findings included:<br><br>1. On 5/8/06 at 12:20 PM, resident 10 was observed to be in her room laying in bed. Resident 10 stated that she has had her call light on for "awhile and nobody comes."<br><br>The following observations were made by a nurse surveyor:<br>a. The call light above resident 10's bed had the red light on. | F 463 | 5. Dietary Services Manager will inservice Dietary staff on properly placing goblets on trays after they have been washed. The goblets will be placed on bar-mat liner. This will allow the goblets to dry appropriately. Inservice will be completed by 06/20/06.<br>6. Dietary Service Manager placed an order for new food storing bins on 05/19/2006. This will eliminate the 4-inch opening in all food storage bins. Inservice will be completed by 06/20/06.<br>7. Please refer to #4 listed above. Inservice will be completed by 06/20/06.<br>8. Dietary Service Manger will inservice dietary staff on how to properly stack trays, which will allow trays to drain and dry appropriately. Inservice will be completed by 06/20/06.<br>9. Please refer to # 3 listed above. Inservice will be completed by 06/20/06. | |

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| F 463 | Continued From page 3<br>b. There was no light signal in the hallway above resident 10's door.<br>c. There was no audible signal being relayed to the nurse's station.<br><br>At 12:30 PM, the nurse surveyor informed the registered nurse (RN) caring for resident 10 that resident 10's call light was not working. The RN went into resident 10's room turned the call light off and then had the resident turn the call light back on. The call light still did not have a light signal in the hallway and there was no audible relay to the nurse's station. | F 463 | The Plan of Correction is being submitted with specific requirements and should not be construed as an admission of guilt or agreement with any of the deficiencies cited on the CMMS 2567-L; nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings all conclusions that form the basis for the deficiency.<br><br>The plan of correction also serves as a credible allegation of compliance. | |
| | At 12:35 PM, the maintenance supervisor went into resident 10's room. He stated that the switch in the bathroom was not lifted up correctly and when that occurs the call light will not work properly. | | **Monitoring/Quality Assurance**<br>Audit tool that addresses #'s 1-9 will be developed by Dietary Service Manager to monitor proper protocols. Dietary Service Supervisor will conduct audits on #'s 1-9, twice a week for six weeks. The Performance Improvement Team (Quality Assurance) will review the results of these audits and further actions will be taken, as the committee deems necessary. | |
| F 502 SS=E | 483.75(j)(1) LABORATORY SERVICES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and medical record review, it was determined that the facility did not obtain timely laboratory services for 5 of 22 sample residents as ordered by the physician. Residents 4, 7, 10, 15 and CL1.<br><br>Findings include: | F 502 | **Responsible Party:**<br>Dietary Service Manger<br><br>**Completion Date:**<br>06/20/2006 | |

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|---|---|---|---|
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| F 502 | Continued From page 4<br><br>1. Resident 7 was admitted to the facility on 6/8/04 with diagnoses which included dementia, diabetes, hyperlipidemia and edema.<br><br>A complete review of resident 7's medical record was completed on 5/10/06.<br><br>On 1/1/05, a physician's ordered was obtained for a HGBA1C (hemoglobin A1C), lipid, CMP (complete metabolic panel) and CBC (complete blood count) every 6 months in June and December.<br><br>There was no documented evidence in the medical record that the HGBA1C, lipid and CMP were completed for June 2005 and December 2005. There was no documented evidence that the CBC for June 2005 was completed.<br><br>On 10/10/05, a physician's order was obtained which documented the following, "Please locate the labs due in June (2005) or draw them. (CBC, CMP, HgbA1C, lipid profile)."<br><br>There was no documented evidence that the CBC was completed.<br><br>On 10/25/06, a physician's order was obtained for a fasting lipid profile in 12 weeks. Based on this order the fasting lipid profile would be due around 1/16/06.<br><br>There was no documented evidence that the fasting lipid profile was completed.<br><br>2. Resident 10 was admitted to the facility on 5/16/05 with diagnoses which included congestive | F 502 | The Plan of Correction is being submitted with specific requirements and should not be construed as an admission of guilt or agreement with any of the deficiencies cited on the CMMS 2567-L; nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings all conclusions that form the basis for the deficiency.<br><br>The plan of correction also serves as a credible allegation of compliance.<br><br>**Tag: F-463 Resident Call System**<br><br>**Corrective Action for Identified Resident:**<br>The call light switch in resident # 10's bathroom was put in the correct position. This facilitates the call light at the bedside to light up in the hall and to ring at the nursing station.<br><br>**Identification of Residents with Potential to be Affected:**<br>All residents have the potential to be affected if the light switch in the resident bathrooms are not in the correct position. | |

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

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| F 502 | Continued From page 5<br><br>heart failure, hypertension, hyperlipidemia, dementia and insomnia.<br><br>A complete review of resident 10's medical record was completed on 5/10/06.<br><br>On 5/19/06, a physician's order was obtained for a CBC and CMP every 6 months.<br><br>There was no documented evidence that the CBC and CMP were completed on or around 11/19/05.<br>3. Resident Cl 1 was admitted to the facility on 2/16/06 with diagnoses that included diabetes mellitus, CVA (cerebral vascular accident), and multiple fractures.<br><br>On 5/9/06, resident Cl 1's medical record was reviewed.<br><br>Resident Cl 1's record documented a physicians order for a PT/INR (protime/international ratio) to be drawn on 3/10/06.<br><br>No documentation of a PT/INR level could be located in the medical record.<br><br>4. Resident 15 was admitted to the facility on 4/14/06 with diagnoses that included depression, anemia and multiple fractures.<br><br>On 5/9/06, resident 15's medical record was reviewed.<br><br>Resident 15's record documented a physicians order on 4/20/06 which stated " CBC, CMP today - Tib/fib Fx...".<br><br>No documentation of CBC or CMP level could be | F 502 | The Plan of Correction is being submitted with specific requirements and should not be construed as an admission of guilt or agreement with any of the deficiencies cited on the CMMS 2567-L; nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings all conclusions that form the basis for the deficiency.<br><br>The plan of correction also serves as a credible allegation of compliance.<br><br>**Monitoring/Quality Assurance:**<br>SDC will perform audits twice a week for three weeks, and then once a week for three weeks. At the completion of the audits the SDC or designee will report compliances to the Performance Improvement Committee (Quality Assurance).Any further audits/reports will be determined by the Committee.<br><br>Maintenance Supervisor or designee will label each resident bathroom call light "On", "Off", and "Neutral" so that staff will be able to visualize the position of the call light switch. | |

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

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|---|---|---|---|
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| F 502 | Continued From page 6<br>located in the medical record.<br>5. Resident 4 was admitted to the facility on 6/17/03 with diagnoses which included senile dementia, urinary tract infection, dehydration, cardiovascular accident, and right hip replacement.<br><br>Resident 4's medical record was reviewed on 5/08/06.<br><br>On 10/18/05 a physician's order was obtained for a CBC and CMP every 6 months due in September and March.<br><br>No documentation of the CBC or CMP for September 2005 could be found in the medical record.<br><br>On 5/9/06, during the mini exit conference the facility administration was given a list of all the missing laboratory values. On 5/10/06, the facility administrative staff were not able to find the missing laboratory values. | F 502 | The Plan of Correction is being submitted with specific requirements and should not be construed as an admission of guilt or agreement with any of the deficiencies cited on the CMMS 2567-L; nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings all conclusions that form the basis for the deficiency.<br><br>The plan of correction also serves as a credible allegation of compliance.<br><br>**Monitoring/Quality Assurance:**<br>SDC will perform audits twice a week for three weeks, and then once a week for three weeks. At the completion of the audits the SDC or designee will report compliances to the Performance Improvement Committee (Quality Assurance).Any further audits/reports will be determined by the Committee.<br><br>**Responsible Party:**<br>Staff Development Coordinator<br><br>**Completion Date:**<br>This will be completed by June 20, 2006. The SDC will be responsible for continued compliance. | |
| F 504 SS=E | 483.75(j)(2)(i) LABORATORY SERVICES<br><br>The facility must provide or obtain laboratory services only when ordered by the attending physician.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review and staff interview, it was determined that the facility did not obtain physician's order before drawing labs on 7 of 22 residents. | F 504 | | |

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| F 504 | Continued From page 7<br><br>Findings include:<br><br>1. Resident 1 was admitted to the facility on 4/12/06 with diagnoses that included Pulmonary contusions, closed head injury, and multiple traumatic fractures.<br><br>On 5/9/06, resident 1's medical record was reviewed.<br><br>Resident 1's record documented a PT/INR performed on 4/20/06.<br><br>No documentation of a physician's order could be located in the medical record.<br><br>2. Resident 5 was admitted to the facility on 2/17/06 with diagnoses that included cardiac dysrhythmias, edema, aphasia, and CVA (cerebral vascular accident).<br><br>On 5/8/06, resident 5's medical record was reviewed.<br><br>Resident 5's record documented a PT/INR performed on 4/7/06, and an Albumin level performed on 4/11/06.<br><br>No documentation of a physician's order could be located in the medical record.<br><br>3. Resident 13 was admitted to the facility on 10/1/03 with diagnoses that included Parkinsons, hypothyroidism, CAD (coronary artery disease), and BPH (benign prostatic hypertrophy).<br><br>On 5/8/06, resident 13's medical record was | F 504 | The Plan of Correction is being submitted with specific requirements and should not be construed as an admission of guilt or agreement with any of the deficiencies cited on the CMMS 2567-L; nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings all conclusions that form the basis for the deficiency.<br><br>The plan of correction also serves as a credible allegation of compliance.<br><br>**Tag: F-502 Laboratory Services**<br><br>**Corrective Action for Identified Resident:**<br>Resident 7 the physician was informed of the missed HGBA1C, lipid, and CMP that were to be obtained in June 2005, and the missed CBC to be done in Oct. 2005, and fasting lipid that was to be done in Jan. 2006. Resident has a physician's order to have CMP, HGBA1C, Lipid Panel, and CBC to be drawn on May 23, 2006 and then every 6 months in May and December.<br><br>Resident 10 physician was informed of missed CBC and CMP that was to be obtained in Nov. 2005. A new order was obtained to draw a CBC and CMP on 5-22-2006. | |

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|---|---|---|---|---|
| F 504 | Continued From page 8<br><br>reviewed. Resident 13's record documented the following lab values:<br>1. A sputum culture obtained on 4/29/06;<br>2. A U/A (urinalysis) completed on 9/14/05;<br>3. A CMP, CBC and TSH (Thyroid Stimulating Hormone) values; drawn on 6/27/06 and 6/29/06.<br><br>No documentation of a physician's order could be located in the medical record.<br><br>4. Resident 14 was admitted to the facility on 6/16/04 with diagnoses that included urosepsis, cellulitis, peripheral neuropathy and dementia.<br><br>On 5/10/06, resident 10's medical record was reviewed.<br><br>Resident 14's record documented a urinalysis obtained on 4/22/06.<br><br>No documentation of a physician's order could be located in the medical record.<br><br>5. Resident CI 1 was admitted to the facility on 2/16/06 with diagnoses that included diabetes mellitus, CVA and multiple fractures.<br><br>On 5/9/06, resident CI 1's medical record was reviewed.<br><br>Resident CI 1's record documented PT/INR's obtained on 3/1/06, 3/6/06, and 4/4/06.<br><br>No documentation of a physicians order could be located in the medical record.<br>6. Resident 17 was admitted to the facility on 2/9/04 with diagnoses which included right hip fracture, chronic aphasia, dementia and thyroid | F 504 | The Plan of Correction is being submitted with specific requirements and should not be construed as an admission of guilt or agreement with any of the deficiencies cited on the CMMS 2567-L; nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings all conclusions that form the basis for the deficiency.<br><br>The plan of correction also serves as a credible allegation of compliance.<br><br>Resident C1 physician was informed of missed lab on 3-10-2006 other labs followed to show no harm. Resident was discharged on 5-06-2006.<br><br>Resident 15 physician was informed of missed CBC and CMP that should have been obtained on 4-20-06. Samples were obtained on 4-21-06 and reported to physician.<br><br>Resident 4 physician informed of missed CBC and CMP for Sept. 2005. Lab was obtained in March 2006. Physician order to continue with CBC and CMP to be done every six months in Sept. and March.<br><br>**Identification of Residents with Potential to be Affected:**<br>All residents who have laboratory order have the potential to be affected | |

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

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| F 504 | Continued From page 9<br>disease.<br><br>A complete review of resident 17's medical record was completed on 5/9/06.<br><br>A review of the laboratory results revealed CBC's (complete blood counts) were completed on 8/4/05, 9/1/05, 10/6/05 and 11/3/05 and a BMP (basal metabolic panel) was completed on 7/26/05.<br><br>Physician orders for these laboratory results could not be located in the medical record.<br><br>On 5/9/06, during the mini exit conference the facility administration was given a list of all the missing laboratory physician orders. On 5/10/06, the facility administrative staff were not able to find the missing laboratory physician orders. | F 504 | The Plan of Correction is being submitted with specific requirements and should not be construed as an admission of guilt or agreement with any of the deficiencies cited on the CMMS 2567-L; nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings all conclusions that form the basis for the deficiency.<br><br>The plan of correction also serves as a credible allegation of compliance.<br><br>**Corrective Action to Prevent Recurrence:**<br>The Licensed nurses and Medical Records staff to be inserviced on May 30, 2006 on new Laboratory procedure. This procedure is to include:<br>A. Lab log that is to be filled out with every lab order. This lab log will include the residents name, room number, type of labs, signature of when lab was drawn and picked up and when lab results are received.<br>B. The lab log is to be checked every day by each licensed nurse. This check is to see if labs that were due on that day have been drawn if not call is to be placed to lab.<br>C. For routine lab draws that are ordered, i.e. a CBC every 6 months, when physician orders are checked at the end of each month for the next month the nurse checking will fill out a requisition form and enter the lab if due the next month into the lab log. | |
| F 514 SS=D | 483.75(l)(1) CLINICAL RECORDS<br><br>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.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by: | F 514 | | |

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| F 514 | Continued From page 10<br><br>Based on medical record review and interview, it was determined that the facility did not maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 1 of 22 sampled residents. Resident identifier 11<br><br>Findings include:<br><br>Resident 11's was admitted to the facility on 12/6/05 with diagnoses which included, diabetes mellitus, hypertension, and methicillin resistant staphylococcus aureus.<br><br>A review of resident 11's medical record was completed on 5/9/06.<br><br>On 3/28/06, a polysomnography study was completed. On 3/30/06, a CPAP (continuous positive airway pressure) titration study was completed. On 4/10/06, the pulmonologist read and interpreted the two studies. The pulmonologist diagnosed resident 11 with severe obstructive sleep apnea, severe baseline hypoxemia and severe sleep fragmentation. The pulmonologist ordered a CPAP at 14 cm of H2O (centimeters of water pressure) with blended oxygen.<br><br>Review of resident 11's medical record revealed no documentation that resident 11 used a CPAP.<br><br>On 5/9/06 at 2:30 PM, the facility nurse who was caring for resident 11 was interviewed. The nurse stated that she was not aware that resident 11 used a CPAP. The nurse reviewed resident 11's treatment sheet and stated it did not include the use of a CPAP. | F 514 | The Plan of Correction is being submitted with specific requirements and should not be construed as an admission of guilt or agreement with any of the deficiencies cited on the CMMS 2567-L; nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings all conclusions that form the basis for the deficiency.<br><br>The plan of correction also serves as a credible allegation of compliance.<br><br>D. After receiving the results of a lab the licensed nurse is to sign off on the lab log that the results have been received and a copy of the results is to be placed in the chart.<br><br>E. After receiving results of lab, the licensed nurse is to check the chart for a copy of the physicians order. If physician order is not in the chart, the physician is to be informed for a clarification . | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 514 | Continued From page 11<br><br>On 5/9/06, resident 11's room was observed to have a CPAP unit and an oxygen concentrator at his bedside.<br><br>On 5/9/06 at 2:50 PM, an interview was conducted with resident 11. He stated that he used the CPAP every night. | F 514 | The Plan of Correction is being submitted with specific requirements and should not be construed as an admission of guilt or agreement with any of the deficiencies cited on the CMMS 2567-L; nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings all conclusions that form the basis for the deficiency.<br><br>The plan of correction also serves as a credible allegation of compliance.<br><br>**Monitoring/ Quality Assurance**<br><br>The Director of Nursing (DNS) or designee will develop an audit tool to audit for presence in chart of physician ordered labs. Audits will be done once a week times six weeks by the DNS or designee with a report to the Performance Improvement Committee (Quality Assurance) at the completion of the audits. Audits and reports will then continue as may be directed by the Committee.<br><br>**Responsible Party:**<br>Director of Nursing<br>Assistant Director of Nursing<br><br>**Completion date:**<br>06/20/2006 | |

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

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DEPARTMENT OF HEALTH AND H AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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**Tag: F-514 Clinical Records**

**Corrective Action for Identified Resident:**
Resident #11 clarification order obtained. Resident now Monitored every night for O2 saturations and documented on treatment administration record.

**Identification of Residents with Potential to be affected:**
All residents with C-PAP /Bi-PAP machines.

**Corrective Action to Prevent Recurrence:**
DNS or designee will inservice all Licensed nurses on correct transcription or MD orders for C-PAP/BI-PAP machines, and correct documentation of usage of C-PAP/Bi-PAP machines.

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