Acceptable POC 4/9/03 Glendi

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465091	A. BUILDING _____ B. WING _____	2/27/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRAPER REHABILITATION & CARE	12702 SOUTH FORT STREET DRAPER, UT 84020

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F 151 SS=B	483.10(a)(1)&(2) EXERCISE OF RIGHTS The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on a confidential group meeting with residents and one additional confidential resident interview, it was determined that the facility did not inform residents of their right to vote and in one case did not help a resident exercise his right to vote. Findings include: During a confidential group meeting held on 2/25/03 at 1:30 PM, 6 of 8 actively participating residents stated that the facility had not informed them of their right to vote. These residents stated that they would like to vote if given the chance. In a confidential interview with one resident on 2/26/03 at 3:10 PM, the resident stated, "I asked a nurse if I could vote last November and the nurse said she had no idea how to go about that". This resident then stated, "I just gave up".	F 151 OK 4/9/03	F151 A copy of Residents Rights is currently given and reviewed with each person who is admitted to the facility, at the time of admission. A special "voter registration information" meeting will be conducted for the residents, to assist those interested in registering to vote. The County Clerk's office has been contacted and is bringing Voter Registration forms to the facility. They will meet with Recreation and Social Services to educate them on the voting registration process. This meeting is set for April 9, 2003. Recreation and Social Services will then hold a special "Voter Registration Meeting" for residents, on April 22, 2003. Recreation will contact each resident in facility who may miss the meeting, and help any who wants to, register to vote. Activities will use a resident roster, to "check off" that each resident has been given a chance to register. Recreation will hold another Resident meeting in August 2003 to ensure that everyone who wants to vote will be registered before the October election. This process will be repeated yearly. In order to help Residents be more aware of their rights, Recreation will review select Residents' Rights in the monthly Resident Council Meeting, and document such in the Resident Council Notes.	
F 156 SS=B	483.10(B)(5) - (10) NOTICE OF RIGHTS AND SERVICES The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and	F 156 OK 4/9/03	Completed by Recreation; monitored by Social Services in Quality Assurance meeting April 23, 2003 and quarterly thereafter.	4/27/03

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 4/8/03

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days aft such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes a description of the manner of protecting personal funds, under paragraph (c) of this section. A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. The facility must comply with the requirements specified in subpart I of part 489 of this chapter relating to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical	F 156	F156 Residents Rights, given to each person admitted to the facility, are also posted on the Information Board, in a prominent place in facility. Information on how to contact the Ombudsman is also displayed at both the front entrance to the facility, and along with advocacy agencies, in a prominent, wheelchair-height poster in a highly visible bulletin board at the entrance to Social Services. Recreation will review select Resident Rights, during the monthly Resident Council. The rights reviewed will be listed in the notes for the meeting. The review will include a discussion of the rights, as well as where to find copies of residents rights, and how to contact the Ombudsman and other advocacy agencies. Recreation will also play "Residents Rights Bingo" with the Residents, on a monthly basis. This will be a regularly scheduled activity listed on the Monthly Recreation Calendar. Social Services will advise Residents and document that each Resident has been made aware of their Resident's Rights and understands them. This will be updated on a yearly basis and kept with the Quality Assurance notes. ---continued---	4/27/03

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F 156	Continued From page 2 treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on a confidential group meeting, one additional resident interview, and staff interviews, it was determined that the facility was not periodically informing residents of their rights as evidenced by: the residents did not know where the resident rights were posted in the facility; when asked, the residents did not know about their rights, including when and how to vote, contacting advocacy agencies, including the ombudsman, reviewing their medical record, attending their interdisciplinary care plan (IDT) meetings. During a confidential group meeting on 2/25/03 at 1:30 PM, 8 of 8 actively participating residents, stated that they were not periodically informed of their resident rights by the facility. They also stated that they did not know where the rights were posted in the building. The residents in the group meeting and one additional resident voiced that they did not have information on who the advocacy agencies were, including the ombudsman. They also were unsure where	F 156	F156 ---continued--- Some very large posters detailing Residents Rights, will be purchased, framed, and hung in at least two prominent areas of the facility. The Ombudsman's office has furnished more of their brightly colored, easy to read posters, detailing how to contact the Ombudsman. At least three of these will be framed and hung in prominent areas of facility by Maintenance, by April 22, 2003. Completed by Recreation, monitored by Social Services. Entire deficiency will be reviewed by the Quality Assurance Committee to ensure continued compliance.	4/29/03

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F 156	Continued From page 3 information on how to contact these agencies was posted in the building. The residents stated they were not made aware that they could look at their medical records, vote or attend their interdisciplinary care plan (IDT) meetings. The residents also stated that their rights were not reviewed routinely in resident council meetings. On 2/26/03 at 9:35 AM, the activity director was interviewed. She stated that she had helped residents conduct the resident council meetings for approximately one and a half years. She stated that during the year and a half she had helped conduct resident council meetings, resident rights were not reviewed. She further stated that about once every six months, the ombudsman would attend the group meetings and explain their role, but information on how to contact advocacy agencies was not routinely reviewed. On 2/26/03 at 9:50 AM, the admissions coordinator was interviewed. She stated that upon admissions, all residents and/or resident representatives, were given a resident rights packet, which they sign as having received. The residents interviewed however, do not feel that the facility routinely reviews their rights with them. Thus, they do not feel fully informed of what rights they possess while in the facility.	F 156	F156 Residents Rights, given to each person admitted to the facility, are also posted on the Information Board, in a prominent place in facility. Information on how to contact the Ombudsman is also displayed at both the front entrance to the facility, and along with advocacy agencies, in a prominent, wheelchair-height poster in a highly visible bulletin board at the entrance to Social Services. To ensure that residents know what their rights are, and how to contact advocacy agencies, the facility will do the following. Some very large posters detailing Residents Rights, will be purchased, framed, and hung in at least two prominent areas of the facility. The Ombudsman's office has furnished more of their brightly colored, easy to read posters, detailing how to contact the Ombudsman. At least three of these will be framed and hung in prominent areas of facility. Completed by Maintenance, monitored by Administrator. Recreation will also review Residents Rights during the monthly Resident Council. The review will include reminding residents where the advocacy information is located, and how to contact them if needed. Completed by Recreation, monitored by Social Services. Entire deficiency will be reviewed by the Quality Assurance Committee to ensure continued compliance.	4/27/03
F 157 SS=D	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	F 157	OK 4/9/03	

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F 157	Continued From page 4 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 record review and interviews the facility did not notify the attending physician for 1 of 15 sampled residents when the resident had a significant change in their condition as evidenced by 1 resident's physician not being notified when there was signs and symptoms of a gastrointestinal bleed, increase in pain, and a need to alter a treatment concerning the resident's poorly fitted leg brace. Resident identifier: 3. Findings include: Resident 3 was an 83 year old female who was admitted to the facility on 11/18/02 with the diagnoses of left total hip arthroscope, chronic obstructive pulmonary disease, anemia, hypertension, dementia with psychotic, anxious and depressive features, peptic	F 157		

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F 157	Continued From page 5 ulcer disease, coronary artery disease, and myocardial infarction. Resident 3's admitting physician orders included an order for the resident to receive aspirin 81 milligrams (mg.) everyday. Resident 3 was discharged to an acute care hospital on 12/15/02, related to gastro-intestinal bleeding. Resident 3 was re-admitted to the facility on 12/18/02, and again discharged to an acute care hospital on 1/6/03, related to a re-dislocation of her hip. Resident 3 was then re-admitted to the facility on 1/21/03. 1. Resident 3's medical records for 11/18/02, 12/18/02, and 1/21/03 admissions were reviewed on 2/25/03 and 3/03/03 and revealed the following documentation. a. A nurse's note, dated 12/1/02 at 12:00 midnight, documented that the resident continued to ooze black colored stool from the rectum. b. A restorative dining progress note, dated 12/3/02 at 5:30 PM, documented, "Resident complaining of her stomach hurting. Drank most of her fluids. Likes to eat saltine crackers." c. A restorative dining progress note, dated 12/04/02., documented, "Breakfast: c/o [complains of] stomach burning, refusal to drink any liquids or eat anything. Nurse notified." d. A nurse' note, dated 12/14/02 at 10:00 AM, documented that resident 3's blood pressure was low at 50/30. The nurse documented that resident 3's attending physician was notified and orders were received to hold the resident's prescribed blood pressure medication for 5 days. The nurse documented that the nursing staff were to monitor resident 3's blood pressure and report back to the physician after 5 days.	F 157		

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F 157	Continued From page 6	F 157		

e. A nurse's note, dated 12/14/02 at 2:00 PM, documented that resident 3 had complaints of not feeling well. The resident's blood pressure was documented to be 48/32 and that resident 3 had four episodes of black colored diarrhea stool. The nurse documented that resident 3 had pale skin. The nurse documented that resident 3's attending physician was notified and a message was left for the resident's daughter.

f. A nurse's note, dated 12/14/02 at 9:00 PM, documented that resident 3's blood pressure was 88/58 and that resident 3 was complaining of abdominal pain. The nurse documented that the resident had not had any further black colored diarrhea stool, so she was unable to test for blood in the stool. The nurse documented that the resident's daughter stated that she did not want the resident hospitalized until the facility staff were certain there was blood in the resident's stool.

g. A nurse's note, dated 12/15/02 at 8:00 AM, documented that resident 3 had a episode of black colored diarrhea stool. The nurse documented possible gastro-intestinal bleeding. The nurse documented that resident 3's attending physician was contacted as well as the resident's granddaughter. The resident was transported to an acute care hospital for further treatment at 10:30 AM.

An interview with resident 3's physician was conducted on 3/05/03 at 3:45 P.M. Resident 3's physician stated that she could not recollect being notified of resident 3's "black farry stool" or "abdominal pain" prior to 12/14/02. The physician stated that if she would have been contacted about any "black tarry stool" that a complete blood count would have been ordered.

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F 157	Continued From page 7 According to the documentation resident 3's physician was not informed about the black tarry stools or resident 3's complaints of abdominal pain, documented in resident 3's medical record until 14 days after the first documentation of a change in resident 3's condition. 2. Resident 3 was admitted to the facility on 11/18/02 with a diagnosis of total hip arthroplasty. The admitting physician orders included an order for an abductor splint to be worn on the left lower extremity at all time except when bathing with supervision. Resident 3 was discharged on 1/6/03 to an acute care hospital related to re-dislocation of her left hip. Resident 3 was then re-admitted to the facility on 1/21/03. A review of the nurse's notes for resident 3 completed on 3/3/03 revealed the following documentation regarding resident 3's leg brace: a. 11/18/02-documented resident 3 was attempting to take the hip brace off. b. 11/21/02-documented resident 3 was experiencing anxiety and wanted a knife to cut the hip brace off. c. 11/25/02-documented resident 3 was attempting to take of the hip brace. d. 11/27/02-documented that resident 3's attending physician believed that resident 3's hip brace was causing the resident pain. Note: Resident 3's orthopedic surgeon was not resident 3's attending physician. e. 11/29/02-documented that resident 3 was found on floor with the hip brace off. f. 12/8/02-documented that resident 3 attempted to take off the hip brace. g. 12/11/02-documented that resident 3 had refused to wear the hip brace.	F 157		

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F 157	Continued From page 8 h. 12/12/02-documented that resident 3 was refusing to wear the hip brace and the staff would try an abductor pillow when the resident refused to wear the hip brace. i. 12/14/02- documented the nurse had place an abductor pillow on resident 3. j. 12/20/02 -documented that resident 3 refused to wear the hip brace. m. Between 12/18/02 and 1/5/03, the nursing staff made several nursing note entries which documented the use of an abductor pillow. A review of physician telephone orders and physician progress notes between, 11/18/02 and 12/15/02, and again between 12/18/02 and 1/6/03 was completed on 3/3/03. There were no physician orders to discontinue resident 3's abductor splint. There were no telephone orders or other documentation to indicate facility staff notified resident 3's orthopedic surgeon that the resident was refusing to wear, or making repeated attempts to remove the abductor splint. Additionally, there were no physician progress notes that addressed resident 3's refusal to wear the abductor brace. On 12/2/02, resident 3 went to the orthopedic surgeon for a follow-up appointment. For this appointment, a facility nurse completed a "Referral To Physicians and Clinics" form. This form includes a section labeled, "Resident's Complaints and Nurses Observations". There was no documentation on this form to indicate resident 3 was refusing to wear, or was making repeated attempts to remove the abductor splint. In an interview with the facility's physical therapist (who was caring for her during this time period), on 3/05/03 at 1:00 PM, the therapist stated that resident 3's abductor brace was not a fitted size for her. The facility's physical therapist stated that resident 3 was not comfortable with the leg brace and it was too large for her. The facility's physical therapist did not call	F 157	Please note: the facility has asked for relief from deficiency F157, through the Informal Dispute Resolution (IDR) process. F157 The Director of Nursing (DON) inserviced all licensed nursing staff on 3/13/03 regarding F157 related to Resident #3. Correct procedures regarding physician notification and documentation of physician notification were discussed. In order to ensure that this deficient practice will not recur with Resident 3 or other Residents, Nursing Administration will implement the following practices: 1) C.N.A. inservicing will be done by Director of Staff Development (DSD) on reporting abnormal findings to licensed nursing staff. This will include signs and symptoms of GI bleeding (i.e. abnormal stool, abnormal vital signs, complaints of abdominal pain); signs and symptoms of generalized pain; and total hip precautions. 2) DON and DSD will provide communication notebooks on the nurses' med carts for C.N.A.'s to write down their concerns for the nurses to follow up. This will not take the palce of verbal reporting, but will enhance the system with an easy check and balance system. This new C.N.A. reporting system to licensed nursing staff of abnormal finding was inserviced by DSD on 3/25/03. The licensed nurses will be inserviced by the DON about this new system. --continued--	4/29/03

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F 157	Continued From page 9 resident 3's orthopedic surgeon about the leg brace not properly fitting. Resident 3's medical record for her 12/18/02 re-admission to the facility did not mention the use of a leg brace nor was there an order for one. On resident 3's "Nursing Admission Assessment" dated 12/18/02, under comments it was documented, "Res. [resident] has had hip relocation but brace has been d/c [discontinued] was sent [with] a wedge to be used when in bed". On 3/05/03 at 3:45 PM, a telephone interview with resident 3's attending physician revealed that she was aware of resident 3's abductor brace not fitting properly. Resident 3's physician stated that she told the facility nursing staff to call resident 3's orthopedic surgeon about the poorly fitted leg brace but could not recollect the date when that occurred. On 3/05/03 at 1:45 PM, a telephone interview with resident 3's orthopedic surgeon was conducted. Resident 3's orthopedic surgeon stated that her leg brace needed to stay on a minimum of 6 weeks in order to be effective for maintaining her left hip and leg in alignment. Resident 3's surgeon denied being aware of the brace not fitting her leg properly. The surgeon stated that he was not contacted when resident 3 was admitted to the hospital on 12/15/02 for her GI bleed. Resident 3's surgeon stated that if he would have been contacted about resident 3's brace not fitting properly, he would have ordered that resident 3 be fitted for a new abductor brace. Resident 3 was discharged from the facility to the hospital on 1/06/03 with the diagnosis of a "dislocated left hip". Within a 34 hour time frame, between 1/05/03 and 1/06/03, resident 3 received 8 p.r.n. (as needed) pain medications and the nurse's notes had	F 157	F157 –continued— 3) Licensed nursing inservicing will be done by DON on assessing changes in Resident's condition, what to report to the physician, when to report it, which physician to report it to (i.e. orthopedic vs. attending physician), and how to document such. Nursing will also enlist physical and occupational therapies' assistance in contacting orthopedic physicians for therapy needs. Draper Rehabilitation and Care Center's attending physician will be involved with this inservice as well. 4) DON will implement new report sheets that are more detailed and have specific guidelines that ensure follow-thru with regards to new lab orders and other general orders, changes in Resident's condition, physician notification, and documentation. A) The DON or DSD will check report sheets and communication book daily through April 30, 2003, to help ensure follow through on new problems and documented on an audit sheet. Report sheets will be updated every week. After April 30, 2003, audits will be done at least one time per week, by DON or DSD, to ensure reporting and communication system is functioning properly. Completed by DON and DSD, monitored by DON and DSD, and reviewed by Quality Assurance Committee on 4/23/03 and quarterly thereafter.	4/29/03

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F 157	Continued From page 10 four entries concerning resident 3's left leg pain. On 3/05/03 at 3:45 PM, a telephone interview with resident 3's medical physician revealed that if she would have had knowledge of the increased pain, she would have ordered more or different pain medications for comfort, a P.T. evaluation, and/or an x-ray of her left leg and hip. On 1/6/03, resident 3 was discharged to an acute care hospital with the diagnosis of a "dislocated left hip".	F 157		
F 253 SS=E	483.15(h)(2) ENVIRONMENT 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 observations on 2/24/03, 2/25/03, 2/26/03, 2/27/03, and staff interviews on 2/26/03, it was determined that the facility did not provide housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior in 30 of 50 resident rooms and bathrooms, one common shower room, the south hall dayroom, a linen closet near resident room 15 and the lower level common area. Findings include: 1. Observations of the resident rooms and bathrooms revealed the following: Room 2 a. The windows and blinds had a gray substance on them. Room 3	F 253		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465091	A. BUILDING _____ B. WING _____	2/27/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRAPER REHABILITATION & CARE	12702 SOUTH FORT STREET DRAPER, UT 84020

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F 253	Continued From page 11 a. The windows and blinds had a gray substance on them. b. The door to the resident room had scrapes just under the handle across that spanned across the whole door and 6 to 8 gashes in the door located just below the scrapes. Room 4 a. The windows and blinds had a gray substance on them. Room 5 a. There were holes in two of the closet doors b. The windows and blinds had a gray substance on them. c. The shower curtain was torn away from the securing loops which did not allow the shower curtain to hang properly. Room 6 a. The windows had a gray substance on them. b. There was a substance spilled on the carpeting by the window. c. There was a rip in the resident's carpet on the side closest to the window. d. The closet door to the closet used by resident 2 was being held closed with a coat hangar. e. There was an area of carpet that was raised, near the entrance to the bathroom. Room 7 a. There were dead insects on the resident's window sill. b. The paint on the window sill was chipped. c. There was exposed wiring coming out of what appeared to be a cable outlet. d. The linoleum floor was cracked. e. The front of the bathroom door was chipped. f. The shower curtain was torn away from the	F 253		

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F 253	Continued From page 12 securing loops which did not allow the curtain to hang properly. g. The tiles in the bathroom had brown stains on them. h. The door casings around the bathroom door had missing paint. i. The area around the bathroom sink scratched and chipped. Room 8 a. There were dead insects and cobwebs on the window sill. b. The door into the resident's room was chipped and had scratches on it. Room 9 a. The slats to the blinds were bent. When this surveyor attempted to pull the blind cord, to bring the blinds up, the blinds would not go up. b. There were dead insects on the window sill. c. The paint on the window sill was chipped. d. The window had a gray substance on it. e. The door to the resident's room was chipped. f. The shower tap in the bathroom was dripping. g. The toilet paper holder was missing the rod which allowed the toilet paper to remain in the holder. h. There was a bedpan stored on the shower floor. Room 11 a. There was a gray substance on the window. b. The paint on the window sill was chipped. c. The door to the resident's room was chipped. d. There were scratches on the door to the bathroom. e. The flooring at the entrance to the resident's room was cracked. f. There was a gray substance on the bathroom floor and coving. Room 12 a. The shower curtain was torn away from the	F 253		

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F 253	Continued From page 13 securing loops, which did not allow the curtain to be attached properly. b. There were scratches on the bathroom door frames. c. The coving in the bathroom a gray substance on it. d. The window had a gray substance on it. e. The paint on the window sill was chipped. f. The wallpaper, by the heat register, was peeling away from the wall. g. The closet, used by resident 30, would not close properly. h. There resident room floor had a scratch or cut in it. Room 13 a. The windows and blinds had a gray substance on them. b. The paint on the window sill was chipped. c. The door to the resident room was chipped and scratched. d. The bathroom door was chipped. Room 14 a. The frame around the bathroom door was scratched at the bottom. b. The windows and blinds had a gray substance on them. Room 15 a. The wallpaper, in the resident shower area, was peeling away from the wall. b. The area around the bathroom sink was scratched at the bottom. c. The bathroom door was scratched and chipped. d. The door to the closet used by resident 10 closet door would not close properly. e. The windows and blinds had a gray substance on them. f. The paint on the window sill was chipped. g. The slat in the blind were bent.	F 253		

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F 253	Continued From page 14 Room 16 a. The front side of the door into the resident room was scratched and chipped. b. The window had a gray substance on it. c. The paint on the window sill was chipped. Room 17 a. There was a bedpan and urinal stored on the bathroom floor. Room 18 a. The bathroom shower curtain was torn away from the securing loops, which did not allow the curtain to hang properly. b. A toilet seat riser was stored on the bathroom floor. Room 19 a. The door to the resident room was chipped and scratched. b. The light fixture above the bathroom sink was cracked. c. The paint on the bathroom wall was chipped. d. The door to the bathroom was scratched and chipped. Room 20 a. The carpeting at the entrance to the resident room was separated. b. In the bathroom, the area below the soap dispenser was unpainted. Room 21 a. The door to the resident room was chipped and scratched. Room 24 a. The slats in the window blinds were bent. Room 25	F 253 OK 4/9/03 DD	F253 Laundry Supervisor along with laundry staff, will complete an extensive inventory of facility linen. All worn linen, especially linen with holes, will be disposed of. She will then inservice staff on the importance of routinely discarding linens that are worn, and replacing them with the new linens that she routinely stocks. Director of Staff Development will, during April 10, 2003 inservice, instruct nursing assistants on the importance of NOT storing such items as urinals, bedpans, and toilet risers on the floor, but placing them in the proper storage areas. She will also review that it is against facility policy to place garbage on the floor—even in garbage bags. It is the responsibility for nursing staff to dispose of garbage from resident care in the proper receptacles. Housekeeping Supervisor and Administrator, as well as DSD, will conduct random inspections of shower rooms and other rooms to ensure garbage is not left on floors, as well as proper storage of other items listed. Housekeeping Supervisor will check rooms weekly, and document on weekly checklist that the rooms are properly cleaned. DSD will do weekly shower/tub room checks and document on designated form. Completed by Laundry, DSD, monitored by DSD, Administrator, and Housekeeping Supervisor. Reviewed by Quality Assurance Committee on April 23rd, and quarterly thereafter. ---continued---	Request 7/3/03 4/9/03

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F 253	Continued From page 15 a. The shower curtain was torn from the securing loops, which did not allow the curtain to hang properly. b. The window had a gray substance on it. c. The tap in the bathroom sink was dripping and there was sink plug for the drain available. d. The bathroom floor was cracked. Room 27 a. There were brown and black stains on the bathroom floor, in the area where the floor tiles met the tub. b. The closet door was scratched. Room 29 a. The door to the closet, used by resident 36, was scratched. b. The tile in the bathroom at the entrance to the bathroom and near the toilet in the bathroom was loose. This area was 3 inches wide and approximately 2 to 3 feet long in length. Room 30 a. The door to the closet, used by resident 34 had a hole in it. b. The light bulb in the light fixture above bed B did not illuminate when the fixture was turned on. Room 31 a. The window blinds would not raise or lower properly. b. The blanket, on bed A, was covered with multiple holes. Room 32 a. The door to the resident room was scratched and chipped. b. The slats in the window blinds were bent. Room 33	F 253	F253 –continued-- While an extension of time is requested for completion of ALL of F253, this portion of F253 will be completed by April 27, 2003. (Request completion date for all of F253, July 31, 2003.) (PoC for remainder of F253 is continued on following pages—see page 18.)	Request 7/31/03

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F 253	Continued From page 16 a. The door to the resident room was chipped. b. The door to the closet was scratched. c. The bathroom floor had a gray substance on it. d. The bathroom floor area near the tub had brown stains on it. Room 34 a. The door to the bathroom sink cabinet was chipped and scratched. b. The frame around the bathroom door was scratched, at the bottom. Room 35 a. The window had a gray substance on it. Room 37 a. The door to the closet, used by resident 62, was scratched and had a hole in it. b. The door to the closet, used by resident 3, would not close completely. 2. Observation of the shower room on the south hall revealed the following: a. There was a piece of rubber stripping which had come loose on the Ferno Recline a Bath. b. The faucet on the Ferno Recline a Bath was dripping. c. Some of the tiles in the shower room were cracked. d. There was some garbage in trash bags stored on the floor. e. The paint in the shower room was chipped. f. The shower curtain was torn away from the securing loops and would not hang properly. g. The bottom of the cabinet around sink was chipped. h. The drain under the sink was leaking water. There was a pan under the drain and the words "Do not remove the drip pan." was written on the side of the pan.	F 253	F253 --continued-- The new Housekeeping Supervisor will create a deep cleaning schedule that includes cleaning areas of the facility, including those listed. She will then hold an inservice with housekeeping staff to instruct them of the importance of following deep cleaning schedule. She then will supervise her staff to ensure they follow the schedule. Completed by Housekeeping Supervisor and monitored by Administrator. Maintenance Supervisor is creating a checklist to ensure all the routine repairs listed are completed. Administrator will review and monitor the checklist, along with Quality Assurance Committee on April 23, 2003. An additional maintenance person was hired by Administrator, on 3/1/03, to help the Maintenance Supervisor complete the repairs. Maintenance will perform monthly walk-through and assess needed repairs of building. These will be documented and completed monthly, and then reviewed by Quality Assurance Committee on a quarterly basis. ---continued---	Request 7/31/03

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F 253	Continued From page 17 i. The towel cupboard was missing a door. 3. Observation of the linen closet located near room 15 revealed the following: a. The floor to the linen closet had a gray substance on it. b. The inside door to the linen closet was scratched at the bottom and missing paint at the top of the closet. 4. Observation of the dayroom located by the south hall revealed the following: a. There were stains on the seat area of a green armchair. b. There was a gray substance and three black spots on the seat area of a brown recliner chair . 5. Observation of the lower level common area revealed the following: a. The floor tiles near the elevator room and near entrance to the large dining room, which were cracked and worn. b. The wallpaper in the dining room, by the tray return area, was coming loose from the wall. 6. Interviews with facility staff revealed: a. On 2/26/03 at 10:10 AM, during an interview with the housekeeping supervisor, he stated that he did not have a deep cleaning schedule for cleaning drapes, windows, bathroom floors, and upholstery in the facility. b. On 2/26/03 at 09:00 AM, during an interview with the maintenance supervisor, he stated that he was aware that some of the rooms needed some repairs. He stated that he was on "light duty" for a while, because of a shoulder injury.	F 253	F253 ---continued--- However, due to the extensive repairs needed, especially the floors in residents' bedrooms, the facility asks for additional time to complete all of F253. A flooring contractor has been contacted, but due to the probable need for new sub-flooring in some of the listed rooms, as well as new floor coverings required some of the listed bedrooms, additional time is needed to complete all the repair work. Completed by Maintenance and professional floor contractor, and monitored by Administrator. Request completion date for this tag, of July 31, 2003.	Rqst 9/31/03

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F 253	Continued From page 18	F 253		
F 280 SS=E	483.20(k)(2) RESIDENT ASSESSMENT A comprehensive care plan must be: Developed within 7 days after the completion of the comprehensive assessment; Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and Periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on a confidential meeting with a group residents and a staff interview, it was determined that the facility was not informing residents of their interdisciplinary care team (IDT) meetings and was holding IDT meetings during a time which was not convenient for many residents to attend. Findings included: A confidential meeting was held with a group of residents on 2/25/03 at 1:30 PM. Eight residents participated in the meeting. Seven (7) of 8 residents indicated they had not been invited to the interdisciplinary team meetings in which their care needs were to be discussed. During a meeting that was held with the facility's administrative staff and the survey team, on 2/25/03 at	F 280 ok 4/9/03 AS	F280 Each resident will receive a physical invitation to attend IDT meeting. The invitation will include an opportunity for the resident to re-schedule the IDT meeting if it conflicts with their schedule. If the IDT does conflict with the resident's schedule—including their desire to attend whatever recreational or social function that may be occurring—then the opportunity for them to review their plan of care with the IDT team will be provided. Copies of these invitations will be reviewed and kept with Quality Assurance notes. A check-off list, signed by the IDT Team during the resident's review, will include a line to indicate if resident has been invited to the IDT meeting. A response from the resident will also be included on the IDT check list. This will include if the resident did attend and a brief summary of their input. If they did not attend it will include why they were not present. Medical Records will audit IDT notes monthly to ensure compliance in this area. Care Plan team will be inserviced as to importance of inviting residents to care plan meeting, and for providing an alternate time if the resident requests such. Completed by Social Services, monitored by Medical Records and reviewed by Quality Assurance Committee for compliance on 4/23/03 and quarterly thereafter.	4/27/03

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

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F 280	Continued From page 19 4:30 PM, the admissions coordinator stated that the interdisciplinary care team meetings are scheduled at the same time as the Relief Society activity. She stated that this was a time when the interdisciplinary team staff members could meet. The admissions coordinator stated she personally invited the residents to their IDT meeting one to two days before the meeting. She stated that residents would need to chose to attend either the scheduled activity or the IDT meeting. She stated many of the invited residents chose to attend the Relief Society activity. The surveyor asked the admissions coordinator if many residents participated in their IDT meeting. The admissions coordinator responded that resident participation was minimal. The surveyor asked the admissions coordinator if resident participation in IDT meetings would increase if the meetings were not in time conflict with scheduled activities. She responded that she believed that more residents would participate if there were no scheduling conflicts.	F 280		
F 281 SS=E	483.20(k)(3)(i) RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and review of manufacturer's and American Diabetes Association guidelines, it was determined that the facility failed to meet professional standards of quality, for 12 of 12 residents receiving insulin injections, none of which were on the sample. Specifically, vials of insulin were not dated when initially opened. Resident identifiers: 7, 11, 17, 21, 29, 46, 50, 51, 65, 67, 68, and 74. Findings include:	F 281		

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F 281	Continued From page 20 1. Observation of the un-refrigerated vials of insulin kept in the South hall medication room, on 2/25/03 at 8:45 AM, revealed the following: Resident 7 had two vials of opened insulin that were not dated when opened. Resident 46 had one vial of opened insulin that was not dated when opened. Resident 67 had one vial of opened insulin that was not dated when opened. Resident 29 had two vials of opened insulin that were not dated when opened. Resident 65 had two vials of opened insulin that were not dated when opened. Resident 21 had two vials of opened insulin that were not dated when opened. Resident 11 had two vials of opened insulin that were not dated when opened. Resident 17 had two vials of opened insulin that were not dated when opened. Resident 51 had one vial of opened insulin that was not dated when opened Resident 74 had one vial of opened insulin that was not dated when opened. 2. Observation of the un-refrigerated vials of insulin kept in the East hall medication room, on 2/25/03 at 2:30 PM, revealed the following: Resident 50 had two vials of opened insulin that were not dated when opened. Resident 68 had two vials of opened insulin that were not dated when opened. 3. In an interview, on 2/25/03 at 9:40 AM, with a facility registered nurse, she stated that the nurses had not been routinely dating insulin vials when they were opened.	F 281 OK 4/9/03 MD	F281 Vials of insulin for Residents 7, 11, 17, 21, 29, 46, 50, 51, 65, 67, 68, & 74, were replaced by the Director of Nursing (DON) and Director of Staff Development (DSD), with new vials and dated that they were opened on 2/26/03. The licensed nurses were inserviced by DON on 3/13/03 regarding the proper storage of insulin. Policies and procedures regarding dating vials when they are opened and when to discard them were also discussed. In order to ensure that this deficient practice will not recur with these or any other Residents who receive insulin, Nursing Administration will implement the following practices: DON will do inservicing and review the following auditing system with the licensed nurses. Licensed nurses will ensure that insulin vials are refrigerated at all times, unless in use. All nurses are responsible to date vials when they are opened. The night shift nurse will be responsible for auditing the insulin vials to ensure that they are dated, discarding vials that are out of date, and reordering new vials. This will be done and documented on an audit sheet kept by each nursing refrigerator, 3 times each week. Nursing Administration will audit for compliance weekly, and document such on the audit sheet. Completed by DON and licensed nurses. Monitored by DON and DSD and reviewed by Quality Assurance Committee on 4/23/02 and quarterly thereafter.	4/29/03

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F 281	Continued From page 21 In an interview, on 3/6/03, at 12:45 PM, with one the pharmacists from the pharmacy the facility utilizes, he stated that Insulin can be stored on the counter and not refrigerated, if disposed of in 30 days. He stated that if the vial of insulin is refrigerated it can be stored for 90 days and then disposed of. He stated that it was common practice to date vials of insulin the day they are opened, so that old insulin can be disposed of in 30 days if not refrigerated. 4. The American Diabetes Association: Continuous subcutaneous insulin infusion (Position Statement). Copyright 2001, documented the following under the paragraph title "Storage", "Although an expiration date is stamped on each vial of insulin, a slight loss of potency may occur after the bottle has been in use for greater than 30 days." 5. Eli Lilly and Company, manufacturer of insulin, storage guidelines for insulin, "In accordance with recommendations by the ICH/CPMP, (International Committee for Harmonization and the Committee for Proprietary Medicinal Products) Eli Lilly and Company suggests disposal of an in-use insulin vial after 28 days. The ICH/CPMP mandates this time limit, providing the following rationale, the storage time following initial use or reconstitution/dilution should be as short as possible, as the risk of microbiological contamination can never be fully eliminated."	F 281		
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		

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F 309	Continued From page 22	F 309		

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, interviews, and medical record review, it was determined the facility did not provide the necessary care and services for 3 of 15 sampled residents. Specifically, resident 3 did not receive prompt services when she presented with signs of gastro-intestinal bleeding, an improperly fitting abductor splint and a dislocated hip. Additionally, residents 33 and 49, who resided on the Special Needs Unit (SNU), and observed to consume their meals, were not offered additional dietary intake. (Resident identifiers: 3, 33, and 49).

Findings included:

1. Resident 3 was an 83 year old female, originally admitted to the facility on 11/18/02, with the diagnoses of left total hip arthroscope, chronic obstructive pulmonary disease, anemia, hypertension, dementia with psychotic, anxious and depressive features, peptic ulcer disease, coronary artery disease, and myocardia infarction. Resident 3 was discharged to an acute care hospital on 12/15/02, related to gastro-intestinal bleeding. Resident 3 was readmitted to the facility on 12/18/02, and again discharged to an acute care hospital on 1/6/03, related to re-dislocation of her left hip. Resident 3 was then readmitted to the facility on 1/21/03.
A review of resident 3's medical records for her 11/18/02, 12/18/02, and 1/21/03 admissions was completed on 3/3/03.

On 11/18/02, resident 3's physician orders included an order to wear a brace on her left lower extremity at all

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

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	465091	A. BUILDING _____ B. WING _____	2/27/03

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F 309	Continued From page 23 times except while bathing with supervision. Resident 3 also had orders to receive aspirin 81 milligrams (mg) everyday, and Trinsicon 110 - 0.5 mg everyday. A review of nursing note entries, for resident 3, between 11/18/02 and 12/15/02 was completed on 3/3/03. The following nursing note entries were documented which indicate signs of possible gastro-intestinal bleeding: a. On 12/1/02 at midnight a nurse documented, ". . . res. [resident] cont. [continues] to have black tarry stool oozing out. . .". b. On 12/14/02 at 10:00 AM, a nurse documented that resident 3's blood pressure was low at 50/30 and her heart rate was 94. The nurse documented that resident 3's attending physician was notified and orders were received to hold the resident's prescribed blood pressure medication, Diovan for five days. The nurse documented that nursing staff were to monitor resident 3's blood pressure and report back to the physician after five days. The nurse documented the resident had a poor appetite. Note: Nursing staff had documented resident 3 had a poor appetite and minimal intake since her admission. c. On 12/14/02 at 2:00 PM, a nurse documented that resident 3 had complaints of not feeling well. The resident's blood pressure was documented to be 48/32 and her heart rate was 98. The nurse documented that resident 3 had diarrhea four times with black colored stool. The nurse documented resident 3 had pale white skin. The nurse documented that resident 3's attending physician was notified and a message was left for the resident's daughter. There was no documentation to indicate the nursing staff tested the resident's stool for blood. d. On 12/14/02 at 9:00 PM, a nurse documented resident 3's blood pressure was 88/58 and her heart rate was 86. The nurse documented that resident 3 had complaints of abdominal pain. The nurse documented	F 309		

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

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F 309	Continued From page 24	F 309		

the resident did not have any bowel movement, so she was unable to test for blood in the stool. The nurse documented the resident's daughter did not want the resident hospitalized until the facility staff were certain there was blood in the resident's stool.

e. On 12/15/02 at 8:00 AM, a nurse documented resident 3 had an episode of diarrhea with black, tarry stool. The nurse documented possible gastro-intestinal bleeding. The nurse documented that resident 3's attending physician was contacted as well as the resident's granddaughter. The resident was transported to an acute care hospital for further treatment and management at 10:30 AM.

A review of restorative dining notes between 11/19/02 and 12/14/02 was completed on 3/3/03. Staff documented that resident 3 refused to eat or had a poor appetite most of the time. However, beginning on 12/3/02, two days after a nursing note entry included documentation of black, tarry stool, staff began to document resident 3 had complaints of stomach pain. These entries were as follows:

a. 12/3/02 at 5:30 PM, a staff member documented, "Resident complaining of her stomach hurting. . ." On 12/3/02, there were no nursing note entries to document the licensed nursing staff was aware of resident 3's complaint of her stomach hurting.

b. 12/4/02 at breakfast, a staff member documented that resident 3 complained that her stomach was burning and refused to drink any liquids or eat anything. This staff member documented the nurse was notified. On 12/4/02, there were no nursing note entries to document the licensed nursing staff was aware of resident 3's complaint of her stomach burning.

c. 12/9/02 at lunch, a staff member documented that resident 3 complained of stomach pain. On 12/9/02, there were no nursing note entries to document the licensed nursing staff was aware of

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F 309	Continued From page 25 resident 3's complaint of her stomach pain. Resident 3's medical record included an endoscopy report dated 12/15/02. The physician who conducted the endoscopy documented the following impression, "Posterior duodenal bulbar ulcer without active bleeding or visible vessel. I am almost certain that this is the source of her bleeding." Resident 3's medical record included a medical history and physical, dated 12/15/02. Per documentation on this report, resident 3 received three units of packed red blood cells during her acute care hospitalization, beginning 12/15/02. When resident 3 arrived at the acute care hospital, her hemoglobin was low at 7.2, and her hematocrit was low at 21.6. Normal range for hemoglobin is 11.5 to 15.5. Normal range for hematocrit is 36 to 48. Resident 3's medical record contained no documentation to indicate her attending physician was informed of the abnormal assessment findings that presented as possible signs of gastro-intestinal bleeding until 12/14/02. A telephone interview with resident 3's attending physician was conducted on 3/5/03 at 3:45 PM. The physician was asked if facility staff had informed her of resident 3's black, tarry stool or complaints of stomach pain prior to 12/14/02. She stated that she did not recall being contacted about those assessment findings prior to 12/14/02, and had she received such information she would have ordered laboratory tests, such as a complete blood count, to determine if the resident were experiencing gastro-intestinal bleeding. She stated the assessment finding of black, tarry stool was pretty indicative of gastro-intestinal bleeding. On 10/26/02, resident 3 had an "open reduction of left	F 309		

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F 309	Continued From page 26 hip with reconstruction of capsule of hip short rotators". Following the surgical procedure resident 3 was placed in an abductor splint. Physician orders for the abductor splint were written when resident 3 was admitted to the facility on 11/18/02. Resident 3 was to wear the abductor splint, to her left lower extremity at all times, except while bathing under supervision. When resident 3 was readmitted to the facility on 12/18/02, her admission orders did not include the use of the abductor splint to her left lower extremity. A review of nursing note entries, for resident 3, between 11/18/02 and 12/15/02, and again between 12/18/02 and 1/6/03, was completed on 3/3/03. The following nursing note entries were documented which related to resident 3's use of her abductor splint; also referred to as a hip brace: a: On 11/18/02 at 3:00 PM, a nurse documented that resident 3 was attempting to take the hip brace off. b. On 11/21/02 at 11:10 PM, a nurse documented that resident 3 was experiencing anxiety and wanted a knife to cut the hip brace off. c. On 11/25/02 at 10:35 PM, a nurse documented that resident 3 was attempting to take off the hip brace. d. On 11/27/02 at 10:15 AM, a nurse documented that resident 3's attending physician believed the resident's hip brace was causing the resident pain. Note: Resident 3's orthopedic surgeon was not her attending physician. e. On 11/29/02 at 3:15 PM, a nurse documented that resident 3 was found on the floor with the hip brace off. The nurse also documented that the hip brace was reapplied. f. On 12/2/02 at 2:00 PM, a nurse documented that resident 3 had gone to the orthopedic surgeon for a follow-up appointment. g. On 12/8/02 at 10:30 PM, a nurse documented that resident 3 tried to take off the hip brace and that a nurse aide put it back on the resident.	F 309		

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F 309	Continued From page 27 h. On 12/11/02 at 11:20 PM, a nurse documented that the AM nurse had said resident 3 refused to wear the hip brace when she was in bed, after lunch. The nurse documented that the hip brace was put on resident 3 before supper. i. On 12/12/02 at 10:30 AM, a nurse documented that resident 3 was refusing to wear the hip brace when laying down. The nurse documented that staff would try an abductor pillow when the resident refused the hip brace. j. On 12/12/02 at 11:05 PM, a nurse documented that resident 3 wanted the hip brace off at 9:00 PM and that the brace was removed and a wedge cushion was placed between the resident's legs. k. On 12/14/02 at 4:30 AM, a nurse documented that a wedge was placed between resident 3's legs and that the wedge was strapped down. l. On 12/20/02 at 2:00 PM, a nurse documented that resident 3 would not wear her hip brace. m. Between 12/18/02 and 1/5/03, nursing staff made several nursing note entries which documented the use of an abductor pillow. A review of physician telephone orders and physician progress notes between, 11/18/02 and 12/15/02, and again between 12/18/02 and 1/6/03 was completed on 3/3/03. There were no physician orders to discontinue resident 3's abductor splint. There were no telephone orders or other documentation to indicate facility staff notified resident 3's orthopedic surgeon that the resident was refusing to wear, or making repeated attempts to remove the abductor splint. Additionally, there were no physician progress notes that addressed resident 3's refusal to wear the abductor brace. On 12/2/02, resident 3 went to the orthopedic surgeon for a follow-up appointment. For this appointment, a facility nurse completed a "Referal To Physicians and Clinics" form. This form included a section labeled, "Resident's Complaints and Nurses Observations".	F 309		

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F 309	Continued From page 28 There was no documentation on this form to indicate resident 3 was refusing to wear, or was making repeated attempts to remove the abductor splint. A review of Utilization Review Meeting and Medicare Rehab Meeting notes for resident 3 was completed on 3/3/03. These notes were made on 11/20/02, 12/4/02, 12/11/02, and 12/24/02, respectively. The notes made on 11/20/02, 12/4/02, and 12/11/02, do not include documentation that resident 3 was refusing to wear, or making repeated attempts to remove the abductor splint. On 12/24/02, a note documented that resident 3's left hip brace was discontinued by physical therapy. A telephone interview with the facility's physical therapist was conducted on 3/5/03 at 1:00 PM. This physical therapist stated he was involved with resident 3's physical therapies. He stated resident 3's abductor splint was not the correct size for her. He stated resident 3 was not comfortable with the leg brace and it was too large for her. He stated he did not contact resident 3's orthopedic surgeon about the abductor splint not fitting properly. A telephone interview with resident 3's attending physician was conducted on 3/5/03 at 3:45 PM. She stated that she had been made aware that resident 3's abductor splint was not fitting properly. She stated she had asked a facility nurse call resident 3's orthopedic surgeon about the poorly fitted brace but could not recall the date when that occurred. A telephone interview with resident 3's orthopedic surgeon was conducted on 3/5/03 at 1:45 PM. Resident 3's orthopedic surgeon stated the resident was to have worn the abductor splint for a minimum of six weeks from the date of the original surgery, on 10/26/02, and preferrably until 12/26/02, in order to be effective in keeping the resident's hip in alignment. The orthopedic surgeon stated that he was not	F 309		

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F 309	Continued From page 29 contacted or made aware that resident 3 had refused to wear or was making repeated attempts to remove the abductor splint. He stated that had he been made aware, he would have made arrangements to have the splint evaluated for fit and possibly other interventions. He stated that he had not been informed that resident 3 was transferred to an acute care hospital on 12/15/02 for gastro-intestinal bleeding and that he had not ordered that the resident's abductor splint be discontinued. A telephone interview was conducted with a staff member of resident 3's orthopedic surgeon's office on 3/5/03 at 4:00 PM. This staff member stated she was the person who would receive phone calls regarding the surgeon's patients. She stated she had not been contacted by the facility regarding resident 3's abductor splint. A review of resident 3's admission Minimum Data Set (MDS) was completed on 3/3/03. The reference date for this assessment was 11/27/02. Facility staff assessed that resident 3 did not resist cares. A review of resident 3's plan of care was completed on 3/3/03. On 11/18/02 and again on 12/4/02, facility staff developed a care plan for resident 3 for the identified problem of impaired mobility. One of the approaches for this identified problem was for resident 3 to wear a brace to her left lower extremity at all times, except while bathing under supervision. Resident 3's plan of care did not address interventions if the resident refused to wear the left lower extremity brace or if the brace fit improperly. The following nurse's notes were documented for resident 3, in the thirty-two hours prior to her discharge to the hospital on 1/6/03 with a re-dislocated left hip:	F 309 OK 4/9/03	Please note: the facility has asked for relief from deficiency F309, through the Informal Dispute Resolution (IDR) process. F309 (Part 1) Resident 3's GI bleed was resolved; the ASA was discontinued and she was started on Prevacid. She has not had any further problems or complaints related to GI bleeding. Also, when Resident 3's hip dislocated again on 1/6/03, she was admitted to the hospital where surgery was performed and the correct size hip was placed. She returned to Draper Rehabilitation and Care Center in a body cast, which was removed by her orthopedic physician on 2/14/03. Resident has had no further complications related to her hip since that time. In order to help ensure that problems of this nature do not recur, Nursing Administration will implement the following. The Director of Nursing (DON) inserviced all licensed nurses on 3/13/03, and the Director of Staff Development (DSD) inserviced C.N.A.'s on 3/25/03 regarding F309 and the circumstances relating to Resident 3. DON and DSD will do further C.N.A. inservicing on abnormal findings, and reporting these to the licensed nurse. DON will provide further inservicing for the nurses, concerning GI bleeds, as well as hip fractures and dislocations, along with total hip precautions, and the use of assistive and orthotic devices. --continued--	4/27/03

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F 309	Continued From page 30 a. On 1/5/03 at 5:00 AM, a nurse documented, "Pt. [patient] has been calling out for assist 'help' all night. Asks for pain med [after] just getting pain med. Says L (left) leg hurts from L knee to L hip, crying, won't stretch legs out. Insisted on lying on side, R (right) side. Medicated [with] Lortab [and] [one] Ativan." b. On 1/05/03 at 1:00 PM, a nurse documented that resident 3 had increased pain to her left hip that morning. The nurse documented that the resident was given Lortab and a hot pack, which were helpful. The nurse documented that resident 3 was placed in her wheelchair for breakfast, then complained of pain again at 10:30 AM. Per documenation, Lortab was given and the resident fell to sleep within 15 minutes. The nurse documented the resident was out of her bed for lunch without complaints of pain. c. On 1/5/03 at 11:25 PM, a nurse documented that resident 3 had complained of spasms to her left hip, and that Flexiril was administered at 2:50 PM. The nurse documented the resident complained of pain in her left hip and was given Lortab at 6:00 PM. d. On 1/6/03 at 1:20 PM, a nurse documented that the therapist assessed resident 3's left leg to be significantly shorter than her right leg. The nurse also documented that resident 3 had increased complaints of pain to her left leg and that the resident could not straighten her left leg. The nurse documented that resident 3's attending physician was notified and a stat X-ray was ordered. The nurse documented the X-ray revealed a left leg dislocation. The nurse documented that resident 3 was discharged to the hospital. A review of the Medication Administration Records (MAR) for resident 3, between 12/18/02 and 1/6/03, was completed on 3/3/03. Upon readmission to the facility on 12/18/02, resident 3 had physician orders to receive Lortab 5 mg, one to two tablets, every six hours, as needed for pain. Resident 3 also had orders	F 309	F309 (Part 1) --continued-- As with the plan of correction for F157, the C.N.A.'s will be inserviced by DSD on reporting abnormal findings to licensed nursing staff. This will include signs and symptoms of generalized pain and total hip precautions. A communication notebook will be used for C.N.A.'s to write down the observations, but does not take the place of verbal reporting. Licensed nursing inservicing will be done by DON on assessing changes in Resident's condition, and proper reporting and documentation prodecures. DON and DSD will audit report sheets and nursing documentation every day through April 30, 2003, and every week thereafter. Inservicing completed by DON and DSD; reporting done by nursing staff. Monitored by DON and DSD, and reviewed by Quality Assurance Committee on 4/23/03, and quarterly thereafter. F309 (Part 2) continues on next page	4/29/03

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F 309	Continued From page 31 to receive Flexeril 10 mg, three times a day, as needed for muscle spasms. On 12/20/02, a physician's telephone order was obtained for resident 3 to receive Ativan 0.5 mg, two times a day, as needed for anxiety. Between 12/18/02 and 1/4/03, facility staff were administering Lortab, Flexeril, and Ativan to resident 3. However, staff had not administered the medications in combination. On 1/5/03, facility staff began administering these medications, in combination, due to resident 3's increased complaints of pain and spasms. On 1/5/03, a telephone order was written to clarify resident 3's Lortab order. This telephone order allowed staff to administer Lortab 5 mg, one tablet, every three hours, as needed rather than one to two tablets every six hours, as needed. A telephone interview was conducted with resident 3's attending physician on 3/5/03 at 3:45 PM. She stated she did not recall being called by facility staff regarding resident 3's increased complaints of hip pain and inability to straighten her leg prior to the day the resident was transferred to the acute care hospital, when the resident was found to have re-dislocated her left hip. Resident 3's attending physician stated that had she been notified of the resident's increased complaints of pain, she would have ordered more or different pain medications, a physical therapy evaluation, and/or an x-ray of the resident's left leg and hip. 2. Resident 49 was admitted to the facility on 6/11/02 with diagnoses that included Alzheimer's disease with depressive and anxious features, osteoarthritis, insomnia, macular degeneration, and knee pain. Observations were made of resident 49 on 2/25/03 from 7:40 AM until 8:30 AM, in the dining room on the Autumn Ridge SNU (special needs unit). Resident 49 had ground sausage, pancakes with syrup, and a	F 309	F309 (Part 2) --continues on next page--	4/27/03

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F 309	Continued From page 32 bowl of oatmeal, apple juice and milk for breakfast. At 7:54 AM, resident 49 had eaten 100% of her sausage and pancakes. From 7:54 AM until 7:58 AM, the resident swiped her fork across her empty plate numerous times. At 7:58 AM, the resident took her empty plate off the warming plate and started swiping her fork across the warming plate until approximately 8:04 AM. At 8:04 AM, resident 49 started to eat her oatmeal. At 8:12 AM, resident 49 ate 100% of her oatmeal. From 8:12 AM to approximately 8:15 AM, resident 49 repeatedly swiped her spoon across the empty oatmeal bowl. At 8:15 AM, a CNA (certified nursing assistant) removed residents 49's meal tray. Resident 49 was not offered additional food. Observations were made of resident 49 on 2/25/03 from 12:34 PM until 1:10 PM, in the dining room on the Autumn Ridge SNU. Resident 49 had mashed potatoes, zucchini and tomatoes, turkey with gravy over a slice of bread (the food was chopped), milk, juice, and strawberry ice cream for lunch. At 1:05 PM, resident 49 had eaten 100% of lunch. Resident 49 then stood up and walked over to resident 19, who was sitting at an adjacent table and took resident 19's spoon and some of resident 19's ground turkey. As resident 49 was about to put the spoon in her mouth, a CNA stopped the resident and took resident 49 out of the room. Resident 49 was not offered additional food. Observations were made of resident 49 on 2/26/03 from 7:35 AM until 8:45 AM, in the dining room on the Autumn Ridge SNU. Resident 49 had scrambled eggs, oatmeal, an orange slice, a muffin, milk and juice for breakfast. By 7:55 AM, resident 49 had eaten 100% of her breakfast and began to swipe her spoon across her empty oatmeal bowl numerous times. After the surveyor interviewed two CNAs and the unit manager about how they determine if a resident would	F 309	F309 (Part 2) DON and DSD provided inservicing regarding F309 and the circumstances related to Residents 33 and 49, with the C.N.A.'s, on 3/25/03, and the licensed nurses, on 3/13/03. The RN Case Manager received new diet orders for double portions for Residents on 2/26/03. Resident 33 has gained 4 pounds since admission to facility, and Resident 49 has gained 1 pound in the month of March, 2003. The C.N.A. staff has charted since the survey was completed, that these Residents have occasionally eaten 100+ for some of their meals. Dietary will send extra trays of food at each meal to Autumn Ridge and assistive dining rooms, for the C.N.A.'s to have, to offer to the Residents when they have consumed 100% of their meal. DSD will conduct C.N.A. training on proper meal documentation when Residents eat more than 100%. DON and DSD, and unit manager will train C.N.A.'s on recognizing different behaviors exhibited by Residents with Dementia including those related to hunger and what those behaviors could mean. Nursing Administration will perform a dining room audit weekly, and a meal percentage charting audit every other week, to ensure that this Plan of Correction is being followed. Completed by Dietary staff, DON, DSD, and RN Case Manager; monitored by Nursing Administration; Reviewed by Quality Assurance Committee on 4/23/03, and quarterly thereafter.	4/29/03

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465091	A. BUILDING _____ B. WING _____	2/27/03

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F 309	Continued From page 33 like additional food, a second plate of food with eggs, a muffin and an orange slice was obtained from the kitchen and given to resident 49. Resident 49 ate 100% of the eggs, muffin, and orange slice. A review of resident 49's medical record was completed on 2/27/03. A review of a quarterly MDS (minimum data set) assessment, dated 2/5/03, was completed. Sections C4 and C5 indicated that resident 49 could rarely if ever make herself understood and could rarely if ever understand others. Section B-4 indicates that resident 49's cognitive skills for daily decision making were moderately impaired. A review of resident 49's plan of care revealed facility staff documented resident 49 was at risk for altered nutritional status related to confusion and aggressive behaviors. This care plan problem was not dated. Approaches for this identified problem included: Diet as ordered (general mechanical soft) with increased protein and increased calorie supplement; assess need to modify diet; assist with meals as necessary; and, try giving the resident her plate at dinner time without the whole tray. The plan of care did not include strategies to optimize the resident's nutritional status when she demonstrated a willingness for additional dietary intake. The "Clients by Vital Parameter" form, which lists resident 49's monthly weights documented that resident 49 had experienced a gradual loss of weight since admission. Resident 49's admission weight, on or near 6/11/02 was 122 lbs. (pounds), on 10/14/02 was 119 lbs., on 11/14/02 was 114 lbs., and on 2/11/03 was 110 lbs.. 3. Resident 33 was admitted to the facility on	F 309		

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

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F 309	Continued From page 35	F 309		

staff documented resident 33 was at nutritional risk secondary to being status post cerebrovascular accident, Alzheimer's disease, and macular degeneration. This plan of care problem was dated 12/27/02. Approaches for this identified problem included: Diet as ordered (puree with nectar thick liquids); assist with meals as necessary; and, restorative dining. The plan of care did not include strategies to optimize the resident's nutritional status when he demonstrated a willingness for additional dietary intake.

On 2/26/03 at 7:55 AM, in the Autumn Ridge SNU dining room, an interview was held with CNA 1. She was asked how she determined if a resident wanted more food to eat, including resident who may have difficulty expressing their needs. CNA 1 stated that she knew the residents and could tell, but that a new aide would have a problem knowing. CNA 1 stated that resident 33 would probably ask for more food and that resident 49 would take food from other residents if she wanted more.

On 2/26/03 at 8:10 AM in the Autumn Ridge SNU dining room CNA 2 was interviewed. CNA 2 was asked how she determined if a resident wanted more food to eat, including residents who may have difficulty expressing their needs. CNA 2 shrugged her shoulders to indicate she did not know.

On 2/26/03 at 8:10 AM, in the Autumn Ridge SNU dining room, the unit manager was interviewed. The unit manager was asked how she determined which residents would like additional food. The unit manager stated that they gave the residents lots of snacks and drinks through out the day, so they did not worry about it.

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F 309	Continued From page 34 12/19/02 with diagnoses that included cerebrovascular disease, macular degeneration, Alzheimer's disease, a history of cancer of the testicle and prostate. Observations were made of resident 33 on 2/25/03 from 7:40 AM until 8:30 AM, in the dining room on the Autumn Ridge SNU. Resident 33 ate 100% of his pancakes, sausage, oatmeal, juice and milk. The resident did not request nor was he offered additional food. Observations were made of resident 33 on 2/25/03 from 12:34 PM until 1:10 PM, in the dining room on the Autumn Ridge SNU. Resident 33 ate 100% of his mashed potatoes, zucchini and tomatoes, turkey with gravy over a slice of bread, milk, juice, and strawberry ice cream for lunch. The resident did not request nor was he offered additional food. Observations were made of resident 33 on 2/26/03 from 7:35 AM until 8:45 AM, in the dining room on the SNU. Resident 33 had scrambled eggs, oatmeal, an orange slice, a muffin, milk and juice. By 7:55 AM, resident 33 had eaten 100% of his breakfast. After the surveyor interviewed two CNA's and the unit manager about how they determine if a resident would like additional food, at 8:16 AM, resident 33 was asked by a staff member if he wanted additional food. Resident 33 indicated that he did want more food. At 8:25 AM, resident 33 received two muffins and a second glass of milk. Resident 33 ate 100% of both muffins and drank 100% of the second glass of milk. On 2/27/03, a review of resident 33's admission MDS dated 1/1/2003 was completed. Section B-4 indicated that resident 33's cognitive skills for daily daily decision making were moderately impaired. A review of resident 33's plan of care revealed facility	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 36	F 323		
F 323 SS=E	483.25(h)(1) QUALITY OF CARE The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the cautionary labels, it was determined that the facility failed to ensure hazardous chemicals located on the housekeeping cart. shower rooms, and in the therapy area, were secured. Findings include: 1. Housekeeping care observations: On 2/24/03 at 11:30 AM, a housekeeping cart located on the South hall was not locked, and the housekeeping cart was unattended. The housekeeper was inside a resident's room cleaning. The housekeeping cart had multiple cleaning agents located on it. On 2/25/03 at 10:40 AM, a housekeeping cart located on the lower level, on the main hall, next to the restrooms, was not locked. The keys to the lock were left in the keyhole. The housekeeping cart was unattended. The housekeeper was inside the women's restroom. The housekeeping cart had multiple cleaning agents located on it. On 2/25/03 at 3:30 PM, a housekeeping cart located on the East hall was not locked, the key was in the keyhole, and the housekeeping cart was unattended. The surveyor could not locate the housekeeper. The following cleaning agents were on the housekeeping cart: 1. Galaxy cleaner	F 323	ok 4/9/03 DS F323 The new Housekeeping Supervisor will instruct all housekeeping staff about the importance of keeping chemicals properly locked at all times, not only on the housekeeping carts, but also in storage areas, and common bathing areas within the facility. Central Supply person will obtain key rings that can attach to a person's belt, with a long, stretchy cord that would allow housekeepers to "wear" the keys to the housekeeping cart on their person, even while unlocking the carts. These key rings will then be given by Housekeeping Supervisor to any housekeeper that chooses to use that type of key ring instead of the ones they currently use, which go around their heads like a necklace. Housekeeping supervisor will audit weekly to ensure compliance. Staff members who do not follow the important safety guidelines about keeping carts and chemicals properly locked, will be subject to disciplinary measures from Housekeeping Supervisor and Administrator. Completed by Housekeeping Supervisor, and Central Supply person getting key rings; monitored by Administrator; reviewed by Quality Assurance Committee for compliance on 4/23/03 and quarterly thereafter.	4/29/03

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F 323	Continued From page 37 2. Glade air freshener 3. hand cleaner 4. citrus cleaner 5. stainless steel cleaner 6. toilet cleaner 7. glass cleaner 8. disinfectant 9. AF79 concentrate 10. Best Scent 2. Shower Room Observations: On 2/25/03 at 8:20 AM, the South hall shower room was observed to have quaternary disinfectant and no rinse bathing solution (Septi-Soft) unsecured in the shower room. The shower room was not locked and was accessible to residents. On 2/25/03 at 8:21 AM, the East hall shower room was observed to have Septi-Soft concentrate with no cap on it. The body wash was in a 1 gallon container, and unsecured. The shower room was not locked and was accessible to residents. On 2/25/03 at 2:25 PM, the East hall shower room was observed to have a "no rinse, septi-soft" body wash, which was in a gallon container, and unsecured. The shower room was not locked and was accessible to residents 3. Therapy area observations: On 2/26/03 at 10:00 AM, the therapy gym area was observed to have one spray bottle of Mint-O-Quat disinfectant and one spray bottle of Neutral Quat 256 disinfectant left unattended and unsecured. The therapy gym area was open and accessible to residents. 4. Interviews:	F 323	F323 --continued— Shower room concerns: The secured cover for the quaternary disinfectant in South Shower room will be repaired and replaced by Maintenance. Concerning the unsecured, no-rinse bathing solution in both East and South shower rooms: The Central Supply person will contact the supplier for this product, who will provide the proper replacement receptacle for this product. Maintenance then will replace the broken receptacles on the walls, and remove the unsecured gallon container from the rooms. The Director of Staff Development (DSD) will instruct nursing assistants on the importance of ensuring that these chemicals are stored and used properly. Nursing Administration will perform audit weekly to ensure compliance. Completed by Central Supply, Maintenance, and DSD; monitored by Administrator. Reviewed by Quality Assurance to ensure continued compliance on 4/23/03 and quarterly thereafter.	4/27/03

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F 323	Continued From page 38 On 2/26/03, at 09:40 AM, four housekeepers were interviewed, with the assistance of the housekeeping supervisor, due to a language barrier. All 4 housekeepers stated that they store multiple cleaning agents on their housekeeping carts all of the time. 5. Review of the cautionary labels: a. Septi-Soft Label warning: For external use only. May cause eye irritation, rinse eyes with water if contact should occur. Consult physician if irritation persists. In rare instances of local sensitivity, discontinue use. Ingredients: soft water, soybean oil, potassium hydroxide, coconut oil, oleic acid, tetra sodium EDTA, quanterium 15, and daphene 22492. b. Quaternary disinfectant Label warning: Causes eye and skin irritation. Wash contact areas with water for 15 minutes. Ingestion: drink milk, water, and fruit juice. Induce vomiting with oil of ipecac. Get medical attention. Ingredients: Alkyl dimethyl ethyl benzyl ammonium chloride and benzalkonium chloride. c. Restroom cleaner (AF79) Causes irreversible eye damage and skin burns. Harmful if swallowed. Ingredients: Octyl dimethyl ammonium chloride, didecyl ammonium chloride, dioctyl dimethyl ammonium chloride. d. PH7Q (disinfectant) Causes moderate eye irritation if absorbed through the skin. Avoid contact with eyes, skin and clothing. Ingredients: Diedecytyl dimethyl ammonium chloride. e. Citrus degreaser Toxic, corrosive, severe skin and eye irritant. Causes burns. Harmful if swallowed. Harmful if inhaled. Ingredients: Sodium metasilicate, cationic surfactant, and tetra sodium. f. Odor counteractant (Best Scent)	F 323		

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

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F 323	Continued From page 39 Undiluted product may cause eye irritation. Avoid contact with eyes. Ingredients: Non-ionic surfactant, perfume oils, isopropyl alcohol, sodium xylene sulfonate. g. Glass cleaner Toxic skin and eye irritant. Vapors harmful if inhaled. Harmful if swallowed. Ingredients: Butoxyethanol, anionic surfactant, tetra sodium EDTA. h. Stainless steel polish Harmful or fatal if swallowed. Do not induce vomiting. Contact physician. Ingredients: petroleum distillates. i. Furniture polish Harmful or fatal if swallowed. Do not induce vomiting. Contact a physician. Ingredients: petroleum distillates. j. Glade air freshener First aid, rinse with water, and keep out of reach of children. Keep away from heat and flame. Ingredients: Propane isobutene, butane and water. k. Thick bowl cleaner (Kling) Corrosive, irreversible eye damage skin or burns. Fatal if swallowed. Harmful if absorbed via skin. Ingredients: Octyl decyl dimethyl ammonium chloride, dioctyl dimethyl ammonium chloride, didecyl ammonium chloride, and hydrogen chloride. l. Gum Off Very flammable avoid heat, sparks, and flames. Avoid contact with skin and eyes. Can cause frostbite. Contact physician. Ingredients: Isobutane blend 75-28, and propane 74-98-6 blend. m. Galaxy cleaner Get medical advice, avoid eye contact. Flush eyes for 15 minutes, call physician. Can irritate upper respiratory tract. Take person to fresh air. Harmful if swallowed. Drink milk or water. Call poison control center. Do not induce vomiting. Ingredients: Sodium dodecylbenzene sulfonate. n. Hand cleaner	F 323		

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F 323	Continued From page 40 Eye irritation; avoid eye contact, flush with water. Call physician if swallowed. Ingredients: chloroxylenol 0.5%. o. Mint-O-Quat Disinfectant. Keep out of reach of children. Danger. p. Neutral Quat 256 Disinfectant. Ingredients: didecyl dimethyl ammonium chloride. Flush eyes and skin with water for 15 minutes. Call physician. If swallowed, drink water and get medical attention.	F 323		
F 371 SS=F	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 and staff interview it was determined that the facility did not store, distribute, serve and prepare food under sanitary conditions as evidenced by: multiple foods and beverages which were either expired and not labeled and/or dated in the kitchen and refrigerators in the kitchen, refrigerator on the Autumn Ridge unit, refrigerator in the electrical room, and refrigerators at the South and East nurse's station; food items in the kitchen not properly covered; unclean areas in the kitchen; scoop handles in food products; observation of improper dish machine temperatures; and the dietary aides were observed to not wash their hands appropriately while washing dishes. Findings include: 1. Observations on 2/24/03 during the initial kitchen tour, from 9:10 AM to 9:50 AM, revealed the following:	F 371	F371 Housekeeping will clean the refrigerators in the electrical room, and in Autumn Ridge unit, and discard any outdated, or undated items, 1x per week. Completed by Housekeeping, monitored by Housekeeping Supervisor, documented on checklist. Reviewed by Quality Assurance on 4/23/03 and quarterly thereafter. Nurses will clean out refrigerators at South and East nurse's station, 1x per week, and document on checklist. Completed by nurses, monitored by Nursing Administration on a monthly basis, and reviewed by Quality Assurance on 4/23/03 and quarterly thereafter. F371---continued---	4/27/03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 41 In the walk-in refrigerator: a. The seam on the ceiling had a rusty, flaky build-up. There was a cart with trays of foods and beverages below this seam and there was potential for contamination of these items. b. There was a baked potato in foil, 8 cups of chocolate pudding, a pitcher of juice, a container of salad, a container of bread and rolls and 2 trays of juice in cups (77 total), which were not dated. There was a bag containing what appeared to be 3 omelets, which was not labeled or dated. A food shall be discarded if it is in a container or package that does not bare a date or day. Reference guidance: FDA (Federal Drug Administration) U.S. Public Health Service 2001 Food Code, page 70. c. There was an expired container of sour cream dated 2/5/03 (19 days old) and an expired container of sour cream dated 2/12/03 (12 days old). There was a cup of pudding dated 2/18/03 (6 days old). d. The following were not dated as to when they had been opened: 1 gallon of lemon juice, 1 gallon of Italian dressing, 1 gallon of buttermilk ranch dressing and 1 gallon barbecue sauce. e. There was a 2-gallon container of sauerkraut, which was not properly covered with the lid, which could allow for contamination of the product, it was not dated as to when it had been opened. f. There was a bag of whipped cream, which was not properly covered and was not dated. There was a container of beef base and a box of dried apricots, which were not properly covered and could allow for contamination of the products. g. There was a 2% gallon milk carton containing pina colada snow cone mix, which was not dated. There were three gallon milk cartons; one which contained a purple liquid, one which contained a red liquid and one which contained a blue liquid. None of the gallon milk cartons were dated. Milk cartons are single-use articles. Single-service and single-use articles may not	F 371	F371 Dietary Services a) Maintenance person will clean and remove the rust build-up in walk-in refrigerator. He will coordinate this with Dietary Supervisor, to ensure no food is contaminated in the process. This problem will be added to the preventative maintenance log, and checked by Maintenance on quarterly basis. Clean up completed by 4/27/03, reviewed in Quality Assurance Committee Meeting on 4/23/03 and quarterly thereafter. b) Dietary Supervisor will inservice kitchen staff concerning the labeling and dating of food items before they are placed in walk-in refrigerator. c) Outdated items have been discarded by dietary staff. d) Containers mentioned have been dated by Dietary Supervisor. e) Dietary Supervisor discarded saurerkraut. f) Dietary Supervisor dated and covered the items mentioned. g) These items were from the Activities Department, and Dietary Supervisor discarded the items. He also instructed Activity staff about not putting single-use items into the refrigerator. Completed by Maintenance Dietary Supervisor; monitored by Administrator, reviewed by Quality Assurance Committee 4/23/03 and quarterly thereafter. F371---continued---	4/27/03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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DRAPER REHABILITATION & CARE	12702 SOUTH FORT STREET DRAPER, UT 84020

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F 371	Continued From page 42 be reused. Reference guidance: FDA (Federal Drug Administration) U.S. Public Health Service 2001 Food Code, page 110. h. There were eight expired ½ pint cartons of fat free milk dated 2/8/03 (16 days old). i. There was a case of strawberry Health Shakes and 11 sugar free Health Shakes, which were not dated as to when they had been taken from the freezer. These shakes have a 14-day shelf life once thawed. j. The floor of the walk-in refrigerator underneath the shelves was dirty with food splatter and debris. In the kitchen: a. There was a scoop in the flour bag with handle in the product. The handle is considered contaminated because staff handles it. b. The top of the counter top had areas of Formica missing which exposed the board underneath making this area unsanitizable. c. One dietary aide was observed in the dish room. He was observed to load a tray of soiled dishes, dip his hands in a bucket of solution, and then put away clean dishes. He was not observed to wash his hands prior to dipping them in the solution. He was asked to check the concentration of the hand dipping solution. He had to ask another dietary employee where the test strips were. When asked if he routinely checked the sanitizer solution he stated no. Food employees shall clean their hands and exposed portions of their arms... after handling soiled equipment and utensils... and after engaging in other activities that contaminate the hands. A hand sanitizer and a chemical sanitizing solution used as a hand dip shall be applied only to hands that are cleaned for at least 20 seconds, using a cleaning compound in a lavatory. Reference guidance: FDA (Federal Drug Administration) U.S. Public Health Service 2001 Food Code, pages 31,32 and 34.	F 371	F371 –continued— h) Items have been discarded by Dietary Supervisor. Leftover food policy will be posted on refrigerated units in Dietary Department. Prep Cook will monitor daily for expired food items. Dietary Supervisor will audit weekly for compliance. Supervisor will inservice dietary staff quarterly on this policy. i) Dietary Supervisor will instruct staff on importance of dating boxes when they are removed from freezer, and importance of individual units being dated when needed for floor-stock use. Dietary staff will date cases when removed from freezer; individual boxes will be dated when sent to the nursing department in patient care areas. j) Walk-in floor has been swept and mopped by dietary staff. This will be done daily by dietary staff , as part of daily tasks. Supervisor will audit weekly for compliance. Kitchen: a) The scoop has been removed, and Dietary Supervisor will instruct staff on proper use and placement of scoops. Cook will check for scoop removal daily, at end of shift, and document on checklist. List will be audited by Supervisor weekly. b) Maintenance will replace the counter top. Completed by April 25 2003. c) Dietary Supervisor will inservice and train dietary staff on the proper hand washing technique, and the testing of chemical solutions. Dietary staff will test chemical solution 2x daily, and document on appropriate checklist. Supervisor will audit checklist weekly. –continued--	4/29/03

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	465091	A. BUILDING _____ B. WING _____	2/27/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 43 In the dry storage room: a. There were 16 cans of expired Glytrol (a dietary supplement), dated 11/4/02, a case of expired Novasource 2.0 (a dietary supplement), dated 2/14/02 and 3 cans of expired Nestle Additions Calorie and Protein Food Enhancer dated 7/12/02. b. There was a scoop in a box of thickener with the handle in the product. The handle is considered contaminated because staff handles it. In the freezer: a. There was a bag of meat patties, which was not labeled or dated as to when they had been opened. There was a bag of stuffed pasta shells, which was not dated as to when they had been opened. b. There was a white box approximately 5 inches by 5 inches, which was not labeled as to what it contained. In the freezer room: a. There was a very dusty vent in the window. 2. Observations in the kitchen on 2/24/03 from 1:57 PM to 2:12 PM revealed the following: In the dish room: a. At 1:57 PM the wash temperature of the dish machine was 112 degrees Fahrenheit. At 2:05 PM the wash temperature of the dish machine was 116 degrees Fahrenheit. The temperature of the wash solution in spray-type warewashers that use chemicals to sanitize may not be less than 120 degrees Fahrenheit. Reference guidance: FDA (Federal Drug Administration) U.S. Public Health Service 2001 Food Code, page 107. b. From 1:57 PM until 2:12 PM observation in the dish room revealed one dietary aide was scrubbing food debris from pans and plates, loading the dirty lunch dishes into the dish machine, dipping his hands	F 371	F371---continued--- Tasks completed by Dietary, Maintenance, and monitored by Dietary Supervisor. Reviewed by Quality Assurance Committee on 4/23/03 and quarterly thereafter for continued compliance. Freezer: a) Vent was vacuumed by Maintenance Supervisor. This task is on the list of routine maintenance items to be done by maintenance staff on a quarterly basis, but was accidentally missed. Maintenance will complete this quarterly, check it off on the routine maintenance log, and the log will be reviewed by Quality Assurance Committee on 4/23/03 and quarterly thereafter. a) The heat exchange unit switch was accidentally bumped and turned off. The switch has been turned back on by Dietary Supervisor, and the temperature is now holding between 135 and 140 degrees. A protective guard will be placed over the switch by maintenance, to prevent it from accidentally being shut off. Completed and documented by Maintenance by 4/25/03. b) Dietary Supervisor will instruct dietary staff about proper hand washing technique. Hand washing instructions are posted above hand washing sink; Dietary Supervisor will review and stress importance of hand washing with staff on a quarterly basis, and perform random observations of staff. ---continued---	4/29/03

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F 371	Continued From page 44 in bleach solution and then putting away the clean dishes. He was not observed to wash his hands with soap and water for at least 20 seconds after touching the food debris on the plates and pans before dipping his hands in the bleach solution. 3. Observations in the kitchen on 2/25/03 from 8:42 AM to 9:13 AM revealed the following: In the dish room: a. At 8:43 AM the wash temperature of the dish machine was 110 degrees Fahrenheit and the rinse temperature was 118 degrees Fahrenheit. At 8:51 AM the wash temperature of the dish machine was 112 degrees Fahrenheit. In the walk-in refrigerator: a. There was a pitcher of juice, 2 cups of pudding and 4 cups of tarter sauce, which were not dated. b. There was a cup of fruit cocktail dated 2/16/03 (9 days old). c. There were 6 sugar free Health Shakes, which were not dated when they were thawed. These shakes have a 14-day shelf life once thawed. d. There was a 2% gallon milk carton containing pina colada snow cone mix, which was not dated. There were three gallon milk cartons, one which contained a purple liquid, one which contained a red liquid and one which contained a blue liquid. None of the gallon milk cartons were dated. e. There was an expired container of sour cream dated 2/5/03 (19 days old) and an expired container of sour cream dated 2/12/03 (12 days old) In the freezer: a. There was a bag of meat patties, which was not labeled or dated as to when they had been opened. b. There was a white box approximately 5 inches by 5 inches, which was not labeled as to what it contained.	F 371	F371---continued--- Completed by Dietary Supervisor and Maintenance; monitored by Administrator, and reviewed by Quality Assurance on 4/23/03, and quarterly thereafter.	4/27/03

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F 371	Continued From page 45 In the freezer room: a. There was a very dusty vent in the window.	F 371		
F 387 SS=E	483.40(c)(1)&(2) PHYSICIAN SERVICES The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that 5 of 15 sampled residents were not seen by a physician at least every 30 days as required for the first 90 days after admission, and at least once every 60 days thereafter. Resident identifiers: 2, 24, 33, 54, 66. Findings include: 1. Resident 2 was admitted to the facility on 2/4/02, with the diagnoses of, congestive heart failure with anxious and depressive features, diabetes mellitus, chronic ischemic heart disease, osteoarthritis, hypertension, organic brain syndrome, coronary artery disease, right eye cataract, and cerebral vascular accident with anxious and depressive features. A review of resident 2's medical record revealed that the resident had been seen by a physician on 7/22/02, 10/1/02 and 1/10/03. Resident 2 should have been seen by a physician on or around 12/1/02. In an interview with the DON (director of nursing), on 2/27/03, she stated that she could not find any further	F 387		

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F 387	Continued From page 46 documentation that resident 2 had any further physician visits than the documented visits in the residents' medical record. 2. Resident 24 was admitted to the facility on 10/1/99, with the diagnoses of paralysis - Parkinson's disease, essential hypertension, and acquired hypothyroidism. A review of resident 24's medical record revealed that the resident had been seen by a physician on 7/22/02, 10/24/02, and 1/10/03. Resident 24 should have been seen by a physician on or around 9/22/02, and 12/24/02. In an interview with the DON, on 2/26/03, she stated that she could not find any further documentation that resident 24 had any further physician visits than the documented visits in the resident's medical record. 3. Resident 54 was admitted to the facility on 4/4/02, with the diagnoses of ischemic colitis, hypertension, osteoarthritis, cholelithiasis, osteoporosis, asthma, chronic headache, and dementia with depressive features. A review of resident 54's medical record revealed that the resident had been seen by a physician on 6/20/02, 9/9/02 and 1/10/03. Resident 54 should have been seen be a physician on or around 11/9/02. 4. Resident 33 was admitted to the facility on 12/19/02 with diagnoses that included cerebrovascular disease, macular degeneration, Alzheimer's disease and a history of cancer of the testicles and prostate. Resident 33's medical record was reviewed on 2/26/03. A review of resident 33's medical record revealed that the resident had been seen by a physician on 12/26/02. Resident 33 should have been seen by a physician on or around 1/26/03. As of 2/27/03, there was no	F 387		

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F 387	Continued From page 47 documentation in the medical record to provide evidence that resident 33 had been seen by a physician since 12/26/03. The nurse manager for the SNU was interviewed on 2/27/03. The nurse manager stated that the only time that resident 33 had been seen by the physician since admission to the facility was on 12/26/03. 5. Resident 66 was admitted to the facility on 5/20/98 with diagnoses including status post fractured femur, senile and pre-senile dementia, hypertension, osteoporosis and anemia. A review of resident 66's medical record was completed on 2/24/03. Documentation in the medical record revealed that on 6/6/02 and again on 11/15/02 a physician had seen resident 66. Resident 66 should have been seen by a physician on or around 8/6/02, 10/6/02, and 1/15/03. On 2/26/03, the facility was asked to provide any documented evidence that resident 56 had been seen by a physician on or around 8/6/02, 10/6/02, and 1/15/03. The facility was unable to provide the survey team with this information. 6. In an interview with the facility DON, on 2/27/03 at 11:00 AM, she stated that the facility staff had been aware that there had been missed physician visits. The DON stated that one of the contributing factors was the medical director reduced his/her hours at the facility during the months of October and November 2002. The DON stated that the facility had recently, within the previous 2 weeks, obtained the services of another physician to help meet the federal requirements for physician visits.	F 387	F387 Each of the identified residents has been seen by a physician. The dates are as follows: Residents # 33 and 66 were each seen by the physician on 2/28/03. Resident # 2, 24, and 54 were each seen by the Physician on 3/13/03. Referring to deficiency in paragraph #6, the D.O.N. flatly denies that she had stated that the Medical Director had reduced her hours at the facility in October and November 2002. However, the D.O.N.'s comment is correct that the Medical Director herself has obtained the services of an additional physician to help ensure timely visits of residents of the facility. Medical records will conduct regular, bimonthly audits to track when physician's visits are due. She will give this information to the Medical Director, the Physician, and their respective support nursing staff. Medical Records will then follow-up on timeliness of the physicians' visits and report any problem areas to both physicians, and to the facility Director of Nursing and Administrator. Completed by Medical Records and Physicians; monitored by Medical Records, Administrator and Director of Nursing. Reviewed by Quality Assurance Committee on 4/23/03 and quarterly thereafter.	4/29/03

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

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F 432 SS=E	483.60(e) PHARMACY SERVICES In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined that the facility did not consistantly kept medications and biologicals in locked compartments. Findings include: During the initial tour of the facility on 2/24/03, resident 47 was observed lying in her bed, a medicine cup which contained multiple medications was observed on her bedside table. During the morning medication pass on 2/25/03, a facility nurse was observed to leave 3 bubble packs of medication which included: Colace, aspirin, and Norvasc, on top of the medication cart at the south nurses station, while she administered medication to two residents. During an interview on 2/27/03 with the nurse who performed medication pass, she stated that the half	F 432 DL 4/9/03 DS	F432 Medications left at Resident 47's bedside on 2/26/03 were removed by the charge LPN. The Charge nurse spoke with Resident 47, stating that she needs to take her medications in the nurse's presence. In order to ensure that this deficient practice will not recur with Resident 47 or any other Resident, Nursing Administration will implement the following practices. The nurses were inserviced by the Director of Nursing (DON) on 3/13/03 about proper storage and administration of medications as well as the policy to keep medication carts locked when they are out of their line of vision. It was reviewed then, that it is the policy of Draper Rehabilitation and Care Center, as well as being a good standard of nursing practice, to watch each Resident swallow their pills, before leaving their side. The nurses identified other Residents who are at risk with this area of concern. This issues was addressed with the Residents at the Residents' Counsel meeting, by Recreation person, on 3/26/03. It was reported by Recreation that all the Residents in attendance were in agreement with nursing's request, to consume their medications in front of the nurse administering the medications. Nursing Administration and Resident Services Coordinator will speak individually with those Residents at risk of refusing to consume meds in nurse's presence, and who did not attend Resident Counsel. --continued--	4/27/03

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F 432	Continued From page 49 door to the nurses station on the south hall is always left open and occasionally residents would come behind the desk where the medication cart was kept. On 2/26/03 at 9:11 AM, on the Autumn Ridge Unit, an unlocked medication cart was observed in the hallway outside of room 46. No licensed personnel were present. Two residents were observed wandering up and down the hallway. On 2/26/03 at 1:20 PM, 2 Fibercon pills were observed in a medication cup at the bedside of resident 47. She was observed to be lying in her bed.	F 432	F432 --continued-- DON will inservice nurses again about the proper storage and administration of medications. DON and DSD will perform a medication pass and storage audit every week at each nurse's stations, including each med cart, to ensure compliance with correct policies and procedures. DON and DSD will also check rooms of identified at risk Residents every week to monitor compliance and document findings on an audit sheet. All nurses will receive a copy of the policies and procedures. Anyone who fails to comply will be subject to disciplinary action.	
F 460 SS=E	483.70(c)(1)(iv&v) PHYSICAL ENVIRONMENT Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation the facility did not have resident rooms equipped to assure full visual privacy for each resident. Four of fifty resident rooms did not have curtains that provided residents with full visual privacy. Room identifiers 12, 44, 47, and 48. Findings include: Observation of resident rooms, from 2/24/03 to 2/27/03, revealed the following in relationship to the privacy curtains:	F 460	Completed by DON and Resident Services; monitored by DON and DSD. Reviewed by Quality Assurance Committee on April 23, 2003 and quarterly thereafter.	4/27/03

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F 460	Continued From page 50 Room 12: The privacy curtain at the foot of the bed for bed A, allowed approximately 2 feet of visualization of the resident. Room 44: The privacy curtain was missing for bed B, which allowed full visualization of the resident. Room 47: The privacy curtain for bed A, allowed approximately 1 foot of visualization of each resident between the center curtain and the curtains at the foot of bed A and bed B. Room 48: The privacy curtain on bed A, allowed approximately 1 foot of visualization of each resident between the center curtain and the curtains at the foot of bed A and bed B. The privacy curtain was missing for bed B across the foot of the bed, which allowed full visualization of the resident. The privacy curtain for bed C, allowed approximately 18 inches of visualization between the wall the foot of the bed.	F 460 AC 4/9/03 DS	F460 Maintenance person removed the privacy curtains that were too short, and disposed of them. Housekeeping Supervisor and Maintenance person will inspect listed rooms, and obtain proper privacy curtains from Laundry, and install them properly, to ensure privacy of residents. This task will be documented and signed off by Housekeeping Supervisor. Housekeeping Supervisor will instruct housekeeping staff and perform monthly walk-throughs with documentation to routinely ensure that privacy curtains are properly hung in all residents' rooms. Completed by Housekeeping Supervisor and Maintenance person, monitored by Administrator, and reviewed by Quality Assurance Committee on 4/23/03 and quarterly thereafter.	4/27/03
F 502 SS=G	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 interview and record review, it was determined that the facility did not obtain laboratory services for 1 of 15 sample residents, as ordered by the physician. (Resident 3) Findings include: Coumadin is an oral anticoagulant used to control and prevent clotting disorders. Prescribing the dose that	F 502		

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F 502	Continued From page 51 both avoids bleeding complications and achieves therapeutic range clotting times requires monitoring through laboratory tests. The prothrombin time (PT) is a laboratory test used for monitoring blood clotting time in a specific individual. (Reference Guidance: Brunner and Suddarth"s textbook of Medical-Surgical Nursing 8th edition 1996 Lippincott pages 802-803). The International Normalized Ratio (INR), is another laboratory test used in conjunction with prothrombin time in determining if therapeutic doses of anticoagulant medication are being administered. (Reference Guidance: Physician"s Desk Reference 53 Edition 1999 Medical Economics Company page 932). Resident 3 was re-admitted to the facility on 1/21/03, with the diagnoses of left total hip arthroscope, chronic obstructive pulmonary disease, anemia, hypertension, dementia with psychotic, anxious and depressive features, peptic ulcer disease, coronary artery disease and myocardial infarction. Resident 3's medical record was reviewed on 2/25/03 and 3/3/03. A review of admission orders, dated 1/21/03, revealed the following: Coumadin 2.5 milligrams (mg) every day; Draw PT/INR on 1/23/03. On 1/23/03, a blood specimen was obtained, from resident 3, for a PT/INR laboratory test. Resident 3's PT was 18.3 seconds and her INR was 1.5 seconds. Based on these laboratory test values, facility staff obtained physician telephone orders to increase resident 3's Coumadin dose from 2.5 mg daily, to 3 mg daily. The physician also ordered that resident 3's PT/INR be rechecked in one week, on 1/30/03. On 1/28/03, resident 3's attending physician wrote a	F 502 dc 4/9/03 AD	F502 There had been a lab requisition slip filled out for the missed blood draw. The reason that Resident 3 did have the "PT/INR" lab missed on 2/4/03 was due to a simple clerical error: the wrong date was mistakenly put on the lab requisition slip. A "PT/INR" lab was done by the lab on 2/16/03, and appropriate corrective medical action was taken by the licensed nurse and physician. The Director of Nursing (DON) discussed this error with the licensed nursing staff on 3/13/03, and also with the individual RN who had made the clerical error. In order to ensure that this deficient practice will not recur with Resident 3 or other Residents, Nursing Administration will implement the following practices. The DON, with the help of the lab, will inservice all licensed nursing staff on "PT/INR" lab results (i.e. normal vs. abnormal results) and the correct protocol for new and routine lab orders. Communication and follow through will be improved with the implementation of the new report sheets. There will be an area for each nurse to show if there are new lab orders each shift. The Night Nurse, Medical Records, and Nursing Administration will do auditing to ensure that labs are followed through according to the policies and procedures. ---continued---	4/27/03

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DRAPER REHABILITATION & CARE	12702 SOUTH FORT STREET DRAPER, UT 84020

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F 502	Continued From page 52 progress note which included the following direction: "Recent GI (gastrointestinal) bleed continue Prevacid. Monitor anticoagulation closely [secondary to] recent bleed." On 1/30/03, a blood specimen was collected, from resident 3, for a PT/INR laboratory test. Resident 3's PT level was 45.8 seconds and her INR was 4.4 seconds. These PT/INR results were deemed high per the laboratory, utilized by the facility. Based on these laboratory test values, facility staff obtained physician telephone orders to hold resident 3's Coumadin for two days then restart Coumadin 2.5 mg daily on 2/1/03. The physician also ordered that resident 3's PT/INR be rechecked on 2/4/03, and the results to be called to the physician. On 2/15/03, a nursing note entry included the following documentation that resident 3 had blood tinged urine. This nursing entry also included documentation that resident 3's attending physician ordered a PT/INR to be drawn from resident 3 on the morning of 2/16/03. On 2/16/03, a blood specimen was collected, from resident 3, for a PT/INR laboratory test. Resident 3's PT level was 24.3 seconds and her INR was 3.8 seconds. Based on these laboratory test values, facility staff obtained physician telephone orders to hold resident 3's Coumadin and to recheck the PT/INR on Tuesday, 2/18/03. A review of resident 3's laboratory results was completed. Resident 3's PT/ INR which should have been drawn on 2/4/03 were not in the medical record. There was no documented evidence that resident 3 had a blood specimen collected for a PT/INR until 2/16/03.	F 502	F502 --continued— The Night Nurse will be responsible to audit new and routine labs every night, and will document completion of such on a daily lab audit sheet. Nursing Administration will audit report sheets, treatment sheets, and lab audit sheets regularly. Medical Records will assist by performing weekly, random audits. Completed by licensed nurses, Medical Records, Don, and DSD; monitored by the Night Shift Nurse, Medical Records, DON, and Director of Staff Development (DSD); Reviewed by Quality Assurance Committee on 4/23/03 and quarterly thereafter.	4/29/03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465091	A. BUILDING _____ B. WING _____	2/27/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 502	Continued From page 53 A telephone interview was held with a laboratory technician, employed by the laboratory utilized by the facility, on 3/6/03 at 1:30 PM. The laboratory technician state that a PT level greater than 20 seconds is considered a "high level". The PT reference range for an individual not on anticoagulant therapy is 10.7-13.5 seconds. The INR reference range for an individual not on anticoagulant therapy is 0.9-1.2. The usual oral anticoagulant range is 2.0 to 3.0 seconds. The high level anticoagulant range is 2.5 to 3.5 seconds. A telephone interview with the Director of Nursing was conducted on 3/5/03 at 1:00 PM. The Director of Nursing stated that the PT/INR laboratory test, ordered to be drawn from resident 3 on 2/4/03, was not done. The Director of Nursing stated there was no PT/INR drawn on resident 3 between 1/30/03 and 2/16/03. A telephone interview was held with resident 3's attending physician on 3/5/03 at 3:45 PM. The physician stated that facility staff had informed her that the PT/INR ordered, 2/4/03, had not been drawn.	F 502		