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 _____	06/15/2006

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and reviews of records, the facility did not care for residents in a manner and an environment that maintained or enhanced each resident's dignity and respect, for 4 sample residents and 4 supplemental resident. (Resident identifiers: 1, 2, 3,13,14, 15, 17, 18.) Findings included: 1. During the annual recertification survey, the breakfast meal was observed on the special needs unit on the morning of 6/13/06 between 7:30 and 8:30 AM. Three residents were observed at the full assist dining table with a facility certified nursing assistant (CNA 1) assisting them to eat. One of the residents, resident identifier 14, was observed to have a moderate amount of clear mucous drainage extending from [her] nose to chin areas and covering [her] mouth. Resident 14 was observed as CNA 1 fed [her] several spoonfuls of food in this condition without cleaning [her] face. At the conclusion of the meal when resident 14 had been pushed away from the table, surveyors observed that [her] face had not been wiped clean. 2. Resident 13 was admitted to the facility in March of 2005 with diagnoses that included coronary artery disease, congestive heart failure, insomnia, dementia, and chronic obstructive	F 241	The Assistant Director of Nursing/Designee will audit C.N.A's work sections and residents with audit form. 4 C.N.A's and sections per day x 1week then 2 C.N.A.'s and sections per week to prevent reoccurrence. A mini in-service audit book will be implemented and R.C.M's will initiate in-services rotating weekly. The mini in-services will cover all aspects of dignity, dining room process, hygiene and cares. Director of Nursing/Designee will provided a general in-service covering all mini in-services on July 7, 2006 and July 10, 2006. Mini in-services will then rotate weekly. The Director of Nursing will over see the C.N.A. audit forms and mini in-service books weekly x 4 weeks and then monthly. Identified trends will be reviewed/reported quarterly and as need to Facility Quality Assurance Team until a lesser frequency is deemed appropriate Utah Department of Health 761308 JUL - 7 2006 Bureau of Health Facility Licensing, Certification and Resident Assessment	8-3-06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Taylor — TITLE: Administrator — (X6) DATE: 7-6-06

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

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F 241	Continued From page 1 pulmonary disease. On 6/12/06 at 7:30 AM, during the initial tour of the facility resident 13 was observed in her room sleeping in bed. From the hall it was observed that her bedroom door and privacy curtain were opened. The resident was laying on the bed uncovered with her nude backside exposed to the hall. It was observed that 4 staff, 2 residents, and 2 surveyors walked past her open room from 7:30 AM to 7:45 AM. On 6/12/06 resident 13's medical record was reviewed. In an "Interdisciplinary Resident Care Plan - Social Services" ,that was not dated, it was documented in the "Need/Concern/Problem" column that resident 13 "sleeps nude." In the "Goal" column it was documented that staff are to keep the resident "covered or curtains closed @ sleep." 3. Multiple observations were made of the secured, special needs unit from 6/12/06 through 6/15/06. The special need unit had one large day room/dining room adjacent to the hallway that led into the residents' rooms. One CNA (certified nursing assistant) was assigned to work in the special needs unit and other staff intermittently assisted the nursing assistant. On 6/12/06 at 9:25 AM, six residents were observed to be in the dining room. Three residents were seated in front of the television and three residents were seated in lounge chairs along the back wall of the dining room.	F 241		

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F 241	Continued From page 2 On 6/12/06 at 9:25 AM, resident 1 was wandering in his wheelchair in the hallway and the dining room. CNA 1 wheeled resident 1 up to a sink in the dining room where the CNA began to shave him. The CNA stated, "I do this in here so I can keep an eye on everyone." At 10:10 AM, CNA 1 put slipper socks on resident 1's feet. One sock was white and had another resident's initials on it. The other sock was purple. The following day, resident 1 was observed to be wearing one purple sock and one green sock. The CNA told the resident his own socks were too tight. On 6/12/06 at 9:32 AM, CNA 1 took resident 15 to the sink and began to clean out his mouth with a sponge. The CNA stated to the resident, "I am making sure you don't have food in your mouth." The CNA cleaned the resident's glasses and shaved him. At 9:40 AM, resident 15 backed his wheelchair into resident 1's feet. Resident 1 tried to back his wheelchair away. The CNA separated the two residents and then locked their wheelchairs, preventing them from moving independently. On 6/12/06 at 10:04 AM, a TRT (recreation staff) entered the dining room. The TRT stepped between the television and the residents who were watching it. Without speaking to the residents who were in the middle of an old movie, the TRT removed the video the residents were watching. The TRT inserted a different video and walked away to set up an activity. On 6/13/06 at 8:35 AM, two residents had been	F 241		

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sitting in front of the television watching a music video. The TRT entered the room and ejected the video without asking the residents who were watching it.

On 6/12/06 during the lunch service, resident 2 sat at a table with three other residents. Resident 2's table mates had been served and were eating with intermittent assistance of CNA 2. Resident 2, who required 1 to 1 assistance to eat, sat from 12:30 PM until 12:46 PM with no food, watching her table mates eat.

On 6/13/06 at 10:15 AM, resident 17 was lying on a bed in his room. A housekeeper entered resident 17's room without knocking and entered the bathroom. The housekeeper left the room, got a mop, and reentered the room without knocking. The housekeeper entered and left resident 17's room four times without knocking or speaking.

On 6/13/06 at 12:15 PM, resident 1 was taken to the bathroom by CNA 2. At 12:22 PM, the nurse walked into resident 1's room without knocking. The nurse had medicines for the resident. Not finding resident 1 in his bed, the nurse went into the bathroom without knocking. Two minutes later, the TRT and another staff walked into resident 1's room without knocking. The other staff backed out of the room. Without knocking, the TRT went into the bathroom to offer assistance to CNA 2 with resident 1's personal care.

On 6/13/06 at 12:15 PM, resident 3 was observed to have a large wet spot on the back of her lavender dress. The wet area covered the lower

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F 241	Continued From page 4	F 241		

back, buttocks and upper thigh area of resident 3's dress. Resident 3 had sat in a wet chair vacated by another resident. Resident 3 was observed to wander around the unit for 20 minutes while CNA 2 was trying to complete cares for resident 1. After 20 minutes, CNA 2 changed resident 3.

On 6/12/06 at 10:39 AM, resident 18 had been sitting at an activity table with a magazine in front of her and beads in her hands. CNA 4 walked up behind resident 18 and began to pull her wheelchair back from the table without speaking to the resident. CNA 4 talked with another staff while moving resident 18. The resident grabbed at the table to keep from being moved, then grabbed the magazine. CNA 4 took the magazine and beads from resident 18's hands and turned her wheelchair. Resident 18 tried to grab another table but was pulled back from that. The CNA removed the resident from the dining room and down the hallway without speaking to her.

On 6/12/06 during lunch service in the special needs unit, different staff continued to enter and exit the dining room to intermittently assist CNA 2 feed the residents their meals. Resident 14 had food on her face and her place at the table. Each staff commented that resident 14 was making a mess. At 12:50 PM, a nurse came to to stay and assist at resident 14's table. The nurse stated, "Holy cripe, who made this mess?" When resident 14 was assisted out of the dining room, a staff stated, "She's quite the mess."

On 6/14/06, resident 15 was observed at the dining table to have a large wet area between his

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F 241	Continued From page 5 legs. Resident 15 was moved from the table and sat watching television and conversing for 45 minutes before he was taken to have his wet slacks changed.	F 241		
F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility did not provide an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident. Findings included: On 6/14/06 at 10:00 AM, the facility had scheduled and posted table games as the resident activity. It was observed that the facility had set out cards, a word search book, and 2 puzzles on 3 tables located in the back of the common area. On 6/14/06 from 10:45 to 11:15 AM, ten residents were observed watching television in the common area. No residents were observed using the activity supplies provided for the activity. It was observed from 10:45 to 11:15 AM, no staff were present in the common room providing	F 248	Activities F248 The recreation mgr. will begin to make some systematic changes. She will individualize activities for the residents by putting a variety of different games, puzzles, ect. in boxes labeled to their varying degrees of cognition and ability. A list will be put at the nurses station advising staff of the type of activities each resident can participate in. The recreation consultant or the administrator will approve the activities calendar prior to the end of each month to assure we have enough of a variety. We will continue to ask the residents about activities in resident council meeting each month to see if they have any desires or changes we can implement. The social worker will report to QA committee her findings from resident council and the administrator will monitor one activity each week and report his findings to QA committee on a quarterly basis plus the recommendations of the recreation consultant.	8-3-06

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F 248	Continued From page 6 encouragement or notifying residents of the activities provided. At 11:15 AM, one resident asked a staff member what the activities were, and the staff member stated that they could check the board to see what was scheduled. On 6/14/06 at 11:30 AM, a "small group" activity was scheduled for the residents. Ten residents were observed watching television in the common room. Staff were observed to be located at the nursing station. No "small groups" were observed in the facility from 11:30 AM to 12:00 PM when residents were prompted to prepare for lunch. On 6/14/06 at 2:00 PM, an "Ice Cream Social" was the scheduled activity for the residents at the facility. From 2:30 PM to 2:50 PM, eight residents were observed watching a movie and receiving smoothies from the activities director. Five staff were observed socializing at the nursing station, and two staff were making the smoothies. No staff was observed to be interacting with the individuals for the social. At 3:00 PM, an announcement was made over the intercom that smoothies were being sold as a fundraiser for staff. At 3:02 PM, a resident was interviewed in her room. The resident stated that she was unaware that there was an ice cream social. At 3:05 PM, a resident was interviewed in her room. She stated that she sleeps, goes to the restroom, and watches television. She stated that she was unaware that there was an ice cream activity, but said she could not eat ice cream, due to it upsetting her stomach.	F 248	An inservice will be held on July 10th with all staff to make sure they know that everyone can assist with activities to make it more enjoyable for the residents. We will discuss the activities boxes and resident lists and how to implement them.	

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F 248	Continued From page 7 On 6/15/06 during exit conference at approximately 4:00 PM, the Administrator stated that the activities in the common room lacked variety.	F 248	Housekeeping and Maint. We will buy a new lounge chair for the special needs unit and clean the others by 7-12-06. The chairs will be put on a quarterly cleaning schedule to be monitored by the housekeeping supervisor. The results of which will be reported to our QA committee meeting on a quarterly basis.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and reviews of record, the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior, for 14 residents in the survey sample and expanded sample. Findings included: An annual recertification survey was conducted at the facility on 6/12/06 through 6/15/06. During the survey the following instances of lack of housekeeping and maintenance to maintain sanitary, orderly and comfortable service environments were observed. Lounge chairs in the special needs unit were observed to be soiled with a build up of debris substances on the armrests. A top shelf of a linen cabinet in the dining room, at approximately five feet above the floor surface,	F 253	The top shelf of the linen cabinet in the main dining room has been cleaned and boarded up. Our Laundry supervisor will be responsible to inspect each linen cabinet in the facility on a monthly basis and report her finding to our QA committee on a quarterly basis. The carpet in room 13 will be ripped out and replaced with tile by 8-4-06. Our maintenance supervisor will be responsible and will inspect each rooms flooring on a monthly basis and report his findings to our quarterly QA committee meeting.	8-3-06

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F 253	Continued From page 8 was observed to be open at the rear of the cabinet to the exterior foundation of the building, allowing exposure of the top of a shelf directly above the shelves where dining table linens and resident clothing protectors were stored to be open to crawl space soil, wiring, ducting, dust and insect debris. An area of carpet inside the entrance to resident Room 13 was observed to be stained and soiled with a brownish yellow substance. The surface of the floor in this area of carpet was observed to be uneven with surface irregularities presenting possible hazards to ambulation. An area of tile near the entrance of Room 44 on the special needs unit was observed to have loose edges of asphalt tile along the edge of two tiles presenting uneven surface regularities with possible hazards to injury and ambulation. Wheelchair arm cushions on wheelchairs used by two residents, identifiers 9 and 13, were observed to be cracked and ripped presenting sharp and uneven surface irregularities with possible injury risk to the residents. Resident 1's bed was observed to be positioned lengthwise along the wall where a bed headboard was affixed parallel to the bed position. This headboard arrangement caused one edge of the headboard to be projected approximately five inches over resident 1's bed surface at the hip level, which presented an impediment to the resident's use of the total bed surface and an injury hazard to the resident when [he] attempted to reposition in the bed.	F 253	The tile that is protruding in room 44 has been inspected and evaluated that it can be glued down sufficiently so as to not be a hazard to the residents. Our maintenance supervisor will be responsible and will inspect each rooms flooring on a monthly basis and report his findings to our quarterly QA committee meeting. The two wheelchairs armrests that need repair will be fixed or replaced by 8-4-06. Our restorative nurse will be responsible to repair them. To make sure this doesn't happen again, the restorative nurse will inspect each wheelchair on a monthly basis and report to our QA committee meeting on a quarterly basis. Resident 1's room has a headboard affixed to the wall causing potential trouble repositioning. The headboard will be removed by 7-12-06. The maintenance supervisor will be responsible for doing room inspections on a monthly basis and reporting to the QA committee on a quarterly basis.	

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F 253	Continued From page 9 On 6/13/06 at 10:27 AM, CNA 5 was asked to check resident 1's oxygen saturation (Sats). CNA 5 stated that it was difficult to get the Sats because the pulse oximeter wasn't working right. CNA 2 stated that she could not get the pulse oximeter to work at all. CNA 5 stated that she had to hold the clip on the residents' fingers and wiggle the wires just right to make the pulse oximeter work, but that she could usually do it. CNA 5 was able to get a saturation reading for resident 1 that ranged from 85% (percent) to 87%. When asked if that was the only pulse oximeter in the facility, CNA 5 stated there was one other but it was for the nursing unit on the south hall. CNA 5 had been using the machine for the north hall. On 6/14/06 at 12:30 PM, CNA 5 was asked to check resident 1's vital signs. The CNA made repeated attempts for three minutes to get a saturation reading from the pulse oximeter. At one point during the attempt, the reading bounced briefly between 85% and 91%. The CNA stated, "I took it earlier and it was okay so . ." Another staff asked if the batteries needed to be replace and CNA 5 stated that she thought the problem was with the wiring. On 6/14/06, the ADON (Assistant Director of Nursing) was asked to check resident 1's Sats before a nursing procedure. The ADON attempted for several minutes to get an accurate reading from the pulse oximeter but was not successful. The ADON stated that it seemed something was wrong with the wiring of the pulse	F 253	Both O2 sat monitors were fixed immediately June 15, 2006. Our central supply person or designee will audit function of O2 monitors every day x 2 weeks and then every week there after. Our DON will monitor that audits are being completed and indentified trends will be reviewed and reported quarterly and as needed to the QA committee until lesser frequency is deemed appropriate.	

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F 253	Continued From page 10 oximeter.	F 253		
F 278 SS=E	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined, that the facility did not ensure that	F 278	F278 All staff completing MDS's will be in-serviced on mistakes made on MDS's. Director of Nursing/Designee will audit all MDS's x 2 weeks and then will audit randomly 30% MDS's x 2 weeks then will randomly audit 2 MDS a month until resolved. Some of our staff will attend a State of Utah MDS training seminar on July 18, 2006 covering MDS's. Identified trends will be reviewed/reported quarterly and as needed to Facility Quality Assurance Team until lesser frequency is deemed appropriate.	8-3-06

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F 278	Continued From page 11 the Minimum Data Set (MDS) assessments accurately reflected residents' status for 7 of 13 sample residents. (Resident identifier: 1, 2, 3, 6, 7, 11, 13) Findings included: 1. Resident 6 was admitted to the facility in December of 2004 with diagnoses that included chronic obstructive pulmonary disease, cerebrovascular accident, congestive heart failure, asthma and depression. On 6/15/06, resident 6's medical chart review was completed. Resident 6's admission MDS (minimum data set) dated 12/17/04 and an annual MDS dated 12/16/05 both documented that resident 6 was diagnosed with hypothyroidism. There was no documentation found in the medical chart indicating that resident 6 had been diagnosed with hypothyroidism. On 6/12/06 at 3:41 PM, resident 6's Resident Care Manager (RCM) was interviewed. When asked if resident 6 had hypothyroidism, she stated that she didn't think so and then reviewed resident 6's medical chart. The RCM could not find any documentation that resident 6 had been diagnosed with hypothyroidism. 2. Resident 13 was admitted to the facility in July of 2004 with diagnoses that included hypertension, heart disease, diabetes,dementia and cerebrovascular accident. On 6/15/06, resident 13's medical chart review was completed. Resident 13's annual MDS, dated 10/14/05 was reviewed. Section V, the Resident	F 278		

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F 278	Continued From page 12 Assessment Protocol Summary (RAP) was signed as being completed on 10/14/05. The 'Location and Date of RAP Assessment Documentation column was blank and the "Care Planning Decision-check if addressed in Care Plan" column was blank. 3. Resident 11 was admitted to the facility October of 2005 with diagnoses that included dementia with aggressive and anxious features and sexually inappropriate behaviors, organic brain syndrome, psychotic organic condition, cellulitis, gastroesophageal reflux, insomnia, osteopenia, and history of motor vehicle accident with short term memory loss. On 6/14/06, resident 11's medical chart review was completed. There were two MDS's in resident 11's medical chart. Resident 11's comprehensive admission MDS assessment dated 10/26/05 and a quarterly MDS dated 1/26/06, documented in section "I" that resident 11 was admitted with zero diagnoses and no diagnoses had been added to [her] record after [she] admitted. When requested by the surveyor, the facility provided a third MDS assessment dated 4/21/06. The April 2006 MDS assessment documented that resident 11 had no diagnoses. The attestation (section AA9) had been signed by several members of the Interdisciplinary Team and the completion date was documented as 4/21/06 (section R2b). There was no Registered Nurse Coordinator's signature to complete the MDS (section R2a). The quarterly MDS assessment, dated 4/21/06, revealed resident 11 had no balance impairment	F 278		

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F 278	Continued From page 13 (section G3) and ambulated with steady gait (section J1). The nurse's note, dated 4/18/06, revealed "CNA (certified nursing assistant) reported that [resident 11] has been staggering a lot this week. This a.m. she was having trouble picking up her feet while walking and was not walking in a straight line." 4. Resident 3 was admitted to the facility in August of 2002 with diagnoses that included diabetes, hypertension, chronic obstructive pulmonary disease, and dementia. A review of resident 3's active medical records was completed on 6/14/06. A quarterly MDS assessment, dated 3/2/06, revealed resident 3 had no bruises or abrasions. The nurse's note, dated 3/2/06 at 6:30 AM, revealed resident 3 had a "huge Blue bruise" on her left forehead. Resident 3's MDS assessment dated 12/2/05 revealed the resident's weight was 148 pounds. The 3/2/06 MDS revealed resident 3's weight to be 147 pounds. The MDS had been documented that resident 3 had experienced a significant weight loss within the previous 30 days to 180 days. Other weights documented in the Weight Report, for resident 3, revealed the resident's weight was 149 pounds September 2005, 152 pounds October 2005, 147.8 pounds November 2005, 148 pounds December 2005, 147.8 pounds January 2006 and 147 pounds February 2006. According to the documentation, resident 3 did not experience a significant weight loss in the previous 180 days.	F 278		

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F 278	Continued From page 14 The MDS assessments dated 3/9/05 and 6/4/05 revealed resident 3's height to be 59 inches. The MDS assessments dated 12/2/05 and 3/2/06 revealed resident 3's height to be 61 inches. (There was no MDS assessment between December 2005 and March 2006. 5. Resident 2 was admitted to the facility in November of 2003 with diagnoses that included diabetes and Alzheimer's disease. A review of resident 2's active medical records was completed on 6/15/06. A quarterly MDS assessment, dated 4/4/06, revealed resident 2's weight was 93 pounds and that the resident had experienced a significant weight loss over the previous 30 to 180 days. The 1/9/06 MDS revealed resident 2's weight was 89 pounds and that the resident had experienced a significant weight loss. The annual 10/9/05 MDS revealed resident 2's weight was 84 pounds and that the resident had experienced a significant weight loss. Resident 2's weight had been documented as 80 pounds on the 7/12/05 MDS assessment. From July 2005 through April 2006, resident 2 had experience a significant weight gain. 6. Resident 1 was admitted to the facility in May of 2001 with diagnoses that included chronic obstructive pulmonary disease, hypertension, dementia and arthritis. A review of resident 1's active medical records was completed on 6/15/06. Resident 1's MDS assessments, dated 3/1/06	F 278		

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F 278	Continued From page 15 and 5/25/06, had documentation that the resident did not use any type of restraint (section P4). Nurse's notes and physician's orders revealed that on 1/18/06, the resident began using a trunk restraint daily, when he was in his wheelchair. Resident 1's MDS assessment, dated 5/25/06, did not have documentation that the resident was receiving hospice care or was in end-stage disease. Hospice records revealed resident 1 had been on hospice for end of life care since 3/30/06. Resident 1's comprehensive MDS assessment, dated 11/29/05, did not have a completed Resident Assessment Protocol (RAP) Summary (section VA 8, 9, 16, 17). The RAP Summary did not provide information regarding the location of assessment documentation for the decision not to care plan for triggered problems related to the resident's mood state or behavior symptoms. There was no information regarding the location of RAP assessment documentation regarding the decision to care plan for triggered problems related to resident 1's risk for pressure ulcers and use of psychotropic drugs. 7. Resident 7 was admitted to the facility in September, 2005 with diagnoses which included neoplasm, Parkinson's disease, and dysphagia. Resident 7's medical record was reviewed on 6/12/06. Resident 7's MDS assessment dated 9/18/05 was noted to document resident 7's height as 71	F 278		

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F 278	Continued From page 16 inches and weight as 71 pounds. An MDS assessment dated 9/23/05 showed resident 7's weight to be 133 pounds and resident 7's weight assessments documented elsewhere in [his] medical record showed correct weights to range from 133 to 140 pounds.	F 278		
F 286 SS=B	483.20(d) RESIDENT ASSESSMENT - USE A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility did not maintain Minimum Data Set (MDS) assessments completed within the previous 15 months in the active clinical record for 4 of 13 sample residents. (Resident identifiers: 1, 2, 3 and 11) Findings included: 1. Resident 1 was admitted to the facility in May of 2001 with diagnoses that included chronic obstructive pulmonary disease, hypertension, dementia and arthritis. A review of resident 1's active medical records was completed on 6/15/06. The oldest MDS assessment on the active medical chart was dated 2/25/05. The most recent MDS on the chart was dated 3/1/06. This constituted 13 months of MDSs, not the required	F 286	F286 Medical Records will perform an audit of all charts to check to see if there are 15 months worth of MDS's present. Medical Records will perform an audit of charts by July 7, 2006 then monthly thereafter. Director of Nursing/Designee will oversee MDS are in charts initially and every month. Identified trends will be reviewed/reported quarterly and as needed to Facility Quality Assurance Team until lesser frequency is deemed appropriate.	8-3-06

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F 286	Continued From page 17 15 months of MDS on the active medical chart. 2. Resident 2 was admitted to the facility in November of 2003 with diagnoses that included diabetes and Alzheimer's disease. A review of resident 2's active medical records was completed on 6/15/06. The oldest MDS assessment on the active medical chart was dated 4/11/05. The most recent MDS on the chart was dated 4/4/06. This constituted 13 months of MDSs the chart, not the required 15 months of MDS on the active medical chart. 3. Resident 3 was admitted to the facility in August of 2002 with diagnoses that included diabetes, hypertension, chronic obstructive pulmonary disease, and dementia. A review of resident 3's active medical records was completed on 6/14/06. The last MDS on the active medical chart was dated 3/2/06. There should have been another MDS dated on or about 6/2/06 on the active medical chart and there was not. A quarterly MDS, dated 5/26/06, was later provided by the facility when requested by the surveyor. 4. Resident 11 was admitted to the facility in October of 2005 with diagnoses that included dementia, gastroesophageal reflux disease, and insomnia. A review of resident 11's active medical records was completed on 6/14/06.	F 286		

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F 286	Continued From page 18 The last MDS on the active medical chart was dated 1/26/06. There should have been another MDS dated on or about 3/26/06 on the active medical chart and there was not. A quarterly MDS, dated 4/21/06, was later provided by the facility when requested by the surveyor.	F 286		
F 309 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview it was determined that the facility did not provide the necessary care and services to attain or maintain the highest practicable physical well being for 2 of 13 sample residents. (Resident identifiers: 1 and 5) Findings Included: 1. Resident 5 was admitted to the facility in June of 2000 and readmitted in February of 2006 with diagnoses that included dementia, cerebrovascular accident and hypertension. A review of resident 5's medical record was completed on 6/15/06.	F 309	F309 The Director of Nursing in-serviced deficient nurse on July 3, 2006 and then will monitor the nurse change dressings until 3 dressings are changed per policy and procedure. The director of nursing will provide a general in-service to all nurses by July 7, 2006 and then bi-annually. The Director of Nursing will over see that all in-services are completed. Identified trends will be reviewed/reported quarterly and as need to Facility Quality Assurance Team until a lesser frequency is deemed appropriate.	8-3-06

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F 309	Continued From page 19 On 2/10/06 at 9:00 AM, LPN 1 (licensed practical nurse) documented the following in a nurse's note,"Client confused, paresis on (right) side, unable to swallow meds w/o (without) choking. S/S (signs ans symptoms) of stroke." On 2/10/06 at 12:00 PM, LPN 1 documented the following in a nurse's note,"Client continues to be confused, dysarthria, drooling, unable to speak clearly. Family was contacted regarding her advanced directive code status. Son still wants 'Full code' and hospitalization if her condition becomes life-threatening. We indicated it was our policy to send them to the hospital..." On 2/10/06 at 3:00 PM, LPN 1 documented the following in a nurse's note,"Client resting in bed quietly. Follows with eyes but still shows pronounced signs of (right) side weakness. (Decreased) ability to speak." No further nurse's notes were documented until 2/11/06 at 12:05 PM by another facility nurse (unable to discern name of nurse). It was documented that, "Res (resident) continues to show S/S stroke (right) sided neglect noted... Res awake, alert, no verbal response to questions, makes eye contact...Son in @ 10:30 discussed res code. Son indicated he would like her sent to hospital for eval...Res discharged to (hospital) ER (emergency room) via ambulance...Res left@ 12:30." It was approximately 27 hours between the documentation of the onset of CVA (cerebrovascular accident) symptoms at 9:00 AM on 2/10/06 and resident 5 being transported to	F 309	A mini in-service audit book will be implemented and R.C.M's will initiate in-service rotating weekly. The mini in-service's will cover toileting and changing patient every two hours, change in condition, documentation and following orders of MAR's Tar's (02 sats, bs, v.s., edema ect.) and C.N.A. charting,. Director of Nursing/Designee will provide a general in-service covering all mini in-services on July 7, 2006 and July 10, 2006. The Director of Nursing will over see that mini in-services are completed weekly x four weeks then monthly. Identified trends will be reviewed/reported quarterly and as needed to Facility Quality Assurance Team until lesser frequency is deemed appropriate.	

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F 309	Continued From page 20 the hospital at 12:05 PM on 2/11/06. Resident 5 was then admitted to the hospital for approximately 12 days and then readmitted to the facility on 2/23/06. On 6/15/06 at 9:15 AM, resident 5's physician was interviewed via the telephone. The physician stated that she was informed by the facility on the morning of 2/10/06 that resident 5 showed S/S of an evolving CVA. She stated that she instructed the nurse to contact a family member about resident 5's code status and then the facility was to transfer resident 5 to the hospital. The physician stated that she was very upset when she was informed that resident 5 was not sent to the hospital until the next day on 2/11/06. The physician stated that the facility should have transported resident 5 to the hospital on 2/10/06. On 6/14/06 at 9:45 AM and at 3:30 PM, LPN 1 was interviewed. LPN 1 stated that when she finished her shift and left work on 2/10/06, she thought that the evening nurse was going to transfer resident 5 to the hospital. LPN 1 stated that she did not work with resident 5 on 2/11/06. 2. Resident 1 was admitted to the facility in May of 2001 with diagnoses that included dementia and arthritis. A review of resident 1's active medical records was completed on 6/15/06. a. On 6/13/06, resident 1 was observed from 7:35 AM when he was brought to the breakfast table, until 12:15 PM when he was taken to the bathroom for personal cares. Resident 1 was in his wheelchair in the dining	F 309	02 sat monitors were fixed immediately June 15, 2006. Central Supply/Designee will monitor function of 02 monitor's every day x 2 weeks and then every week there after. Director of nursing will monitor that checks are being completed/identified trends will be reviewed/reported quarterly and as needed to Facility Quality Assurance Team until lesser frequency is deemed appropriate.	

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room at 7:35 AM. CNA 2 called a second staff to assist her transfer resident 1 into a lounge chair at 9:35 AM and the resident's feet were elevated. Resident 1 remained in the lounge chair until he was transferred back into his wheelchair at 12:15 PM. CNA 2 took the resident to the bathroom to toilet him and change his wet clothing. Resident 1 had not been assisted to the bathroom for 4 hours and 40 minutes.

b. On 6/14/06, LPN 3 was observed by two nurse surveyors during a dressing change procedure for resident 1's pressure sores. The nurse washed, gloved and followed proper procedure to remove the old dressings from resident 1's feet. After cleansing resident 1's right foot wound, the LPN did not change his gloves or wash his hands before applying the clean dressing.

The DON (Director of Nursing) was present during the dressing change to resident 1's left foot wound. The LPN repeated the procedure as before. LPN 3 did not change his gloves or wash his hands between cleansing the left foot wound and beginning to apply the clean dressing.

c. Resident 1 had an order for oxygen to be used as needed and for his oxygen saturation to be tested each shift to help determine the need.

On 6/13/06 during breakfast, the surveyors observed resident 1's hands to be purple. At 10:27 AM, CNA 5 came to the special needs unit dining room with equipment to check another resident's vital signs. CNA 5 was asked to check resident 1's oxygen saturation (SATs). The CNA had stated that it was difficult to get the SATs because the pulse oximeter wasn't working right.

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CNA 2 stated that she could not get it to work at all. CNA 5 stated that she had to hold the clip on the residents' finger and wiggle the wires just right to make the pulse oximeter work, but that she could usually do it.

CNA 5 was able to get a saturation reading for resident 1 that ranged from 85% (percent) to 87%. The CNA cued resident 1 to breath deeply and the saturation reading raised to 87% and 88%. Resident 1 was given oxygen via nasal cannula until 12:15 PM when he was taken to his room.

On 6/14/06, resident 1 was noted by CNA 2 to be weaker than usual. The surveyors observed the resident had a deep coarse sounding cough. At 12:30 PM, CNA 5 was asked to check resident 1's oxygen saturation. The CNA made repeated attempts for three minutes to get a saturation reading from the pulse oximeter. At one point during the attempt, the reading bounced briefly between 85% and 91%. The CNA stated, "I took it earlier and it was okay so . .", and the CNA left the room.

Review of resident 1's medical record revealed the resident had a physician's order, dated 5/21/04 and recertified May 2006, for oxygen saturations to be checked every shift and more as needed. A physician's order dated 7/26/04 revealed resident 1 was to be given oxygen as needed to keep his oxygen saturations above 90%.

Resident 1's TARs (Treatment Administration Record), dated March 2006 through June 2006 revealed the resident's saturations were being

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F 309	Continued From page 23 checked once daily or less. Resident 1's June 2006 TAR, for dates 1 through 13 revealed the resident's saturation had not been checked on Sunday, 6/11/06. The record revealed once daily saturations checks on: 6/1/06 saturation 90%, no oxygen given, 6/2/06 saturation 90%, no oxygen given, 6/3/06 saturation 88%, oxygen given to raise saturation to 91%, 6/4/06 saturation 88%, no oxygen given, 6/5/06 saturation 91%. 6/6/06 saturation 92, 6/7/06 saturation 91%, 6/8/06 saturation 92%, 6/9/06 saturation 90%, no oxygen given, 6/10/06 saturation 88%, no oxygen given, 6/11/06 not checked, 6/12/06 saturation 92 on 2 liters of oxygen, 6/13/06 saturation 94 on 2 liters of oxygen. d. Resident 1 had a physician's order, dated 3/23/05 and recertified May 2006, for resident 1 to receive a diuretic medication every other day and his edema to be checked every shift. The nurses were to document in the MAR (Medication Administration Record) when the medication was given and what the result of the edema check was. Review of resident 1's MAR revealed the facility did not record edema checks every shift or every day. The June 2006 MAR for resident 1 had an area for the nurse's to document edema but it had been left blank from 6/1/06 through 6/13/06.	F 309		

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F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined the facility did not store, prepare, distribute and serve foods under sanitary conditions. Findings included: During the initial tour of the kitchen, on 6/12/06 at 6:55 AM, two surveyors observed that 3 of the 3 kitchen staff were not wearing hair nets. Breakfast preparations were in the final stages and trays were being readied. The staff donned hair nets after the surveyors asked if any hair covering was available. An uncovered tray of approximately 46 glasses of apple juice were observed to be on a shoulder high shelf in the walk in refrigerator. A box of bacon in the refrigerator was uncovered, not dated and not on a tray. When the surveyors entered the kitchen, glasses of milk, juice and thickened water were observed to be arranged on the counter and on a wheeled cart. The breakfast foods were waiting on the steam table. The staff was asked to take the temperatures of the foods and beverages before beginning to serve them. The pureed eggs tested to be 136 degrees F (Fahrenheit) at the first	F 371	Dietary All Dietary staff will be inserviced by 7-11 on proper procedures, including buy not limited to use of hairnets at all times, proper dating of food items, covering foods, proper handwashing procedures, acceptable food temperature, the correct cleaning solution mixture, our dented can policy, and the proper use of gloves. The administrator or designee will audit these deficient practices daily for 5 working days, then weekly for one month, then monthly. The administrator or designee will report the findings to our QA committee on a quarterly basis.	8-3-06

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F 371	Continued From page 25	F 371		

attempt, with the thermometer halfway into the mixture. The temperature raised to 140 degrees F when the thermometer was pushed down deeper into the pan.

The scrambled eggs tested to be 128 degrees F at the edge of the pan, and 140 degrees in the center of the pan.

The fortified milk tested to be 48 degrees F and the soy milk tested to be 50 degrees F.

The danger area for food born bacteria is between 41 degrees F and 140 degrees F.

A test tray was requested to be added to the serving cart that went to the special needs unit. As soon as the last person had been served on the special needs unit, the surveyors tested the temperature of the foods on the test tray. The food temperatures were tested in the presence of the dietary manager.

The test tray food temperatures were:
Scrambled eggs, 98 degrees F,
Oatmeal, 126 degrees F,
Fortified Milk, 62 degrees F,
Orange Juice, 62 degrees F.

Before serving, a kitchen staff took a cleaning cloth from a bucket of milky topped water and rinsed it under tap water to wipe the serving counter.

A gallon can of beets and a gallon can of yams were observed stacked on shelves in the pantry. The cans were dented at the top rims. Beets were served to the residents for lunch on 6/6/06.

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F 371	Continued From page 26 On 6/7/06, the dietary manager stated that the beets were not thrown away and the can was not put in his office where dented cans are kept until they can be returned for credit. The dietary manager and the surveyor noted that the dented can of yams was still on the shelf, but that the dented can of beets was no longer there. On 6/13/06 at 11:35 AM, kitchen staff were observed during lunch preparation. A staff member was observed wearing gloves, touched a cupboard and a counter and picked up a large bag of pasta. The staff opened the pasta bag and reached in with her gloved hand, removed handfuls of noodles and put them in a pot to cook. The staff then removed her gloves. The staff took a spatula from a drawer and used it to lift a grilled cheese sandwich. The staff touched the bread with her left hand as she turned the sandwich. Another kitchen staff was wearing gloves as she prepared garlic toast. The staff touched a cupboard, containers of garlic and parsley and the oven door handle. The staff put an oven mitten over her gloved hand to remove a tray of toast from the oven. The staff removed the oven mitten but not the glove. The staff then picked up toast tips with her gloved hands to put the toast in individual sandwich bags. A kitchen staff cleaned up the preparation dishes with gloved hands. The staff put oven mittens on over her gloves to take food to the steam table. The staff removed the mittens and went into the refrigerator for a tray of fruit cups. The staff member picked up a box of tin foil and took her pen from her pocket to write on it. The staff lifted	F 371		

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F 371	Continued From page 27 the four ladles off their hooks by holding the scoop ends, and carried them to the steam table to serve the meal. On 6/14/06 at 2:05 PM, the kitchen was observed during lunch cleanup. Mashed potatoes, chicken noodle soup and tomato soup were in containers set on a counter cooling at room temperature. A cleaning cloth was in a bucket of water in the dish washing area. When the staff was asked to test the water in the bucket for sanitizer, she stated that there was only water in the bucket. A cleaning cloth was in a bucket of water near the preparation table. When the staff was asked to test the water for sanitizer, she stated that it probably wouldn't be enough because it had been out a long time and was due to be changed. The sanitizer in the water tested to be greater than 200 parts per million. In an interview with the dietary manager, he stated he would retrain the kitchen staff to only use one capful of sanitizer to a bucket of water.	F 371		
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by:	F 444		

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F 444	Continued From page 28 Based on observations and interviews, the facility did not ensure that facility staff washed their hands after each instance of direct resident contact for which handwashing was indicated by accepted professional practice, for 8 of 13 sampled residents. (Resident identifiers: 1, 2, 6, 9, 11, 14, 16, 18) Findings included: 1. Resident 9 was admitted to the facility during May, 2006 with diagnoses which included insulin dependent diabetes mellitus, urosepsis, stage IV decubitus ulcer coccyx area, and tube feeding for nutrition. On 6/13/06 at approximately 9:45 AM, three facility staff members were observed while providing catheter care and pressure ulcer dressing care to resident 9. Certified Nursing Assistant 1 (CNA 1) was holding resident 9 to position [her] on [her] right side during the procedure. After the procedure was finished, CNA 1 was observed to remove [his] gloves and leave the room without first washing [his] hands. CNA 2 was observed to be gloved and to provide peri care to resident 9. After the procedure was finished, CNA 2 was observed to handle resident 9's peri wipe container and place it on the bedside table providing full contact to the container with the soiled gloves. CNA 2 was observed to then remove the soiled gloves and leave resident 9's room without first washing [her] hands. 2. Resident 6 was admitted to the facility in December of 2004 with diagnoses that included	F 444	F444 The Director of Nursing /Designee will perform a general in-service on July 7, 2006 and July 10, 2006 on infection control. A hand washing in-service was completed on 6/12/06. A mini in-service book will be implemented and R.C.M's will initiate in-services rotating weekly. The mini in-service covers hand washing. The Director of Nursing/Designee will over see that mini in-services are completed weekly x four weeks then monthly. Identified trends will be reviewed/reported quarterly and as need to Facility Quality Assurance Team until lesser frequency is deemed appropriate.	8-3-06

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F 444	Continued From page 29 chronic obstructive pulmonary disease, cerebrovascular accident, congestive heart failure, asthma and depression. On 6/13/06 at approximately 8:45 AM, CNA 3, who was wearing gloves turned resident 6 from his back onto his side so that a facility nurse could inspect his back. Resident 6's skin on his lower and mid back was red and his buttock had a white protective cream on it. CNA 3 touched the reddened areas on the resident's back and also his buttock. When the nurse was through looking at his back, CNA 6 turned resident 6 onto his back. CNA 3 proceeded to get the resident ready for a shower and without changing his gloves or washing his hands, the CNA, using both hands, took the nasal cannula off of resident 6's face. On 6/13/06 at 9:02 AM, the ADON (assistant director of nursing) was interviewed. He stated that resident 6 had reddened skin on his back because the resident had a skin infection. 3. Observations were made in the special needs unit during meals on 6/12/06, 6/13/06, 6/14/06 and 6/15/06. Fourteen dependent residents from both the special needs unit and other areas of the facility were brought to the special needs unit for assisted dining. Multiple nursing staff who assisted the residents, during each of the meals, were observed to feed residents without washing their hands between potentially contaminated contacts. Observations included but were not limited to: On 6/12/06 at the lunch meal, CNA 2 assisted residents at three different tables until help arrived. CNA 2 did use hand sanitizer between	F 444	The Director of Nursing in-serviced deficient nurse on July 3, 2006 and then will monitor the nurse change dressings until 3 dressings are changed per policy and procedure. The Director of Nursing will provide a general in-service to all nurses by July 7, 2006 and then bi-annually. The Administrator will over see that all in-services are completed. Identified trends will be reviewed/reported quarterly and as need to Facility Quality Assurance Team until a lesser frequency is deemed appropriate.	

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F 444	Continued From page 30 some contacts that required hand cleaning, but not all. The CNA adjusted a resident 16 glasses, handed resident 14 a piece of bread, patted another resident's back and then sanitized her hands. The CNA handled resident 14's cup that the resident had smeared with food, then resident 16's straw, then resident 2's tray, then resident 11's bread, and then sanitized her hands. CNA 2 left the sanitizer on the table where resident 11 put it in her mouth while the CNA assisted another resident. CNA 1 recapped the bottle that resident 11 had handled, put it in her pocket and turned to feed resident 2. CNA 3 assisted four residents at a horseshoe table. CNA 3 was observed to run his fingers through his hair, across his moustache, and across his forehead intermittently while feeding and assisting the residents to eat. CNA 3 was observed to wipe resident 18's mouth with a napkin, wipe another resident's mouth with a different napkin, then open a milk carton for resident 18, without washing or sanitizing his hands. CNA 3 picked up a napkin from the floor, move a stuffed horse/ball that had been used to keep a resident's ankles apart (and was on the table near another resident's tray), and continued to assist the resident's without washing or sanitizing his hands. 4. On 6/14/06, LPN 2 was observed by two nurse surveyors during a dressing change procedure for resident 1's pressure sores. The nurse did not change his gloves or wash his hands after cleansing the wounds and before applying the clean dressing.	F 444		

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F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility did not equip each resident's room with a functioning call light for 3 of 6 residents' rooms and 1 of 6 bathrooms in the special needs unit. (Resident identifiers: 1, 3 and 17.) Findings included: During breakfast service on 6/12/06, resident 17 stayed in his bed. A CNA (certified nursing assistant) came from an area outside the special needs unit to see why no one was answering resident 17's call light. None of the staff working in the special needs unit was aware the call light had been activated because the light above the door did not work and there was no audible alarm within the unit. On 6/12/06, two surveyors checked the call light system in the special needs unit. There were three beds and three call light cords in resident 17's room. One of the call light cords did not activate the call system and none of the call light cords / buttons activated the light above the door. It was observed the call light switch in resident 17's bathroom had been tied down with strings attached to a safety bar that prevented it from being used.	F 463	Call Lights All the call lights in the unit will be repaired and added by 8-2-06. An inservice will be done addressing the need for functioning call lights and to never tie them down and to always have them within reach of the resident. The maintenance man will do monthly call light audits to assure they are always working. He will then report his findings on a quarterly basis to our QA committee.	8-3-06

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F 463	Continued From page 32 There were two beds and two residents in resident 1's room. Resident 1's bedroom did not have call light cords to use. Resident 1's care plan specified that the resident was to be encouraged to use his call light. Resident 3's room did not have call light cords to be used. Resident 3's care plan specified that the staff were to ensure the resident's call light was within reach and answered promptly and to encourage the resident to wait for assistance to come.	F 463		