DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 2/15/01
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465055	A. BUILDING ______ B. WING ______	2/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEDERAL HEIGHTS REHAB AND NURS	41 S 900 E SALT LAKE CITY, UT 84102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 274 SS=D	483.20(b)(2)(ii)RESIDENT ASSESSMENT Within 14 days after the facility determines, or should have determined, that there has been a significant change in the residents physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the residents status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the residents health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review the facility did not ensure that comprehensive assessments (including RAI) of the residents' needs were completed within 14 days after the facility determines, or should have determined, that there had been a significant change in the residents physical or mental condition. Significant change assessments were not completed for 2 of 20 sampled residents who had showed declines with the quarterly assessments. (Residents 42 and 48). Finding include: RESIDENT 42: Resident 42 was admitted on 08/14/00 with diagnoses including dementia, malnutrition, osteoporosis, aphasia, dysphagia, history of decubitis ulcer right hip, incontinence, deafness, contractures and right hemiplegia. A review of resident 42's medical record was completed on 1/29/01.	F 274	This Plan of Correction is being submitted in accordance with specific regulatory requirement and should not be construed as an admission of guilt or agreement with any of the deficiencies cited on the HCFA 2567-L; nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge legal proceedings, all deficiencies, statements, findings, facts and conclusions that for the basis for the deficiencies. 274 Federal Heights Rehab is committed to accurately assessing each resident **Corrective action for Identified Residents** Resident 42 no longer resides at Federal Heights Rehabilitation. A new assessment was done on Resident 48 on 12/2/01 to reflect the change in condition. **Identification of Resident Potentially affected** All residents have the potential to be affected. **Measure to prevent recurrence** Licensed nursing staff participating in the MDS Process will be in-serviced by 3/27/01 by the Director of Nursing Services or Designee on how to accurately identify residents with significant change in condition and need for comprehensive assessment.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brian Davis

TITLE: Administrator

(X6) DATE: 3/8/01

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

03/28/01 HT

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F 274	Continued From page 1 On 08/21/00, an admission comprehensive MDS assessment was completed for the resident.. On 11/13/00, a quarterly MDS assessment was completed for the resident. A comparison of the two assessments documents a significant change in the residents condition. These significant changes should have triggered a comprehensive MDS assessment. The areas where significant changes were documented included: 1. The resident had a documented decline in Eating: a. MDS (08/21/00) Section G1 Eating (2 = Limited assistance needed). b. MDS (11/13/00) Section G1 Eating (3 = Extensive assistance needed). 2. The resident had a documented weight loss: a. MDS (08/21/00) Section K2-b WT (lb.) = 98. Section K3- a Weight Loss (0 = No). b. MDS (11/13/00) Section K2-b WT (lbs.) = 92. Section K3-a Weight Loss (1 = Yes). A comprehensive MDS assessment was not done to reflect resident 42 significant change in her eating and weight loss. 2. Resident 48 as admitted on 6/4/00 with diagnoses of hypothyroid, hypertension, dementia other than Alzheimer, emphysema, congestive obstructive pulmonary disease, and anemia. Review of resident 48's last two MDS (Minimum Data Set), 9/1/00 (comprehensive assessment) and	F 274	**Monitoring/Quality Assurance** The Director of Nursing Services or Designee will audit for accuracy of MDS assessments using audit tools developed by 3/27/01. Audits will be done monthly for 3 months with reports to be given to the Performance Improvement Committee. Audits will continue as directed by the Performance Improvement Committee. Corrective action will be completed 4/6/01. The DON will be responsible for continued compliance	

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F 274	Continued From page 2 12/2/00 (quarterly assessment), indicated that there had been a significant change in resident condition. This significant change should have triggered a comprehensive assessment I MDS assessment. The areas where these significant changes were documented included: 1. The resident had a documented decline in Bathing: a. MDS (9/1/00) Section G2 Bathing (1 = Supervision only needed). b. MDS (12/2/00) Section G2 Bathing (3 = Extensive assistance needed). 2. The resident had a documented decline in Bowel Continence: a. MDS (9/1/00) Section H1-a Bowel Continence (0 = Continent of bowel). b. MDS (12/2/00) Section H1-a Bowel Continence (3 = Frequently incontinent of bowel). 3. The resident had a documented decline in Bladder Continence: a. MDS (9/1/00) Section H1-b Bladder Continence (1 = Usually continent of bladder). b. MDS (12/2/00) Section H1-b Bladder Continence (3 = Frequently incontinent of bladder). A comprehensive MDS assessment was not done to reflect resident 48's significant change.	F 274		

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F 309 SS=E	483.25QUALITY 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. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff and medical record review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical wellbeing in accordance to the comprehensive assessment and plan of care as evidenced by: One resident's head of the bed was not maintained above 30 degrees during and after enteral feeding. One dressing change, on a resident, did not follow the standards of nursing practice. In 2 of 20 sampled residents, the physician's orders were not followed as ordered. Resident identifiers: 16, 27, 102. Findings include: 1. Resident 16 was a 77 year old male resident who was readmitted on 12/21/00 to the facility with diagnoses of peripheral vascular disease, hypertension, hyperlipidemia, cerebral vascular accident, endocarditis, aspiration pneumonia, dementia, below the knee amputation, and aortic stenosis.	F 309	F 309 Federal Heights Rehab is committed to ensuring that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the comprehension assessment and plan of care **Corrective Action for Identified Residents** Resident 16 and 102 no longer resides at Federal Heights Rehabilitation. Resident 27 will have dressing changes done according to the physician facility policy and procedure of how to change a dressing. Resident 27 will be served the diet as ordered by Physician. **Identification of Residents Potentially affected** All residents have potential to be affected. **Measure to prevent recurrence** The licensed nursing staff will be inserviced by 3/27/01 by the Director of Nursing Services or Designee on: 1. Policy and Procedures for residents body position during and after enteral feeding 2. Policy and Procedures on dressing change 3. Policy and Procedure on notification by nursing of diet change to dietary 4. Policy and Procedure on following physician's orders monitoring/ Quality	

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F 309	Continued From page 4 A review of resident 16's medical record documented that on 02/10/96, the physician ordered the head of resident 16's bed to be elevated at least 30 degrees during feedings and one hour after. On 1/30/01, at 8:00 AM, resident 16 was observed for 30 minutes to be laying flat on a low bed with one pillow behind his head while the nurse gave his enteral feeding. On 1/31/01, at 7:30 AM, 7:40 AM, 8:00 AM and 8:20 AM, resident 16 was observed laying flat on a low bed with one pillow behind his head with no enteral feeding running. On 1/31/01, at 7:40 AM, an interview was conducted with the nurse regarding resident 16's bed. She was asked if the head of the bed could be elevated. The nurse stated that the bed could not be elevated but that she elevates resident 16's head with pillows. On 1/31/01, at 8:20 AM, an interview was conducted with the nurse regarding resident 16's enteral feeding and when it was done. The nurse stated she started resident 16's enteral feeding a little after 7:00 AM that day. On 2/1/01, at 1:30 PM, resident 16 was observed laying flat in a low bed with one pillow behind his head receiving a bolus feeding of water. On 2/1/01, at 1:30 PM, an interview was conducted with resident 16 regarding his body position while he received his enteral feeding. He was asked if the staff ever had him sit up during his feedings. Resident 16 stated that the staff has never had him sitting up while his feeding was going.	F 309	The Director of Nursing Services or Designee will audit using audit tools developed by 3/27/01. Audits will be done weekly for 6 weeks on body position during and 30 minutes after enteral feeding, weekly for 6 weeks on dressing changes, and weekly for 6 weeks on notification of diet change to dietary by nursing. Reports will be given at the Performance Improvement Committee meeting monthly for 2 months, then as directed by the Performance Improvement Committee. Corrective action will be completed 4/6/01	

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F 309	Continued From page 5 A review of resident 16's January Medication Administration Record (MAR), revealed that on 1/30/01, 1/31/01 and 2/1/01, the nurse signed that she had resident 16's head of the bed elevated 30 degrees during the feeding and for one hour after the feeding. A review of resident 16's nurses notes revealed that the resident had not refused to have his head elevated since his readmit on 12/21/00. According to the facilities policy and procedure the correct way to administer enteral feeding through a feeding tube was to elevate the head of a resident's bed to 30 to 45 degrees during the feeding and for a least one hour after the feeding. Proper delivery of enteral feedings is to elevate the head of the bed 30 degrees to prevent aspiration by gastroesophageal reflux and promote digestion. (Reference Guidance: Springhouse Handbook of Clinical Skills 1997 Springhouse Corporation pages 904) 2. Resident 27 was an 83 year old male who was admitted on 12/21/00 with the diagnoses of a gastrointestinal bleed, cerebral vascular accident, benign prostatic hypertrophy, myocardial infarction renal insufficiency, hypertension, dementia, and duodenal ulcer. On 1/31/01, at 10:00 AM, resident 27's dressing change by the nurse was observed. The nurse was observed to don gloves prior to changing the dressing on resident 27's heals. The nurse changed her gloves between taking off the dirty dressing and the clean dressing. However, she allowed resident 27 's heals to rest on the mattress overlay.	F 309		

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F 309	Continued From page 6 According to the facilities policy and procedure of how to change a dressing, the nurse did not use the suggested supplies to prevent infection or prevent cross contamination. One of facilities purpose of the procedure is to prevent infection and spread of infection. One of the general infection control guidelines is to observe standard precautions. One of the supplies needed during the dressing change of resident 21 heals was a paper towel or towelette drape between the resident heals and the mattress . The facilities written procedure is to create a clean field with paper towels or towelette drape. Meticulous aseptic technique during dressing changes help prevent microorganism from entering the wound. Reference guidance : Brunner and Suddarth's Textbook of Medical Surgical Nursing 8th edition 1996 Lipponcott page 416) 3. Resident 27 was a 83 year old male who was admitted on 12/21/00 with the diagnoses of a gastrointestinal bleed, cerebral vascular accident, benign prostatic hypertrophy, myocardial infarction renal insufficiency, hypertension, dementia, and duodenal ulcer. A review of resident 27's medical record revealed that the physician ordered on 12/21/01 for resident 27 to have a regular diet. On 12/26/00 the physician ordered for resident 27 to receive a 4 gram sodium diet. On 1/23/01 the physician ordered for resident 27 to receive a high calorie and high protein diet. A review of resident 27 medical record revealed that a copy of the dietary communication slip was present in the resident chart. On 1/30/01 and 1/31/01 during breakfast, resident 27	F 309		

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F 309	Continued From page 7 was observed not to have a diet slip on his tray. Resident 27 was observed to have consumed 100 percent of his meal. On 1/31/01 the dietitian and Assistant Director of Nursing (ADON) was interviewed in regards to the resident 27 recent weight loss. The dietitian stated that she makes the recommendations and it is up to nursing to carry her recommendations through. On 02/01/01 at 12:00 PM, an interview was conducted with the food service supervisor concerning fortified enriched foods and the food supervisor was asked if resident 27 received any of the fortified enriched foods. The food service supervisor stated that resident 27 was receiving a 4 gram sodium diet. She further stated that she had not received any other diet slip and that sometimes there is miss communication between nursing and dietary. On 2/5/01 at 8:30 AM, an interview was conducted with the food service supervisor on the process of which diet forms are to be filled out and what diet resident 27 was currently receiving. The dietary supervisor stated that the dietitian makes her recommendations, the nurses are to fill out the diet slip and give her the slip so she can make the necessary changes. She stated that resident 27 continues to be on 4 gram sodium diet. 4. Resident 102 was readmitted to the facility on 03/02/00 with the diagnoses of insulin dependant diabetes mellitus, chronic obstructive pulmonary disease, osteoporosis, cancer of the bladder, renal insufficiency, hypothyroidism, hyperlipidemia, depression, obesity, peripheral neuropathy, ataxia, hypertension and chronic constipation.	F 309		

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F 309	Continued From page 8 A review of the the resident's closed medical record was done on 02/05/01. A physician's order had been written on 06/18/00 for the resident to have Foley catheter changes and irrigations to be done every other week. A physician's order written on 09/13/00 stated "please remember to flush/irrigate catheter q.o (every other) weekly." A review of the September treatment record showed that no catheter changes or irrigations had been initialed by the nurses as being done, there was a hand written note on the treatment record stating that the catheter had been changed on 9/30/00. A nurse's note written on 09/15/00 at 1500 stated "new down drain bag replaced (with) 700 cc (cubic centimeters) of yellow urine emptied". There was no documentation that the catheter had been irrigated or changed as ordered. In an interview with the DON on 02/05/01 at 4:30 PM, regarding the catheter changes and irrigations not being done, she stated "the physician's recertification orders from June through September all indicated to change the catheter monthly and as needed". When she was shown the physician's orders written on 6/18/00 and 9/13/00 to do every other weekly catheter changes and irrigations she said "a nurse should have called the physician for clarification".	F 309		
F 312 SS=E	483.25(a)(3)QUALITY OF CARE A resident who is unable to carry out activities of	F 312		

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	daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations during meals in the facility it was determined that the facility did not assure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition by providing needed assistance with dining. This occurred in 5 of 20 residents observed in the first floor dining room and 3 of 5 residents observed in the second floor assistive dining room. Resident identifiers: 34, 35, 45, 55, 59, 64, 75, 86. Findings include: 1. Observations on 01/30/01, in the North dining room, of the breakfast meal from 7:40 AM to 8:26 AM and the lunch meal from 12:50 PM to 1:40 PM revealed the following: a. Breakfast meal: Resident 45 was observed to receive her tray at 8:00 AM. She was provided set-up help and the aide continued to pass trays to other residents. The resident made no attempt to feed herself and in fact, did not consume any foods or liquids from her tray. At 8:25 AM a CNA (certified nursing assistant) assisted the resident with one bite of food and then left the table to assist other residents. The resident received no further assistance from the staff and was wheeled from the dining room without consuming any additional foods or fluids from her tray. b. Lunch meal:		F 312 Federal Heights Rehab is committed to ensuring that each resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene **Corrective Action for Identified Residents** Resident 45 no longer resides at Federal Heights. Residents 34, 35, 55, 59, 64, 75, and 86 dining needs will be reassessed by the Director of Nursing or Designee and indicated intervention instituted and care planned by 3/27/01. **Identification of Residents Potentially Affected** Any resident in need of assistance with dining to maintain good nutrition has the potential to be affected. **Measures to Prevent Recurrence** Licensed nursing staff and certified nursing assistants will be inserviced on 3-27-01 by the Director of Nursing or Designee on: 1. Preparing dining rooms for meals 2. Serving trays in a manner so tables are served together. 3. Assisting residents with meal set-up by removing covers and cutting up food as needed. 4. Assisting, timely, those residents in need of assistance and cueing with eating. 5. Replacing food as needed such as when resident may pour salt in cereal or milk into water or if another resident takes the residents food.	

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F 312	Continued From page 10 Resident 35 was a 75 year old female with diagnoses including CVA, dementia and protein calorie malnutrition. She had been assessed on her MDS (minimum data set) dated 11/10/00 and 12/11/00 as being totally dependent on staff for eating. The resident's meal tray was uncovered and set-up for her at 1:00 PM. She was not observed to receive assistance with her meals until 1:20 PM. Other residents at her table were being assisted by staff or were feeding themselves. Twenty minutes passed before the resident was offered assistance. Resident 59 was observed to receive his tray at 12:50 PM. He made no attempt to feed himself and received no prompting or assistance from the staff. He consumed nothing from his tray and was observed to move his food items around on his plate. At 1:30 PM, a CNA began to help feed him and he did begin to eat. Forty minutes passed before any assistance was offered. 2. Observations on 01/31/01, in the North dining room, of the lunch meal from 12:38 PM- 1:25 PM revealed the following: Resident 55 received her lunch tray at 12:59 PM. She ate her meal with her fingers with no prompting or assistance provided by staff. She was served a Mighty shake supplement on her tray which was still partially frozen. The resident was attempting to drink the shake but it was too thick. The staff was not observed to replace the shake or help to thaw it so it could better be consumed. She did not drink the shake. Resident 35 received her tray at 1:04 PM, it was set-up by staff and uncovered. She was first assisted by staff with feeding at 1:14 PM, 1 bite of french fry was given to the resident by the CNA. She was not	F 312	All residents will be assessed by a Dining Committee for appropriateness of dining room by 3-27-01 placement in relation to assistance needed and appropriateness of seating. Indicated changes will be made by 4-3-01 The Dietary Service Manager will in-service dietary staff by 3-13-01on necessity of serving nightly shakes at an appropriate temperature and not frozen. **Monitoring/Quality Assurance** The Director of Nursing or Designee will develop an audit tool by 3-27-01 to monitor compliance with proper timely assistance with meals, replacing food as indicated, and serving meals so tables are served together. Audits will be done by Director of Nursing or Designee weekly for 6 months and then monthly for two months with monthly reports to the Performance Improvement Committee (Quality Assurance) for three months. Thereafter audits and reports will continue directed by the Performance Improvement Committee. The Director of Nursing will be responsible for continued compliance. Corrective action will be completed by 4/3/01. Audits will be done weekly for 6 weeks instead of 6 months.	

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F 312	Continued From page 11	F 312		

again assisted with her meal until 1:25 PM. During the meal, 2 other residents at the table were being assisted by staff and the third was attempting to feed herself. Resident 35 waited 10 minutes from the time she initially received her tray until she was fed 1 bite of food then an additional 11 minutes passed before she was again assisted to eat.

Resident 34 received her tray at 1:08 PM, 9 minutes after the first tray at her table had been passed. The other 3 residents at her table had received their trays and 2 of the residents were eating. She was observed to pick up her dessert saucer, which contained a slice of pie, and attempted to drink from the dish. She then began to eat her pie with her fingers. No staff prompting or assistance was provided. She was not encouraged to eat the other foods items on her tray or to drink any of the fluids provided. At 1:25 she began to eat her hamburger. No staff assistance was provided during the meal.

3. Observation on 02/05/01, in the North dining room, of the breakfast meal from 7:30 AM to 8:25 AM and the lunch meal from 12:00 PM to 12:59 PM revealed the following:

a. Breakfast meal:

Resident 35 received her breakfast tray at 8:09 AM. Her tray was uncovered and placed before her by a CNA. She received assistance with her meal at 8:23 AM, 14 minutes after her tray had been placed in front of her and uncovered. She watched as the other residents at her table were assisted by staff or were feeding themselves prior to being assisted.

b. Lunch meal:

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F 312	Continued From page 12 Resident 35 received her tray at 12:48 PM. She was fed a few bites of food at 12:52 PM, 4 minutes later by the CNA. The aide then began to assist other resident's at the table. She next received assistance at 1:05 PM when she was fed one bite of food, 13 minutes after she was initially assisted. She then waited until 1:15 PM when she was fed another bite of food, ten minutes had passed. Again, the CNA began to assist other residents until 1:25 PM when the aide sat down and helped resident 35 finish her meal. Thirty seven minutes passed between the resident receiving her meal and being assisted to complete her meal. 3. Observation of the second floor assistive dining room on 1/30/01, during the breakfast meal, revealed the following: a. Resident 64 was observed at 8:10 AM seated at the dining room table in her wheel chair waiting for her breakfast to be delivered. She was petite in stature and in a wheel chair appropriate for her size, however the table surface where her plate would rest was at her eye level. At 8:20 AM, resident 64 did not have her tray yet even though her table mates had theirs. Resident 86 who was seated next to her had his tray in front of him but was sleeping and not eating. Resident 64 reached over to his tray and took his glass of juice and was attempting to remove the plastic wrap cover. Staff were in and out of the dining room but no one observed her take the juice. At 8:25 AM, resident 64 was observed trying to drink the juice she had taken from the other resident and was attempting unsuccessfully to drink it with the	F 312		

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F 312	Continued From page 13 plastic wrap covering still on it. After struggling with it for a few more minutes she managed to get the cover off enough to drink all of the juice. Staff never noticed that she took the juice nor did they give resident 86 another juice. At 8:40 AM, resident 64 received her tray after waiting for 30 minutes. The tray was placed on the dining room table so that the plate of food was at her eye level and the resident had to reach up to get her food. Staff did not transfer her to another chair or place her at a table which would better accommodate her small stature. The resident was observed to move her utensils and dishes around on the table but was eating little. At 8:50 AM, resident 64 continued to eat very little and a nurse's aide walked by and said "[Resident 64] why aren't you sitting at your table?" and gestured toward an over bed table (adjustable in height) which was sitting nearby unused. The resident was not moved so that she could see her food and reach it. At 8:56 AM, resident 64 asked for a donut. The staff member took the donut, which was on the tray already, fed her a bite of it and placed it where the resident could see it and reach it. The resident after being assisted with a few more bites of food from her tray began to feed herself. b. Resident 86 was observed sitting up to the table in his wheel chair sleeping at 8:05 AM. His breakfast tray was in front of him with the cover on it. At 8:20 AM, resident 86 woke up and began moving items about on his tray. He took the cover off his plate and ate a couple of bites of egg with his fingers. He was observed to be extremely shaky and had	F 312		

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F 312	Continued From page 14 difficulty getting the egg to his mouth. At 8:25 AM, resident 86 was coughing and staff who were in and out of the dining room did not check on him. After the coughing spell, he began to moan. At 8:30 AM, resident 86 continued to moan and was making no attempt to eat. At 8:35 AM, 30 minutes later the a staff person started to assist resident 86 to eat. c. Resident 75 arrived in the dining room at 8:10 AM and was given her tray. At 8:20 AM, the resident was observed moving items around on her tray, stirring her cereal and not eating anything. At 8:25 AM, resident 75 opened her packet of salt and stirred it into her cereal. Staff who were in and out of the dining room did not notice the resident place the salt in her cereal nor did they assist her or prompt her to eat. The cereal with the salt in it was not replaced. At 8:35 AM, resident 75 requested a drink of water which staff gave her and she was prompted to eat. At 8:45 AM, the resident continued to move items around on her tray and was eating very little. She was observed to pour her milk into her glass of water. Staff did not observe this happen and neither the water or the milk was replaced. At 8:50 AM, 40 minutes after the resident arrived in the dining room the staff began to feed her and she ate reluctantly.	F 312		

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F 312	Continued From page 15 d. Observation of the second floor assistive dining room from 8:00 AM until 8:35 AM, where six to seven residents who required assist/prompting with eating were seated, revealed that staff were in and out of the dining room. Some of the resident's had their meal trays in front of them with the plate covers on. Two of the resident's trays had been set up so they could eat. No consistent assistance was given to any of the residents. At 8:30 AM, the director of nurses came into the dining room and made a comment about no one being there to feed the residents and left. At 8:35 AM, staff members came into the dining room and began feeding residents.	F 312		
F 329 SS=G	483.25(l)(1)QUALITY OF CARE Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and medical record review, it was determined that residents' drug regimens were not free from unnecessary doses of coumadin for 2 of 20 residents (103 and 104) and 1 additional supplemental residents (resident identifiers 21). An unnecessary drug is any drug which is used without monitoring and in the presence of adverse consequences which would	F 329	F329 Federal Heights Rehabilitation is committed to ensuring that residents are free from unnecessary drugs. **Corrective Action for Identified Residents** Residents 21, 102, 104 no longer reside in the facility Resident 103 instead of Resident 102 **Identification of Residents Potentially affected** Any resident receiving an anticoagulant has the potential to be affected. **Measures to Prevent Recurrence** The licensed nursing staff will be inserviced by the Director of Nursing or Designee by 3/27/01 on : 1. Definition of an unnecessary drug. 2. How coumadin may fall into the definition of an unnecessary drug.	

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F 329	Continued From page 16 indicate the dose should be reduced or discontinued. Reference to F-502. Findings include: Coumadin is an oral anticoagulant used to control and prevent clotting disorders. Prescribing the dose that both avoids bleeding complications and achieves therapeutic range of clotting times requires monitoring through laboratory testing. 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), another laboratory test, is used in conjunction with prothrombin time in determining if therapeutic doses of anticoagulant medications are being administered (Reference Guidance: Physicians' Desk Reference 53 Edition 1999 Medical Economics Company page 932) Resident 21, 103 and 104 had physician orders for the medication coumadin along with PT and INR monitoring laboratory tests. Resident 21 received seven doses of coumadin despite the physician order to discontinue coumadin. Resident 103 received 2 doses of coumadin with a PT of 32.3 and INR of 8. Resident 104 received eight doses of coumadin without the laboratory test INR being done every other day as ordered by the physician. According to the laboratory that the facility uses, a	F 329	3. Role of the laboratory tests, Prothrombin time (PT) and International Normalized Ratio (INR) play in monitoring use of anticoagulants, Therapeutic ranges will also be explained 4. Necessity of careful monitoring of laboratory tests to follow physician orders and to timely notify physician of any labs outside of goal range (also see the plan of correction for F502). 5. Necessity of timely obtaining orders from the physician as to what the nurse should do with laboratory tests are outside of goal range. 6. Necessity of accurately transcribing anticoagulant order from physician orders to MAR (Medication Administration Record) and TAR (Treatment Administration Record) 7. Protocol for Administration of anticoagulants with input from the Medical Director and Pharmacist Consultant. **Monitoring/ Quality Assurance** An audit tool will be developed by the Director of Nursing Services or Designee by 3/13/01 to monitor continued compliance with the protocol on anticoagulant therapy. The Director of Nursing Services or Designee will do weekly audits for 5 weeks starting 3/20/01 with continuing audits completed on 3/20/01, 3/27/01, 4/3/01, 4/10/01, and 4/16/01. The audits will be reported to the Performance Improvement Committee in April. Further audits will be done as directed by the Performance Improvement Committee.	

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F 329	Continued From page 17 normal PT range is 10.00 seconds through 12.00 seconds. A normal INR range is 2.00 through 3.00. Any PT or INR laboratory value out of the above range is abnormal. Resident 104 Resident 104 was admitted to the facility on 10/23/00 with the diagnoses of deep vein thrombosis, pulmonary embolus, hypertension, atrial fibrillation, osteoarthritis, obesity and mild renal failure. 1. Review of the resident's medical record from the facility documented the following: a. A physician's admission order dated 10/23/00, stated: "Coumadin 2.5 Po QD [every day]. QOD [every other day] PT, INR [with] goal 2-3." b. A laboratory report for a PT, INR test done on 10/24/00 documented a PT of 24.9 and INR of 4, which was outside of the goal range. No other laboratory results could be found in the resident's medical record. A review of the facility's laboratory log book showed no entries for PT and INR between 10/24/00 and 10/30/00. An entry was made in the laboratory log book for a PT, INR test to be done on 11/01/00 but was not initialed by the laboratory technician as being done. During an interview with a laboratory technician on 01/31/01 at 1:00 PM, she was asked if there was a laboratory result for the PT, INR test ordered for 11/01/00. She stated "there was no laboratory results for any test done for the resident on that date". She was asked what it meant if the resident's name was entered on the laboratory log book but had not been initialed by a laboratory technician. She stated "that	F 329	**The Director of Nursing Services or Designee will be responsible for continued compliance.** Corrective Action will be completed by 4/17/01 B correction date will be 04/06/01.	

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F 329	Continued From page 18 it meant the specimen had not been collected". There were no entries on the resident's treatment record for the PT and INR which should have been done according to the order on 10/26, 10/28, and 10/30. c. A review of the resident's MAR (medical administration record) documented that the resident continued to receive 2.5 mg (milligrams) of coumadin daily from 10/23/00 through 11/01/00. Resident 104 received eight doses of unnecessary medication. d. A physician's order dated 11/01/00 was for the resident to be admitted to the hospital for observation. e. No documentation could be found in the medical record to indicate why resident 104 had been transferred to the hospital other than a nurse's note dated, 11/01/00 at 1930, which stated: "Day nurse reported pt (patient) had been transferred to the hospital for evaluation". 2. A review of resident 104's hospital medical record documented the following: a. The emergency room history and physical dated 11/01/00 stated: ..."presents to the emergency room brought by her family for nose and mouth bleeds. In the emergency department was found to have a 'supratherapeutic' INR level of 15.3". ..."we will hold all Coumadin treatment and transfuse the patient with 6 units of frozen plasma..." b. A physician's order written on 11/02/00 stated: "give 6 units FPS [fresh frozen plasma] this AM (with) 5 mg Vit. (vitamin) K subq (subcutaneous)."	F 329		

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F 329	Continued From page 19 c. Resident 104 was treated at the hospital from 11/01/00 to 11/03/00 and discharged to another long term care facility. Resident 21 Resident 21 was an 81 year old who was readmitted on 11/9/00, to the facility with the diagnoses of urosepsis, urethral trauma, and coumadin toxicity. A review of resident 21's physician's order dated 11/17/00 documented that the resident was to receive 7.5 mg of coumadin on every Wednesday and Saturday and 5 mg of coumadin on the other days of the week. On 12/9/00 at 4:00 PM, the physician gave a verbal order to discontinue 5 mg of coumadin every day. A review of the resident MAR documented that resident 21 received 5 mg of coumadin every day at 5:00 PM on 12/8/00, 12/10/00, 12/11/00, 12/12/00, 12/14/00, and 12/17/00. According to the MAR 5 mg of coumadin was not administered on 12/18/00 due to the physician's discontinuing the current coumadin order. Therefore, seven times the resident received an unnecessary medication. Resident 103 Resident 103 was admitted to the facility on 09/13/00, with the diagnoses of deep vein thrombosis, diarrhea, anemia, insulin dependant diabetes mellitus, paraplegia, hypothyroidism, chronic renal insufficiency, ileo conduit urostomy and fractured femur with nailing. 1. A review on 02/05/01, of resident 103's closed medical record documented the following:	F 329		

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F 329	Continued From page 20 a. A physician's order written on 09/15/00, was to check the INR and PT every week. It was noted that the physician had written an order to hold the coumadin on 9/16/00 because the INR result was 5.5. b. A laboratory report of a PT and INR test done on 09/26/00 showed a PT of 32.3 and INR of 8. A note on the laboratory report showed that the report had been faxed instead of reported by telephone to the physician on 9/26/00. There was no indication the physician responded to the abnormal laboratory results before 9/28/01. c. A review of the MAR documented that the resident had received coumadin 5 mg on 09/26/00 and coumadin 2.5 mg on 09/27/00. Therefore, the resident received two doses of unnecessary medication. d. A physician's order written on 09/28/00 was to hold coumadin today and tomorrow 9/28, 9/29 and to give Vitamin K 2.5 mg Po (by mouth) today. e. A laboratory report for an INR test done on 9/29/00 showed a PT of 41.1 and INR of 12.7. A physicians order written on 09/29/00 was to give Vitamin K 2.5 mg Po today. f. A physician's progress note written on 10/02/00 stated "[Resident] became significantly over anticoagulated last week & received Vitamin K."	F 329		
F 332 SS=E	483.25(m)(1)QUALITY OF CARE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		

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This REQUIREMENT is not met as evidenced by:
Based on 2 observations of medication pass, interviews with staff, review of the medication administration record (MAR), and review of physician's orders, it was determined the facility did not ensure it was free of medication error rates of five percent or greater. For 68 opportunities, 8 medication errors occurred involving three residents representing an 11.7% error rate. Resident identifiers: 48, 47, 51.

Findings include:

Observations of medication administration were made on 1/30/01 between 7:30 AM and 11:45 AM. Two nurse surveyors observed nurses provide medications for residents in two different areas of the facility. The following was observed:

Resident 48

1. On 1/30/01, the medication nurse was observed to administer Lanoxin 0.125 mg (milligram) to resident 48. The dosage of Lanoxin was scheduled to be given at 8:00 AM. This medication was missing from the medication cart so the dose was not given until it was obtained from the pharmacy. The Lanoxin dose was given to resident 48 at 12:45 PM (4 hours and 45 minutes later than the ordered time). Standards of practice indicate that a medication is considered late if given more than 1 hour after it's scheduled time.

2. On 1/30/01, the medications Synthroid 0.15 mg and Lasix 20 mg were also missing from the medication cart at the scheduled administration time of 8:00 AM. Both of these medications needed to be obtained from the pharmacy. The dosages of Synthroid and Lasix were obtained and provided to

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F 332	Continued From page 22 resident 48 at 12:45 PM (4 hours and 45 minutes later than the ordered time). 3. On 1/30/01, 2 ampules of the medication Albuterol 2.5 mg/Atrovent were ordered to be given via nebulizer. The nurse placed the medication in his shirt pocket at approximately 9:00 AM. At 11:00 AM the surveyor noticed that resident 48 was using her nebulizer. When the medication nurse was questioned regarding the observation of resident 48 and the nebulizer treatment he indicated that the medication still needed to be given. The medication was not in the nebulizer that resident 48 was using. The 2 ampules of medication were then placed into the nebulizer by the medication nurse and the treatment was started. 4. On 1/30/01 at 11:00 AM, after the above nebulizer medication had been given to resident 48 the surveyor asked the medication nurse if all the respiratory medications that had been scheduled for the morning medication pass had been given. The nurse indicated they had. The surveyor noted earlier that the AeroBid inhaler ordered for 8:00 AM, had not been given to resident 48. A while later the medication nurse told the surveyor that he/she had checked the MAR (medication administration record) and had found that the AeroBid had not been given. But that it had now been provided to resident 48. Resident 47 1. On 1/30/01, the medication Thyroxine 0.1 mg was missing from the medication cart at the scheduled administration time of 8:00 AM. This medication needed to be obtained from the pharmacy. The ordered dosage of Thyroxine was obtained and provided to resident 47 at 12:40 PM (4 hours and 40	F 332	F 332 Federal Heights Rehabilitation is committed to ensure it is free of medication error rates of five percent or greater. **Correction Action for Identified Residents** Residents 48, 47, 51 are receiving medication at the scheduled times and within the accepted standard of practice. **Identification of Residents Potentially affected** All residents have the potential to be affected. **Measures to Prevent Recurrence** Licensed nursing staff will be in-serviced by 3/27/01by Director of Nursing Services or Designee on facility Policy and Procedures on proper and timely administration of medication. In-service will also include: 1. Timely administration of insulin according to standard of practice 2. Standard of Practice for administration of inhalers 3. Process for ordering medications to ensure that medications are available for administration at scheduled times.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 2/1
FORM APPRO
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465055	A. BUILDING ____ B. WING ____	2/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEDERAL HEIGHTS REHAB AND NURS	41 S 900 E SALT LAKE CITY, UT 84102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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) COMPL DATE
F 332	Continued From page 23	F 332		

minutes later than the ordered time).

Resident 51

1. On 1/30/01, the medication nurse was observed to setup and administer 16 units of regular insulin and 26 units of NPH insulin per injection to resident 51. The medication was scheduled to be given at 8:00 AM. The insulin dosage was observed to be given to resident 51 at 9:15 AM, over one hour after he had eaten his breakfast. Scheduling insulin during/after breakfast does not meet the guidelines of acceptable standards of practice. The medication was given 1 hour and 15 minutes later than the scheduled 8:00 AM.

In the Textbook of Basic Nursing, sixth edition, Caroline Bunker Rosdahl, RN-C, BSN, MA, copyright 1995, page 1067, stated, "Regular insulin and semilente insulin are quick acting and are given 15 to 30 minutes before a meal so they will reach the bloodstream at about the same time as the glucose from the meal...Intermediate-acting insulin are usually given 30 minutes before breakfast...Their action will handle the glucose from meals during the day. Regular insulin is often combined with intermediate and long acting insulin for the best glucose management."

Page 1069 stated "Nursing Skill Guideline: Giving Insulin...Insulin is usually given before meals. (Rationale: To make sure the patient is not getting too much or too little insulin.) Give the insulin on time. (Rationale: The dosage depends on the schedule. Alteration in the time is dangerous to the patient.)"

2. On 1/30/01, the medication nurse was observed to

Monitoring/Quality Assurance

An audit tool will be developed by 3/27/01 by the Director of Nursing or Designee to monitor continued compliance with the administration of medication within the scheduled times and within the accepted standard of practice related to insulin and inhalers. Audits will be done weekly for 6 weeks with reports by the Director of Nursing or designee to the Performance Improvement Committee (Quality Assurance) monthly for 2 months and then as directed by the Performance Improvement Committee.

The Director of Nursing Services or Designee will be responsible for continued compliance.

Corrective action be completed by 4/16/01

B correction date 04/06/01 instead of 04/16/01

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F 332	Continued From page 24 provide resident 51 with 2 ordered respiratory inhalers, Ipratrophum Bromide 10 mcg (micrograms) 2 puffs and Albuterol 90 mcg 2 puffs. These medications were ordered to be given as needed. Resident 51 was complaining of having some respiratory distress and requested the inhalers. The medication nurse placed the inhaler opening into resident 51's mouth and asked, "Are you ready?". When resident 51 indicated that he was, the medication nurse released a puff from the inhaler. After the release of medication into the resident's mouth, resident 51 took a breath. This continued throughout the 4 puffs given to resident 51. Observation of the method used by the nurse to administer the inhalers indicated the resident did not receive the full dosage possible. Without the resident being in the process of inhaling at the beginning of the administered puff, most of the medication droplets are sprayed onto the back of the throat and do not reach the intended target, the lungs. The four puffs of medication were administered without a pause for the medication to absorb. The accepted standard of practice when giving inhaler medication is to wait at least 1 minute between puffs. This waiting time as noted in the reference below when teaching residents to do their own inhalation treatments may be of a longer duration with further benefit. The Mosby Year Book of Basic Nursing Theory and Practice, second edition, Patricia A. Potter, RN, MSN, and Anne G. Perry, RN, MSN, ANP, EdD, copyright 1991, pages 600 - 601, provides instruction and rationale for the use of inhalers and in part stated, "...Open lips and place inhaler in mouth...Exhale fully...While inhaling slowly and	F 332		

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F 332	Continued From page 25 deeply through mouth, fully depress medication canister...hold breath for approximately 10 sec....Exhale...wait 5 to 10 minutes between inhalations or as ordered by physician." The rationale section stated, "Medication is distributed to airways during inhalation...allows tiny drops of aerosol spray to reach deeper branches of airways...Drugs must be inhaled sequentially. First inhalation opens airways and reduces inflammation. Second or third inhalations penetrate deeper airways."	F 332		
F 368 SS=E	483.35(f)(1)-(3)DIETARY SERVICES Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on comments from 8 of 10 residents in a confidential group meeting and interviews with 3 additional residents , it was determined that the facility did not offer snacks at bedtime daily. Findings include:	F 368	F368 Federal Heights Rehabilitation is committed to offering snacks at bedtime daily **Corrective Action for Identified Residents** No specific residents were identified **Identification of Residents Potentially Affected** All residents have the potential to be affected **Measures to Prevent Recurrence** Nursing staff will be inserviced by 3/27/01 by the Director of Nursing Services or Designee on the requirement of offering snacks at bedtime daily. **Monitoring/Quality Assurance** All audit tools will be developed by the Director of Nursing or Designee by 3/27/01 to audit continued compliance with the offering of a bedtime snack daily. Audits will be monthly for 3 months by Director of	

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F 368	Continued From page 26 1. A confidential group meeting was held 01/31/01 at 10:30 AM. Eight out of 10 residents stated that they were not offered and did not receive a snack at bedtime. 2. Interviews with 3 additional alert residents, not present in the group interview, revealed that they too denied being offered or receiving a snack at bedtime on a daily basis.	F 368	Nursing or Designee with reports to the Performance Improvement Committee (Quality Assurance) in April and May and then as directed by the Performance Improvement Committee. Continued compliance will be the responsibility of the Director of Nursing Services. Corrective action will be completed 4/16/01. Correction date will be 04/06/01	
F 371 SS=E	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 observations it was determined that the facility did not store, prepare, distribute and serve food under sanitary conditions. Findings include: The following observations were made 01/29/01 from 10:05 AM- 10:35 AM. 1. Four and a half bags of hamburger meat were sitting on a tray by the sink. Except during preparation, cooking, or cooling potentially hazardous food shall be maintained at 41 degrees Fahrenheit or less. Reference Guidance: US Public Health Service FDA 1999 Food Code, page 63. 2. Two cleaning cloths were behind the sink, not in use and not in a sanitizing solution.	F 371	F 371 Federal Heights Rehabilitation is committed to store, prepare, distribute, and serve food under sanitary conditions **Corrective Action for Identified residents** No residents were identified. **Identification of Residents potentially affected** All Residents have the potential to be affected **Measures to Prevent Recurrence** Dietary staff will be in-serviced by the Dietary Service Manager or Designee on the following policies and procedures 1. Thawing meat properly 2. Placement of cleaning cloths in sanitizing solution 3. Not stacking dishes wet 4. Not leaving scoops in bins 5. Covering, dating , labeling, closing food items in the refrigerators or freezers 6. Discarding expired food items	

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F 371	Continued From page 27 3. Two trays of 4oz (ounces) glasses, 79 glasses total, and two trays of 8oz glasses, 121 glasses total, were stacked wet. Stacking dishes wet provides a medium for bacterial growth. 4. There was a scoop in the brown sugar container with the handle in the product. The handle is considered contaminated because it is handled by staff. 5. The walls behind the sink, beside the sink, behind the microwave and behind the food preparation table were dirty with liquid and food splatters and had a greasy film covering them. 6. The ceiling was dirty and dusty above the sprinkler heads. The following items were found in the reach-in refrigerator: 1. A container of chicken base was uncovered. 2. A bag of ham was unlabeled and undated. 3. A tray containing 14 cups of pudding was uncovered, unlabeled and undated. 4. An open bag of whipped cream, an open bag of rolls, 2 glasses of milk, and 16 glasses of juice were not dated. 5. There was an expired container of strawberry low fat yogurt dated 01/23/01 (6 days old). 6. A container of applesauce had a plastic cup lying in the product. Because the cup is handled by staff it	F 371	**Monitoring/ Quality Assurance** Audit tools will be developed by Dietary Service Manager or Designee by 3/20 /01 To monitor continued compliance with the six in-service items listed above. Audits will be done weekly for 8 weeks starting 3/15/01 with monthly reports for two months by Dietary Service Manager or Designee to the Performance Improvement Committee (Quality Assurance) and then as directed by the Performance Improvement Committee. The Dietary Service Manager will be responsible for continued compliance. Correction date will be 4/06/01 Correction will be complete by 4-16-01 Audits will be done weekly for Eight weeks beginning 3/20/01 instead of 3/15/01. B	

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F 371	Continued From page 28 is considered contaminated. The following items were found in the walk-in refrigerator: 1. Two pans of jello were uncovered, unlabeled and undated. 2. There was an open box of margarine reddies (individual margarine portions). The open box would allow contamination of the product. 3. An open box of 1 pound margarine blocks were observed to be below pans of uncovered jello. Jello had spilled into the open box and onto 2 of the margarine blocks thus contaminating them. 4. Chicken soup in a pitcher dated 01/20/01 (9 days old), 3 bean salad dated 01/23/01 (6 days old), noodles with tomato sauce, unlabeled and dated 01/25/01 (4 days old), hash browns dated 01/19/01 (10 days old). Left over food should be used or thrown away within 72 hours after initial use. 5. Three cans of Nepro (a renal dietary supplement) were dated 01/01/00. (over 1 year old) The following was observed in the walk-in freezer: 1. A bag of pepperoni and a bag of hamburger meat were unlabeled and undated. 2. A box of liver which was not properly covered, was not labeled or dated. The top layer of the meat appeared freezer burned.	F 371		

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F 372 SS=D	483.35(h)(3)DIETARY SERVICES The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations, and an interview the facility failed to assure that garbage and refuse was properly disposed of. Findings include: On 1/29/01 at 9:40 AM, the facility parking lot was observed to have 29 garbage bags outside of the garbage receptacle. The lids of the two garbage receptacle were observed to be closed. One of the garbage receptacle opened from the top. The other garbage receptacle opened from the side. Both garbage receptacles were observed to be full of garbage. Ninety percent of the 29 garbage bags observed outside the garbage receptacle contained resident incontinence pads. Other substances contained in the garbage bags were open metal containers of food, a 10cc syringe and a resident basin. Three of the 29 garbage bags were torn open and four resident incontinence pads were observed on the asphalt of the facility parking lot. Two empty boxes of cheerios cereal, 2 empty cartons of milk, a half of a stock of celery, and pieces of bread and muffin were observed outside of plastic garbage bags on the asphalt. While the survey was making these observations the facilities maintenance person came out of the building to dispose of the garbage bags correctly. The maintenance man stated that the garbage falls out while the receptacles are being emptied and that the people who empty the receptacles refuse to pick up the garbage left behind. The maintenance person	F 372	F 372 Federal Heights is committed to disposing of garbage properly **Corrective Action for Identified Residents** No residents were identified **Identification of Residents Potentially Affected** All residents have the potential to be affected **Measures to Prevent Recurrence** Housekeeping, dietary and nursing staff will be in-serviced by 3/22/01 by the Administrator on the facility policy pertaining to disposing of garbage properly including keeping the lids to the outside receptacle closed, disposing of garbage inside the garbage receptacles and keeping area around the garbage receptacle free of garbage. **Monitoring/Quality Assurance** An audit tool will be developed by 3/20/01 by the housekeeping supervisor or designee to audit facility compliance with the policy of disposing of garbage properly. B Audits to be done weekly for 4 weeks starting 03/27/01 The housekeeping supervisor will be responsible for continued compliance. Corrective action will be completed by 4-16-01. B Correction date will be 04/06/01	

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F 372	Continued From page 30 further stated that the certified nurses aides on night shift place the garbage bags on top of the lid of the garbage receptacle. He further stated they can't open the lid and put the garbage into the garbage receptacle at the same time. The maintenance person stated that he has repeatedly told the CNA's how to dispose of the garbage properly. He felt that the facility could not fire the CNA's who are disposing the garbage incorrectly since there is such a shortage of help. The maintenance person thought that the garbage receptacles were emptied on every Monday, Wednesday, and Friday. On 1/30/01 at 11:00 AM, 2:00 PM and 3:00 PM, the lid of the garbage receptacle that opened from the top was observed to be open while there was garbage in the receptacle. On 2/1/01 at 10:30 AM, the Director of Nursing (DON) was observed to be carrying a bag of garbage to the receptacle. The lid of the garbage receptacle that opened on the side was open. The DON placed the garbage she was carrying into the the side opening receptacle. She walked to the other garbage receptacle to dispose of two other garbage bags and a cardboard box that were left laying on the asphalt. On 2/5/01 at 7:20 AM, the lids of garbage receptacle that opened from the top were observed to be propped open by garbage. The garbage receptacle that opened from the side was only half way full.	F 372		
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	F 432	F 432 Federal Heights Rehabilitation is committed to storing all drugs and biologicals in locked compartments with only authorized personnel having access to the keys.	

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	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, the facility did not maintain drugs in a locked compartment that only authorized personnel had access to as evidenced by: One nurse was observed to leave the medication cart unlocked and in the hallway, out of her view, during medication administration. One medication cart was observed to have several medications prepared in cups stacked on top of it with no personnel within view of that cart. Findings include: On 1/30/01, observation during the morning medication administration on the east medicare hall, revealed that the medication nurse prepared and administered medications to the residents on the hall she was assigned to. During the time that the nurse administered resident medications, she walked away from the medication cart and entered each resident's room. The medication cart was not in view of the nurse and was left unlocked when she entered the residents' rooms. The medications in the cart were left accessible to residents and staff who passed. On 2/6/01, at 11:10 AM, observation revealed that		**Corrective action for Identified Residents** No residents were identified. **Identification of Residents Potentially Affected** All residents have the potential to be affected. **Measures to Prevent Recurrence** Licensed nursing staff will be in-serviced by the Director of Nursing Services or Designee by 3/27/01on the facility policy and procedure of maintaining drugs in a locked compartment (medication cart) and keeping medication carts locked at all times when out of view of nurse and of the unacceptability of stacking medications prepared in cups on top of the medication cart with no personnel within view of the cart. **Monitoring/ Quality Assurance** An audit tool will be developed by 3/13/01by the Director of Nursing Services or Designee to monitor compliance with keeping drugs locked. Audits will be done weekly starting 3/13/01 for 6 weeks, with reports to the Performance Improvement Committee (Quality Assurance) at the April and May meetings and then as directed by the Performance Improvement Committee. The Director of Nursing Services will be responsible for continued compliance. Corrective action will be completed by 3/27/01	

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F 432	Continued From page 32 several cups of medications were prepared for residents and stacked on top of the medication cart, at the nurses station, on the west medicaid floor. The nurse responsible for the medication pass was observed at the north end of the hall passing medications to other residents. Observation revealed no personnel present at the nurses station. On 2/6/01,at 12:00 PM, observation revealed the same cups of medications remained on the top of the medication cart at the nurses station. Observation revealed no personnel present at the nurses station.	F 432		
F 444 SS=E	483.65(b)(3)INFECTION CONTROL The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observations, the facility did not follow accepted standards of professional practice for handwashing as evidenced by: A nurse did not wash or sanitize her hands between medications passed to residents after direct contact with the residents, nursing staff did not wash or sanitize their hands between assisting residents in the dining room and dietary staff did not wash or sanitize their hands prior to and during the preparation of food. Findings include: 1. On 1/30/01, during observation of the morning medication administration on the east medicare hall, the nurse was observed to administer medication to residents. She was observed to touch the resident's	F 444	F 444 Federal Heights Rehabilitation is committed to ensure all staff wash their hands as indicated by accepted professional practice. **Corrective action for Identified Residents** No residents were identified. **Identification of Resident Potentially affected** All residents have the potential to be affected. **Measure to prevent recurrence** Facility staff will be in-serviced by 3/27/01 by the Director of Nursing Services or Designee on hand washing after each direct resident contact or other contact that would merit washing or sanitizing of hands. The nursing staff will be inserviced by4/10/01 the Director of Nursing or Designee on the specific area cited that apply to the nursing staff.	

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F 444	Continued From page 33 bed with the first medication pass. The nurse was not observed to wash or sanitize her hands after leaving the resident's room or before preparing the next resident's medications. She placed her left thumb inside the medication cup, touched the side and bottom of the inside of the cup, and administered the medication to the second resident. She was not observed to wash or sanitize her hands when she returned to the medication cart. The nurse placed the first finger of her left hand inside the medication cup, touched the side and bottom of the cup, then administered the medication to the next resident. 2. On 1/30/01, during the lunch meal in the North dining room, a CNA (certified nursing assistant) was observed assisting residents with eating. The CNA was observed to feed a resident a bite of meat which the resident spit out. The CNA placed her hand under the resident's chin and caught the meat in her hand. The CNA was then observed to wipe her hand on the resident's clothing protector and without washing or sanitizing her hands, she began to feed another resident at the table. 3. During the same lunch meal, another CNA was observed to pick up soiled clothing protectors off of the floor and place them in a bag with other soiled clothing protectors and to take dirty food trays from the dining room to the food cart in the hallway. Without washing or sanitizing her hands, she returned to the dining room and began to feed residents . 4. On 1/31/01, during the breakfast meal in the North dining room , a CNA was observed to pick up a residents cup by the lip after the resident had drank from the cup. Her fingers were observed to be in the cup. The resident continued to drink from the cup.	F 444	The Dietary Staff will be inserviced by 4/10/01 the Dietary Service Manager or Designee on the specific areas cited that apply to the dietary staff. Inservices will be prior to 04/06/01 **Monitoring/ Quality Assurance** Audit tools will be developed by the Director of Nursing or Designee and Dietary Service Manager or Designee by 3/13/01 to monitor compliance with accepted standards of professional practice for hand washing/ sanitizing in the areas of : 1. Medication pass 2. Meal delivery and assistance 3. Dietary in relation to food preparation and dishwashing The Director of Nursing or designee will do weekly audits of medication pass and meal delivery and assistance related to hand washing/sanitizing compliance. The Dietary Service Manager or Designee will do weekly audits of Dietary in relation to food preparation and dishwashing related to hand washing/hand sanitizing compliance. **Audits will be done weekly for 6 weeks starting 3/13/01 and continuing 3/20/01, 3/27/01, 4/03/01, 4/10/01 and 4/16/01. With** reports to the Performance Improvement Committee (Quality Assurance) at the March 2001 and April 2001 meeting with continues audits and reports as directed by the Performance Improvement Committee. The Director of Nursing Services and Dietary Service Manager will be responsible for continued compliance. Corrective action will be completed by 4/16/01 Correction date will be 04/06/01	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 2/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 444	Continued From page 34 The CNA was observed to then assist another resident with her meal without washing or sanitizing her hands. 5. On 1/31/01, during the lunch meal in the North dining room, a CNA was observed to assist 3 residents with opening their cartons of milk. The CNA opened the milk containers by pushing back the top of the milk carton and then sticking her finger inside the lip of the carton to fully open the container. She did not wash or sanitize her hands prior to opening , in between opening or after opening the milk cartons. 6. On 2/06/01, during the breakfast meal in the main dining room, a CNA was squatting down to find a resident's tray in the food cart. He was observed to loose his balance and slip, catching himself with his hand on the floor. He was not observed to wash or sanitize his hands. He continued to set-up resident trays by cutting up french toast and opening and pouring syrup, and to pass trays. This CNA was then observed, without washing or sanitizing his hands, to assist a resident with eating. Sanitizer was noted to be available on top of the food cart. 7. On 1/29/01, in the kitchen, the cook was observed to be preparing the evening meal. She was not wearing gloves. She was observed to lift the lid of the garbage can and then without washing or sanitizing her hands, she dispensed aluminum foil, touching both sides of the aluminum foil with her hands, then covered a pan of food and placed it in the steamer. The cook then went to the walk-in refrigerator and brought parsley over to the food prep table. She washed her hands and put on gloves. The cook was then observed to go get several loaves of bread,	F 444		

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F 444	Continued From page 35 touching the bread trays. She got a piece of aluminum foil and pressed it into a pan, touching the surface where the bread was to be placed with her gloves. Wearing the same gloves, she opened a drawer to get a knife. Without changing her gloves, she opened the bread and took out the slices. She then cut the bread and placed it in the pan without changing her gloves or washing or sanitizing her hands. 8. On 1/29/01, the dietary aid was observed to place a rack of dirty dishes and utensils into the dish machine. She was not wearing gloves and did not wash or sanitize her hands. She was then observed to pull the now clean rack of dishes and utensils from the dish machine back to the dirty side, again with out washing or sanitizing her hands or donning gloves. She was observed to pick up a clean scoop by the scoop itself. She then lifted the garbage can lid. She did not wash or sanitize her hands. She walked into the kitchen from the dish room and began to portion jello with the scoop she had just picked up without washing or sanitizing her hands, donning gloves or re-washing the scoop.	F 444		
F 502 SS=E	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 staff interviews and review of medical records, it was determined that the facility failed to provide or obtain timely laboratory services to meet	F 502		

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F 502	Continued From page 36 the needs for 1of 20 sampled residents and 1of 2 additional supplemental sample residents. Residents identifiers: 21and 104 Findings include: 1. Policy and Procedure: During an interview with the DON (Director of Nursing) on 02/01/01 at 11:45 AM, she was asked for the procedure for laboratory blood sample collection. She stated "the clerk takes off the physician order and enters the laboratory test to be done and the date it is to be done on the resident's treatment record , the charge nurse then will make a double check of the order to make sure it is correct, The night nurse fills out the laboratory requisition and places it in the wall mounted laboratory file box. The laboratory technician collects the requisitions for that day and enters the resident's name in the laboratory log book and initials that the specimen has been collected". 2. Resident 104 was admitted to the facility on 10/23/00, with the diagnoses of deep vein thrombosis, pulmonary embolus, hypertension, atrial fibrillation, osteoarthritis, obesity and mild renal failure. Resident 104's closed medical record was reviewed on 01/31/01. Resident 104's physician's admission orders written on 10/23/00 was for "Coumadin 2.5 mg (milligrams) Po (by mouth) daily". and "QOD (every other day) PT (prothrombin time) and INR (international normalization ratio) [with] goal 2-3". A laboratory report of an INR test done on 10/24/00 showed a PT of 24.9 and INR of 4.8. No other	F 502	F 502 Federal Heights Rehabilitation is committed to provide or obtain laboratory services to meet the needs of its residents. **Corrective Action for Identified Residents** Residents 21 and 104 no longer reside in the facility **Identification of Residents Potentially Affected** All residents having laboratory services have the potential to be affected **Measures to Prevent Recurrence** The policy and procedures for providing laboratory services will be reviewed and revised as may be indicated by the Director of Nursing Services or Designee by 3/20/01. Licensed nursing staff will be in-serviced by the Director of Nursing Services or Designee by 3/20/01 on the facility laboratory services policies and procedures. **Monitoring/Quality Assurance** An audit tool will be developed by the Director of Nursing Services or Designee by 3/13/01 to monitor continued compliance with the policy and procedure on laboratory services. The Director of Nursing Services or Designee will do weekly audits for 5 weeks with continuing audits completed on 3/22/01, 3/27/01, 4/3/01, 4/10/01 and 4/17/01. The audits will be reported to the Performance Improvement Committee in April. Further audits will be done as directed by the Performance Improvement Committee.	

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F 502	Continued From page 37 laboratory results could be found in the resident's medical record. A review of the facility's laboratory log book showed no entries for PT and INR to be done for resident 104 between 10/24/00 and 10/30/99. No entries were made on 10/26, 10/28 or 10/30 in the resident's treatment record indicating an INR was done every other day as ordered. . An entry in the laboratory log book was made for a PT, INR to be done on 11/01/00 but had not been initialed by the laboratory technician as being done. During an interview with a laboratory technician on 01/31/01 at 1:00 PM, she was asked if there was a report that a PT, INR test was done for resident 104 on 11/01/00, she stated "there was no record of any test being done for the resident on that date". She was asked what it meant if a resident's name was entered in the laboratory log book but was not initialed, she stated " that it meant the specimen had not been collected". A review of the resident's MAR showed the resident continued to receive 2.5.mg of Coumadin daily from 10/23/00 through 11/01/00. On 11/01/00 a physician's order was written for the resident to be admitted to the hospital for observation. No documentation could be found in the medical record to indicate why resident 104 had been transferred to the hospital. A review of nurse's notes written on 11/01/00 at 1930 stated "Day nurse reported pt (patient) had been transferred to hospital for evaluation." A review of resident 104's hospital medical record showed the emergency room history and physical	F 502	The Director of Nursing Services will be responsible for continued compliance. Corrective Action will be completed by 3/27/01	

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F 502	Continued From page 38 done 11/01/00 stated, ..."presents to the emergency room brought by her family for nose and mouth bleeds. In the emergency department was found to have a 'supratherapeutic' INR of 15.3." ..."we will hold Coumadin treatment and transfuse the patient with 6 units of frozen plasma..." Resident 104 was treated at the hospital from 11/01/00 to 11/03/00 and discharged to another long term care facility. 3. Resident 21 was an 81 year old who was readmitted on 11/9/00 to the facility with diagnoses of urosepsis, urethral trauma, and coumadin toxicity. Resident 21's medical record was reviewed on 2/5/01. A review of the facility's laboratory log forms and the laboratory results between the dates 11/9/00 through 1/31/01, showed that the blood specimens were not collected, as the physician ordered for a PT (prothrombin time), basic metabolic panel (BMP), complete blood count (CBC) and albumin level. In an interview with the staff coordinator on 2/6/01 at 11:00 AM it was determined that laboratory tests were delayed or missed for resident 21. The laboratory tests were two BMP, one CBC, one PT, and one albumin test. According to the physician orders dated 12/18/00, resident 21 was to have several laboratory tests on 12/19/00. This included: a urinalysis (UA) with culture and sensitivity (C & S) if indicated, a basic metabolic panel (BMP), a complete blood count (CBC), and PT. A review of the facilities laboratory log for resident	F 502		

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F 502	Continued From page 39 21 documented a UA, C & S, BMP, CBC, and PT were to be collected and sent to the laboratory on 12/19/00. However, the BMP, CBC, and PT had been crossed out in the laboratory log and re-written on to a separate laboratory log sheet to be collected and sent to laboratory on the 12/20/00. A review of resident 21's laboratory results, documented, that the laboratory result had been faxed to the facility on 12/20/00 at 6:51 AM. On resident 21's 12/20/00 laboratory result, the nurse documented that she "phoned [MD on] 12/21/00 at 12:15[PM]." The physician was notified of resident 21's abnormal laboratory results 1 day later after the facility had received the results. A review of a nurses note, dated 12/19/00, at 2:30 PM, documented that the PT and INR was not taken that day. The nurse documented that she asked the laboratory to collect the sample and they were unable to find a vein. The nurse's note indicated she notified the physician and the laboratory would try again in the morning. No physician order was found for the laboratory to be drawn on 12/20/00. A review of resident 21's treatment sheet for December documented that a blood sample for BMP, PT and CBC was collected on 12/19/01 from resident 21. A review of resident 21's laboratory results for the prothrombin time were a PT of 23.2 seconds and a INR 4.2. These PT results were in an abnormally high range. Resident 21's physician orders revealed that on 12/18/00 the physician ordered to discontinue resident 21's current coumadin order. A review of resident 21's medical record	F 502		

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F 502	Continued From page 40 documented that the physician ordered on 11/30/00, a PT and INR to be collected for two weeks. Therefore, a blood specimen would need to be collected from resident 21 during the days of 12/1/00 through the 12/7/00 so that the laboratory could provide the facility with a test result. A review of the facility laboratory log revealed that resident 21's specimen was ordered and collected but results never returned back to the facility. Resident 21's December treatment sheet was marked for having a PT to be done on 12/7/00. An interview was conducted on 2/6/00 at 11:00 AM with the staff developer regarding the resident's missing laboratory results. He stated that the laboratory that the facility uses had no record of the PT ever being done. On the facility laboratory log there was no signature or date noting that the PT result was back from the laboratory for resident 21. Resident 21 did not have a another PT test done until 12/18/00 when the physician ordered another PT test to be done on 12/4/00. On 12/4/00 the physician ordered a PT be done in two weeks. Therefore, resident 21 did not have a PT test until 18 days later. Resident 21's laboratory result was a PT 26.1 seconds and INR 5.2. These laboratory values were above the therapeutic range. A review of resident 21's medical record documented that the physician had ordered on 11/21/00 to check resident 21's BMP on Monday. A review of the facility laboratory log revealed that no request were made for resident 21 to have a BMP test. A review of resident 21's laboratory results revealed that there were no BMP result for 11/27/00. On 2/6/01 an interview with the staff director was conducted regarding the missing laboratory results. He stated that the laboratory had no request or result for	F 502		

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F 502	Continued From page 41 resident 21's BMP that was to be done on the 11/27/00. He further stated that some of the laboratory log forms had been thrown away. A review of resident 21's medical record documented that the physician ordered on 11/11/00 a BMP, PT and a INR on Monday. A review of the documentation in the facility laboratory log revealed that there were no laboratory requests made for resident 21 to have a BMP and PT done on 11/13/00. On 2/6/01 at 11 00 PM, an interview was conducted with the staff developer regarding resident 21's delayed test results. The staff developer stated that sometimes the night shift nurses ordered laboratory tests the night before or the day the test was due. He stated sometimes the laboratory tests do not get taken until the day after the test was ordered. The facility had no record of resident 21's November treatment sheet. A review of resident 21's medical record documented that the physician had ordered an albumin test on 11/18/00 due to the resident's recent weight loss. According to the facility's laboratory results the albumin test was not requested until 12/13/01. On December's treatment sheet for resident 21 the nurses documented that the albumin test was collected on 12/11/01. On resident 21's laboratory result report the nurse noted that the physician was notified on 12/15/01. On 2/6/01 at 11: 00 AM an interview was conducted with the staff developer regarding the delay in resident 21's test results. The staff developer stated that the facility throws out the laboratory log forms. He further stated that he thought the nurse may have accidentally requested the albumin to be taken a month later.	F 502		

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F 514 SS=D	483.75(l)(1)ADMINISTRATION The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. This REQUIREMENT is not met as evidenced by: Based on interview and medical record review, the facility did not maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented as evidenced by: Two of twenty sampled residents had incomplete documentation in their medical records concerning cares provided to them. Resident identifiers: 27, 31 Finding include: 1. Resident 31 was a 54 year old female admitted to this facility on 11/10/00 with the diagnoses of end stage renal disease, requiring dialysis, diabetes with neuropathy (decreased sensation in her lower extremities), coronary artery disease with decreased vascular circulation, gastroesophageal reflux disorder and multiple stage II pressure sores on her buttocks. a. The medical record for resident 31 showed no documentation of weekly skin assessments from 11/10/00 through 2/6/01. On 2/1/01, at 11:45 AM, during an interview with the charge nurse and a staff nurse on the medicare unit, they were questioned concerning the facility protocol for skin assessments. The charge nurse and the staff nurse agreed that skin assessments were done on admission and weekly. The staff nurse also stated	F 514	**F514** **Federal Heights Rehabilitation is committed to maintaining clinical records in accordance with Professional standards.** **Corrective Action for Identified Residents** Residents 31's medical record is being documented to reflect cares provided such as weekly skin checks, turning and repositioning and dressing changes. Resident 27's medical record is being documented to reflect weekly skin assessment. **Identification of Residents Potentially Affected** All residents have the potential to be affected. **Measures to Prevent Recurrence** Nursing staff and the Health Information Services Department (Medical Records) will be in-serviced by the Director of Nursing or Designee by 3/27/01 on the facility policies to maintain resident medical records complete, accurate and organized related to documentation of Resident care provided, related to skin assessment, turning and repositioning and dressing changes. **Monitoring/Quality Assurance** An audit tool will be developed by 3/20/01 by the Health Information Services Director or Designee to audit documentation of skin assessments, dressing changes and turning and repositioning in the resident medical records for completeness.	

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F 514	Continued From page 43 that the CNAs (certified nurse aids) would notify them of any other occurrences. b. Review of the medical record concerning position changes for resident 31 revealed the following: On 1/30/01, review of the fourteen day MDS dated 11/24/00 revealed, that during the assessment period of the previous 14 days, resident 31 required extensive physical assistance for bed mobility with a one person assist and was bedfast all or most of the time. The MDS documented that during the last seven days of the assessment period, some of her skin treatments were pressure relieving devices for chair and bed and a turning and repositioning program. Resident 31's care plan number 4, dated 11/10/00, documented the problem of "impaired physical mobility." One of the goals for care plan number 4, dated 11/10/00, was "will not develop complications of immobility eg. pressure sores." Two approaches to care plan number 4 were "turn and reposition, report any red or open areas." On 1/31/01, review of the physician's orders for resident 31, revealed a physician's order, dated 11/15/00, for hydrocolloid dressings to be applied to the resident's sacrum for multiple stage II [breakdown] and change the resident's position every 2 hours and prn (as needed). The physician's signature was present on the order. The treatment record which indicated that position changes every two hours and as needed were to be done. The nurse documented the position changes were done on their shift by initialing that date on the flow sheet. The treatment record for December 2000	F 514 TB	Audits will be done bi-monthly for 8 weeks starting 3/20/01 and will be reported to the Performance Improvement Committee for 2 months and then continue as directed by the Committee. The Director of Nursing Services will be responsible for continued compliance. Corrective action will be completed by 4/16/01. Correction Date will be 04/06/01	

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F 514	Continued From page 44 had no initials for the entire day on: 12/6, 12/7, 12/9, 12/10, 12/17, 12/28. On 12/5, 12/12, 12/18, 12/19, 12/26 the night shift was not initialed. On 12/17 and 12/18 the day shift was not initialed. The treatment record for the month of January 2001 did not list turning and positioning at all. A request was made to the medical records department, on 2/6/01, for any type of flow sheet for resident 31, that documented a repositioning program every 2 hours for the month of November, 2000. The medical records department was unable to obtain any type of documentation of a turning and repositioning program for resident 31 for the month of November, 2000. c. Interviews concerning the care for resident 31 revealed the following: On 1/31/01, at 8:10 AM, during an interview with resident 31, she was questioned concerning her medical condition on admission to the facility. Resident 31 stated that she had been living alone in an assisted living situation. She stated that her daughter assisted her at times. Resident 31 stated that she had become very weak in her lower extremities and could not transfer. She stated her physician had informed her that she had developed diabetic neuropathy. Resident 31 was asked if she had a loss of sensation from the waist down and she replied that the decrease in sensation was only in her legs. Resident 31 was questioned concerning her plan of care and the staff assistance given to her. When questioned concerning how often she was turned, she stated that she was turned three or four times a day. On 2/5/01, at 12:00 PM, during an interview with two	F 514		

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	465055	A. BUILDING ______ B. WING ______	2/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEDERAL HEIGHTS REHAB AND NURS	41 S 900 E SALT LAKE CITY, UT 84102

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F 514	Continued From page 45	F 514		

CNAs, they were questioned concerning the process of documentation on the CNA flow sheet in the areas of toileting, repositioning, and oral care. One CNA stated that when initials are placed in that area, all cares had been done. The second CNA stated that when the resident was toileted or their briefs were changed, that would be considered repositioning.

d. Medical record review on 01/31/01, revealed the following concerning resident 31's dressing changes to her sacral pressure sore:

A nursing note on 11/15/00, at 5:30 PM, documented seven (7) stage II pressure sores on resident 31's sacrum. These pressure sores measured as follows: 4.5cm (centimeters) x 3cm, 2cm x 1.75cm, 1.5cm x .75cm, 1.5cm x .5cm, 1cm x 1cm, 1cm x .5cm, and .5cm x .5cm. The same nursing note stated that duoderm (a self-adhering hydrocolloid dressing) was applied to be changed every third day.

Review of the treatment flow sheet for the month of December 2000 revealed the following:

A treatment order dated 12/05/20 was listed as "Santyl oint. (ointment). Cover with coverderm to sacrum stage III breakdown. Change every day". This dressing change was not initialed as done on 12/6, 12/7, 12/17, and 12/28.

Review of the treatment flow sheet for the month of January 2001 revealed the following:

The dressing change dated 01/04/01 was listed as "Normal Saline wet to dry dressing to sacrum bid [two times a day]".

The dressing was not initialed as done at all on 1/12,

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F 514	Continued From page 46 1/13, 1/27, and 1/31. On 1/8, 1/9, 1/10, 1/11, 1/15, 1/16, 1/19, 1/21, 1/22, 1/24, 1/25, 1/26, 1/28, and 1/30 the dressing was not initialed as done on the night shift. On 1/7, 1/18, and 1/27 the dressing was not initialed as done on the day shift. 2. Resident 27 was an 83 year old male who was admitted on 12/21/00 with the diagnoses of a gastrointestinal bleed, cerebral vascular accident, benign prostatic hypertrophy, myocardial infarction renal insufficiency, hypertension, dementia, and duodenal ulcer. A review of resident 27's physician's recertification orders documented that the physician ordered, on 12/21/00, skin checks every week to be documented on a skin sheet. A review of resident 27's medical record revealed no weekly skin sheet was present. A review of resident 27's admission nursing assessment documented that resident 27 had bruises on his right and left forearms and a scab on his elbows and some redness on his knees. A review of resident 27's treatment sheet revealed that he had weekly skin checks on the following dates. 1/6/01 (Saturday), 1/10/01 (Wednesday), 1/19/01 (Friday) and 1/27/01 (Saturday). A review of resident 27's nurses notes documented the following regarding resident 27's skin. On 1/6/01, there was no nurses note present. On 1/19/01, the nurse documented that she changed resident 27's dressing to both of his ankles. On 1/27/01, the nurse documented the skin as warm and dry to touch., sores on ankles and dressing change per physician order.	F 514		

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F 514	Continued From page 47 A review of the occupational therapist notes documented on 1/10/01 that resident 27 had a skin tear on his right shin as well as skin breakdown on both ankles. A review of the nurses notes dated 1/10/01, documented that resident 21 crossed his legs while walking, rubbing the inner aspects of his ankles together causing the scabs to bleed. Skin warm to touch. The nurses notes on 1/10/01 do not document the skin tear on resident 27's right shin. On 1/29/01, at 10:00 AM, resident 27 was observed to have several scabs on his abdomen. On 1/29/01 through 1/31/01 the nurses notes did not document resident 27's scabs on his abdomen. In the bowel and bladder assessment the nurse practioner noted that resident 27 had dry skin on his abdomen and ordered Eucerin cream to be applied BID (two times a day). Review of resident 27's treatment record documented no treatment on either the day or night shifts on 1/29/01; or night shift on 1/30/01 or 1/31/01. A review of the certified nursing aides flow sheet documented "0 = other, report to nurse and record on ADL sheet." On the back of resident flow sheet, a CNA documented on 1/15/01, "a DQ [pressure ulcer] on resident 27's bottom nurse notified ." On 2/1/01, at 10:00 AM, resident 27's skin was observed by the nurse surveyor and a facility nurse and a stage 1 pressure area was present on his coccyx. A review of 1/15/01 through 1/31/01 nurses notes does not document any pressure ulcer on resident 27's coccyx. On 2/1/01, at 9:30 AM, an interview was conducted	F 514		

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F 514	Continued From page 48 with the nurse who the CNA charted that he/she had notified. The nurse stated that she was not notified and continued to say that she thought it was a stage I on resident 27's coccyx. On 2/6/01, at 10:00 AM, an interview was conducted with the Assistant Director of Nursing (ADON) and Director of Nursing (DON) regarding where the weekly skin assessments would be located in the residents' chart. The ADON stated that the weekly skin assessments would be located in the treatment book. There was no weekly skin assessment in the treatment book for resident 27. A review of the resident pressure ulcer record documented four ulcers on resident 27's feet that started on 1/23/01. No pressure ulcer was documented on resident 27's coccyx. On 2/6/01, at 9:30 AM, an interview with the staff developer was conducted regarding the facility's policy and procedure for the weekly skin assessment. The skin assessments were to be done on the resident's shower days by the nurses. Resident 27 was to have a shower every Monday , Wednesday and Friday. On 2/6/01, at 10:00 AM, an interview was conducted with the ADON and the DON regarding resident 27's weekly skin assessments. They stated that the nurses were to chart daily on residents and that the treatment sheet documents when the skin assessment occurred. They stated that the nurses were to chart in the nurses notes their assessments of the residents' skin. They further stated that they were in the process of changing to a body diagram form to show where and when the skin breakdown occurred.	F 514		

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