acceptable POA
5/21/0 - ASGlenda RN

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 _____	4/10/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEDERAL HEIGHTS REHABILITATION AND N	41 SOUTH 900 EAST SALT LAKE CITY, UT 84102

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F 157 SS=G	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This Requirement is not met as evidenced by: Based on physician interviews and review of resident medical records, it was determined for 2 of 22 sample residents, the facility did not immediately consult with the resident's physician when there was a significant change in the resident's physical or mental status with a need to alter treatment significantly. Specifically, the facility did not notify the physician with the results of a UA (urinalysis) and C&S (culture	F 157	409834 MAY 2 0 2003 CR	5/28/03

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 5/16/03

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

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F 157	Continued From page 1 and sensitivity) when a resident was receiving an antibiotic that was resistant to the infection nor did the facility report to the physician possible feces coming out of the resident's vaginal vault. This was cited at an actual harm. In addition, the facility did not notify the physician when one resident had low blood sugars. Resident Identifier: 83 and 84. Findings include: 1. Resident 83 was originally admitted to the facility on 5/9/00 with the diagnoses of cerebrovascular dementia with depressive features, deep vein thrombosis, recurrent pneumonia with severe hypoxia, osteoporosis, B12 deficiency, atrial fibrillation, congestive heart failure, neuromuscular dysphagia, recurrent urinary tract infections and a history of urosepsis. On 4/7/03 resident 83's medical record was reviewed and revealed the following. A physician order, with no date documented, "UA (urinalysis) [with] C&S (culture and sensitivity) if indicated- then start on Levaquin 250 mg PO (by mouth) QD (every day) X (times) 10 d (days) DX (diagnosis) UTI (urinary tract infection)..." On 3/24/03 at 4:00 PM, a facility nurse documented, "Order given for UA [with] C&S if indicated. Urine sample obtained [and] sent to lab (laboratory)." The results for the UA with C&S could not be located in resident 83's medical record. On 4/7/03 at 2:45 PM, resident 83's physician asked the nurse surveyor for resident 83's medical record. The physician had a copy of the lab (laboratory) results of the UA with C&S, dated 3/25/03. The UA	F 157 OK 5/21/03 JS	F 157 G **Corrective action for identified Residents** Resident # 84 who was a hospice resident expired on April 11, 2003. Resident # 83's physician was notified of the results of the UA (urinalysis) and C&S (culture and sensitivity) as indicated in the CMS 2567 and appropriate antibiotic administration was instituted on 4-7-03. As indicated in the CMS 2567 this physician was also notified of the possible feces in resident # 83's vaginal vault and he conducted an appropriate vaginal exam with documented results on 4-10-03.	

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F 157	Continued From page 2 with C&S indicated that resident 83 had an infection, that cultured positive for Escherichia Coli and Enterococcus. The UA with C&S also indicated that the bacteria was resistant to Levaquin. There was no documentation on the lab results to provide evidence that the nursing staff at the facility had reviewed the UA with C&S results or that the facility staff had informed the physician of the results. The results indicated that they were received by the facility's fax machine on 3/31/03 at 2:47 PM. On 4/7/03 at 2:55 PM, a facility nurse stated that the lab results come to the nurse's desk and they call the physician or fax the physician and document that on the lab results. On 4/7/03 at 3:00 PM, resident 83's physician stated to the nurse surveyor that he was not made aware of the UA results until that day. This was 7 days after facility staff became aware of the laboratory results which identified that the antibiotics which had been given to resident 83 for her urinary tract infection were ineffective. During a mini exit with facility administration on 4/9/03 at 5:00 PM, the corporate nurse stated that they had not received the UA results until 3/31/03. She further stated that the facility should have called the physician but they didn't. The DON (director of nurses) stated that resident 83's physician policy was to have the results placed in his box for him to review on his next visit. Review of other lab results completed for resident 83 provided documentation that the facility nurses called and/or faxed the results to the physician. The lab results did not indicate that the facility placed the results in a box for the physician to review at a later	F 157	**Identification of residents potentially affected** Residents with physician orders for laboratory tests for UA and C&S, residents with observed abnormalities not documented in the resident's history and physical or the physician's progress notes and residents with low blood sugars have the potential to be affected. **Measures to prevent recurrence** The Director of Nursing or designee will develop a policy and procedure to track ordered labs for timely draw, timely notification of the facility of the laboratory results and timely notification of the physician of abnormal results and of results requiring further physician follow-up, i.e. C&S that indicates a need for a change in the ordered antibiotic. This will be developed by May 7, 2003.	

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F 157	Continued From page 3 date. Numerous interviews conducted with facility CNA's on 4/7/03 through 4/10/03, provided evidence that facility CNA's had suspected possible feces coming out of resident 83's vaginal vault for approximately the past 2 weeks. On 4/10/03 at 8:45 AM, nurse #5 stated that she had been told that resident 83 had feces coming out of her vaginal vault a week or so ago but did not do anything because the CNAs had made it sound like an on going problem. She further stated that she did not chart on it nor did she call and report the problem to the physician. On 4/10/03 at 12:55 PM, the facility DON stated that she was not aware that resident 83 possibly had feces coming from her vaginal vault until 4/9/03. She further stated that she was not aware that the nurses and CNAs had known about this problem for the past 2 weeks. She stated that she had called the physician that morning concerning the problem. On 4/10/03 at 2:50 PM, resident 83's physician stated, in a phone interview, that he had not been made aware of possible feces coming out of resident 83's vaginal vault around two weeks ago or anytime after that. He further stated that he was just recently informed of the problem. 2. Resident 84 was re-admitted to the facility on 1/17/03 with diagnoses, which included diabetes mellitus, pain, urinary tract infection, congestive heart failure and chronic renal insufficiency. Resident 84's medical record was reviewed on 4/8/03. Resident 84 had a physician's order, dated 11/18/02, to have her blood sugars checked twice daily.	F 157	The Director of Nursing or designee will inservice the licensed nurses on this policy and procedure by May 14, 2003. The licensed nurses will be inserviced by May 17, 2003 by the Director of Nursing or designee on: 1. Importance of obtaining, as part of the sliding scale insulin and blood sugar checks orders, the parameters of when the ordering physician wants to be notified. 2. Need for diligence in notifying the physician of low blood sugar check results and in complete and accurate documentation of physician notification and of interventions administered. 3. Need for diligence in notifying the physician of abnormal laboratory results and of laboratory results requiring further physician follow-up. i.e. C&S that indicates a need for a change in the ordered antibiotic.	

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F 157	Continued From page 4 Resident 84' "Diabetic Record" for November 2002 from 11/18/02 to 11/30/02 was reviewed and the following was documented: On 11/18/02 at 4:30 PM resident 84's blood sugar was 53. On 11/22/02 at 4:30 PM resident 84's blood sugar was 49. A review of the nursing notes, written 11/18/02 and 11/22/02, was completed on 4/8/03. There was no documented evidence that the physician was notified of resident 84's low blood sugars on these days. Resident 84' "Diabetic Record" for January 2003 from 1/1/03 to 1/14/03 was reviewed and the following was documented: On 1/7/03 at 6:30 AM resident 84's blood sugar was 46. On 1/10/03 at 6:30 AM resident 84's blood sugar was 49. On 1/12/03 at 6:30 AM resident 84's blood sugar was 39. A review of the nursing notes, written 1/7/03, 1/10/03 and 1/12/03, was completed on 4/8/03. There was no documented evidence that the physician was notified of resident 84's low blood sugars on these days. On 4/10/03 at 12:25 PM, the DON (director of nurses) stated that a physician should be contacted for any blood sugars below 60 or above 400. She further stated that this was a facility policy signed by the medical director. On 4/15/03, resident 84's physician was interviewed. She stated that she was not notified about the low	F 157	4. Need for licensed nurses to document and follow-up with the physician on concerns communicated to them by the certified nursing assistants as these concerns relate to abnormalities that are not documented in the resident's history and physical exam or in the physician's progress notes. **Monitoring/Quality Assurance** The Director of Nursing or designee will develop an audit tool by May 16, 2003. This tool will monitor compliance with timely: 1. Notification of the physician of laboratory results that are abnormal or need further physician follow-up i.e. change of antibiotic order. 2. Notification of the physician of low blood sugar check results	

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F 157	Continued From page 5 blood sugars obtained on 11/18/02, 11/22/02, 1/7/03, 1/10/03 and 1/12/03. She did say that she wanted to be notified if a resident's blood sugar was less that 55.	F 157	3. Notification of the physician of abnormalities identified that are not documented in the resident's history and physical or in the physician's progress notes. The Director of Nursing or designee will do weekly audits for six weeks to determine the level of compliance. At the completion of the audits the Director of Nursing or designee will report results to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the frequency of any continued audits and reports based on the percent of compliance as indicated by the audits. When the audits indicate the attainment of 100 percent compliance, the audits and reports will then be done, at a minimum, quarterly for two quarters. The Committee will then determine if there is a need	5/28/03
F 241 SS=E	483.15(a) QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This Requirement is not met as evidenced by: Based on observations and interviews with staff and residents and a confidential group interview, it was determined that for 15 of the 110 residents in the facility, the facility did not provide care in a manner of respect to promote each resident's dignity for dependent residents who did not have their needs and requests responded to timely, for dependent residents who were dressed in clothing that identified their name and/or room number in bold print that was visible to passers by, for dependent residents who were awakened and taken to sit in the dining room for up to two hours before breakfast, for resident's who were put to bed on top of their bed coverings, and for 3 of 4 residents in a confidential group interview who did not have their call lights answered promptly. Resident identifiers: 36, 80, 81, 99, 102, 103, 112, 84, 113 ,62, 13 and 93. Findings include: 1. During the initial tour on 4/7/03 at approximately 6:15 AM until 7:00 AM, resident 36, 80 and 81 were observed to be asleep on top of their bedcovers. On 4/8/03 at approximately 6:15 AM, residents 81,	F 241		

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F 241	Continued From page 6 99,102, 103 and 112 were observed to be sleeping on top of their bedcovers. On 4/8/03 at approximately 6:20 AM, a graveyard CNA (certified nursing assistant) stated that when she gets to the facility most of the residents are already in bed. 2. On 4/7/03 at 9:40 AM, a facility nurse was observed to give resident 84 her medications crushed in applesauce. The facility nurse left resident 84's room without giving her a drink with her medications. A CNA was in resident 84's room assisting the other resident. Resident 84 kept saying over and over, "Oh, I want water." The CNA replied, "just a minute." At 9:45 AM the CNA left resident 84's room without giving her a drink of water. 3. On 4/8/03 at 7:10 AM, a facility CNA brought resident 84 into the 2nd floor dining room. At 8:10 AM, resident 84 was observed to be sleeping in her wheelchair at a dining room table. At 8:20 AM, resident 84 was served her breakfast by a CNA. The CNA had to wake up resident 84. The facility meal time for breakfast on the 2nd floor dining room is approximately 8:10 AM. On 4/10/03 at 6:13 AM, a graveyard CNA was observed to be bringing residents into the 2nd floor dining room. When asked why they brought residents into the dining room so early, she replied, that they are told to do so, to help out the day shift. 4. On 4/8/03 at 7:15 AM until 7:45 AM, resident 113 was observed in the 2nd floor dining room. Resident 113 was observed to have his shirt up around his chest with his stomach and back exposed. Resident 113 sat	F 241	for any further audits and reports. The Director of Nursing will be responsible for continued compliance. Completion date: May 28, 2003	

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F 241	Continued From page 7 and talked with the surveyor during this time and was observed to be trying to pull his shirt down to cover his stomach. 5. A confidential group interview was held with residents on 4/9/03, at 3:00 PM. When asked about call lights 3 out of 4 resident who stated they used their call lights said they usually wait longer than 15 minutes. One of the 4 residents stated that they had waited as long as 30 minutes and another resident stated they had waited as long as 35 minutes. 6. During a confidential group interview on 4/9/03 at 3:00 PM, a resident stated that a few nights ago they needed some medication at about 1:00 AM and at 2:20 AM still had not received the medication. The resident further stated that they had checked with the CNA at about 2:20 AM, the CNA replied that the nurse was on their way. The resident stated they ended up never getting the medication and when the resident asked the nurse about it the next night he stated that he was never told that the resident wanted any medications. 7. On 4/7/03 at 1:27 PM, resident 62 was observed sitting in a wheelchair in the main hallway. Her shoes were labeled with her name in big, bold black marker. It was also observed that the dress resident 62 was wearing came half way up her thighs. Resident 62 had been given a white towel, folded in half, to cover the tops of her legs. The towel was not sufficient to cover her thighs which were often observed to be exposed. This situation was observed with resident 62 all days of survey 4/7/03 - 4/10/03. 8. On 4/8/03 at 7:28 AM, a facility staff member was observed walking down the hall with resident 13. Resident 13 was observed to be wearing a light green jacket with her name and room number printed in big,	F 241 OK 5/13/03	F 241 E **Corrective action for identified residents** The Director of Nursing spoke with Residents # 36, 80,81,99,102,103 and 112 and requested that they sleep at night under their bedcovers. They were additionally requested to put on nightclothes for sleeping at night. These residents continue to be non-compliant by continuing to sleep in their clothes on top of the bedcovers. His or her preference to continue this practice has been care planned for each resident. Resident # 84 who was a hospice resident expired on April 11, 2003. Resident # 113 is having his shirts that are too small replaced with shirts that fit by May 7, 2003. Resident # 62's family brought her in new shoes. Resident was dissatisfied with new shoes. She liked having her name, that she could read, on her shoes. Resident # 62 is care planned to be allowed to wear either pair of shoes as she chooses. Resident is being provided a lap robe to cover her legs. Resident # 13 and her family requested that Residents #13 be allowed to keep her coat as it is. Care plan and nurses notes updated.	

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F 241	Continued From page 8 bold black marker across the bottom outside hem. The bottom outside hem hung directly over the resident's buttocks, providing others with her name and room number. 9. On 4/7/03 at 1:51 PM a call light was observed to have been activated for room 212 which was directly across from the nurse's station. At 1:52 PM, the nurse who was sitting at the nurse's desk entered room 212 and told the resident who was lying in bed that, "They'll be in in a few minutes. They're cleaning up trays." At 1:55 PM a certified nurse aide (CNA) entered room 212, turned off the light and left the room. The light came right back on. At 1:59 PM, the resident began calling out for help. At 2:00 PM the nurse who had been sitting at the desk went to the dining room to ask the CNA to assist the resident who was still calling for help. The CNA stated she could only leave the dining room if the nurse would sit with the resident there. The nurse then found another CNA who was taking soiled laundry to the utility room and asked that CNA to assist the resident in room 212. The nurse went into room 212 and turned off the light. The resident asked for help and the nurse said, "They'll be in in a minute." At 2:02 PM another CNA entered room 212 and assisted the resident. It was eleven minutes before the resident received assistance.	F 241	Resident # 93 was not addressed as to what the specific concern was for this resident so no specific actions can be addressed. **Identification of residents potentially affected** All residents have the potential to be affected. **Measures to prevent recurrence** The nursing staff will be inserviced by May 17, 2003 by the Staff Development Coordinator or designee on: 1. Respecting residents' dignity by not labeling clothing with residents' names and/or room numbers that would be visible to passers by. If resident or family representative requests such labeling or labels clothing in such a manner, speak to resident and/or family and document and care plan the response. Honor residents' preferences in regard to this issue. 2. Respecting residents' dignity by not taking dependent residents to the dining room too early. 3. Respecting residents' dignity by assisting them to sleep at night under their bedcovers. Licensed nurses are to care plan if residents prefer/choose to sleep on top of the bedcovers and if they prefer to not change into night clothing.	
F 253 SS=C	483.15(h)(2) ENVIRONMENT The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This Requirement is not met as evidenced by: Based on observation from 4/7/03 through 4/10/03, the facility did not maintain maintenance services necessary to maintain a sanitary, orderly and	F 253		5/28/03

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F 253	Continued From page 9 comfortable interior as evidenced by loose and peeling coving, missing window slats, scratched door jams, torn and/or peeling wallpaper, exit doors without weather stripping leaving gaps for potential pests, leaks in the dining room ceiling, and chipped and/or broken tiles. Findings include: The elevator doors were scratched. On the 1st floor the elevator up button would not light up. The coving around the elevator on the 2nd floor was loose and peeling away from the wall. The 2nd floor dining room, east window was missing 3 slats from its blinds. The 2nd floor assisted dining room, west window was missing 3 slats from its blinds. The following had scratched door jams: room 113, ice machine Medicare hall, clean utility Medicare hall, emergency exit Medicare hall, room 119, soiled utility room Medicare hall, storage room Medicare hall, custodial closet between rooms 110 and 111, room 112, main dining room, patio doors main dining room, around soda and snack machines, storage room, public restroom, staff developer office, custodial closet, soiled linen closet, room 149, shower room between room 144 and 145, social services office, clean linen west hall 2nd floor, room 202, room 210, ice machine room 2nd floor, clean linen east hall 2nd floor, exit door east hall 2nd floor, custodial closet east hall 2nd floor, and the utility closet east hall 2nd floor. The following bathrooms had scratched door jams: 102, 103, 104, 105, 106, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 119, 120, 122, 126, 127, 128, 129, 130, 131, 135, 136, 137, 139, 140, 141, 143, 144, 145,	F 253	4. Respecting residents' dignity by assisting residents to have properly fitting clothing. 5. Respect residents' dignity by offering residents water after administering medications crushed in applesauce. 6. Respect residents' dignity by responding promptly to residents' request i.e. request for pain medications, request for water and request for help by turning on the call light. **Monitoring/Quality Assurance** The Director of Nursing or designee will develop and audit tool by May 16, 2003. This tool will monitor compliance with: 1.Proper labeling of clothing 2. Taking dependent residents to the dining room for meals in a timely manner by not taking residents to dining rooms too early. 3. Assisting residents to sleep at night under the bedcovers. Care planning of residents who choose to not comply with this practice. 4. Assisting residents to have properly fitting clothing. 5. Offering residents water after administering medications crushed in applesauce. 6. Promptly responding to residents' request for pain medications. 7. Promptly responding to call lights.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	465055	A. BUILDING _____ B. WING _____	4/10/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEDERAL HEIGHTS REHABILITATION AND I	41 SOUTH 900 EAST 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 253	Continued From page 10 146, 148, 149, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, and 223. Room 116 had coving around the door loose and peeling away from the wall. The east and west exit doors, next to the main dining room, both had a 1-centimeter gap in between the doors, leaving a potential for pests and small rodents to get into the facility. The main dining room, the east double door did not close or lock properly. There was a 2-centimeter gap in between the doors, leaving a potential for pests and small rodents to get into the facility. The door was held closed with a chain and lock. The patio door, facing east, had a 1 1/2 centimeter gap along the bottom, leaving a potential for pests and small rodents to get into the facility. The north dining room had a hole in the ceiling approximately 1-½ feet by 1-½ feet. The blinds on the bigger window were tied up. The wallpaper next to the 1st door closest to the nurse's station was peeling and torn off of the wall. The wallpaper next to the 2nd door was also peeling and torn off of the wall. The vent in the center of the dining room was dirty. There was an area approximately 1-½ feet by 1 foot, in the ceiling closest to the big window that had paint peeling. Room 131 had wallpaper and coving peeling away from the wall next to the bathroom door. The shower room, next to room 132, had coving loose around the door jam. The exit door, next to room 135, had a 1-centimeter	F 253	The Director of Nursing or designee will do weekly audits for four weeks and then report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine if there is a need for any further audits and reports. The Director of Nursing will be responsible for continued compliance. Completion date: May 28, 2003 OK AH 5/23/03 F 253 C **Corrective Action for identified conditions** The elevator door scratches will be repaired by May 28, 2002. The bulb for the up button light has been replaced. The coving around the elevator on the second floor will be repaired by May 28, 2003. The 2nd floor dining room, east window blind and the 2nd floor assisted dining room; west window blind will be repaired by May 28, 2003.	

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F 253	Continued From page 11 gap along the bottom, leaving a potential for pests and small rodents to get into the facility. Room 135 had coving peeling away from the wall door. Room 141 had 8 tiles in front of the bathroom door that were scratched up and discolored. Room 144 next to the bathroom door, had wallpaper approximately 2 feet in length that was torn off. Room 146 next to the bathroom door, had wallpaper and coving peeling away from the wall. The exit door, by room 148, was propped open by a small rock, leaving a potential for pests and small rodents to get into the facility. There was one chair in the main dining room that had the right arm broken off. Room 202 the corner of the window tile was chipped and cracked. Room 203 the corner of the window tile was chipped and broken off, in addition 4 other tiles were chipped and broken off. Room 204 the coving around the bathroom door was loose and peeling away from the wall. Room 205 the coving around the bathroom door was loose and peeling away from the wall. Room 206 the coving around the bathroom door was loose and peeling away from the wall. In a confidential group meeting, on 4/9/03, 4 of the 8	F 253	The following scratched door jams will be repaired by May 28, 2003: Room 113, ice machine Medicare hall, clean utility Medicare hall, emergency exit Medicare hall, room 119, soiled utility room Medicare hall, storage room Medicare hall, custodial closet between rooms 110 and 111, room 112, main dining room, patio doors main dining room, around soda and snack machine, storage room, public restroom, staff developer office, custodial closet, soiled linen closet, room 149, shower room between room 144 and 145, social services office, clean linen west hall 2nd floor, room 202, room 210, ice machine room 2nd floor, clean linen closet east hall 2nd floor, exit door east hall, custodial closet east hall 2nd floor, and the utility closet east hall 2nd floor. The following bathroom scratched door jams will be repaired by May 28, 2003: 102, 103, 104, 105, 106, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 119, 120, 122, 126, 127, 128, 129, 130, 131, 135, 136, 137, 139, 140, 141, 143, 144, 145,146, 148, 149, 201,202,203,204,205,206,207,208, 209, 210,211,212,213,214,215 and 223. Coving around room 116 will be repaired by May 28, 2003.	

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F 253	Continued From page 12 residents actively participating in the meeting, stated that the maintenance in the building was lacking and that they often bring up problems in their resident council meetings. Two of the residents stated that the hole in the north dining room had been there for sometime and that when it rains water would leak through.	F 253	The gaps between or at the bottom of the following doors will be repaired by May 28, 2003: east and west exit doors (next to the main dining room), the main dining room east double door, the patio door facing east and exit door next to room 135. The closure and lock on the main dining room east double door will be repaired by May 28, 2003.	
F 257 SS=B	483.15(h)(6) ENVIRONMENT The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71-81degrees Fahrenheit. This Requirement is not met as evidenced by: Based on observation and interview, it was determined the facility did not provide comfortable temperatures for 1 of 23 sample resident and 2 additional residents who voiced complaints about being cold. Residents 73, 87 and 88. Findings include: On 4/7/03 at 9:15 AM, resident 88 was interviewed in her room. Resident 88 repeatedly complained of "freezing". Resident 88 was observed to be curled up in bed with her bed covers pulled up over her ears and under her chin. A thermometer was placed on resident 88's over-bed table for five minutes. The room tested to be at 62 degrees Fahrenheit. During the interview a nurse entered the room and resident 88 complained to her of "freezing". The nurse offered to get another blanket, but no one checked to see if the room heater was working properly. From 9:15 AM until 9:35 AM, resident 87 was observed in her room, which she shared with resident	F 257	The following concerns in the north dining room will be repaired by May 28, 2003: 1.hole in ceiling 2. Blinds on big window 3. Wallpaper 4. Peeling paint on ceiling Also the vent in the ceiling has been cleaned. The wall paper and or coving will be repaired by May 28, 2003 at the following locations: room 131,shower room next to room 132, room 135, room 144 next to bathroom door, room 146, room 204, room 205 and room 206. Tiles in front of bathroom door in room 141 will be repaired by May 28, 2003. The chair in the main dining room will be repaired, replaced or removed by May 28, 2003Chipped tiles in room 202 and 203 will be repaired by May 28, 2003.	5/28/03

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F 257	Continued From page 13 88. Resident 87 was dressed in pants, shirt, sweater, shoes and socks, but she complained of being too cold. At 9:35 AM, resident 87 had taken the blanket from her bed and wrapped it around her torso and shoulders, but she still complained of feeling cold. On 4/8/03 at 7:15 AM, four residents were observed to be in the assistance dining room on the second floor. Resident 73 complained of the room being too cold, but there was no staff in the room. A thermometer was placed on a couch in the room for 5 minutes. The room temperature tested to be 66 degrees Fahrenheit. When a nurse's aide entered the room with another resident, resident 73 complained again of freezing. The nurse's aide stated that she couldn't do anything about the room temperature but asked if the resident wanted a blanket. Resident 73 stated that she did. A folded blanket was brought and wrapped around resident 87's shoulders and back. Resident 73 asked to be taken out of the room with no response. Resident 73 asked twice more to be taken out but, each time, the nurse aide at her table said just a minute. Resident 73 was able to work her wheelchair near the door, where another staff member came in and assisted the resident out of the dining room. On 4/8/03 at 7:40 AM, three nurse aides had entered the dining room to assist the residents with breakfast. A forth aide entered the dining room and the lead nurse aide offered to let the forth aide trade places and stay in the dining room. The forth aide declined the offer stating that she didn't want to stay in the dining room because she was too cold.	F 257	The residents who are propping open the exit door by room 148 will be counseled by the Administrator or designee by May 28, 2003 to stop this practice. **Identification of residents potentially affected** All residents have the potential to be affected. **Measures to prevent recurrence** The Maintenance Supervisor and the Administrator will do joint facility environmental rounds bimonthly for two months. **Monitoring/Quality Assurance** The Maintenance Supervisor will secure a rounds sheet to address the concerns of loose and peeling coving, missing window slats, scratched door jams, torn and/or peeling wallpaper, exit doors without weather stripping which results in gaps between and under doors, leaks in ceiling and broken tiles. The Maintenance Supervisor will do bimonthly environmental rounds with the Administrator for two months. The Maintenance Supervisor will report the results of these rounds to the Performance Improvement Committee (Quality Assurance). The Committee will determine the need for any further rounds and reports.	
F 279 SS=D	483.20(k) RESIDENT ASSESSMENT The facility must develop a comprehensive care plan for each resident that includes measurable objectives	F 279		5/28/03

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F 279	Continued From page 14 and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under s483.25; and Any services that would otherwise be required under s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4). This Requirement is not met as evidenced by: Based on interview and review of resident medical records, it was determined that for 2 of the 22 sample residents, the facility did not develop a comprehensive care plan for each resident based on the needs identified by staff. Resident identifiers: 83 and 88. Findings include: 1. Resident 83 was originally admitted to the facility on 5/9/00 with the diagnoses of cerebrovascular dementia with depressive features, deep vein thrombosis, recurrent pneumonia with severe hypoxia, osteoporosis, B12 deficiency, atrial fibrillation, congestive heart failure, neuromuscular dysphagia, recurrent urinary tract infections and a history of urosepsis. On 4/7/03 resident 83's medical record was reviewed and revealed the following. A physician order, with no date documented, "UA (urinalysis) [with] C&S (culture and sensitivity) if indicated- then start on Levaquin 250 mg PO (by	F 279	The Maintenance Supervisor will be responsible for continued compliance. Completion date: May 28, 2003 F 257 B OK 5/15/03 JA **Corrective action for identified residents** The nursing staff on the second floor who care for Residents # 73, 87 and 88 will be inserviced by the Staff Development Coordinator or designee on how to check the room heaters for proper functioning and how to set the heaters to keep the room temperature at the acceptable range of 71-81 degrees Fahrenheit. **Identification of residents potentially affected** All residents have the potential to be affected **Measures to prevent recurrence** Nursing staff will be inserviced by the Staff Development Coordinator or designee by May 28, 2003 on how to check the room heaters for proper functioning and how to set the heaters to keep the room temperature at the acceptable range of 71-81 degrees Fahrenheit.	

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F 279	Continued From page 15 mouth) QD (every day) X (times) 10 d (days) DX (diagnosis) UTI (urinary tract infection)..." On 3/24/03 at 4:00 PM, a facility nurse documented, "Order given for UA [with] C&S if indicated. Urine sample obtained [and] sent to lab (laboratory)." A review of resident 83's plan of care revealed that a recent urinary tract infection, recurrent urinary tract infection or a history of urosepsis had not been incorporated into her plan of care. Resident 83 had a physician order dated 1/28/03, with a re-certification order dated 3/10/03, for oxygen via nasal cannula and to titrate until saturations were greater than 90% on room air, chart liter flow used. Observations of resident 83, during the survey, 4/7/03 through 4/10/03, provided evidence that resident 83 continued on oxygen therapy. A review of resident 83's plan of care revealed that the use of oxygen therapy had not been incorporated into her plan of care. 2. Resident 88 was admitted to the facility on 11/13/02 with diagnoses that included seizure disorder, dementia, depression, osteoporosis, anemia, and left eye blindness. Resident 88's medical record was reviewed on 4/9/03. The quarterly Minimum Data Set (MDS) assessment dated 2/11/03 and the comprehensive MDS assessment dated 11/19/02 documented, in sections G1 and G2, that resident 88 required limited assistance of one staff member for: a. Bed mobility, how resident moves to and from lying	F 279	**Monitoring/Quality Assurance** The Staff Development Coordinator or designee will develop an audit tool by May 12, 2003 to monitor compliance with keeping room temperatures within the acceptable range of 71-81 degrees Fahrenheit. The Staff Development Coordinator or designee will do weekly audits for four weeks and then report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine if there is a need for any further audits and reports. The Staff Development Coordinator will be responsible for continued compliance. Completion date: May 28, 2003	

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F 279	Continued From page 16 position, turns side to side, and positions body while in bed. b. Transfer, how resident moves between surfaces such as bed, chair standing position. g. Dressing, how resident puts on and fastens, and takes off street clothing. i. Toilet use, how resident uses the toilet room, transfers on/off toilet and cleanses and adjusts clothing. j. Personal hygiene, combing hair, brushing teeth, washing/drying face and hands and perineum. G2. Bathing, how resident takes full-body bath/shower, excluding back and hair. Resident 88 was observed intermittently on 4/7/03, 4/8/03, 4/9/03 and 4/10/03. Resident 88 was observed to be able to position herself in bed, get up from bed and into bed, and transfer from/to bed and chairs without any assistance. Resident 88 was interviewed on 4/7/03 at 9:15 AM. Regarding the assistance she receives from the staff, resident 88 stated, "I can't really say they do anything to help me, but they don't do anything to hinder me." Resident 88 stated that the only thing she didn't do alone was leave the facility. A certified nurse's aide (CNA), who had provided care for resident 88 since the resident admitted to the facility, was interviewed on 4/8/03 at 9:00 AM. The CNA stated that resident 88 did not like to be touched and was very independent. The CNA stated that resident 88 dressed, groomed, transferred and moved around in her bed without any assistance of any staff. On 4/8/03 at 12:30 PM, a second CNA who had provided care for resident 88 for more than six months, was interviewed. The CNA stated that resident 88 did everything for herself. The CNA said, "We make her bed but we encourage her to do it herself."	F 279	F 279 D OK SMB 5/13/03 DVJ **Corrective action for identified resident** Resident # 83's careplan will be updated by May 8, 2003 to reflect her history of recurrent urinary tract infections, history of urosepsis and use of oxygen. Resident # 88's careplan will be updated by May 8, 2003 to reflect her independence in turning and repositioning and her continence of bowel and bladder. Resident # 64's careplan will be updated by May 8, 2003 to reflect the discontinuation of the use of oxygen and of a urinary catheter. **Identification of residents potentially affected** All residents have the potential to be affected. **Measures to prevent recurrence** The licensed nurses will be inserviced by the Staff Development Coordinator or designee by May 18, 2003 on the necessity and importance of accurately careplanning each resident's problems and of timely updating of the careplans as conditions and treatments change.	

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F 279	Continued From page 17 Problem number 3 on resident 88's current care plan, dated 12/3/03, documented the nurse's aides were supposed to use a turn sheet to reposition the resident while she was in bed and that they were to turn and reposition her every two hours. Problem number 7 in the current care plan for resident 88 documented the resident had a problem of impaired physical mobility, dated 12/3/2002. It was documented that the nurse's aides and physical therapy staff were to place the resident's joints in functional positions: proper alignment. It documented that the nurse's aides were to turn and reposition resident 88 every two hours. Problem number 10 on the current care plan for resident 88 documented the resident's routine care needs were to be met by turning and positioning her every two hours and peri care was to be done every shift and after each incontinent episode. The quarterly MDS assessment dated 2/11/03 and the comprehensive MDS assessment dated 11/19/02 documented, in sections H1 and H2, resident 88 was not incontinent and had complete control of her bowel and bladder. 3. Resident 64 was re-admitted to the facility on 12/2/02 with diagnoses which included status post hip, humerus and wrist fractures, dysphagia, congestive heart failure and a history of cerebrovascular accident. Resident 64's medical record was reviewed on 4/7/03. The facility staff developed a care plan for resident 64 regarding her altered cardiac output and diagnosis of congestive heart failure. The care plan was not dated, however, it remained in resident 64's active medical record and had not been discontinued. One documented approach, which address the altered	F 279	**Monitoring/Quality Assurance** The Director of Nursing or designee will develop and audit tool by May 14, 2003. This tool will monitor compliance with accurately careplanning problems presented by the resident and with updating careplans as conditions and treatments change. The Director of Nursing or designee will do weekly audits for four weeks and then report to the Performance Improvement Committee (Quality Assurance). The Committee will then determine if there is a need for any further audits and reports. The Director of Nursing will be responsible for continued compliance. Completion date: May 28, 2003	

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F 279	Continued From page 18 cardiac output problem, was that resident 64 was ordered oxygen via nasal canula which was to be titrated to keep her oxygen saturation level great than 90 percent. A review of resident 64's physician telephone orders was completed on 4/7/03. On 3/1/03, there was an order to discontinue resident 64's oxygen. The facility staff developed a care plan for resident 64 addressing her routine care needs. The care plan was dated 12/2/02 and was in resident 64's active medical record. One approach documented noted that resident 64 used a Foley catheter. A review of resident 64's physician telephone orders was completed on 4/7/03. On 2/4/03, there was an order to discontinue resident 64's Foley catheter.	F 279		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This Requirement is not met as evidenced by: Based on review of resident medical records and interviews, it was determined for 1 of 22 sample residents, the facility did not provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being. Specifically, the facility did not notify the	F 309 OK 5/28/03 DS	F 309 G **Corrective action for identified resident** Resident # 83's physician was notified of the results of the UA (urinalysis) and the C&S (culture and sensitivity) as indicated in the CMS 2567 and appropriate antibiotic administration was instituted. As indicated in the CMS 2567 this physician was also notified of the possible feces in resident # 83's vaginal vault and he conducted an appropriate vaginal exam with documented results on 4-10-03.	5/28/03

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F 309	Continued From page 19 practicable physical, mental and psychosocial well-being. Specifically, the facility did not notify the physician with the results of a UA (urinalysis) and C&S (culture and sensitivity) when the resident was receiving an antibiotic that was resistant to the infection nor did the facility report to the physician possible feces coming out of the resident's vaginal vault. In addition, the facility did not accurately document findings and assessments in the resident's medical record. Resident identifiers: 83 Findings include: 1. Resident 83 was originally admitted to the facility on 5/9/00 with the diagnoses of cerebrovascular dementia with depressive features, deep vein thrombosis, recurrent pneumonia with severe hypoxia, osteoporosis, B12 deficiency, atrial fibrillation, congestive heart failure, neuromuscular dysphagia, recurrent urinary tract infections and a history of urosepsis. On 4/7/03 resident 83's medical record was reviewed and revealed the following. A physician order, with no date documented, "UA (urinalysis) [with] C&S (culture and sensitivity) if indicated- then start on Levaquin 250 mg PO (by mouth) QD (every day) X (times) 10 d (days) DX (diagnosis) UTI (urinary tract infection)..." On 3/24/03 at 4:00 PM, a facility nurse documented, "Order given for UA [with] C&S if indicated. Urine sample obtained [and] sent to lab (laboratory)." The results for the UA with C&S could not be located in resident 83's medical record.	F 309	**Identification of residents potentially affected** Residents with physician orders for the laboratory tests for UA and C&S and residents with identified abnormalities that are not documented in the resident's history and physical exam or in the physician's progress notes have the potential to be affected. **Measures to prevent recurrence** The Director of Nursing or designee will develop a policy and procedure to track ordered labs for timely draw, timely notification of the facility of laboratory results and timely notification of the physician of abnormal results and of results requiring further physician follow-up, i.e. C&S that indicates a need for a change in the ordered antibiotic. This will be developed by May 7, 2003. The Director of Nursing or designee will inservice the licensed nurses on this policy and procedure by May 14, 2003. The licensed nurses will be inserviced by the Director of Nursing or designee by May 17, 2003 on:	

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F 309	Continued From page 20 The nursing progress notes were reviewed from 3/3/03 through 3/24/03. The facility nurses did not document any reasons, in the progress notes, to indicate why resident 83 required a UA with C&S. There was no documented evidence in the medical record that the facility had received any results of the UA with C&S completed on 3/24/03. On 4/7/03 at 2:45 PM, resident 83's physician asked the nurse surveyor for resident 83's medical record. The physician had a copy of the lab (laboratory) results of the UA with C&S, dated 3/25/03. The UA with C&S indicated that resident 83 had an infection, that cultured positive for Escherichia Coli and Enterococcus. The UA with C&S also indicated that resident 83 was resistant to Levaquin. Review of the MAR (medication administration record) for March 2003 and April 2003, revealed that resident 83 was given Levaquin 250 mg, from 3/24/03 through 4/2/03. Resident 83 received the full dose of an antibiotic that was resistant to her infection. There was no other documented evidence on the March 2003 and April 2003 MAR that resident 83 received any other antibiotics prior to 4/7/03. The nursing progress notes were reviewed from 3/24/03 through 3/30/03. There was no documentation to provide evidence that resident 83 was still having signs and symptoms of a UTI or that she was showing improvement from the antibiotic therapy started on 3/24/03. There was no documentation on the lab results to provide evidence that the nursing staff at the facility had reviewed the UA with C&S results or that the	F 309	1. Need for diligence in notifying the physician of abnormal laboratory results and of laboratory results requiring further physician follow-up, i.e. C&S that indicates a need for a change in the ordered antibiotic. 2. Need for licensed nurses to document and follow-up with the physician on the concerns communicated to them by the certified nursing assistants as these concerns relate to abnormalities that are not documented in the resident's history and physical exam or in the physician's progress notes. 3. Need for licensed nurses to document changes in the resident's condition both as to decline or to improvement. i.e. the signs and symptoms that the resident exhibited to lead the nurse to obtain an order for a UA and C&S and how the resident responded to any ordered treatment. 4. The signs and symptoms of a urinary tract infection and the possible nursing and medical interventions for treatment.	

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F 309	Continued From page 21 facility staff had informed the physician of the results. The results indicated that they were received by the facility's fax machine on 3/31/03 at 2:47 PM. On 4/7/03 at 2:55 PM, a facility nurse stated that the lab results come to the nurse's desk and they call the physician or fax the physician and document that on the lab results. On 4/7/03 at 3:00 PM, resident 83's physician stated to the nurse surveyor that he was not made aware of the UTI results until today. This was 7 days after facility staff became aware of the laboratory results which identified that the antibiotics which had been given to resident 83 for her urinary tract infection were ineffective. During a mini exit with facility administration on 4/9/03 at 5:00 PM, the corporate nurse stated that they had not received the UA results until 3/31/03. She further stated that the facility should have called the physician but they didn't. The DON (director of nurses) stated that resident 83's physician policy was to have the results placed in his box for him to review on his next visit. On 4/10/03 at 10:35 AM, the laboratory that provides services to this facility stated, in a phone interview, that on 3/25/03 at 6:00 AM, they received the UA sample. They stated that at 7:52 AM they faxed the results of the UA, but not culture, to the facility. The representative from the lab continued to say that on 3/26/03 at 3:56 PM they faxed the preliminary results of the UA culture and beginning on 3/27/03 they tried 12 different times over the next 4 days to fax the final results to the facility. On 3/31/03, a laboratory representative talked to graveyard nurse #1 and explained that they had not been able to get the results through to the facility. The lab stated that graveyard	F 309	**Monitoring/Quality Assurance** The Director of Nursing or designee will develop an audit tool by May 16, 2003. This tool will monitor compliance with: 1. Timely notification of the physician of laboratory results that are abnormal or need further physician follow-up, i.e. change of antibiotic ordered in response to a possible urinary tract infection. 2. Timely notification of the physician of abnormalities identified that are not documented in the resident's history and physical exam or in the physician progress notes. **3.** Documentation by the licensed nurses on the signs and symptoms exhibited by the resident prior to having a UA and or C&S for a suspected urinary tract infection and documentation of the resident's response to any interventions for treatment of a urinary tract infection	

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FEDERAL HEIGHTS REHABILITATION AND M	41 SOUTH 900 EAST SALT LAKE CITY, UT 84102

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F 309	Continued From page 22 nurse #1 stated "our printer is out of ribbon." The laboratory stated they faxed the results to the Medicare floor on 3/31/03, after numerous attempts for 4 days. The laboratory further stated that they don't have problems like this with other facilities. Review of other lab results completed for resident 83 provided documentation that the facility nurses called and/or faxed the results to the physician. The lab results did not indicate that the facility placed the results in a box for the physician to review at a later date. On 4/10/03 at 12:55 PM, the DON stated that lab results come through the fax machine at the nurses desk for each floor. Stated that they had just recently purchased a new fax machine for the 2nd floor prior to the beginning of March. She stated that if there was a problem with the fax machine that the lab can fax to the other two fax machines in the building. The DON stated she would expect the UTI results back in 24 hours and that there is an audit book that the nurses are to sign to indicate they have received the results in a timely manner. Review of the laboratory audit book on 4/10/03, at approximately 1:00 PM, provided no documentation to evidence that the facility nurse's had done an audit to ensure that resident 83's UA and C&S results, dated 3/25/03, had been received. On 4/7/03 at 4:00 PM, resident 83's physician documented in a progress note, "[increasing] lethargy [and] decline, poor appetite...totally dependent for all care...disoriented [except] to self..." On 4/8/03 at 6:15 AM, CNA#1 (certified nursing assistant) stated that a little longer than a week ago they were not sure if resident 83 had feces coming out	F 309	The Director of Nursing or designee will do weekly audits for six weeks to determine the level of compliance. At the completion of the audits, the Director of Nursing or designee will report results to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the frequency of any continued audits and reports based on the percent of compliance as indicated by the audits. When the audits indicate the attainment of 100 percent compliance, the audits and reports will then be done, at a minimum, of quarterly for two quarters. The Committee will then determine if there is a need for any further audits and reports. The Director of Nursing will be responsible for continued compliance. Compliance date: May 28, 2003	

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F 309	Continued From page 23 of her vaginal vault or if she had an infection. She further stated that resident 83 will usually have a soaked brief on the first round of the night and then after that she will dribble. She stated there was a foul urine odor, but it doesn't appear as bad. On 4/10/03 at 6:05 AM, graveyard nurse #1 stated that the signs and symptoms for resident 83's UTI started about 2 weeks ago. He stated she had lethargy, increased confusion and foul odor. When asked if the signs and symptoms had gotten better he replied, "not really". On 4/10/03 at 6:15 AM, graveyard nurse #2, stated that she and the facility DON had inspected resident 83 last night and they suspect a vaginal fistula. She stated when the resident was lifted she cried out in pain and that you really had to read her signs and symptoms because she doesn't verbally express them. She further stated that she was pretty sure yesterday was not the first day that facility staff had suspected feces coming out of resident 83's vaginal vault. On 4/10/03 at 6:25 AM, in a 2nd interview with CNA #1 she stated that she had told nurse #3 about feces possibly coming out of resident 83's vaginal vault about 2 weeks ago. She stated that she was told it was already reported to the day shift. She further stated that resident 83 was normally confused, usually had foul smelling urine, she also stated that she had an increase in pain. CNA #1 stated last night it appeared resident 83 still had feces coming from her vaginal vault On 4/10/03 at 6:40 AM, CNA#2 stated that she felt resident 83 was dehydrated, had foul smelling urine, urinates a lot and had feces coming out of her vaginal vault for about 2 weeks. She further stated that she had reported this to nurse #4. She stated that the feces	F 309		

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F 309	Continued From page 24 from the vaginal vault had not improved, "the more you clean the more there is." She stated that resident 83 was normally confused but her eating had decreased over the past few weeks. On 4/10/03 at 6:55 AM, CNA#3 stated that resident 83 had concentrated urine with a foul odor, low back pain and a decreased appetite. She further stated that she felt these signs and symptoms had decreased because they had been pushing fluids. She further stated that for the past 2 weeks she had noticed an increase of feces in the front of her brief but she could not be sure where it was coming from, she felt that this could be contributing to the UTI. She stated that she had reported this to both nurse #4 and #5. On 4/10/03 at 8:45 AM, nurse #5 stated that she had been told that resident 83 had feces coming out of her vaginal vault a week or so ago but did not do anything because the CNAs had made it sound like an on going problem. She further stated that she did not chart on it nor did she call and report the problem to the physician. On 4/10/03 at 12:55 PM, the facility DON stated that she was not aware that resident 83 possibly had feces coming from her vaginal vault until 4/9/03. She further stated that she was not aware that the nurses and CNAs had known about this problem for the past 2 weeks. She stated that she had called the physician that morning concerning the problem. The nursing progress notes from 3/24/03 - 4/10/03 were reviewed a 2nd time on 4/10/03. The facility staff did not document in the progress notes that resident 83 had possible feces coming out of her vaginal vault until 4/10/03. It should be noted, that the physician saw resident 83	F 309		

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F 309	Continued From page 25 on 4/7/03 at 4:00 PM. The physician did not document nor indicate in his progress note that he was made aware that resident 83 had possible feces coming out of her vaginal vault. On 4/10/03 at 2:50 PM, resident 83's physician stated, in a phone interview, that he had not been made aware of possible feces coming out of resident 83's vaginal vault around two weeks ago or anytime after that. He further stated that he was just recently informed of the problem. In addition to a progress note by resident 83's physician, he ordered a BMP (Basic Metabolic Panel) and CBC (Complete Blood Count). The lab results were faxed to the facility on 4/8/03 at 10:54 AM. A facility nurse documented that she faxed and called the physician with the results on 4/8/03. The BMP and CBC had the following abnormal lab values: Sodium 146 mmol/L (High) Chloride 111 mmol/L (High) BUN 28 mg/dl (High) BUN/Creatinine Ratio 40 Ratio (High) White Blood Cells 3.2 K/dl (Low) Monocytes 12.7% (High) Neutrophils, Absolute 1.60 K/dl (Low) An elevated sodium, chloride, BUN, and BUN/Creatinine Ratio can all be indications of dehydration. An increased BUN and BUN/Creatinine Ration can also indicate renal dysfunction. Decreased white blood cells, elevated monocytes and decreased neutrophils can all be indications of an infection. Neutrophils during an acute infection are the body's first line of defense. Monocytes are the second line of defense against bacterial infections. (Reference Guide:Laboratory and Diagnostic Tests with Nursing	F 309		

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F 309	Continued From page 26 Implications, 6th edition, 2002, pages- 84- 85, 117, 399 and 451- 455).	F 309	F 310 G **Corrective action for identified resident.**	
F 310 SS=G	483.25(a)(1) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This Requirement is not met as evidenced by: Based on interview, observation and record review, it was determined that, according to the comprehensive assessment, the facility did not ensure that a resident's ability to maintain her balance did not diminish when the facility did not implement a physician's order for 1 of 23 residents reviewed to be evaluated by physical therapy for possible rehabilitation therapy. Resident 88. Findings include: Resident 88 was a 72-year-old female who was admitted to the facility on 2/2/01 with diagnoses that included seizure disorder, osteoporosis, hypertension and left eye blindness. Resident 88's medical record was reviewed on 4/8/03. The MDS assessment test for standing balance describes three different foot positions for the resident to attempt, as able, and specifies how the resident's ability to balance should be coded. If a stance can be	F 310 OK 5/28/03 JD	Resident # 88 had a therapy evaluation completed on 4-10-03 and she was put on therapy case load for general conditioning five times a week. Resident #88 agrees to participate in therapy and then very frequently refuses. The physical therapist spoke with Resident #88 on 4-15-03 and explained the benefits of therapy participation and the risk of non-participation. Resident #88's reply was as quoted by the therapist, "I don't care." She will be evaluated for discontinuation of therapy and for possible placement in the nursing restorative program by the therapist and the Director of Nursing by May 7, 2003. **Identification of residents potentially affected** Residents who demonstrate unsteadiness in their standing balance and have a physician's order for physical therapy evaluation for possible rehabilitation therapy have the potential to be affected.	5/28/03

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F 310	Continued From page 27 maintained for ten seconds, the resident may attempt the next stance. For the first stance, the resident is to stand with feet planted firmly on the floor, side-by-side. If the resident can maintain that position for ten seconds, they may attempt the second stance with one foot halfway in front of the other, as in taking a small step. For the third stance, the resident is to be observed with one foot in front of the other in a heel-toe position. If the resident is able to demonstrate all three positions and maintain each of them for ten seconds, their score is zero. A resident can score from zero, one, two or three. The registered nurse (RN) who was the MDS coordinator and who documented the balance tests with resident 88 was interviewed on 4/8/02. The RN stated that he conducted the balance tests according to the specific MDS criteria. The RN stated that he had used that criteria when he tested resident 88 for her latest MDS assessment which was dated 2/11/03. It was documented on resident 88's comprehensive Minimum Data Set (MDS) assessment dated 11/19/02, and the quarterly MDS assessment dated 2/11/03, that the resident was able to maintain her balance while standing. When tested according to the standardized MDS balance test, section G3a, resident 88 was documented as scoring "1", "unsteady but able to rebalance self without physical support." On 4/10/03, two months after resident 88's latest MDS assessment, the RN assessment coordinator was observed to conduct the standardized MDS balance test with the resident. Resident 88 was able to follow instructions to attempt the tests, but was unable to maintain the required positions without using an over-bed table to physically support herself. A physician's order, dated 1/22/03, stated that resident	F 310	**Measures to prevent recurrence** By May 11, 2003 the Director of Nursing or designee will develop a communication system to be utilized to impart written information from nursing to the therapy department to inform the therapy department of physician orders for therapy interventions. The licensed nurses and the therapy staff will be inserviced on this system by the Director of Nursing or designee by May 18, 2003 By May 11, 2003 the Director of Nursing or designee will implement a procedure whereby the licensed nurses will be required to date and sign physician orders as "noted" to indicate that the orders have been processed. The licensed nurses will be inserviced on this procedure by the Director of Nursing or designee by May 18, 2003. **Monitoring/Quality Assurance** The Director of Nursing or designee will develop an audit tool by May 16, 2003. This tool will monitor compliance with: 1. Timely notification of the Therapy Department by nursing of physician orders for therapy interventions. 2. Notation of physician orders by nursing.	

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F 310	Continued From page 28 88 was to be evaluated by physical therapy for referral to restorative nursing and was to have a laboratory test done. There was a nurse's note, dated 1/22/03, that documented the order. On 4/10/03, the nurse who had worked on 1/22/03 was interviewed. The nurse stated that the physician wrote the order and the nurse signed it. The nurse stated that when she receives an order for physical therapy, she calls the therapy department to relay the order, and she documents the order in the nurses' notes. On 3/8/03, a physical therapist stated that resident 88's name was on a list of residents who needed to be reviewed by physical therapy. The physical therapist stated that a second physical therapist had put resident 88 on the list after an observation of the resident a week or two earlier. On 3/9/03, two physical therapists and the restorative nurse aide were interviewed in their office regarding resident 88. They each stated they were not aware of any physical therapy order that had been received in January and they estimated it had been nearly a year since any of them had worked with resident 88. The therapists stated that they had put resident 88 on their list of residents to be reviewed because one of the therapists had seen the resident trying to ambulate but that resident 88 looked to be very unsteady. The physical therapist stated that she needed a nurse aide to assist her to help the resident get where she was going. The physical therapy supervisor entered the office during the interview. The supervisor stated that no order had been received in January for resident 88 to have an evaluation, and that resident 88 had not been treated by physical therapy for about a year. In a telephone interview with resident 88's physician, the physician stated that he could not remember the	F 310	The Director of Nursing or designee will do weekly audits for six weeks to determine the level of compliance. At the completion of the audits the Director of Nursing or designee will report results to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the frequency of any continued audits and reports based on the percent of compliance as indicated by the audits. When the audits indicate the attainment of 100 percent compliance, the audits and reports will then be done, at a minimum, quarterly for two quarters. The Committee will then determine if there is a need for any further audits and reports. The Director of Nursing will be responsible for continued compliance. Completion date: May 28, 2003.	

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F 310	Continued From page 29 specifics about his order for physical therapy, but that it would have been due to her condition at the time. The physician's progress note, dated 1/22/03, documented resident 88 was "unsteady, fall risk - [L] LE [left lower extremity weakness." The physicians's progress noted, dated 3/17/03, documented resident 88 had "unsteadiness / increased risk for falls / [L] leg weakness." Resident 88 did not receive the physical therapy ordered for her by her physician. Interviews with facility staff and review of the resident's medical record reveal an avoidable decline in resident 88's condition.	F 310	F 325 H **Corrective actions for identified residents** Resident # 64, 106, 54. 101 and 109 will have a full nutritional assessment completed by the new consulting Registered Dietitian (RD). Accurate heights and weights will be obtained and documented to ensure accuracy of these nutritional assessments. This RD will calculated the calorie and protein requirements of each of these residents based on his/her individual risk factors. Each of these residents will receive nutritional interventions and diets to address his/her individual needs as recommended by the RD. These nutritional assessments will be completed and interventions instituted by May 12, 2003. Each of these resident's care plan will be updated by May 12, 2003 to reflect any changes indicated by the RD. Resident # 84, a hospice resident, expired on April 11, 2003 **Identification of residents potentially affected** Residents with unplanned weight loss, pressure ulcers and/or laboratory values reflecting malnutrition have the potential to be affected	
F 325 SS=H	483.25(i)(1) QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This Requirement is not met as evidenced by: Based on clinical record review, interviews and observations, it was determined that the facility did not ensure that 6 of 23 sampled residents maintained acceptable parameters of nutritional status. Specifically, 2 of 23 sampled residents did not receive timely dietary interventions to prevent significant weight loss. Resident identifiers 101 and 106. Two of 23 sampled residents did not receive adequate nutritional assessments and/or interventions to increase protein in their diets to promote the healing of pressure sores and try to prevent the pressure sores from increasing in size. Resident identifiers 54 and 64. Finally, 2 of 23 sampled residents had no documented	F 325 OK 5/28/03 AD		5/28/03

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F 325	Continued From page 30 evidence in the medical record that the facility registered dietitian completed full nutrition assessments, which calculated calorie and protein needs, to assess whether the diets and nutritional interventions implemented were adequate to meet their nutrient requirements. Resident identifiers 84 and 109. Calculating weight loss percentages are done by subtracting the current weight from the previous weight, dividing the difference by the previous weight and multiplying by 100. Significant weight losses are as follows: 5 % in one month, 7.5 % in 3 months and 10 % in 6 months. Severe weight losses are as follows: greater than 5 % in one month, greater than 7.5 % in 3 months and greater than 10 % in 6 months. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000). The facility was found to be providing sub-standard quality of care (a pattern of actual harm) in this area. Findings include: 1. Resident 101 was admitted to the facility on 7/19/02 with diagnoses including multiple sclerosis, glaucoma, osteoporosis, anemia and insomnia. Resident 101's medical record was reviewed 4/08/03 through 4/ 09/03. On 7/26/02, the facility's registered dietitian (RD) completed an initial nutritional assessment, which documented resident 101's height was 5 feet, 8 inches, and he weighed 125 pounds. Resident 101 was ordered a regular diet. The RD assessed resident 101 to be slightly below his ideal body weight range (IBWR) of 131 - 164 pounds. Recommendations made by the RD were for evening snacks to be offered	F 325	**Measures to prevent recurrence** The facility has secured the services of a replacement Registered Dietitian (RD) with 7 years of experience. This RD is reviewing each current resident's dietary assessment for accuracy of nutritional need and is making changes and recommendations for interventions as each case may indicate. This review will be completed by May 12, 2003. This RD is the facility's current consulting RD and will be a member of the weight and wound committee. The Director of Nursing has replaced the Assistant Director of Nursing as the chairperson of the weight and wound committee. Other members of the committee include the Dietary Service Manager and the wound nurse. Committee members will seek input from the direct care staff as may be indicated. A project team selected by the Administrator has reviewed the facility's process and system for addressing weight and nutrition management. The team has developed a policy and procedure for obtaining accurate and timely weights and heights and for their	

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F 325	Continued From page 31 and for meal intakes to be encouraged to increase weight. A review of resident 101' s weight history, obtained from the dietitian, revealed the following: July 19, 2002 125 pounds. July 2002 123 pounds. August 2002 122 pounds. September 2002 122 pounds. October 2002 120 pounds. November 2002 119 pounds. December 2002 115 pounds. January, 2003 111 pounds. This represents a significant weight loss of 9 pounds, or 7.5% between the months of October 2002 and January 2003 and a 14-pound, or 11.2% significant weight loss between the months of July 2002 and January 2003. February 2003 108 pounds. This represents a significant weight loss of 11 pounds, or 9.2% between the months of November 2002 and February 2003 and a 14-pound, or 11.4% significant weight loss between the months of August 2002 and February 2003. March 2003 110 pounds. This represents a significant weight loss of 12 pounds, or 10% between the months of September 2002 and March 2003. April 2003 109 pounds. A laboratory (lab) value, taken at the facility and dated 2/21/03, showed an albumin (a protein and indicator of nutritional status) level of 3.1 g/dl (grams per deciliter). The lab reference range for an acceptable level was 3.5-5.0 g/dl. An albumin level of less than 2.4 g/dl is considered a	F 325	accurate documentation. The team has also developed a tool for the meeting to facilitate assessment, documentation and follow-up on recommended interventions. The Director of Nursing or designee will inservice by May 17, 2003 the licensed nurses and the weight and wound committee on the policy and procedure for obtaining and documenting weights and heights and on the tool for the weight and wound committee meetings. The facility has designated certain Certified Nursing Assistants as the team to obtain weights and heights. This team will be inserviced by the Staff Development Coordinator by May 9, 2003 on proper techniques for obtaining weights and heights and how to properly document. The dietary staff will be inserviced by May 15, 2003 by the Registered Dietitian or designee on following tray cards and on following therapeutic diets as ordered. This inservice will also include information on portion sizes and use of the right utensils for measurement.	

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F 325	Continued From page 32 severe visceral protein deficit, an albumin level of 2.4 g/dl- 2.9 g/dl is considered a moderate visceral protein deficit and an albumin level of 3.0 g/dl-3.5 g/dl is considered a mild visceral protein deficit. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000, page 22). On 10/16/02, the dietitian completed a dietary note, which documented that resident 101 had experienced a gradual weight loss since April 2002 but that his weight trend appeared "somewhat stable". The RD documented that resident 101 was nutritionally stable and that she would monitor resident 101's weight trend to assess for interventions as appropriate. On 11/20/02, the dietitian completed a dietary note, which documented that resident 101's weight had been on a downward trend and although not significant was a concern if the downward trend continued. It was documented that resident 101 consumed 100% of his meals and that he had been spoken to many times regarding food preferences. In an addendum note, the RD documented that resident 101 was aware of his weight loss and wanted to maintain and/or gain weight. On 11/25/02, the RD documented that resident 101 requested double portions at meals to "arrest wt (weight) loss." On 12/11/02, a physician's progress note documented that resident 101 had requested double portions at meals but was not receiving them. On 1/9/03, 40 days later, the RD completed a dietary note, which documented that resident 101's physician re-certification orders noted that resident 101's diet order was for regular portions. The RD documented that she would re-write a diet order to clarify that resident 101 was to receive double portions. This note	F 325	**Monitoring/Quality Assurance** The Director of Nursing or designee will develop and audit tool by May 12, 2003.This tool will monitor compliance with: 1. Accurate and timely obtaining and documenting of weights and heights 2. Timely interventions for identified nutritional problems 3. Dietary following therapeutic diets as ordered 4. Current reassessments of residents, who present with new risk factors, such as significant weight loss, skin ulcers, low albumen levels and initiation of enteral feedings. 5. Timely weight and wound committee assessments when indicated	

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F 325	Continued From page 33 further documented that resident 101's weight on 1/4/03 was 111 pounds and was slowly decreasing. It was noted that resident 101 would be addressed in the facility's weight committee meeting to determine appropriate interventions. There was no documented evidence that the dietitian identified that resident 101 experienced a significant weight loss of 9 pounds, or 7.5% between the months of October 2002 and January 2003 and a 14-pound, or 11.2% significant weight loss between the months of July 2002 and January 2003. There was no documented evidence that the dietitian re-assessed resident 101's nutritional requirement, including calorie and protein needs, based on his significant weight loss, or recommended appropriate interventions to increase calories in his diet to prevent further weight decline. On 4/15/03 at 3:20 PM, the facility director of nurses (DON) was interviewed. She stated that the weight and skin committee was composed of the facility RD, facility assistant director of nurses (ADON), a licensed nurse and the dietary manager. On 4/16/03 at 12:55 PM, the facility ADON was interviewed. She stated that the weight and skin committee met on a weekly basis to discuss residents that had skin breakdown and/ or weight loss. The ADON stated that she reviewed weights weekly to decide which residents needed to be reviewed by the team. A review of resident 101's "Significant Weight Change Report", dated 1/9/03, documented that resident 101 was receiving a mechanical soft diet with double portions. Under the section labeled "possible reason for weight change", there was a question mark. The documented intervention was to start weekly weights. There were no documented recommendations made which would increase the calories in resident 101's diet	F 325	The Director of Nursing or designee will do weekly audits for six weeks to determine the level of compliance. At the completion of the audits, the Director of Nursing or designee will report to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the frequency of any continued audits and reports based on the percent of compliance as indicated by the audits. When the audits indicate the attainment of 100 percent compliance, the audits and reports will then be done, at a minimum for two quarters. The Committee will then determine if there is a need for any further audits and reports. The Director of Nursing will be responsible for continued compliance. Completion date: May 28, 2003	

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F 325	Continued From page 34 to try and prevent a further weight decline. On 1/12/03 and 1/26/03 the weight committee again reviewed Resident 101. There were no documented recommendations made which would increase the calories in resident 101's diet to try and prevent a further weight decline. A review of resident 101's physician telephone orders was completed on 4/9/03. On 1/15/03, 51 days after resident 101 requested double portions at meals, and 6 days after the weight committee documented that he was receiving double portions at meals, a telephone order was written to place resident 101 on weekly weights and to clarify his diet order to mechanical soft with double portions. On 1/20/03, the dietary manager completed a dietary note, which the RD co-signed. It was documented that resident 101 had experienced a gradual weight loss and appeared nutritionally stable. His weight was recorded at 110 pounds. On 1/20/03, the dietitian completed a dietary note, which documented that she talked with resident 101 regarding his weight loss. It was documented that resident 101 stated that he ate 100% of most meals and felt that he was not always being served double portions at meals. On 1/22/03, the RD documented that she notified resident 101's physician that he had experienced significant weight loss and recommended that the same interventions would be continued. On 2/3/03, the RD documented that resident 101 wanted to be weighed monthly versus weekly and that she had talked with him about his recent weight loss.	F 325		

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F 325	Continued From page 35 She documented that resident 101 was receiving double portions at meals and was eating 100%. There was no documented evidence that the dietitian identified that resident 101 experienced a significant weight loss of 11 pounds, or 9.2% between the months of November 2002 and February 2003 and a 14-pound, or 11.4% significant weight loss between the months of August 2002 and February 2003. There was no documented evidence that the dietitian re-assessed resident 101's nutritional requirement, including calorie and protein needs, based on his significant weight loss, or recommended appropriate interventions to increase calories in his diet to prevent further weight decline. There was no documented evidence that the dietitian assessed whether double portions at meals was adequate to meet resident 101's nutritional needs. On 3/5/03, the RD completed a dietary note, which documented that resident 101 had an albumin level of 3.1 g/dl and that his nutritional status would likely improve due to his good meal intakes. It was further documented that resident 101's weight had increased to 110 pounds. On 3/10/03, the RD documented that resident 101 had experienced a significant weight loss of 12 pounds or 10% in 6 months and that she was monitoring his weight trend. There was no documented evidence that the dietitian re-assessed resident 101's nutritional requirement, including calorie and protein needs, based on his significant weight loss, or recommended appropriate interventions to increase calories in his diet to prevent further weight decline. There was no documented evidence that the dietitian assessed whether double portions at meals was adequate to meet resident 101's nutritional needs. On 4/8/03, the dietary manager documented that	F 325		

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F 325	Continued From page 36 resident 101 weighted 109 pounds (on 4/4/03), had a low albumin level of 3.1 g/dl and that his weight was stable. This represented a 1-pound weight decrease in a month. There was no documented evidence that the dietitian completed a full nutritional assessment based on resident 101's history of significant weight loss and the low albumin level of 3.1 g/dl to determine his calorie and protein requirements. There was no documentation to evidence that the dietitian determined whether double meal portions were adequate to meet resident 101's calorie needs to prevent further weight decline and to help improve his protein status. A nutrition care plan, dated 10/29/02 and reviewed 1/22/03, documented that resident 101's nutrition was altered related to his admission weight being below his ideal body weight, the diagnosis of multiple sclerosis, a recent illness and being lactose intolerant. A documented goal was that resident 101's total intake would meet his nutritional needs. Documented approaches for this problem included the dietitian would be notified regarding problems, complaints, or requests, meal percentages would be monitored and replacements offered if a meal was refused and a nighttime snack would be offered. On 1/22/03, it was documented that due to recent weight loss double portions of meals were added. Review of resident 101's medical record evidenced that the facility staff were not documenting meal percentages daily per the nutrition care plan. A review of resident 101's meal intakes, documented on the "Flow Sheet Record" for November 2002 revealed the facility nurse aides were documenting meal intake in percentages. Out of a possible 30 breakfast meals for the month, 16 were documented at 100%, 2 were documented at 75% and 12 had no meal	F 325		

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F 325	Continued From page 37 intake documented. Out of a possible 30 lunch meals for the month, 17 were documented at 100%, 1 was documented at 75% and 12 had no meal intake documented. Out of 30 possible dinner meals for the month, 18 were documented at 100% and 12 had no meal intake documented. A review of resident 101's meal intakes for December 2002 revealed the following: out of a possible 31 breakfast meals for the month, 20 were documented at 100% and 11 had no meal intake documented. Out of a possible 31 lunch meals for the month, 18 were documented at 100% and 13 had no meal intake documented. Out of a possible 31 dinner meals for the month 18 were documented at 100% and 13 had no meal intake documented. A review of resident 101's meal intakes for January 2003 revealed the following: out of a possible 31 breakfast meals for the month, 21 were documented at 100% and 10 had no meal intake documented. Out of a possible 31 lunch meals for the month, 20 were documented at 100%, 1 was documented at 75% and 10 had no meal intake documented. Out of a possible 31 dinner meals for the month, 23 were documented at 100%, 1 was documented at 75% and 7 had no meal intake documented. A review of resident 101's meal intake for February 2003 revealed the following: out of a possible 28 breakfast meals for the month, 20 were documented at 100%, 1 was documented at 90%, 3 were documented at 75% and 4 had no meal intake documented. Out of a possible 28 lunch meals for the month, 16 were documented at 100%, 1 was documented at 90%, 2 were documented at 80%, 3 were documented at 75%, 1 was documented at 60% and 5 had no meal intake documented. Out of a possible 28 dinner meals for the month, 15 were documented at 100% and 13 had no	F 325		

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F 325	Continued From page 38 meal intake documented. A review of resident 101's meal intake for March 2003 revealed the following: out of a possible 31 breakfast meals for the month, 20 were documented at 100%, 1 was documented at 90%, 3 were documented at 75 %, 1 was documented at 60% and 6 had no meal intake documented. Out of a possible 31 lunch meals for the month, 15 were documented at 100%, 2 were documented at 90%, 3 were documented at 80%, 5 were documented at 75% and 6 had no meal intake documented. Out of a possible 31 dinner meals for the month, 20 were documented at 100% and 11 had no meal intake documented. A review of resident 101's meal intake for April 2003, from 4/1/03 to 4/8/03, revealed the following: out of a possible 8 breakfast meals for the month, 7 were documented at 100% and 1 had no meal intake documented. Out of a possible 8 lunch meals for the month, 3 were documented at 100%, 1 was documented at 90%, 2 were documented at 75%, 1 was documented at 70% and 1 had no meal intake documented. Out of a possible 8 dinner meals for the month, 4 were documented at 100% and 4 had no meal intake documented. On 4/7/03 at 1:10 PM, resident 101 was interviewed. He stated that he had not been receiving double portions at meals since he requested them "3-4 months ago". Resident 101 stated that he communicated to the facility nursing staff and the facility dietitian that he was not receiving double meal portions and his food likes and dislikes but still receives items with his meals that he dislikes. He further stated that he is not offered alternative foods when he refuses a food item on his tray. Observations:	F 325		

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F 325	Continued From page 39 On 4/07/03 at 1:10 PM, during the lunch meal, resident 101was served the following: 2 glasses of water, 2 servings of fruit cocktail, 1 scoop of mashed potatoes and gravy, 1 scoop of chicken, 1 scoop of peas, and 2 slices of bread. Resident 101 was observed to refuse the fruit cocktail. When interviewed, he stated that because he had a history of elevated blood sugar he had eliminated sugar from his diet and that his blood sugar was now within a normal range. Resident 101 stated that the facility dietitian was aware of his concerns about sugar in his diet. Resident 101 was also observed to refuse his peas and bread. Resident 101 ate 100 % of his mashed potatoes and gravy and chicken. Facility staff were not observed to offer resident 101 an alternate for his fruit cocktail, peas or bread. On 4/08/03 at 8:45 AM, during the breakfast meal, resident 101was served the following: 2 glasses of water, 6 slices of bacon, 1 scoop of scrambled eggs, and 2 slices of toast. Resident 101 was observed to consume 100 % of breakfast and stated, "This is the first time I have ever received 6 slices of bacon, usually I get 2 to 4 slices". On 4/08/03 at 1:25 PM, during the lunch meal, resident 101 was served the following: 2 glasses of water, 1 scoop of chicken with gravy, 2 scoops of potatoes with gravy, 1 scoop of Jell-O, 1 slice of bread, and 1 glass of tomato juice. Resident 101 was observed to consume 100 % of all the lunch items served, except the Jell-O. Resident 101 refused the Jell-O. Facility staff were not observed to offer resident 101 an alternative for the Jell-O.	F 325		

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F 325	Continued From page 40 Per the facility's policy on "Deviation From Standard Portions", a double portion is described as double portions of all menu items including desserts. 2. Resident 109 was re-admitted to the facility on 12/19/02 with diagnoses including hip fracture, congestive heart failure, osteoporosis, dementia, anemia and constipation. Resident 109's medical record was reviewed 4/08/03 through 4/09/03. Resident 109's weights were listed on the "Resident Care System Weight History" form in her medical record. Resident 109's weight history revealed the following: December 2002 125 pounds. January 2003 115 pounds. This represents a significant weight loss of 10 pounds, or 8% between the months of December 2002 and January 2003. February 2003 111 pounds. March 2003 109 pounds. This represents a significant weight loss of 16 pounds, or 12.8% between the months of December 2002 and March 2003. April 2003 112 pounds. A lab value, obtained at the hospital on 12/16/02, three days prior to resident 109's re-admission to the facility, showed an albumin level of 3.1 g/dl. This represented a mild visceral protein deficit.	F 325		

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F 325	Continued From page 41 Resident 109 had an incision to her left hip upon her re-admission to the facility after undergoing surgery to repair a fracture. On 12/19/02, the dietitian completed an initial dietary assessment, which documented that she was unable to fully assess resident 109 because there was no height, weight or diet order available. It was documented that resident 109 had a low albumin level of 3.1 g/dl in the hospital. The dietitian noted that she was unable to make recommendations or fully assess resident 109 due to lack of information and recommended a height and weight be obtained. On 12/23/02, a 5-day Medicare MDS (minimum data set) assessment documented that resident 109's height was 64 inches (5 feet, 4 inches). On 12/23/02, resident 109's physician completed a progress note, which documented that resident 109 had no edema. On 1/27/03, resident 109's physician completed a progress note, which documented that resident 109 had experienced a 7-pound weight decline in one month. A dietary consult was ordered as was well as albumin and lymphocyte lab values. There was no documented evidence that the lab values were obtained. On 12/30/02, 11 days after resident 109's re-admission to the facility, the RD completed a dietary note. It was documented that there was still no height or weight available. The RD recommended that a height and weight be obtained and recorded in the chart. It was documented that resident 109 had no edema and was consuming 25-50% of a regular diet with some refusals. The RD documented that she would follow up after a height and weight were obtained to assess and adjust interventions. There was no documented	F 325		

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F 325	Continued From page 42 evidence that the dietitian made recommendations to increase calories or protein in resident 109's diet based upon her fair to poor meals intakes, low albumin level and to help with the healing of her left hip incision. There was no documented evidence that the RD was aware that a height of 64 inches was available from the 12/23/02 5-day Medicare MDS assessment. On 1/06/03, the RD documented in that resident 109's weight on 1/1/03 was 122 pounds, her oral intake was 75% and at that she was at risk for skin breakdown. This was 18 days after resident 109's re-admission to the facility and the RD again requested that a height be obtained. There was no documented evidence that the dietitian completed a full nutrition assessment, which calculated resident 109's nutrition needs including calorie and protein requirements as she documented that there was no height yet available. Nutritional requirements cannot be calculated without a height. There was no documented evidence that the RD was aware that a height of 64 inches was available from the 12/23/02 5-day Medicare MDS assessment. On 1/15/03, 27 days after her re-admission, the RD documented that resident 109's weight had decreased to 115 pounds on 1/12/03, from 122 pounds on 1/1/03; this was a 7 pound, or 6% weight loss in 12 days. The RD documented that resident 109 was ordered a 3 gram sodium diet, consumed 50% of most meals. She recommended an a diet change to a no added salt, an enriched diet and again requested resident 109's height be obtained. There was no documented evidence that the dietitian completed a full nutrition assessment, which calculated resident 109's nutrition requirements including calorie and protein needs. There was no documented evidence that the dietitian assessed the calories and protein that resident 109 had been receiving from her diet to determine if this was adequate to meet her required nutrient needs and that	F 325		

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F 325	Continued From page 43 resident 109 had experienced a significant weight decline. On 1/15/03, a physician telephone order was written to obtain resident 109's height and to record it in the chart. Resident 109's diet was also changed from a 3-gram sodium to a no added salt due to her recent weight loss. A review of resident 109's nurses' notes from 1/3/03 to 1/24/03 was completed on 4/9/03. There was no documented evidence that resident 109 had edema or inflammation of the left hip incision site. On 1/29/03, the RD documented that resident 109's weight was 115 pounds and appeared stabilized. It was documented that resident 109's oral intake was 50% at most meals. There was still no documented evidence that the RD was aware that a height was available from the 12/23/02, 5-day Medicare MDS assessment. There was still no documentation to provide evidence that that the dietitian calculated resident 109's calorie and protein requirements based on her low albumin level prior to admission and her significant weight loss. On 2/07/03, 50 days after resident 109 was re-admitted to the facility and 31 days after the RD documented she had experienced significant weight loss, a physician telephone order was written for Med Pass 2.0, 120 cc (cubic centimeters) to be given 4 times a day with medication passes. On 2/10/03, the dietitian completed a 60-day dietary note, which documented that resident 109's weight on 2/9/03 was 111 pounds, down from 122 pounds on 1/1/03 and 115 pounds on 1/15/03. This would represent a significant weight decline of 11 pounds, or 9% from 1/1/03 to 2/9/03. It was documented that	F 325		

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F 325	Continued From page 44 resident 109 consumed 50-75% of most meals and that her diet was enriched. The RD recommended that Med Plus 2.0, 120 cc, 4 times a day begin. There was no documentation to provide evidence that the RD was aware that a height was available from the 12/23/02 5-day Medicare MDS assessment. The RD would be unable to determine if the enriched, no added salt diet she was receiving and that the addition of Med Pass 2.0 would be adequate to meet resident 109's nutritional needs as there was still no documentation to provide evidence that that the dietitian calculated resident 109's calorie and protein requirements based on the significant weight loss. On 3/10/03, the a dietary progress note was completed by the RD, which documented that resident 109 had experienced a weight loss of 13 pounds, or 11% in one month. She documented that resident 109's weight trend had been monitored and that her weights for the past two months had ranged from 109-122 pounds (a 13 pound range). It was noted that resident 109 consumed 50% of her meals. Again, there was no documented evidence that the RD was aware that a height was available from the 12/23/02, 5-day Medicare MDS assessment. The RD would be unable to determine if the enriched, no added salt diet she was receiving and that the addition of Med Pass 2.0 would be adequate to meet resident 109's nutritional needs as there was still no documentation to provide evidence that that the dietitian calculated resident 109's calorie and protein requirements based on the significant weight loss. On 3/12/03, the facility dietary manager completed a quarterly dietary assessment for resident 109, which the RD co-signed on 3/17/03. This assessment documented that resident 109's average meal intakes were 50 - 75%, which was good and that her weight was stable.	F 325		

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F 325	Continued From page 45 As of 4/08/03, 110 days after she had been re-admitted to the facility, there were was no documentation to provide evidence that the RD completed a full nutritional assessment, which calculated resident 109's nutritional requirements had been completed. Resident 109 entered the facility with a low albumin level, a surgical incision and experienced significant weight decline. A nutrition care plan, dated 12/30/02, and updated 2/10/03, documented that resident 109 had altered nutrition related to osteoporosis, hypertension and a decreased appetite. The goal was that resident 109 would meet her total nutrition needs with meal intakes. Documented approaches included provide diet as ordered, monitor percentage of meals eaten and record, offer a snack at night and provide a supplement. A second nutrition care plan, dated 12/31/02 and updated 1/15/03 and 3/17/03, documented that resident 109 had altered nutrition related to being "less than body requirements", having a decreased appetite and poor fitting dentures, having dementia, osteoporosis and constipation. One documented goal was for resident 109's weight to remain between 118-128 pounds. Approaches to address the nutrition problem included provide an enriched diet and for facility staff to monitor the percentage of meals eaten and offer a replacement if resident 109 consumed less than 76% of her meals. Upon record review there was no documentation to provide evidence that the facility staff documented meal percentages every day as per the care plan. A review for resident 109's meal intakes, documented on the "Flow Sheet Record" for January 2003 revealed	F 325		

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F 325	Continued From page 46 the facility nurse aides were documenting meal intake in percentages. Out of a possible 31 breakfast meals for the month, 1 was documented at 100%, 4 were documented at 75%, 1 was documented at 60%, 9 were documented at 50%, 1 was documented at 40%, 5 were documented at 25% and 3 were documented as refused and 7 had no meal intake documented. Out of a possible 31 lunch meals for the month, 2 were documented at 100%, 2 were documented at 75%, 2 were documented at 60%, 11 were documented at 50%, 5 were documented at 25%, 2 were documented as refused and 7 had no meal intake documented. Out of a possible 31 dinner meals for the month, 2 were documented at 100%, 15 were documented at 50% 7 were documented at 25%, 1 was documented as refused and 6 had no meal intake documented. A review of resident 109's meal intake for February 2003 revealed the following: out of a possible 28 breakfast meals for the month, 1 was documented at 100%, 3 were documented at 75%, 1 was documented at 70%, 1 was documented at 60%, 13 were documented at 50%, 4 were documented at 25% and 5 had no meal intake documented. Out of a possible 28 lunch meals for the month, 1 was documented at 100%, 2 were documented at 75%, 1 was documented at 70%, 1 was documented at 60%, 12 were documented at 50%, 1 was documented at 45%, 6 were documented at 25%, and 4 had no meal intake documented. Out of a possible 28 dinner meals for the month, 1was documented at 100%, 2 were documented at 75%, 12 were documented at 50%, 4 were documented at 25%, 1 was documented as refused and 8 had no meal intake documented. A review of resident 109's meal intakes for March 2003 revealed the following: out of a possible 31 breakfast meals for the month, 4 were documented at 100%, 1 was documented at 95%, 3 were documented	F 325		

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F 325	Continued From page 47 at 75%, 1 was documented at 70%, 1 was documented at 60%, 14 were documented at 50%, 1 was documented at 25% and 6 had no meal intake documented. Out of a possible 31 lunch meals for the month, 4 were documented at 100%, 1 was documented at 80%, 4 were documented at 75%, 14 were documented at 50%, 1 was documented at 30%, 2 were documented at 25% 1 was documented as refused and 4 had no meal intake documented. Out of a possible 31 dinner meals for the month, 7 were documented at 100%, 1 was documented at 80%, 2 were documented at 75%, 5 were documented at 50%, 10 were documented at 25% and 6 had no meal intake documented. A review of resident 109's meal intake for April 2003 revealed the following: out of a possible 8 breakfast meals for the month, 5 were documented at 75%, 2 were documented at 50% and 1 had no meal intake documented. Out of a possible 8 lunch meals for the month, 7 were documented at 50% and 1 had no meal intake documented. Out of a possible 8 dinner meals for the month, 1 was documented at 75%, 3 were documented at 50%, 2 were documented at 25% and 2 had no meal intake documented. Observations: On 4/07/03 at 1:10 PM, during the lunch meal, resident 109 was served the following: chicken, sweet potatoes, peas, fruit cocktail, a dinner roll, a cup of hot chocolate, a glass of milk and a glass of cranberry juice. Resident 109 was observed to consume the following: 100% of hot chocolate, 75% of chicken, 50% of 2% milk, no sweet potatoes, no peas, no dinner roll, no fruit cocktail and no cranberry juice. Resident 109 was not observed to be encouraged to eat or assisted with her meal by facility staff.	F 325		

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F 325	Continued From page 48 On 4/08/03 at 8:30 AM, during the breakfast meal, resident 109 was served the following: French toast with syrup, a bowl of hot cereal, eggs, yogurt, a glass of milk, a glass of apple juice, a cup of coffee and a glass of water. Resident 109 was observed to consume the following: 100 % of water, 25% of French toast, 25% of coffee, no hot cereal, no eggs, no yogurt, no syrup, no apple juice and no milk. Facility staff was not observed to help resident 109 pour syrup on the French toast or open the yogurt, which was out of her reach. Resident 109 was not observed to be encouraged to eat or assisted with her meal by facility staff. On 4/08/03 at 2:20 PM, resident 109 was weighed and measured by 2 facility CNA's with 2 nurse surveyors present. Resident 109's height was 54 inches or 4 feet, 5 inches and she weighed 111 pounds. Resident 109 was observed to have 3 + edema to left foot and no edema to her right foot. There was 10-inch discrepancy between the 5-day Medicare MDS, completed 12/23/02, and the height obtained on 4/8/03. Per the facility's "Corporate Policy on Height and Weight", nursing services would be responsible for the initial determination and documentation of each resident's weight and height. It was dietary services' responsibility to determine the resident's ideal body weight range. 3. Resident 64 was re-admitted to the facility on 12/2/02 with diagnoses which included status post hip, humerus and wrist fractures, dysphagia, congestive heart failure and a history of cerebrovascular accident. From her re-admission to the facility on 12/2/02 until 1/2/03, resident 64 received all of her nutrition via	F 325		

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F 325	Continued From page 49 gastrostomy tube (G-tube). Resident 64 began to eat meals by mouth (PO) on 1/2/03, however, she continued to receive tube feedings at night in addition to her meals. Resident 64's medical record was reviewed on 4/7/03. On 12/2/02, facility nursing staff completed an admission "Nursing Assessment". There was no documented height or weight. It was documented that resident 64 had a stage II pressure sore on her back. Per the facility "Pressure Ulcer Record", on 12/4/02, resident 64's pressure sore was a stage II and measured 2cm x 1cm (centimeters). On 12/4/02, 2 days after resident 64's admission, the registered dietitian (RD) completed an initial nutritional assessment that documented resident 64 was 65 inches (5 feet 5 inches) tall, in parenthesis it was documented that this was a stated height, and weighed 120 pounds. The RD documented that resident 64 had a stage II pressure sore on her back and an albumin (a protein and indicator of nutritional status) level of 1.9gm/dl (grams per deciliter) on 11/30/02. An albumin level of less than 2.4 gm/dl is considered a severe visceral protein deficit. (Reference Guidance: Manual of Clinical Dietetics, Sixth Edition, page 22). The diet documented was NPO (nothing by mouth) and resident 64 was noted to be receiving TwoCal HN at 33 cc (cubic centimeters) an hour via her G-tube. This provided 65.6 grams of protein. The RD calculated resident 64's nutritional needs using the height of 65 inches and the weight of 120 pounds (54.5 kilograms). The RD calculated resident 64's protein requirements by multiplying her weight in kilograms (kg), 54.5 (kg) by a protein requirement factor of 1.3 grams (gm) per kg. Resident 64's protein requirements were calculated to be 71	F 325		

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F 325	Continued From page 50 grams per day. The RD recommended that resident 64's tube feeding be changed to Two Cal HN at 37 cc an hour for 20 hours. This tube feeding regimen would provide 61 grams of protein a day, 10 grams less than what the RD estimated resident 64's protein needs to be. On 12/5/02, the RD recommended that 500 mg (milligrams) of vitamin C be started twice a day to help with wound healing. Per the facility "Pressure Ulcer Record", on 12/9/02, resident 64's pressure sore was a stage II and measured 2cm x 2cm. (It should be noted that resident 64's pressure sore had increased in size.) On 12/11/02, the RD documented that resident 64 was receiving TwoCal HN at 37 cc an hour for 20 hours via her G-tube. Resident 64's protein requirements had not been recalculated since the 12/2/02 initial RD assessment and resident 64 was still receiving 10 grams less protein per day than her calculated requirements. On 12/16/02, the RD documented that resident 64 had a stage II pressure sore on her back which measured 2x2 cm (centimeters). She documented that the vitamin C she recommended 11 days prior had not yet been started. Per the facility "Pressure Ulcer Record", on 12/16/02, resident 64's pressure sore had progressed to a stage III measuring 3cm x 3 cm. (It should be noted that resident 64's pressure sore had increased in size.) On 12/19/02, 3 days later, the RD documented that resident 64's pressure sore was "...now 3x3 cm" and was still a stage II. Resident 64 continued to receive TwoCal HN at 37 cc per hour for 20 hours via her	F 325		

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F 325	Continued From page 51 G-tube as her sole source of nutrition. Resident 64's protein requirements had not been recalculated since the 12/2/02 initial RD assessment and resident 64 was still receiving 10 grams less protein per day than her calculated requirements. Per the RD note, the vitamin C recommended on 12/5/02, 14 days prior, to help with wound healing had yet to be started. Per the facility "Pressure Ulcer Record", on 12/23/03, resident 64's pressure sore was a stage III and measured 3cm x 4 cm. (It should be noted that resident 64's pressure sore continued to increase in size.) On 12/30/02, 11 days later, the RD documented that resident 64 continued to receive TwoCal HN via her G-tube at 37 cc an hour for 20 hours. She documented that the speech therapist wanted the tube feeding changed so that resident 64 could begin eating. Resident 64's tube feeding was changed to TwoCal HN 40 cc an hour for 12 hours with 1 can of TwoCal HN to be bolused every day. This would provide 59.7 grams of protein a day. On this date, the dietitian recalculated resident 64's protein needs and estimated that she would require 60 grams per day. This protein re-calculation was done by multiplying resident 64's weight in kilograms, 54.5, by a protein requirement factor of 1.1grams per kilogram. This was 0.2 grams less than the 1.3 protein requirement factor used for her initial nutritional assessment on 12/4/03 when it was noted that resident 64 had a stage II pressure sore. Per the facility "Pressure Ulcer Record", it was documented that resident 64's pressure sore had increased from a stage II on 12/4/03 to a stage III on 12/23/03. The "Enteral Feeding Worksheet" used by the facility documented that a 1.4 gram protein factor was to be used to figure protein needs for someone with a stage III pressure sore. This would place resident 64's protein needs at 76.3 grams per day, 16.3	F 325		

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F 325	Continued From page 52 grams higher than the 60 grams the RD calculated. The RD documented,"vit [vitamin] C still [not] added. Will recommend again [secondary] to stage II (pressure sore) on spine." On 12/30/02, a physician telephone order was written to begin vitamin C 500 mg twice a day. This was 25 days after the RD's initial recommendation. Resident 64's pressure sore had increased in size from a stage II measuring 2 cm x 1cm to a stage III measring 3 cm x 4 cm during this time per the facility's documentation in the "Pressure Ulcer Record". On 1/1/03, 2 days later, the dietitian documented that resident 64's pressure sore was "...now 3cm x 4cm. Was 3x3 cm [centimeters] previously." She documented that it was a stage II. Per the facility "Pressure Ulcer Record", on 1/1/03, resident 64's pressure sore was a stage III and measured 3cm x 4 cm. On 1/6/03, the dietitian changed resident 64's tube feeding again, to try and increase her appetite at meals, to TwoCal HN at 40 cc an hour for 12 hours to provide 40 grams of protein a day. This was 20 grams less than resident 64's protein requirements of 60 grams calculated by the RD on 12/30/02. Resident 64 had begun to eat some foods by mouth, on 1/2/03, however her documented meal intakes were 25 percent. This, per the facility "Nutrition Analysis" of the menus would provide approximately 21 grams of protein. The tube feeding and 25% meal consumption would provide 61 grams of protein a day. Per facility protein calculation guidelines, resident 64's protein needs should have been calculated at 76.3 grams a day (54.5kg multiplied by 1.4 grams of protein per kilogram). This would place resident 64's protein needs at 76.3 grams per day, 16.3 grams higher than	F 325		

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F 325	Continued From page 53 the 60 grams the RD calculated. Per the facility "Pressure Ulcer Evaluation Report", on 1/9/03, resident 64's pressure sore was a stage III-IV secondary to necrotic tissue and measured 3.3cm x 1.6cm with a depth of 0.3 cm. (It should be noted that resident 64's pressure sore was increasing in depth.) Per the facility "Pressure Ulcer Evaluation Report", on 1/15/03, resident 64's pressure sore was a stage III-IV with necrotic tissue and measured 3cm x 1.5 cm with a depth of 0.4 cm. (It should be noted that resident 64's pressure sore was increasing in depth.) On 1/22/03, the RD re-assessed resident 64's protein needs to be 70 grams a day. She calculated this by multiplying 54.5 kg, the residents weight by a protein requirement factor of 1.3 gm per kilogram. The RD changed resident 64's tube feeding to TwoCal HN at 50 cc an hour for 12 hours which provided 50 grams of protein a day. It was documented that resident 64 was eating 25% of her meals which provided approximately 20 additional grams of protein for a total of 70 grams a day. The "Enteral Feeding Worksheet" used by the facility documented that a 1.4 gram protein factor was to be used to figure protein needs for someone with a stage III pressure sore and a 1.6 gram protein factor was to be used to figure protein needs for someone with a stage IV pressure sore . This would place resident 64's protein needs at 76.3-81.7 grams per day, 6.3-11.7 grams higher than the 70 grams the RD calculated. From her admission on 12/2/02 until 12/30/03, resident 64 was not receiving a therapeutic diet which provided adequate protein to meet her estimated need of 71 grams per day as calculated by the dietitian on 12/4/02. During this time resident 64's pressure sore increased in size from a stage II to a stage III.	F 325		

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F 325	Continued From page 54 Resident 64 was also noted to have severe visceral protein depletion with and albumin level of 1.9 gm/dl upon admission. From 12/30/03 until 1/22/03, the dietitian calculated resident 64's protein requirements using a lower protein requirement than the facility "Enteral Feeding Worksheet" guidelines. Thus, the dietitian made diet recommendations which provided less protein than what resident 64 should have received per the facility's guidelines. During this time resident 64's pressure sore increased in depth from a stage III measuring 3cm x 4 cm to a stage III measuring 3.3cm x 1.6cm with a depth of 0.3cm per the facility's pressure sore documentation. 4. Resident 106 was admitted to the facility on 8/9/01 with diagnoses, which included diabetes mellitus, chronic obstructive pulmonary disease, hypothyroidism, depression and osteoporosis. Resident 106's medical record was reviewed on 4/9/03. A review of resident 106's weights, obtained from the facility assistant director of nursing (ADON) on 4/7/03, revealed the following: October 2002 118 pounds. November 2002 121 pounds. December 2002 113 pounds. This represents a significant weight loss of 8 pounds or 6.6% between the months of November and December 2002. January 2003 118 pounds. February 2003 109 pounds. This represents a significant weight loss of 9 pounds or 7.6% between the months of January and February 2003 and 12	F 325		

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	465055	A. BUILDING _____ B. WING _____	4/10/2003

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FEDERAL HEIGHTS REHABILITATION AND N	41 SOUTH 900 EAST SALT LAKE CITY, UT 84102

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F 325	Continued From page 55 pounds or 9.9% between the months of November 2002 and February 2003. March 2003 107 pounds. April 2003 108 pounds. This represents a significant weight loss of 10 pounds or 8.4% between the months of January and April 2003. A review of the physician orders documented that resident 106 was ordered an enriched, no concentrated sweet pureed diet with Mighty Shakes at each meal. On 4/7/03 at 1:12 PM, the dietary manager was interviewed. She stated that an enriched diet consisted of high calorie cereal at breakfast, extra margarine with meals and fortified mashed potatoes, when mashed potatoes were on the menu. Resident 106 was also ordered 120 cc of Med Pass 2.0 (a high calories supplement) four times a day with each medication pass. This provided 960 calories and 40 grams of protein. A review of resident 106's medication records for the months of December 2002, January 2003, February 2003, March 2003 and April 2003 documented that resident 106 drank 100% of the 120 cc Med Pass 2.0 supplement when it was offered. On 4/9/03, a review of all resident 106's dietary notes from 6/29/02 through 4/9/03 was completed. There was no documented evidence that the dietitian had completed a full nutritional assessment, which calculated resident 106's nutritional needs including calorie and protein requirements. On 12/4/02, the dietitian completed a nutrition note which documented, "... wt [weight] on 12/1 113	F 325		

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FEDERAL HEIGHTS REHABILITATION AND I	41 SOUTH 900 EAST SALT LAKE CITY, UT 84102

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F 325	Continued From page 56 [pounds] [down] 5 [pounds] and 4% since prior wk [week]. po [by mouth] intake poor per nsg. [Nursing]. Several interventions in place: enriched [diet] Mighty shakes, med pass, ice cream bid [twice a day]. Will address [with] wt [weight] committee to determine appropriate intervention..." There was no documented evidence that the dietitian calculated resident 106's calorie and protein requirements, based on her significant weight loss, to assess whether the ice cream and Mighty Shakes and Med Pass 2.0 supplement interventions were adequate to meet her nutritional needs. A review of the "Significant Weight Change Report", dated 12/4/02, was completed on 4/9/03. It was documented that resident 106 had experienced a 7% weight loss from November 2002 when she weighted 122 pounds to December 2002 when she weighted 113 pounds. It was documented that the possible reason for the weight change was poor meal intakes and recent diarrhea. A review of all nursing notes, from 9/12/02 to 2/13/03, was completed on 4/9/03. There was no documented evidence that resident 106 had experienced diarrhea during the months of October, November or December 2002. On 2/5/03, the dietitian completed a nutrition note which documented that resident 106's weight was 109 pounds on 2/2/03 and this was a decrease from 114 pounds the previous week. She documented that resident 106 consumed 25-50% of meals with some meal refusals noted. Nutritional interventions documented included ice cream twice a day, Mighty Shakes three times a day and Med Plus 2.0 four times a day. There was no documented evidence that the dietitian calculated resident 106's calorie and protein requirements, based on resident 106's significant	F 325		

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F 325	Continued From page 57 weight loss of 9 pounds or 7.6% between the months of January and February 2003 and 12 pounds or 9.9% between the months of November 2002 and February 2003, to assess whether the ice cream and supplement interventions were adequate to meet her nutritional needs. A review of physician progress notes was completed on 4/9/03. On 3/17/03, resident 106's physician documented that she had weight loss, refused to eat and did not like the food. On 3/17/03, a dietary consult was ordered related to a 9-pound weight loss and because the resident did not like the food. On 3/18/03, the dietitian completed a nutrition note which documented, "Dietary consult ordered for obtaining food preferences". The dietitian did not document that the telephone order for the dietary consult was also for weight loss. The dietitian listed a long list of food items that the resident stated she disliked. She documented that the only food resident 106 liked was vanilla or butterscotch pudding, which her family brought in. The dietitian documented that resident 106 was on multiple nutrition interventions and Remeron (an antidepressant), which could increase weight and appetite. (Resident 106 had been receiving Remeron since 11/17/01 per review of the physician orders). She further documented that resident 106 stated that she liked the supplement provided and did drink it. The dietitian documented that she would send vanilla or butterscotch pudding for lunch and dinner. There was no documented evidence that the dietitian calculated resident 106's calorie and protein requirements, based on the significant weight loss, which had been occurring since February 2003. There was no documented evidence that the dietitian assessed the nutritional content of the pudding that	F 325		

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F 325	Continued From page 58 resident 106's family was bringing in to determine it's nutritional adequacy or whether the ice cream and supplement interventions were adequate to meet her nutritional needs. There was no documented evidence that the dietitian identified that resident 106 consumed 100% of the Med Pass 2.0 four times a day with her medications and that she may consume more of this supplement if offered. A nutrition care plan, originally dated 11/15/02 and updated 4/7/03, documented that resident 106 had a feeding deficit related to diabetes mellitus and dementia and that she refused many foods. The documented goal was that she would eat 25-75 percent of meals with minimal supervision. Approaches documented to achieve this goal included: "Allow time to feed self. Supervise with prompting [and] verbal cueing assist as needed to complete task." Also documented was to provide an enriched diet, Mighty shakes and Med Plus. It was not documented on this care plan that resident 106 was not eating her meal trays but was eating 2 containers of pudding at each meal. A second nutrition care plan, originally dated 11/15/02, documented that resident 106 had an altered nutritional status related to being less than body requirements and the inability to eat regular textured foods. There was no documented goal. Documented approaches included: Monitor percentage of meals eaten and offer a replacement if the resident refused meal, determine food preferences and provide and supervise dining and encourage eating. It was not documented on this care plan that resident 106 refused to eat many foods, was not offered her meal trays and was only eating 2 containers of pudding at each meal. On 4/9/03 at 1:14 PM, resident 106's lunch tray was delivered to the 200 hall. A review of the lunch diet	F 325		

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F 325	Continued From page 59 card documented that a Mighty Shake was to be sent on the tray. There was no Mighty Shake on resident 106's lunch tray. It was not documented that resident 106 was to receive ice cream at lunch. There was no ice cream on resident 106's tray. There was no pudding on resident 106's tray per the dietitian recommendation made 3/18/03. At 1:35 PM, resident 106's lunch tray had not been delivered to her although she was in her room, in bed and her roommate was eating her lunch. On 4/9/03, at 1:35 PM, C.N.A. (certified nurses aide) was passing the hall trays, was asked why resident 106 had not gotten her tray. She stated that resident 106 never wanted her tray and she had not taken it in to offer it to her. She stated all she ate for lunch was pudding. The C.N.A. was not observed to offer resident 106 her lunch tray. On 4/9/03, at approximately 1:40 PM, resident 106 was interviewed. She stated that the aides do not bring her tray into her room or offer it to her and that they did not bring a milkshake into her at meals. She stated that she did not like the food and ate 2 cups of pudding for each meal. She opened the drawer to her nightstand and there were several packages of vanilla Kraft Handi-Snack pudding cups. According to the package, each pudding cup contained 110 calories and less than 1 gram of protein per serving. When asked, she stated again that all she ate at mealtime was 2 cups of pudding, so she ate 6 a day. Six pudding cups would provide 660 calories and less than 6 grams of protein. She was asked if she liked ice cream and she shook her head no. Resident 106 was asked if she thought she had lost weight. She said, "yes" and stated that it bothered her but she did not know what to do about it. On 4/9/03 at 6:45 PM, resident 106's supper tray was	F 325		

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F 325	Continued From page 60 delivered to the 200 hall. A review of the supper diet card documented that a Mighty Shake was to be sent on the tray. There was no Mighty Shake on resident 106's supper tray. It was not documented that resident 106 was to receive ice cream at supper. There was no ice cream on resident 106's tray. There was no pudding on resident 106's tray per the dietitian recommendation made 3/18/03. Observation revealed that resident 106 was not offered her supper tray. On 4/10/03 at 8:35 AM, resident 106's breakfast tray was delivered to the 200 hall. A review of the breakfast card at 9:16 AM did not document that a Mighty Shake was to be sent. There was no Mighty Shake on resident 106's breakfast tray. Observation revealed that resident 106 was not offered her breakfast tray. On 4/10/03, at approximately 9:25 AM, the dietary manager was asked for a copy of resident 106's dietary cards for breakfast, lunch and supper. At 9:48 AM, the dietitian provided a copy of resident 106's dietary cards for all three meals. For the breakfast meal, strawberry Mighty Shake had been added to the card. On 4/10/03, at 8:16 AM, a C.N.A. was interviewed. She was asked about resident 106's meal trays. She stated that she did not think that resident 106 was even sent meal trays. She stated that other staff members told her that she would just eat 2 puddings at each meal. On 4/10/03 at 12:36 PM, resident 106 and her husband were interviewed. Resident 106 again stated that facility staff did not offer her meal trays. Her husband stated that she was not offered her meal tray at lunch when he was visiting. She stated that she used to eat mashed potatoes and gravy from the kitchen but that the facility began to put "green leaves" in the potatoes,	F 325		

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F 325	Continued From page 61 which she was unable to eat. She stated that she liked the supplement they gave her with her medications and drank all of it each time. When asked, she stated that she would drink more of the supplement, which she got with her medications, if it was offered. There was no documented evidence that the dietitian completed an assessment to calculate resident 106's nutritional requirements, including calories and protein needs after she experienced significant weight loss. There was no documented evidence that the dietitian assessed the use of an enriched diet and Mighty Shakes on the meal trays to provide extra calories and protein to resident 106 when through interviews with both the resident, the resident's family, facility staff members and direct observation, resident 106 was not offered her meal trays. There is no documented evidence, until 3/18/03, after the physician ordered a dietary consult, that the dietitian was aware that resident 106 was only consuming 2 containers of pudding at each meal and assessed the calorie and protein content of the pudding to determine it's nutritional adequacy. There is no documented evidence that the dietitian identified the fact that resident 106 drank 100% of the Med Pass 2.0 supplement four times a day and would perhaps drink more if offered. 5. Resident 84 was re-admitted to the facility on 11/14/02 with diagnoses, which included diabetes mellitus, congestive heart failure, chronic renal insufficiency and a right hip fracture. Resident 84's medical record was reviewed on 4/8/03. An initial nursing assessment, completed 11/14/02 documented that resident 84 had a surgical incision on her right hip.	F 325		

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F 325	Continued From page 62 An initial dietary assessment was completed on 11/18/02, 4 days after resident 84 was re-admitted to the facility. The dietitian documented that there was no height or weight recorded in the chart. It was documented that resident 84 had been a resident in the facility before and had not eaten well during her previous stay at the facility. The dietitian recommended that resident 84's diet be liberalized from a 1600 ADA (American Diabetes Association) diet to a no concentrated sweet diet "to allow more kcal (calories) and prevent wt (weight) loss." The dietitian noted that resident 84 was on Lasix (a diuretic) and may be subject to weight changes. It was documented that she would monitor resident 84 as needed and as more data became available. On 11/20/02, the dietitian documented that resident 84 had experienced a significant weight loss from 105 pounds in October 2002 to 96 pounds in November 2002 and attributed this to resident 84's recent hospitalization. It was documented that resident 84 was consuming 25-75 % of meals with occasional refusals. There was no documented evidence that the dietitian completed a full nutrition assessment, which calculated resident 84's calorie and protein requirements based on resident 84's apparent significant weight loss with her recent hip fracture and surgical incision. A review of resident 84's "Meal Monitor" form, from 11/15/02 until 11/20/02, when the dietitian completed her initial dietary note, was completed. Resident 84's breakfast intake averaged 29 %, her lunch intake averaged 33% and her supper intake averaged 42%. On 11/21/02, a nurse documented that resident 84 developed a right heel pressure ulcer.	F 325		

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F 325	Continued From page 63 On 11/25/02, the dietitian documented that resident 84 weighed 92 pounds and had lost 3 pounds in a week. She attributed the weight loss to hypokalemia (low potassium), which she documented "can [decrease] appetite". It was documented that resident 84's meal intakes were 50-100% with some at 25% and that resident 84's po (by mouth) intakes were good. The dietitian noted that resident 84's good meal intakes "may improve nutritional status". There was no documented evidence that the dietitian completed a full nutrition assessment, which calculated resident 84's calorie and protein requirements based on resident 84's significant weight loss with her recent hip fracture and surgical incision. There was no documentation to provide evidence that the dietitian was aware that resident 84 had developed a pressure sore on her right heel on 11/21/02. A review of resident 84's "Meal Monitor" form, from 11/21/02 until 11/25/02, was completed. Resident 84's breakfast intake averaged 50 %, her lunch intake averaged 50% and her supper intake averaged 60%. Per the facility "Pressure Ulcer Record", on 11/26/02 and 12/3/02, resident 84's pressure sore was a stage II and measured 4 cm in circumference. On 12/4/02, the dietitian documented that resident 84's weight had increased from 96 pounds in November 2002 to 108 pounds in December of 2002, a total of 12 pounds in one month. A re-weight was requested. On 12/5/02, the dietitian documented that resident 84's weight was 103 pounds. It was documented that resident 84's weight had increased from 92 pounds (on 11/24/02) to 103 pounds (an 11 pound weight increase in 11 days). The dietitian documented that the weight gain was "desirable". There was no documentation to	F 325		

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F 325	Continued From page 64 provide evidence that the dietitian was aware that resident 84 had developed a pressure sore on her right heel on 11/21/02. There was no documented evidence that the dietitian completed a full nutrition assessment, which calculated resident 84's calorie and protein requirements to assess whether the diet provided was adequate to meet her nutritional needs. A review of resident 84's "Meal Monitor" form, from11/26/02 until 12/5/02, was completed. Resident 84's breakfast intake averaged 49 %, her lunch intake averaged 38% and her supper intake averaged 36%. On 12/9/02, 18 days after it developed, the dietitian documented that resident 84 had a stage II pressure sore on her heel. She documented that resident 84's meal intakes were good. There was no weight documented. There was no documented evidence that the dietitian completed a full nutrition assessment, which calculated resident 84's calorie and protein requirements to assess whether the diet provided was adequate to meet her nutritional needs. On 12/11/02, the dietitian documented that resident 84's weight was fluctuating up and down with her current weight documented at 106 pounds, a 3-pound increase in a week. It was documented that resident 84 was eating 50-75% of meals. A review of resident 84's "Meal Monitor" form, from12/6/02 until 12/11/02, was completed. Resident 84's breakfast intake averaged 66%, her lunch intake averaged 58% and her supper intake averaged 55%. On 12/19/02, the dietitian noted that resident 84's weight was 102-pounds, which was a 4 pound weight loss in one week. It was noted that resident 84 had been reviewed in a weight meeting and that she was not eating well and was lethargic. The dietitian	F 325		

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F 325	Continued From page 65 documented that resident 84 may drink a supplement. The dietitian recommended that 120 cc of house supplement be added three times a day, this was 28 days after resident 84 developed a pressure sore. There was no documented evidence that the dietitian completed a full nutrition assessment, which calculated resident 84's calorie and protein requirements to assess whether the diet provided and the addition of 120 cc of house supplement was adequate to meet her nutritional needs. Per the facility "Pressure Ulcer Record", on 12/23/02, resident 84's pressure sore was a stage II and measured 5 cm in circumference. (It should be noted that resident 84's pressure sore was increasing in size.) Per the facility "Pressure Ulcer Record", on 1/1/03, resident 84's pressure sore was a stage II and measured 6cm x 4cm in circumference. (It should be noted that resident 84's pressure sore was continuing to increase in size.) On 1/1/03, the dietitian completed a dietary note. It was documented that resident 84's weight on 12/29/02 was 110-pounds which was 8 pounds greater than the previous weight of 102 pounds on 12/15/02. There was no documentation regarding resident 84's pressure sore, which had increased in size. It was documented that a house supplement had been started. There was no documentation to provide evidence that the diet and house supplement being provided were adequate to meet resident 84's nutritional needs. A full nutrition assessment, which would calculate resident 84's calorie and protein requirements, had not been completed by the dietitian. On 1/6/03, the dietitian documented that resident 84's wound care was continuing. There was no weight documented. There was no documented evidence that	F 325		

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F 325	Continued From page 66 the dietitian completed a full nutrition assessment, which calculated resident 84's calorie and protein requirements to assess whether the diet provided and the addition of a supplement was adequate to meet her nutritional needs. Per the facility "Pressure Ulcer Evaluation Report", on 1/8/03, resident 84's pressure sore was a stage III-IV and measured 5cm x 4cm. (It should be noted that resident 84's pressure sore had progressed from a stage II to a stage III-IV.) On 1/9/03, the dietitian documented that resident 84's weight was 115 pounds, a 5-pound weight increase in one week, which was attributed to edema. It was documented that resident 84's meal intakes were good. There was no documentation regarding resident 84's pressure sore, which continued to increase in size and was now a stage III-IV. There was no documentation to provide evidence that the diet and house supplement being provided were adequate to meet resident 84's nutritional needs. A full nutrition assessment, which would calculate resident 84's calorie and protein requirements, had not been completed by the dietitian. A review of resident 84's "Meal Monitor" form, from1/1/03 until 1/9/03, was completed. Resident 84's breakfast intake averaged 46%, her lunch intake averaged 52% and her supper intake averaged 36%. On 1/15/03 resident 15 was admitted to the hospital with pneumonia. From 11/14/02, when resident 84 was re-admitted to the facility, until 1/15/03 when she was discharged to the hospital, there was no documented evidence that the dietitian completed a full nutrition assessment to calculate resident 84's nutritional requirements, including calories and protein needs. There was no	F 325		

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FEDERAL HEIGHTS REHABILITATION AND I	41 SOUTH 900 EAST SALT LAKE CITY, UT 84102

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F 325	Continued From page 67 documented evidence that the diet and house supplement being provided to resident 84 were adequate to meet her nutritional requirements as there were no calculations to evidence what her nutritional requirements were. There was no documented evidence that the dietitian assessed resident 84 calorie and protein requirements after she developed a pressure sore on 11/21/02. 6. Resident 54 was admitted to the facility on 1/29/03 with diagnoses, which included cerebrovascular accident, gastric distress, anemia, anxiety, pain and depression. Resident 54's medical record was reviewed on 4/8/03. On 2/3/03, the dietitian completed an initial nutrition assessment. Resident 54's height was recorded at 66" (5 feet 6 inches) and her weight was 144 pounds. The dietitian documented that resident 54's skin was intact. Resident 54's nutritional needs were calculated and it was doc umented that resident 54 required 1690 calories and 72 grams of protein a day. Resident 54 was ordered a regular diet, which the dietitian noted provided approximately 2000 calories and 80 grams of protein a day. On 2/12/03, a facility nurse documented that resident 54 developed a stage II pressure sore on her right outer ankle, which measured 0.5 cm. On 2/12/03, the dietitian completed a dietary note. She documented that she had been informed that resident 54 had a stage II pressure sore. She documented that resident 54 was consuming 50-100 % of meals and that the current diet provided over 100% of her estimated nutrient needs. The dietitian recommended that a multi-vitamin with minerals and vitamin C 500 mg twice a day begin. There was no	F 325		

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F 325	Continued From page 68 documented evidence that the dietitian re-calculated resident 54's nutritional requirement, including calorie and protein needs, after she developed a stage II pressure sore. A review of resident 54 "Meal Monitoring" form for February 2003 was completed on 4/8/03. Resident 54's breakfast intake averaged 75%, her lunch intake averaged 76% and her supper intake averaged 60%. Resident 54's daily meal intake average for the month of February was 70%. Based on resident 54's average meal intake of 70% and the dietitian's documentation that resident 54's diet provided approximately 2000 calories and 80 grams of protein, resident 54 was consuming an average of 1400 calories and 56 grams of protein during the month of February. This was 290 calories and 16 grams less protein a day than the dietitian calculated resident 54 required on 2/3/03. There was no documented evidence that the dietitian recommended nutritional interventions to help increase the calories and protein in resident 54's diet to better meet her estimated needs. On 2/22/03, a facility nurse documented that resident 54's pressure sore had increased redness and in size to 1cm x 1cm. On 2/26/03, a facility nurse documented that resident 54's pressure sore had a black center and had increased in size to 2cm x 2cm. On 2/26/03, a "wound team" note documented that resident 54 had a stage II pressure sore which measured 1cm x 1cm and had a depth of 0.3 cm. On 3/6/03, a "wound team" note documented that resident 54's wound measured 1cm x 1.2 cm and had a	F 325		

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F 325	Continued From page 69 depth of 0.5 cm. On 3/17/03, the dietitian documented that resident 54 was consuming 50-100% of meals. On 3/31/03, the dietitian documented that resident 54's wound was 1.3 cm x 1.5 cm with a depth of 0.2 cm and was "slightly larger". She documented that resident 54 was consuming 50% of most meals with some meals eaten at 25% and some meal refusals. The dietitian recommended that the current diet be continued. There was no documented evidence that the dietitian re-calculated resident 54's nutritional requirement, including calorie and protein needs, after she developed a stage II pressure sore, which was increasing in size. A review of resident 54 "Meal Monitoring" form for March 2003 was completed on 4/8/03. Resident 54's breakfast intake averaged 66%, her lunch intake averaged 51% and her supper intake averaged 47%. Resident 54's daily meal intake average for the month of March 2003 was 54%. Based on resident 54's average meal intake of 54% and the dietitian's documentation that resident 54's diet provided approximately 2000 calories and 80 grams of protein, resident 54 was consuming an average of 1080 calories and 43.2 grams of protein during the month of March. This was 610 calories and 28.8 grams less protein a day than the dietitian calculated resident 54 required on 2/3/03. There was no documented evidence that the dietitian recommended nutritional interventions to help increase the calories and protein in resident 54's diet to better meet her estimated needs. There was no documented evidence that the dietitian re-assessed resident 54's nutritional requirements after	F 325		

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F 325	Continued From page 70 that the dietitian identified that resident 54 average meal intakes were not meeting her calorie and protein needs as assessed 2/3/03. There was no documented evidence that the dietitian implemented appropriate nutrition interventions to increase calories and protein in resident 54's diet after she developed a pressure ulcer.	F 325		
F 326 SS=H	483.25(i)(2) QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident receives a therapeutic diet when there is a nutritional problem. This Requirement is not met as evidenced by: Based on observation, interview and medical record review, it was determined that for 5 of 23 sampled residents, the facility did not ensure that each resident received a therapeutic diet when there was a nutritional problem as evidenced by: one resident who experienced significant weight loss did not receive double portions at meals per physician order, two residents with low protein levels and pressure sores did not receive diets that provided adequate protein as calculated by the facility registered dietitian and the pressure sores increased in size and two residents did not receive high calorie supplements on their meal trays per physician orders, both had experienced a weight decline. Resident identifiers: 54, 64, 74, 80, and 101. The facility was found to be providing sub-standard quality of care (a pattern of actual harm) in this area. Findings include: 1. Resident 64 was re-admitted to the facility on 12/2/02 with diagnoses which included status post hip,	F 326 OK 5/28/03	F 326 H **Corrective actions for identified residents** Resident # 64, 54, and 101 will have a full nutritional assessment completed by the new Registered Dietitian (RD). Accurate heights and weights will be obtained and documented to ensure accuracy of these nutritional assessments. This RD will calculate the calorie and protein requirements of each of these residents based on his/her individual risk factors. Each of these residents will receive nutritional interventions and diets to address his/her individual needs as recommended by the RD. These nutritional assessments will be completed and interventions initiated by May 12, 2003. Each of thee resident's care plan will be updated by May 12, 2003 to reflect any changes indicated by the RD.	5/28/03

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F 326	Continued From page 71 humerus and wrist fractures, dysphagia, congestive heart failure and a history of cerebrovascular accident. Resident 64's medical record was reviewed on 4/7/03. Resident 64 was admitted to the facility receiving all of her nutrition via gastrostomy tube. In addition, resident 64 was admitted to the facility with a stage II pressure ulcer and a severe visceral protein depletion with an albumin level of 1.9 g/dl. From her re-admission to the facility on 12/2/02 until 12/30/02, resident 64 was not receiving a therapeutic diet which provided adequate protein to meet her estimated need of 71 grams per day, as calculated by the dietitian on 12/4/02. During that time resident 64's pressure ulcer increased in size from a stage II to a stage III. From 12/30/02 until 1/22/03, the dietitian calculated resident 64's protein requirements using a lower protein requirement than the facility "Enteral Feeding Worksheet" guidelines. Thus, the dietitian made dietary recommendations which provided less protein than what resident 64 should have received per the facility's guidelines. During this time resident 64's pressure sore increased in depth from a stage III measuring 3 cm x 4 cm to a stage III measuring 3.3 cm x 1.6 cm with a depth of 0.3 cm per the facility's pressure sore documentation. There was no documented evidence that the facility provided resident 64 with a therapeutic diet to promote wound healing and provide adequate protein to meet resident 64's estimated needs. 2. Resident 54 was admitted to the facility on 1/29/03 with diagnoses, which included cerebrovascular accident, gastric distress, anemia, anxiety, pain and depression. Resident 54's medical record was reviewed on 4/8/03.	F 326	Resident # 80 is receiving mighty shakes with each meal as ordered. Resident # 80 will have an updated nutritional assessment completed by the new consulting RD by May 12, 2003. She will have likes and dislikes reviewed with her by the Dietary Service Manager by May 8, 2003. Resident # 74 is receiving sugar free mighty shakes with her meals, her diet is pureed and her water is thickened as ordered. She will have an updated nutritional assessment completed by May 12, 2003 by the new consulting RD. **Identification of residents potentially affected** Residents placed on therapeutic diets have the potential to be affected. **Measures to prevent recurrence** The facility has secured the services of a replacement Registered Dietitian (RD) with 7 years of experience. This RD is reviewing each current resident's dietary assessment for accuracy of nutritional need and is making changes and recommendations for interventions as each case may indicate. This review will be completed by May 12, 2003. This RD is the facility's current consulting RD and will be a member of the weight and wound committee.	

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F 326	Continued From page 72 Resident 54 developed a pressure sore on 2/12/03, which continued to increase in size. A review of resident 54's medical record dietary notes revealed that no dietary assessment addressing the pressure ulcer had been completed for resident 54. There was no documented evidence that the dietitian identified that resident 54's average meal intake was not meeting her caloric and protein needs that were assessed on 2/3/03, prior to resident 54's development of the pressure sore on 2/12/03. There was no documented evidence that the dietitian implemented appropriate nutritional interventions to increase calorie and protein needs for resident 54 after she developed a pressure ulcer. There was no documented evidence that the facility provided resident 54 with a therapeutic diet to promote wound healing. 3. Resident 101 was admitted to the facility on 7/19/02 with diagnoses which inlcuded multiple sclerosis, glaucoma, osteoporosis, anemia and insomnia. Resident 101's medical record was reviewed 4/8/03 through 4/9/03. Resident 101 experienced a 13.6% unplanned weight loss from 7/19/02 th February, 2003 and a 9% unplanned weight loss from November, 2002 to February 2003. On 10/16/02 the dietitian documented that resident 101 was nutritionally stable even though he was 81% of his ideal body weight (which is considered a moderate state of malnutrition), the dietitian did not document any dietary interventions be implemented. On 11/25/02, the dietitian documented that resident 101 requested double portions due to weight loss. It was not until 1/20/03 (51 days later) that resident 101's diet was changed. On 1/20/03, the dietitian documented that resident 101 was nutritionally stable at 110 pounds, 73.8% of his ideal	F 326	The Director of Nursing has replaced the Assistant Director of Nursing as the chairperson of the weight and wound committee. Other members of the committee include the Dietary Service Manager and the wound nurse. Committee members will seek input from the direct care staff as may be indicated. A project team selected by the Administrator has reviewed the facility's process and system for addressing weight and nutrition management. The team has developed a policy and procedure for obtaining accurate and timely weights and heights and for their accurate documentation. The team has also developed a tool for the meeting to facilitate assessment, documentation and follow-up on recommended interventions. The Director of Nursing or designee will inservice by May 17, 2003 the licensed nurses and the weight and wound committee on the policy and procedure for obtaining and documenting weights and heights and on the tool for the weight and wound committee meetings. The facility has designated certain Certified Nursing Assistants as the team to obtain weights and	

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F 326	Continued From page 73 body weight (which is considered a severe state of malnutrition), the dietitian did not document any dietary interventions be implemented. A lab value taken at the facility and dated 2/21/03, showed an albumin of 3.1, which is a mild visceral protein depletion and an indication of malnutrition. The dietitian did not address the low albumin until 4/8/03, at which time she did not make any dietary intervention to increase resident 101's protein requirements, even though his albumin reflected a mild visceral protein depletion. Upon interview with resident 101, on 4/7/03, he stated that he had not received a double portion diet since his request to receive one 3-4 months prior. Observation on 4/7/03 and 4/8/03 provided evidence that resident 101 was not receiving a therapeutic diet with double portions. 4. Resident 80 was re-admitted to the facility on 1/11/03, with the diagnoses of poor circulation, hypertension, depression, hypothyroidism, radial fracture, tibial fracture, asthma and constipation. On 4/9/03 resident 80's medical record was reviewed. A lab (laboratory) value taken at the facility and dated 3/24/03 showed an albumin (protein) level of 3.1 g/dl. An albumin level of 3.0-3.5 g/dl is considered a mild visceral protein deficit. (Reference guidance: Manual of clinical Dietetics, American Dietetic Association, 6th edition, 200, page 22). On 3/26/03, a physician order documented the following, "House supplement 120 cc PO (by mouth) QID (four times a day) DX (diagnoses) [decreased] albumin." On 4/2/03 a physician order documented the following, "D/C (stop) house suppl (supplement) 120 cc QID (four times a day) [due to] pt (patient) refusal. [Change] to Mighty Shakes 6 oz (ounces) TID (three times a day) [with] meals."	F 326	heights. This team will be inserviced by the Staff Development Coordinator by May 9, 2003 on proper techniques for obtaining weights and heights and how to properly document. Dietary orders on the physician recerts for May 2003 will be checked for accuracy by checking the recert order against the most recent physician hand written or telephone order. The Director of Nursing or designee will complete this audit by May 14, 2003 and any indicated changes or clarifications will be completed by May 15, 2003. By May 16, 2003 the Dietary Service Manager or designee will audit tray cards for accuracy by comparing the tray cards with the most current physician orders. The dietary staff will be inserviced by May 15, 2003 by the Registered Dietitian or designee on the importance of following the tray cards as written to ensure that therapeutic diets are being served as ordered. This inservice will also include information on portion sizes and the use of appropriate utensils for measurements.	

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F 326	Continued From page 74 At lunch on 4/9/03, resident 80 was observed to receive a glass of the house supplement. She was not observed to receive a mighty shake with her meal. The dietary card next to resident 80's meal stated she was to receive an enriched regular diet. The diet card did not indicate that resident 80 was to receive Mighty Shakes with her meals. On 4/9/03 at 1:00 PM, resident 80 stated she did not know why they send that pink milk, it was to sweet and she could not tolerate it. At breakfast on 4/10/03, resident 80 was observed to receive a glass of the house supplement. She was not observed to receive a Mighty Shake with her meal. During an interview with resident 80 on 4/10/03, at approximately 7:15 AM, she stated that she got the house supplement with all of her meals and she refused to drink them because they made her ill. She further stated that she had never been served a Mighty Shake, but would be willing to try one. 5. Resident 74 was a 80 year old female who admitted to the facility on 2/8/02 with diagnoses that included diabetes, decubitus, hypertension and Alzheimer's disease. On 4/7/03, resident 74's medical record was reviewed. Resident's recorded weights per Resident Care System Weight History: Week 1 Week 2 Week 3 Week 4 March 2003 123 126 - - February 2003 119 119 119 122 January 2003 120 119 - 119 December 2002 123 122 121 119 November 2002 126 127 125 126 Resident 74's vital signs and weight record	F 326	The Department Heads and the nursing staff will be inserviced by the Staff Development Coordinator or designee by May 17, 2003 on the importance of comparing the tray as presented against what is documented on the tray cards. Any discrepancies will be corrected prior to serving the tray to the resident. **Monitoring/Quality Assurance** The Director of Nursing or designee will develop an audit tool by May 12, 2003. This tool will monitor compliance with: 1. Serving therapeutic diets as ordered 2. Tray cards accurately reflecting the physicians' orders 3. Registered Dietitian assessments reflecting consideration of resident's increased risk factors such as significant weight loss, low albumen levels and/or development of skin ulcers.	

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F 326	Continued From page 75 documented her weight as: 119 pounds on 12/22/02, 120 pounds on 1/5/03, 119 pounds on 1/11/03, 113 pounds on 2/9/03, 115 pounds on 3/30/03, 116 pounds on 4/4/03. There were no other weights documented on the report. The Nutritional Progress Notes for resident 74, dated 3/24/03 by the registered dietician, documented the resident weighed 115 pounds and that the weight represented a 9 pound and 7.3 percent weight loss. Resident 74's weight of 115 pounds was compared to a weight of 124 pounds but the time frame or the date the resident weighed 124 pounds was not documented. The previous weight documented in resident 74's medical record was on the vital signs and weight record; 113 pounds dated 2/9/03. The registered dietician, noted that there was "ø [no] apparent reason for the weight loss." The registered dietician also documented that resident 74's "Diet order is NCS [no concentrated sweets] puree enriched, also on diet mighty shakes tid [three times daily]." Resident 74's nutritional care plan, dated 4/7/03, documented the resident was to receive 4 ounces of diet mighty shake tid. The Kardex, the nurse's aide's working care plan, for resident 74 did not document the resident was to receive a diet mighty shake at meals. The medication administration record for resident 74 documented the resident's medications were to be crushed and taken in Med Pass 2.0 (nutritional supplement), that she was to have sugar free mighty shakes with meals, her liquids were to be thickened, and her meal was to be pureed smooth.	F 326	The Director of Nursing or designee will do weekly audits for six weeks to determine the level of compliance. At the completion of the audits, the Director of Nursing or designee will report to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the frequency of any continued audits and reports based on the percent of compliance as indicate by the audits. When the audits indicate the attainment of 100 percent compliance, the audits and reports will then be done, at a minimum, for two quarters. The Committee will then determine if there is a need for any further audits and reports. The Director of Nursing will be responsible for continued compliance. Completion date: May 28, 2003	

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F 326	Continued From page 76 Observations were made of resident 74 during lunch on 4/7/03, breakfast and lunch on 4/8/03, lunch and supper on 4/9/03, and breakfast on 4/10/03. Resident 74 did not receive a diet mighty shake or any house supplement at any of the meals. On 4/10/03 after breakfast, resident 74's a nurse's aide who had worked with the resident since the resident was admitted to the facility, was asked if the resident ever received a nutritional shake with her meals. The nurse's aide stated that resident 74 did not get the nutritional shakes. While resident 74 was waiting for breakfast on 4/10/03, a nurse's aide entered the assisted dining room with a pitcher of water and poured it for each of the residents. The nurse's aide assisted resident 74 to drink the water that had not been thickened. For her lunch meals and for breakfast on 4/8/03, resident 74 received cottage cheese that was not smooth and had not been pureed. Resident 74 would not eat the lumpy cottage cheese. On 4/8/03 and 4/9/03, resident 74's nurses stated that the resident would not eat anything with even the tiniest lump in it.	F 326		
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 observation, it was determined that the facility did not store and serve food under sanitary conditions. Specifically, there were multiple food items which were expired and/or not properly labeled or dated found in the 2nd floor resident refrigerator,	F 371		5/28/03

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F 371	Continued From page 77 This Requirement is not met as evidenced by: Based on observation, it was determined that the facility did not store and serve food under sanitary conditions. Specifically, there were multiple food items which were expired and/or not properly labeled or dated found in the 2nd floor resident refrigerator, the North hall resident refrigerator and the Medicare hall resident refrigerator. Findings include: The following observations were made on 4/8/03 at approximately 12:35 PM. 2nd Floor resident refrigerator: 1. There was an expired carton of butter pecan 2.0 med pass supplement dated as opened 4/3/03 (5 days old). 2. There was 1 carton of yogurt with an expiration date of 4/5/03 (3 days old). The following observations were made on 4/9/03 at 9:05 AM. North hall resident refrigerator: 1. There were 2-1/2 egg salad sandwiches with no dates. 2. There was a glass of apple juice with no date. 3. There was a loaf of homemade bread with a date of 3/23/03 (17 days old). The following observations were made on 4/10/03 at approximately 2:15 PM. Medicare hall resident refrigerator: 1. There was a bowl of pasta salad which was not dated as to when it had been opened. 2. There was an expired carton of 2% (percent) milk,	F 371	F 371 E **Corrective action for identified concern** The multiple food items which were expired and/or not properly labeled or dated found in the 2nd floor resident refrigerator, the North hall resident refrigerator and the Medicare hall resident refrigerator were all discarded during the survey process. **Identification of residents potentially affected** All residents have the potential to be affected. **Measures to prevent recurrence** The residents' refrigerators on the 2nd floor, North hall and Medicare will be put on a schedule to be checked daily for properly stored food. Any improperly stored food will be discarded. The licensed nurses will be inserviced by the Director of Nursing or designee by May 17, 2003 on, checking the resident refrigerators daily for and discarding, any expired and/or not properly dated food found.	

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

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F 371	Continued From page 78 dated 3/28/03 (13 days old), which had a resident's name on it. 3. There were two expired 1/2 gallons of skim milk, one dated 4/4/03 (6 days old) and one dated 4/9/03 (a day old), which had a resident's name on them. 4. There was a container of apple-cherry sauce which was not dated as to when it had been opened. It had a resident's name on it. Ready to eat, potentially hazardous food prepared and held refrigerated for more than 24 hours in a food establishment shall be clearly marked at the time of preparation to indicate the date by which the food shall be consumed which is, including the day of preparation: 4 calender days or less from the day the food is prepared, if the food is maintained at 45 degree Farenheit or less. Reference Guidance: US Public Health Service FDA 2001 Food Code, page 69.	F 371	**Monitoring/Quality Assurance** The Director of Nursing will develop an audit tool by May 9, 2003. This tool will monitor compliance with maintaining the resident refrigerators free of expired and/or not properly labeled food. The Director of Nursing or designee will complete daily audits for 3 weeks and then report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine if further audits and reports are needed. The Director of Nursing will be responsible for continued compliance. Completion date: May 28, 2003.	
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 observation during the survey the facility did not dispose of garbage and refuse properly. The dumpster in the facility parking lot had the lids open exposing the garbage to possible pest infestation. Findings include: 1. On 4/8/03, at 1:30 PM, the two facility dumpster were observed. The first dumpster had one of the 1/2 lids broken off and the side door opened. The dumpster contained plastic bags of garbage as well as boxes of garbage. The 2nd dumpster was observed to	F 372 OK 5/23/03 DJ	F 372 D **Corrective action for identified concern** The dumpster with the broken lid was repaired on April 10, 2003. The doors and lids of the dumpsters were closed. **Identification of residents potentially affected** All residents have the potential to be affected.	

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	465055	A. BUILDING _____ B. WING _____	4/10/2003

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F 372	Continued From page 79 have the side door opened. The dumpster contained plastic bags of garbage. 2. On 4/9/03, at 9:00 AM, the two facility dumpster were observed. The first dumpster had plastic bags of garbage and boxes of garbage and it was not covered with the lids. One of the lids was broken off. The 2nd dumpster contained plastic bags of garbage and it was not covered with the lids. 3. On 4/10/03, at approximately 11:00 AM, both dumpster were observed to have plastic bags of garbage and the side doors on each were opened. On the 1st dumpster one of the upper lids was broken off.	F 372	**Measures to prevent recurrence** The nursing, housekeeping and dietary staff will be inserviced by the Staff Development Coordinator or designee by May 19, 2003 on the proper disposal of garbage and refuse into the dumpsters. The inservice will include closure of the top lids and side doors. **Monitoring/Quality Assurance** The Staff development Coordinator or designee will develop and audit tool by May 19, 2003. This tool will monitor compliance with keeping the lids and side doors of the dumpsters closed. The Housekeeping Supervisor or designee will do daily audits for three weeks and then report compliance to the Safety Committee. The Safety Committee Chairperson will report compliance to the Performance Improvement Committee (Quality Assurance). The Performance Improvement Committee will then determine if further audits are needed. The Housekeeping Supervisor will be responsible for continued compliance. Completion date: May 28, 2003	
F 426 SS=E	483.60(a) PHARMACY SERVICES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This Requirement is not met as evidenced by: Based on record review, observations, and interviews it was determined that the facility licensed staff did not provide accurate pharmaceutical services to meet each of the residents needs as evidenced by 1 of 23 sampled residents (42) did not have blood glucose results or sliding scale insulin amounts documented, 5 of 23 sampled residents (80, 82, 83,105 &106) did not have their antidepressant documented as given, 19 supplemental residents did not have their medication's documented as given; and 1 supplemental resident (108) was observed not to receive or have her medication documented as given. Sampled resident identifiers: 42, 80, 82, 83, 105 & 106. Supplemental resident identifiers: 8, 72, 75, 77, 81, 84, 85, 96, 97,	F 426		5/28/03

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F 426	Continued From page 80 99, 100, 103, 104, 107, 108, 110, 111 & 112. Findings include: 1. Resident 106 was admitted to the facility on 8/9/01 with diagnoses including depression related to medical condition and pain, hypothyroidism, osteoporosis and chronic obstructive pulmonary disease. Review of resident 106's medical record was completed on 4/9/03 and 4/10/03. A review of the physician re-certification orders documented the following: a. On 11/17/01, resident 106 was placed on Remeron, 30 mg a day, for dementia with depressive features. On 4/10/03, a review of her April 2003 MAR, provided no documented evidence that resident 106 had received her Remeron, as ordered, from 4/1/03 through 4/9/03. b. On 1/22/03, resident 106 was ordered Prevacid 30 mg by mouth once a day for 60 days. Resident 106 should have received the Prevacid until 3/23/03. On 4/10/03, a review of resident 106's March 2003 and April 2003 MAR's was completed. It was documented that resident 106 received 30 mg of Prevacid from 3/24/03 to 3/31/03 and from 4/1/03 to 4/4/03, 12 days longer than ordered. c. On 1/22/03, resident 106 was ordered FE-SO4 (an iron supplement) 325 mg by mouth three times a day. It was ordered that it be held for two weeks until 2/6/03.	F 426	F 426 E **Corrective action for identified residents** Resident # 106 has had her May MAR (medication administration record) cross checked with her physician recertification orders for May for accuracy Resident # 42's blood sugar checks and administration of insulin are being documented in the MAR even when resident is self testing his blood sugar levels and self administering his ordered insulin. The following residents are having their antidepressant medications given as ordered and documented in the MAR: resident # 106, 105,83,82,80,8,72,75,77,81,84,85,96,97,99,100,103,104,107,108,110, 111 and 112. Resident # 84, a hospice patient, expired on April 11, 2003. **Identification of residents potentially affected** All residents have the potential to be affected.	

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F 426	Continued From page 81 On 4/10/03, a review of resident resident 106's February 2003 MAR was completed. It was documented that resident 106 received 325 mg of FE-SO4 three times a day from 2/1/03 to 2/5/03. 2. Resident 42 was admitted to the facility on 2/3/03 with diagnoses which included diabetes mellitus, peripheral vascular disease and hypertension. A review of resident 42's medical record was completed on 4/9/03 and 4/10/03. A review of the physician re-certification orders for April 2003 documented,"Pt [patient] may test own sugars [and]administer insulin, supplies must be kept in a locked box, make sure all sugars [and] insulin are recorded in MAR [medication administration record] even when pt [patient] is testing". Resident 42's blood sugar level was to be checked 4 times a day before meals and before bed. There was a physician order, dated 2/3/03 for sliding scale insulin to be administered when resident 42's blood sugars were elevated. A review of resident 42's "Patient Diabetic Record" for February 2003 was completed on 4/9/03. The following was documented: At breakfast there were 8 of 25 days where no blood sugar levels were recorded. There were 22 of 25 days were the amount of sliding scale insulin administered was not documented. At lunch there were 21 of 25 days where no blood sugar levels were recorded. There were 24 of 25 days were the amount of sliding scale insulin administered was not documented.	F 426	**Measures to prevent recurrence** The Director of Nursing or designee will inservice the licensed nurses by May 17, 2003 on 1. Documentation of blood sugar checks and administration of insulin in the MAR even when checked and administered by the resident. 2. Procedure for documenting on the MAR to indicate when medications are to be held. 3. Procedure for documenting on the MAR the date when medications, that are ordered with a specific discontinuation date, are to be discontinued. 4. Procedure for accurately documenting antidepressants. 5. The importance of questioning, checking physician's orders and following-up when there is a pattern of a certain category of medication not on the MAR for many residents when it was there the day before.	

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F 426	Continued From page 82 At dinner there were 22 of 25 days where no blood sugar levels were recorded. There were 23 of 25 days were the amount of sliding scale insulin administered was not documented. Before bed there were 25 of 25 days where no blood sugar levels were recorded. There were 25 of 25 days were the amount of sliding scale insulin administered was not documented. A review of resident 42's "Patient Diabetic Record" for March 2003 was completed on 4/9/03. The following was documented: At breakfast there were 31 of 31 days where no blood sugar levels were recorded. There were 31 of 31 days were the amount of sliding scale insulin administered was not documented. At lunch there were 31 of 31 days where no blood sugar levels were recorded. There were 31 of 31 days were the amount of sliding scale insulin administered was not documented. At dinner there were 31 of 31 days where no blood sugar levels were recorded. There were 31 of 31 days were the amount of sliding scale insulin administered was not documented. Before bed there were 31 of 31 days where no blood sugar levels were recorded. There were 31 of 31 days were the amount of sliding scale insulin administered was not documented. A review of resident 42's "Patient Diabetic Record" for April 2003, from 4/1/03 to 4/7/03, was completed on 4/9/03. The following was documented:	F 426	**Monitoring/Quality assurance** The Director of Nursing or designee will develop an audit tool by May 16, 2003. This tool will monitor compliance with: 1. Documentation of blood sugar checks and administration of insulin in the MAR when self checked and administered by the resident. 2. Proper documentation on MAR to indicate when medications are to be held. 3. Proper documentation on the MAR of discontinuation date for medications ordered with a specific discontinuation date. 4. Proper documentation of antidepressants. The Director of Nursing or designee will do weekly audits for four weeks and then report to the Performance Improvement Committee (Quality Assurance). The Committee will then determine if there is a need for further audits and reports. The Director of Nursing will be responsible for continued compliance. Completion date: May 28, 2003.	

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F 426	Continued From page 83 At breakfast there were 7of 7 days were the amount of sliding scale insulin administered was not documented. At lunch there were 7 of 7 days were the amount of sliding scale insulin administered was not documented. At dinner there were 7 of 7 days were the amount of sliding scale insulin administered was not documented. Before bed there were 7 of 7 days were the amount of sliding scale insulin administered was not documented. A review of the physician telephone orders was completed on 4/10/03. On 2/5/03, resident 42's physician wrote the following order, "Please make sure all blood sugars [and] Humalog [insulin] given are recorded in MAR (medication administration record) even if patient is testing [and] administering". On 4/7/03, resident 42's physician wrote the following order, "Please record sugars in MAR (medication administration record) even if patient does his testing-this was already ordered 2/5 [2002]". On 4/7/03, resident 42's physician completed a progress note. Regarding resident 42's diabetes mellitus she documented, "[resident 42] checks his own sugars. Nurses are still not recording sugars. Will re-write order." On 4/15/03 at 8:35 AM, resident 42's physician was interviewed. She stated that the facility nurses had not been documenting resident 42's blood sugars or how much sliding scale insulin was being administered. She stated that the nurses should have been documenting this information. She further stated that she had recently re-written the order for resident 42's	F 426		

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F 426	Continued From page 84 blood sugars and insulin administration to be recorded because it was not being done. 3. Resident 80 was originally admitted to the facility on 9/12/02, with the diagnoses of poor circulation, hypertension, hypothyroidism, radial fracture, tibial fracture, asthma, constipation and depression. Review of resident 80's medical record revealed the following: On 12/18/02, resident 80 was placed on Paxil 20 mg, once a day for depression, by her physician. On 4/10/03, a review of her April 2003 MAR (medication administration record), provided no documented evidence that resident 80 had received her Paxil, as ordered, from 4/1/03 through 4/6/03. 4. Resident 82 was admitted to the facility on 8/13/02 with the diagnoses of stroke, constipation, osteoarthritis, right knee deformity, incontinence, debilitation and moderate depression. Review of resident 82's medical record revealed the following: On 3/12/03, resident 82 was placed on Celexa 30 mg, once a day for dementia with depressive features, by her physician. On 4/10/03, a review of her April 2003 MAR, provided no documented evidence that resident 82 received her Celexa, as ordered, from 4/1/03 through 4/6/03. 5. Resident 83 was originally admitted to the facility on 5/9/00 with the diagnoses of cerebrovascular dementia with depressive features, deep vein thrombosis, recurrent pneumonia with severe hypoxia,	F 426		

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F 426	Continued From page 85 osteoporosis, B12 deficiency, atrial fibrillation, congestive heart failure, neuromuscular dysphagia, recurrent urinary tract infections and a history of urosepsis. Review of resident 83's medical record revealed the following: On 2/13/03, resident 83 was placed on Remeron, 30 mg, at hour of sleep for dementia with depressive features, by her physician. On 4/10/03, a review of her April 2003 MAR, provided no documented evidence that resident 83 had received her Remeron, as ordered, from 4/1/03 through 4/6/03. 6. Resident 105 was an 84 year old female, who was admitted to the facility on 9/04/02 with the diagnoses of Dementia, Congestive heart failure, hypertension, gastroesophageal regurgitation disease and depression. Review of resident 105's medical record was completed on 4/9/03. A review of the physician re-certification orders documented the following: a. On 11/25/01, resident 105 was placed on Prozac, 30 mg a day, for depression. On 4/09/03, a review of her April 2003 MAR, provided no documented evidence that resident 105 had received her Prozac, as ordered, from 4/1/03 through 4/9/03. 7. Supplemental residents: On 4/08/03, during a medication pass observation, it was observed that residents on a psychotropic medication did not have documentation as receiving it	F 426		

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F 426	Continued From page 86 for the month of April, 2003. An interview with the facility licensed practical nurse was conducted at this time of 7:45 AM. The facility LPN stated that the previous nurses must have forgotten to place new medication sheets in the MAR (Medication Administration Record). When asked how she knew whether or not the medication was administered, she replied, "I just know, they would not just NOT give it". The following supplemental resident MAR's were reviewed and revealed the following: a. On 2/14/03, resident 8 was placed on Seroquel 100 mg every evening, for dementia with anxiety and confusion. On 4/09/03, a review of her April 2003 MAR, provided no documented evidence that resident 8 had received her Seroquel, as ordered, from 4/1/03 through 4/9/03. b. On 10/15/02, resident 72 was placed on Celexa 60 mg a day, for dementia with compulsive and repetitive behaviors. On 3/12/03, resident 72 was placed on Paxil 30 mg a day. On 4/09/03, a review of her April 2003 MAR, provided no documented evidence that resident 72 had received her Celexa and Paxil, as ordered, from 4/1/03 through 4/08/03. c. On 2/26/03, resident 75 was placed on Effexor 150 mg every AM and 225 mg every night for Schizo-Affective Disorder. On 4/09/03, a review of her April 2003 MAR,	F 426		

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F 426	Continued From page 87 provided no documented evidence that resident 75 had received her Effexor, as ordered, from 4/1/03 through 4/07/03. d. On 5/21/01, resident 77 was placed on Prozac 20 mg every day, for depression. On 4/09/03, a review of her April 2003 MAR, provided no documented evidence that resident 77 had received her Prozac, as ordered, from 4/1/03 through 4/07/03. e. On 4/02/03, resident 81 was placed on Paxil 40 mg every day, for dementia with depressive features. On 4/09/03, a review of her April 2003 MAR, provided no documented evidence that resident 81 had received her Paxil, as ordered from 4/03/03 through 4/08/03. f. On 1/17/03, resident 84 was placed on Lexapro 10 mg every day, for depression. On 4/09/03, a review of her April 2003 MAR, provided no documented evidence that resident 84 had received her Lexapro, as ordered from 4/01/03 through 4/09/03. g. On 9/11/02, resident 85 was placed on Celexa 40 mg every day, for Alzheimers with depressive features. On 3/15/02, resident 85 was placed on Trazodone 100 mg every night, for Alzheimers with depressive features. On 4/09/03, a review of her April 2003 MAR, provided no documented evidence that resident 85 had received her Celexa, as ordered from 4/01/03 through 4/06/03. On 4/09/03, a review of her April 2003 MAR,	F 426		

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F 426	Continued From page 88 provided no documented evidence that resident 85 had received her Trazodone, as ordered from 4/01/03 through 4/09/03. h. On 2/12/03, resident 96 was placed on Paxil 20 mg and Remeron 15 mg every evening, for dementia with depressive features. On 4/09/03, a review of his April 2003 MAR, provided no documented evidence that resident 96 had received his Paxil or Remeron, as ordered from 4/01/03 through 4/09/03. i. On 4/25/02, resident 97 was placed on Celexa 20 mg every day, for dementia with depressive features. On 4/09/03, a review of his April 2003 MAR, provided no documented evidence that resident 97 had received his Celexa, as ordered from 4/01/03 through 4/08/03. j. On 1/20/03, resident 99 was placed on Trazodone 100 mg every evening as needed, for dysthymia. On 4/09/03, a review of his April 2003 MAR, provided no documented evidence that resident 99 had received his Trazodone, as ordered from 4/01/03 through 4/09/03. k. On 1/25/01, resident 100 was placed on Celexa 30 mg every day, for cerebral vascular accident with depressive features. On 4/09/03, a review of his April 2003 MAR, provided no documented evidence that resident 100 had received his Celexa, as ordered from 4/01/03 through 4/09/03. l. On 1/16/03, resident 103 was placed on Remeron	F 426		

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F 426	Continued From page 89 30 mg every evening, for depression and appetite stimulant. On 4/09/03, a review of her April 2003 MAR, provided no documented evidence that resident 103 had received her Remeron, as ordered from 4/01/03 through 4/09/03. m. On 9/26/02, resident 104 was placed on Celexa 20 mg every morning, for depression related to End Stage Renal Disease. On 4/09/03, a review of her April 2003 MAR, provided no documented evidence that resident 104 had received her Celexa, as ordered from 4/01/03 through 4/08/03. n. On 2/26/03, resident 107 was placed on Effexor XR 75 mg every morning and evening, for Bipolar Disorder. On 4/09/03, a review of her April 2003 MAR, provided no documented evidence that resident 107 had received her Effexor, as ordered from 4/01/03 through 4/09/03. o. On 1/29/03, resident 108 was placed on Paxil 20 mg every day, for dementia with depressive and anxious features. On 4/09/03, a review of her April 2003 MAR, provided no documented evidence that resident 108 had received her Paxil, as ordered from 4/01/03 through 4/09/03. p. On 8/20/01, resident 110 was placed on Remeron 30 mg every evening, for dementia with depressive features.	F 426		

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(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 426	Continued From page 90 On 4/09/03, a review of his April 2003 MAR, provided no documented evidence that resident 110 had received his Remeron, as ordered from 4/01/03 through 4/06/03. q. On 8/24/02, resident 111 was placed on Remeron 45 mg every evening, for cerebral vascular accident with depressive features. On 4/09/03, a review of his April 2003 MAR, provided no documented evidence that resident 111 had received his Remeron, as ordered from 4/01/03 through 4/09/03. r. Resident 112 was placed on Celexa 40 mg every day on 10/25/02 and Trazodone 100 mg every evening on 3/17/03 for depression. On 4/09/03, a review of his April 2003 MAR, provided no documented evidence that resident 112 had received his Celexa or Trazodone, as ordered from 4/01/03 through 4/09/03. s. On 4/10/03 at 8:00 AM, a medication pass with facility LPN 1 was observed by a registered nurse surveyor. Resident 108 had an order for "Paxil 20 mg every day" and was observed not to receive the medication. The facility LPN stated that there was no where to document the medication as given. The facility LPN stated that she did not know if resident 108 had received her medication since April 1, 2003. The nurse surveyor observed the MAR for resident 108 at 2:00 PM and there was no evidence of documentation that resident 108 received her Paxil as ordered.	F 426		

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	465055	A. BUILDING _____ B. WING _____	4/10/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEDERAL HEIGHTS REHABILITATION AND N	41 SOUTH 900 EAST SALT LAKE CITY, UT 84102

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F 432	Continued From page 91	F 432	F 432 E	
F 432 SS=E	483.60(e) PHARMACY SERVICES In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This Requirement is not met as evidenced by: Based on observation and interview it was determined that the facility did not consistently kept medications and biologicals in locked compartments. Specifically, observations were made on 4/7/03 and 4/8/03 of resident medications unsecured on top of nurse medication carts with no nursing staff present and on 4/8/03 a nurse was observed to leave the medication keys on top of an unlocked medication cart, and leave the cart unattended for approximately 30 seconds. Findings include: 1. On 4/7/03 at 8:37 AM, a bubble pack containing 24 iron capsules was observed lying on top of one of the medication (med) carts for the 100 halls. On the other 100 hall med cart, there was an unsecured Albuterol inhaler. The nurse was in the dining room administering medications to a resident. At 8:38 AM, the nurse was paged to the phone at the nurse's desk and was observed not watching the med carts. At 9:13 AM, both med carts were parked at the nurse's station	F 432	**Corrective actions for identified residents** No residents were identified. **Identification of residents potentially affected** All residents are potentially affected. **Measures to prevent recurrence** The Director of Nursing or designee will inservice the licensed nurses by May 16, 2003 on the regulation that all drugs and biologicals must be stored in locked compartments. **Monitoring/ Quality Assurance** The Director of Nursing or designee will develop and audit tool by May 18, 2003. The Director of Nursing or designee will do weekly audits for four weeks and then report compliance to the Performance Improvement committee (Quality Assurance). The Committee will then determine if further audits and reports are needed. The Director of Nursing will be responsible for continued compliance. Completion date: May 28, 2003	5/28/03

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F 432	Continued From page 92 on the 100 hall. The iron capsules and the Albuterol inhaler were still lying on top of the cart. The nurse was not present at the nurse's station and a resident was observed walking in the hallway. 2. On 4/8/03 at 6:25 AM and 6:53 AM, 6 bubble packs of medications, which contained 8 Terazosin capsules, 31 Clonidine capsules, 14 Lisonopril tablets, 45 Dilantin capsules, 30 folic acid tablets and 14 Prevacid capsules were observed lying unsecured on top of a med cart on the 100 hall. No nurse was observed at the med cart nor was a nurse observed in the hallway. The certified nurse aide standing at the nurse's desk on the 100 hall was asked if he knew where the nurse was. The aide stated that the nurse was on the Medicare hall, which was on the other side of the building. There was a resident with the psychiatric diagnosis of schizophrenia walking in the hallway. 3. On 4/8/03 at 1:32 PM, a Nicoderm patch was observed lying at the end of the nurse's desk right by the entry way and it was not secured. There was no nurse present in the area and there were 2 residents in the hallway.	F 432		
F 460 SS=E	483.70(c)(1)(iv&v) PHYSICAL ENVIRONMENT Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.	F 460	F 460 E **Corrective action for identified concerns** Room 218 has a privacy curtain that was re-installed on April 9, 2003. The window blinds will repaired by May 28, 2003 in the following rooms; 102, 103, 104, 105, 106, 109, 112, 117, 119, 120, 122, 129, 130, 137, 139, 140, 141,146, 148, 150, 201, 202, 203,106, 207, 209, 211, 212 and 222.	5/28/03

OK 5/28/03 JB

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F 460	Continued From page 93 This Requirement is not met as evidenced by: Based on observation the facility did not have a resident room equipped to assure full visual privacy for each resident with curtains suspended from the ceiling which extended around the bed to provide total visual privacy in combination with adjacent walls and curtain. In addition, the facility did not have resident rooms equipped with window blinds that ensured full visual privacy for each resident. Findings include: Room 218. There was no privacy curtain in the center, dividing the two beds. Which allowed full visualization between the first and second bed. Room 102. The window blinds were missing 3 slats. Room 103. The window blinds were missing 2 slats. There was a towel hung up over the blinds that were missing. Room 104. The window blinds were missing 5 slats. Room 105. The window blinds were missing 3 slats. Room 106. The window blinds were missing 1 slat. Room 109. The window blinds were missing 1 slat. Room 112. The window blinds were missing 1 slat. Room 117. The window blinds were tied back. Room 119. The window blinds would not open or close. Room 120. The window blinds would not close.	F 460	**Residents potentially affected** All residents have the potential tom be affected. **Measures to prevent recurrence** The Housekeeping Supervisor will be inserviced by the Administrator or designee by May 12, 2003 on: 1. ensuring that every resident that is not in a private room has a privacy curtain 2. ensuring that the curtains are clean and in good repair. The Maintenance Supervisor will be inserviced by the Administrator or designee on putting the checking of the blinds for missing slats on weekly rounds and on timely repair of blinds found to have missing slats or to not be in working order. **Monitoring/Quality Assurance** The Maintenance Supervisor or designee will develop and audit tool by May 14, 2003. This tool will monitor compliance with having the facility blinds with complete slats and with having blinds in working order. The Maintenance Supervisor or designee will do weekly audits for three weeks and then report compliance to the Performance Improvement Committee (Quality Assurance. Audits and reports will then continue as determined by the Committee.	

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F 460	Continued From page 94 Room 122. The window blinds were missing 6 slats. Room 129. The window blinds were missing 2 slats. Room 130. The window blinds were missing 2 slats. Room 137. The window blinds were missing 1 slat. Room 139. The window blinds were missing 1 slat. Room 140. The window blinds were missing 3 slats. Room 141. The window blinds were missing 1 slat. Room 146. The window blinds were missing 1 slat. Room 148. The window blinds were missing 1 slat. Room 150. The window blinds were missing 1 slat. Room 201. The window blinds were missing 3 slats. Room 202. The window blinds were missing 4 slats. Room 203. The window blinds were missing 4 slats. Room 206. The window blinds were tied back. Room 207. The window blinds were missing 3 slats. Room 209. The window blinds were missing 1 slat. Room 211. The window blinds were missing 3 slats. One side of the window blinds were tied back. Room 212. The window blinds were missing 2 slats. Room 222. The window blinds were missing 2 slats.	F 460	The Housekeeping Supervisor or designee will develop an audit tool by May 14, 2003. This tool will monitor compliance with having a privacy curtain for every resident who is not in a private room. The Housekeeping Supervisor or designee will do weekly audits for three weeks and then report to the Performance Improvement Committee (Quality Assurance). Audits and reports will then continue was may be determined by the Committee. The Maintenance Supervisor will be responsible for continued compliance with working blinds without missing slats. The housekeeping Supervisor will be responsible for continued compliance with the provisions of privacy curtains. Compliance date; May 28, 2003	

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F 460	Continued From page 95 In an interview with a resident on 4/8/03, he stated that at night the lights from the vehicles can be bothersome because he is not able to close his window blinds.	F 460		
F 490 SS=H	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This Requirement is not met as evidenced by: Based on observation, interviews, medical record review and facility policy and procedures during the annual survey from 4/7/03 through 4/10/03, it was determined that the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to ensure that residents were provided the opportunity to attain or maintain their highest practicable physical, mental and psychosocial well-being. Specifically, the facility did not ensure that each resident with unplanned weight loss, pressure ulcers and or low albumin (protein) levels were addressed with appropriate nutritional assessments and or interventions. Findings include: On April 10, 2003, a Standard Extended survey was completed which resulted in the determination of Sub-Standard Quality of Care. The determination of Sub-Standard Quality of Care was based on the lack of dietary assessment and intervention for 6 residents who either had unplanned weight loss, pressure ulcers and or laboratory values reflecting malnutrition as well as 3 residents who did not receive therapeutic diet to	F 490 OK 5/28/03 AD	F 490 H For **Corrective actions for identified residents** and for **Identification of residents potentially affected** and for **Measures to prevent recurrence**: Refer to F 325 H; F326 H; F157 G; F241 E; F253 C; F257 B; F279 D; F309 G; F310 G; F371 E; F372 D; F426 E; F432 E; F460 E; F496 E; F502 E; and F514 F	5/28/03

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F 490	Continued From page 96 meet their nutritional needs. [42 Code of Federal regulations (CFR) 483.25 (i) Tag F - 325 and F - 326]. 1. Facility administration failed to ensure that residents maintained parameters of nutritional status. (Refer to F - 325, Scope and Severity "H"). 2. Facility administration failed to ensure that residents received a therapeutic diet when there was a nutritional problem. (Refer to F - 326, Scope and Severity "H"). a. Nutritional Assessment and Intervention: Please refer to F- 325 and F326. A pattern of actual harm was identified for 6 residents (54, 64, 84, 101, 106 and 109) who experienced either significant unplanned weight loss, pressure ulcers and or laboratory values which reflected nutritional deficits and did not receive adequate nutritional assessment or intervention. In addition, a pattern of actual harm was identified for 3 residents (54, 64 and 101) who did not receive therapeutic diets to meet their nutritional needs. Resident 54 developed a pressure sore on 2/12/03, which continued to increase in size. A review of resident 54's medical record dietary notes revealed that no dietary assessment addressing the pressure ulcer had been completed for resident 54. There was no documented evidence that the dietitian identified that resident 54's average meal intake was not meeting her caloric and protein needs that were assessed on 2/3/03, prior to resident 54's development of the pressure sore on 2/12/03. There was no documented evidence that the dietitian implemented appropriate nutritional interventions to increase calorie and protein needs for resident 54 after she developed a pressure ulcer. There was no documented evidence that the facility	F 490	**Monitoring/Quality Assurance** The Administrator will be responsible for continued compliance along with the designated position identified in each F tag plan of correction for the above tags cited. As chairperson of the facility's Performance Improvement Committee (Quality Assurance), the Administrator will continue to facilitate the facility staff in making the indicated changes and in monitoring for continued compliance. Completion date: May 28, 2003	

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F 490	Continued From page 97 provided resident 54 with a therapeutic diet to promote wound healing. Resident 64 was admitted to the facility receiving all of her nutritional needs via gastrostomy tube. In addition, resident 64 was admitted to the facility with a stage II pressure ulcer and a severe visceral protein depletion with an albumin level of 1.9 g/dl. From her admission on 12/2/02 until 12/30/02, resident 64 was not receiving a therapeutic diet which provided adequate protein to meet her estimated need of 71 grams per day, as calculated by the dietitian on 12/4/02. During that time resident 64's pressure ulcer increased in size from a stage II to a stage III. From 12/30/02 until 1/22/03, the dietitian calculated resident 64's protein requirements using a lower protein requirement than the facility "Enteral Feeding Worksheet" guidelines. Thus, the dietitian made dietary recommendations which provided less protein than what resident 64 should have received per the facility's guidelines. During this time resident 64's pressure sore grew in size and depth from a stage III measuring 3 cm x 4 cm to a stage III measuring 3.3 cm x 1.6 cm with a depth of 0.3 cm per the facility's pressure sore documentation. There was no documented evidence that the facility provided resident 64 with a therapeutic diet to promote wound healing and provide adequate protein to meet resident 64's estimated needs. Resident 84 was readmitted to the facility on 11/14/02 with a right hip incision. A review of resident 84's medical record dietary notes revealed that no full dietary assessment addressing the right hip incision, caloric or protein needs had been completed for resident 84. On 11/21/02, resident 84 developed a pressure ulcer on her right heel. The dietitian did not address the pressure ulcer on the right heel until 18 days after it had developed. The dietitian did not	F 490		

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F 490	Continued From page 98 complete a full nutritional assessment, which would have calculated resident 84's caloric and protein requirements to assess whether the diet provided was adequate to meet her nutritional needs and promote wound healing of the incision and pressure ulcer. The dietitian did not make any dietary changes for resident 84 until 12/19/02, 28 days after the pressure ulcer had developed, at which time the dietitian added the house supplement three times a day. However, the dietitian did not complete a full nutritional assessment to assess whether the diet provided and the house supplement was adequate to meet resident 84's nutritional needs and promote wound healing of the incision and pressure ulcer. On 1/8/03, resident 84's pressure ulcer had increased from a stage II to a stage III-IV. Again, the dietitian had still not completed a full nutritional assessment to assess whether the diet and house supplement were adequate to meet resident 84's nutritional needs and promote wound healing of the incision and stage III-IV pressure ulcer. Resident 101 experienced a 13.6% unplanned weight loss from 7/19/02 th February, 2003 and a 9% unplanned weight loss from November, 2002 to February 2003. On 10/16/02 the dietitian documented that resident 101 was nutritionally stable even though he was 81% of his ideal body weight (which is considered a moderate state of malnutritio), the dietitian did not document any dietary interventions be implemented. On 11/25/02, the dietitian documented that resident 101 requested double portions due to weight loss. It was not until 1/20/03 (51 days later) that resident 101's diet was changed. On 1/20/03, the dietitian documented that resident 101 was nutritionally stable at 110 pounds, 73.8% of his ideal body weight (which is considered a severe state of malnutrition), the dietitian did not document any dietary interventions be implemented. A lab value taken at the facility and dated 2/21/03, showed an	F 490		

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F 490	Continued From page 99 albumin of 3.1, which is a mild visceral protein depletion and an indication of malnutrition. The dietitian did not addressed the low albumin until 4/8/03, at which time she did not make any dietary intervention to increase resident 101's protein requirements, even though his albumin reflected a mild visceral protein depletion. Upon interview with resident 101, on 4/7/03, he stated that he had not received a double portion diet since his request to receive one 3-4 months prior. Observation on 4/7/03 and 4/8/03 provided evidence that resident 101 was not receiving a therapeutic diet with double portions. Resident 106 experienced a 6.6% unplanned weight loss from November 2002 to December 2002, a 7.6% unplanned weight loss from January 2003 to February 2003, a 9.9% unplanned weight loss from November 2002 to February 2003 and an 8.4% unplanned weight loss from January 2003 and April 2003. A review of resident 106's medical record dietary notes revealed no dietary assessment which calculated nutritional requirements, including caloric and protein needs after she had experienced a significant weight loss. There was no documentation to provide evidence that the dietitian had assessed whether the enriched diet and Mighty shakes provided were adequate to meet resident 84's nutritional needs and promote weight gain. Interview with the resident, resident family member and staff, as well as, observation determined that resident 106 was not offered her meal trays and only consumed 2 containers of pudding at each meal. There was no documented evidence that the dietitian was aware that resident 106 only consumed 2 containers of pudding at each meal until 3/18/03, at which time the dietitian failed to assess the caloric and protein content of the pudding to determine it's nutritional adequacy. There was no documented evidence that the dietitian identified the fact that resident 106 drank 100% of the Med Pass 2.0	F 490		

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F 490	Continued From page 100 supplement four times a day and would perhaps drink more, if offered. There was no documented evidence that the dietitian had determined if the Med Pass 2.0 supplement was adequate to meet resident 106's nutritional needs. The dietitian did not calculate resident 106's fluid, caloric and protein requirements, based on the significant weight loss, which had been occurring since February 2003. Without an estimated calculation of fluid requirements, caloric requirements and protein requirements it would not be possible for the facility staff to know whether or not the pudding and 2.0 Med Pass supplement would meet the needs of this resident. Resident 109 experienced an 8% unplanned weight loss from December 2002 to January 2003 and a 12.8% unplanned weight loss from December 2002 to March 2003. A lab value taken on 12/16/02, three days prior to re-admission to the facility showed an albumin of 3.1, which is a mild visceral protein depletion. Resident 109 was re-admitted back to the facility after hip surgery. A review of resident 109's medical record dietary notes revealed incomplete dietary assessments due to incomplete information such as, a height for resident 109, therefore resident 109's caloric, protein or fluid needs were not calculated by the dietitian. Without an estimated calculation of caloric, protein or fluid requirements it would not be possible for the facility staff to know whether or not the dietary interventions were adequate to meet resident 109's needs to promote weight gain, protein improvement and wound healing. 3. In addition to the areas of Sub -Standard Quality of care stated above, the facility's administrator failed to effectively and efficiently use its resources to ensure that each resident attained or maintained their highest practicable physical, mental and psychosocial well-being in the following areas of deficient practice	F 490		

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F 490	Continued From page 101 cited during the survey completed 4/10/03. a. Facility administration failed to ensure that the physician was immediately notified regarding a change in a resident's condition which required the plan of care to be altered. This was cited at an actual harm level. (Refer to F-157, Scope and Severity "G"). b. Facility administration failed to ensure each resident was treated with dignity and respect. (Refer to F-241, Scope and Severity "E"). c. Facility administration failed to ensure that maintenance of the building was kept up. (Refer to F-253, Scope and Severity "C"). d. Facility administration failed to maintain a comfortable temperature in the building. (Refer to F-257, Scope and Severity "B"). e. Facility administration failed to ensure that the plan of care reflected each individual resident. (Refer to F-279, Scope and Severity "D"). f. Facility administration failed to ensure that each resident was provided the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being. This was cited at an actual harm. (Refer to F-309, Scope and Severity "G"). g. Facility administration failed to enure a residents activities of daily living did not diminish. This was cited at an actual harm. (Refer to F-310, Scope and Severity "G"). h. Facility administration failed to ensure that food was stored, prepared and distributed under sanitary conditions. (Refer to F-371, Scope and Severity "E").	F 490		

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(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 490	Continued From page 102 i. Facility administration failed to dispose of garbage and refuse properly. (Refer to F-372, Scope and Severity "D"). j. Facility administration failed to ensure that medications were accurately administered. (Refer to F-426, Scope and Severity "E"). k. Facility administration failed to ensure medications were accurately stored. (Refer to F-432, Scope and Severity "E"). l. Facility administration failed to ensure that resident rooms were equipped to ensure full visual privacy. (Refer to F-460, Scope and Severity "E"). m. Facility administration failed to ensure that the State Nurse Aide Registry was called prior to hiring nurse aides. (Refer to F-496, Scope and Severity "E"). n. Facility administration failed to ensure that laboratory services were met for a resident. (Refer to F-502, Scope and Severity "D"). o. Facility administration failed to ensure that medical records were accurately documented and systematically organized. (Refer to F-514, Scope and Severity "F").	F 490		
F 496 SS=E	483.75(e)(5)-(7) ADMINISTRATION Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or before allowing an	F 496		5/28/03

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F 496	Continued From page 103 individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This Requirement is not met as evidenced by: Based on interview and record review, it was determined the facility did not seek State registry verification from the local State registry and/or from every other State registry that the facility had reason to believe may have had information on the individual for 3 of 6 newly hired nurse aides before allowing the aides to provide direct care to residents. Nurse's aides E1, E2, E3. Findings include: On 4/10/03, the employee records were reviewed for 6 nurse's aides who had been hired between December 2002 and March 2003. Nurse's aide E1 had been working for the facility since 2/24/03. There was no documentation that the State registry had been called regarding E1. Nurse's aide E2 had been working for the facility since 3/27/03. There was no documentation that the State registry has been called regarding E2. On 4/8/03, E3 was observed providing direct care, feeding a	F 496 OK 5/21/03 AS	F 496 E **Corrective action for identified employees** Utah State registry verification was obtained for E-1, E-2 and E-3 on May 5 , 2003. Registry verification from the state where E-3 was previously employed was also obtained on May 5 , 2003. **Identification of residents potentially affected** All residents have the potential to be affected **Measures to prevent recurrence** The Staff Development Coordinator was inserviced on April 15, 2003 by the Director of Nursing on the regulation that before allowing an individual to serve as a nurse aide the facility must receive local state registry verification that the individual has met competency evaluation requirements. Verification from every other state registry, that the facility has reason to believe may have information on the individual, must also be sought.	

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F 496	Continued From page 104 dependent resident, with another orienting nurse's aide but with no supervision in the dining room. Nurse's aide E3 was hired by the facility to begin orientation on 4/7/03. There was no documentation that the State registry in the local area or the State registry in the state the employee had been previously working in, as a nurse's aide, had been called by the facility. On 4/8/03, E3 was observed providing direct care, feeding a dependent resident who had swallowing problems, with another orienting nurse's aide but no supervision in the dining room. On 4/10/03, the staff developer was interviewed. The staff developer stated that she was the one who did the hiring and screening of nurse's aides. The staff developer described the procedure used for prescreening nurse's aides including calling the State registry for certified nurse's aides. The staff developer stated that State registries had not been called for nurse's aides E1, E2 or E3. The staff developer stated she had not been aware of the requirement to contact State registries in other states that the facility had reason to believe might have information regarding the nurse's aide they were considering for hire. The staff developer further stated she had not been aware of the requirement to contact the local State registry for nurse's aides who had not claimed to have been certified.	F 496	**Monitoring/Quality Assurance** The Staff Development Coordinator or designee will develop an audit tool by May 16, 2003. This tool will monitor compliance with timely registry verification before allowing an individual to serve as a nurse aide in the facility. The Staff Development Coordinator or designee will do weekly audits for four weeks and then report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine if there is a need for further audits and reports. The Staff Development Coordinator will be responsible for continued compliance. Completion date: May 28, 2003 The Director of Nursing or designee will do weekly audits for four weeks and then report to the Performance Improvement Committee (Quality Assurance). The Committee will then determine if there is a need for any further audits and reports. The Director of Nursing will be responsible for continued compliance. Completion date: May 28, 2003	
F 502 SS=D	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:	F 502		5/17/03

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F 502	Continued From page 105 Based on medical record review and interview, it was determined that the facility failed to provide timely laboratory services and adequate monitoring of anticoagulation therapy for 1 of 23 sample residents. In addition, the facility did not obtain laboratory services to meet the needs of the resident. Coumadin is an oral anticoagulant used to control and prevent blood clotting disorders. Prescribing the dose that both avoids bleeding complications and achieves therapeutic range of clotting times requires monitoring through laboratory tests. The prothrombin time (PT) is a laboratory test used to monitor blood clotting in a specific individual. (Reference Guide: Brunner and Sarddarth's textbook of Medical-Surgical Nursing, 8th Edition, 1996 Lippincott, Pages 802-803.) The International Normalization Ratio (INR), another laboratory test, is used in conjunction with the PT in determining if therapeutic doses of anticoagulant are being administered. (Reference Guide: Physician's Desk Reference, 53 Edition, 1999 Medical Economics Company, Page 932.) Resident Identifier: 83 Findings include: 1. Resident 83 was originally admitted to the facility on 5/9/00 with the diagnoses of cerebrovascular dementia with depressive features, deep vein thrombosis, recurrent pneumonia with severe hypoxia, osteoporosis, B12 deficiency, atrial fibrillation, congestive heart failure, neuromuscular dysphagia, recurrent urinary tract infections and a history of urosepsis. On 1/30/03, the physician ordered a potassium to be drawn on 2/10/03 due to hypokalemia.	F 502 OK 5/21/03 NS	F 502 D **Corrective action for identified residents** Resident # 83's physician ordered a PT/INR (prothrombin time/international normalization ratio) for 4-21-03, 4-23-03, 4-24-03 and 4-28-03 This was done and the physician was timely notified of the results. Her physician chose to not order another potassium level. **Identification of residents potentially affected** Residents with ordered laboratory tests have the potential to be affected. **Measures to prevent recurrence** A system for tracking ordered laboratory tests was developed by a team of the Performance Improvement Committee (Quality Assurance) to track timely: 1. Ordering by the physician 2. Noting of the order by nursing 3. Requisitioning the lab by nursing 4. Drawing of the test by the lab 5. Notifying the facility nursing staff by the lab 6. Notifying the physician by the facility nursing staff 7. Placing the test into the resident's chart 8. Following through with any ordered interventions.	

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F 502	Continued From page 106 No laboratory results for the potassium could be found for resident 83. On 3/17/03, a physician order documented, "...PT/INR on Mon- Thurs [times] 3 wks (weeks) DVT (deep vein thrombosis) [right] leg...". The only PT/INR laboratory result found in resident 83's medical record during that three week period was dated 3/23/03. No laboratory results for PT/INR could be found for the dates 3/24/03, 3/27/03, 3/31/03, 4/3/03 and 4/7/03. On 3/10/03 at 6:30 PM, the DON (director of nurses) was interviewed. She stated that she knew some of the PT/INR results were missing. She further stated that she thought the potassium for 2/10/03 was completed but when she called the lab they were unable to locate the results.	F 502	The licensed nurses will be inserviced by May 17, 2003 by the Director of Nursing or designee on this system. **Monitoring/Quality Assurance** The Director of Nursing or designee will develop and audit tool by May 16, 2003 to monitor compliance with the system as outlined above.	
F 514 SS=F	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 record review and facility staff interviews, it was determined that the facility did not ensure that residents clinical records were complete and documentation was accurate for 16 of 23 sample residents. Resident identifiers: 14, 54, 64, 74, 76, 80, 82, 83, 84, 86, 88, 92, 101, 105, 106 and 109.	F 514 OK 5/21/03 DD	F 514 F **Corrective action for identified residents** Resident # 84, a hospice patient, expired on April 11, 2003. The percent of meal consumption is being documented for Resident # 106, 64, 101, 105, 54 and 109. Residents # 106, 64, 74, 101, 105, 109 and 83 are being offered HS (bedtime) snacks. The offerings are then being documented.	5/28/03

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F 514	Continued From page 107 Findings include: 1. Resident 106 was admitted to the facility on 8/9/01 with diagnoses, which included diabetes mellitus, rectal prolapse, chronic obstructive pulmonary disease, depression and hypothyroidism. A review of resident 106's medical record was completed on 4/9/03. a. Meal Percentage Documentation Resident 106's December 2002 "Flow Sheet Record" documented that the facility staff had not recorded meal intake percentages for 13 of 93 meals. Resident 106's January 2003 "Flow Sheet Record" documented that the facility staff had not recorded meal intake percentages for 20 of 93 meals. Resident 106's February 2003 "Flow Sheet Record" documented that the facility staff had not recorded meal intake percentages for 14 of 84 meals. Resident 106's March 2003 "Flow Sheet Record" documented that the facility staff had not recorded meal intake percentages for 12 of 93 meals. b. Offer of Bed Time (HS) Snack Documentation Resident 106's December 2002, January 2003, February 2003 and March 2003 had no documented evidence that an HS snack had been offered on any day during these 4 months. c. Supplement Documentation Resident 106's "Medication Record" for April 2003	F 514	The facility is providing and documenting the following care areas for Resident # 54: 1. correct weight 2. correct pressure sore measurements 3. percent of meal consumption The facility is providing and documenting the following care areas for Resident # 83: 1. vital signs as ordered 2. oxygen liter flow as ordered 3. potential for urinary tract infections 4. offering of HS (bedtime) snacks The facility is providing and documenting the following care areas for Resident #64: 1. tube feeding water flush 2. feeding tube placement checks 3. indwelling urinary catheter care 4. indwelling urinary catheter to down drain output 5. right upper extremity sling/swath checks 6. pressure sore treatment 7. percent of meal consumption 8. offering of HS (bedtime) snacks 9. correct height.	

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F 514	Continued From page 108 was reviewed. Nursing staff documented that resident 106 received a Might Shake nutritional supplement for the lunch and supper meals on 4/9/03 and the breakfast meal on 4/10/03. Observation of resident 106's lunch and supper trays on 4/9/03 and her breakfast tray on 4/10/03 revealed that she was not sent a Mighty Shake nutritional supplement on those trays. 2. Resident 64 was re-admitted to the facility on 12/2/02 with diagnoses, which included status post hip, humerus and wrist fractures, dysphasia and congestive heart failure. Resident 64's medical record was reviewed on 4/7/03. a. Tube Feeding Water Flush Documentation Resident 64's "Medication Record" for February 2003 revealed that facility-nursing staff did not document water flushes had been given for 8 of 79 opportunities. b. Tube Feeding Placement Documentation Resident 64's "Medication Record" for February 2003 revealed that facility-nursing staff did not document that the feeding tube placement had been checked every 8 hours for 17 of 84 opportunities. Resident 64's "Medication Record" for March 2003 revealed that facility-nursing staff did not document that the feeding tube placement had been checked every 8 hours for 18 of 93 opportunities. c. Indwelling Catheter Care Resident 64's "Treatment Record" for January 2003 revealed that facility-nursing staff did not documented that catheter care had been provided for 26 of 62 opportunities.	F 514	The facility is providing and documenting the following care areas for Resident # 106: 1. percent of meal consumption 2. Offering of HS (bedtime) snacks 3. Supplements as ordered. The facility is providing and documenting the following care areas for Resident # 86: 1. tube feeding water flushes 2. bolus tube feeding administration 3. gastrostomy tube site treatment Accurate weights will be obtained and documented for Residents # 109, 80, 82, 74, 92, 88, 54 and 14. The facility's new Registered Dietitian (RD) Consultant will complete updated nutritional assessments by May 12, 2003 for Resident # 105 and 109. The Minimum Data Set (MDS) assessments for Residents # 76, 92, 88, 74, 80, and 82 will be reviewed by May 19, 2003 by the facility's Utilization Specialist, who is a registered nurse. Indicated interventions will be instituted to include correction and/or initiation of new assessments.	

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F 514	Continued From page 109 Resident 64's "Treatment Record" for February 2003 revealed that facility-nursing staff did not document that catheter care had been provided for 5 of 6 opportunities. d. Indwelling Catheter to Down Drain Output Documentation Resident 64's "Treatment Record" for January 2003 revealed that facility-nursing staff did not document catheter output for 93 of 93 opportunities. Resident 64's "Treatment Record" for February 2003 revealed that facility-nursing staff did not document catheter output for 7 of 9 opportunities. e. Right Upper Extremity Sling/Swath Check Documentation Resident 64's "Treatment Record" for January 2003 revealed that facility-nursing staff did not document checking the resident's right upper extremity sling and swath QID (four times a day), per the physician order, for 124 of 124 opportunities. Resident 64's "Treatment Record" for February 2003 revealed that facility-nursing staff did not document checking the resident's right upper extremity sling and swath QID (four times a day), per the physician order, for 112 of 112 opportunities. f. Pressure Sore Treatment Documentation Resident 64's "Treatment Record" for February 2003 revealed that facility-nursing staff did not document applying the physician ordered pressure sore treatment for 15 of 56 opportunities.	F 514	**Identification of residents potentially affected** All residents have the potential to be affected **Measures to prevent recurrence** The facility has secured the services of a replacement Registered Dietitian (RD) with 7 years of experience. This RD is reviewing each current resident's dietary assessment for accuracy of nutritional need and is making changes and recommendations for interventions as each case may indicate. This review will be completed by May 12, 2003. This RD is the facility's consulting RD and will be a member of the weight and wound committee. The Director of Nursing has replaced the Assistant Director of Nursing as the chairperson of the weight and wound committee. Other members of the committee include the Dietary Service Manager, and the wound nurse. Committee members will seek input from the direct care staff as may be indicated.	

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F 514	Continued From page 110 Resident 64's "Treatment Record" for March 2003 revealed that facility-nursing staff did not document applying the physician ordered pressure sore treatment for 14 of 62 opportunities. g. Meal Percentage Documentation Resident 64's January 2003 "Flow Sheet Record" documented that the facility staff had not recorded meal intake percentages for 22 of 87 meals. Resident 64's February 2003 "Flow Sheet Record" documented that the facility staff had not recorded meal intake percentages for 13 of 84 meals. Resident 64's March 2003 "Flow Sheet Record" documented that the facility staff had not recorded meal intake percentages for 12 of 93 meals. h. Offer of Bed Time (HS) Snack Documentation Resident 64's February 2003 "Flow Sheet Record" documented that the facility staff recorded that an HS snack was offered on 2/8/03 and 2/27/03. There was no documented evidence that HS snacks had been offered the other 26 days of the month. Resident 64's March 2003 "Flow Sheet Record" documented that the facility staff recorded that an HS snack was offered on 3/8/03, 3/9/03, 3/13/03, 3/16/03, 3/22/03, 3/23/03, 3/25/03 3/29/03 and 3/30/30. There was no documented evidence that HS snacks had been offered the other 22 days of the month. i. General Charting/ MDS Documentation On 12/4/03, facility dietitian completed an admission "Enteral Feeding Worksheet" form. On this form, resident 64's height was recorded at 5 feet 5 inches.	F 514	A project team selected by the Administrator has reviewed the facility's process and system for addressing weight and nutrition management. The team has developed a policy and procedure for obtaining accurate and timely weights and heights and for their accurate documentation. The Director of Nursing or designee will inservice by May 17, 2003 the licensed nurses and the weight and wound committee on the policy and procedure for obtaining and documenting weights and heights and on the tool for the weight and wound committee meetings. The facility has designated certain Certified Nursing Assistants as the team to obtain weights and heights. This team will be inserviced by the Staff Development Coordinator by May 9, 2003 on the proper technique for obtaining weights and heights and how to properly document.	

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F 514	Continued From page 111 On 12/13/02, facility staff completed an initial 5 day medicare MDS assessment. This MDS assessment documented resident 64's height was 5 feet. 3. Resident 86 was re-admitted to the facility on 1/23/02 with diagnoses, which included aspiration pneumonia, non-insulin dependent diabetes mellitus, dementia and hypothyroidism and received her nutrition via gastrostomy tube (G-tube). Resident 86's medical record was reviewed on 4/10/03. a. Tube Feeding Water Flush Documentation Resident 86's "Medication Record" for December 2002 revealed that facility-nursing staff did not document water flushes had been given QID per the physician order for 124 of 124 opportunities. Resident 86's "Medication Record" for January 2003 revealed that facility-nursing staff did not document water flushes had been given QID per the physician order for 124 of 124 opportunities. Resident 86's "Medication Record" for February 2003 revealed that facility-nursing staff did not document water flushes had been given QID per the physician order for 42 of 112 opportunities. Resident 86's "Medication Record" for March 2003 revealed that facility-nursing staff did not document water flushes had been given QID per the physician order for 29 of 124 opportunities. b. Bolus Tube Feeding Administration Documentation Resident 86's "Medication Record" for December 2002 revealed that facility-nursing staff did not	F 514	The nursing staff will be inserviced by the Director of Nursing to designee by May 18, 2003 on: 1. The importance of and the expectation that HS (bedtime) snacks will be offered daily, except where there may be a contraindication i.e. NPO (nothing by mouth) status. 2. The expectation that the offering of HS snacks will be documented daily 3. The importance of and the expectation that meal consumption percentages will be accurately documented for each meal daily 4. The expectation that accurate weights and heights will be obtained and documented 5. The expectation that urinary catheter output to down drains will be documented 6. The expectation that indwelling urinary catheter care will be documented. The Director of Nursing or designee will inservice the licensed nurses by May 18, 2003 on: 1. The expectation of complete and accurate documentation of enteral care to include tube feeding water flushes, tube placement checks, bolus feeding administration and gastrostomy tube site care.	

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F 514	Continued From page 112 document bolus tube feedings had been given TID (three times a day) per the physician order for 13 of 25 opportunities and BID (twice a day) per the physician order for 2 of 46 opportunities. Resident 86's "Medication Record" for January 2003 revealed that facility-nursing staff did not document bolus tube feedings had been given BID per the physician order for 7 of 62 opportunities. Resident 86's "Medication Record" for February 2003 revealed that facility-nursing staff did not document bolus tube feedings had been given BID per the physician order for 21 of 56 opportunities. Resident 86's "Medication Record" for March 2003 revealed that facility-nursing staff did not document bolus tube feedings had been given BID per the physician order for 38 of 62 opportunities. c. Gastrostomy Tube (G-tube) Site Treatment Documentation Resident 86's "Medication Record" for December 2002 revealed that facility-nursing staff did not document the application of Bacitracin with a dressing the G-tube site BID per the physician order for 30 of 62 opportunities. Resident 86's "Medication Record" for January 2003 revealed that facility-nursing staff did not document the application of Bacitracin with a dressing the G-tube site BID per the physician order for 29 of 62 opportunities. 4. Resident 84 was re-admitted to the facility on 1/17/03 with diagnoses which included right hip fracture, pain, pleural effusion, diabetes mellitus, chronic renal insufficiency and congestive heart	F 514	2. The expectation of accurate documentation of supplement administration, oxygen administration, sling checks, and pressure sore measurements. A project team will be appointed by the Administrator by May 7, 2003 to focus on determining the cause of MDS (Minimum Data Set) accuracy problems and ways to improve the accuracy. This team will report to the Performance Improvement Committee (Quality Assurance) **Monitoring/Quality Assurance** The Director of Nursing or designee will develop audit tools by May 16, 2003. These tools will audit for accuracy and completeness of documentation in various areas. These areas to include enteral administration and gastrostomy care; HS snack offerings; meal percentage consumption; MDS accuracy; oxygen administration and oxygen saturation levels; accurate heights and weights; indwelling urinary catheter care and measuring of output; pressure sore measurement and treatment; supplement administration; and vital signs.	

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F 514	Continued From page 113 failure. Resident 84's medical record was reviewed on 4/8/03. a. General Charting/ MDS Documentation On 1/17/03, facility-nursing staff completed an admission "Nursing Assessment" form. On this form, resident 84's height was recorded at 5 feet 2 inches. On 1/27/03, facility staff completed an initial MDS assessment. This MDS assessment documented resident 84's height at 4 feet 8 inches. 5. Resident 88 was admitted to the facility on 11/13/02 with diagnoses that included seizure disorder, dementia, depression, osteoporosis, anemia, and left eye blindness. Resident 88's medical record was reviewed on 4/9/03. The quarterly Minimum Data Set (MDS) assessment dated 2/11/03 and the comprehensive MDS assessment dated 11/19/02 documented, in sections G1 and G2, that resident 88 required limited assistance of one staff member for, as assessment code of "2". Resident 88 was documented as needing staff assistance for: a. Bed mobility, how resident moves to and from lying position, turns side to side, and positions body while in bed. b. Transfer, how resident moves between surfaces such as bed, chair standing position. g. Dressing, how resident puts on and fastens, and takes of street clothing. i. Toilet use, how resident uses the toilet room, transfer on/off toilet and cleanses and adjusts clothing. j. Personal hygiene, combing hair, brushing teeth, washing/drying face and hands and perineum. G2. Bathing, how resident takes full-body bath/shower, excluding back and hair.	F 514	The Director of Nursing or designee will do weekly audits for six weeks. At the completion of the audits the Director of Nursing or designee will report compliance to the Performance Improvement Committee (Quality Assurance). The Committee will then determine if there is a need for any further audits and reports. The Director of Nursing will be responsible for continued compliance, Completion date: May 28, 2003	

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F 514	Continued From page 114 Resident 88 was observed intermittently on 4/7/03, 4/8/03, 4/9/03 and 4/10/03. Resident 88 was observed to be to position herself in bed, get up from bed and into bed, transfer from/to bed and chairs without any assistance. Which would have been coded on the MDS assessment as "0". A certified nurse's aide (CNA) who provided care for resident 88 since the resident had been admitted to the facility, was interviewed on 4/8/03 at 9:00 AM. The CNA stated that resident 88 did not like to be touched and was very independent. The CNA stated that resident 88 dressed, groomed, toileted, transferred and moved around in her bed without any assistance of any staff. On 4/8/03 at 12:30 PM, a second CNA who had provided care for resident 88 since the resident had been admitted to the facility, was interviewed. The CNA stated that resident 88 did everything for herself. The CNA said, "We make her bed but we encourage her to do it herself." The 11/19/02 comprehensive MDS assessment documented in section K that resident 88 weighed 164 pounds. The Resident Care System Weight History for resident 88 listed the first weight for the resident to be during the forth week of November 2002 and was documented to be 108 pounds. It was documented on a nursing assessment dated 11/13/02, that resident 88 weighed 110 pounds. The dietary assessment, dated 11/18/02, documented that resident 88's usual weight was 110 pounds. The quarterly MDS assessment, dated 2/11/03, documented that resident 88 weighed 115 pounds and that the resident had experienced a significant weight loss. The nutritional assessment, dated 2/14/03, documented resident 88's weight was stable.	F 514		

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F 514	Continued From page 115 6. Resident 92 was admitted to the facility on 1/12/03 and most recently readmitted on 3/23/03. Resident 92's diagnoses include congestive heart failure, atrial fibrillation , diabetes, pneumonia and left below knee amputation. Resident 92's medical record was reviewed on 4/10/03. The comprehensive MDS assessment dated 12/27/02 was documented as the admitting assessment for resident 92. The comprehensive MDS assessment dated 1/19/03 was also documented as the admitting assessment for resident 92. A new assessment was not required, but if the facility chose to complete one, it should have been coded as a significant change or quarterly. Coding a second assessment as an initial assessment would affect the facilities quality indicator results in the MDS tracking system. Resident 92 had been temporarily discharged from the facility to the hospital on 1/8/03, 1/18/03, 2/8/03 and 3/20/03. Each time the resident returned to the facility, it was a re-admit for MDS tracking purposes. Resident 92's comprehensive MDS assessment dated, 12/27/02, documented the resident's admitting date was 1/12/03, section A3, and that there was no readmission, section A4a. Resident 92's comprehensive MDS assessment dated, 12/27/02, documented the resident weighed 230 pounds Resident 92's comprehensive MDS assessment dated, 1/19/03, documented the resident weighed 214 pounds and that the resident had not experienced a significant weight loss. A significant weight loss is 5% (percent) in 30 days, 7.5% in 90 days, or 10% in 180 days. Resident 92 had experienced a significant weight loss of 7% in 23 days.	F 514		

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Resident 92 was admitted to the facility on 12/6/02 with diagnoses that included diabetes, depression, pneumonia and asphyxia.

Resident 92's full MDS assessment dated, 2/2/03, documented the resident weighed 94 pounds Resident 92's quarterly MDS assessment dated, 3/4/03, documented the resident weighed 105 pounds and that the resident had not experienced a significant weight gain. Resident 11 had experienced a significant weight gain of 9.6% in 30 days.

7. Resident 74 was a 80 year old female who admitted to the facility on 2/8/02 with diagnoses that included diabetes, decubitus, hypertension and Alzheimer's disease.

On 4/7/03, resident 74's medical record was reviewed.

Resident's recorded weights per Resident Care System Weight History:

	Week 1	Week 2	Week 3	Week 4
March 2003	123	126	-	-
February 2003	119	119	119	122
January 2003	120	119	-	119
December 2002	123	122	121	119
November 2002	126	127	125	126

Resident 74's vital signs and weight record documented her weight as:
119 pounds on 12/22/02,
120 pounds on 1/5/03,
119 pounds on 1/11/03,
113 pounds on 2/9/03,
115 pounds on 3/30/03,
116 pounds on 4/4/03.
There were no other weights documented on the report.

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F 514	Continued From page 117 The Nutritional Progress Notes for resident 74, dated 3/24/03 by the registered dietician, documented the resident weighed 115 pounds and that the weight represented a 9 pound and 7.3 percent weight loss. To calculate the 9 pound weight loss, resident 74's weight of 115 pounds would have had to be compared to a weight of 124 pounds There was no documentation in resident 74's record that the resident weighed 124 pounds. The previous weight documented in resident 74's medical record was on the vital signs and weight record and that documentated the resident weighed 113 pounds on 2/9/03. 8. Resident 101 was a 55 year old male, who was admitted to the facility on 7/19/02 with the diagnoses of Multiple Sclerosis, glaucoma, osteoporosis, anemia and insomnia. A record review for resident 101 was conducted on 4/08/03 to 4/ 09/03. Resident 101's care plan, dated 10/29/02, documented the following problem: "Nutrition altered R/T [Related To] admit wt [weight] below IBW. The approaches for this problem were as followed: 1. Notify RD [Registered Dietician] [regarding] problems, complaints, or requests. 2. Monitor % of meals eaten & offer replacement if patient refuses meal. Record % of replacement. 3. Offer HS [night] snack and document A = Accept or R = Refuse. 4. Recent wt [weight] loss- double portions, dated, 1/22/03. Upon record review it was discovered that the facility staff did not document meal percentages every day as the care plan stated for resident 101. A review of resident 101's meal intakes, documented on the "Flow Sheet Record" for November 2002 revealed the facility nurse aides were documenting meal intake in	F 514		

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F 514	Continued From page 118 percentages. Out of a possible 30 breakfast meals for the month, 12 had no meal intake documented. Out of a possible 30 lunch meals for the month, 12 had no meal intake documented. Out of 30 possible dinner meals for the month, 12 had no meal intake documented. A review of resident 101's meal intakes for December 2002 revealed the following: out of a possible 31 breakfast meals for the month, 11 had no meal intake documented. Out of a possible 31 lunch meals for the month, 13 had no meal intake documented. Out of a possible 31 dinner meals for the month 13 had no meal intake documented. A review of resident 101's meal intakes for January 2003 revealed the following: out of a possible 31 breakfast meals for the month, 10 had no meal intake documented. Out of a possible 31 lunch meals for the month, 10 had no meal intake documented. Out of a possible 31 dinner meals for the month, 7 had no meal intake documented. A review of resident 101's meal intake for February 2003 revealed the following: out of a possible 28 breakfast meals for the month, 4 had no meal intake documented. Out of a possible 28 lunch meals for the month, 5 had no meal intake documented. Out of a possible 28 dinner meals for the month, 13 had no meal intake documented. A review of resident 101's meal intake for March 2003 revealed the following: out of a possible 31 breakfast meals for the month, 6 had no meal intake documented. Out of a possible 31 lunch meals for the month, 6 had no meal intake documented. Out of a possible 31 dinner meals for the month, 11 had no meal intake documented.	F 514		

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F 514	Continued From page 119 A review of resident 101's meal intake for April 2003 revealed the following: out of a possible 8 breakfast meals for the month, 1 had no meal intake documented. Out of a possible 8 lunch meals for the month, 1 had no meal intake documented. Out of a possible 8 dinner meals for the month, 4 had no meal intake documented. Resident 101 did not have documentation or evidence of accepting or refusing HS snacks as requested in his care plan. 9. Resident 105 was an 84 year old female, who was admitted to the facility on 9/04/02 with the diagnoses of Dementia, Congestive heart failure, hypertension, gastroesophageal regurgitation disease and depression. A record review for resident 105 was conducted on 4/08/03 to 4/ 09/03. On 12/04/02, the facility RD assessed resident 105 in the quarterly notes as "nutritionally stable". The facility RD stated, "has lost 10 pounds in 3 months - acceptable rate". On 12/19/02 the facility RD documented, "[down] 20 [pounds] 12%. [Weight] likely an error. Request re-weigh, will f/u prn." The facility RD documented for resident 105 on 1/15/03 the following: "[patient] on 1/12 was 172 # [pounds]. [Weight] on past week was 147 # - likely an error. [Patient] is on NCS [No Concentrated Sweet] [low] fat 2 g Na diet. 0 apparent reason for NCS 0 [diagnosis] of [diabetes], 0 [diabetic] meds. 0 fingersticks, etc. [Nursing] states [patient] is not diabetic according to chart. Recommend [discontinue] NCS, 2 gm Na, [low] fat. Change diet to NAS [No Added Salt]. Will monitor & f/u [follow up] p.r.n. [as needed]. On 1/29/03 the facility RD documented, "[weight] on 1/26 140 #, [down] from 172 # prior week. [Weights] have been Oct 165, Nov 163, Dec 170. [Weight] is likely an error. Will request re-weigh, [follow-up as needed]."	F 514		

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F 514	Continued From page 120 The facility was not able to produce evidence of a re-weigh or an incorrect weight for resident 105. The facility RD made the following note concerning resident 105's weight loss on 2/05/03: [Weight] on 2/2 was 136 [down] from 140 [pounds] prior week. [Weights] in Oct - Dec about 163 - 170 - asked [nursing] about [weight] discrepancy. [Nursing] states they re-weighed [patient] - wts [weights] before were likely inaccurate R/T [related to] chair weight - nsg [nursing] states [patient] true [weight] is approx 136 # [pounds]. 0 new labs. PO [oral] intake record 0 located. Will request record to be created if missing, F/U PRN [follow up as needed]." There were 2 different Flow Sheet Records in resident 105's record that documented percentage of meal intake. Resident 105's nutritional quarterly note, dated 3/03/03, documented that she was consuming 50 - 75% of her meals. The facility dietary manager documented under "Laboratory Results" the following: "Labs on 2/21/03 CMP, BUN [elevated] 35, albumin [low] 4.7, Biliburin [low] 2.2, BMP on 2/21/03 WNL [within normal limits]". The albumin level was actually 2.2 g/dl. The facility dietary manager documented under "Assessment Summary", "[patient] [weight] 2/23 135 # [pounds]. MD informed, labs on 2/21/03 CMP Album. [albumin] low 4.7 [patient] receiving 1 can Ensure, PO [oral] intake is good, skin intact. Will continue monitor". The facility RD signed the 3/03/03 quarterly assessment that was completed by the dietary manager for resident 105. The albumin level was 2.2, not 4.7 and there is no such test as "Biliburin" for the laboratory results of 2/21/03 that were documented in the 3/03/03 quarterly dietary notes.	F 514		

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F 514	Continued From page 121 Resident 105's care plan reflected the following: 9/04/02 "Problem: Feeding Deficit" with the "Goal: Will eat 75% of meals with minimal supervision", the "Approach: Allow time to feed self. Supervise with prompting & verbal cueing. Assist as needed to complete task." 9/09/02, 12/04/02 and 3/03/03 "dietary reviewed", "Nutrition altered R/T [related to] admit weight above IBW. Admit weight 176 lbs. IBW 115 - 135.; Depression; and Congestive Heart Failure" with "Goals: Will have no further weight gain or 1-2 # weight loss per week; Total intake will meet nutritional needs", the "Approaches: Diet as ordered enriched; Monitor % of meals eaten & offer replacement if patient refuses meal. Record % of replacement; Offer HS snack, Document A=Accept R=Refuse; 2/10/03 Provide supplement of Ensure 1 can qd [everyday]; 2/26/03 Med Plus 120 cc QID [4 times per day]". Upon record review it was discovered that the facility staff did not document meal percentages every day as the care plan stated for resident 105. A review for resident 105's meal intakes, documented on the "Flow Sheet Record" for November 2002 revealed the facility nurse aides were documenting meal intake in percentages. Out of a possible 30 breakfast meals for the month, 12 had no meal intake documented. Out of a possible 30 lunch meals for the month, 14 had no meal intake documented. Out of a possible 30 dinner meals for the month, 7 had no meal intake documented. A review of resident 105's meal intakes for December 2002 revealed the following: out of a possible 31 breakfast meals for the month, 2 had no meal intake documented. Out of a possible 31 lunch meals for the	F 514		

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F 514	Continued From page 122 month, 7 had no meal intake documented. Out of a possible 31 dinner meals for the month, 4 had no meal intake documented. A review of resident 105's meal intakes for January 2003 revealed the following: out of a possible 31 breakfast meals for the month, 10 had no meal intake documented. Out of a possible 31 lunch meals for the month, 11 had no meal intake documented. Out of a possible 31 dinner meals for the month, 6 had no meal intake documented. Resident 105 had 2 "Flow Sheet Records" for the month of February 2003 with different meal percentages documented. A review of resident 105's meal intakes for the first February 2003's "Flow Sheet Record" revealed the following: out of a possible 28 breakfast meals for the month, 7 had no meal intake documented. Out of a possible 28 lunch meals for the month, 10 had no meal intake documented. Out of a possible 28 dinner meals for the month, 11 had no meal intake documented. The second "Flow Sheet Record" for resident 105's February 2003 meal intake documentation revealed the following: out of a possible 28 breakfast meals for the month, 20 had no meal intake documented. Out of a possible 28 lunch meals for the month, 19 had no meal intake documented. Out of a possible 28 dinner meals for the month, 19 had no meal intake documented. A review of resident 105's meal intakes for March 2003 revealed the following: out of a possible 31 breakfast meals for the month, 4 had no meal intake documented. Out of a possible 31 lunch meals for the month, 4 had no meal intake documented. Out of a possible 31 dinner meals for the month, 6 had no meal intake documented.	F 514		

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F 514	Continued From page 123 A review of resident 105's meal intake for April 2003 revealed the following: out of a possible 8 breakfast meals for the month, 1 had no meal intake documented. Out of a possible 8 lunch meals for the month, 1 had no meal intake documented. Out of a possible 8 dinner meals for the month, 2 had no meal intake documented. Resident 105 did not have documentation of being offered her evening snacks as the facility had care planned. 10. Resident 109 was a 97 year old female, who was re-admitted to the facility on 12/19/02 with the diagnoses of hip fracture, congestive heart failure, Osteoporosis, dementia, anemia and constipation. A record review for resident 109 was conducted on 4/08/03 to 4/09/03. On 12/19/03, resident 109 had an incomplete initial dietary assessment upon her re-admission to the facility. Resident 109 did not have her height and weight documented or her IBW, therefore resident 109's calorie, protein, or fluid need's were not calculated. The facility RD documented the following in her initial assessment summary: "Unable to fully assess pt [patient] - 0 wt[weight], 0 ht [height], 0 diet orders. 0 meds [medications]. Alb [albumin] 3.1 low in hospital. Pt [patient at nutritional risk [secondary to] HTN, CHF, dementia, other dx [diagnosis]. Unable to make recommendations at this time or fully assess pt. [patient] d/t [due to] lack of information. Will continue to monitor prn [as needed] as more information becomes available. Recommend obtain wt [weight], ht [height]." The 12/30/02, "Nutritional Progress Notes", 11 days after admission, for resident 109 had no height or weight available. The facility RD documented that resident 109 had no edema and that her oral intake was	F 514		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEDERAL HEIGHTS REHABILITATION AND N	41 SOUTH 900 EAST 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 514	Continued From page 124 25 - 50% with "occasional refusals". Resident 109 was on a regular diet. The facility RD's recommendations were "obtain ht [height] & wt [weight] & record in [chart]". Resident 109's weight was recorded in the "Vital Signs And Weight Record" on 12/31/02 as 122 pounds but no height was documented. On 1/06/03, the facility RD documented in the "Nutritional Progress Notes" that resident 109's oral intake was 75% and at risk for skin breakdown. This was 18 days after admission and the facility RD was requesting a height for resident 109. On 1/15/03, resident 109 had a "Physician's Telephone order" for "[change] diet to NAS [No Added Salt] enriched, D/C [discontinue] 3 gm [gram] Na D/T [due to] recent wt [weight] loss. Please obtain height and record in chart." As of 4/08/03, there was no height documented in the chart and no dietary needs for resident 109 had been assessed 110 days after her admission. The admission MDS, dated 12/26/02, for resident 109 documented no "Oral Problems". The height was documented at "64 inches" which was incorrect information and a weight of "125 pounds". Resident 109 had "None of Above" marked for "Nutritional Problems". "Nutritional Approaches" was left blank for resident 109. The quarterly 90 day medicare MDS, dated 3/17/03, for resident 109 documented no "Oral Problems". The height was documented at "64 inches" which was incorrect information and a weight of "109 pounds". "Weight Loss" was marked for "Weight Change" and "Nutritional Problems" had "Leaves 25% or more of	F 514		

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F 514	Continued From page 125 food uneaten at most meals" marked. Resident 109 had "Mechanically altered diet" and "Therapeutic diet" marked for "Nutritional Approaches". Resident 109's care plan, dated 12/30/02, 11 days after her admission, documented "Nutrition Altered" as a problem related to "decreased appetite" with the goal of "Total intake will meet nutritional needs". The approaches were as followed: "Diet as ordered", "Monitor % of meals eaten & offer replacement if patient refuses meal record % of replacement", "Offer HS [night] snack Document A= Accept R= Refused", and "Provide supplement (dated 2/10/03)". The second problem identified was "Feeding deficit", dated 1/28/02, with the first goal of "Will eat 75% of meals with minimal supervision" and the approach of "Allow time to feed self. Supervise with prompting & verbal cueing. Assist as needed to complete task". The second goal was "will maximize ability to feed self" with the approach of "Evaluate for assistive device & supply as needed" and "Prepare food for resident, ie cut meat, butter bread, remove wrappers." On 3/17/03, the problem of "Nutrition altered: less than body requirements decreased appetite, poor fitting dentures, dementia, osteoporosis, r/t [related to] constipation" with the goal of, "Weight will remain 118 - 128 #". The approaches were: "Monitor % of meals eaten and offer replacement if resident consumes less than 75% of meal, enrich diet (dated 1/15/03), monitor lab values as ordered". Upon record review it was discovered that the facility staff did not document meal percentages every day as the care plan stated and as the facility RD requested to monitor for resident 109. A review for resident 109's meal intakes, documented on the "Flow Sheet Record" for January 2003 revealed the facility nurse aides were documenting meal intake in percentages. Out of a possible 31 breakfast meals for the month, 7 had no	F 514		

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F 514	Continued From page 126 meal intake documented. Out of a possible 31 lunch meals for the month, 7 had no meal intake documented. Out of a possible 31 dinner meals for the month, 6 had no meal intake documented. A review of resident 109's meal intake for February 2003 revealed the following: out of a possible 28 breakfast meals for the month, 5 had no meal intake documented. Out of a possible 28 lunch meals for the month, 4 had no meal intake documented. Out of a possible 28 dinner meals for the month, 8 had no meal intake documented. A review of resident 109's meal intakes for March 2003 revealed the following: out of a possible 31 breakfast meals for the month, 6 had no meal intake documented. Out of a possible 31 lunch meals for the month, 4 had no meal intake documented. Out of a possible 31 dinner meals for the month, 6 had no meal intake documented. A review of resident 109's meal intake for April 2003 revealed the following: out of a possible 8 breakfast meals for the month, 1 had no meal intake documented. Out of a possible 8 lunch meals for the month, 1 had no meal intake documented. Out of a possible 8 dinner meals for the month, 2 had no meal intake documented. Resident 109 did not have any HS [night] snacks documented in her record as "accepted or refused" per her care plans request. On 4/08/03 at 2:20 PM, resident 109 was weighed and measured by 2 facility CNA's with 2 nurse surveyors present. Resident 109's height was 54 inches or 4 feet, 5 inches and weighed 111 pounds. The MDS documentation that resident 109's height was 64 inches was incorrect.	F 514		

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F 514	Continued From page 127 11. Resident 76 was admitted to the facility on 6/30/98 with diagnoses of left hip fracture, congestive heart failure, urinary tract infection, dehydration, manic depression, constipation and osteoporosis. A review of resident 76's medical record was completed on 4/10/03. a. MDS A care plan updated 12/17/02 documented, "...1/2 side rails up when in bed at all times for increased bed mobility [and] positioning..." An annual MDS dated 3/11/03, revealed the following: Under section G6-b., Modes for Transfer., Bed rails used for bed mobility or transfer was not checked. A physician order dated 9/26/03 documented that all of resident 76's medications were stopped due to refusal. An annual MDS (minimum data set) dated 3/11/03, revealed the following: Under section O4 a and b., Days received the following medications., Antipsychotic and Antidepressant were checked as being given during the last 7 days. 12. Resident 80 was originally admitted to the facility on 9/12/02, with the diagnoses of poor circulation, hypertension, hypothyroidism, radial fracture, tibial fracture, asthma, constipation and depression. A review of resident 80's medical record was completed on 4/10/03.	F 514		

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F 514	Continued From page 128 a. MDS A weight history revealed the following weights for resident 80: October 2002, 1st week 102 lbs. (pounds) November 2002, 1st week 109 lbs. December 2002, 1st week 108 lbs. January 2003, 1st week 105 lbs. February 2003, 1st week 102 lbs. March 2003, 1st week 99 lbs. A quarterly MDS dated 3/4/03, revealed the following. Under section K2b., Height and Weight., the weight was recorded as 101 lbs. According to the weight history resident 80's weight was 99 lbs. Under sections K3b., Weight Change, they documented that resident 80 had a weight gain of 5% or more in last 30 days; or 10% or more in last 180 days. According to the weight history resident 80 had not had a weight gain. 13. Resident 82 was admitted to the facility on 8/13/02 with the diagnoses of stroke, constipation, osteoarthritis, right knee deformity, incontinence, debilitation and moderate depression. A review of resident 82's medical record was completed on 4/10/03. a. Weight Records A "Vital Signs and Weight Record", revealed the following: 8/14/02 (2nd week August) 120 lbs. 4th week August No Recording 9/29/02 (5th week September) 119 lbs. 10/6/02 (1st week October) 121 lbs.	F 514		

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3rd week October No Recording
11/3/02 (1st week November) 118 lbs.
11/10/02(2nd week November)116 lbs.
11/17/02(3rd week November) 118 lbs.
11/24/02(4th week November) 116 lbs.
5th week November No Recording
2nd week December No Recording
3rd week December No Recording
4th week December No Recording
1/8/03 (1st week January) 115 lbs.
4th week January No Recording
1st week February No Recording
2/9/03 (2nd week February) 109 lbs.
3rd week February No Recording
4th week February No Recording
1st week March No Recording
2nd week march No Recording
3/27/03 (4th week March) 112 lbs.
4/4/03 (1st week April) 112 lbs.

A "Resident Care System Weight History", revealed the following:

August 2nd week No Recording
August 4th week 120 lbs.
September 5th week No Recording
October 1st week 119 lbs.
October 3rd week 121 lbs.
November 1st week 120 lbs.
November 2nd week 118 lbs.
November 3rd week 116 lbs.
November 4th week 118 lbs.
November 5th week 116 lbs.
December 2nd week 116 lbs.
December 3rd week 116 lbs.
December 4th week 115 lbs.
January 1st week 115 lbs.
January 4th week 113 lbs.
February 1st week 112 lbs.
February 2nd week 112 lbs.

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February 3rd week 111 lbs.
February 4th week 111 lbs.
March 1st week 109 lbs.
March 2nd week 113 lbs.
March 4th week No Recording
April 1st week No Recording

The "Vital Sign and Weight Record" and "Resident Care System Weight History" forms were both located in resident 82's medical record. One was found under the nursing progress notes the other under the weight and skin notes. The 2 forms did not always match and make it very difficult to follow resident 82's weights.

During an interview with the medical director on 4/10/03 at 10:00 AM, she stated it was hard to tell what was going on in the medical records, it was hard to tell if the weights in the medical records were the most current. She further stated that the registered dietitian had told her there was not another weight log used by the facility.

b. MDS

A quarterly MDS dated 2/11/03, revealed the following.

Under section K2b., Height and Weight., the weight was recorded as 113 lbs. On 2/9/03 resident 82's weight was documented as 109 lbs. There was no documented weight of 113 lbs. for the month of February on either form used by the facility staff.

Under sections K3b., Weight Change, they documented that resident 82 had not had a weight loss - 5% or more in last 30 days; or 10% or more in last 180 days. From 1/8/03 to 2/9/03, resident 82, lost 6 lbs (5.2%) in one month.

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F 514	Continued From page 131 14. Resident 83 was originally admitted to the facility on 5/9/00 with the diagnoses of cerebrovascular dementia with depressive features, deep vein thrombosis, recurrent pneumonia with severe hypoxia, osteoporosis, B12 deficiency, atrial fibrillation, congestive heart failure, neuromuscular dysphagia, recurrent urinary tract infections and a history of urosepsis. A review of resident 83's medical record was completed on 4/10/03. a. Vital Signs On 3/17/03, resident 83's physician order blood pressure, pulse and respirations to be checked every day for 14 days. Resident 83's March 2003, MAR documented that the facility staff had not recorded the blood pressure, pulse and respirations every day for the 14 days. Review of the March 2003, MAR (medication administration record) documented blood pressures to be done twice a day starting on 3/14/03. Resident 83's March 2003, MAR documented that the facility staff had not recorded the blood pressure 34 of 36 times. b. Oxygen Liters Resident 83 had a physician order dated 1/28/03, with a re-certification order dated 3/10/03, for oxygen via nasal cannula and to titrate until saturations were greater than 90% on room air, chart liter flow used. Resident 83's January 2003 "Treatment Record" documented that the facility staff had not recorded	F 514		

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F 514	Continued From page 132 oxygen liter flow used for 0 of 4 days. Resident 83's February 2003 "Treatment Record" documented that the facility staff had not recorded oxygen liter flow used for 0 of 28 days. Resident 83's March 2003 "Treatment Record" documented that the facility staff had not recorded oxygen liter flow used for 29 of 31 days. c. Urinary Tract Infection A physician order, with no date documented, "UA (urinalysis) [with] C&S (culture and sensitivity) if indicated- then start on Levaquin 250 mg PO (by mouth) QD (every day) X (times) 10 d (days) DX (diagnosis) UTI (urinary tract infection)..." On 3/24/03 at 4:00 PM, a facility nurse documented, "Order given for UA [with] C&S if indicated. Urine sample obtained [and] sent to lab (laboratory)." The results for the UA with C&S could not be located in resident 83's medical record. The nursing progress notes were reviewed from 3/3/03 through 3/24/03. The facility nurses did not document any reasons, in the progress notes, to indicate why resident 83 required a UA with C&S. There was no documented evidence in the medical record that the facility had received any results of the UA with C&S completed on 3/24/03. Interviews with facility nurses and CNAs, 4/7/03 through 4/10/03, provided evidence that resident 83 continued with signs and symptoms of an infection, as well as possible feces coming from her vaginal vault. Please see F-309.	F 514		

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F 514	Continued From page 133 The nursing progress notes from 3/24/03 - 4/10/03 were reviewed on 4/10/03. The facility staff did not document any signs and symptoms of a continued infection nor did they document possible feces coming out of resident 83's vaginal vault until 4/10/03. d. Offer of Bed Time (HS) Snack Documentation Resident 83's January 2003, February 2003 and March 2003 had no documented evidence that an HS snack had been offered on any day during these 3 months. 15. Resident 54 was admitted to the facility on 1/29/03 with diagnoses, which included cerebrovascular accident, gastric distress, anemia, anxiety, pain and depression. Resident 54's medical record was reviewed on 4/8/03. On 2/12/03, resident 54 was identified to have a pressure sore. On 2/26/03, a facility nurse documented that resident 54's pressure sore had a black center and had increased in size to 2cm x 2cm. On 2/26/03, a "wound team" note documented that resident 54 had a stage II pressure sore which measured 1cm x 1cm and had a depth of 0.3 cm. Measurements and descriptions obtained by professional staff on the same day, 2/26/03, differ significantly. There was no documentation in the	F 514		

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F 514	Continued From page 134 medical record of resident 54 to evidence that staff were aware of the different measurements or had attempted clarification. The admission weight for resident 54, obtained 1/29/03, was recorded as 168. Five days later, on 2/3/03, resident 54's weight was recorded as 144. There was no documentation in the medical record of resident 54 to explain the 24 pound discrepancy. The February 2003 flow sheet record for resident 54 was missing meal percentage documentation for 14 meals. The March 2003 flow sheet record for resident 54 was missing meal percentage documentation for 13 meals. 16. Resident 14 was admitted to the facility on 3/7/03. The admit nurse recorded a weight of 120 pounds. Fifteen days later, on 3/22/03, facility staff recorded a weight of 108 pounds. This would equal a 10% weight loss in 3 weeks, which is significant. Facility staff did not question the weight loss. Upon extensive review by the surveyor, it was determined through interview with the admit nurse that the weight of 120 pounds was "an approximate weight". There was no documentation on the admission assessment to evidence that the weight of 120 pounds was "approximate" and not actual.	F 514		