PRINTED: 05/22/2006
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465139	A. BUILDING ______ B. WING ______	05/04/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN TERRACE ALZHEIMERS	1201 EAST 4500 SOUTH SALT LAKE CITY, UT 84117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 286 SS=B	483.20(d) RESIDENT ASSESSMENT - USE A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility did not maintain Minimum Data Sets (MDS) assessments completed in the previous 15 months on the resident active record for 3 of 15 sample residents. Resident identifiers: Resident 2, 3 and 12 Findings include: Resident 2 was admitted to the facility on 10/3/03 with diagnoses that included Alzheimer, dementia with behaviors, Atrial fibrillation, osteoporosis, osteoarthritis, anemia, insomnia and psychosis. Resident 2's medical record was reviewed on 5/1/06. The medical record did not contain 15 months on MDS, resident 2 was missing a quarterly MDS that was due on or about 4/06. Resident 3 was admitted to the facility one 10/30/03 with diagnoses that included osteoarthritis, Alzheimer, dementia with behaviors, osteoporosis, hypertension, and cerebral vascular accident Resident 3's medical record was reviewed on 5/1/06. The medical record did not contain 15 months on MDS, resident 3 was missing a quarterly MDS that was due on or about 4/06.	F 286	6/12/06 POC acceptable completion date 6/16/06 [signature] RN Garden Terrace submits this Plan of Correction (POC) as required by law. This POC does not constitute an admission of liability on the part of the facility, nor does it constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding the findings are correctly applied. F286 The facility maintains all resident assessments completed within the previous 15 months in the resident's active record. 1) Resident 3 and 12's quarterly's and resident 2's initial MDS assessment were placed in their respective charts on 5/4/06. 2) Other resident's having the potential to be affected by this practice will be identified by: Reviewed other active charts to ensure they contained 15 months of resident assessments. 3) Measures put into place to ensure success in this quality area include: Inserviced MDS Coordinator and medical records staff on maintaining 15 months of resident assessments in resident's active record. 4) The facility plans to monitor its performance to ensure that solutions are achieved and sustained by: random audits will be performed by Director of Nursing (D.O.N.) or	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature] W. Sargent, RN	Staff Development Coordinator	6/8/06

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

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F 286	Continued From page 1 Resident 12 was admitted to the facility on 4/11/06 with diagnoses that included: congestive heart failure, coronary heart disease, mitral valve insufficiency, thrombocytopia, high blood pressure, osteoarthritis, hyperlipidemia and chronic kidney disease. On 5/1/06, a review of resident 12's medical record revealed a MDS background face sheet, that had been sighed by the MDS coordinator on 4/12/06. The initial MDS assessment was not in resident 12's medical record. An interview with the corporate nurse, on 5/4/06 at 10:30 AM, confirmed that the initial MDS assessment was not in resident 2's chart and the quarterly's were not in 3 and 12's charts.	F 286	designee specifically assessing that resident charts contained 15 months of resident assessments. Audits will be brought to the facility Performance Improvement (PI) meeting and reviewed until threshold reached. D.O.N. to monitor issue. Compliance date: 6/16/06	
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility did not follow the current physicians orders for 2 of 15 sampled residents; therefore, not ensuring each residents highest practicable physical health. Specifically, resident 3 did not have his physician	F 309	F309 The facility provides to each resident the necessary care and services needed to attain and maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 1) Resident 3 and 6 were evaluated by medical staff or occupational therapy for appropriate services in regards to ted hose, hand splints and glove use. Inserviced nursing staff, therapy and restorative aides on specifics of care services regarding resident 3 and 6. 2) Other resident's having the potential to be affected by this practice will be identified by: Reviewed other resident	

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F 309	Continued From page 2 ordered TED hose on and resident 6 did have the physician ordered splint on. Resident identifier 3, 6. Findings include: Resident 6 was admitted to the facility on 1/3/06 with diagnoses including, MS (Multiple Sclerosis), Falls, ROM (Range of Motion) restraint, and Vascular Dementia. Resident 6's clinical record was reviewed multiple times between 5/1/06 and 5/4/06. Resident 6 had the following physicians orders in her clinical record for the month of May: On the "Restorative Nurses Aide Progress Notes" dated 4/26/06 the following entry is documented, "...Continue use of palm splint in conjunction [with] glove....". Resident 6 also had "Restorative Nursing Program" sheets documenting "...Splint assistance and Isotoner glove 6 [times week]". This treatment was documented as having been performed as ordered. Observations of resident 6 were made from 5/1/06 through 5/4/06. On 5/1/06, resident 6 was observed to have neither her glove, nor her splint on her left hand throughout the day. On 5/2/06, resident 6 was observed to have neither her glove, nor her splint on her left hand throughout the day. On 5/3/06, resident 6 was observed to have her	F 309	charts for application of necessary care and services. 3) Measures put into place to ensure success in this quality area include: Care services items such as ted hose and splints will be added to C.N.A. Assignment Sheets for easy reference by the floor staff. Inserviced nursing staff, therapy staff and restorative staff on ensuring application of necessary care services such as ted hose and splints. 4) The facility plans to monitor its performance to ensure that solutions are achieved and sustained by: Twice monthly audits will be performed by D.O.N. or designee on application of necessary care services such as ted hose and splints. Audits will be brought to the facility Performance Improvement (PI) meeting and reviewed until threshold reached. D.O.N. to monitor issue. Compliance date: 6/16/06	

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F 309	Continued From page 3 splint on her left hand throughout the day;however, her glove was not in place. On 5/4/06, resident 6 was observed to have her glove on her left hand throughout the day; however, her splint was not in place. During an interview with resident 6's family member, he was asked why resident 6 was not wearing her splint and glove. The family member did not know why, but stated that resident 6 had not worn the glove or splint for several days. At that time, a facility OT (Occupational Therapist) was nearby and resident 6's family member stated " ....splint is missing again...". The OT stated that she would investigate the problem. On 5/4/06 at 9:40 AM, an interview was conducted with a facility OT. When asked about resident 6's splint and glove the OT stated that resident 6 was no longer receiving occupational therapy at that time, but that the facility RNA's (Restorative Nursing Assistants) were working with resident 6. The OT further stated that they had tried several different splints on resident 6 with resulting problems, so resident 6 was not to be wearing the splint at that time, but that the glove should always be on her. When asked if she had documented these changes, she stated that she had not, but she thought that the RNA's had. On 5/4/06 at 9:48 AM, a facility RNA was interviewed. The RNA stated that he worked with resident 6 often and that she was to have treatments including removing the splint and glove then washing, massaging, and performing ROM to her left hand before replacing the glove and splint. He further stated that he thought	F 309		

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F 309	Continued From page 4 resident 6's gloves were going to be discontinued. Resident 3 was admitted on 10/30/03 with diagnoses that included osteoarthritis, Alzheimer dementia with behaviors, osteoporosis, hypertension, and cerebral vascular accident. Resident 3's medical record was reviewed on 5/1/06. The physician's recertification for may 2006 document "knee high TED hose on during day & (and) off Q (every) HS (night)." Observations of resident 3 were made from 5/1/06 through 5/3/06. 5/1/06 at 9:00 AM resident 3 was observed sitting in a wheel-chair in the hallway next to resident's room, resident 3 was not wearing TED hose. 5/1/06 at 1:00 PM resident 3 was observed sitting in wheel-chair across from the nurse station. Resident 3 was not wearing TED hose. 5/2/06 at 1:50 PM resident 3 was observed sitting in wheel-chair by the nurse station. Resident 3 was not wearing TED hose. 5/3/06 at 7:20 AM resident 3 was observed in a wheel-chair in the hall by resident's room. Resident 3 was not wearing Ted hose. In an interview with the DON, (Director of Nursing) on 5/3/06 at 2:00 PM, she was not aware that resident 3 was not wearing the TED hose as ordered.	F 309		

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F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility did not ensure that a resident received proper respiratory care and treatment. This occurred for 1 of 15 sampled residents . Resident identifier: 1. Findings included: Resident 1 was admitted to the facility on 4/12/06, with diagnoses that included: laryngectomy, neck disection, tracheostomy, herpes zoster, depressive disorder. Review of resident 1's medical record revealed that resident 1 was admitted to the facility on hospice care with orders for "O2 (oxygen) at 30% humidified air via (per) trach mask". On 5/1/06 at 1:45 PM, observation of resident 1's respiratory care equipment revealed a large volume cool nebulizer attached to an air compressor that was at the bedside. Blue corrugated tubing was connecting the	F 328	F328 The facility ensures that residents receive proper treatment and care for the following special services: Injections; parenteral and enteral fluids; colostomy, ureterostomy, or ileostomy care; tracheostomy care; tracheal suctioning; respiratory care; foot care; and prostheses. 1) On 5/3/06 Resident 1's respiratory care orders were reviewed and clarified with physician. Resident 1 was discharged on 5/21/06. 2) Other resident's having the potential to be affected by this practice will be identified by: Reviewed other residents receiving oxygen therapy. 3) Measures put into place to ensure success in this quality area include: Inserviced staff on treatment and care issues on oxygen therapy. 4) The facility plans to monitor its performance to ensure that solutions are archieved and sustained by: Twice monthly audits will be performed by D.O.N. or designee on residents receiving special services. Audits will be brought to the facility Performance Improvement (PI) meeting and reviewed until threshold reached. D.O.N. to monitor issue. Compliance date: 6/16/06	

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F 328	Continued From page 6 tracheostomy mask to the large volume nebulizer. The tracheostomy mask was around resident 1's neck providing humidification to the open tracheal stoma. The air compressor had a pressure manometer dial that was reading 48 psi (pounds per square inch). It was observed that no oxygen was being used by the resident as there was no oxygen concentrator, or other devices to deliver oxygen, in resident 1' s room. An interview was held on 5/1/06 at 12:00 PM, with RN 1, a facility registered nurse. RN 1 stated she was assigned to resident 1 on that day. RN 1 stated that resident 1 was receiving oxygen at 30% via a tracheostomy mask. An interview was held on 5/2/06 at 2:00 PM, with LPN (Licensed Practical Nurse) 1. LPN 2 stated she was assigned to resident 1 on that day. When asked why resident 1 was not receiving oxygen, LPN 2 stated that he was and she proceeded to show the surveyor the air compressor at the resident's bedside. The surveyor pointed out that the device was an air compressor, but that it did not deliver oxygen. LPN 2 then stated that she had just assumed that it was oxygen because one of the nurses from the hospice agency had called a respiratory therapist to set up the equipment when resident 1 was admitted. LPN 2 went on to state that the hospice agency provided cares to resident 1 and that they came in twice a day. An interview was conducted on 5/3/06 at 8:10 AM, with a hospice agency nurse. When asked about resident 1's admit orders for oxygen at 30% humidified air via tracheostomy mask, the nurse stated that those were the orders that resident 1	F 328		

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F 328	Continued From page 7 came with, from the cancer center. She went on to say that a respresentative of the hospice agency had called the cancer center to verify the oxygen orders. When asked why resident 1 was not receiving 30% oxygen, the hospice nurse stated that he was and she pointed to the air compressor. The surveyor asked the hospice nurse how the device delivered 30% oxygen. The hospice nurse pointed out the pressure manometer, which was now set at 42 psi. The hospice nurse then stated that resident 1's oxygen was adjusted by turning the pressure knob. The surveyor explained that the manometer read the pressure at which air was compressed and not the percentage of oxygen being delivered. The hospice nurse then pointed to the Venturi valve at the top of the large volume nebulizer and stated that by turning the Venturi valve the amount of oxygen could be adjusted. NOTE: A Venturi Valve is a device used to mix ambient air with compressed air or oxygen if oxygen was connected. The surveyor explained that an adjustment to the Venturi Valve would not affect the level of resident 1's oxygen as there was no oxygen connected. At this time, the hospice nurse stated that resident 1's admission orders included 30% humidity not 30% oxygen. The surveyor asked how the hospice nurse measured or read that resident 1 was receiving 30% humidified air. The hospice nurse responded that she did not know how the percentage of humidified air could be measured. The hospice nurse was asked about a physician telephone order, dated 4/24/06, in which resident 1 was to receive, "oxygen at 5 liters per nasal	F 328		

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F 328	Continued From page 8 cannula placed inside Venturi mask at trach site to keep sats (saturation)(greater than) 90%". The hospice nurse stated that she wrote the order because the large volume nebulizer on resident 1's "oxygen machine" had broken and a replacement would not be available until the next morning. The surveyor asked the hospice nurse to clarify why resident 1 was placed on 5 liters of oxygen if the the admission orders were for only humidified air. The hospice nurse responded that she believed, at that time, that resident 1 was receiving oxygen through the humidified tracheostomy mask. An interview was conducted on 5/3/06 at 11:13 AM, with the hospice agency's Marketing Director. He stated that he was a former respiratory therapist and that he was the individual who looked at resident 1's respiratory therapy equipment on 4/20/06. The surveyor asked the Marketing Director to clarify resident 1's admission order, dated 4/12/06, for "O2 via 30% humidified air". The Marketing Director stated that it meant that resident 1 should be receiving 30% humidification. He then clarified the order to mean that resident 1 was to be receiving 30% oxygen. A review of resident 1's medical record was completed on 5/3/06. On 4/20/06 at 5:15 AM, facility nursing notes revealed that resident 1's humidifier was not working properly, and that the hospice nurse was notified. Per documentation in the nursing notes, the hospice nurse came in and fixed the "concentrator" and stated that she would have someone come check the "concentrator" later that day.	F 328		

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F 328	Continued From page 9 On 4/20/06 at 11:00 AM, facility nursing notes documented that a respiratory therapist, from the hospice agency, came in to check resident 1's respiratory equipment. Review of resident 1's hospice nursing notes revealed the following documentation: On 4/23/06 at 7:15 PM, "...to use humidified O2 (oxygen) prn (as needed) On 4/24/06 at 1020 AM, ""Turned humidifier back on 30%" On 4/25/06 at 1:30 PM, "Humidified air in place at 30%" On 4/28/06 at 3:00 PM, "...humidified air at 30% per mask". On 4/29/06 at 1:30 PM, "Humidified O2 per trach mask at 32 psi". A review of the comprehensive care plan for resident 1 was completed on 5/3/06. Facility staff had not developed a care plan to address resident 1' s use of oxygen. A review of the hospice agency's care plan, dated 4/12/06, for resident 1 was completed on 5/3/06. It showed an equipment need and supply order for oxygen and a suction machine. The treatment care plan orders showed oxygen via 30% humidified air.	F 328		

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F 369 SS=B	483.35(g) DIETARY SERVICES - ASSISTIVE DEVICES The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, and clinical record review, it was determined that the facility did not provide special utensils for 2 out of 15 sampled residents who needed them consistently. Specifically, Residents 3 and 6 did not receive their built up utensils with each meal. Findings include: Resident 6 was admitted to the facility on 1/3/06 with diagnoses including, MS (Multiple Sclerosis), Falls, ROM (Range of Motion) restraint, and Vascular Dementia. Resident 6's clinical record was reviewed multiple times between 5/1/06 and 5/4/06. Resident 6 had the following physicians recertification orders in her clinical record for the month of May: "... supplement.. with meals and built up utensils.". Resident 6 was observed to have received her ordered built up utensils for the breakfast meal on 5/3/06 only. Resident 6 was observed to not have received her special utensils on all other meal observations between 5/1/06 and 5/4/06. Resident 3 was admitted to the facility one 10/30/03 with diagnoses that included osteoarthritis, Alzheimer, dementia with	F 369	F369 The facility provides special eating equipment and utensils for residents who need them. 1) Resident 3 and 6 were evaluated by occupational therapy for appropriate special services in regards to special eating equipment. Inserviced nursing staff, therapy and restorative aides on specifics of special eating equipment regarding resident 3 and 6. 2) Other resident's having the potential to be affected by this practice will be identified by: Reviewed other resident charts for special eating equipment and utensil needs. 3) Measures put into place to ensure success in this quality area include: Inserviced dietary, nursing, therapy and restorative staff on specifics of special eating equipment and utensils. 4) The facility plans to monitor its performance to ensure that solutions are achieved and sustained by: Twice monthly audits will be performed by D.O.N. or designee specifically assessing application of special eating equipment and utensils. Audits will be brought to the facility Performance Improvement (PI) meeting and reviewed until threshold reached. D.O.N. to monitor issue. Compliance date: 6/16/06	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465139	A. BUILDING _____ B. WING _____	05/04/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN TERRACE ALZHEIMERS	1201 EAST 4500 SOUTH SALT LAKE CITY, UT 84117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 369	Continued From page 11 behaviors, osteoporosis, hypertension, and cerebral vascular accident Resident 3's medical record was reviewed on 5/1/06. The physician's recertification orders for May 2006 documented "regular, mech (mechanical), soft diet w(with)/weighted utensils." Resident 3 was observed at breakfast in the restorative dining room, on 5/2/06 and 5/3/06, eating without the use of weighted/built up utensils. In an interview with Staff member 1, on 5/3/06 at 8:10 AM, in the restorative dining room, staff member 1 said the resident seem to be having more problems trying to eat with the built up utensil and he felt he did better with regular utensils.	F 369		
F 514 SS=B	483.75(l)(1) CLINICAL RECORDS 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. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514	F514 The facility maintains clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. 1) On 5/2/06 resident 7's oxygen saturation orders were reviewed and clarified by physician. On 5/03/06 Resident 3's progress note was placed into the resident's chart. 2) Other resident's having the potential to be affected by this practice will be identified by: Reviewed other resident charts specifically for complete and	

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F 514	Continued From page 12 Based on observation, interview and record review, it was found that the facility did not maintain accurate clinical records for 2 of 15 sample residents. Specifically related to complete and accurate documentation of oxygen saturations (SATS) for one resident and no progress notes for another resident. Resident identifiers 3 and 7. Findings include: Resident 7 was admitted to the facility on 10/27/06 with diagnoses including: Hypertension, Asthma, Chronic Airway Obstruction, Dementia, Alzheimer's disease, and Cerebrovascular accident. Observations of resident 7 revealed the following: On 05/01/06 from 1:30 to 4:45 PM and on 05/02/06 from 7:10 AM to 1:20 PM it was observed that resident 7 had no oxygen in place. On 05/02/06 at 8:08 AM, the physician's verbal order for oxygen was reviewed. The verbal order written on 3/14/02 for resident 7 reads..."O2 (oxygen) via N/C (nasal cannula) @ 1-3 L (liters) prn (as needed) titrate to keep saturations greater than 90%. " Resident 7's care plan was reviewed on 05/02/06 at 8:35 AM, the care plan documented, " Gas Exchange related to Coronary Obstructive Pulmonary Disease" (COPD) addresses.."check oxygen SATS at least Q shift.. "oxygen as ordered by Medical Doctor (MD)." On 05/02/06 at 1:35 PM, review of the treatment	F 514	accurate documentation of oxygen saturations. Reviewed other resident charts for updated medical progress notes. 3) Measures put into place to ensure success in this quality area include: Inserviced nursing staff on specifics of ensuring complete and accurate documentation of oxygen saturations. Inserviced medical records and medical staff on maintaining timely, completed medical assessments in charts. 4) The facility plans to monitor its performance to ensure that solutions are achieved and sustained by: random audits will be performed by D.O.N. or designee specifically assessing complete and accurate documentation of oxygen saturations. Random audits performed by Health Information Manager or designee on maintaining timely, completed medical assessments in charts. Audits will be brought to the facility Performance Improvement (PI) meeting and reviewed until threshold reached. D.O.N. to monitor issue. Compliance date: 6/16/06	

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F 514	Continued From page 13 record for March 2006 documents resident 7's SATS from 90 to 91%. The treatment record for April or May has no documentation of SATS. On 05/02/06 at 1:50 PM, resident 7's medication record was reviewed for April 2006 and May 2006. There was no order or documentation of SATS documented for April 2006 or May 2006. Resident 7's medical record was reviewed, on 05/02/06 at 8:30 AM, the vital sign flow sheet had no documentation that resident 7's SATS were performed from 2/01/06 to 4/23/06. Licensed Pracrical Nurse (LPN) 1 was interviewed, on 05/02/06 at 1:42 PM, concerning resident 7's SATS. LPN 1 was not aware that resident 7 had SATS ordered. LPN 1 walked to medication record and stated,... "there is no oxygen or SATS ordered on the medication record." Resident 3 was admitted to the facility one 10/30/03 with diagnoses that included osteoarthritis, Alzheimer, dementia with behaviors, osteoporosis, hypertension, and cerebral vascular accident Resident 3's medical record was reviewed on 5/1/06. The current clinical record did not have a progress note for April 2006. In an interview with the Physician's Assistant, on 5/3/06 at 1:10 PM she confirmed that the progress note for April was not on the clinical record and that it had be located in medical records and was done on 4/13/06.	F 514		