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
	465097	A. BUILDING ______ B. WING ______	05/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE CENTER	**350 EAST 300 NORTH** **AMERICAN FORK, UT 84003**

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F 241 SS=E	483.15(a) DIGNITY	F 241		7/20/07

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, the facility did not promote care in a manner that maintained or enhanced each residents' dignity and respect in full recognition of their individuality. Specifically, the facility did not answer call lights in a timely manner.

Findings include:

1. During a confidential group resident interview on 5/22/05 at 10:00 AM, the following was revealed:

a. Five of nine residents interviewed showed by raise of hands that they had waited more than 15 minutes for their call lights to be answered, and that this had occurred on more than one occasion.

b. The residents stated that the staff would turn off their call light at the nurses' station and not come to their room to see what they needed.

2. A confidential resident interview was conducted on 5/24/07 at 1:30 PM. The resident was asked how the staff responded when she used her call light. The resident stated that she frequently had to wait more than fifteen minutes for help.

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

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

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F 241	Continued From page 1 3. The following observations were made of call lights. a. On 5/22/07 room 314 activated their call light at 8:26 AM. The call light was answered by a nursing assistant at 8:33 AM -seven minutes later. b. On 5/24/07 room 117 activated their call light at 1:15 PM. The call light was answered by a nursing assistant at 1:23 PM - eight minutes later. c. On 5/24/07 room 112 activated their call light at 1:35 PM. It was answered by a nursing assistant at 1:47 PM - twelve minutes later. During the twelve minutes the call light was activated it was observed that two nursing assistants and the administrator walked by and did not answer the residents call light.	F 241		
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 and interview it was determined that the facility did not provide the necessary care to maintain the highest practical physical well being for 1 supplemental resident out of 16 sampled residents and 3 supplemental residents. (Resident identifier: S 19) Findings included:	F 309		7/20/07

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Resident S 19 was admitted to the facility on 3/10/06 with diagnoses that included seizure disorder, hypertension and injury to head and neck.

On 5/22/07 at approximately 8:00 AM, during the medication observation, nurse 1 was observed to place the following medications, for resident S 19, into a medication cup; Topamax 200 mg (milligrams) - 1 pill, multi-vitamin - 1 pill, calcium with /vitamin D - 1 pill, hydrochlorothiazide 12.5 mg - 1 pill, phenytoin 100 mg - 5 pills, vitamin C 500 mg - 1 pill, zaroxolyn 5 mg - 1 pill, Lasix 20 mg - 1 pill and potassium 20 milliequivalent - 2 pills. (This was a total of 14 pills.) At that time, resident S 19 was in the dining room eating his breakfast. Nurse 1 gave the medication cup with 14 pills in it, to resident S 19. Resident S 19 took the medication cup into his hand, put the cup up to his mouth and poured all 14 pills into his mouth. Resident S 19, then put water into his mouth and proceeded to swish the water and pills back and forth in his mouth. Nurse 1 instructed the resident to put his head back and swallow the pills. Resident S 19 held the pills in his mouth, while swishing them back and forth for approximately 2 to 3 minutes. Resident S 19 started to cough and then spit his pills out into a cup of water.

Nurse 1, then stated that resident S 19 usually does not have a problem taking all of his morning medications at one time. She stated that if she divided his medications up that resident S 19 would get irritated with her. She stated that resident S 19 was not very awake this morning and that she would return and re-administer resident S 19's morning medications later.

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On 5/22/07 at 9:45 AM, nurse 1 was observed to place the following medications, for resident S 19, into a medication cup; Topamax 200 mg (milligrams) - 1 pill, multi-vitamin - 1 pill, calcium with /vitamin D - 1 pill, hydrochlorothiazide 12.5 mg - 1 pill, phenytoin 100 mg - 5 pills, vitamin C 500 mg - 1 pill, zaroxolyn 5 mg - 1 pill, Lasix 20 mg - 1 pill and potassium 20 milliequivalent - 2 pills. (This was a total of 14 pills.) Nurse 1 gave the medication cup with 14 pills in it, to resident S 19. Resident S 19 took the medication cup into his hand, put the cup up to his mouth and poured all 14 pills into his mouth. Resident S 19, then put water into his mouth and proceeded to swish the water and pills back and forth in his mouth. Nurse 1 instructed the resident to put his head back and swallow the pills. Resident S 19 held the pills in his mouth, while swishing them back and forth for approximately 2 to 3 minutes. Resident S 19 started to cough and then swallowed all 14 pills.

On 5/22/07, resident S 19 was observed eating his breakfast and lunch meal in the dining room across from the DON's (director of nursing) office. Resident S 19 was observed feeding himself independently. Resident S 19 was observed to take small amounts of food on his spoon at a time. Resident S 19 was also observed on 5/23/07 at breakfast in the dining room. The resident was observed to take small amounts of food on his spoon at a time.

On 5/23/07 at 9:00 AM, nurse 2 was interviewed. Nurse 2 stated that when she administers resident S 19's morning medications to him that she puts two pills in yogurt on a spoon at a time. When asked if she ever gave resident S 19 all his morning medications in a cup, at one time, she

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F 309	Continued From page 4 responded, "No, he chokes if I give him more than 2 pills at a time."	F 309		
F 329 SS=E	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, it was determined that facility staff did not ensure that each resident's drug regimen received adequate monitoring. This occurred for 3 of 16 sampled residents who received sliding scale insulin. Resident identifiers: 2, 5, and 13. Findings included:	F 329		7/20/07

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1. Resident 2 was admitted to the facility on 4/04/07 with diagnoses that included, diabetes mellitus, hypertension, atrial fibrillation, atherosclerosis and rheumatoid arthritis.

On 5/22/07, a review of resident 2's medical record was completed.

Resident 2 had a physician order, dated 4/04/07, for Glucoscan checks in AM and at HS (hour of sleep). Novolog (fast acting) insulin was to be administered based on the blood sugar results according to the following sliding scale:

<149 = 0 units
150 - 199 = 1 unit
200 - 249 = 2 units
250 - 299 = 3 units
300 - 349 = 4 units
350 - 399 = 5 units
>400 = Call MD

Resident 2's computer generated Medication Administration Record (MAR) and Vitals Report for April and May were reviewed, and revealed the following:

On 5/16/07, it was documented at 5:58 AM, that resident 2 's blood glucose was 227. There was no documentation that Resident 2 received any insulin. Resident 2 should have received 2 units of Novolog insulin.

On 5/12/07, it was documented at 6:23 PM, that resident 2 's blood glucose was 315. There was no documentation that Resident 2 received any insulin. Resident 2 should have received 4 units of Novolog insulin.

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F 329	Continued From page 6 On 5/5/07, it was documented at 6:32 PM, that resident 2 's blood glucose was 180. There was no documentation that Resident 2 received any insulin. Resident 2 should have received 1 unit of Novolog insulin. On 5/4/07, it was documented at 6:24 PM, that resident 2 's blood glucose was 193. There was no documentation that Resident 2 received any insulin. Resident 2 should have received 1 unit of Novolog insulin. On 5/2/07, it was documented at 6:42 PM, that resident 2 's blood glucose was 180. There was no documentation that Resident 2 received any insulin. Resident 2 should have received 1 unit of Novolog insulin. On 4/28/07, it was documented at 7:40 PM, that resident 2 's blood glucose was 251. There was no documentation that Resident 2 received any insulin. Resident 2 should have received 3 units of Novolog insulin. On 4/27/07, it was documented at 8:20 PM, that resident 2 's blood glucose was 185. There was no documentation that Resident 2 received any insulin. Resident 2 should have received 1 unit of Novolog insulin. On 4/21/07, it was documented at 8:01 PM, that resident 2 's blood glucose was 220. There was no documentation that Resident 2 received any insulin. Resident 2 should have received 2 units of Novolog insulin. On 4/15/07, it was documented at 6:03 PM, that resident 2's blood glucose was 216. There was	F 329		

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F 329	Continued From page 7 no documentation that Resident 2 received any insulin. Resident 2 should have received 2 units of Novolog insulin. On 4/11/07, it was documented at 3:28 PM, that resident 2's blood glucose was 154. There was no documentation that Resident 2 received any insulin. Resident 2 should have received 1 unit of Novolog insulin. On 4/6/07, it was documented at 10:30 AM, that resident 2's blood glucose was 152. There was no documentation that Resident 2 received any insulin. Resident 2 should have received 1 unit of Novolog insulin. On 4/5/07, it was documented at 6:06 PM, that resident 2's blood glucose was 214. There was no documentation that Resident 2 received any insulin. Resident 2 should have received 2 units of Novolog insulin. On 4/4/07, it was documented at 6:03 PM, that resident 2's blood glucose was 180. There was no documentation that Resident 2 received any insulin. Resident 2 should have received 1 unit of Novolog insulin. 2. Resident 13 was admitted to the facility on 10/13/06 with diagnoses that included, diabetes mellitus, hypertension, hyperlipidemia, dysphagia, and cerebral aneurism. On 5/24/07, a review of resident 13's medical record was completed. Resident 13 had a physician order, dated 12/14/06, for blood sugar checks BID (twice daily)	F 329		

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at 8:00 AM and 5:00 PM. 14 units of Novolin N was to be administered twice a day and Novolin R was to be administered based on the blood sugar results according to the following sliding scale:

80 - 120 = 0 units
121 - 150 = 2 units
151 - 180 = 3 units
181 - 210 = 4 units
211 - 250 = 5 units
251 - 300 = 8 units
>300 = Call MD

On 3/29/07, resident 13's blood glucose was documented only once, at 6:05 AM. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 5:00 PM.

On 3/26/07, it was documented at 4:15 PM, that resident 13's blood glucose was 111. Documentation revealed that resident 13 received 2 units of insulin. Per physician's order, a blood sugar of 111 per sliding scale, no insulin should have been given.

On 3/11/07, it was documented at 11:41 AM, that resident 13's blood glucose was 247. Documentation revealed that resident 13 received 2 units of insulin. Resident 13 should have received 5 units of Novolin R insulin.

On 3/9/07, it was documented at 6:26 PM, that resident 13's blood glucose was 192. There was no documentation that resident 13 received any insulin. Resident 13 should have received 4 units of Novolin R insulin.

On 3/3/07, it was documented at 8:06 PM and at

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8:46 PM, that resident 13's blood glucose was 174. Documentation revealed that resident 13 received 3 units of insulin at 8:06 PM.

3. Resident 5 was re-admitted to the facility on 8/1/05 with diagnoses that included, diabetes mellitus, hypertension, Parkinson's disease, dementia with behaviors, depression, and congestive heart failure.

On 5/24/07, a review of resident 5's medical record was completed.

Resident 5 had a physician order, dated 1/3/2007, for blood sugar checks at 8:00 AM and 8:00 PM.

Resident 5 had a physician's order, dated 1/3/2007 for Novolog R (regular) insulin that was to be administered at 8:00 PM based on the blood sugar results according to the following sliding scale:

> 200=5 units
> 300=10 units
> 400=15 units

Resident 5's computer generated Medication Administration Record (MAR) and Vitals Report for May of 2007 was reviewed and the following was documented:

On 5/22/07, it was documented at 10:58 PM, that resident 5's blood glucose was 180. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM.

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F 329	Continued From page 10 On 5/21/07, it was documented at 6:27 PM, that resident 5's blood glucose was 178. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 5/20/07, it was documented at 10: 25 PM, that resident 5's blood glucose was 181. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 5/19/07, it was documented at 6:37 PM, that resident 5's blood glucose was 101. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 5/17/07, it was documented at 6:18 PM, that resident 5's blood glucose was 248. It was documented that resident 5 received 5 units of insulin. Per the physician's orders resident 5 should not have had a blood sugar done until 8:00 PM and should not have received any regular sliding scale insulin until 8:00 PM. On 5/16/07, it was documented at 6:21 PM, that resident 5's blood glucose was 89. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 5/15/07, it was documented at 6:15 PM, that resident 5's blood glucose was 196. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 5/14/07, it was documented at 6:10 PM, that	F 329		

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resident 5's blood glucose was 271. It was documented that resident 5 received 5 units of insulin. Per the physician's orders resident 5 should not have had a blood sugar done until 8:00 PM and should not have received any regular sliding scale insulin until 8:00 PM.

On 5/13/07, it was documented at 9:23 PM, that resident 5's blood glucose was 136. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM.

On 5/12/07, it was documented at 6:23 PM, that resident 5's blood glucose was 359. It was documented that resident 5 received 10 units of insulin. Per the physician's orders resident 5 should not have had a blood sugar done until 8:00 PM and should not have received any regular sliding scale insulin until 8:00 PM.

On 5/10/07, it was documented at 6:19 PM, that resident 5's blood glucose was 363. It was documented that resident 5 received 10 units of insulin. Per the physician's orders resident 5 should not have had a blood sugar done until 8:00 PM and should not have received any regular sliding scale insulin until 8:00 PM.

On 5/9/07, it was documented at 11:24 PM, that resident 5's blood glucose was 148. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM.

On 5/7/07, it was documented at 11:16 PM, that resident 5's blood glucose was 114. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been

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done at 8:00 PM.

On 5/6/07 there was no documentation that the 8:00 PM blood sugar was completed. However, on 5/5/07, it was documented at 1:58 AM, that resident 5's blood glucose was 218 and the resident was administered 5 units of insulin.

On 5/4/07, it was documented at 6:24 PM, that resident 5's blood glucose was 247. It was documented that resident 5 received 10 units of insulin. Per the physician's orders resident 5 should not have had a blood sugar done until 8:00 PM and should not have received any regular sliding scale insulin until 8:00 PM. (Note: for a blood sugar of 247 per sliding scale the resident should only have received 5 units of regular insulin.)

On 5/3/07, it was documented at 6:27 PM, that resident 5's blood glucose was 344. It was documented that resident 5 received 10 units of insulin. Per the physician's orders resident 5 should not have had a blood sugar done until 8:00 PM and should not have received any regular sliding scale insulin until 8:00 PM.

On 5/2/07, it was documented at 6:42 PM, that resident 5's blood glucose was 487. It was documented that resident 5 received 15 units of insulin. Per the physician's orders resident 5 should not have had a blood sugar done until 8:00 PM and should not have received any regular sliding scale insulin until 8:00 PM.

Resident 5's computer generated Medication Administration Record (MAR) and Vitals Report for April of 2007 was reviewed and the following was documented:

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F 329	Continued From page 13 On 4/30/07, it was documented at 6:17 PM, that resident 5's blood glucose was 181. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 4/27/07, it was documented at 6:55 PM, that resident 5's blood glucose was 110. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 4/26/07, it was documented at 6:23 PM, that resident 5's blood glucose was 110. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 4/25/07 there was no documentation that the 8:00 PM blood sugar with possible insulin coverage was completed. On 4/24/07, it was documented at 6:15 PM, that resident 5's blood glucose was 89. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 4/23/07, it was documented at 6:09 PM, that resident 5's blood glucose was 195. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 4/22/07, it was documented at 10:38 PM, that resident 5's blood glucose was 168. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been	F 329		

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done at 8:00 PM.

On 4/22/07, it was documented at 6:43 PM, that resident 5's blood glucose was 267. The "insulin units given" column was blank. Per the physician's orders resident 5 should not have had a blood sugar done until 8:00 PM and at 8:00 PM should have received 5 units of regular sliding scale insulin.

On 4/1907, it was documented at 6:25 PM, that resident 5's blood glucose was 293. It was documented that resident 5 received 5 units of insulin. Per the physician's orders resident 5 should not have had a blood sugar done until 8:00 PM and should not have received any regular sliding scale insulin until 8:00 PM.

On 4/18/07, it was documented at 6:17 PM, that resident 5's blood glucose was 307. It was documented that resident 5 received 10 units of insulin. Per the physician's orders resident 5 should not have had a blood sugar done until 8:00 PM and should not have received any regular sliding scale insulin until 8:00 PM.

On 4/17/07, it was documented at 10:27 PM, that resident 5's blood glucose was 148. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM.

On 4/16/07, it was documented at 6:20 PM, that resident 5's blood glucose was 311. It was documented that resident 5 received 10 units of insulin. Per the physician's orders resident 5 should not have had a blood sugar done until 8:00 PM and should not have received any regular sliding scale insulin until 8:00 PM.

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On 4/15/07, it was documented at 6:03 PM, that resident 5's blood glucose was 361. It was documented that resident 5 received 10 units of insulin. Per the physician's orders resident 5 should not have had a blood sugar done until 8:00 PM and should not have received any regular sliding scale insulin until 8:00 PM.

On 4/13/07, it was documented at 6:40 PM, that resident 5's blood glucose was 145. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM.

On 4/12/07, it was documented at 6:02 PM, that resident 5's blood glucose was 226. It was documented that resident 5 received 5 units of insulin. Per the physician's orders resident 5 should not have had a blood sugar done until 8:00 PM and should not have received any regular sliding scale insulin until 8:00 PM.

On 4/11/07, it was documented at 10:53 PM, that resident 5's blood glucose was 128. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM.

On 4/10/07, it was documented at 6:31 PM, that resident 5's blood glucose was 175. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM.

On 4/9/07, it was documented at 6:15 PM, that resident 5's blood glucose was 431. It was documented that resident 5 received 15 units of insulin. Per the physician's orders resident 5

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F 329	Continued From page 16 should not have had a blood sugar done until 8:00 PM and should not have received any regular sliding scale insulin until 8:00 PM. On 4/6/07, it was documented at 6:22 PM, that resident 5's blood glucose was 300. It was documented that resident 5 received 10 units of insulin. Per the physician's orders resident 5 should not have had a blood sugar done until 8:00 PM and should not have received any regular sliding scale insulin until 8:00 PM. On 4/5/07, it was documented at 6:06 PM, that resident 5's blood glucose was 96. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 4/4/07, it was documented at 6:03 PM, that resident 5's blood glucose was 288. It was documented that resident 5 received 5 units of insulin. Per the physician's orders resident 5 should not have had a blood sugar done until 8:00 PM and should not have received any regular sliding scale insulin until 8:00 PM. On 4/2/07, it was documented at 10:07 PM, that resident 5's blood glucose was 156. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 4/1/07, it was documented at 5:53 PM, that resident 5's blood glucose was 336. It was documented that resident 5 received 10 units of insulin. Per the physician's orders resident 5 should not have had a blood sugar done until 8:00 PM and should not have received any regular sliding scale insulin until 8:00 PM.	F 329		

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F 329	Continued From page 17 Resident 5's computer generated Medication Administration Record (MAR) and Vitals Report for March of 2007 was reviewed and the following was documented: On 3/31/07, it was documented at 6:04 PM, that resident 5's blood glucose was 179. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 3/29/07, it was documented at 6:16 PM, that resident 5's blood glucose was 158. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 3/27/07, it was documented at 6:35 PM, that resident 5's blood glucose was 163. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 3/26/07, it was documented at 6:46 PM, that resident 5's blood glucose was 91. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 3/23/07, it was documented at 6:29 PM, that resident 5's blood glucose was 98. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 3/22/07, it was documented at 9:16 PM, that resident 5's blood glucose was 280. It was documented that resident 5 received 5 units of	F 329		

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F 329	Continued From page 18 insulin. Per the physician's orders resident 5 should not have had a blood sugar done until 8:00 PM and should not have received any regular sliding scale insulin until 8:00 PM. On 3/19/07, it was documented at 6:11 PM, that resident 5's blood glucose was 70. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 3/18/07, it was documented at 10:20 PM, that resident 5's blood glucose was 179. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 3/16/07, it was documented at 6:45 PM, that resident 5's blood glucose was 113. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 3/14/07, it was documented at 11:59 PM, that resident 5's blood glucose was 193. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 3/13/07, it was documented at 10:29 PM, that resident 5's blood glucose was 255. It was documented that resident 5 received 5 units of insulin. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 3/11/07, it was documented at 11:50 PM, that resident 5's blood glucose was 160. Per physician's orders a blood sugar, with possible	F 329		

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F 329	Continued From page 19 sliding scale insulin coverage, should have been done at 8:00 PM. On 3/10/07, it was documented at 6:45 PM, that resident 5's blood glucose was 264. It was documented that resident 5 received 5 units of insulin. Per physician's orders a blood sugar, with sliding scale insulin coverage, should have been done at 8:00 PM. On 3/9/07, it was documented at 6:26 PM, that resident 5's blood glucose was 394. It was documented that resident 5 received 10 units of insulin. Per physician's orders a blood sugar, with sliding scale insulin coverage, should have been done at 8:00 PM. On 3/7/07, it was documented at 6:19 PM, that resident 5's blood glucose was 290. It was documented that resident 5 received 5 units of insulin. Per physician's orders a blood sugar, with sliding scale insulin coverage, should have been done at 8:00 PM. On 3/6/07, it was documented at 6:31 PM, that resident 5's blood glucose was 148. Per physician's orders a blood sugar, with possible sliding scale insulin coverage, should have been done at 8:00 PM. On 3/4/07, it was documented at 6:03 PM, that resident 5's blood glucose was 210. It was documented that resident 5 received 5 units of insulin. Per physician's orders a blood sugar, with sliding scale insulin coverage, should have been done at 8:00 PM. On 3/2/07, it was documented at 6:32 PM, that resident 5's blood glucose was 290. It was	F 329		

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F 329	Continued From page 20 documented that resident 5 received 5 units of insulin. Per physician's orders a blood sugar, with sliding scale insulin coverage, should have been done at 8:00 PM. There was no documentation found in resident 5's Vitals Report that on 3/1/07 at 8:00 PM a blood sugar was done.	F 329		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility did not store, distribute and serve food under sanitary conditions. Findings included: 1. On 5/21/07 at 11:00 AM, the following observations were made of the facility kitchen: a. Large particles of dust were observed on the top three shelves of a five-shelf metal rack where resident trays are stored between meals. b. Two papers covered in plastic were hung by chains above the steam tables. Large particles of dust were observed on both of the papers as well as the chains hanging from the ceiling. 2. On 5/21/07 at 11:00 AM, the following observations were made of the facility refrigerator: a. One plate of salad, covered, no date or	F 371		7/20/07

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label. The dietary manager stated that this was to be eaten by an employee and that her staff did not label food in the refrigerator if it was for staff.

b. Seventeen individually portioned cups of yogurt, covered, and 21 individually portioned cups of fruit, covered, with a label of 5/15/07.

3. On 5/21/07 at 11:00 AM, the following observation was made of the facility freezer:

a. Three individually portioned cups of a pink ice cream-like substance, covered, but not labeled or dated.

4. On 5/22/07 at 12:00 PM, the following observations were made in the facility kitchen during the lunchtime trayline service:

a. Dietary staff member (DSM)1 was observed to lick his right index finger and then touch residents' tray cards in order to separate the tray cards. DSM 1 was observed to lick his right index finger before touching resident tray cards a total of 18 times during lunchtime trayline service on 5/22/07. DSM 1 was then observed to touch various objects in the kitchen, including resident milk glasses, resident juice glasses, the handle of the juice dispenser, the handle of the refrigerator, and resident food trays. At no time during the lunchtime trayline service was DSM 1 observed to wash his hands or put gloves on.

b. DSM 1 was observed to place prepared resident trays on the staff handwashing sink while waiting for a certified nurse aid to pick them up and deliver them to the resident. This observation was made three times during the lunchtime trayline service on 5/22/07.

5. On 5/22/07 at 12:30 PM, in the secondary dining room, food service by facility staff was observed. Each of the dining room tables had a

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F 371	Continued From page 22 basket of rolls on them. As facility staff passed out a roll to individual residents eating lunch, the roll was placed directly onto the dining room table. No plates or napkins were used underneath the rolls to protect them from possible cross-contamination. This practice was observed 12 times during lunch on 5/22/07.	F 371		
F 406 SS=D	483.45(a) SPECIALIZED REHABILITATIVE SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility did not provide the required specialized rehabilitative services (SRS) for 1 out of 16 sample residents due to the resident's inappropriate behaviors and transportation difficulties. Resident identifier: 4. Findings include: Resident 4 was admitted to the facility on 11/27/02 with diagnoses that included moderate mental retardation, migraine, mood disorder, seizure disorder, incontinence, insomnia, agitation and adjustment disorder with depression.	F 406		7/20/07

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F 406	Continued From page 23 1. On 5/21/07 at approximately 11:30 AM, an interview with nurse 1 was held. Nurse 1 stated, "Don't get too close to [resident 4]. He'll kick you." On 5/22/07 at 8:15 AM, an interview with nurse 3 was held. Nurse 3 stated that resident 4 spits on staff and is at times physically abusive. On 5/24/07 at 9:10 AM, an interview was held with CNA (certified nursing aid) 1. "I try to get [resident 4] up in the mornings but he kicks, spits, and swears." When asked if resident 4 was a difficult resident, CNA 1 stated, "That's an understatement. He's not right for our facility." On 5/24/07 at 2:00 PM, the facility Assistant Administrator (AA) was interviewed. The AA stated "He's not as violent lately, but my CNA's are leery of [resident 4]. He (resident 4) started swearing about two years ago and started refusing to go to work 12-18 months ago. For over a year he's been a problem to get up in the mornings. In the afternoons he sits in the activity room. When he's in the lunchroom he swears and offends other residents at dinner. At night he doesn't want to go to bed. He's controlling us and he knows it. In the past he has kicked someone across the room." A review of resident 4's clinical record was completed on 5/24/07. A review of the 4/15/07 annual MDS (Minimum Data Set) and the 1/22/07 quarterly MDS for resident 4 revealed that resident 4 was verbally abusive, socially inappropriate and resisted cares one to three times a week. Per the previous interviews, resident 4 was reported to also be	F 406		

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F 406	Continued From page 24 physically abusive. This was not documented in either of the MDS assessments. Based on resident 4's annual MDS assessment dated 4/15/07, resident 4 triggered in the behavioral symptoms area of section V, the RAPS (resident assessment protocol summary), indicating that a care plan relating to behavioral symptoms must be developed. Review of resident 4's care plan revealed that the ADL (activities of daily living) care plan documented that resident 4, "refuses to get OOB (out of bed) at times. Physical and verbal abuse toward staff at times." No specific facility interventions or behavioral approaches were listed in the ADL care plan, or any other area of resident 4's comprehensive care plans. On 5/23/07 at 9:00 AM, an interview was held with the facility resident advocate regarding resident 4's behaviors. "The current behavior program we have in place is when he (resident 4) is good we put a dinosaur in a bucket and then when the bucket is full he gets to go on an outing with a recreation therapist." On 5/23/07 at 9:45 AM an interview was held with the facility AA regarding resident 4. "We haven't been consistent with him. The sleeping in is also a behavior.....[The psychiatrist] told us that we've reinforced [resident 4]'s negative behavior and to just walk away when [resident 4] is spitting or yelling. The psychiatrist also told us that our program is not narrow enough, that we've given him too much room for behaviors, and that we need to shorten our behavior program." Resident 4's monthly SRS evaluations dated	F 406		

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12/8/06, 1/8/07, 2/14/07, and 3/27/07 were reviewed. The evaluations documented that resident 4's behaviors were interfering with his SRS goals. However, the SRS team did not address possible underlying causes for resident 4's behaviors nor did they develop more appropriate SRS goals. (Per interview with RNA 1 on 5/29/07 at 10:00 AM the SRS team consisted of the resident advocate, the corporate QMRP (qualified mental retardation professional), and recreation therapy as well as RNA 1.)

2. Resident 4's monthly SRS evaluations dated 12/8/06, 1/8/07, 2/14/07, 3/27/07, 4/25/07 and 5/15/07 were reviewed. These reports each indicated a goal for resident 4 to attend a day program three times per week and was to be transported by bus to and from the day program.

On 5/24/07 a piece of paper that was taped to the inside cover of the SRS book was reviewed. It was documented each time on 4/23/07 and 4/24/07 that the "bus is canceled." On 4/25/07 facility staff documented that resident 4 was taken off of the bus because his wheelchair was not certified by the bus company. On 5/1/07 facility staff documented that the facility canceled the bus because the wheelchair still was not certified. On 5/2/07 SRS data sheets indicate that "Pt (patient) up ready to go to day program, but no transportation available." An SRS monthly report dated 5/15/07 documented that "Res attended [work] three times for the whole month (of April). Transportation issues." The monthly report also documented a goal for resident 4 to attend his day program three times a week.

Recreation therapy notes dated 4/19/07 documented that resident 4 "has refused to get

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F 406	Continued From page 26 out of bed... in mornings which causes res (resident) to miss going to [day program] due to not being ready for bus rides." On 5/23/07 at 9:00 AM, an interview was held with the facility resident advocate. The resident advocate stated that the problems with transportation with resident 4 were two-fold:1) resident 4 won't get out of bed and 2) "if the bus driver gets here and [resident 4] isn't ready he gets mad and leaves. . . We were trying to arrange with our van driver to try to take [resident 4] to the day program 2-3 times a week, but it's just hard because he takes other residents to their doctors' appointments. This (transportation issue) has been a problem for a couple of months. . . Also, if it's the man bus driver he'll pick [resident 4] up, but if it's the lady bus driver, she won't pick [resident 4] up because she has a different wheelchair description on file. We haven't contacted [the bus company] yet to work things out." On 5/30/07 at 1:30 PM an interview with a day program employee who worked with resident 4 was conducted by telephone. The day program employee stated that resident 4 has not been in to the day program at all during the month of May.	F 406		
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services	F 425		7/20/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465097	A. BUILDING ___ B. WING ___	05/24/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 425	Continued From page 27 (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record reviews and an interview, it was determined that the facility did not ensure that each resident's drug regimen received adequate monitoring. It was determined that the facility pharmacist did not do a comprehensive medication review for 2 of 16 sampled residents who received sliding scale insulin. (Resident identifiers: 5 and 13.) Findings included: Resident 5 was re-admitted to the facility on 8/1/05 with diagnoses that included, diabetes mellitus, hypertension, Parkinson's disease, dementia with behaviors, depression, and congestive heart failure. On 5/24/07, a review of resident 5's medical record was completed. Resident 5's Vitals Report for April 1,2007 to April 30,2007 was reviewed. There were 24 documented errors in the tracking of blood sugars and/or in the administration of insulin. (Refer to	F 425		

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F 425	Continued From page 28 tag F 329) Resident 5's Vitals Report for March 1,2007 to March 31,2007 was reviewed. There were 20 documented errors in the tracking of blood sugars and/or in the administration of insulin. (refer to tag F 329) Resident 5's "Consultant Pharmacist Drug Regimen Review" form was reviewed. There was no documentation found in the 3/20/07 and the 4/13/07 sections of the form that indicated that the pharmacist had reviewed resident 5's blood glucose monitoring and/ or insulin administration. In both sections the "No new suggestions" area was checked off. Resident 13 was admitted to the facility on 10/13/06 with diagnoses that included, diabetes mellitus, hypertension, hyperlipidemia, dysphagia, and cerebral aneurism. On 5/24/07, a review of resident 13's medical record was completed. Resident 13's Vitals Report for March 1,2007 to March 31,2007 was reviewed. There were 5 documented errors in the tracking of blood sugars and/or in the administration of insulin. (refer to tag F 329) Resident 13's "Consultant Pharmacist Drug Regimen Review" form was reviewed. There was no documentation found in the 3/20/07 section of the form that indicated that the pharmacist had reviewed resident 13's blood glucose monitoring and/ or insulin administration. The "No new suggestions" area was checked.	F 425		

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F 425	Continued From page 29 On 5/30/07 at 10:25 AM, the facility pharmacist was interviewed via the telephone. The pharmacist stated that she does not look at the tracking of blood sugars or insulin on the Vitals Reports unless the resident's Hemoglobin A1c is "greater than 8." (This test is used mainly as a measurement of the effectiveness of diabetic therapy. An elevated hemoglobin A1c greater than 8% indicates uncontrolled diabetes.)The pharmacist stated that the residents "Vitals Report" is "too hard to follow." The pharmacist stated that the computer program for tracking blood sugars and insulin administration is "inadequate." She stated that it is "very alarming to us" that the work the nurses are doing is "not properly recorded."	F 425		