STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465128	A. BUILDING _____ B. WING _____	11/8/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE REHABILITATION CENTER	1216 EAST 1300 SOUTH SALT LAKE CITY, UT 84105

POC accepted 12-28-01 EDL

(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 225 SS=D	483.13(c)(1)(ii) STAFF TREATMENT OF RESIDENTS	F 225		

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:

Based on interviews with the facility administrator, the facility social worker, group interview and a

DE 12-28-01 EDL

The preparation of the plan of correction for these deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions and/or in the statement of deficiencies. The plan of correction was prepare solely because the provisions of the state and federal law require.

F225-
On 11/7/01 the follow-ups and results of the investigation were to the State Survey Agency for the incidents in question.

On 6/25/01, the pool agency was contacted and stated that the nurse in question was no longer working for the agency. A statement was sent to the State Survey Agency.

It is the policy and Hillside will continue to not employ individuals who have been found guilty of abusing, neglecting or mistreating residents and that the results of all investigations be reported to the appropriate individuals under the State and Federal law.

DEC 27
388369 HT

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE 12/27/01

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 aft 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 225	Continued From Page 1 confidential resident interview, review of incident reports, review of State Survey and Certification Agency records and review of facility abuse protocol, it was determined that the facility did not submit a follow up report of a staff to resident sexual abuse allegation within 5 working days of the allegation, and did not report an incident of alleged inappropriate physical contact between a male nurse and a female resident. Findings include: 1. An incident of alleged staff to resident sexual abuse was reported to the State Survey and Certification Agency (state agency) on 6/25/01. A report of the investigation results was not received by the state agency within 5 working days of the allegation. On 7/10/01 at 1:30 PM, a call was made from the state agency to the acting director of nursing service (ADON) regarding the follow-up report, she stated she was new to the position and was not aware that a follow-up report needed to be sent to the state agency, she stated that she would fax the final report. The report was not received by the state agency. On 8/8/01 at 9:00 AM, a call was made to the facility administrator regarding the follow-up report of the 6/25/01 allegation, he stated that he would fax the report to the state agency. The report was not received by the state agency. In an interview with the administrator, on 11/7/01 at 2:15 PM, regarding the follow-up report of the 6/25/01 allegation, he stated that he was waiting for the police report before submitting the final report to the state agency. 2. On 10/30/01 at 1:30 PM, during the group	F 225	On 12/12/01the facility had an inservice for all department heads on the protocol for reporting any alleged abuse situation to their department head/ or the administrator. A review of the facility abuse policy, which states that all allegations of abuse will be reported immediately to the state and other concerned parties (i.e. APS and the ombudsman) and followed up on within 5 days by the Administrator or appointee, was incorporated into the education program. An inservice was done for all staff on 12/24/01 to teach protocol for abuse. At the time of the alleged abuse is reported, an investigation will be immediately started and the results of the investigation will be reported in the accordance with State and Federal law. All alleged abuse incidents will be reviewed during the morning QA meeting and further appropriate interventions will be taken as indicated. Resident council will be informed of the importance of reporting any concerns of inappropriate behavior to any department head to ensure appropriate investigation and action is taken. All incidents will be reviewed during the weekly, monthly and quarterly Quality Assurance meeting, as an added measure	

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F 225	Continued From Page 2	F 225		

interview, a female resident reported that a male nurse from a staffing agency had kissed her on the shoulder last evening. The female resident felt the incident was very inappropriate and made her feel uncomfortable.

In a follow up interview with this female resident, on 11/6/01 at 1:00 PM, she stated that she had reported the kissing incident to the ADON and to a nurse.

In an interview with the facility social worker, on 11/7/01 at 1:00 PM, she stated she had investigated the kissing incident and had reported back to the resident that the nurse will no longer be working at the facility. The social worker stated that she had not reported the incident to the state agency.

In an interview with the administrator, on 11/7/01 at 2:15 PM, he stated that he had called the staffing agency regarding the kissing incident with the female resident and told them that he did not want the nurse to work at this facility. The administrator also stated that he did not think the incident needed to be reported to the state agency.

Facility abuse policy states:

"The administrator will immediately notify Adult Protective Services or local law enforcement authorities [and if staff abuse is alleged, also notify the Bureau of Facility Review] and the local long term care ombudsman."

"The facility will report the results of its findings within five working days to the required state agencies as above as well as the resident's physician and the resident or his/her legal representative."

to ensure appropriate action has been taken

The Administrator will be responsible for monitoring this system.

The facility compliance anticipated date is 12/24/01.

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F 253 SS=E	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 observations and group and staff interviews, it was determined that the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior as evidenced by: Thirty-two of forty-three resident rooms, twenty-two of twenty-five resident bathrooms and the resident common areas, revealed housekeeping and maintenance services were not provided routinely. Findings include: On 10/30/01 at 1:30 PM, a confidential group interview was conducted about the appearance and condition of the building. The following comments were made: One resident stated that housekeeping does not change the mop water and that they go from room to room, even isolation rooms, without changing the mop water. Another resident stated that housekeeping does not dust. A third resident stated that he/she has to clean his/her own floor because when he/she opens the window the dust blows around. The third resident stated further that he/she had observed the same drinking glass sit on the toilet for over a month. He/she stated further that he/she has gone to take a shower and there was a bowel movement on the floor from the resident before him/her. A review of Resident Council Minutes was performed on 10/30/01. On 8/6/01 the resident council documented their concerns about housekeeping not deep cleaning.	F 253	F253- A housekeeping supervisor has been hired to monitor quality of cleaning and provide in-services for the housekeeping staff. Housekeeping rounds will be done 5 days per week and documented by the housekeeping supervisor and will include all resident rooms and common areas. Documentation of rounds will be analyzed each week and findings will be brought to the QI committee for quality assurance. The maintenance Manager will be responsible for bringing finding to the QI meeting. On 12/5/01 a contractor was in the facility to provide a bid for services to replace all bathroom floors. Total replacement time will bring the completion date to 3/31/02. This will remedy the problem with the chipped floor tiles in S-1, S-3, S-4, S-7, S-10, N-1, N-3, N-6, N-14, and N-18. A request was sent to the bureau for a variance on the time frame to be extended from 1/7/02 to 3/31/02 for replacement of the tile. The maintenance manager will perform quality rounds each week, which will include: Floor Maintenance- tiles, carpet Door Repair Wall Repair Bed Repair Heater/ Air Conditioner Repair The findings of the maintenance quality rounds will be brought to QI meeting for quality assurance.	

gk
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12/28/01

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F 253	Continued From Page 4 On 9/4/01 the resident council documented their concerns about bathrooms needing to be cleaned. Observation of the facility during the recertification survey on 11/7/01 revealed the following: All of the resident rooms, except for the resident rooms with the carpets, were observed to have a wax buildup of grey substance along the edges where the floor meets the wall. All resident bathrooms were observed to have dirt and grey buildup around the edges, especially in the corners and on the floor around the door frames. The hall corridors through out the entire facility was also observed to have dirt and old grey buildup along all of the edges. On 11/7/01 at 4:00 PM, the director of maintenance was interviewed. He stated the grayish substance against the edges of the floor was wax buildup, he also stated that he felt housekeeping did not change the mop water frequently enough. SOUTH HALL: The bathroom between room S-1 and S-2 was observed to have several pieces of broken/chipped floor tiles. By one door there were 4 pieces of broken/chipped floor tile, by the other door there was an area of approximately 4 by 6 inches of broken/chipped floor tile and there were several broken/chipped pieces below the sink, all of these broken/chipped tiles had a buildup of sticky black dirt and wax in the cracks. The towel dispenser was observed to have a layer of dust. The bathroom smelled of urine. The bathroom sink faucet of room S-3 was dripping water, and had three broken/chipped pieces of floor tile that had a black dirt and wax buildup in the cracks.	F 253	Housekeeping staff in-service has been held on 11/8/01, from the new Housekeeping Supervisors, to teach the appropriate way to clean a room. Regular in-services will be held on a monthly basis from the manufacturer for 6 months and every quarter thereafter. Spaces between heater frame and heater have been sealed on 12/7/01in S-13 and other rooms with similar problems. Weekly maintenance rounds will detect any further problems. Corners and doors needing repair S-19 and S-20 and others have been identified and repaired on 12/7/01. Future concerns will be identified in maintenance rounds and safety committee. Findings will be brought to the QI committee for quality assurance. The toilet in room N-12 has been replaced. Future problems will be identified and remedied by maintenance and safety committee rounds and findings will be reported to the QI committee for quality assurance. The Maintenance Manager will be responsible for ensuring compliance to this tag. The facility anticipated date for compliance is 1/7/02 for all but the tile replacement.	

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The bathroom between rooms S-4 and S-5 was observed to have three 1 inch square floor tiles missing. Approximately 3 x 6 inch piece of tile coving, next to the door frame by the toilet, appeared to have been replaced, the tile and surrounding area were still covered with white substance.

The bathroom between rooms S-6 and S-8 was observed to have tissue paper stuck to the shower stall floor and a glove turned inside out on the floor by the trash can.

The bathroom between rooms S-7 and S-9 had an area measuring approximately 6 x 16 inches of missing 1 inch square floor tiles.

The bathroom between rooms S-10 and S-12 had five missing 1 inch square floor tiles.

Room S-13 was observed to have a privacy curtain, for both A and B beds, where the bottom edge of curtains dragged on the floor approximately 12 inches, causing a fall hazard. The trash container in the room was observed to be overflowing with trash. The heater in the room, which is on the outside wall, had a crack around the edge, between the heater and the wall, measuring approximately 1/2 inch wide by 18 inches long, large enough to see through to the outside. There was a dried pink liquid stain on the floor, by the entry door, measuring approximately 4 x 4 inches.

The bathroom between rooms S-13 and S-14, on the floor next to the sink, under the soap dispenser was observed to have a buildup of liquid soap, and tissue paper that was stuck to the top of the soap.

The bathroom between rooms S-15 and S-16 was observed to have a dirty gray sticky buildup, in the

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corner under the sink, measuring approximately 2 feet along each wall. The toilet bowel had dust build up on the edge behind the toilet seat.

Room S-16 was observed to have a yellow liquid spilled on the floor measuring approximately 3 inches by 3 inches. The spill was observed to remain in the resident north east corner of her room from 10/29/01 to 11/7/01.

Room S-17 was observed to have approximately 17 inches of metal edging (corner bead) that was not covered by plaster or paint on the corner of the wall by the bed.

Room S-19 was observed to have one piece of cracked linoleum.

The bathroom between rooms S-18 and S-20 was observed that the bottom edges of the wooden doors, on the inside of the bathroom between the two rooms, were peeling from the lower edges of the doors, measuring from approximately 2 inches to 18 inches up the doors. The peeling areas were very rough and had jagged edges of splintery wood. The door frame into the bathroom from room S-18 appeared to have been replaced with a new metal frame and the wall edges along the door frame, in the bathroom next to the toilet and in room S-18, was not repaired, exposed unrepaired and unpainted wall board could be seen extending the entire length of the door frame, in the bathroom and in the resident room, extending approximately 1/2 inch from the door frame.

NORTH HALL:

In the bathroom of N-1 and N-2, the wall between the shower stall and the toilet had approximately 2 x 1 inch area, which was approximately 12 inches from the

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ceiling, where metal was exposed and rusting. Live ants were observed by the trash can near the toilet . Dead ants were observed by the shower and bathroom door. There was a strong odor of urine. The administrator accompanied the surveyors, on 11/7/01 at 3:00 PM, and verified the urine odor.

Room N-1 was a carpeted room and had a sink in the room that had an area of linoleum which had been covered with a sealant before it had been cleaned. The administrator verified this observation on 11/7/01 at 3:00 PM.

The bathroom of N-3 had three pieces of 1 inch floor tile missing by the sink and had an area where the floor was bulging.

The bathroom between N-4 and N-5 was observed to have dust buildup on the paper towel dispenser.

The bathroom between N-6 and N-7 was observed to have six 1 inch square floor tiles missing by the toilet.

Room N-8, bed B, was observed to have a spider web on the wall, approximately 12 inches from the ceiling next to the window. Bed A had seven stained linoleum floor tiles, measuring approximately 2 x 4 feet.

The bathroom in room N-12 was observed to have a large break at the base of the toilet, which measured approximately 2 x 6 inches.

Room N-14 was observed to have a spider web behind the entry door and a large spider was seen under bed A. There were 2 brown smears on the floor by bed A. The wall by Bed B was observed to have large scrapes. The two areas were next to the window and measured approximately 4 inches wide by 24 inch long and an

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area at the head of the bed that measured approximately 3 inches wide by 36 inches long.

The bathroom between N-14 and N -15 was observed to have several missing 1 inch floor tiles, mostly around the toilet.

The bathroom between N-16 and N-17 was observed to have dried white residue on three tiles on the wall by the toilet.

The bathroom between N-18 and N-19 was observed to have one tile coming loose from the coving around the shower stall.

Room N-20 had a glove that was rolled inside out on the floor by bed A.

The bathroom between room N-20 and N-21 was observed to have paper towels around and overflowing out of the garbage can. Dust buildup was observed on the paper towel dispenser.

On at 11/1/01 at approximately 11:00 AM, an interview with the housekeeper about how many times she changes the mop water. She stated she changes the mop water 3 to 4 times for all the resident rooms and hallway.

On 11/7/01 at approximately 4:00 PM, the facility director of maintenance was interviewed regarding the cleaning schedule and work orders for missing floor tile. He stated that he had no work orders for replacing floor tile. He stated that the facility had a deep cleaning schedule for each hall and a map that showed which rooms had been deep cleaned.

A review of the facility map of deep cleaning was done and showed that rooms S-1 through S-5 and

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F 253	Continued From Page 9 room S-12 had been deep cleaned. The surveyor had the director of maintenance observed rooms S-4 and S-5 and bathroom on 11/7/01 at 4:00 PM. The dirt and wax buildup around the edges of the rooms was still present. The facility "5 step daily room cleaning" instructions were reviewed and stated that "a putty knife was to be used along floor edges, around door frames and in corners... and to wet mop floor being careful to avoid buildup along edges and in corners."	F 253		
F 281 SS=E	483.20(k)(3)(i) RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility did not meet professional standards of quality when caring for residents with urinary catheters. The population of residents with urinary catheters in this facility was 6 out of 66. Standards of clinical practice were not met for 2 of the 6 residents with urinary catheters in which the tubing was observed on the floor. Resident 51 was a sample resident and resident 49 was an additional resident. In addition, the facility did not meet professional standards of quality when providing services for 1 of 2 residents with gastrointestinal tubes. Resident identifier: 66. Findings include: 1. Resident 66 was a 65 year old male who was admitted to the facility on 11/20/92. Resident 66 had a gastrointestinal tube (G-tube) with orders from the	F 281	F281- It is policy of, and Hillside will continue to provide services that meet professional standards of quality. 1-All dressing will be dated and monitored to ensure proper care of resident #66. Nurses have been re-educated on the importance of following the doctor's ordered treatments. Documentation will be reflected on the MAR that the treatment has been done as ordered and dressings will be dated when done. The ADON will be responsible for monitoring that all treatments have been completed as ordered during weekdays. Documentation will be kept in the skin book on a weekly basis. The ADON will be responsible for treatments and bringing pertinent documentation for review by the QA team to ensure quality care.	

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F 281	Continued From Page 10 physician to "clean around G-tube site with N/S (normal saline) and gauze X 2 Q WK & PRN (twice every week and as necessary)." Review of the October 2001 treatment record for resident 66 revealed no documentation to evidence that 6 of 9 scheduled cleanings had been performed as ordered. A nurse's note from the medical record of resident 66, dated 10/29/01, documented the following: "Resident's G-tube site hasn't been cleaned since 10/25/01. Area red/very dry, crusted, with indent of the tube stopper around the abdomen. Gauze clinging with pieces actually into resident's skin." The nurse who wrote the entry on 10/29/01 was interview on 11/6/01 at 8:10 AM. When asked regarding the incident with resident 66 on 10/29/01, she stated that "part of the gauze dressing was embedded into the resident's skin around the tube site. It was pretty bad." On 11/6/01 at 7:45 AM, a facility nurse aide stated she knew that skin treatments were not getting done. She stated that resident 66 had not received his skin care on his gastric tube for four days. She stated that she had observed the dressing on resident 66 and that it "was dried and stuck to his skin." 2. On 10/31/01 at 8:10 AM, resident 49 was observed sitting up in a wheelchair in her room. Six inches of resident 49's catheter tubing was observed to be lying on the floor. This resulted in direct contamination of the catheter tubing. The resident 's catheter bag was observed to be completely full of urine and bulging. The catheter tubing was also observed to be completely full of urine which was backed up toward the bladder.	F 281	All catheter care and tubing will be monitored as per the following system to ensure proper compliance with regulations for residents # 49 & 51. 2- Daily random observations will be performed to ensure that neither catheter bags nor tubing are on the floor and that catheter bags are emptied as necessary. Staff has been in-serviced on the infection control issues that relate to improper care of the catheter. 1-1 education is also being done immediately as needed. 3- Audit tools for monitoring catheter care tubing as well as treatments being done has been implemented 4-The Administrator has designated the DON, in writing, to be responsible to monitor urinary catheters care within the facility. The DON will be responsible to ensure that current professional standards of quality are maintained when caring for residents with urinary catheters. Results of the observations will be documented and included in the weekly reports faxed to the State Survey Agency. Information on catheter care and treatments will be provided to every nurse who works in the facility. The DON will report to the QA team results of the audits so that interventions can be implemented as necessary to ensure quality. The ADON has overall responsibility for compliance to this tag. 5- The facility compliance anticipated date is 1/7/02.	

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At 9:00 AM, resident 49 was observed sitting in a wheelchair in her room. Six inches of the resident's catheter tubing was observed to be lying on the floor.

On 11/1/01, at 1:00 PM, resident 49 was observed sitting in a wheelchair in her room. Six inches of resident 49's catheter tubing was observed lying on the floor.

On 11/6/01 at 8:37 AM, resident 49 was observed lying in her bed. Six inches of resident 49's catheter tubing was observed lying on the floor.

On 11/7/01 at 8:00 AM, resident 49 was observed sitting up in a wheelchair in her room. Twelve inches of resident 49's catheter tubing was observed lying on the floor.

3. On 10/31/01 at 12:12 PM, resident 51 was observed sitting in her wheelchair while a nurse aide pushed her down the hall. Approximately 12 inches of tubing from resident 51's urinary catheter was observed to be dragging on the floor under the wheelchair.

Brunner and Suddarth's Textbook of Medical-Surgical Nursing, Eighth Edition, Lippincott-Raven Publishers, 1996, Smeltzer and Bare, page 1147, states "When catheters are used, microorganisms may gain access to the urinary tract...the most common way, by migrating to the bladder along the internal lumen of the catheter after the catheter has become contaminated." Page 1149, states "...No part of the collection bag or drainage tube should ever be contaminated. Urine should not be allowed to collect in the tubing because a free flow of urine must be maintained to prevent infection... The drainage bag must never touch the floor. The bag and collecting tubing are changed if contamination occurs...The bag

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F 281	Continued From Page 12 is emptied at least every 8 hours through the drainage valve, and more frequently if there is a large volume of urine, to lessen the risk of bacterial proliferation..."	F 281		
F 314 SS=H	483.25(c) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of medical records, facility policies and procedures, and Quality Assurance and Assessment Committee Minutes, it was determined that for 3 of 15 focus residents (26, 50,51) and 2 additional residents (8,27), the facility did not ensure that pressure sores did not develop when the individual's clinical condition demonstrated that they were avoidable and that residents who had pressure sores received the necessary treatments and services to promote healing. This was evidenced by: Two residents were lacking pressure relieving devices to pressure sore areas. Pressure sore dressings were not provided as ordered by the physician. Pressure sores identified to facility nursing staff by surveyors were not addressed timely. Facility staff were not implementing all the interventions listed on the residents care plans. Weekly skin assessments within the facility were not performed as required by the facility's "skin integrity/wound care program" and as required by the	F 314	F314- It is the policy, and Hillside will continue to ensure a resident who enters the facility without a pressure sore does not develop pressure sores unless the individual 's clinical condition demonstrates that they were unavoidable, and a resident having a pressure sore receives the necessary treatment, and services to promote healing, prevent infection, and prevent new sores from developing. 1-The ADON is monitoring the treatment, turning, and consistency of care for resident 51. On 12//01 the sore was cultured to discover why sore has difficulty healing. Medications have been administered to help healing. Resident 8 has a pressure reliving pad put in chair. Reddened area treated with Calmoceptine and resolved. Resident 26,s Nurse Practitioner stated that area was not an ulcer, but continues to do well. A pressure relieving pad was put in his chair was instituted and is checked per schedule. Resident 27's Nurse Practitioner identified area as an irritated hair follicle which is now resolved.	

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F 314	Continued From Page 13 facility's plan of correction for the last annual recertification survey, dated 8/10/00. The facility was not following its own skin integrity/wound care policies and procedures. The facility had not identified any quality deficiency issues regarding the identification, assessment, appropriate treatment and prevention of the development of pressure sores. The physician had not been notified regarding one of the pressure sores and there were no orders to treat it. Resident identifiers: 8, 26, 27, 50 and 51. Findings include: 1. Resident 50 was a 93 year old female who was admitted to the facility on 5/22/01 with the diagnoses of Alzheimer's disease, chronic renal failure, asthma, history of visual hallucinations, iron deficiency, coronary artery disease, hypertension, macular degeneration, left ventricular diastic disease, history of gastrointestinal bleed, hearing loss and diverticulitis. Facility staff were observed to use a lap buddy restraint for resident 50 while she was sitting up in her wheelchair. The MDS (minimum data set), a mandatory comprehensive assessment of the resident completed by facility staff, dated 10/18/01, documented that the cognitive skills of resident 50 were moderately impaired, and that she needed extensive assistance when moving to and from a lying position, turning side to side, positioning her body in bed, and moving to or from a bed or wheelchair. This MDS also documented that resident 50 was incontinent of bowel and bladder and did not have any pressure or stasis ulcers. The care plan for resident 50, updated 11/1/01, included the problem "Potential for skin breakdown D/T (due to) decreased mobility - B & B (bowel and bladder) incontinence - wears briefs and daily use of	F 314	Resident 50's Nurse Practitioner identified area as an old blister, which has now been resolved. Pressure relieving pad is in bed and chair. Regular monitoring of treatment and following the procedures below will ensure proper care for residents 50,26,27,and 8. 2- An audit tool has been implemented which is used to ensure that skin checks are performed weekly by a licensed nurse to ensure that no breakdown occurs and that the treatment sheets are being completed properly. 3- The facility Administrator has designated, in writing, the ADON to be responsible to perform random observations of residents to ensure that incontinence care and repositioning are provided at least every 2 hours. These random observations will be performed at least 2 times a week and will be documented as to which residents were observed and the results of the monitoring. The facility has a skin team, lead by the ADON, who is an RN, that meets at least every 7 days to evaluate effectiveness of treatment of those with skin breakdown. The skin team assesses, measures, and evaluates those identified by nursing with skin breakdown at least every 7 days.	

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F 314	Continued From Page 14 diuretics". The goal stated "skin will be intact, clean and dry". The care plan interventions included: "weekly skin check", "toilet q 2 hrs & prn (every 2 hours and when necessary)" and "change brief q 2 hrs & prn". The most recent "Braden Scale for Predicting Pressure Sore Risk" assessment for resident 50, completed by facility staff on "11/01", documented a score of 12. The facility's protocol for "At Risk" residents stated that "If Braden score is 11-14 - Moderate pressure ulcer prevention precautions will be implemented." The "moderate risk pressure ulcer preventions" were: "- assess skin daily - keep skin clean and dry - use skin protectant ointments to protect skin exposed to urine, stool or wound drainage - if bedbound, reposition every two hours; if chairbound, reposition every hour" The facility's skin integrity/wound care program documented that "All patients will have a Braden score done on admission and monthly thereafter." There was no documentation in the medical record of resident 50 to evidence that Braden scale pressure sore risk assessments had been completed monthly. The most current assessments were dated "6/6/01", "8/01", and "11/01". On 10/31/01, from 7:40 AM to 12:40 PM, resident 50 was monitored by a registered nurse surveyor. During this 5 hour period of time, resident 50 was not taken out of her wheelchair or released from her restraint. At 12:40 PM, the surveyor noted that resident 50 had a very strong urine odor. On 11/6/01, at 6:40 AM, two registered nurse surveyors performed a skin check on resident 50, with	F 314	The ADON will perform 5 random observations every 7 days, of residents evaluated as being "at risk" for pressure sores, to ensure that skin checks performed by staff are accurate. The ADON will also ensure that issues of breakdown are made known to the physician, and if orders are received, are transcribed to the treatment sheet. The ADON will observe (of different nurses) at least 2 random dressing changes as performed by floor nurses. This will be done each week. The nurse treating nurses, as well as the residents being treated will be documented. All dressings are currently being dated and at least 3 random observations of dressings every 7 days are being done to ensure that the dressings (including those for G-tube sights) are being changed timely, and as ordered by the physician. The ADON, with the skin team will ensure that dietary recommendations, which would promote healing of pressure sores, are communicated to the physicians for their consideration. Inservices to nursing staff regarding pressure sore care and policy was provided on 12/11/01. The DON has been given the responsibility of ensuring that all nurses who provide care in the facility are inserviced on facility policy and procedure as it relates to pressure sores. 4-The facility will maintain the audit tools for positioning, treatment monitoring, and skin team observations. These tools will be discussed and evaluated each QA meeting to ensure that no new, avoidable breakdown occurs.	

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F 314	Continued From Page 15 the assistance of a facility nurse aide. The survey nurses observed a pressure sore located on the right iliac crest of resident 50. The pressure sore measured approximately 0.5cm (centimeters) by 0.5cm. The epidermis was not intact. The pressure sore did not have a dressing on it. Upon leaving the room of resident 50, the survey nurses saw the facility nurse who was responsible for the care of resident 50 and asked him if he knew that resident 50 had a pressure sore on her right iliac crest. The facility nurse replied that he did not, but stated that he would take care of it. Both the facility's skin integrity/wound care policies and procedures and The Nurse's Clinical Guide, Wound Care, Cathy Thomas Hess, Springhouse Corporation, 1995, define a stage 2 pressure ulcer (sore) as "Partial thickness skin loss involving epidermis or dermis. The ulcer presents clinically as an abrasion, blister, or shallow crater." On 11/7/01, the director of nurses (DON) asked to do a second skin check on resident 50 with the survey nurses. She stated that the assistant director of nurses, the floor nurse and herself had assessed the right hip of resident 50 and did not agree with the findings of the survey nurses. On 11/7/01, at 2:50 PM, the DON, the floor nurse (same floor nurse who was informed of the pressure sore on 11/6/01) and a registered nurse surveyor performed a second skin check on resident 50. Resident 50 was observed to have a dressing to her right hip area, but not covering the pressure sore which had been observed the previous day. The dressing was located approximately half an inch away from the pressure sore. The floor nurse stated, "We thought you were referring to the red area on her hip. I think we know where to put it now (referring to the dressing)." At this second observation, the pressure	F 314	5- The facility compliance anticipated date is 1/7/02.	

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sore appeared to measure approximately 1cm by 1 cm, larger than it had been the day before.

There was no documentation in the nurse's notes or treatment sheets to evidence that facility staff were following the "moderate risk" protocol interventions as directed by the facility's policies, such as daily skin checks, keeping the resident clean and dry (see 5 hour observation of 10/31/01), using skin protective ointments to protect skin exposed to urine and stool, or repositioning.

2. Resident 51 was an 87 year old female who was admitted to the facility on 9/15/98 with the diagnoses of bronchitis, urinary tract infection, anemia, vertigo, peptic ulcer disease, and a history of both an arm and leg fracture.

The MDS for resident 51, dated 11/5/01, documented that she was totally dependent upon staff to provide turning and positioning in bed and with transfers. The MDS, dated 11/5/01, also documented the presence of a stage 2 pressure sore.

The "Braden Scale for Predicting Pressure Sore Risk" was completed for resident 51 on "3-1", "5-22", "8/01" and most currently, "11/01". There was no documentation in the medical record of resident 51 to evidence that the facility followed its own policy by completing the Braden scale on a monthly basis. The Braden score of resident 51 on "11/01" was 14. Based on the facility's policy for skin integrity/wound care, resident 51 rated "moderate risk".

The care plan for resident 51 included the problem "Alteration in skin integrity R/T (related to) stage 2 pressure ulcer...located on sacral area." The care plan interventions included, "QD (everyday) treatment, to pressure ulcer, as per MD order."

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On 10/16/01, the physician for resident 51 changed the treatment to the sacral pressure sore and ordered:
"1. Clean sacral wound with NS (normal saline) et (and then) pat dry bid (twice a day)"
"2. Apply stratasorb or equivalent in such a way that wound is open to air but protected from feces."
"3. Increase exposure to air, fan, etc."

The October and November 2001 treatment sheet for resident 51 revealed the following:

October 2001

From October 16th through the 31st, there was no documentation to evidence that the treatment was provided as ordered by the physician for 10 of 32 scheduled treatments.

November 2001

On the November treatment sheets, the task of cleaning the wound with normal saline twice a day and the task of applying stratasorb and having the wound open to air were separated into different sections of the treatment record.

From November 1st through the 7th, there was no documentation to evidence that the task of cleaning the wound with normal saline had been performed for 9 of the 14 scheduled times.

From November 1st through the 7th, there was no documentation to evidence that the task of applying the stratasorb and having the wound open to air was performed as ordered by the physician for 3 of the 7 scheduled times.

Three observations of the wound to resident 51 were

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performed, once on 11/5/01 and twice on 11/6/01. At each observation, two registered nurse surveyors were present.

The first observation occurred on 11/5/01, at 5:15 PM, with the assistance of a facility nurse. Resident 51 was found to be lying in bed on a cloth chux pad which was saturated (approximately 30 inches in diameter) with urine. The facility nurse said that her (resident 51) "foley must be leaking". The pressure sore of resident 51 was located in the lower gluteal fold in close proximity to the anus. The nurse had to lift the right buttock of resident 51 for the pressure sore to be visible or to be exposed to air. The pressure sore of resident 51 was found, not open to air and there was no stratasorb or other dressing on or near the wound, as ordered by the physician. The pressure sore appeared to measure approximately 3 cm by 2 cm with a depth of approximately 0.5 cm. The wound bed had a whitish appearance.

The second observation occurred on 11/6/01, at 6:45 AM, with the assistance of a facility nurse aide. The pressure sore of resident 51 was not open to air and there was no stratasorb or other dressing on or near the wound.

The third observation was performed on 11/6/01, at 1:30 PM, with the assistance of a facility nurse aide. Resident 51 was transferred from her wheelchair to her bed by the nurse aide. Upon viewing the pressure sore, it did not have a dressing on or near it. The pressure sore appeared to have been cleaned. The wound bed no longer had a whitish appearance and appeared red.

All three observations revealed that facility staff were not following physician's orders for this pressure sore.

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During the previous recertification survey, dated 8/2/00 to 8/10/00, the facility was cited at an actual harm level for the lack of services and treatment to a pressure sore of this same resident (resident 51). This is the second citing at actual harm for this resident.

The plan of correction for the previous recertification survey, dated 8/2/00 to 8/10/00, stated the following:

"this resident (referring to resident 51, who was referred to as resident 24 in the previous survey) is also being monitored in the skin and weight meetings weekly". It also stated that "The Director of Nursing or designee and Administrator will monitor the flow sheets, treatment sheets and I/O sheets for compliance and report to the QI committee."

Review of facility skin team notes revealed that they met on 7/18/01, 8/3/01, 9/6/01, 10/29/01 and 11/5/01. Resident 51 was not being reviewed by the skin team weekly and had documentation of a pressure sore in her medical record through each of these months (July-November 2001).

Review of the facility's QI (Quality Improvement) committee meeting minutes dated 6/19/01, 7/31/01, 8/28/01, 9/24/01 and 10/29/01 revealed no documentation to evidence that flow sheets, treatment sheets or I/O (intake and output) sheets had been reviewed for compliance or that results of the reviews had been reported to the QI committee. Specifically, there was no documentation in the QI committee minutes of 10/29/01 to evidence that the facility was aware of the lack of compliance with the treatment to resident 51 during October 2001.

3. Resident 26 was a 101 year old male who was admitted to the facility on 6/18/99 with diagnoses of osteoporosis, spinal kyphosis, anemia, urinary incontinence, hearing loss, senile dementia, psychosis,

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and depression with aggressive features. Resident 26 also had a documented history of pressure sores on his buttocks.

The Minimum Data Set (MDS), dated 8/20/01, documented that resident 26 required extensive assistance
with transfers and limited assistance with his bed mobility. The MDS further documented that resident 26 had one stage 4 pressure sore for which the facility had placed him on a turning schedule and had a pressure relieving device for his wheelchair and bed.

On 10/30/01, during the initial tour of the facility with a facility staff member, she stated she thought the pressure sore on resident 26's buttocks had healed.

On 10/31/01, at 6:10 AM, during an interview with a facility nurse, she stated that the pressure sore to resident 26's buttocks had healed and had been healed for two weeks.

A review of the treatment record for October 2001, revealed documentation that the sore on the buttocks of resident 26 had healed on 10/18/01.

A review of the care plan for resident 26, dated 5/18/01, and updated on 8/17/01 was done. The care plan documented that resident 26 had an "Alteration in Skin Integrity" and one of the nursing interventions was to have a pressure relieving device in his wheelchair.

A review of the physician's orders, dated 6/30/01, documented that resident 26 was to have a pressure relieving mattress on his bed and a pressure relieving device in his wheelchair.

The "Braden Scale for Predicting Pressure Sores Risk"

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assessment for resident 26 was completed on 8/21/01, and assessed resident 26 with a score of 13. The bottom of the form dictated that "adults with a score of 18 or below were considered a risk."

The facility policy and procedure regarding skin care was given to the survey staff, on 11/6/01, at 1:30 PM. The facility policy documented protocols/interventions to be applied according to the resident's Braden score. During a review of the "Protocols for at risk patients" it was noted that resident 26 was at a moderate risk for developing a pressure sore.
The protocols/interventions for a moderate risk resident included the following:

1. Assess skin daily.
2. Keep skin clean and dry.
3. Use moisture barrier.
4. Do not massage bony prominences.
5. Protect skin from moisture, use underpads and briefs.
6. Use protective skin ointments to protect skin exposed to urine, stool, or wound drainage.
7. Use lift pads/trapezes to minimize friction and shear.
8. Use a pressure reduction device on bed and wheelchair.
9. Encourage proper dietary intake.
10. If bed bound, reposition every two hours; if chairbound every hour.
11. Elevate heels off bed surface and use pillows between knees.
12. Increase mobility and activity as tolerated.

On 10/30/01, at 1:00 PM, resident 26 was observed eating in the dining room without any pressure relieving device in his wheelchair.

On 10/30/01, at 4:50 PM, resident 26 was observed to be in the hallway without any pressure relieving device

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in his wheelchair.

On 10/31/01, at 7:40 AM through 8:30 AM, resident 26 was observed to be in the hallway without any pressure reliving device in his wheelchair.

On 11/1/01, at 7:25 AM through 9:00 AM, resident 26 was observed sitting in his wheelchair with a white blanket folded up in his wheelchair.

On 11/1/01, at 2:00 PM, two registered nurse surveyors and a facility nurse performed a skin check on resident 26. On the right buttock of resident 26 was a pressure sore which appeared to measure .25cm X .5cm (centimeters). Resident 26 was wearing an incontinent brief and did not have a dressing on the pressure sore. When the nurse was asked whether she had been aware of this breakdown, the nurse replied "No, I wasn't."

On 11/1/01, at 2:35 PM, a CNA (certified nursing aide) was interviewed. The nursing assistant stated that he had showered resident 26 on 10/30/01, and had noticed that resident 26 had a sore on his buttocks. The CNA further stated that resident 26 had always had a pressure sore.

Review of the nurses notes and treatment sheets revealed that there was no evidence that treatments were performed on this pressure sore from 10/18/01 through 11/1/01.

On 11/5/01, at 4:10 PM, resident 26 was observed again in the hallway with no pressure relieving device in his wheelchair.

On 11/6/01 a review of resident 26's medical record revealed no new physician's order, since 10/24/01, to treat resident 26's right buttock. A review of the

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November, 2001 treatment sheet, revealed that the nurses documented that they were applying stratasorb every day to right buttock of resident 26. There was no documentation to evidence that facility nurses had notified the physician of the pressure sore or that an order had been obtained to treat it.

4. Resident 8 was a 101 year old female who was admitted to the facility on 2/09/94 with the diagnoses of dementia with hallucinations and agitation, constipation, pain, osteoporosis, history of positive PPD, bilateral cataracts and severe macular degeneration.

The MDS (minimum data set), a mandatory comprehensive assessment of the resident, completed by facility staff, dated 8/29/01, documented that the cognitive skills of resident 8 were severely impaired, and that she was totally dependent on staff to turn her from side to side while she was in bed, positioning her body in bed, and transfer from bed or a wheelchair. The MDS also documented that resident 8 was incontinent of bowel and bladder and did not have any pressure or stasis ulcers nor did she have an ulcer that was resolved or cured in the last 90 days.

The care plan for resident 8, dated 8/30/01, for the problem "Potential for alteration in skin integrity R/T (related to) decreased bed mobility, dementia, and incontinent of bowels". The goal stated, "Resident will present with no S/Sx (signs and symptoms) of skin integrity compromise". The care plan interventions included the following: "Nurse to perform skin check q (every) week", "Pressure relief to wheelchair", "reposition resident q 2 h (hours) and PRN (as needed), while in bed, turn clock in room", "Offer, encourage and assist fluid intake" and "Offer, encourage and assist nutritional intake". There was a care plan dated 10/03/01 for the problem "Alteration in skin integrity R/T actual breakdown M/B

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(manifested by) open area on left buttocks", but this care plan had a line crossed through that stated, "Dc'D (discontinued) Healed 10/15/01".

The most recent "Braden scale for predicting Pressure Sore Risk" assessment for resident 8, completed by facility staff on "8/01", documented a score of 11. The facility's protocol for "At risk" residents stated that "If Braden score is 11-14 - Moderate pressure ulcer prevention precautions will be implemented." The "moderate risk pressure ulcer preventions" included:

"-assess skin daily
-keep skin clean and dry
-use skin protectant ointments to protect skin exposed to urine, stool or wound drainage
-use a pressure reduction device on the bed and chair
-elevate heels off bed surface and use pillows between knees"

The facility's skin integrity/wound care program documented that "All patients will have a Braden score done on admission and monthly thereafter." There was no documentation in the medical record of resident 8 to evidence that Braden Scale pressure sore risk assessments had been completed monthly. The most current assessments were dated "3/2", "6/4/01", and "8/01".

On 11/06/01, at 8:57 AM, two registered nurse surveyors performed a skin check on resident 8, with the assistance of the facility's ADON (Assistant Director Of Nursing). The survey nurses observed a pressure sore located on the right buttock. The pressure sore measured approximately 0.5cm (centimeters) by 0.5cm. The epidermis was not intact. The pressure sore did not have a dressing on it. The survey nurses observed a black, hard cushion in resident 8's wheelchair. The ADON, who was also on

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the skin team committee, used his hand to push down on the cushion of resident 8's wheelchair and stated the the cushion was "definitely not soft". When asked if he was aware of the skin breakdown, the ADON stated that he "was not".

On 11/06/01, at 10:00 AM, the nursing treatment record documented that on 11/5/01, resident 8's skin was intact for the weekly skin check assessment documented by the L.P.N. (licensed Practical Nurse). The "Weekly Nursing Summary," dated 11/06/01, documented the following for skin condition: "Dry & Fragile, Free of any open areas".

On 11/07/01, at 2:00 PM, the medical record for resident 8 reflected no treatment documented for the pressure sore that was identified on 11/06/01. There was no evidence of an order, notification of physician and family, or assessment of the stage 2 pressure sore.

5. Resident 27 was a 97 year old female who was admitted to the facility on 3/16/98 with the diagnoses of senile dementia, paralysis agitans and hypothyroidism.

The MDS, completed by facility staff, dated 8/24/01, documented that the cognitive skills of resident 27 were severely impaired, and that she was totally dependent on staff to turn her from side to side while she was in bed, positioning her body in bed, and transfer from bed or a wheelchair. The MDS also documented that resident 27 was incontinent of bowel and bladder, did not have any pressure or stasis ulcers and the skin treatments in place were as follows: pressure relieving device for chair and bed, turning and repositioning program, application of dressings other than to feet, and application of ointments/ medications (other than to feet).

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The care plan for resident 27, updated 8/28/01, included the problem "Potential for skin breakdown R/T bowel & bladder incontinence, immobility." The goal stated, "Res (resident) will be free from skin breakdown TNR (Til Next Review)". The care plan interventions included the following: "Keep the resident clean and dry, change q 2 hr or as needed", "Turn and reposition q 2 hrs around the clock", "Weekly skin checks", "Pressure relief mattress on bed" and " Pressure relief on w/c (wheelchair)". The care plan did not include the application of dressings or application of ointments, as indicated in the MDS dated 8/24/01.

The 2001 July, August, September, October and November treatment sheets for resident 27 were reviewed. The facility nurses had physician's orders to perform weekly skin checks of resident 27. From July 1, 2001 through the end of the survey on November 8, 2001, the nurses should have performed 18 skin checks of resident 27. There was no documentation to evidence that 7 of the 18 scheduled skin checks had been performed as ordered by the physician. The dates that resident 27 did not receive the skin checks were: 7/22/01, 7/29/01, 8/07/01, 8/14/01, 9/07/01, 9/28/01 and 11/02/01.

The most recent "Braden Scale for Predicting Pressure Sore Risk" assessment for resident 27, completed by facility staff on "6/05/01", documented a score of 13. The facility's protocol for "At Risk" residents stated that "If Braden score is 11-14 - Moderate pressure ulcer prevention precautions will be implemented." Some of the "moderate risk pressure ulcer preventions" were:

"-assess skin daily
-keep skin clean and dry
-use skin protectant ointments to protect skin exposed

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to urine, stool or wound drainage
-if bedbound, reposition every two hours; if chairbound, reposition every hour"

On 11/07/01, at 3:20 PM, in an interview with a facility nurse, the nurse confirmed that resident 27 was not receiving skin protectant ointments as indicated on the 8/28/01 MDS and the "Moderate risk pressure ulcer prevention" protocol. The LPN assigned to resident 27 stated, "If it's not in the treatment book or an order for it, then she doesn't have it."

The facility's skin integrity/wound care program documented that "All patients will have a Braden score done on admission and monthly thereafter." There was no documentation in the medical record of resident 27 to evidence that Braden scale pressure sore risk assessments had been completed monthly. The most current assessments were dated "3/02/01" and "6/05/01".

On 11/6/01, at 9:20 AM, two registered nurse surveyors performed a skin check on resident 27, with the assistance of the facility's ADON. Resident 27 was in her room sitting in her wheelchair with her upper body leaning over the right side of the chair. The ADON and a nursing assistant transferred resident 27 from her wheelchair to her bed. The nurse surveyors observed a reddened area on resident 27's right flank and rib area that measured approximately 10cm by 12cm. The ADON stated that he did not know what the reddened area was from but that it was blanchable. The nurse surveyors observed a sore to resident 27's right lower perineum area that measured approximately 0.2cm by 0.2cm by 0.1cm. The sore had liquid feces next to the area of breakdown and resident 27's brief was wet. The ADON stated that this was a new breakdown and he was not aware of it.

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F 314	Continued From Page 28 On 11/07/01, at 3:05 PM, a registered nurse surveyor performed another skin check on resident 27, with the assistance of the facility's DON (Director Of Nursing) and a nursing assistant. The nurse surveyor observed a sore to resident 27's right lower perineum that did not have a dressing in place. The sore measured approximately 0.5cm by 0.25cm by 0.1cm. The same sore, that had been observed by the nurse surveyor the previous day, appeared to have increased in size. The nurse surveyor observed the nursing assistant and the DON remove resident 27's wet brief and then after the skin check, immediately apply a dry brief without providing pericare for the incontinent resident. 11/07/01, at 3:55 PM, resident 27's medical record and treatment record reflected no documentation of the perineum sore or treatment for the sore, that was identified on 11/06/01 with the facility's ADON. On 11/08/01, at 8:48 AM, two registered nurse surveyors performed a third skin check on resident 27, with the assistance of the facility's DON, ADON and FNP (Family Nurse Practitioner). The nurse surveyors observed a sore on resident 27's right lower perineum that did not have a dressing in place. The sore measured approximately 0.5cm by 0.5cm by 0.1cm. The sore observed on the previous two days had again appeared to increase in size. On 11/13/01, at 8:50 AM, the facility's administrator brought additional medical record information for resident 27, to the nurse surveyors. The nurse's notes for resident 27 had documentation on 11/08/01, at 12:00 PM, stated the following: "Assessed res (resident) skin with FNP et (and) DON. Res has small open area to lower perineal area. As res has decreased ROM (range of motion) it is hard to measure but is less than or equal to 0.5 cm in diameter without drainage or odor. Will con't (continue) to monitor	F 314		

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F 314	Continued From Page 29 area. New, softer pad put in w/c. Staff reminded to change position frequently while up". There was no documentation for protectant ointment to protect skin from urine and stool as indicated by the facility's "Moderate risk pressure ulcer prevention" protocol or that the physician was notified of resident 27's skin breakdown.	F 314		
F 354 SS=E	483.30(b)(1)-(3) NURSING SERVICES Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview, review of staffing records, and review of the facility's daily census reports for September and October 2001, it was determined that the facility did not use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Findings include The facility's daily census for September 2001 and October 2001 revealed that the facility census was at least 61 or greater for each day.	F 354	F354- The facility has maintained an RN for 8 consecutive hours per day since 11/01/01. Management and schedulers have been inserviced on 12/12/01, on the need for an RN to be used (not including the DON) for 8 consecutive hours per day, seven days per week. The nurse scheduler will provide the administrator with a weekly report of compliance; the in QA committee will monitor compliance. The DON will be responsible for ensuring compliance to this tag. The facility compliance date is 12/12/01.	

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F 354	Continued From Page 30 Review of the facility's skilled nurse staffing reports for September 2001 and October 2001 revealed that the facility did not use the services of a registered nurse on the following days: September 2001: 19th, 20th, 25th, 26th, 27th, and 29th October 2001: 1st, 2nd, 3rd, 4th, 9th, 10th, 11th and 25th On 11/1/01 at 7:10 AM, a facility nurse was interviewed regarding staffing patterns within the facility. The facility nurse stated that there had been days when no registered nurse was available. During interview with the corporate administrator on 11/8/01, he confirmed that a lack of registered nurse coverage had been a problem within the facility.	F 354		
F 364 SS=E	483.35(d)(1)&(2) DIETARY SERVICES Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, individual and group interviews, and temperature results obtained from a breakfast and lunch test tray, it was determined that the facility did not prepare food by methods that conserved the appearance, attractiveness, palatability, or the proper temperatures of the food	F 364	F364- 1- On 11/28/01, a plate heater and pellets that fit into the plate insulators to provide added heat were ordered. This will ensure added heat during transport of hall trays. There are also two aides that are designated to pass the hall trays with the most people to be served, whenever necessary. Sectioned plates have been purchased and are currently being used that make the presentation of the pureed food more attractive.	

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Findings include:

1. Observation of the breakfast meal preparation on 10/31/01 revealed the north hall trays left the kitchen at 7:40 AM. The last north hall breakfast tray was observed to be passed at 8:20 AM. The surveyor checked food temperatures on a north hall test tray at 8:20 AM. The cooked cereal temperature was 82 degrees Fahrenheit and the egg was 80 degrees. Both the cereal and egg were cool to the touch and were not palatable.

Observation of the lunch meal preparation on 11/1/01 revealed the north hall trays left the kitchen at 12:40 PM. The last north hall lunch tray was observed to be passed at 1:40 PM. The surveyor checked the food temperatures on a north hall test tray at 1:40 PM. The chicken noodle soup temperature was 98 degrees Fahrenheit and the milk was 50 degrees. The chicken noodle soup was cool to the touch and was not palatable.

2. The breakfast meal preparation was observed on 11/1/01 at 6:30 AM. The cook was observed to prepare the pureed diets by mixing eggs, bread, thickener, and milk together into a yellow, thick consistency. The cook was observed to serve a single scoop of the pureed mixture on a plate with no other food or garnish present. The pureed eggs and toast were not attractive in appearance when served to the residents.

3. The minutes from the Resident Council meeting were reviewed on 10/30/01 and revealed the following concerns regarding the appearance, attractiveness, palatability, and proper temperatures of the food:
8/8/01 Complaint: Residents still say meals are bad Meat is tough.
8/21/01 Complaint: Serving small pieces of pie. No

F 364

2-On 12/5/01the facility interviewed residents to ask if there was a desire for a separate meeting to discuss food issues with the dietary staff. The residents felt that this was a good idea. It will be held every other week.
3-On 12/7/01 there was an inservice for all dietary staff on how to prepare meat more tenderly, and how to serve more attractive meals with appropriate portions.
4- The department heads are on a schedule for monitoring meal temperatures, palatability, and attractiveness. There will be a test tray on random meals each day. The test tray will be the last tray served in the longest hall. The results will be brought to the QA committee to be evaluated for compliance with F364.
5- The facility compliance anticipated date is 1/7/02.

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F 364	Continued From Page 32 presentation of food. BLT (bacon, lettuce and tomato) sandwich last week-bacon was raw. Cake wasn't good yesterday. 10/2/01 Concerns/Issues: Residents want bacon medium cooked. Meat is tough. Food is cold (room trays and in the dining room). 4. On 10/30/01 at 1:30 PM, a confidential group interview was conducted. Six of ten residents who participated in the group interview stated the facility did not serve hot foods hot and that the food was not palatable because of this. 5. On 11/7/01, at approximately 2:00 PM, resident 46 stopped a surveyor in the hallway near her room and asked the surveyor to "come look at this." Resident 46 appeared upset and picked up the dish cover off her lunch and asked several times, "Would you eat this? Would you eat this?" Resident 46 then stated, "I can't eat it. Look at it."	F 364		
F 367 SS=D	483.35(e) DIETARY SERVICES Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and interview, it was determined that 2 of 15 sample residents did not receive a therapeutic diet as prescribed by the physician. The facility did not add Promod (a high protein nutritional supplement) to resident 25's food, and resident 51 did not receive an enriched diet, as prescribed by the physician. Findings include: 1. Resident 25 was admitted to the facility on 7/18/01	F 367	F367- 1- A monitoring tool is being used by the Food Service Manager to ensure that the use of Promod and enrichment is being used, with special attention to residents 25 and 51 2- The Food Service Manager and the Dietician will perform audits of meals to monitor and instruct 3-On 12/7/01 the Dietician inserviced the dietary staff on the appropriate use of enrichments and how to add enrichment using butter or gravy to boost calories.	

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F 367	Continued From Page 33 with the diagnoses of diabetes mellitus, malignant hypertension, obesity, and cellulitis of the legs. Review of resident 25's medical record revealed a physician's order, dated 7/31/01, for the resident to receive Promod 3 scoops added to food, 3 times daily. Observation of the breakfast meal preparation on 10/31/01, 11/1/01, and 11/6/01 revealed resident 25 did not receive any Promod added to the food for these meals. 2. Resident 51 was admitted to the facility on 9/15/98. During the time of survey, 10/30/01 through 11/8/01, the facility had orders to treat a stage 2 pressure sore to the sacral area of resident 51. Resident 51 also had physician's orders to receive an enriched puree diet. While watching the preparation of the breakfast meal on 11/6/01, the surveyor did not observe the facility staff "enrich" the puree food of resident 51 prior to serving it to her.	F 367	4- The Food Service Manager will monitor one meal 2 days a week and the Dietician will monitor one meal per week to ensure compliance. These audits will be documented and kept in the dietary office. The audits will include the date, the meal audited, and any issues. They will be presented to the QA meeting to ensure compliance. 5- The facility compliance anticipated date is 1/7/02.	
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 prepare, distribute and serve food under sanitary conditions. Findings include: 1. The following observations of the kitchen were made on 10/31/01 and 11/1/01 The air conditioner and the air vent were both	F 371	F-371 1- The air conditioner vent is current on a schedule of the maintenance department for regular cleaning. On 12/7/01 the nursing assistants were provided with antiseptic hand wash and were inserviced to use the hand was between every patient tray in the hall and in the dining room when touching anything other than sterile food service The food carts are washed between every meal. The containers in the kitchen have been sterilized	

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observed to be soiled with dark greasy dust. The air conditioner was observed to be running during food preparation.

Observations of the north and south hall tray cart covers revealed the inside of the covers were soiled with multiple dried food spills. The covers were observed to be use during the delivery of each meal without being cleaned.

A large white garbage can , located by the sink, was observed to have multiple dried food spills on the sides, the handle, and inside and outside of the lid.

A plastic flour container, located under a food preparation table, was observed to have multiple food spills on the top and edges of the lid.

2. On 10/31/01 at 7:40 AM , the north hall tray cart was observed to be taken out of the kitchen. A tray with uncovered bowls of cereal and uncovered cups of coffee and hot chocolate was observed on the bottom shelf of the north hall tray cart. By being uncovered, this increased the potential for the cereal and drinks to become contaminated during the serving process.

A pool nurse aide and a student nurse aide were observed to pass the breakfast trays to the north hall residents from 7:40 AM through 8:20 AM. During the serving process, both nurse aides were observed to touch their hair and face multiple times, causing contamination to their hands. The nurse aides were not observed to wash their hands at any time while they were serving the residents.

At 7:40 AM, the student nurse aide was observed to serve resident 46's breakfast tray in her room. At 7:50 AM, the resident was observed to bring the breakfast tray back to the hall tray cart and hand it to the pool

2- There is now a daily audit of the cleanliness of the kitchen.

Inservice for nursing is ongoing and will be for all nursing assistants. The inservice consists of nursing assistants being provided with antiseptic hand wash and being taught to use the hand was between every patient tray in the hall and in the dining room when touching anything other than sterile food service. As of 12/20/01 all nursing assistants were inserviced on this. It will be the responsibility of the Aid Coordinator to ensure that anyone providing aid care in the facility are inserived.

On 12/7/01 the dietary staff was inserviced by the dietician on cross contamination and the cleaning schedule.

3-The dietary cleaning audit will be ongoing.

There is a random meal critique, which includes the observation of sanitation issues.

4- The meal critiques are reviewed in the weekly QA meeting to ensure that there are sanitary conditions during tray pass

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F 371	Continued From Page 35 nurse aide. The tray was observed to have a pink liquid spilled and dripping from the tray. The pool nurse aide was then observed to place the soiled tray back on the tray cart, above the tray of uncovered cereal and drinks. By placing a soiled tray on the clean hall tray cart, this increased the potential for the cereal, drinks, and other resident's food trays to become contaminated. On 11/1/01, a nurse aide was observed to pass the north hall breakfast trays from 7:40 AM through 8:30 AM. At 7:50 AM, the nurse aide was observed to serve resident 46's breakfast tray to her room. At 8:55 AM the resident was observed to bring the breakfast tray back to the hall tray cart and hand it to the nurse aide. The tray was observed to have spilled milk dripping from the tray. The nurse aide was then observed to place the soiled tray back on the clean hall tray cart above the clean breakfast trays. This practice increased the potential for the clean breakfast trays to become contaminated before they are served to the residents. The nurse aide was observed to continue to serve the other resident's breakfast trays. 3. On 11/1/01 at 7:45 AM, a male nurse aide was observed to handle multiple objects, including water pitchers, glasses and breakfast trays. The aide was then observed to pat a resident on the back and then walk away and help another resident peel the hard shell off her boiled egg. The aide did not wash his hands prior to performing this task. 4. On 11/1/01 at 8:01 AM, a female staff was observed assisting in the dining room at breakfast time. The female staff was observed to handle cups, bowls and a resident's utensils. The female staff was then observed to walk away and assist resident 47 to peel the hard shell off her boiled egg. The staff member did not wash her hands prior to performing this task	F 371	The Dietician is and will perform weekly sanitation audits of the kitchen Any issues will be brought to the QA for problem solving. 5- The facility compliance anticipated date is 1/7/02.	

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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 medical record review, it was determined that for 4 of 15 sample residents and 3 additional residents, the facility did not provide pharmaceutical services, including the accurate administering of all drugs and biologicals, to meet the needs of each resident. The facility did not obtain blood sugar levels and correctly administer sliding scale insulin as ordered by the physician for 4 of 6 insulin dependent diabetics, did not provide a dose of intravenous antibiotics as ordered and did not administer vitamins as ordered. Resident identifiers: 9, 10, 13, 14, 25, 29 and 65. Findings include: 1. Resident 25 was admitted to the facility on 7/18/01 with diagnoses that include insulin dependent diabetes, morbid obesity, depression and lower extremity cellulitis. Resident 25's medical record was reviewed on 11/7/01. A physician's admission orders written on 7/18/01, stated to monitor resident 25's blood sugar (BS) four times a day and to administer sliding scale (SS) regular insulin as follows: BS of 80-120 give 3 units (U)	F 426	F-426 1-The DON, with the RN Consultant, will monitor residents 25,10,65,13,14,and 29's sliding scale insulin to ensure correct dosage and documentation on a daily basis. 2- The DON, with the RN Consultant, will monitor all residents on sliding scale insulin, on a daily basis to ensure correct dosage and documentation. 3- Administration of insulin by direct care nurses will be monitored at least once a day, 7 days a week for at least a month until compliance is achieved. Three of the observations are to be done by the RN Consultant. The remaining four observations will be performed by the DON. Observations are random and include all shifts that insulin is administered. All nurses who provide care in the facility must demonstrate proper and accurate administration of insulin to the RN Consultant. The insulin monitoring will continue until all nurses can demonstrate proficiency. These records are taken weekly to the State Survey Agency. The MDS Coordinator has been designated by the Administrator in writing, to be responsible to audit the medication sheets, on a daily basis, for completeness, until substantial compliance is achieved. All missing data will be the responsibility of the DON to have appropriate nurses correct	

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BS of 121-180 give 9 U.
BS of 181-240 give 12 U.
BS of 241-300 give 15 U.
BS 301-400 give 20 U.

Resident 25's Medication Administration Record (MAR) for August 2001, September 2001 and October 2001 were reviewed.

August 2001

The MAR for August 2001, documented the insulin administration as follows:

On 8/4/01 at 4:30 PM, resident 25 had a BS of 162. Resident 25 received 12 U of SS insulin, but should have received 9 U.

On 8/4/01 at 8:00 PM, resident 25 had a BS of 227. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 12 U of SS regular insulin.

On 8/5/01 at 6:00 AM, resident 25 had a BS of 202. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 12 U of SS regular insulin.

On 8/5/01 at 11:30 AM, resident 25 had a BS of 172. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 9 U of SS regular insulin.

On 8/5/01 at 4:30 PM, resident 25 had a BS of 224. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 12 units of SS regular insulin.

On 8/5/01 at 8:00 PM, resident 25 had a BS of 218

4- Records of these audits will be kept in the facility. The data from these records will be brought to the QA meetings to ensure the compliance is maintained.
The DON will be responsible to inservice or have inserviced any nurse who provides care at Hillside on the administration of medication procedures at the facility. The DON will have overall responsibility for compliance to this tag.

5- The facility compliance anticipated date is 1/7/02.

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There was no documentation to show that SS insulin had been administered. Resident 25 should have received 12 U of SS regular insulin.

On 8/6/01 at 6:00 AM, resident 25 had a BS of 182. On the MAR, zero U was documented that no insulin was administered. (zero units). Resident 25 should have received 12 U of SS regular insulin.

On 8/6/01 at 8:00 PM, resident 25 had a BS of 177. On the MAR, it was documented that no insulin was administered. (zero units). Resident 25 should have received 9 U of SS regular insulin.

On 8/7/01 at 6:00 AM, resident 25 had a BS of 201. There was documentation to show that no SS insulin had been administered. (zero units). Resident 25 should have received 12 U of SS regular insulin.

On 8/7/01 at 8:00 PM, resident 25 had a BS of 165. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 9 U of SS regular insulin.

On 8/8/01 at 6:00 AM, resident 25 had a BS of 215. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 12 U of SS regular insulin.

On 8/10/01 at 8:00 PM, resident 25 had a BS of 188. There was documentation to show that 9 units of SS insulin had been administered. Resident 25 should have received 12 U of SS regular insulin according to physician's orders.

On 8/11/01 at 4:30 PM, resident 25 had a BS of 175. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 9 U of SS regular insulin.

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On 8/12/01 at 8:00 PM, resident 25 had a BS of 155. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 9 U of SS regular insulin.

A physician's order written on 8/15/01, stated to administer a new SS regular insulin regimen as follows:

BS of 150-200 give 4 U.
BS of 201-250 give 6 U.
BS of 251-300 give 8 U.
BS of 301-350 give 10 U.
BS of 351-400 give 12 U.

On 8/16/01 at 4:30 PM, resident 25 had a BS of 266. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 8 U of SS regular insulin.

On 8/18/01 at 11:30 AM, resident 25 had a BS of 180 There was documentation to show that 6 U of SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin.

On 8/18/01 at 4:30 PM, resident 25 had a BS of 192. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin.

On 8/18/01 at 8:00 PM, resident 25 had a BS of 168.

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There was no documentation to show that SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin.

On 8/23/01 at 4:30 PM, resident 25 had a BS of 160. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin.

On 8/25/01 at 8:00 PM, resident 25 had a BS of 195. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin.

On 8/26/01 at 8:00 PM, resident 25 had a BS of 157. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin.

On 8/27/01 at 6:00 AM, resident 25 had a BS of 214. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 6 U of SS regular insulin.

On 8/29/01 at 4:30 PM, resident 25 had a BS of 170. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin.

On 8/30/01 at 4:30 PM, resident 25 had a BS of 166. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin.

September 2001

The MAR for September 2001, documented the insulin administration as follows:

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On 9/1/01 at 8:00 PM, resident 25 had a BS of 190. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin

On 9/2/01 at 6:00 AM, resident 25 had a BS of 168. There was documentation to show that 6 U of SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin.

On 9/2/01 at 4:30 PM, resident 25 had a BS of 224. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 6 U of SS regular insulin.

On 9/3/01 at 6:00 AM, resident 25 had a BS of 167. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin.

On 9/5/01 at 4:30 PM, resident 25 had a BS of 191. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin.

On 9/17/01 at 4:30 PM, resident 25 had a BS of 160. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin.

On 9/23/01 at 11:30 AM, resident 25 had a BS of 215 There was no documentation to show that SS insulin had been administered. Resident 25 should have received 6 U of SS regular insulin.

On 9/23/01 at 4:30 PM, resident 25 had a BS of 207 There was no documentation to show that SS insulin had been administered. Resident 25 should have received 6 U of SS regular insulin.

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On 9/24/01 at 4:30 PM, resident 25 had no BS documented as being performed. Resident 25 received 6 U of SS regular insulin.

On 9/29/01 at 6:00 AM, resident 25 had a BS of 158. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin.

October 2001

The MAR for October 2001, documented the insulin administration as follows:

On 10/6/01 at 4:30 PM, resident 25 had no BS documented as being performed. Resident 25 received no SS regular insulin.

On 10/8/01 at 6:00 AM, resident 25 had a BS of 169. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin.

On 10/13/01 at 6:00 AM, resident 25 had a BS of 185. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin.

On 10/13/01 at 4:30 PM, resident 25 had a BS of 166. On the MAR, it was documented that no insulin was administered (zero units). Resident 25 should have received 4 U of SS regular insulin.

On 10/13/01 at 8:00 PM, resident 25 had a BS of 187. On the MAR, it was documented that no insulin was administered (zero units). Resident 25 should have received 4 U of SS regular insulin.

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On 10/14/01 at 6:00 AM, resident 25 had a BS of 199. On the MAR, it was documented that no insulin was administered. (zero units). Resident 25 should have received 4 U of SS regular insulin.

On 10/14/01 at 8:00 PM resident 25 had a BS of 201. On the MAR, it was documented that no insulin was administered. (zero units). Resident 25 should have received 6 U of SS regular insulin.

On 10/15/01 at 6:00 AM, resident 25 had a BS of 178. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin.

On 10/16/01 at 6:00 AM, resident 25 had a BS of 156. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin.

On 10/24/01 at 11:30 AM, resident 25 had a BS of 192. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin.

On 10/26/01 at 4:30 PM, resident 25 had a BS of 162. There was no documentation to show that SS insulin had been administered. Resident 25 should have received 4 U of SS regular insulin.

2. Resident 10 was admitted to the facility with diagnoses that include diabetes, end stage renal disease, hypertension, anemia, urinary tract infection, thrombophlebitis, and hypothyroidism.

Resident 10's medical record was reviewed on 10/30/01.

A physician 's order written on 9/22/98, stated to monitor resident's BS four times a day and to

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administer SS regular insulin for resident as follows:

BS of 0-199 give 0 (zero) U
BS of 200-250 give 6 U
BS of 251-300 give 8 U
BS of 301-350 give 10 U
BS of 351-400 give 12 U

Resident 10's MAR for September 2001, and October 2001 were reviewed.

September 2001

The MAR for September 2001, documented the insulin administration as follows:

On 9/01/01 at 8:00 PM, resident 10 had a BS of 255. Resident 10 received 6 U of SS regular insulin, but should have received 8 U.

On 9/2/01 at 6:30 AM, resident 10 had a BS of 211. There was no documentation to show that SS insulin had been administered. Resident 10 should have received 6 U of SS regular insulin.

On 9/2/01 at 4:00 PM, resident 10 has a BS of 224. There was no documentation to show that SS insulin had been administered. Resident 10 should have received 6 U of SS regular insulin.

On 9/3/01 at 10:30 AM, resident 10 had a BS of 222. On the MAR, it was documented that no insulin was administered. (zero units). Resident 10 should have received 6 U of SS regular insulin.

On 9/6/01 at 6:30 AM, resident 10 had a BS of 236. There was documentation to show that no SS insulin had been administered. (zero units). Resident 10 should have received 6 U of SS regular insulin

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On 9/6/01 at 10:30 AM, resident 10 had a BS of 269. On the MAR, it was documented that no insulin was administered. (zero units). Resident 10 should have received 6 U of SS regular insulin.

On 9/9/01 at 4:00 PM, resident 10 had no BS documented as being performed. On the MAR, it was documented hat no SS insulin had been administered. (zero units).

On 9/10/01 at 6:30 AM, resident 10 had a BS of 222. There was documentation to show that no SS insulin had been administered. (zero units). Resident 10 should have received 6 of SS regular insulin.

On 9/12/01 at 4:00 PM, resident 10 had a BS of 223. There was documentation to show that no SS insulin had been administered. (zero units). Resident 10 should have received 6 U of SS regular insulin.

On 9/15/01 at 10:30 AM, resident 10 had a BS of 302. Resident 10 received 8 U of SS regular insulin but should have received 10 U of SS.

On 9/15/01 at 4:00 PM, resident 10 had no BS as documented as being performed. There was no documentation that SS insulin had been administered.

On 9/17/01 at 4:00 PM, resident 10 had a BS of 210. On the MAR it was documented that no insulin was administered. (zero units). Resident 10 should have received 6 U of SS regular insulin.

On 9/18/01 at 10:30 AM, resident 10 had a BS of 257 There was no documentation to show that SS insulin had been administered. Resident 10 should have received 8 U of SS regular insulin.

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On 9/18/01 at 4:00 PM, resident 10 had no BS documented as being performed. There was no documentation to show that SS insulin had been administered.

On 9/22/01 at 4:00 PM, resident 10 had no BS documented as being performed and there was no documentation to show that SS insulin had been administered.

On 9/23/01 at 4:00 PM, resident 10 had no BS documented as being performed. There was no documentation to to show that SS insulin had been administered.

On 9/24/01 at 4:00 PM, resident 10 had no BS documented as being performed. There was no documentation to show that SS insulin had been administered.

On 9/27/01 at 10:30 AM, resident 10 had no BS documented as being performed. There was no documentation to show that SS insulin had been administered.

On 9/27/01 at 4:00 PM, resident 10 had no BS documented as being performed. There was no documentation to show that SS insulin had been administered.

On 9/29/01 at 4:00 PM, resident 10 had no BS documented as being performed. There was no documentation to show that SS insulin had been administered.

On 9/30/01 at 6:30 AM, resident 10 had no BS documented as being performed. There was no documentation to show that SS insulin had been administered.

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October 2001

The MAR for October 2001, documented the insulin administration as follows:

On 10/19/01 at 4:00 PM, resident 10 had a BS of 243. On the MAR, it was documented that no insulin was administered. (zero units). Resident 10 should have received 6 U of SS regular insulin.

On 10/22/01 at 6:30 AM, resident 10 had a BS of 204. There was documentation to show that no SS insulin had been administered. (zero units). On the MAR, LOA (leave of absence) was documented next to the 0 U of insulin. It was noted that the BS was taken and no SS insulin was administered while resident was on LOA status. Resident 10 should have received 6 U of regular insulin.

On 10/27/01 at 10:30 AM, resident 10 had a BS of 207. There was no documentation to show that SS insulin had been administered. Resident 10 should have received 6 U of SS regular insulin.

On 10/28/01 at 10:30 AM, resident 10 had a BS of 241. There was no documentation to show that SS insulin had been administered. Resident 10 should have received 6 U of SS regular insulin.

On 10/28/01 at 4:00 PM, resident 10 had no BS documented as being performed. There was no documentation to show that SS insulin had been administered.

On 10/29/01 at 4:00 PM, resident 10 had a BS of 259. There was no documentation to show that SS insulin had been administered. Resident 10 should have received 8 U of SS regular insulin.

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3. Resident 65 was admitted to the facility on 2/22/98 with diagnoses that include insulin dependent diabetes, hypertension and Parkinson's disease.

A physician's order, written on 2/27/01, stated to check resident 65's BS four times a day and to administer SS regular insulin as follows:

BS of 201-250 give 2 U.
BS of 251-300 give 4 U.
BS of 301-350 give 6 U.
BS of 351-400 give 8 U.
If BS < 50 or > 450 call MD.

The MAR for October 2001 for resident 65, documented the insulin administration as follows:

On 10/01/01 at 4:30 PM, resident 65 had no BS documented as being performed. Resident 65 received 2 U of SS regular insulin.

On 10/13/01 at 11:30 AM, resident 65 had a BS of 269. On the MAR, it was documented that no insulin was administered (zero units). Resident 65 should have received 4 U of SS regular insulin.

On 10/18/01 at 4:30 PM, resident 65 had no BS documented as being performed. Resident 65 received no SS regular insulin.

On 10/25/01 at 11:30 PM, resident 65 had a BS of 124. There was documentation to show that 2 U of SS
insulin had been administered. Resident 65 should have received no insulin, (zero units)

On 10/29/01 at 4:30 PM, resident 65 had a BS of 215. There was no documentation to show that SS insulin had been administered. Resident 65 should have

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received 2 U of SS regular insulin.

4. Resident 13 was admitted to the facility on 9/7/01 with diagnoses that include insulin dependent diabetes, hypertension, blindness and seizure disorder.

Physician's orders, written on 9/7/01 stated to check resident 13's BS before meals and at bedtime and to administer SS regular insulin as follows:

BS of 200 give 0 U.
BS of 201-250 give 3 U.
BS of 251-300 give 5 U.
BS of 301-350 give 8 U.
BS of 351-400 give 10 U.
BS >400 give 12 U.

The MAR for October 2001, documented the insulin administration as follows:

On 10/01/01 at 5:00 PM, resident 13 had a BS of 346. There was no documentation to show that SS insulin had been administered. Resident 13 should have received 8 U of SS regular insulin.

On 10/03/01 at 5:00 PM, resident 13 had a BS of 453. There was no documentation to show that SS insulin had been administered. Resident 13 should have received 12 U of SS regular insulin.

On 10/03/01 at 8:00 PM, resident 13 had a BS 473. There was documentation to show that 10 U of SS regular insulin had been administered. Resident 13 should have received 12 U of SS regular insulin.

On 10/05/01 at 12:00 PM, resident 13 had a BS 254. There was documentation to show that 3 U of SS insulin had been administered. Resident 13 should

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have received 5 U of SS regular insulin.

On 10/06/01 at 6:00 AM, resident 13 had a BS of 216. There was no documentation to show that SS insulin had been administered. Resident 13 should have received 3 U of SS regular insulin.

On 10/07/01 at 6:00 AM, resident 13 had a BS of 467. There was no documentation to show that SS insulin had been administered. Resident 13 should have received 12 U of SS regular insulin.

On 10/08/01 at 6:00 AM, resident had a BS of 216. There was no documentation to show that SS insulin had been dominions. Resident 13 should have received 3 U of SS regular insulin.

On 10/15/01 at 8:00 PM, resident 13 had a BS of 196. There was documentation to show that 3 U of SS insulin had been administered. Resident 13 should have received no insulin, (zero units).

On 10/18/01 at 12:00 PM, resident 13 had a BS of 266. There was documentation to show that 3 U of SS
insulin had been administered. Resident 13 should have received 5 U of SS regular insulin.

On 10/20/01 at 5:00 PM, resident 13 had a BS of 326. There was no documentation to show that SS insulin had been administered. Resident 13 should have received 8 U of SS regular insulin.

5. Resident 14 was re-admitted to the facility on 10/12/01 with diagnoses that include diabetes mellitus, dementia, Parkinson's disease, dehydration and osteoporosis.

Physician's orders, written 10/12/01, stated to check

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resident 14's BS and administer SS regular insulin before meals and at bed time as follows:

BS of 150-200 give 2 U.
BS of 201-250 give 4 U.
BS of 251-300 give 6 U.
BS of 301-350 give 8 U.
BS > 351 give 10 U.

The MAR for October 2001, for resident 14, documented the insulin administration as follows:

On 10/13/01 at 11:30 AM, resident 14 had no BS documented as being performed. There was no documentation to show that SS insulin had been administered.

On 10/13/01 at 4:30 PM, resident 14 had no BS documented as being performed. There was no documentation to show that SS insulin had been administered.

On 10/15/01 at 4:30 PM, resident 14 had no BS documented as being performed. There was no documentation to show that SS insulin had been administered.

On 10/16/01 at 4:30 PM, resident 14 had a BS of 161. On the MAR, it was documented that no insulin was administered. (zero units). Resident 14 should have received 2 U of regular SS insulin.

On 10/17/01 at 4:30 PM, resident 14 had no BS documented as being performed. Resident 14 received no SS regular insulin.

On 10/18/01 at 11:30 AM, resident 14 had no BS documented as being performed. Resident 14 received no SS regular insulin

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On 10/18/01 at 4:30 PM, resident 14 had no BS documented as being performed. Resident 14 received no SS regular insulin.

On 10/19/01 at 4:30 PM, resident 14 had no BS documented as being performed. Resident 14 received no SS regular insulin.

On 10/25/01 at 4:30 PM, resident 14 had no BS documented as being performed. Resident 14 received no SS regular insulin.

On 10/26/01 at 6:00 AM, resident 14 had no BS documented as being performed. Resident 14 received no SS regular insulin.

On 10/26/01 at 11:30 AM, resident 14 had no BS documented as being performed. Resident 14 received no SS regular insulin.

On 10/27/01 at 4:30 PM, resident 14 had no BS documented as being performed. Resident 14 received no SS regular insulin.

On 10/29/01 at 11:30 AM, resident 14 had no BS documented as being performed. Resident 14 received no SS regular insulin.

On 10/29/01 at 4:30 PM, resident 14 had no BS documented as being performed. Resident 14 received no SS regular insulin.

On 10/30/01 at 11:30 PM, resident 14 had no BS documented as being performed. Resident 14 received no SS regular insulin.

On 10/30/01 at 4:30 PM, resident 14 had no BS documented as being performed. Resident 14 received

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no SS regular insulin.

6. Resident 29 was a 41 year old male admitted to the facility on 10/3/01. Some of the diagnoses of resident 29 include endocarditis, septic pulmonary emboli and methicillin resistant staphylococcus aureus. Resident 29 arrived at the facility with a physician's order to receive 1 gram of Vancomycin twice a day for 5 weeks. On 10/18/01, the physician changed the vancomycin order to "3/4 gram every 12 hours."

A nurse's note, dated 10/20/01, documented the following:

"Pt cont (continuing) ABX (antibiotic) Tx (treatment). Did not receive 0900 ABX Tx per no nurse available with IV (intravenous) certification. Call D.O.N. (Director of Nurses) and made aware of situation. PM nurse is aware of situation as well. DON notified this morning. She stated she would try and find someone to come but no one did."

The October 2001 treatment sheet for resident 29 did not contain documentation to reflect that resident 29 received his intravenous antibiotics on the morning of 10/20/01.

7. Resident 9 was admitted to the facility on 9/30/98 with diagnoses that include the following: dementia, hypothyroidism, hypertension, gastroesophageal reflux disease, congestive heart failure, breast cancer and osteoporosis.

On 12/29/00 the physician had ordered vitamin E 400 IU capsules twice a day.

A review of resident 9's "Wound Clinic Encounter" revealed there was a physician's order written on 10/5/01 for resident 9 to receive: Zinc gluconate 25

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F 426	Continued From Page 54 milligrams by mouth every day Vitamin C 500 milligrams by mouth every day Vitamin E 400 IU by mouth every day. The physician order dated on 10/5/01 for resident 9 was not signed off by the facility nursing staff or transcribed onto the MAR. A review of the MAR for October had no documentation that resident 9 received zinc gluconate and vitamin C as ordered by the physician on 10/5/01. The MAR reflected that resident 9 received the vitamin E at 9:00 AM and 9:00 PM per 12/29/00 physician's order. Resident 9 should have received only 1 dose of vitamin E as per physician's order dated 10/05/01.	F 426		
F 441 SS=E	483.65(a)(1)-(3) INFECTION CONTROL The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on review of the facility's infection control policy and staff interview, it was determined that the facility did not establish an infection control program which investigates, controls, and prevents infections in the facility, and did not maintain a record of incidents and corrective actions related to infections. Findings include:	F 441	F-441 1-On 12/5/01 an infection control committee was organized by the RN Consultant, consisting of the RN/DON, Dietary, Housekeeping, and Medical Director. The committee meets every 14 days to discuss trending of infections in the facility and ways to control the spread of infections, until substantial compliance is achieved. After substantial compliance is achieved the committee will meet monthly for three months, then quarterly thereafter. The committee has made a tracking tool which has been implemented has been on 11/28/01. This tracking tool is used in the committee meetings to evaluate trends and use of special precautions	

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1. The administrator was interviewed regarding the facility's Infection Control Program on 11/1/01 at 8:55 AM. The administrator stated, "We haven't been following the manual." When asked if the facility had a system in place to monitor and investigate causes of nosocomial and community acquired infections, the manner of spread; maintained a separate record on infection that identified each resident with an infection, the date, causative agent, site, cautionary measures to prevent the spread; or if the facility analyzed infection clusters, changes in the prevalent organisms, or increases in the rate of infection in a timely manner, the administrator stated, "No".

2. The facility's Infection Control Program policy was reviewed and revealed the following:

"I. Goals. The goals of the Infection Control Program are to:

A. Decrease the risk of infections to patients and personnel.

B. Monitor for occurrence of infection and implement appropriate control measures.

C. Identify and correct problems relating to infection control practices.

D. Insure compliance with state and federal regulations relating to infection control.

II. Scope of the Infection Control Program. The Infection Control Program is comprehensive in that it addresses detection, prevention and control of infections among patients and personnel. The major activities of the program are:

A. Surveillance of infections. There is on-going monitoring for infections among patients and personnel and subsequent documentation of infections that occur.

B. Implementation of control measures.

Infection information is gathered from the nurse's 24-hour report and the quarterly infection log from the lab. The DON is responsible for inserving staff on general precautions and other infection control issues. The information is brought to the QA committee for ensuring completeness and compliance.
The DON is responsible for ensuring that the facility remains in compliance with this tag.
The facility compliance anticipated date is 12/27/01.

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Prevention of spread of infections is accomplished by use of universal precautions and other barriers, appropriate treatment and follow-up, and employee work restrictions for illness.

C. Prevention of infection. Staff and patient education is done to focus on risk of infection and practices to decrease risk. Policies, procedures and aseptic practices are followed by personnel in performing procedures and in disinfecting of equipment. Immunizations are offered as appropriate to patients and personnel to decrease the incidence of preventable infectious diseases.

III. Division of responsibilities for infection control activities. The administrator is ultimately responsible for the Infection Control Program.

A. Infection Control Practitioner. Responsibility is delegated to the Infection Control Practitioner (ICP) to carry out the daily functions of the Infection Control Program. Those functions are described in the ICP job description. The ICP has knowledge and interest in Infection Control.

B. Infection Control Committee. The Infection Control Committee meets quarterly as part of the Quality Assurance Committee and provides input and direction for the Infection Control Program. Policies and procedures relating to Infection Control are approved by the committee. Reports of infections are presented to the committee which recommends actions and control measures when needed.

IV. Reporting mechanisms for infection control.

A. Patient Infection Cases are monitored by the ICP. The ICP completes the line of listing of infections and the monthly report form and reports: 1. Monthly to the Administrator/Director of Nursing. 2. Quarterly to the Infection Control Committee...

C. Compliance with Infection Control Practices is monitored and documented by: 1. Staff evaluation. 2.

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Observation of practices. The ICP, Director of Nursing and Department Managers review the compliance monitoring and initiate appropriate actions.

V. Updating the Infection Control Plan. The infection Control Plan will be reviewed annually by the Infection Control Committee. Note:...Minutes of the Infection Control Committee meetings are maintained."
There was no documentation to evidence that infection control committee minutes were maintained.

3. The laboratory the facility used produced a quarterly "Organism Occurrence Report". The Organism Occurrence Report for the third quarter, 7/1/01 through 9/30/01, recorded the following isolates within the facility:

- methicillin resistant staphylococcus aureus
- klebsiella oxytoca
- escherichia coli
- enterococcus faecalis
- acinetobacter baumannii
- staphylococcus aureus
- pseudomonas aeruginosa (multiple antibiotic resistant)
- klebsiella pneumoniae
- citrobacter braakii
- enterobacter aerogenes
- proteus mirabilis
- enterococcus faecium
- enterococcus gallinarium
- Group B Beta-streptococcus

The facility had no documentation to evidence that they had performed trending or cluster analysis of these isolates. The facility had no documentation to evidence that they had identified and corrected

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problems relating to infection control practices or that they had implemented appropriate control measures.

4. As per the facility's policy, "The Infection Control Committee meets quarterly as part of the Quality Assurance Committee and provides input and direction for the Infection Control Program."

The Quality Assurance (QA) and Assessment Committee Minutes from June - October 2001 were reviewed. The following information was the total data recorded in the QA minutes relating to infection control.

6/19/01 - "culture infections"
7/13/01 - "review and test for"
8/28/01 - no data was recorded
9/24/01 - "UTI (urinary tract infection) tracking" - "tracking to be in place this wk (week)"
10/29/01 - "tracking to be done by 10/30/01"

5. During the survey of 10/30/01 through 11/08/01, the facility was caring for resident 29 who had methicillin resistant staphylococcus aureus and hepatitis C. When the Director of Nurses and other facility nurses were interviewed, on 10/31/01, as to whether resident 29 had been tested for tuberculosis (TB), as required by stated law and the facility's own policies, the facility staff did not know. The "TB Mantoux skin test history" in the medical record of resident 29 was blank. On 11/7/01, the facility presented documentation that resident 29 had been tested for TB at his previous long term care facility. The results of the test were negative. Resident 29 had been residing in the facility 35 days before the staff were aware of his TB status.

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	465128	A BUILDING ____ B WING ____	11/8/01

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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 observations, interviews and review of resident medical records, facility policy and procedures and review of Quality Assurance (QA) and Assessment Committee Minutes during the survey from 10/30/01 through 11/8/01, it was determined that the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical well-being for each resident in the area of pressure sore treatment and prevention and was found to be providing Sub-Standard Quality of Care. Facility administration failed to ensure continuing compliance even though pressure sore treatment and prevention had been previously identified as an area of deficient practice, at an actual harm level, on the facilities previous recertification survey completed on 8/10/00. In addition to the finding Sub-Standard Quality of Care and non-compliance with pressure sore treatment and prevention, deficient practice was identified in 13 other areas, excluding this tag. Findings include: 1. On November 8, 2001, 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 treatment and services to 5 residents with pressure sores [42 Code of Federal Regulation (CFR) 483.25 (c) Tag F - 314].	F 490 SD ETD 12/28/01	F-490 On 11/28/01 the RN Consultant provided an inservice for the Administrator on the responsibilities of a nursing facility administrator. On 12/4/01 RN Consultant inserviced the Administrator on how to keep a pulse on the issues of the facility. The Administrator meets two times each week with the Corporate Administrator to discuss tags and issues related to the maintaining of quality care in the facility. The issues stated in the survey will be reviewed in the QA meeting with the RN Consultant to ensure appropriate handling of issues. The facility compliance anticipated date is 1/7/02.	

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A pattern of actual harm was identified for 5 residents who developed an avoidable pressure sore, and/or did not receive treatment and services to promote healing of a pressure sore.

The facility was not aware of 4 of the 5 pressure sores until the facility nurses were informed by survey nurses.

The facility's quality assurance and assessment meeting minutes for the dates 6/19/01, 7/31/01, 8/28/01, 9/24/01, and 10/29/01 were reviewed on 11/7/01. In reviewing the documentation of the minutes, it was noted that the facility did not identify any quality deficiency issues regarding the identification, assessment, appropriate treatment and prevention of the development of pressure sores.

The plan of correction for the previous recertification survey in which actual harm was cited regarding pressure sores, dated 8/2/00 to 8/10/00, stated the following:

"this resident (referring to resident 51 in this current survey, who was referred to as resident 24 in the previous 8/10/00 survey) is also being monitored in the skin and weight meetings weekly". It also stated that "The Director of Nursing or designee and Administrator will monitor the flow sheets, treatment sheets and I/O sheets for compliance and report to the QI committee."

Review of facility skin team notes revealed that they met on 7/18/01, 8/3/01, 9/6/01, 10/29/01 and 11/5/01. Resident 51 was not being reviewed by the skin team weekly even though the presence of a pressure sore had been identified in her medical record for all of these months (July-November 2001).

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Review of the facility's QI (Quality Improvement) committee meeting minutes dated 6/19/01, 7/31/01, 8/28/01, 9/24/01 and 10/29/01 revealed no documentation to evidence that flow sheets, treatment sheets or I/O (intake and output) sheets had been reviewed for compliance or that results of the reviews had been reported to the QI committee. Specifically, there was no documentation in the QI committee minutes of 10/29/01 to evidence that the facility was aware of the lack of compliance with the treatment to resident 51 during October 2001.

2. In addition to the area of Sub-Standard Quality of Care stated above, the facility administration 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 cited during the survey completed on 11/8/01.

a. Facility administration failed to ensure that the results of all investigations of alleged mistreatment, neglect, abuse or injuries of unknown origin were reported to the State survey and certification agency within 5 working days of the incident.
(Refer to Tag F-225)

b. Facility administration failed to ensure that the facility housekeeping and maintenance staff provided services necessary to maintain a sanitary, orderly and comfortable interior.
(Refer to Tag F-253)

c. Facility administration failed to ensure that the facility staff meet professional standards of quality when caring for residents with urinary catheters.
(Refer to Tag F-281)

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d. Facility administration failed to ensure that the facility used the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.
(Refer to Tag F-354)

e. Facility administration failed to ensure that the facility staff prepared food by methods that conserved the appearance, attractiveness, palatability, or the proper temperatures of the food.
(Refer to Tag F-364)

f. Facility administration failed to ensure that the facility staff provided therapeutic diets as prescribed by the physician.
(Refer to Tag F-367)

g. Facility administration failed to ensure that the facility staff prepared, distributed and served food under sanitary conditions.
(Refer to Tag F-371)

h. Facility administration failed to ensure that the facility staff provided pharmaceutical services, including the accurate administering of all drugs and biologicals, to meet the needs of each resident.
(Refer to Tag F-426)

i. Facility administration failed to ensure that the facility established an infection control program which investigated, controlled, and prevented infections in the facility.
(Refer to Tag F-441)

j. Facility administration failed to ensure that the facility obtained laboratory services to meet the needs of all residents.
(Refer to Tag 502)

k. Facility administration failed to ensure that the

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2. In addition to the area of Sub-Standard Quality of Care stated above, the facility administration 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 cited during the survey completed on 11/8/01.

a. Facility administration failed to ensure that the results of all investigations of alleged mistreatment, neglect, abuse or injuries of unknown origin were reported to the State survey and certification agency within 5 working days of the incident.
(Refer to Tag F-225)

b. Facility administration failed to ensure that the facility housekeeping and maintenance staff provided services necessary to maintain a sanitary, orderly and comfortable interior.
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c. Facility administration failed to ensure that the facility staff meet professional standards of quality when caring for residents with urinary catheters.
(Refer to Tag F-281)

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A pattern of actual harm was identified for 5 residents who developed an avoidable pressure sore, and/or did not receive treatment and services to promote healing of a pressure sore.

The facility was not aware of 4 of the 5 pressure sores until the facility nurses were informed by survey nurses.

The facility's quality assurance and assessment meeting minutes for the dates 6/19/01, 7/31/01, 8/28/01, 9/24/01, and 10/29/01 were reviewed on 11/7/01. In reviewing the documentation of the minutes, it was noted that the facility did not identify any quality deficiency issues regarding the identification, assessment, appropriate treatment and prevention of the development of pressure sores.

The plan of correction for the previous recertification survey in which actual harm was cited regarding pressure sores, dated 8/2/00 to 8/10/00, stated the following:

"this resident (referring to resident 51 in this current survey, who was referred to as resident 24 in the previous 8/10/00 survey) is also being monitored in the skin and weight meetings weekly". It also stated that "The Director of Nursing or designee and Administrator will monitor the flow sheets, treatment sheets and I/O sheets for compliance and report to the QI committee."

Review of facility skin team notes revealed that they met on 7/18/01, 8/3/01, 9/6/01, 10/29/01 and 11/5/01. Resident 51 was not being reviewed by the skin team weekly even though the presence of a pressure sore had been identified in her medical record for all of these months (July-November 2001).

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F 490	Continued From Page 63 facility maintained clinical records on each resident in accordance with accepted professional standards and practices that were complete, accurately documented and systematically organized. (Refer to Tag F-514) l. Facility administration failed to ensure that the facility maintained a quarterly QA committee which included a physician designated by the facility. (Refer to Tag F-520) m. Facility administration failed to ensure that the facility quality assessment and assurance committee identified issues with respect to quality assessment and assurance activities that were necessary; and developed and implemented appropriate plans of action to correct identified quality deficiencies. (Refer to Tag F-521)	F 490		
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: Based on staff interview and review of resident medical records, the facility did not obtain laboratory services to meet the needs of 1 of 15 sample residents. Specifically, the facility did not obtain lab results requested by the physician for resident 66 who had a seizure disorder. Findings include: Resident 66 was a 65 year old male who was admitted	F 502	F-502 1- Resident 66's labs are being monitored at least 3 days per week to ensure that all labs ordered are drawn. 2- All labs are audited at least 3 days a week to ensure that all physician ordered labs are drawn. 3- The Administrator designated the Medical Records Clerk, in writing, to monitor and ensure that timely results are obtained for labs which are ordered by the physician. Results of monitoring will be documented and included in the weekly reports faxed to the State Survey Agency. The Lab Policy and Procedure was reviewed and revised. 4- Missing or inadequate data will be addressed in the QA meeting. 5- The facility compliance anticipated date is 1/7/02.	

12/28/01

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to the facility on 11/20/92 with the diagnoses of seizure disorder, dementia, pain, cerebral degeneration, benign hypertrophy of the prostate and a pruritic disorder.

A nurse's note regarding resident 66, dated 9/14/01 at 9:00 AM, documented, "Resident was watching TV when tonic clonic seizure activity started. Episode lasted approx. (approximately) 60 sec (seconds). Jerking of L (left) arm and leg most evident with cyanosis (bluish color) of face. Was taken to room and placed on L (left) side due to Post ictal state."

A second nurse's note, dated 9/14/01, documented, "Dr. in to see pt. Order noted for Dilantin, VPA (valproic acid) and Tegretol, CMP and CBC level's."

The physician's order, dated 9/14/01 at 11:40 AM, read, "Dilantin, VPA, tegretol, CMP, CBC (in AM)". The labs should have been obtained the morning of 9/15/01.

On 11/1/01, the facility was requested to provide documentation that these labs were obtained as ordered by the physician. On 11/6/01, a second request was made for the facility to provide documentation that these labs were obtained for resident 66, as ordered by the physician. During a review of the laboratory results of this resident with the medical records coordinator on 11/7/01, she stated that she could not find the results of those labs due 9/15/01 and that they were "not done."

A physician's order, dated 6/1/01, read, "Dilantin, VPA, tegretol level, CBC, CMP..." The medical record of resident 66 did not contain documentation to evidence that these labs had been obtained as ordered by the physician. Another physician's order in the medical record of resident 66 read, "Please post labs

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ordered 6/1 - if not done, draw today and call results." Results of the labs, which were initially ordered 6/1/01, were obtained and reported to the physician on 7/5/01, 34 days after the initial request.

The Dilantin, valproic acid and tegretol were all medications to control the seizures of resident 66. Without these laboratory results, the physician would not be able to ascertain whether resident 66 was receiving therapeutic doses to control his seizures.

F 514 SS=D — 483.75(l)(1) ADMINISTRATION

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

This REQUIREMENT is not met as evidenced by:

Based on medical record review and a staff interview, the facility did not maintain clinical records on each resident in accordance with accepted professional standards and practices that were complete, accurately documented and systematically organized as evidenced by: one of fifteen sampled residents had a medical record that was incomplete in the documentation of admission, transfer and discharge from the facility; and inaccurate data on the medication administration record. Resident identifier: CR1

Findings include:

Resident CR1 had a right above the knee amputation approximately a year and a half prior to her admission to an acute care facility on 8/10/01 for weakness, UTI

F 514

F-514
2- The Medical Records Clerks does the discharge summary audit that is done within 2 weeks of discharge. All departments with incomplete areas are notified in that time period. The departments have 1 week to complete these areas. All nurses and other departments will be inserviced regarding policies for discharge by 12/19/01 The DON will be responsible to ensure that pool nurses are inserviced. Incomplete data will be brought to the QA committee to revise plan of action.
5- The facility compliance anticipated date is 1/7/02.

12/28/01

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(urinary tract infection), and left foot decubitus ulcer. The plan of care from the acute care facility was to get resident CR1 some physical and occupational rehabilitation to increase upper body strength for means of moving her wheelchair. Resident CR1 had been using her left foot to mobilize herself and then developed an ulcer. Resident CR1 was admitted to Hillside Rehabilitation Center on 8/14/01 at 4:00 PM with the diagnoses of UTI, decubitus ulcer to foot, PVD (peripheral vascular disease) and CHF (congestive heart failure). Resident CR1 was discharged to an acute care facility on 8/15/01.

On 11/05/01, during record review, the "Admission Nursing Assessment" was found to have multiple blanks and missing information. The "Nurse's Checklist for Admissions" was given to the registered nurse surveyor by the administrator on 11/07/01 as a reflection of the facility's admission protocol. The following areas were left blank on the "Admission Nursing Assessment" form:

1. Vital signs (the vital signs were not found anywhere in the chart during resident CR1's stay.)
2. PPD (tuberculosis) information
3. Attending physician
4. Hearing
5. Vision
6. Communication
7. Eating and Nutrition
8. Sleep Patterns
9. Bathing
10. General Grooming
11. Staff member that completed the assessment (no signature, title, or date)
12. The Inventory of Personal Effects was blank

The "Daily Patient Assessment" forms that were to be completed every shift were lacking vital signs on

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8/14/01 for night shift and 8/15/01 for day shift.

There was a physician's order, for resident CR1, on 8/15/01 to "send to [hospital emergency room] to eval [evaluate]". The "Discharge Summary/ Post Discharge Plan of Care" was to be completed within 30 days of discharge in accordance with the facility's discharge summary policy. The following areas were incomplete on the discharge summary:

1. No discharge final diagnosis
2. No summary of the resident's status
3. No treatment modalities
4. No discharge disposition
5. No social information
6. No physician listed or physician's signature
7. No condition of resident at time of discharge noted
8. No signature of resident or responsible party
9. No vital signs
10. No evidence of resident or family participation of discharge planning noted
11. No evidence that social services assisted with discharge planning
12. No evidence of discharge teaching

On 11/07/01 at 2:50 PM, during an interview with the facility's social service staff member, she stated that she thought resident CR1 was transferred to the hospital. The social service personnel stated that it was the responsibility of the admission's coordinator to follow up on all hospitalizations. The facility's admission coordinator that was employed in August of 2001 was no longer in that position. Through the interview with the facility's social service personnel, it was stated that the facility's admission coordinator was responsible to notify social services if the resident was not going to return to the facility. The facility's social service personnel did not recollect speaking to any family members of resident CR1 or the admission's

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F 514	Continued From Page 68 coordinator after CR1's transfer to the hospital. The facility's "Post - Discharge Plan" policy and procedure stated: "1. The charge nurse on duty during the shift of the discharged resident will be responsible to assure that the post- discharge plan is completed with the assistance of social services". The MAR (Medication Administration Record) for resident CR1 had inaccurate data reflected by having had a nurse's initials in the 8/17/01 box when the resident was transferred and discharged to a hospital on 8/15/01. The following medications were initialed as given at 8:00 AM on 8/17/01 for resident CR1: 1. Amaryl 2 mg (milligrams) 2. Celebrex 200 mg 3. Zocor 10 mg 4. Remeron 15 mg 5. Protonix 40 mg 6. Diflucan 150 mg 7. Lasix 20 mg and also documented as given at 5:00 PM 8. Levaquin 250 mg 9. Coumadin 5 mg 10. Diovan 160 mg 11. HCTZ 25 mg 12. K-Dur 20 mEq (Milliequivalents) 13. Hydralazine 12.5 mg	F 514	F-520 The facility has communicated with the Medical Director the importance of attending the QA meetings himself and not sending the Nurse Practitioner. The regulations were communicated to all department heads. Review of this policy will occur during QA meetings. On 12/13/01 the physician was present for the QA meeting. The facility compliance anticipated date is 1/7/02.	
F 520 SS=D	483.75(o)(1) ADMINISTRATION A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520	DR EJD 12/28/01	

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	465128	A. BUILDING _____ B. WING _____	11/8/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE REHABILITATION CENTER	1216 EAST 1300 SOUTH SALT LAKE CITY, UT 84105

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This REQUIREMENT is not met as evidenced by:
Based on interview and review of the facility quality assurance and assessment (QA) committee program, it was determined that the facility did not maintain a quarterly QA committee which included a physician designated by the facility.

Findings include:

During an interview on 11/8/01 at 8:00 AM, the administrator stated the physician attended the QA meetings "about half the time".

QA minutes for June 2001, July 2001, August 2001, September 2001 and October 2001 were reviewed and showed that a physician was not documented as attending any QA meetings during that time period.

F 521 SS=H	483.75(o)(2)&(3) ADMINISTRATION	F 521	F-521

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

This REQUIREMENT is not met as evidenced by:
Based on review of the facility's quality assurance and assessment program, facility monitoring systems,

12/28/01

On 11/28/01 the RN Consultant provided an inservice for the Administrator on the responsibilities of a nursing facility administrator. On 12/4/01 RN Consultant inserviced the Administrator on how to keep a pulse on the issues of the facility and how to utilize QA to ensure quality. The RN Consultant provides weekly direction on running an effective QA program to identify and write action plans for issues in the facility. On 12/6/01 a training session was provided by the RN Consultant to all of the department heads and QA members on how to write an effective plan of action. The facility compliance anticipated date is 1/7/02.

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F 521	Continued From Page 70	F 521	F521 The QA committee will meet at least weekly for 2 months or until substantial compliance is achieved. Changes made with verbal permission of the Administrator via telephone conversation on 12/28/01 at 8:50 AM.	

review of the quality assurance and assessment committee minutes, and staff interview, it was determined that the facility's quality assessment and assurance program failed to identify quality deficiencies regarding the identification, assessment, appropriate treatment and prevention of the development of pressure sores, resulting in actual harm for 3 of 15 sample residents and 2 additional residents. Residents 8, 18, 26, 50, and 51. In addition to the issue of pressure sores, the facility also failed to identify, establish and implement corrective action plans for Pharmaceutical Services, Infection Control, Professional Standards of Quality, Environment, and Food palatability, attractiveness and temperature.

Findings include:

1. .The administrator was interviewed on 11/8/01 regarding the facility's quality assurance and assessment program. The administrator stated the quality assurance and assessment meetings were held monthly and were attended by the administrator, the director of nurses, the medical director and all department managers. When asked how quality issues were identified, the administrator stated they were brought to the meetings by the committee members. The administrator stated any quality issues that were identified from the daily staff meetings, skin and weight meetings, and infection control meetings, were also reviewed monthly in the quality assessment and assurance committee.

2. The facility's quality assurance and assessment meeting minutes for the dates 6/19/01, 7/31/01, 8/28/01, 9/24/01, and 10/29/01 were reviewed on 11/7/01. In reviewing the documentation of the minutes, it was noted that the facility did not identify any quality deficiency issues regarding the identification, assessment, appropriate treatment and

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prevention of the development of pressure sores.

3. The facility's quality assurance and assessment committee failed to identify and subsequently establish corrective action plans to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. (Refer to Tag F-314.)

4. The facility's quality assurance and assessment committee failed to identify and subsequently establish corrective action plans to ensure the facility was administered in a manner that enabled it to use it's resources either efficiently or effectively to ensure that residents were provided the opportunity to attain or maintain their highest practicable well-being. (Refer to Tag F-490.)

5. In 1997, 1998 and 2000, this facility was cited at an actual harm level for issues relating to pressure sores. In 1998, they were also cited with actual harm at the follow-up survey for failure to follow their plan of correction with an additional instance of harm to a resident which related to pressure sores.

6. In addition to the issue of pressure sores, the facility also failed to identify, establish and implement corrective action plans for the following deficiencies:

a. Please also refer to F 426 - Pharmaceutical Services. Four of 6 insulin dependent diabetics in the facility had multiple insulin errors. Multiple errors were identified in August, September and October of 2001. One resident did not receive his intravenous antibiotic as ordered in October 2001. One resident

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did not receive her supplemental vitamins as ordered in October 2001.

The QA minutes for 8/28/01 documented regarding "Medication Error Review: none reported".
The QA minutes for 9/24/01 documented regarding "Medication Error Review: 2 med errors".
The QA minutes for 10/31/01 documented regarding "Medication Error Review: review".

Medication errors identified through the survey process are as follows:

August 2001 - total of 24
September 2001 - total of 31
October 2001 - total of 52

There was no documentation within the QA minutes to evidence that these errors had been identified or that a plan of correction had been established to address them.

b. Please also refer to F 441 - Infection Control. The facility did not establish an infection control program which investigated, controlled, and prevented infections in the facility, and did not maintain a record of incidents and corrective actions related to infections.

The administrator was interviewed regarding the facility's Infection Control Program on 11/1/01 at 8:55 AM. The administrator stated "We haven't been following the manual." When asked if the facility had a system in place to monitor and investigate causes of nosocomial and community acquired infections, the manner of spread; maintained a separate record on infection that identified each resident with an infection, the date, causative agent, site, cautionary measures to prevent the spread; or if the facility

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analyzed infection clusters, changes in the prevalent organisms, or increases in the rate of infection in a timely manner, the administrator stated "No".

There was no documentation to evidence that infection control committee minutes were maintained.

As per the facility's policy, "The Infection Control Committee meets quarterly as part of the Quality Assurance Committee and provides input and direction for the Infection Control Program."
The Quality Assurance (QA) and Assessment Committee Minutes from June -October 2001 were reviewed. The following information is the total data recorded in the QA minutes related to infection control:

6/19/01 - "culture infections"
7/13/01 - "review and test for"
8/28/01 - no data recorded
9/24/01 - "UTI (urinary tract infection) tracking" - "tracking to be in place this wk (week)"
10/29/01 - "tracking to be done by 10/30/01"

There was no documentation to evidence any tracking or follow-up had been performed based on these notes.

c. Please also see F 281 - Professional Standards of Quality.

One resident with a gastrointestinal tube (G-tube) did not have the G-tube site cleaned or the dressing changed 6 of 9 scheduled times in October 2001. A nurse's note from the medical record of resident 66, dated 10/29/01, documented the following "Resident's G-tube site hasn't been cleaned since 10/25/01. Area red/very dry, crusted, with indent of the tube stopper around the abdomen. Gauze clinging with pieces actually into resident's skin."

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Issues regarding the lack of facility staff performing dressing changes to another resident, as ordered by the physician, were also addressed in F-314.

During interview with a facility nurse on 10/31/01, she stated that the dressing changes for the south hall were changed "to nights" so the night nurse would do them because the pool nurses in the facility "weren't doing them."

Standards of clinical practice were not met for 2 of the 6 residents with urinary catheters in which the tubing was observed on the floor.

There was no documentation in the QA minutes for 8/28/01, 9/24/01 or 10/29/01 to evidence that any of these issues had been identified or addressed by the facility.

d. Please also see F 253 - Environment. Thirty-two of forty-three resident rooms, twenty-two of twenty-five resident bathrooms and the resident common areas, revealed housekeeping and maintenance services were not provided routinely

The QA minutes for 8/28/01, 9/24/01 and 10/31/01, did not identify any environmental concerns.

e. Please also see F 364 - Food Palatability, Attractiveness and Temperature.

The minutes from the Resident Council meeting were reviewed on 10/30/01 and revealed the following concerns regarding the appearance, attractiveness, palatability, and proper temperatures of the food:
8/8/01 Complaint: Residents still say meals are bad. Meat is tough.
8/21/01 Complaint: Serving small pieces of pie. No

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F 521	Continued From Page 75 presentation of food. BLT (bacon, lettuce and tomato) sandwich last week-bacon was raw. Cake wasn't good yesterday. 10/2/01 Concerns/Issues: Residents want bacon medium cooked. Meat is tough. Food is cold (room trays and in the dining room). There was no documentation in the QA minutes, dated 8/28/01, 9/24/01, or 10/31/01, to evidence that the concerns of the residents regarding the food had been addressed.	F 521		

HILLSIDE REHABILITATION CENTER

1216 EAST 1300 SOUTH
SALT LAKE CITY, UTAH 84105
801-487-5865 801-487-5869

12/31/01

[redacted]
Bureau of Medicare/ Medicaid Program
Certification and Resident Assessment

Dear [redacted]:

As we discussed, there are a few adjustments to the plan of correction that are felt could be appropriate at this time. We are currently working with an interim DON; our new DON will start on 1/15/01. We are requesting that you review these and provide your input or approval:

1. Insulin checks could be changed to include new agency nurses and infrequently scheduled nurses only. The nurses that are regular have demonstrated skill in administration of the insulin and accuchecks.
2. Monitoring of catheters could be changed to 5 days per week instead of 7 days. There has been significant improvement shown.
3. Monitoring skin assessments to continue with until each licensed nurse can demonstrate accurate assessments to RN Consultant. This area is still a major concern.
4. MAR audits could be changed from 7 days a week. Monday checks to include Friday – Sunday. There has been significant improvement in this area.
5. Infection Control Meetings could be held monthly. The new DON who attended the meeting on 12/27/01 has a clear understanding of the process.

Thank you for your consideration of these matters. Please call if you have any further questions.

Paula deAnda
Paula deAnda
RN Consultant

Addendum accepted
1/7/02
OK to Anne 1/7/02

JAN – 2 2002