DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 7/18/02
FORM APPROVED
2567-L

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 ______	7/11/02

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 8-29-02 Etd

(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 157 SS=D	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview with a physician and review of resident medical records, it was determined that for 1 of 14 sample residents, the facility did not consult with the resident's physician when there was a need to alter treatment. Specifically, one resident developed a stage 2 pressure sore and the physician was not consulted to obtain orders to treat the wound. Resident identifier: 53.	F 157	F-157 The Physician was notified of Resident 53's condition change on 7/8/02. All residents have the potential of being affected. Residents with a change in condition will have the change explained to them, the attending physician will be notified for the appropriate treatment and the family member / responsible party will be notified of the change and the treatment. All will be documented in the resident's chart. A policy was written on when to notify family and physician regarding change in condition. An audit will be done weekly times 8 wks, Bi –monthly x 2, then monthly by the ADON of order changes and skin changes reflecting a condition change. The audit will monitor notification of physician and family / responsible parties. Results of the audits will be presented to the QA Committee. Any change in condition will be reported to the DON/ ADON and monitored for compliance in reporting and documentation. An In-service on proper documentation procedures was completed on 7/25/02 by the SDC. An In-service on notification of family and physician regarding resident changes of condition will be done on 8/9/02 by the SDC.	8/9/02 8/9/02

Utah Dept. of Health
AUG 12 2002
#507106 #7
Bur. of Medicare/Medicaid Prog.
Certification and Res. Assessment

Please Also refer to POC addendum.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dennis L Gehring	Administrator	12 August 02

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

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	7/11/02

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

(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 157	Continued From page 1 Findings: Resident 53 was a 93 year old female who was admitted to the facility on 3/20/00 with the diagnoses of urosepsis, congestive heart failure, history of a left hip fracture and dementia. On 5/17/02, a nurse performing a weekly skin check of resident 53 identified her skin as "NI" (not intact). This same nurse also made an entry in the nurse's notes, dated 5/17/02, which documented "Skin check performed. Skin is not intact. Presents a 0.75cm stage II superficial ulcer on coccyx. Granulex applied." There was no documentation in the medical record of resident 53 to evidence that the physician was notified of the pressure sore identified on 5/17/02. There was no documentation to evidence that physician orders were obtained to provide treatment for this newly identified pressure sore. During interview with the resident's physician on 7/11/02, he was asked if he had been notified of the skin breakdown which occurred on 5/17/02. The physician went through the chart of resident 53 and stated that it was not mentioned in his notes. The May 2002 treatment sheet for resident 53 was reviewed on 7/11/02. There was no documentation to evidence that the newly identified (as of 5/17/02) pressure sore had received any new treatment.	F 157		
F 252 SS=E	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent	F 252		

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 ______	7/11/02

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

(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 252	Continued From page 2 possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not maintain a clean environment. Specifically, carpets and furniture had multiple stains, the north hall had a strong lingering urine odor, linoleum was missing from the dining room floor, one resident complained of bugs, live ants were viewed in the dining area, and the north shower room was left with trash items on the floor for two days. Findings include: Observation of the carpet located in the main entrance, and in the hallway going to the Administrator's office revealed it to have multiple large (a foot or more) grayish-black stains on it all three days of survey. The couch located in the main dining room across from the television had 2 large round stains (measuring approximately 18 inches in diameter) on the seat cushion. On 7/10/02, the north shower room had a triangular shaped piece of tile (approximately 1 inch by 1 inch) laying in the shower drain. There was a salt and sugar packet laying on the floor next to the far wall and a discarded rubber glove laying next to the bath tub. All of these items were again observed on the north shower room floor on 7/11/02, just prior to exit. Near the kitchen and the courtyard exit door, there was a piece of linoleum missing from the dining room floor exposing the cement. The exposed area measured approximately 3 1/2 feet by 6 inches. The cement area, next to the outside window, had a build up of dirt and food crumbs. Live ants were observed in this area. This was observed all days of survey, 7/9/02 -	F 252	F-252 Environment: Carpet Replacement: The carpet located in the main entrance of the facility and the hallway to the administrator's office will be removed and replaced with new floor coverings by August 31, 2002. The sub-floor surface, in the main entrance and hallway to the administrators office, upon which the new floor coverings will be placed require professionally trained personnel to treat and prepare the sub-floor surface prior to replacing the new floor covering. This floor preparation procedure must precede the laying of the new floor covering to prevent the same type of staining from re-occurring. [handwritten: initials 8-29-02] The carpeted floors will be placed on a cleaning schedule and housekeeping staff will be trained on the proper equipment and time intervals that should be maintained for cleaning. New carpet will be monitored daily by housekeeping to identify problems of potential staining. A housekeeping record will be kept to insure the new carpeting is properly maintained and cleaned as recommended by the manufacturer. Stained Couch: The couch, with the stained fabric, across from the television was removed from service in July following the survey exit. It will remain out of service until the couch can be re-covered or replaced by the fabric manufacturer. The staff of the housekeeping department will monitor furniture as they clean on a daily basis. Stained furniture will be reported to the supervisor and efforts to clean and remove	8/31/02 8/31/02 8/31/02 7/25/02 8/31/02

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 ______	7/11/02

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

(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 252	Continued From page 2 possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not maintain a clean environment. Specifically, carpets and furniture had multiple stains, the north hall had a strong lingering urine odor, linoleum was missing from the dining room floor, one resident complained of bugs, live ants were viewed in the dining area, and the north shower room was left with trash items on the floor for two days. Findings include: Observation of the carpet located in the main entrance and in the hallway going to the Administrator's office revealed it to have multiple large (a foot or more) grayish-black stains on it all three days of survey. The couch located in the main dining room across from the television had 2 large round stains (measuring approximately 18 inches in diameter) on the seat cushion. On 7/10/02, the north shower room had a triangular shaped piece of tile (approximately 1 inch by 1 inch) laying in the shower drain. There was a salt and sugar packet laying on the floor next to the far wall and a discarded rubber glove laying next to the bath tub. All of these items were again observed on the north shower room floor on 7/11/02, just prior to exit. Near the kitchen and the courtyard exit door, there was a piece of linoleum missing from the dining room floor exposing the cement. The exposed area measured approximately 3 1/2 feet by 6 inches. The cement area, next to the outside window, had a build up of dirt and food crumbs. Live ants were observed in this area. This was observed all days of survey, 7/9/02 -	F 252 Cont.	stains will be made. Furniture with stains that cannot be cleaned and removed will be taken out of service.	
			North Shower Room Tile by the shower drain was replaced the last week of July 2002. The North shower room floor will be power scrubbed and the entire shower room deep cleaned by August 31, 2002.	7/29/02
			Housekeeping staff and Nursing staff will monitor and identify by location when they see tile broken and in need of repair. They will write up the location and nature of the damage on the maintenance repair forms located at the nursing stations. The maintenance director will collect these requests for repair on a daily basis and evaluate and report the damage and cost to repair the damage to the administrator. The repair will then be scheduled and completed.	8/31/02
			Monitoring will be conducted of the two shower rooms by the Housekeeping supervisor, maintenance director or weekend manager to insure the proper cleaning of the shower rooms. The housekeepers on a daily basis will keep a written record documenting the cleaning of the shower rooms.	8/31/02
			Nursing and Housekeeping staff will be responsible to remove all clothing, linen, gloves, soap and shampoo and any other debris associated with giving a shower from the shower room following the bathing of each resident. If such items are left in the shower room the problem must be reported to the Maintenance super visor, which will coordinate problem with the DON.	8/31/02

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 ______	7/11/02

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

(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 252	Continued From page 2 possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not maintain a clean environment. Specifically, carpets and furniture had multiple stains, the north hall had a strong lingering urine odor, linoleum was missing from the dining room floor, one resident complained of bugs, live ants were viewed in the dining area, and the north shower room was left with trash items on the floor for two days. Findings include: Observation of the carpet located in the main entrance and in the hallway going to the Administrator's office revealed it to have multiple large (a foot or more) grayish-black stains on it all three days of survey. The couch located in the main dining room across from the television had 2 large round stains (measuring approximately 18 inches in diameter) on the seat cushion. On 7/10/02, the north shower room had a triangular shaped piece of tile (approximately 1 inch by 1 inch) laying in the shower drain. There was a salt and sugar packet laying on the floor next to the far wall and a discarded rubber glove laying next to the bath tub. All of these items were again observed on the north shower room floor on 7/11/02, just prior to exit. Near the kitchen and the courtyard exit door, there was a piece of linoleum missing from the dining room floor exposing the cement. The exposed area measured approximately 3 1/2 feet by 6 inches. The cement area, next to the outside window, had a build up of dirt and food crumbs. Live ants were observed in this area. This was observed all days of survey, 7/9/02 -	F 252 Cont.	Housekeeping is responsible to clean up whatever is found in the shower rooms when they doing the daily cleaning. "Linoleum" missing from dinning room floor: The missing floor covering was repaired and replaced in the dinning room near the south courtyard the last week of July 2002. A licensed Pest control specialist treated the area to control the ant problem Box elder bugs in windowsill: The window screen on the window of room N23 will be repaired by August 31, 2002 to prevent boxelder bugs from getting in the windowsill. Housekeeping staff will also monitor and clean the windowsill area daily to insure that bugs and spiders do not get into the resident room through the window area. Urine Odor in North Hallway: Housekeeping and Nursing staff identified the source of the Urine odor and the area was deep cleaned July 15,2002 which resolved the odor problem. Nursing staff and Housekeeping staff will monitor daily for Urine odors and will identify and resolve problems related to the source of the odor on a daily basis. All department Heads, as they make compliance rounds will monitor for Urine odors and will report any odor problems and identify the source. Once identified proper steps will be taken to resolve and prevent the odor from reoccurring.	 7/31/02 8/31/02 7/15/02

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 ____	7/11/02

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

(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 252	Continued From page 3 7/11/02. On 7/10/02, a resident complained of bugs in her room. Observation of room N23 revealed boxelder bugs in the window sill. The outside screen was observed bent in one or more areas and had come apart from the window frame. On all days of survey, 7/9/02 - 7/11/02, all three surveyors noted a strong urine odor in the north hallway near the nurses station. The odor was not transient. During confidential interview with a family member of a resident on the north hallway, the family member stated that he/she had also noticed the strong odor.	F 252		
F 312 SS=E	483.25(a)(3) QUALITY OF CARE A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations during 1 breakfast meal and 2 lunch meals in the facility's main dining room restorative and assisted dining areas, it was determined that the facility did not ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition by providing needed assistance with dining for 4 of 14 sample residents. Resident identifiers 20, 22, 50, 53. Findings include: 1. Resident 50 was a 75 year old female re-admitted to the facility on 4/19/02 with diagnoses including dementia, seizure disorder, hypothyroidism and	F 312	Resident 50 has been relocated to an assist table to give her more consistent assistance with meals. Resident 20 has a mouth motor symptom associated with Tardive Dyskinesia, which causes some difficulties eating solid foods therefore resident 20 has been placed on a liquid puree diet. Resident 20 does not have dental or mouth problems and has refused to complete the process by which he would have a new set of dentures. Resident 20 is located at the Restorative table receiving increased encouragement in eating. With the change in diet resident 20 is able to feed self with cueing. Resident 22 had an evaluation completed by Dr. Joseph on 7/19/02. She has been placed at a table where the other residents are not served a puree diet. She becomes upset when placed with residents who are served a pureed diet. She is receiving increased cueing at the new table.	9/16/02 7/19/02

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 ____	7/11/02

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 312	Continued From page 4 generalized chronic pain.	F 312 Cont.	There is no action at this time that can change for the identified Resident 53, however she was not adversely affected by the weight loss.	

A review of resident 50's medical record on 7/11/02, revealed Medicare 5 day, 14 day and 30 day Minimum Data Set (MDS) assessments dated 4/23/02, 5/5/02 and 5/23/02 respectively, documented under section G., Physical Functioning and Structural Problems, h., Eating, that resident 50 required extensive assistance with one person physical assist to eat.

A review of resident 50's facility admission orders and physician re-certification orders dated April 2002 through June 2002, and signed by the physician, documented resident 50, "...needs help with eating".

A review of resident 50's restorative notes was done. There, a list of "Dining Room Suggestions for Restorative" was found. The following suggestions were among those noted, " While in dining room needs 1:1 assistance" and "Positive reinforcement-thank [resident 50] for coming to the dining room, tell her you're proud of her for eating meals, try to carry on simple conversation, etc.".

A review of resident 50's nutrition care plan on 7/11/02, documented that she was at nutritional risk and was to be served meals in the assistive dining area and the staff were to provide set-up help with her tray and assist as needed.

On 7/10/02, observation of resident 50 during the lunch meal revealed the following:

Resident 50 was observed in the dining room at a table in the assisted dining area at 12:30 PM. On the table in front of resident 50 was her meal tray, which consisted of puree barbecued chicken, mashed potatoes, pureed wax beans, pureed cantaloupe, a

---

Residents requiring assistance in the Dining Room have been identified. The dining room seating has been reviewed and revised by the NAR Team so that all residents who need assistance will be placed at the appropriate table. — 9/16/02

The % of meal consumed will be monitored daily by the charge nurses. The designate NAR committee nurse will monitor weekly.

The % of meal consumption will be discussed in the NAR (Nutrition At Risk Meeting) meetings held weekly.

The RD will In-service the CNA's regarding: — 9/10/02

- Proper feeding technique including sitting while assisting residents.
- Cueing and talking to residents regarding what is on the tray.
- Recording meal percentages and proper documentation.
- Offering of substitutes and alternates.

The daily meal service will be monitored by the Food Service Supervisor and cooks for timeliness, food temperatures, likes and dislikes and overall presentation to the residents obtaining verbal feedback from the residents. The dietitian will also monitor on visits to the facility. Food Quality meetings will be held on a weekly basis to discuss issues identified by the residents and the FSS. Results will be reported to the QA Committee at each meeting. — 9/16/02

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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 ____	7/11/02

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 312	Continued From page 5	F 312		

piece of slurry bread, 4 ounces of orange juice, and a carton of milk. Resident 50 was not observed to attempt to feed herself.

At 12:48 PM (18 minutes after resident 50 was first observed with her tray), a facility certified nursing assistant gave resident 50 two bites of pureed cantaloupe.

At 1:19 PM (49 minutes after resident 50 was first observed with her tray), a facility nursing assistance gave resident 50 a sip of milk. Resident 50 was then taken from the dining room.

During the lunch meal observation from 12:48 PM to 1:19 PM (31 minutes), no further attempts were made by the facility staff to assist resident 50 one on one with her meal. The certified nursing assistant was observed to stand (not sit) next to the resident when offering foods or fluids. The certified nursing assistant was not observed to tell resident 50 what she was being offered or verbally encourage resident 50 to consume her foods or fluids. Resident 50 was observed to consume no pureed chicken, no pureed wax beans, no mashed potatoes and no bread. Her orange juice was not uncovered or offered to her during the meal.

On 7/11/02, observation of resident 50 during the breakfast meal revealed the following:

Resident 50 was observed in the dining room sleeping at a table in the assisted dining area at 7:10 AM.

At 7:24 AM, resident 50's tray was placed in front of her and uncovered. The meal consisted of hot cereal, pureed eggs, pureed hash browns, milk and juice. Resident 50 was not observed to attempt to feed herself.

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 ____	7/11/02

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

(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 312	Continued From page 6	F 312		

At 7:28 AM (4 minutes after her tray was delivered), a facility certified nursing assistant was observed to sit down beside the resident and assist her to eat 1 bite of food. This staff member then left to assist another resident.

At 7:37 AM (13 minutes after her tray was delivered), resident 50 was observed sleeping at the table.

At 7:49 AM (25 minutes after her tray was delivered), a facility certified nursing assistant was observed attempting to give resident 50 sips of milk. Resident 50 had her eyes closed.

At 8:04 AM (40 minutes after her tray was delivered), resident 50 was given 2 sips of milk by a facility certified nursing assistant. She was then taken from the table.

During the breakfast meal observation from 7:28 AM to 8:04 AM (36 minutes), other than offering sips of milk, no further attempts were made by the facility staff to assist resident 50 one on one with her meal. The certified nursing assistant was observed to stand (not sit) next to the resident when offering fluids. The certified nursing assistant was not observed to tell resident 50 what she was being offered or verbally encourage resident 50 to consume her foods or fluids. Resident 50 was observed to consume only 1 bite of her meal and sips of milk.

On 7/11/02, observation of resident 50 during the lunch meal revealed the following:

Resident 50 was observed in the dining room sleeping at a table in the assisted dining area at 12:26 PM.

At 12:29 PM, resident 50's tray was placed in front of

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 ____	7/11/02

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

(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 312	Continued From page 7	F 312		

her and uncovered. The meal consisted of puree pork chop, mashed potatoes, pureed beets, slurry cookies and cream cake, slurry bread, milk and juice. Resident 50 was not observed to attempt to feed herself.

At 12:36 PM (7 minutes after her tray was delivered), a facility certified nursing assistant was observed to stand beside resident 50 and give her 1 bite of pork. The aide stated, "You need to eat a little bit [resident 50]". She then assisted resident 50 to consume 5 bites of mashed potatoes and 1 ounce of juice and at 12:39 PM, left the table.

At 12:45 PM, resident 50 was observed sleeping at the table.

At 12:57 PM (28 minutes after her tray was delivered), resident 50 was given one bite of food by the certified nursing assistant.

At 1:10 PM (41 minutes after her tray was delivered), resident 50 was given 4 sips of juice by the certified nursing assistant.

At 1:12 PM, resident 50 was taken from the table.

During the lunch meal observation from 12:29 PM to 1:12 PM (43 minutes), the certified nursing assistant was observed to stand (not sit) next to the resident when offering foods or fluids. The certified nursing assistant was not observed to tell resident 50 what she was being offered or verbally encourage resident 50 to consume her foods or fluids. Resident 50 was observed to consume 1 bite of pureed pork chop. 5 bites of mashed potatoes and approximately one ounce of juice. Resident 50 was not offered any beets, cake, bread or milk during the meal.

2. Resident 20, a 89 year old male, was readmitted to the facility on 5/3/02 with the diagnoses of brain

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 ___	7/11/02

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

(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 312	Continued From page 8 condition, schizophrenia, senile dementia, glaucoma, hyperplasia of prostate, gastric distress, dermatitis, generalized chronic pain, visual loss in one eye and urinary incontinence. On 7/11/02, a review of resident 20's medical record was done. A nutritional care plan for resident 20, dated 5/18/02 and updated 6/02, identified as a problem, "at nutritional risk related to hx (history) of significant weight loss, intakes less than 75% and continued significant wt (weight) loss rt (related to) dental problems, psychosis."An approach for this identified problem was to "assist as needed." A review of resident 20's MDS, dated 6/19/02, documented that resident 20 was independent in feeding himself and only required the staff to help set up his meals(G1h). The MDS did not indicate that resident 20 had any oral problems, such as, chewing problems, swallowing problems or mouth pain (K1). A review of the nursing notes, weekly nursing assessments, monthly nursing assessments a physician notes did not reveal that resident 20 had any complaints of dental problems. During an interview with the DON on 7/11/02, she stated she could not find any evidence that resident 20 had any complaints of dental problems. A nurse's note dated 7/8/02 documented, "Reports from CNA's (certified nursing assistant) saying res (resident) will not feed him self but will eat every thing if he is fed." A restorative referral dated 7/9/02 documented that resident 20 was on a puree liquid diet, his food is to be in cups and they are to encourage resident to eat and drink. The goal for resident 20 was "to increase wt gain et (and) to become independent (independent)."	F 312		

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 ____	7/11/02

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

(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 312		F 312		

Continued From page 9

On 7/11/02, resident 20 was observed to receive his breakfast tray at 7:30 AM. Resident 20 made no attempt to feed himself. At 7:34 AM the restorative aide was observed to feed resident 20 3 bites, one of the bites fell out of his mouth. The aide then left resident 20. Resident 20 took a few sips of his milk. At 7:38 AM resident 20 left the dining room. At 7:39 AM the restorative aide brought the resident back into the dining room and assisted him with a few more bites of him breakfast. At 7:48 AM the nurse gave resident 20 his medications and 50cc of 2.0 supplement. Resident 20 left the dining room after receiving his medication.

3. Resident 22, a 79 year old female, was admitted to the facility on 6/28/01 with the diagnoses of dementia and weakness.

On 7/11/02, a review of resident 22's medical record was done. A nutritional care plan for resident 22, dated 4/2/02 and updated 6/25/02, identified as a problem, "at nutritional risk related to inadequate intake r/t dementia, hx of weight loss resulting in low body weight, poor dental status and wt loss continues."An approach for this identified problem was to "set up tray and assist as needed and prompt and encourage throughout meal." A review of resident 22's MDS, dated 6/20/02, documented that resident 22 was independent in feeding herself and only required the staff to help set up her meals(G1h). The MDS did not indicate that resident 22 had any oral problems, such as, chewing problems, swallowing problems or mouth pain (K1).

A review of the nursing notes, weekly nursing assessments, monthly nursing assessments a physician notes did not reveal that resident 22 had any complaints of dental problems.

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 ____	7/11/02

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

(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 312	Continued From page 10	F 312		

A registered dietitian's progress note dated 4/2/02, documented, "resident states that she just loves the food. She does not want any changes and we give her what she wants..."

A food service supervisor's (FSS) progress note dated 4/4/02, documented, "res (resident) is now going to restorative feeding. Res says everyone is in a hurry so she does not eat the food so the change was made so res could have interaction and eat at her own pace." The FSS then documents on 6/20/02, "...res is on small por (portions) enriched but still does not eat her food she picks at food and complains about everyone around her res need more one on one she fills better if there is someone there to speak to while she eats she's a slow eater...".

On 7/11/02, observation of resident 22 during the breakfast meal revealed the following:

Resident 22 was observed in the dining room sleeping at the table in the restorative dining area at 7:10 AM.

At 7:22 AM, resident 22's tray was placed in front of her and uncovered. The meal consisted of hot cereal, eggs, hash browns, milk and juice. Resident 22 was not observed to attempt to feed herself.

At 7:24 AM, resident 22 picked up her milk glass and consumed several sips.

At 7:37 AM (15 minutes after her tray was delivered), resident 22 had not eaten any food items from her plate. She was not observed to receive any verbal encouragement or physical assistance to eat from the facility staff.

At 7:50 AM (28 minutes after her tray was delivered),

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 ______	7/11/02

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

(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 312	Continued From page 11	F 312		

resident 22 still had not eaten any food items from her plate. She was not observed to receive any verbal encouragement or physical assistance to eat from the facility staff.

At 7:54 AM (32 minutes after her tray was delivered), a facility certified nursing assistant asked resident 22 to eat. Resident 22 stated "I don't want it". She was not observed to receive any verbal encouragement or physical assistance to eat from the facility staff. She was not asked if she would like an alternate breakfast.

At 8:07 AM (45 minutes after her tray was delivered), resident 22 stated again "I don't want it" when asked to eat. She was not observed to receive any verbal encouragement or physical assistance to eat from the facility staff.

At 8:18 AM (56 minutes after her tray was delivered), resident 22 was asked by a facility staff member if she was going to eat any more. Resident 22 stated, "I'm all finished". She was not observed to receive any verbal encouragement or physical assistance to eat from the facility staff.

At 8:34 AM, resident 22 was taken from the dining room.

During the breakfast meal observation from 7:22 AM to 8:34 AM (1 hour and 12 minutes), other than a few sips of milk, resident 22 was not observed to consume any of her breakfast meal. No attempts were made by the facility staff to assist resident 22 with her meal. The certified nursing assistant was not observed to verbally encourage resident 22 to consume her foods or fluids. Resident 22 was not offered other food items in an effort to get her to eat.

On 7/11/02, resident 22 was observed to receive her

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 ____	7/11/02

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

(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 312	Continued From page 12	F 312		

lunch tray at 12:30 PM. The restorative aide assisted resident 22 in setting her meal up. Resident 22 did not attempt to eat on her own.

At 12:40 PM resident 22 continued to sit up at the dining room table not eating, a restorative aide was sitting next to her helping another resident. The restorative aide did not prompt or encourage resident 22 to eat.

At 12:50 AM resident 22 was still sitting at the table not eating.

At 1:05 PM resident 22 continued to sit at the table, the DON was sitting next to her helping another resident. The DON did not prompt or encourage resident 22 to eat.

At 1:13 PM resident 22 continued to sit at the table, the DON and restorative aide were at the table assisting another resident. Neither the DON or restorative aide prompted or encouraged resident 22 to eat.

At 1:20 PM the DON asked resident 22 if she needed any help, the resident replied "no". The DON sat down for 2 minutes to interact with resident 22 then left her.

At 1:24 PM the restorative aide sat down next to resident 22 to encourage her to eat. The resident appeared angry and told the restorative aide that she didn't need to worry about her. The cook and FSS came out to encourage resident 22 to eat.

At 1:30 PM the FSS continued to sit with resident 22 prompting and encouraging her to eat.

At 1:40 PM the FSS continued to sit with resident 22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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 ______	7/11/02

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 312	Continued From page 13	F 312		

prompting and encouraging resident 22 to eat. Resident 22 had eaten a few bites of her baked potato, a few bites of cake, 90 cc of milk and 100 cc of water.

At 1:50 PM the surveyor left the dining room for less than 5 minutes when she returned resident 22 was gone and her tray was cleared from the table.

4. Resident 53 was a 93 year old female who was admitted to the facility on 3/20/00 with the diagnoses of urosepsis, congestive heart failure, history of a left hip fracture and dementia.

The diet order for resident 53 during January 2002 and through May 15, 2002 was an enriched puree with two glasses of milk at each meal.

The minimum data set (MDS), a mandatory comprehensive assessment of the resident completed by facility staff, dated 4/26/02, documented that resident 53 needed supervision (oversight, encouragement or cueing) with eating and had received one person physical assist with eating and drinking.

In January 2002, resident 53 weighed 124.4 pounds. In July of 2002, resident 53 weighed 100.8 pounds. Resident 53 experienced a weight loss of 18.97% in six months, which is considered significant.

On 7/10/02, observation of resident 53 during the lunch meal revealed the following:

Resident 53 was observed in the dining room at a table in the restorative dining area at 12:30 PM. On the table in front of resident 50 was her meal tray, which consisted of drinkable puree barbecued chicken, drinkable mashed potatoes, drinkable pureed wax beans, pureed cantaloupe, a glass of orange juice, and

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 ______	7/11/02

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

(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 312 Continued From page 14 F 312

2 glasses of milk. Resident 53 was not observed to attempt to feed herself.

At 1:03 PM (33 minutes after resident 53 was first observed with her tray), a facility certified nursing assistant gave resident handed resident 53 a cup of her food. She was observed to hold the cup but not consume any of the food.

At 1:09 PM (39 minutes after resident 53 was first observed with her tray), resident 53 was observed to drink 2 sips of the food item in the cup and then set the cup down.

At 1:14 PM (44 minutes after resident 53 was first observed with her tray), resident 53 was observed to pick up her milk glass and drink approximately 1 ounce.

At 1:24 PM (54 minutes after resident 53 was first observed with her tray), resident 53 was taken from the table.

During the lunch meal observation from 1:09 PM to 1:24 PM (15 minutes), no further attempts were made by the facility staff to assist resident 53 with her meal. The certified nursing assistant not observed to tell resident 53 what she was being offered or verbally encourage resident 53 to consume her foods or fluids. Resident 53 was observed to consume 2 sips of one of the food items on her tray. The other food items were not offered to her. Her orange juice was not uncovered and offered to her during the lunch meal.

On 7/11/02, observation of resident 53 during the breakfast meal revealed the following:

Resident 53 was observed in the dining room at a table in the restorative dining area at 7:12 AM.

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 ____	7/11/02

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

(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 312	Continued From page 15	F 312		

At 7:20 AM, resident 53's tray was placed in front of her and uncovered. The meal consisted of drinkable hot cereal, drinkable pureed eggs, drinkable pureed hash browns, milk and juice. Resident 53 was observed to attempt to feed herself by picking up a cup of food but did not lift it to her mouth.

At 7:40 AM (20 minutes after her tray was delivered), resident 53 sat the cup of food down. No facility staff was observed to verbally encourage or physically assist resident 53 with eating.

At 7:57 AM (37 minutes after her tray was delivered), a facility certified nursing assistant attempted to hand resident 53 her juice but resident 53 did not take it from her. The nursing assistant told resident 53 to eat and left the table. No verbal encouragement to eat was offered to resident 53.

At 8:02 AM (42 minutes after her tray was delivered), resident 53 picked up her milk and drank a sip.

At 8:08 AM (48 minutes after her tray was delivered), a facility nursing assistant was observed to place a cup of resident 53's food in her hand. At 8:10 AM, resident 53 sat the cup down without consuming anything from it.

At 8:34 AM (1 hour and 14 minutes after her tray was delivered), resident 53 was asked by a facility nursing assistant if she was done eating and took her tray.

During the breakfast meal observation from 7:20 AM to 8:34 AM (1 hour and 14 minutes), The certified nursing assistant was not observed to tell resident 53 what she was being offered or verbally encourage or physically assist resident 53 to consume her foods or fluids. Resident 53 was observed to sips of milk and

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 ____	7/11/02

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 312	Continued From page 16 none of her breakfast meal.	F 312		
F 314 SS=D	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: This is a repeat deficiency from the last annual survey ending 11/8/01. Based on observation, interview and review of medical records, it was determined that for one of 1 sample residents, the facility did not ensure that a resident did not develop pressure sores. Specifically, one resident developed a stage 2 pressure sore in May 2002, the physician was not notified and no orders were obtained to treat the pressure sore. Weekly skin checks were not performed for one resident as directed. This same resident developed eight stage 2 pressure sores on both buttocks and the back of her left upper thigh. The facility was not following the directed plan of correction given to them following their last annual survey ending 11/8/01 which resulted in Sub-Standard Quality of Care. Resident identifier: 53. Findings include: Resident 53 was a 93 year old female who was admitted to the facility on 3/20/00 with the diagnoses of urosepsis, congestive heart failure, history of a left	F 314	F-314 There is no action at this time that can change for the identified Resident 53, however she was not adversely affected by the skin breakdown. Resident 53 has expired. At risk would be all other residents with a Braden score of 17 or less. The residents now have a current Braden Score and will be re-done quarterly as per facility policy. The MDS/Skin nurse is responsible for insuring this is done. An audit will be done quarterly of the Braden Scale and the results reported to the QA Committee. The same staff and consultants constituting the Weight Committee will meet weekly to discuss the status of all residents with identified skin problems. See F-157 regarding notification.	8/31/02 8/31/02

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 ______	7/11/02

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

(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 314	Continued From page 17 hip fracture and dementia. The last skin risk assessment performed for resident 53 was dated 12/20/01 and reflected a score of 13. The skin risk form documented that a score of "12 or below equals high risk". This skin risk assessment, for 12/20/01, reflected that resident 53 had "adequate" nutrition (eating over half of most meals). Since the time of the 12/20/01 skin risk assessment, resident 53 experienced a significant weight loss of 18.97%. The facility did not follow their directed plan of correction which required them to complete skin risk assessments on each resident at least quarterly. (The facility was missing 2 skin risk assessments for resident 53, one due on March 2002 and the other due in June 2002.) On 5/17/02, a nurse performing a weekly skin check of resident 53 identified her skin as "NI" (not intact). This same nurse also made an entry in the nurse's notes, dated 5/17/02, which documented "Skin check performed. Skin is not intact. Presents a 0.75cm stage II superficial ulcer on coccyx. Granulex applied." There was no documentation in the medical record of resident 53 to evidence that the physician was notified of the pressure sore identified on 5/17/02. There was no documentation to evidence that physician orders were obtained to provide treatment for the pressure sore identified 5/17/02. During interview with the resident's physician on 7/11/02, he was asked if he had been notified of the skin breakdown which occurred on 5/17/02. The physician went through the chart of resident 53 and stated that it was not mentioned in his notes. It should be noted that a Weekly Nursing Summary,	F 314 Cont.	The facility will enforce and maintain weekly skin checks on all residents with pressure sores or at risk for pressure sore problems in an effort to prevent and identify as early as possible any skin problems a resident may be developing. Assessments and interventions will be reviewed. Staff will review weekly weights, dietary intake, and supplement intake for all residents with skin problems and residents at risk for skin breakdown as identified by the team. The team will monitor residents until the resident's skin problems are resolved. Nursing will insure that the physicians of residents with identified pressure sores are notified and treatment orders obtained and resident families notified. Nursing will insure residents are on pressure reducing mattresses and that the individual care plan addresses the treatment and intervention needs and that treatments are carried out as ordered by the physician. The MDS/Skin nurse has resumed monitoring for the following: • Dating, Timing and Initials on all dressings. • Preventative measures in place. • Weekly skin checks being completed. • Random skin checks done to monitor for accuracy of skin checks. An In-service on Skin checks and measuring was done on 7/25/02 by the MDS / Skin nurse and the SDC.	8/31/02 8/31/02

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 ______	7/11/02

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

(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 314	Continued From page 18	F 314		

also dated 5/17/02, completed by a different nurse, reflected that resident 53's skin was "free of any open areas". This contradicted the other nurse's documentation of 5/17/02 which described a stage 2 pressure sore.

The May 2002 treatment sheet for resident 53 was reviewed on 7/11/02. There was no documentation to evidence that the facility performed weekly skin checks on resident 53, as required by the directed plan of correction and as ordered by the physician, on 5/24/02 or 5/31/02. Weekly skin checks for this resident would have been essential considering her documented breakdown on 5/17/02.

On 7/11/02, a skin check of resident 53 was performed with two registered nurse surveyors and a facility nurse. Resident 53 was observed to have eight stage II pressure sores on both buttocks and on the back of her left upper thigh. The largest sore measured approximately 3 cm (centimeters) by 2 cm and the smallest sore measured approximately 0.5 cm by 0.5 cm.

The directed plan of correction required the facility to establish a skin team to include a registered nurse and at least one other person familiar with skin integrity problems. The team was required to meet at least every 7 days. The last documented skin meeting was dated 6/12/02.

During interview with the Director of Nurses on 7/11/02, she stated that the facility "had missed a few meetings."

The facility was not following their directed plan of correction by not completing weekly skin checks on each resident. The facility was not following their directed plan of correction by not performing skin risk

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 ____	7/11/02

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 314	Continued From page 19 assessments of each resident at least quarterly. The facility was not following their directed plan of correction by not holding skin team meetings (consisting of a registered nurse and one other person familiar with skin integrity problems) at least every 7 days.	F 314		
F 325 SS=H	483.25(i)(1) QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. **This REQUIREMENT** is not met as evidenced by: Based on clinical record review and staff interviews it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by 3 of 14 sampled residents who experienced significant weight loss with no dietary interventions implemented to prevent further weight decline. Resident identifiers 22, 50, 53. Calculating weight loss percentages is done by subtracting the current weight from the previous weight, dividing the difference by the previous weight and multiplying by 100. Significant weight losses are as follows: 5% in one month, 7.5% in 3 months and 10% in 6 months. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000). The facility was found to be providing Sub-Standard Quality of Care (a pattern of actual harm) in this area. Findings include:	F 325	RD assessed residents 22, 50 and 53 as required in the directed plan of correction and as part of that assessment evaluated calorie, protein and fluid needs and evaluated these with actual and reported intake to determine nutritional needs and appropriate interventions. Recommendations were made and implemented to resolve nutritional issues. All residents have a potential for nutritional problems that could lead to weight loss. The facility weight team in the weekly NAR meeting will monitor the Weight of all residents on monthly, and weekly weighing schedule. Resident meal intake percentages will be evaluated daily by nursing and reported to dietitian as issues of intake are identified. When weight and/or food intake issues are identified, recommendations for interventions will be addressed in the weekly NAR meeting to resolve identified problems. All residents admitted to the facility will be placed on weekly weights for 4 weeks and evaluated to determine if the resident is experiencing significant weight changes. Significant Weight changes are changes $\geq 2\%$ in one week, $\geq 5\%$ in 30 days, $\geq 7.5\%$ in 90 days, $\geq 10\%$ in 6 months.	9/16/02 9/16/02

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 ______	7/11/02

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

(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 325 Continued From page 20

1. Resident 50 was a 75 year old female re-admitted to the facility on 4/19/02 with diagnoses including dementia, seizure disorder, hypothyrodism and generalized chronic pain.

On 7/11/02, resident 50's medical record was reviewed.

On 4/25/02, 6 days after her admission, the food service manager completed an initial dietary assessment that documented resident 50 was 5'1" (61 inches) tall, weighed 91.2 pounds and her ideal body weight range was documented as 94 to 116 pounds. The diet documented was regular.

A review of resident 50's admission weight, documented on the "Admission Nursing Assessment" form dated 4/19/02, revealed that she weighed 92.2 pounds. A review of resident 50's weekly weights, documented on "Weekly Weights" forms and provided to the survey team by the food service manager on 7/11/02, were as follows:

4/19/02 92.2 pounds.

5/6/02 86.8 pounds. This represents a significant weight loss of 5.4 pounds, or 6% from 4/19/02 to 5/6/02 (17 days).

5/13/02 85.8 pounds. This represents a significant weight loss of 6.4 pounds, or 7% from 4/19/02 to 5/13/02 (24 days).

5/20/02 81 pounds. This represents a significant weight loss of 4.8 pounds, or 5.6% in one week and 11.2 pounds, or 12% from 4/19/02 to 5/20/02 in one month.

5/27/02 87.4 pounds.

F 325 Cont.

Provider's Plan of Correction	Complete Date
Dietitian will evaluate weight information in the MDS for new admissions and residents experiencing significant weight changes to insure accuracy of data and proper interventions.	9/16/02
The RD will review evaluate and co-sign all initial, annual and quarterly assessments completed by the Food Service Manager on a monthly basis.	9/16/02
The RD will review, evaluate and co-sign change of condition assessments completed by the Food Service Manager on a monthly basis.	9/16/02
The Food Service Manager will use the forms provided by the dietitian consulting company and will document from the medical record calorie, protein, and fluid needs on the initial and annual nutrition at risk forms.	9/16/02
When asked, Resident 50 has denied oral pain/ or lesions. Nursing has completed an oral exam and noted no obvious lesions /. Or problems. A Dental Consult will be done by Aug. 31, 2002.	8/31/02
Resident 50 will be assessed for a calorie, protein and fluid needs by the RD and recommendations developed as needed by the RD and the Weight loss team in the Weekly NAR Meetings.	8/31/02
RD will evaluate all residents identified with significant weight loss to insure proper recommendations have been made and appropriate interventions are in place and being implemented to address the weight loss.	8/31/02

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 ____	7/11/02

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

(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 325	Continued From page 21 6/3/02 87.6 pounds. 6/10/02 85.4 pounds. 6/17/02 83.2 pounds. 6/24/02 79.2 pounds. This represents a significant weight loss of 4 pounds, or 4.8% in one week and 8.2 pounds or 9.4% in one month. 7/1/02 78 pounds. This represents a significant weight loss of 9.6 pounds, or 10.9 in one month. 7/8/02 74.4 pounds. This represents a significant weight loss of 3.6 pounds, or 4.6% in one week, 11 pounds or 12.8% in one month and 17.8 pounds or 19.3 % in three months. A review of resident 50's medical record on 7/11/02, revealed Medicare 5 day MDS (minimum data set) assessment was completed on 4/23/02. The MDS documented under section K., Oral/Nutritional Status, 1. Oral Problems, no chewing or swallowing problems. Resident 50's weight was documented at 92 pounds and there was no weight change noted. A Medicare 14 day MDS (minimum data set) assessment was completed on 5/3/02. The MDS documented under section K., Oral/Nutritional Status, 1. Oral Problems, no chewing or swallowing problems. Resident 50's weight was documented at 90 pounds and there was no weight change noted. A Medicare 30 day MDS (minimum data set) assessment was completed on 5/15/02. The MDS documented under section K., Oral/Nutritional Status, 1. Oral Problems, no chewing or swallowing problems. Resident 50's weight was documented at 90 pounds and there was no weight change noted. The weekly weight, documented by the facility on	F 325 Cont.	Nursing will notify MD of all residents who have gained or lost $\geq$ 5% or 5 pounds for each monthly weight. The weekly weight team will monitor to insure the physician has been notified.	9/16/02
			All weights, weekly and monthly have been entered into the Quick Care (MDS Computer) program to assist in identifying weight changes and will then trigger appropriately on the MDS. The weight report will be discussed in the weekly NAR meeting.	8/31/02
			All residents have been assigned to a specific nurse (Primary Care Nurse) to complete assessments, weekly and monthly summaries. This will allow the nurses to become more familiar to their assigned residents and will be alerted to any change in condition. The ADoN and SDC will audit documentation on all residents and report the status to the DoN.	8/31/02
			The skin and weight team will meet weekly to review weekly skin checks and monitor the progress of residents with identified skin problems. Residents' weights and meal intake record sheets will be monitored daily. The MDS/Skin Nurse will report the outcome of these meetings in the QA meeting monthly. Recommendations made and progress will be evaluated by the RD.	8/31/02
			Residents at high risk for weight loss or gain and residents at high risk for skin problems have been put on a predetermined schedule for review by the skin and weight team as they meet on a weekly basis. See F-521 for NAR meeting schedule. RD conducted in-service training for the nursing department 8-9-02 addressing feeding techniques for residents in the assisted feeding	8/31/02

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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 ____	7/11/02

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

(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 325 Continued From page 22
5/13/02, was 85.8 pounds down from 92.2 pounds on 4/19/02. This was a 6.9% weight loss in 30 days and should have been identified on the 5/15/02 MDS assessment.

An initial dietary assessment, completed by the food service supervisor on 4/25/02, documented, "Gangrene [right] arm just had surgery snacks tid [three times a day] fortified hot chocolate plate guard need assist [with] feeding change diet from reg [regular] to mech [mechanical] soft enriched 4-25-02 due to poor teeth cannot chew reg [regular]". This initial assessment identified resident 50 required assistance with eating, had her own teeth which were in poor condition, was very tired, was having difficulty eating and was refusing meals. The food service supervisor's documented plan for resident 50 was to monitor weight, intake, hydration, labs and skin. There was no documented referral for a dental consult. This initial dietary assessment was not co-signed by the facility's registered dietitian. There was no documented evidence that resident 50's nutritional needs, including calorie, protein and fluid needs, were calculated by either the food service supervisor or the registered dietitian.

On 5/15/02, the facility's registered dietitian completed a progress note which documented resident 50 had experienced a 9 pound weight loss since being re-admitted to the facility. The dietitian recommended a diet change to enriched puree, 60 cc (cubic centimeters) of 2 calorie supplement be started 4 times a day, 1 on 1 assist with feeding for resident 50 and weekly weights begin. There was no documented evidence that resident 50's nutritional needs, including calorie and protein needs were calculated by the registered dietitian.

On 7/10/02, a quarterly nutritional reassessment was

F 325 Cont.

program and how to record Meal intake percentages accurately for all residents in the assisted feeding program. The RD conducted the training in English and Spanish. She speaks fluent Spanish and functioned as her own interpreter. A second in-service will be held for nursing on 9-10-02 and thereafter the SDC will conduct the in-services for new employees. — 9/16/02

Resident 50's supplement intake will be recorded on the MAR by nursing and the meal % of intake on the Meal consumption sheets. — 9/16/02

All residents receiving supplements will have percent of intake recorded on the MAR if passed by the licensed nurse or on the Meal consumption sheets recorded in % of Intake at each meal. The meal consumption sheets will be monitored by the charge nurses daily and the % of intake on the MAR will be monitored by the oncoming charge nurse at the change of shift each day. The MDS/Skin Nurse will complete an audit of the MAR weekly. — 9/16/02
The skin and weight team will monitor the percent of supplement intake by residents requiring supplements at the weekly NAR meeting.

Nursing will report to RD when the resident refuses to take supplements four (4) Consecutive times so the RD can interview the resident to try to determine the problem and a possible solution. The resident refusing more than 50% of their supplements will be evaluated in the weight committee meeting and recommendations developed to address the problem. — 9/16/02

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 ______	7/11/02

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

(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 325	Continued From page 23 completed by the food service supervisor. The weights documented on this assessment were: April 92.2 pounds. May 90.6 pounds. June 87.6 pounds. July 78.0 pounds. The food service supervisor documented that there had been a significant weight change of 14 pounds. She also documented that resident 50 was assisted with feeding. There was no documented evidence that resident 50's nutritional needs, including calorie and protein needs had been assessed. The food service supervisor's documented plan for resident 50 was to monitor weight, labs, hydration, skin and intake. There was no documented evidence that resident 50's significant weight loss had been identified as a concern and no interventions were documented as being implemented. There was no documented evidence that the previously nutritional interventions implemented by the registered dietitian on 5/15/02 were re-evaluated to determine their effectiveness. This quarterly nutritional reassessment was not co-signed by the facility's registered dietitian. No further documented dietary notes were found in resident 20's medical record. A review of resident 50's "Malnutrition Risk Assessment", completed by a facility nurse, was done. Resident 50 was assessed on 5/24/02 as having a total score of 16. Per this form, a total score above 10 placed the resident at high nutritional risk. A nutritional care plan, which appeared to have been updated on 5/2/02, 5/15/02 and 6/2/02, documented that resident 50 was at nutritional risk related to a history of significant weight loss, a chewing deficit	F 325 Cont.	Refer to Dietitian in-service on feeding techniques and cueing. Food Service Manager, Cooks and designated Nursing and administrative staff will monitor daily the feeding of residents in restorative and assisted feeding program to insure aides are using proper feeding technique and are properly cueing and positively reinforcing resident in the restorative and assisted feeding program. The dietitian will also monitor the feeding of residents in the restorative feeding program when in the facility. Aides will be trained and monitored to insure they are offering resident 50 the alternate menu items when resident 50 refuse to eat items on the main menu. Refer to in-service training by RD on 9 Aug 02. All residents in the restorative and assisted feeding program are potential residents who may need to be assisted using proper feeding techniques and reinforcement and cueing to assist them in their consumption of food at meal times. All residents in the restorative and assisted feeding program will be offered alternatives if they refuse to eat what is served as the main menu. The food service manager and other designated administrative staff will monitor to insure residents are being assisted using proper feeding techniques and proper cueing and reinforcement and the offering of an alternative menu items if they refuse the main course menu. Meal monitors will insure aides are recording percentages of meal consumed and charge nurses will monitor for documentation daily.	 9/16/02 8/31/02 9/16/02

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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 ______	7/11/02

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

(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 325 Continued From page 24
with poor dental status, difficulty getting food into her mouth, a reduced ability to feed herself, inadequate meal intake, periods of refusal to eat, being a slow eater, weight loss related to dementia, continued weight loss, dementia, surgery and constipation and would have a weight increase of 1-2 pounds per month, consume greater than 75% of meals daily and would remain hydrated. Approaches to the problem on the care plan included, resident 50 was to receive meals in the assistive dining area and her tray was to be set-up and she was to be assisted with meals as needed.

A review of the facility's "Weight Skin Meeting" minutes was done.

The minutes, dated 5/15/02, revealed that resident 50 had been identified by the facility as at nutritional risk related to significant weight loss of 7% in one month from 4/19/02 to 5/13/02. Recommendations included, " Recommend enriched pureed diet, 60 cc 2.0 supplement QID (4 times a day) by nursing, Feed 1:1, Weekly weights, Notify family and physician on weight loss, Tube feeding desired by family. It is indicated".

A physician telephone order, dated 5/15/02 and signed by the physician, was reviewed. The following was ordered, an enriched pureed diet, 60 cc of 2.0 supplement 4 times a day, resident was to receive 1 on 1 assistance with feeding and a tube feeding was indicated.

The facility's "Weight Skin Meeting"minutes, dated 6/12/02, revealed that resident 50 had been identified by the facility as at nutritional risk related to significant weight loss of 4% in one month and 11% in 6 months. The facility's registered dietitian documented that a tube feeding was indicated and that

F 325 Cont. — 9/16/02

By the dietitian's documentation the resident 22 had an Ideal body weight of between 77 and 95. The resident medical record shows a weight in December of 85 lbs. In January, the facility held an Inter Disciplinary team meeting and a friend of Resident 22 attended that meeting. In the course of the meeting she mentioned that resident 22 had been treated for a "shrunken esophagus" in the past. The staff was addressing the need to have a new primary care physician assigned, Dr. Grange. The friend indicated that resident 22 had a history of being treated for a "shrunken esophagus" and would like Dr. Joseph to be her doctor for that procedure when needed. No referral was made at that time because there were no signs or symptoms of weight loss or any indication of resident 22 having a problem with a stricture of the esophagus. During the months of January, February and March resident 22 had a weight loss of 2.4 lbs. This loss is not considered a significant loss and the resident was still well within her ideal weight range. The resident experienced a weight loss over the next three months of 2.2 lbs. And in June the facility attempted to get an appointment for an evaluation for a possible esophageal stricture with Dr. Joseph. The office scheduled an appointment for September. The facility tried to get an earlier appointment but was informed she would have to go on a waiting list for the earliest opening. The Doctors office was made aware of her weight loss. The facility involved the family and friend and told them of the delayed appointment and asked them to try to get the appointment moved up. It was not until the end of July that an appointment came up and even then the Dr. tried to cancel the evaluation and procedure. It took the involvement of Dr.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 7/18/02
FORM APPROVED
2567-L

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 ____	7/11/02

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

(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 325	Continued From page 25 resident 50's Exelon medication should be re-evaluated due to anorexia. No further diet interventions were documented. A physician telephone order, dated 6/12/02 and signed by the physician, was reviewed. The following was ordered, "1) tube feeding is indicated 2) re eval [evaluate] Exelon D/T [due to] anorexia". A review of resident 50's medical treatment plan, updated 6/17/02 and signed by the resident, documented that she did not wish to have a feeding tube. A review of all documented physician and nurse practitioner progress notes completed from resident 50's re-admission on 4/19/02 through 7/11/02 was done. There was no documented evidence that resident 50's Exelon medication had been re-assessed. On 6/27/02, the nurse practitioner documented, "Poor eating, losing wt. [weight]". She ordered resident 50's Zonegran level and TSA (thyroid stimulating hormone) level be checked. She also discontinued resident 50's Paxil medication and ordered Remeron for weight loss. Prior to this progress note, there was documented evidence that resident 50's significant weight loss had been addressed by the physician. Resident 50 had been identified by the facility as a nutritional risk related to weight loss on 5/15/02 and 6/12/02. There were no documented "Weight Skin Meeting" minutes in the medical record or provided to the survey team after 6/12/02 addressing resident 50's significant weight loss since 6/12/02. On 7/11/02, at 3:42 PM, the food service manager was	F 325 Cont.	Grange's office to get Dr. Joseph to keep the appointment. Dr. Joseph had the endoscopy lab call to cancel the appointment and the facility refused to accept the cancellation. We were then referred to the physicians' office and they tried to cancel the appointment because they were not sure she would sign the consent and perhaps was too demented to be able to sign the consent. We contacted Dr. Grange's office and they got involved and the appointment was kept. The Physician was notified (regarding Exelon) on 4/7/02 with a change in order to "Hold exelon doses when nauseated", 5/15/02 "When exelon is gone increase to 6mg BID with food", 6/1/02 "Change exelon to q day with largest meal resident eats", 6/12/02 "Re-Evaluate exelon d/t anorexia". Recommendation for physician notifications of issues related to weight loss such as medications that may be negatively impacting a residents' weight are filled out on a recommendation sheet and given to nursing. If the physician does not respond nursing will document all calls and responses related to the recommendations. Resident 22 will be monitored to ensure she eats her meals. Aides will be trained to properly cue and prompt resident 22 to eat. Seating arrangements will be evaluated and residents placed at tables where they can receive the level of assistance they need to be able to eat. Seating arrangements will have 2 residents requiring feeding and 1 requiring prompting per aide.	9/16/02 9/16/02 9/16/02

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 ______	7/11/02

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

(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 325	Continued From page 26	F 325 Cont.		

Summary Statement of Deficiencies (F 325, continued):

interviewed. She stated that the facility had not held a weight/skin meeting since 6/12/02. She stated this was because some of the team members had been on leave from the facility and the facility had been in between dietitians.

A review of the "Monthly Summary" assessment form, completed by facility nursing staff, dated 5/19/02 documented resident 50's weight was 90.6 pounds and her appetite was usually poor.

A review of the "Monthly Summary" assessment form, completed by facility nursing staff, dated 6/19/02 documented resident 50's weight was 87.6 pounds and her appetite was usually poor.

A review of resident 50's "Weekly Nursing Summary" forms, completed by facility nursing staff, dated 4/26/02 through 7/7/02 was done. The following weights were documented:

4/26/02: weight 92 pounds.

5/3/02: weight 97 pounds. The facility "Weekly Weights" form documented a weight of 92.2 pounds on 4/19/02.

5/10/02: weight 97 pounds. The facility "Weekly Weights" form documented a weight of 86.6 pounds on 5/6/02.

5/17/02: weight 97 pounds. The facility "Weekly Weights" form documented a weight of 85.5 pounds on 5/13/02.

5/24/02: weight 97 pounds. The facility "Weekly Weights" form documented a weight of 81 pounds on 5/20/02.

Provider's Plan of Correction (F 325 Cont.):

A seating chart will be developed with specific assignments for feeding. Aides will be assigned to feed specific residents and the seating chart will be based on those specific assignments. Aide will complete meal consumption documentation following each meal and will give them to the charge nurse. An audit of the food consumption documentation will be completed by the PM nurses and totaled daily. Less than 50% of meal intake will be documented in the residents chart and reported to the DoN/ADoN daily. — 9/16/02

The seating assignment of resident 22 has been re-evaluated. She has expressed her dislike of being with residents who eat pureed food and have to be fed. The seating arrangement will be discussed with her and she will be placed with residents who are more independent and who do not eat pureed foods. — 9/16/02

The "House Supplement" has been Med Pass 2.0 since January 2002 and upon auditing the charts it was identified that the orders read give "house supplement". When clarified the orders to state "Med Pass 2.0" to be given.

RD assessed the dietary needs of Resident 53 in July 2002. The dietitian assessment was discussed in the weekly skin and weight meeting. — 8/31/02

The dietitian will assess, evaluate and recommend changes in diet orders of all residents experiencing continued weight loss. The assessment will evaluate calorie, protein, and fluid needs and meal consumption history as well as the feeding technique of staff and — 8/31/02

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 7/18/02
FORM APPROVED
2567-L

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 ______	7/11/02

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

(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 325	Continued From page 27 6/3/02: weight 87.6 pounds. 6/10/02: no weight documented. 6/17/02: weight 87.6 pounds. The facility "Weekly Weights" form documented a weight of 83.2 pounds on 6/17/02. 6/30/02: weight 87.6 pounds. The facility "Weekly Weights" form documented a weight of 79.2 pounds on 6/24/02. 7/7/02: weight 78 pounds. After reviewing the 10 "Nursing Weekly Summary" forms completed by facility nursing staff, there were was no documented evidence that resident 50's significant weight loss was identified as a concern and no nutritonal interventions were documented as being implemented. Of these 10 completed forms, 6 had discrepancies in the weights recorded on the "Nursing Weekly Summary" form versus those recorded on the "Weekly Weights" form. A review of resident 50's nursing notes from 4/20/02 to 7/5/02 was done. On 4/20/02, the nurse documented that resident 50 was assisted with food intake. On 6/27/02, the nurse documented that resident 50 "eats very little". A review of resident 50's meal intakes, documented on the "Resident Meal Consumption Sheet" for April 2002, from 4/20/02 through 4/30/02, revealed the nurse aides were documenting meal intakes in percentages. Out of a possible 11 breakfast meals reviewed 4 were documented at between 76 and 100%, 2 were documented between at 51 and 75%, 4 were documented as refused and 1 had no meal percentage documented. Out of a possible 11 lunch meals	F 325 Cont.	the general eating environment in an effort to determine what might stabilize and increase the weight of a resident. Skin and weight meetings will be held weekly and resident weight changes will be reviewed and discussed. Lists will be developed of residents exhibiting weight changes and who need to be assessed and recommendations made as to interventions needed to address the changes in weight. All residents identified at high risk for weight loss will be reviewed and discussed in the weekly NAR meeting. Residents not identified high risk for weight loss but who are loosing weight or are not consuming adequate amounts of food at each meal will be referred to the skin and weight team meeting (NAR) and will be discussed and evaluated and recommendations made and progress tracked.	8/31/02 9/16/02

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 ______	7/11/02

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

(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 325	Continued From page 28	F 325		

reviewed 2 were documented between 76-100%, 2 were documented between 26-50% 1 was documented between 0-25%, 2 were documented as refused, and 4 had no meal percentage documented. Out of a possible 11 supper meal reviewed 1 was documented between 51 and 75%, 1 was documented between 26 and 50%, 3 were documented between 0-25%, and 6 had no meal percentage documented.

A review of resident 50's meal intakes, documented on the "Resident Meal Consumption Sheet" for May 2002 revealed the nurse aides were documenting meal intakes in percentages. Out of a possible 31 breakfast meals for the month, 16 were documented between 76 and 100%, 8 were documented between 51 and 75%, and 7 were documented between 26 and 50%. Out of a possible 31 lunch meals for the month, 3 were documented between 76 and 100%, 7 were documented between 51 and 75%, 18 were documented between 26 and 50%, 1 was documented between 0 and 25% and 1 had no meal percentage documented. Out of a possible 31 supper meals for the month, 8 were documented between 76 and 100%, 8 were documented between 51 and 75%, 10 were documented between 26 and 50%, 3 were documented between 0 and 25%, 1 was documented as having been refused and 1 had no meal percentage documented.

A review of resident 50's meal intakes, documented on the "Resident Meal Consumption Sheet" for June 2002 revealed the nurse aides were documenting meal intakes in percentages. Out of a possible 30 breakfast meals for the month, 4 were documented between 76 and 100%, 8 were documented between 51 and 75%, 11 were documented between 26 and 50% and 7 were documented between 0 and 25%. Out of a possible 30 lunch meals for the month, 0 were documented between 76 and 100%, 5 were documented between 51 and 75%, 14 were documented between 26 and 50%, 7

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 ______	7/11/02

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

(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 325		F 325		

Continued From page 29
were documented between 0 and 25%2 were documented as having been refused and 2 had no meal percentage documented. Out of a possible 30 supper meals for the month, 0 were documented between 76 and 100%, 3 were documented between 51 and 75%, 12 were documented between 26 and 50%, 11 were documented between 0 and 25%, 1 was documented as having been refused and 3 had no meal percentage documented.

A review of resident 50's meal intakes, documented on the "Resident Meal Consumption Sheet" from July 2002, from 7/1/02 through 7/10/02, revealed the nurse aides were documenting meal intakes in percentages. Out of a possible 10 breakfast meals for the month, 0 were documented between 76 and 100%, 1 was documented between 51 and 75%, 4 were documented between 26 and 50%, 2 were documented between 0 and 25% and 3 had no meal percentage documented. Out of a possible 10 lunch meals for the month, 0 were documented between 76 and 100%, 2 were documented between 51 and 75%, 0 were documented between 26 and 50%, 5 were documented between 0 and 25%, 2 were documented as having been refused and 1 had no meal percentage documented. Out of a possible 10 supper meals for the month, 0 were documented between 76 and 100%, 1 was documented between 51 and 75%, 2 were documented between 26 and 50%, 5 were documented between 0 and 25% and 2 were documented as having been refused.

A review of resident 50's supplement intakes, documented on the "Medication Sheet" for June and July 2002 was done. Resident 50 was ordered the high calorie nutritional supplement 4 times per day. The "Medication Sheets" documented the supplement was offered to resident 50 five times per day. For the month of June, out of a possible 150 opportunities to

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 ____	7/11/02

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

(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 325	Continued From page 30	F 325		

receive the supplement, it was documented that resident 50 refused to consume it 47 times. Six areas were blank. For the month of July, from 7/1/02 to 7/9/02, out of a possible 45 opportunities to receive the supplement, it was documented that resident 50 refused to consume it 18 times.

A nurse familiar with resident 50's medical care was interviewed on 7/11/02 at 2:12 PM. She was asked if the nurse administering the supplement circled their initials, or documented the letter R on the "Medication Sheet" what that meant. She stated that it meant the resident had refused the medication or supplement. The nurse stated that resident 50 had recently been refusing to drink her supplement or take her medications. When asked if resident 50's supplement was reported to anyone, the nurse stated she could only speak for herself but she would report the supplement refusal to the Director of Nursing (DON) and the food service supervisor.

On 7/11/02, the food serivce supervisor was asked how a resident's refusal of their supplement was reported to her. She stated that the nurses would someimtes mention it to her and that she would also look on the "Medication Sheets" to see if the supplement was being consumed.

On 7/11/02, the DON indicated that she was unaware that resident 50 had been refusing her supplement.

A review of resident 50's medical record on 7/11/02, revealed Medicare 5 day, 14 day and 30 day Minimum Data Set (MDS) assessments dated 4/23/02, 5/5/02 and 5/23/02 respectively, documented under section G., Physical Functioning and Structural Problems, h., Eating, that resident 50 required extensive assistance with one person physical assist to eat.

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 ______	7/11/02

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

(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 325	Continued From page 31	F 325		

A review of resident 50's facility admission orders and physician re-certification orders
dated April 2002 through June 2002, and singed by the physician, documented resident 50, "...needs help with eating".

A review of resident 50's restorative notes was done. There, a list of "Dining Room Suggestions for Restorative" was found. The following suggestions were among those noted, " While in dining room needs 1:1 assistance" and "Positive reinforcement-thank [Resident 50] for coming to the dining room, tell her your proud of her for eating meals, try to carry on simple conversation, etc.".

Observations of resident 50, from 12:30 PM to 1:19 PM during the lunch meal on 7/10/02 revealed the following:

Resident 50 was observed in the dining room at a table in the assisted dining area at 12:30 PM. On the table in front of resident 50 was her meal tray, which consisted of puree barbequed chicken, mashed potatoes, pureed wax beans, pureed cantaloupe, a piece of slurry bread, 4 ounces of orange juice, and a carton of milk.

During the lunch meal observation from 12:48 PM, when 2 bites of food were fed to resident 50 by a facility certified nursing assistant, to 1:19 PM (31 minutes) no attempt was made by the facility staff to assist resident 50 one on one with her meal. The certified nursing assistant was observed to stand next to the resident when offering foods or fluids. The certified nursing assistant was not observed to tell resident 50 what she was being offered or verbally encourage resident 50 to consume her foods or fluids. Resident 50 was observed to consume no pureed chicken, no pureed wax beans, no mashed potatoes

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 ______	7/11/02

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

(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 325	Continued From page 32 and no bread. Her orange juice was not uncovered or offered to her during the meal. On 7/11/02, observation of resident 50 during the breakfast meal from 7:24 AM to 8:04 AM, revealed the following: At 7:24 AM, resident 50's tray was placed in front of her and uncovered. The meal consisted of hot cereal, pureed eggs, pureed hash browns, milk and juice. At 7:28 AM, a facility certified nursing assistant was observed to sit down beside the resident and assist her to eat 1 bite of food. This staff member then left to assist another resident. At 7:37 AM, resident 50 was observed sleeping at the table. At 7:49 AM, a facility certified nursing assistant was observed attempting to give resident 50 sips of milk. Resident 50 had her eyes closed. At 8:04 AM, resident 50 was given 2 sips of milk by a facility certified nursing assistant. She was then taken from the table. During the breakfast meal observation from 7:28 AM, when 1 bite of food was fed to resident 50 by a facility certified nursing assistant, to 8:04 AM (36 minutes), other than offering sips of milk, no attempt was made by the facility staff to assist resident 50 one on one with her meal. The certified nursing assistant was observed to stand next to the resident when offering fluids. The certified nursing assistant was not observed to tell resident 50 what she was being offered or verbally encourage resident 50 to consume her foods or fluids. Resident 50 was observed to consume only 1 bite of her meal and sips of milk.	F 325		

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 ______	7/11/02

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

(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 325	Continued From page 33	F 325		

On 7/11/02, observation of resident 50 during the lunch meal from 12:29 PM to 1:12 PM revealed the following:

At 12:29 PM, resident 50's tray was placed in front of her and uncovered. The meal consisted of puree pork chop, mashed potatoes, pureed beets, slurry cookies and cream cake, slurry bread, milk and juice.

During the lunch meal observation from 12:36 PM to 1:12 PM (36 minutes), the certified nursing assistant was observed to stand next to the resident when offering foods or fluids. The certified nursing assistant was not observed to tell resident 50 what she was being offered or verbally encourage resident 50 to consume her foods or fluids. Resident 50 was observed to consume 1 bite of pureed pork chop, 5 bites of mashed potatoes and approximately one ounce of juice. Resident 50 was not offered any beets, cake, bread or milk during the meal.

On 7/11/02, at 2:20 PM, the certified nursing assistant, who was assisting at resident 50's table was interviewed. She stated that resident 50 had been refusing meals for about a week. She stated that resident 50 would spit out her food.

During the above meal observations, resident 50 was not observed to spit out any food or fluid offered to her.
Resident 22, a 79 year old female, was admitted to the facility 6/28/01 with diagnoses of dementia and weakness.

A review of resident 22 weight revealed the following:

January 2002 84.0 lbs
February 2002 84.4 lbs

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 ______	7/11/02

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

(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 325		F 325		

Continued From page 34

March 2002	81.6 lbs
April 2002	78.8 lbs
May 2002	78.4 lbs
June 2002	76.6 lbs
July 2002	72.2 lbs

Between the months of January and July resident 22 lost 11.8 lbs. (14%) which was significant.

Between the months of April and July resident 22 lost 6.6 lbs. (8.4%) which was significant.

Between the month of June and July resident 22 lost 4.4 lbs. (5.7%) which was significant.

A review of resident 22's medical record revealed that no RD assessment addressing the current weight loss had been completed for resident 22.

Resident 22 had a care plan completed on 4/2/02 and updated on 6/25/02. The care plan documented, "at nutritional risk related to inadequate intake RT dementia, hx of weight loss resulting in low body weight, poor dental status, wt loss continues." goals included, "resident will eat greater than 50% of meals TNR, resident will take the supplement offered TID, resident will remain hydrated TNR."

On 1/7/02 the FSS documented the following, "reg sm por enriched house supplement."

On 1/10/02 a quarterly IDT meeting was held concerning resident 22. One of resident 22's friends attended this meeting representing the family. She informed the staff present at this meeting that resident 22 had a "shrunken esophagus" and would like for the resident to go to a doctor she suggested. The IDT meeting notes documented the physician's name and phone number.

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 ______	7/11/02

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

(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 325	Continued From page 35	F 325		

No documentation could be provided by the facility that they attempted to get resident 22 an appointment with the physician suggested by the family or with any other physician concerning the esophageal stricture.

Resident 22 continued on a regular small portion enriched diet.

On 1/25/02 a nurse's note documented a physician's order for, "...exelon 1.5 mg QD X3 wks then BID X3 wks the 3mg BID X4wks then 4.5 mg BID."

On 4/2/02 the RD documented the following, "Resident states that she just loves the food. She does not want any changes and we give her what she wants. Weight continues to decline related to poor intakes and advancing dementia. Her intakes are generally less than 30%. Weight is down. She does take the supplement. Suggest ½ portions of enriched regular food. Visit resident and send only foods she likes and will eat. Offer 2.0 cocoa (½ cup) at breakfast. Seat at prompt and cue table. Suggest talking with the physician about an appetite stimulant...Resident is on exelon which can negatively effect the appetite. Suggest the balance of the exelon vs the weight loss be discussed with physician and family."

No documentation could be found that provided evidence that the exelon had been discussed with the physician and family. No documentation or physician order could be found concerning an appetite stimulant. An IDT meeting was held 5/15/02 and there was no documentation concerning exelon, an appetite stimulant or weight loss.

On 4/4/02 the FSS documented, "res is now going to restorative feeding res says everyone is in a hurry so she does not eat her food so the change was made so

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 ______	7/11/02

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

(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 325	Continued From page 36	F 325		

res could have interaction and eat at her own pace."

On 5/10/02 the FSS documented, "res has been added to the snack list TID, due to wt loss will monitor her wt."

On 5/15/02 a nurse's note documented the following physician's order, "when exelon is gone [increase] to 6 mg PO BID.

On 6/1/02 a nurse's note documented the following, "res was reported to have n/v (nausea and vomiting) after taking exelon, [physician] was called orders received to [decrease] exelon to QD [and] to give [with] largest meal resident eats during the day." On 6/1/02 a physician's telephone order was written concerning the exelon medication change.

On 6/12/02 the RD and FSS documented on their weight skin meeting that resident 22 has had a 3% weight decrease in one month and an 11% in 6 months, "weight 76, intake is 10/20/50 (intake at breakfast 10%, intake at lunch 20% and intake at dinner 50%), diet is sm portion reg enriched. Cause: poor appetite. Recommended changes 120 cc 2.0 medpass QID, eval exelon."

On 6/12/02 a physician's order was written for the dietary recommendations, "1. 120 cc 2.0 medpass QID 2. Re-eval exelon d/t anorexia."

No documentation could be found that provided evidence that the exelon had been evaluated.

On 6/20/02 the FSS documented, "...res is on a small por enriched but still does not eat her food she picks at food and complains about everyone around her res need more one on one she fills better if there is someone there to speak to while she eats she's a slow

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 ____	7/11/02

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

(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 325	Continued From page 37	F 325		

eater...had a request from dietitian to have meds checked waiting for results..."

No documentation could be found that provided evidence that the exelon had been evaluated.

On 6/24/02 a nurse's note documented the following, "Appt. Made for 9/10/02 [with] Dr... R/T esophageal dilation- Dr. office states she needs an office visit before procedure so she will be seen 9/10 et (and) then procedure will be scheduled after that."

On 6/25/02 a quarterly IDT meeting was held concerning resident 22. One of resident 22's family members attended this meeting. They discussed the appointment scheduled for resident 22 to see physician in September 2002 regarding esophagus.

Resident 22 continued on a regular small portion enriched diet.

On 7/11/02, resident 22 was observed to receive her lunch tray at 12:30 PM. The restorative aide assisted resident 22 in setting her meal up. Resident 22 did not attempt to eat on her own. At 12:40 PM resident 22 continued to sit up at the dining room table not eating, a restorative aide was sitting next to her helping another resident. The restorative aide did not prompt or encourage resident 22 to eat. At 12:50 AM resident 22 was still sitting at the table not eating. At 1:05 PM resident 22 continued to sit at the table, the DON is sitting next to her helping another resident. The DON did not prompt or encourage resident 22 to eat. At 1:13 PM resident 22 continued to sit at the table. the DON and restorative aide are at the table assisting another resident. Neither the DON or restorative aide prompted or encouraged resident 22 to eat. At 1:20 PM the DON asked resident 22 if she needed any help. the resident replied "no". The DON sat down for 2

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 ______	7/11/02

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 325	Continued From page 38	F 325		

minutes to interact with resident 22 then left her. At 1:24 PM the restorative aide sat down next to resident 22 to encourage her to eat. The resident appeared angry and told the restorative aide that she didn't need to worry about her. The cook and FSS came out to encourage resident 22 to eat. At 1:30 PM the FSS continued to sit with resident 22 prompting and encouraging her to eat. At 1:40 PM the FSS continued to sit with resident 22 prompting and encouraging resident 22 to eat. Resident 22 had eaten a few bites of her baked potato, a few bites of cake, 90 cc of milk and 100 cc of water. AT 1:50 PM the surveyor left the dining room for less than 5 minutes when she returned resident 22 was gone and her tray was cleared from the table.

During a phone conference on 7/16/02 with the DON and administrator they stated the house supplement is the 2.0 medpass and has been that since January. On 1/7/02 the FSS documented that resident 22 was on house supplement then on 6/12/02 an order was written for resident 22 to receive 2.0 medpass QID. There was never a change in the supplement being given to resident 22, both the house supplement and 2.0 med pass supplement are the same.

3. Resident 53 was a 93 year old female who was admitted to the facility on 3/20/00 with the diagnoses of urosepsis, congestive heart failure, history of a left hip fracture and dementia.

The diet order for resident 53 during January 2002 and through May 15, 2002 was an enriched puree with two glasses of milk at each meal.

The minimum data set (MDS), a mandatory comprehensive assessment of the resident completed by facility staff, dated 4/26/02, documented that resident 53 needed supervision (oversight, encouragement or cueing) with eating and had

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 ____	7/11/02

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

(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 325	Continued From page 39	F 325		

received one person physical assist with eating and drinking.

In January 2002, resident 53 weighed 124.4 pounds. In July of 2002, resident 53 weighed 100.8 pounds. Resident 53 experienced a weight loss of 18.97% in six months, which is considered significant.

On 3/6/02, when resident 53 weighed 117.4, the dietitian identified the weight loss and noted that resident 53 eats in "restorative" and "receives fortified hot choc. (chocolate) BID (twice daily)." The dietititian reiterated what resident 53 had thus far been recieveing, but did not implement anything new to try and address the weight loss.

On 3/14/02, when resident 53 weighed 113.0, the dietitian identified addtional weight loss and recommended "an appetite stimulant". At this time, resident 53 should have triggered for significant weight loss at 9.16% in 2 1/2 months. There was no documentation in the medical record of resident 53 to evidence that the facility had attempted to implement some type of appetite stimulant per the dietitian's recommendation.

Sometime between 3/14/02 and 4/30/02, the facility changed their dietary consultant.

By 4/1/02, resident 53 weighed 112.2, a significant weight loss of 9.8% in 3 months. The next day, on 4/2/02, the facility held a Nutritional Intervention Meeting in which it discussed the nutritional status of 18 of the facility's residents. Based on review of the Nutritional Intervention Meeting minutes for this day, it was noted that resident 53 was not mentioned in the meeting.

The next Nutritional Intervention Meeting, held on

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 ______	7/11/02

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

(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 325	Continued From page 40	F 325		

4/17/02, documents the name of resident 53, acknowledges a significant weight loss of "5# (pounds) in 1 mo (month) and 10% in 3 mo (months) to 113# (pounds), documents "intake: restorative 20-40%", but did not document any recommendations to address the weight loss issue.

After the assessment by the dietitian on 3/14/02, resident 53 was not assessed by a dietitian again until six weeks later, on 4/30/02, when she weighed 107 pounds, a 13.98% weight loss since January 2002.

On 4/8/02, the restorative aide noted in her notes that resident 53 "is only drinking."
On 4/16/02, restorative aide noted in her notes that resident 53 "is only drinking liquids."
On 4/24/02, the restorative aide noted in her notes that resident 53 "is only drinking liquids."

On 4/30/02, the dietitian documented that the diet for resdient 53 was "enriched pureed with fortified liq. (liquids)". The dietitian continued to document that resident 53 "refusing to each much, but drinks well." The dietitian's recommendations were to "notify family and physician, weekly wts (weights), and warm nutrient dense liquids." There was no follow-up by the new dietitian to see why the appetite stimulant had not been attempted as recommended by the previous dietitian.

A monthly physician's progress note, dated 5/5/02, does not mention weight loss and documented "nurses report no new problems."

On 5/15/02. 37 days after the restorative aide first noted that resident 53 was "only drinking", a dietary recommendation was made to "fortify drinkable puree with increased calories, 1/2 portions."

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 ______	7/11/02

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

(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 325	Continued From page 41	F 325		

On 5/16/02, the resotrative aide noted that resident 53 "is doing good. All meals are in liquid form as due to she is not eating and only drinking."

On 6/8/02, the restorative aide documented the following regarding resident 53: "Lots of encouragement needed, some assist needed."

On 6/10/02, facility weight records documented that resident 53 weighed 107.4 pounds, a significant weight loss of 13.66% since January 2002. Two days later, on 6/12/02, the facility held a "Skin and Weight Meeting", attended by the dietitian. The dietitian, along with 2 facility staff, discussed the nutritional status of 14 facility residents. Based on the review of the "Skin and Weight Meeting" minutes for 6/12/02, resident 53 was not discussed.

The facility did not have documentation to evidence that a nutritional intervention meeting or weight meeting had occured since 6/12/02.

By 7/8/02, resident 53 weighed 100.8 pounds, a significant weight loss of 18.97% since January 2002.

It should be noted that on 7/11/02, a skin check of resident 53 was performed with two registered nurse surveyors and a facility nurse. Resident 53 was observed to have eight stage II pressure sores on both buttocks and on the back of her left upper thigh. The largest sore measured approximately 3 cm (centimeters) by 2 cm and the smallest sore measured approximately 0.5 cm by 0.5 cm.

Meal observations of resident 53 during survey:

(Please note that resident 53 was in the restorative dining program.)

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 ______	7/11/02

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 325	Continued From page 42	F 325		

On 7/10/02, observation of resident 53 during the lunch meal revealed the following:

Resident 53 was observed in the dining room at a table in the restorative dining area at 12:30 PM. On the table in front of resident 50 was her meal tray, which consisted of drinkable puree barbecued chicken, drinkable mashed potatoes, drinkable pureed wax beans, pureed cantaloupe, a glass of orange juice, and 2 glasses of milk. Resident 53 was not observed to attempt to feed herself.

At 1:03 PM (33 minutes after resident 53 was first observed with her tray), a facility certified nursing assistant handed resident 53 a cup of her food. She was observed to hold the cup but not consume any of the food.

At 1:09 PM (39 minutes after resident 53 was first observed with her tray), resident 53 was observed to drink 2 sips of the food item in the cup and then set the cup down.

At 1:14 PM (44 minutes after resident 53 was first observed with her tray), resident 53 was observed to pick up her milk glass and drink approximately 1 ounce.

At 1:24 PM (54 minutes after resident 53 was first observed with her tray), resident 53 was taken from the table.

During the lunch meal observation from 1:09 PM to 1:24 PM (15 minutes), no further attempts were made by the facility staff to assist resident 53 with her meal. The certified nursing assistant not observed to tell resident 53 what she was being offered or verbally encourage resident 53 to consume her foods or fluids. Resident 53 was observed to consume 2 sips of one of

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 ____	7/11/02

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

(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 325	Continued From page 43 the food items on her tray. The other food items were not offered to her. Her orange juice was not uncovered and offered to her during the lunch meal. On 7/11/02, observation of resident 53 during the breakfast meal revealed the following: Resident 53 was observed in the dining room at a table in the restorative dining area at 7:12 AM. At 7:20 AM, resident 53's tray was placed in front of her and uncovered. The meal consisted of drinkable hot cereal, drinkable pureed eggs, drinkable pureed hash browns, milk and juice. Resident 53 was observed to attempt to feed herself by picking up a cup of food but did not lift it to her mouth. At 7:40 AM (20 minutes after her tray was delivered), resident 53 sat the cup of food down. No facility staff was observed to verbally encourage or physically assist resident 53 with eating. At 7:57 AM (37 minutes after her tray was delivered), a facility certified nursing assistant attempted to hand resident 53 her juice but resident 53 did not take it from her. The nursing assistant told resident 53 to eat and left the table. No verbal encouragement to eat was offered to resident 53. At 8:02 AM (42 minutes after her tray was delivered), resident 53 picked up her milk and drank a sip. At 8:08 AM (48 minutes after her tray was delivered), a facility nursing assistant was observed to place a cup of resident 53's food in her hand. At 8:10 AM, resident 53 sat the cup down without consuming anything from it. At 8:34 AM (1 hour and 14 minutes after her tray was	F 325		

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 ____	7/11/02

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

(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 325	Continued From page 44 delivered), resident 53 was asked by a facility nursing assistant if she was done eating and took her tray. During the breakfast meal observation from 7:20 AM to 8:34 AM (1 hour and 14 minutes), The certified nursing assistant was not observed to tell resident 53 what she was being offered or verbally encourage or physically assist resident 53 to consume her foods or fluids. Resident 53 was observed to sips of milk and none of her breakfast meal. During the 7/11/02 lunch meal, resident 53 was again observed (by all three surveyors) to receive no promting or encouragement to drink her food.	F 325		
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 and staff interviews, it was determined that the facility did not store, distribute and serve food under sanitary conditions. Findings include: The following observations were made during the initial kitchen tour done Tuesday July 9,2002 from 10:14 AM to 10:32 AM: In the walk-in refrigerator: 1. There were 2 outdated cartons of Med Plus 2.0, one had been opened and one had not, which were dated June 25, 2002. 2. There was a tray containing 2 bowls of cottage	F 371	F 371- Dietary Services: Outdated containers of Med Plus 2.0 were identified and discarded by Nursing and Dietary staff prior to the end of the survey on July 11, 2002. The dietary supervisor and DON will provide in-service training to all cooks, dietary aides and nursing staff to insure they know how to monitor for expiration dates on products and how to rotate stock by August 31, 2002. All staff prior to use will insure the products are not outdated. Nursing staff on the night shift will review all products in the refrigerators and discard all out dated product. Staff will inspect and discard all outdated product immediately. Stock will be dated when stored and rotated to insure oldest products are used first and are not outdated.	7/31/02 8/31/02

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 ______	7/11/02

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

(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 371	Continued From page 47 5. There was a cup in the flour bin. This could potentially contaminate the flour, as a staff member would have to place their hand into the flour to retrieve the cup. 6. The interior of the juice machine was dusty and there were many juice splatters on the surface. 7. The top of the plate warmer was covered in a greasy, dusty film. The following observation was made July 11, 2002 at 3:38 PM: 1. A dietary staff member was observed preparing pureed macaroni and cheese without wearing a hair restraint.	F 371 Cont.	The standing mixer was removed from the kitchen 7-12-2002 and was sanded and re-painted and returned to service 7-25-2002. In the interim a hand mixer was purchased for use by the dietary staff. The dietitian will conduct sanitation audits that will be written up and submitted to the Administrator and Food Service manager and results will be reported in QA Meetings. Concerns identified by the dietitian in her audits will have plans developed to resolve those concerns and to maintain continued compliance.	7/25/02 9/16/02 9/16/02
F 521 SS=H	483.75(o)(2)&(3) ADMINISTRATION 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 (QA) Committee minutes (dated 3/20/02, 3/29/02, 4/30/02, 5/23/02 and 6/27/02), it was determined that the facility's QA committee did not identify quality deficiencies regarding identification, assessment,	F 521	F-521 Administration: The facility will implement and carry out the directed plan of correction required by the state survey team. The facility had a contract for the services of a registered dietitian in place at the time of the annual survey and she had been in the facility July 5, 2002 to meet and orient the food service manager to the new consulting dietitian and the new policies and forms she would be using. The survey team will need to notify facility if she is "approved" as defined in the directed plan of correction. The dietitian will complete nutritional assessments, which include calorie and protein needs for residents identified as having significant weight loss during the survey.	

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 ____	7/11/02

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

(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 521	Continued From page 48 intervention, implementation of a corrective action plan and then re-evaluation for residents with significant unplanned weight loss, resulting in actual harm for 3 of 14 sample residents (22, 50 and 53). The facility was found to be providing Sub-Standard Quality of Care (a pattern of actual harm) in this area. Findings include: The facility's QA committee met on 3/20/02, 3/29/02, 4/30/02, 5/23/02 and 6/27/02. The QA minutes were reviewed on 7/11/02 after the implementation of an extended survey. A review of the QA minutes revealed the following: a. Resident 53 should have initially triggered for significant weight loss on or around 3/14/02 when facility staff recorded a weight of 113 (9.16% loss since January 2002). Resident 53 was not discussed in any of the QA minutes until 4/30/02 when they documented "5# (pounds) in 1 mo (month) and 10% in 3 mo (months) to 113# (pounds), documents "intake: restorative 20-40%". Facility staff did not document any recommendations to address the weight loss issue. No further mention was made of resident 53 in any of the remaining QA minutes (5/23/02 or 6/27/02). b. Resident 22 should have triggered for significant weight loss on 6/12/02 when the registered dietitian and the food service supervisor documented on their weight/skin meeting minutes that resident 22 has "had a 3% weight decrease in one month and an 11% in 6 months..." Resident 22 was not addressed in the QA minutes of 6/27/02. c. Resident 50 should have initially triggered for significant weight loss on 5/6/02 with a weight loss of 6% in 17 days. She should have triggered again on 5/13/02. with a weight loss of 7% in 24 days, and	F 521 Cont.	When assessments are completed Nursing will contact the resident's physician and implement the recommendations approved by the physician. Residents with significant weight loss will be weighed twice weekly and monitored for effectiveness of interventions including the meal intake sheets to insure the meal percentages and nourishment's offered are being documented, until resident's weight becomes stable. Quality Assessment and Assurance meetings with the Medical Director will be held at least quarterly. Interim QA Meetings will be held monthly with the members from the facility and with the Medical director or his designee. Other sub committee meetings will be held weekly to review Skin and weight issues of residents in the facility and any other items that come up from week to week that require review and intervention. The focus of the sub-committee meetings will be to prevent actual harm occurring to residents of the facility. During QA Meetings the team will focus on identification, assessment, intervention and implementation of corrective action plans and the re-evaluation of residents with skin problems and weight loss issues. In the QA meetings the committee will review interventions implemented and the results obtained. The need for changing interventions will be discussed, evaluated and recommendations for changes formulated.	9/16/02 9/16/02 9/16/02 9/16/02 9/16/02

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 ______	7/11/02

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

(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 521	Continued From page 49 again on 5/20/02 with a 12% weight loss in one month (from 4/19/02 to 5/20/02). Resident 50 should have triggered a fourth time for significant weight loss on 6/24/02 with a 9.4% weight loss in the previous month. Resident 50 was addressed the QA minutes dated 5/23/02. The total comments made in the QA minutes were "resident concern with [resident 50]. Restorative working with her/getting her up." The QA committee did not identify resident 50 with significant weight loss or initiate an appropriate plan of action. It should be noted that the QA minutes of 6/27/02 did not contain any follow-up to the concerns regarding resident 50 brought up in the 5/23/02 minutes. d. The QA minutes, dated 5/23/02, documented "dietary, 6 wt (weight) loss, program special diets, monitor wt (weight) every other day, and every week and every month. Monitor eating, hydration, salt." The 6 residents referred to in the QA minutes were not named. The QA minutes, dated 6/27/02, did not contain any follow-up to the "6 wt loss" discussed in the minutes of 5/23/02.	F 521 Cont.	The QA process will help determine whether skin problems and/or weight issues identified are unplanned and controllable or the result of uncontrollable factors such as end of life variables over which there is no control. These findings and recommendations will be documented.	9/16/02
			The facility will establish an effective weight management team to monitor residents with weight loss and skin problems and this team will meet weekly. The team will consist of a registered dietitian, the dietary manager, and the director of nursing or a responsible designee. After 9/30/02 the dietitian will attend the NAR meetings twice monthly times 2 months and monthly after that time period.	9/16/02
			During the Weight (NAR) meetings staff will review weekly weights, dietary intake and supplement intake for residents with weight loss and residents at risk for weight loss as identified by the team. The team will monitor residents until the resident's weight is stable for a period of 4 weeks and then monthly thereafter. All residents in the facility will be assessed and weighed for baseline information. Minutes of the weight management team must be submitted weekly to Elizabeth Iund or Kim Pate at the department of health for review until 9/30/02 or until the facility is back in substantial compliance.	9/16/02
			The registered dietitian consultant will perform on-site visits at least twice a week to monitor for compliance with F-Tag 312 until9/30/02 then weekly for 2 months and then at least monthly	9/16/02

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 7/18/02
FORM APPROVED
2567-L

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 ____	7/11/02

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

(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 521	Continued From page 49 again on 5/20/02 with a 12% weight loss in one month (from 4/19/02 to 5/20/02). Resident 50 should have triggered a fourth time for significant weight loss on 6/24/02 with a 9.4% weight loss in the previous month. Resident 50 was addressed the QA minutes dated 5/23/02. The total comments made in the QA minutes were "resident concern with [resident 50]. Restorative working with her/getting her up." The QA committee did not identify resident 50 with significant weight loss or initiate an appropriate plan of action. It should be noted that the QA minutes of 6/27/02 did not contain any follow-up to the concerns regarding resident 50 brought up in the 5/23/02 minutes. d. The QA minutes, dated 5/23/02, documented "dietary, 6 wt (weight) loss, program special diets, monitor wt (weight) every other day, and every week and every month. Monitor eating, hydration, salt." The 6 residents referred to in the QA minutes were not named. The QA minutes, dated 6/27/02, did not contain any follow-up to the "6 wt loss" discussed in the minutes of 5/23/02.	F 521 Cont.	The registered dietitian consultant will submit written reports to the State Survey Agency outlining the in-service training conducted, the facilities movement towards correction of the identified problems in the survey and any problems identified which were not previously identified in the "Statement of Deficiencies". These reports will be submitted weekly until the facility is back in substantial compliance.	9/16/02

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 7/18/02
FORM APPROVED
2567-L

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 ______	7/11/02

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

(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 521 Continued From page 49

again on 5/20/02 with a 12% weight loss in one month (from 4/19/02 to 5/20/02). Resident 50 should have triggered a fourth time for significant weight loss on 6/24/02 with a 9.4% weight loss in the previous month. Resident 50 was addressed the QA minutes dated 5/23/02. The total comments made in the QA minutes were "resident concern with [resident 50]. Restorative working with her/getting her up." The QA committee did not identify resident 50 with significant weight loss or initiate an appropriate plan of action. It should be noted that the QA minutes of 6/27/02 did not contain any follow-up to the concerns regarding resident 50 brought up in the 5/23/02 minutes.

d. The QA minutes, dated 5/23/02, documented "dietary, 6 wt (weight) loss, program special diets, monitor wt (weight) every other day, and every week and every month. Monitor eating, hydration, salt." The 6 residents referred to in the QA minutes were not named. The QA minutes, dated 6/27/02, did not contain any follow-up to the "6 wt loss" discussed in the minutes of 5/23/02.

F 521 Cont.

The monitoring will include ensuring that the facility is adequately assisting residents eating in the restorative and assisted dinning area. The visits will vary in days with at least one visit each week performed during the breakfast hour and one visit each week performed during the dinner hour. — 9/16/02

The registered dietitian consultant will provide at least 2 in-service training sessions for the nursing staff. The dietitian will train the facility staff developer to conduct these in-services for those nursing staff not previously trained by the dietitian. All nursing staff must attend one of these In-service training sessions. The in-services will address the following: — 9/10/02

- The importance of reporting poor meal and/or supplement intake to the weight management team.
- The importance of providing assistance with eating to those residents who require physical or verbal assistance to consume their meals and/or supplements.
- A review of the proper way to feed and assist residents at mealtime.
- The importance of offering substitutes to residents who refuse to eat.
- Provide an interpreter for those employees who do not speak the dominant language in the facility to insure they understand what is being discussed in the in-service training sessions. Signature of interpreter will be recorded in minutes of the in-service.
- A record of the in-services will be submitted to the state survey agency with an itemized content of what was discussed and a sign in sheet identifying the employees who attended.

POC ADDENDUM

August 27, 2002

Elizabeth Iund, RN.
Bureau of Medicare / Medicaid Program
Certification and Resident Assessment
Utah Department of Health

Dear Mrs. Iund,

The following information is our response to your request for clarification of questions that you had regarding our plan of Correction for the survey ending 7/11/02.

I hope that the following responses clarify the issues and questions you asked of us.

Re: F-252

Compliance rounds will be made at least 3 times a week and will be document on a compliance round form. The form has been designed for the purpose of implementing facility standards in specific areas of operation and helping the facility administration to monitor these areas and assist in maintaining and insuring compliance with facility standards.

The results of compliance rounds will be reviewed in QA meetings and the Maintenance Supervisor will report and identify trends and issues that have been maintained and those needing attention and further intervention.

Re: F-312

The staff member who has the overall responsibility for the implementation of this tag is the Director of Nursing.

Re: F-314

The audits will be conducted by the MDS/skin care nurse and will be monitored by the ADON. The audits will involve the review of the Resident Records of those residents who were scheduled for the quarterly audit to determine if the Braden scale has been completed timely within the quarter as per facility policy. The audit will consist of an evaluation as to whether or not all items on the scale have been addressed and are complete. The audit will also insure that the score has been recorded and that residents with scores of 17 or less have been placed on the skin at risk list for review in the Skin and Weight Meeting.

The MDS/Skin Nurse will be the staff member reviewing to insure the assessments and interventions have been completed on a weekly basis.

The audits of the dressings and skin checks will be performed weekly and will be recorded on the skin and dressing audit sheets. The skin check audits will be performed for all residents. The dressing audits will be for all residents with dressings.

The ADON will monitor for the implementation of this plan of correction tag.

F-325

Residents eating less than 50% at each meal are referred to the NAR meeting and evaluated. The RD is a part of the NAR meeting at the present time and is training staff present on assessment and interventions appropriate for such residents. Residents with 3 days of less than 50 % intake is reported to the DON and FSS who are to develop a plan for intervention for the resident. If the plan is not working the RD is involved for consultation and input.

Staff members who are to attend the facility weight committee meetings are as follows:

- RD until substantial compliance is met.
- The Food Service Supervisor
- The Director of Nursing
- The MDS/Skin Nurse
- The Assist. Director of Nursing

When the Food Service Manager, Cooks and RD and department heads do meal monitoring of resident meal times they will keep documentation on the daily Meal Monitoring Form which has been revised and is being reviewed by the RD at the NAR Meeting on August 29, 2002.

It is the responsibility of the FSS to do all initial, Annual and change of condition quarterly assessments. The RD will review these assessments and cosign. The RD will do all high risk charting related to significant weight change, pressure ulcers, dialysis, tube feeding, and abnormal labs. The RD has done some initial Nutritional Risk Assessments with the Food Service Supervisor who she is training to be able to function independently in this area.

"Adequate amounts of food/nutrition" is determined for each individual resident during the nutritional assessment process. Based on gender, height and age as well as other considerations such as, nutritional needs for calories, protein and fluids are calculated. The % of intake that is needed is also calculated to evaluate if the residents' intake is meeting their nutritional needs. For inclusion in the NAR meeting weekly, anyone eating less than 50% is defined as being at nutritional risk even in the absence of any actual negative consequences of the reduced intake.

The DON and Food Service Supervisor working in consultation with the Dietitian have the over all responsibility to ensure that the Plan of Correction for this tag is implemented.

F-371

The RD will do sanitation audits weekly until substantial compliance is achieved and then at least monthly thereafter.

The Food Service manager is responsible to ensure that the plan of correction for this tag is implemented.

F-521

The RD will perform on-site visits twice a week until substantial compliance is achieved.