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

PRINTED: 8/22/2003
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 ______	8/13/2003

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

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F 279 SS=D	483.20(k) RESIDENT ASSESSMENT	F 279	F-Tag Plan of Corrections	
	The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.		F – 279 – A care plan for resident 20 was updated 11 August 2003 addressing the treatment of the pressure sore identified the same date.	8/11/2003
	The care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under s483.25; and		Resident 35 will be assessed and her care plan updated. The care plan will include a toileting program. The care plan will be developed and implemented by the MDS Coordinator or her designee. Completion date 15 October 2003.	10/15/2003
	Any services that would otherwise be required under s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4).		An audit tool will be developed by the DON or her designee by 20 September 2003 to ensure care plans describe the services that are to be furnished by the facility for residents to attain or maintain their highest practicable physical, mental and psychosocial well being.	9/20/2003
	This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility did fully develop comprehensive care plans for 2 of 14 sample residents that addressed the residents' medical and nursing needs that were identified in the residents' comprehensive assessments. (Residents 20 and 35.)		Audits will be done by the DON or her designee weekly X's 4 and monthly X's 2 and randomly thereafter. The first weekly audit will be completed 30 September 2003.	9/30/2003
	Findings include:		Audits will be reviewed in QA Meeting with the first QA Meeting taking place 3 October 2003.	10/03/2003
	1. Resident 20 was originally admitted to the facility on 6/28/01, with the diagnoses of organic brain syndrome, dementia, confusion, weakness, hypothyroidism, hyperlipidemia, hypertension, diarrhea, dyspepsia, anemia, arthritis, osteoporosis and esophageal reflux disease.		SEP - 4 2003 #403100-47	
	A review of resident 20's medical record was completed on 8/13/03.			
	An MDS (minimum data set), a quarterly assessment			

POC acceptable with attached addendum completion date 10-10-03 Busenbark RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dennis G. Stehring
TITLE: Administrator
(X6) DATE: 4 Sept 2003

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

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F 279	Continued From page 1 completed by the facility staff, dated 6/2/03, documented that the cognitive skills for resident 20 were moderately impaired. Facility staff documented on the MDS that resident 20 required no assistance when moving to and from a lying position, turning side to side, positioning herself while in bed and she needed limited assistance when moving to or from a bed or wheelchair. The MDS also documented that resident 20 was frequently incontinent of bladder and had one stage II pressure ulcer. A"Braden Scale for Predicting Pressure Sores Risk" assessment completed by a facility nurse for resident 20 on 3/3/03, documented a score of 12 which indicated high risk. On 5/28/03, the facility wound nurse documented the following on a "E-Z Graph Wound Assessment Worksheet", "...[Left] outer ankle...Stage 2...Length .5 cm Width .5 cm...5/23/03 nurse reported stage I area [right] outer ankle. LPN (licensed practical nurse) immediately cleansed area [and] applied hydrocolloid. Today presents [with] small Stage II area [with] erythema around [and complains of] tenderness. Change TX (treatment) to pressure reducing oval. ABX (antibiotic) ointment and border gauze. To be reviewed by podiatry on his next visit." The care plan for resident 20, updated 5/29/03 included a problem "At increased risk for skin impairment R/T [related to] B&B [bowel and bladder] incontinence, dementia, chronic diarrhea." The goal stated , "Resident will be clean, dry, odor free and free from skin breakdown QD [every day] TNR [till next review]." Approaches documented included, "...Monitor skin with cares, weekly skin checks..." Another care plan for resident 20, updated 5/29/03, included a problem "At risk of pressure ulcer AEB [as	F 279		

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F 279	Continued From page 2 evidenced by] Hx [history of] pressure ulcer." The goal stated, "resident will have skin remain intact by_____" Approaches documented included, "Follow above approaches. Tx [treatment] A/O [as ordered]." A care plan which addressed actual skin breakdown could not be located in resident 20's medical record. 2. Resident 35 was admitted to the facility on 12/18/02, with diagnoses of hypertension, senile dementia, venous thrombosis, B-complex deficiency, constipation and generalized pain. A "Nursing Admission Assessment" completed by a facility nurse on 12/18/02, documented that resident 35 was continent of bowel and bladder. A"Bowel and Bladder Assessment" for resident 35 was completed by a facility nurse on 6/9/03, documented a score of 12 (candidate for toileting timed voiding and prompting). An MDS, a mandatory annual assessment, completed by the facility staff, dated 7/14/03, documented that the cognitive skills for resident 35 were moderately impaired and that she required extensive assistance with toilet use. The MDS also documented that resident 35 was usually continent of stool, frequently incontinent of bladder and she was on any scheduled toilet program. Review of resident 35's care plan dated 10/19/02, and updated 7/14/03, was done on 8/11/03. A care plan which addressed a toilet program could not be found in the medical record.	F 279		

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F 287	Continued From page 3	F 287	F – 287 – All medical charts in the facility did have 15 months of MDS reports in the medical records by 16 August 2003.	8/16/2003
F 287 SS=B	483.20(f)(1-4) Resident Assessment Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: Admission assessment; Annual assessment updates; Significant change in status assessments; Quarterly review assessments; A subset of items upon a resident's transfer, reentry, discharge, and death; Background (face-sheet) information, if there is no admission assessment; Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by HCFA and the State. A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month, including the following: Admission assessment; Annual assessment; Significant change in status assessment; Significant correction of prior full assessment;	F 287	The DON or her designee will develop an MDS audit tool. The audit tool will be completed by 1 October 2003. The Medical records clerk will randomly audit active charts monthly and document the records audited. Findings will be reviewed in QA Meetings by 10 October 2003.	10/01/2003 10/10/2003

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F 287	Continued From page 4 Significant correction of prior quarterly assessment; Quarterly review; A subset of items upon a resident's transfer, reentry, discharge, and death; Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. The facility must transmit data in the format specified by HCFA or, for a State which has an alternate RAI approved by HCFA, in the format specified by the State and approved by HCFA. This REQUIREMENT is not met as evidenced by: Based on record reviews, it was determined that the facility did not maintain MDS (minimum data set) assessments completed within the previous 15 months in the resident's active record for 3 of 14 sampled residents. Residents identifiers: 20, 24 and 5. Findings include: 1. Resident 20 was originally admitted to the facility on 6/28/01, with the diagnoses of organic brain syndrome, dementia, confusion, weakness, hypothyroidism, hyperlipidemia, hypertension, diarrhea, dyspepsia, anemia, arthritis, osteoporosis and esophageal reflux disease. A complete review of resident 20's active medical record was done on 8/11/03. The medical record contained an annual MDS dated 9/7/02, and four quarterly MDS's dated 1/4/02, 12/4/02, 2/28/03 and	F 287		

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F 287	Continued From page 5 6/2/03. The active medical record did not contain any assessments that had been completed between 1/4/02 and 9/7/02. Resident 7's active medical record did not contain 15 months of MDS's. 2. Resident 24 was re-admitted to the facility on 12/8/02 with diagnoses which include, bilateral cerebral vascular accident, diabetes, GERD (gastro-esophogeal reflux disease), osteoarthritis and hypertension. Resident 24's current medical record was reviewed on 8/11/03, and 8/12/03. Resident 24 had been a resident at the facility since 6/9/02. Resident 24 was admitted/transferred to the hospital on December 4, 2002, with pneumonia. The resident was admitted back to the nursing care facility on 12/8/02. The following MDS's were on resident 24's medical record: 1. 12/8/02 Admission MDS 2. 12/12/02 Significant change MDS 3. 12/21/02 14 Day assessment MDS 4. 3/7/03 Quarterly assessment MDS 5. 6/9/03 Quarterly assessment MDS Resident 24's prior MDS assessments that had been completed prior to her hospitalization were not available on her current medical record. 3. Resident 5 was re-admitted to the facility on 4/28/03 with diagnoses which include, gastro-intestinal bleed, MS (multiple sclerosis), depression, COPD (chronic obstructive pulmonary disease), osteoporosis, right leg amputation, deep vein thrombosis, and hypertension. Resident 5's current medical record was reviewed on 8/11/03, and 8/12/03. Resident 5 had been a resident at the facility since 6/8/02. Resident 5 was admitted/transferred to the hospital on April 23,2003, with a gastro-intestinal bleed. The resident was	F 287		

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F 287	Continued From page 6 admitted back to the nursing care facility on 4/28/03. The following MDS was on resident 5's medical record: 1. 5/13/03 Admission MDS Resident 5's prior MDS assessments that had been completed prior to her hospitalization were not available on her current medical record.	F 287	F – 309 - Residents 35 and 47 have been assessed as being appropriate for participation in a toileting program designed to meet their ADL needs. The toileting programs will be individualized. Staff in-servicing and program implementation will be achieved by 25 September 2003.	9/25/2003
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview it was determined that the facility did not provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being for 2 of 14 sample. Specifically, 2 residents were assessed by facility staff as being candidates for a toileting program which was not being provided. Resident identifiers: 35 and 47 Findings include: 1. Resident 35 was admitted to the facility on 12/18/02, with diagnoses of hypertension, senile dementia, venous thrombosis, B-complex deficiency, constipation and generalized pain.	F 309	All residents currently in the facility have been assessed for the appropriateness of their participation in a toileting program. The review was completed 2 September 2003. Bowel and Bladder assessments will be completed for new residents admitted to the facility. Any resident deemed to be an appropriate candidate will be placed on the toileting program Nursing staff will be in-serviced on the utilization and implementation of the toileting program. A visual symbolic reminder will be placed in the resident room and will serve to prompt staff, which residents are in the program by 26 September 2003. A toileting log will be kept for participants of the program. The toileting log will be reviewed monthly to assess the establishment of any resident patterns or preferences. 30 September 2003. The restorative team will be responsible for reviewing documentation and reporting findings to the DON or her designee. A formal toileting program will be integrated into the facility's QA review at least quarterly by 15 October 2003.	9/2/2003 9/26/2003 9/30/2003 10/15/2003

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F 309	Continued From page 7 A review of resident 35's medical record was done on 8/12/03. A "Nursing Admission Assessment" completed by a facility nurse on 12/18/02, documented that resident 35 was continent of bowel and bladder. A"Bowel and Bladder Assessment" for resident 35 was completed by a facility nurse on 6/9/03, which documented a score of 12 (candidate for toileting timed voiding and prompting). An MDS (minimum data set), a mandatory annual assessment completed by the facility staff, dated 7/14/03, documented that the cognitive skills for resident 35 were moderately impaired and that she required extensive assistance with toilet use. The MDS also documented that resident 35 was usually continent of stool, frequently incontinent of bladder and she was on any scheduled toilet program. On 8/11/03 at 2:40 PM, a facility RN (registered nurse) stated that resident 35 was not continent of bowel or bladder and was not on a toilet program because she could not transfer herself and was not really aware when she needed to go to the bathroom. On 8/12/03 at 7:00 AM, a facility CNA (certified nursing assistant) stated that resident 35 was incontinent of bowel and bladder. She further stated that resident 35 was aware when she goes to the bathroom and at times would ask to be taken to the bathroom, but was not on a toilet program because it was usually to late. On 8/12/03 at 9:25 AM, a facility LPN (licensed practical nurse) stated that resident 35 was at times aware of her bowel and bladder needs but mostly was	F 309		

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F 309	Continued From page 8 not. She further stated that resident 35 was not on a toilet program and that she used briefs. 2. Resident 47 was re-admitted to the facility on 8/6/03, with diagnoses of heart failure, pulmonary edema, diabetes mellitus, hyperkalemia, anemia, congestive heart failure, increased lipids, osteoporosis, hypothyroidism and chronic pleural effusions. A review of resident 47's medical record was done on 8/12/03. A "Nursing Admission Assessment" completed by a facility nurse on 8/6/03, documented that resident 47 required extensive assistance with toileting. The assessment documented that resident 47 was continent of bladder. A"Bowel and Bladder Assessment" for resident 47 was completed by a facility nurse on 8/6/03, which documented a score of 10 (candidate for toileting timed voiding and prompting). On 8/12/03 at 9:00 AM, resident 47 stated that she was continent of bowel and bladder but had not been going to the bathroom because she could not walk and required assistance to the bathroom and she had not been getting that assistance. On 8/12/03 at 9:25 AM, a facility LPN stated that resident 47 had not been continent on admit due to being weak and lethargic. She further stated that she noticed resident 47 was continent and that she was going to look into getting her a bed pan.	F 309		
F 312 SS=D	483.25(a)(3) QUALITY OF CARE A resident who is unable to carry out activities of	F 312		

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F 312	Continued From page 9 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 and interviews, it was determined the facility did not enure that incontinence care was provided for 2 of 14 sampled residents. Resident identifiers: 27 and 5. Findings include: 1. Resident 27 was a 45 year old male who was admitted to the facility on 12/7/1999, with a history of anoxic brain injury, substance abuse, dysphagia, aspiration pneumonia, osteoporosis and hypocalcemia. Resident 27's medical record was reviewed on 8/113/03. The facility completed a quarterly MDS (Minimum Data Set) assessment on 6/20/03, for resident 27. Section H.b. Bladder incontinence, the facility has scored resident 27 as a "4". Four is defined as, Incontinent - Had inadequate control Bladder, multiple daily episodes; Bowel, all (or almost all) of the time. On 8/13/03, resident 27's care plan was reviewed. Resident 27's care plan, dated 6/17/03, had a goal for resident 27 to be clean, dry, odor free and free from skin breakdown every day for 90 days. The approach was to have staff provide assistance with toileting every 2 hours and PRN (as needed), change promptly with good peri and anal care after each incontinent episode. Resident 27 was observed on 8/11/03, at 7:55 AM, to be sitting in the facility main dining room TV (television) area, watching TV. Resident 27 was	F 312	F – 312 Resident 27 has been assessed and found to be appropriate for a toileting program by 2 September 2003. Resident 27 will be placed on an individualized toileting program. He will have a care plan developed and implemented by October 15, 2003 that will ensure incontinence care is provided to the resident. Resident 5 has been assessed and found to be inappropriate for participation in a toileting program. Incontinence care will be provided as care planned. Any resident determined to be inappropriate for the toileting program will receive incontinence care Q 2 hours and PRN. A nursing assistant will monitor the halls for call lights during meal times to ensure residents get the care they need in a timely manner. Facility administration will perform random call light audits 3 X's a week for 2 weeks, 2 X's a week for 1 week and randomly thereafter each month.	9/2/2003 10/15/2003

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F 312	Continued From page 10 wearing tan sweatpants. Resident 27 was observed at random times on 8/11/03, from 7:55 AM to 12:47 PM. Resident 27 was observed to be sitting in the facility main dining room and TV area. He was wearing tan colored sweatpants. At 12:47 PM, resident 27's tan sweatpants were noted to be wet, in the groin area and going down his legs. A facility nurse aide was observed to take resident 27 to his room, changed his clothes, and then brought the resident back to the dining room to eat lunch. Resident 27 was observed on 8/12/03 at random times from 7:45 AM to 12:55 PM. Resident 27 was observed to be sitting in the facility main dining room and TV area. He was wearing blue sweat pants. At 12:55 PM, resident 27's blue sweat pants were noted to be wet in the groin area and going down his legs. A facility nurse aide attempted to assist him to his assigned lunch area. The nurse aide noticed that resident 27 was wet. She then assisted him to his room to be changed. Resident 27 was later seen eating in the dining room with different clothing on. On 8/12/03, a facility nurse aide was interviewed at 10:10 AM, regarding resident 27. The facility nurse aide stated that resident 27 can be, "Continent if toileted. He will go in the toilet. Staff is not taking him to the bathroom." 2. Resident 5 was a 59 year old female admitted to the facility on 6/8/02, with diagnoses which include the following, multiple sclerosis, depression, COPD (chronic obstructive pulmonary disease) right above knee amputation, chronic pain and hypertension. Resident 59's medical record was reviewed on 8/11/03. The facility completed an admission MDS assessment	F 312		

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F 312	Continued From page 11 on 5/13/03, for resident 5. Section H.a., Bowel incontinence, the facility has scored resident 4 as a "4". Four is defined as, Incontinent - Had inadequate control Bladder, multiple daily episodes; Bowel, all (or almost all) of the time. On 8/11/03, at 2:10 PM, resident 5 was interviewed. During the interview resident 5 stated that she was incontinent of bowel and that she has a BM (bowel movement) almost every day around lunchtime. She stated, "To get changed, sometimes it takes 2 hours."	F 312	F – 314 There is no action at this time that can change the condition for the identified Resident 20. The pressure sore identified 11 August 2003 was resolving and at the time of expiration, was smaller than when identified. She was not adversely affected by the skin break down. Resident 20 has expired. Residents with Braden assessment scores of 17 or less will be considered at risk for potential skin breakdown. Braden assessment scores will continue to be re-assessed on a quarterly basis per facility policy. The MDS/Skin nurse or her	
F 314 SS=G	483.25(c) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review, it was determined that for 1 of 14 sample residents, the facility did not ensure that residents at risk for developing pressure sores received the necessary treatment and services to prevent a pressure sore from recurring. Resident identifier: 20 This is a repeat deficiency from the last annual recertification survey completed on 7/11/02. Findings include:	F 314	designee is responsible for a quarterly audit of the Braden scale. Results will be reported to the QA Committee. Weekly NAR/Weight committee meetings will be held to discuss the status of all residents with identified skin problems. The facility will enforce and maintain weekly skin checks on all residents. Any skin check revealing skin breakdown will be reported to the facility wound nurse and the primary care physician and will be reviewed weekly by the Skin/Wound nurse, the physician and the NAR/Weight committee. New areas of skin breakdown or new skin treatments will be reported to the wound nurse for follow-up. Nurses will notify nursing aides at shift change of residents with new skin care issues that need to be addressed during their shift. Facility will develop a protocol for communicating and obtaining orders for pressure sores acquired in the facility and for residents admitted with pressure sores. The protocol will be developed by the	

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	465128	A. BUILDING _____ B. WING _____	8/13/2003

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F 314	Continued From page 12 Resident 20 was originally admitted to the facility on 6/28/01, with the diagnoses of organic brain syndrome, dementia, confusion, weakness, hypothyroidism, hyperlipidemia, hypertension, diarrhea, dyspepsia, anemia, arthritis, osteoporosis and esophageal reflux disease. A review of resident 20's medical record was completed on 8/13/03. An MDS (minimum data set), a quarterly assessment completed by the facility staff, dated 6/2/03, documented that the cognitive skills for resident 20 were moderately impaired and that she required no assistance when moving to and from a lying position, turning side to side and positioning herself while in bed and she needed limited assistance when moving to or from a bed or wheelchair. The MDS also documented that resident 20 was frequently incontinent of bladder and had one stage II pressure ulcer. A"Braden Scale for Predicting Pressure Sores Risk" assessment completed by a facility nurse for resident 20 on 3/3/03, documented a score of 12 (high risk). The most recent "Braden Scale for Predicting Pressure Sore Risk" assessment completed by the MDS coordinator/wound nurse for resident 20 on 6/3/03, documented a score of 14 (moderate risk). On 5/28/03, the facility wound nurse documented the following on a "E-Z Graph Wound Assessment Worksheet", "...[Left] outer ankle...Stage 2...Length .5 cm Width .5 cm...5/23/03 nurse reported stage I area [right] outer ankle. LPN (licensed practical nurse) immediately cleansed area [and] applied hydrocolloid. Today presents [with] small Stage II area [with] erythema around [and complains of] tenderness.	F 314	DON or her designee in conjunction with the medical director and approved by the QA Committee. Nursing staff will be in-serviced by the DON or her designee, on the use and implementation of the Pressure-sore Protocol, the meaning of the visual symbolic reminder and the process and techniques of offloading to relieve pressure. A written copy of the Protocol will be placed at each nursing station in the Nurse Resource Manual. A visual symbolic reminder will be developed and placed in the resident room and will serve to prompt staff which residents require off loading and pressure relief related to actual or potential skin breakdown problems. The nurse on duty when the pressure sore is identified will initiate a written care plan which will be updated PRN until the pressure sore is resolved and treatments discontinued. Medical records will do a monthly audit of routine skin checks and report the findings of the audit to the DON and MDS/Skin Nurse to verify completion of the skin checks.	10/15/2003

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F 314	Continued From page 13 Change TX (treatment) to pressure reducing oval. ABX (antibiotic) ointment and border gauze. To be reviewed by podiatry on his next visit." There was no documentation in resident 20's medical record to evidence that physician orders were obtained to provide treatment to the stage I pressure ulcer that was identified on 5/23/03. There was no documentation in resident 20's medical record to evidence that physician orders were obtained to provide treatment to the stage II pressure ulcer that was identified on 5/28/03. The care plan for resident 20, updated 5/29/03 included a problem "At increased risk for skin impairment R/T [related to] B&B [bowel and bladder] incontinence, dementia, chronic diarrhea." The goal stated , "Resident will be clean, dry, odor free and free from skin breakdown QD [every day] TNR [till next review]." Approaches documented included, "...Monitor skin with cares, weekly skin checks..." Another care plan, updated 5/29/03 included a problem "At risk of pressure ulcer AEB [as evidenced by] Hx [history of] pressure ulcer." The goal stated, "resident will have skin remain intact by_____" Approaches documented included, "Follow above approaches. Tx [treatment] A/O [as ordered]." A care plan which addressed actual skin breakdown could not be located in resident 20's medical record. On 5/29/03, a facility nurse documented the following on a "Monthly Summary and Assessment of Nursing care Needs", "...[yes] [no] decubitus stage II Size 1 cm [by] 1 cm...[left] lateral stage II pressure sore noted." On 6/5/03, the facility wound nurse documented the	F 314		

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F 314	Continued From page 14 following on a "E-Z Graph Wound Assessment Worksheet, "...[Left] outer ankle...Stage 2...Length 1.25 cm Width 1 cm...Much improvement noted..." On 6/6/03, a facility nurse documented the following on a "Monthly Summary and Assessment of Nursing care Needs","...[left] lateral stage II pressure sore resolving..." On 6/24/03, the facility wound nurse documented the following on a "E-Z Graph Wound Assessment Worksheet", "...Wound Location [Left] outer ankle TX being used Eucerin cream..." On 7/22/03, the facility wound nurse documented the following on a "E-Z Graph Wound Assessment Worksheet, "...[Left] outer ankle Tx being used heel protector when in bed..." On 7/22/03, a facility nurse documented the following on a "Monthly Summary and Assessment of Nursing care Needs", "...[no] decubitus..." A physician's order, dated 7/23/03, documented the following order, "Continue to wear heel protectors when in bed DX (diagnoses) resolved stage II." On 7/24/03, the facility podiatrist documented the following, "...Preulcertive[sic] stage I ulcer [left] lateral maleolus [sic] [zero] infected, due to pressure...Sperative[sic] pad placed around [left] ankle ulcer...Will have staff monitor [left] ankle [and] dress as needed - keep pads on to offload area." A physician's order written by the podiatrist, dated 7/24/03, documented the following, "Watch for breakdown [left] lateral ankle use pads to offload area (given to [facility nurse])."	F 314		

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F 314	Continued From page 15 On 7/31/03, the facility wound nurse documented the following on a "E-Z Graph Wound Assessment Worksheet, "...[Left] outer ankle Tx being used spence booties..." On 8/11/03 at 3:15 PM, the facility wound nurse stated that resident 20's pressure ulcer was on her left outer ankle and had healed about 3 weeks ago. She stated that it had been a stage II. She further stated that resident 20 does not have any breakdown at this time. On 8/11/03 at 3:20 PM, a registered nurse surveyor performed a skin check on resident 20 with the facility wound nurse. The surveyor observed resident 20 in bed, laying on her left side. Resident 20 was not observed to have heel protectors on nor was she observed to have her left ankle offloaded. When the wound nurse removed resident 20's left sock the surveyor and the wound nurse observed a pressure sore on resident 20's left ankle. The wound nurse gave a measurement of "1/2 centimeter in diameter of breakdown and 1 1/2 centimeter of redness." The wound nurse staged the pressure ulcer at a "Stage II." The pressure ulcer did not have a dressing covering it. On 8/11/03 at 4:35 PM, resident 20 was observed to be in bed laying on her left side. Resident 20 was not observed to have heel protectors on nor was she observed to have her left ankle offloaded. On 8/12/03 at 6:55 AM, resident 20 was observed to be in bed laying on her left side. Resident 20 was not observed to have heel protectors on nor was she observed to have her left ankle offloaded. On 8/12/03 at 3:35 PM, resident 20 was observed to be in bed laying on her left side with her shoes on. Resident 20 was not observed to have heel protectors on nor was she observed to have her left ankle	F 314		

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F 314	Continued From page 16 offloaded. On 8/12/03 at 3:40 PM, the facility wound nurse stated that the facility treats all wounds, the facility nurse's will write the physician telephone orders as to what they feel needs to be done unless they don't know what to do. She stated that when the physician comes in he reviews the telephone orders and changes the treatment if he feels that needs to be done. She further stated that she usually does rounds with the nurse's and they write the telephone order's for treatment of wounds. The wound nurse was asked if she could locate the physician's telephone order for treatment of resident 20's stage I pressure ulcer identified on 5/23/03, and stage II pressure ulcer identified on 5/28/03. The wound nurse reviewed the medical record and was not able to find either telephone order. On 8/12/03 at 4:05 PM, a registered nurse surveyor performed a skin check on resident 20's coccyx with a facility nurse. Resident 20 was observed to be laying on her left side with her shoes on. Resident 20 was not observed to have her left ankle offloaded. The surveyor nurse observed two areas of redness on resident 20's coccyx. The facility nurse stated the redness on the left side was a stage I and 1/2 centimeter in diameter and the redness on the right side was a stage I and 3 centimeters in diameter. When the surveyor asked the facility nurse about the pads that were to be used to offload resident 20's left ankle she stated that she was sure they were all used up because they had another resident who had a wound on his ankle. She further stated that they could order some more. On 8/13/03 at 7:20 AM, the facility nurse who received the offload pads from the podiatrist stated	F 314		

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F 314	Continued From page 17 that the pads were all used up. He further stated that he was not aware that resident 20's left ankle had reopened.	F 314	F-329 Resident 48 was reviewed and medications monitored 8/14/03 by the facility psychotropic committee. He has been found to be free of unnecessary drugs or potentially harmful side effects that could be related to psychotropic medications. The psychotropic committee, interdisciplinary team and house physician will monitor the total plan of care in quarterly meetings. Nursing will monitor resident behaviors and potential side effects of psychotropic medications daily on the anti-psychotic monthly record. Resident 48 is being monitored by a Hospice Health Care Provider.	8/14/2003
F 329 SS=G	483.25(l)(1) QUALITY OF CARE Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on record review and interview with facility staff, it was determined that for 1 of 14 sample residents, the facility failed to ensure that a residents drug regimen was free from unnecessary drugs. The facility also failed to adequately monitor a resident on antipsychotic medications, and did not intervene when the resident exhibited symptoms of possible side effects from the medications. (Resident 48) Findings include: Resident 48 was originally admitted to the facility on 2/19/01 and was discharged to an acute psychiatric facility on 1/31/03. Resident 48 was readmitted to the facility on 2/17/03 with diagnosis of bipolar I, manic with paranoid psychosis, recurrent improved, mixed personality disorder with narcissism, history of hip and heel fractures, hypercholesterolemia, and arthritis. A review of resident 48's medical record was done on 8/11/03 and 8/12/03.	F 329	To ensure the accuracy of admission orders, the following measures will be implemented by October 15, 2003: 1. Orders will be reviewed and clarified by house physician upon admit. 2. The medical records clerk will also review all new admit orders and monitor for any discrepancies or medication errors. Any errors identified will be reported to the DON and primary care physician. Nursing will monitor daily behaviors and potential adverse side effects of all residents receiving psychotropic medication for a psychiatric diagnosis. The tracking and monitoring of behaviors and adverse side effects will be reviewed at least quarterly by the facility psychotropic committee. Significant changes in behaviors or adverse side effects are	10/15/2003

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F 329	Continued From page 18 Review of the record for resident 48 for the stay at the facility from 2/19/01 through 2/17/03, revealed that facility staff and the resident's physician, documented that resident 48 had exhibited behaviors of combativeness with staff and other residents and was resistive to cares. On 1/31/03, resident 48's physician documented that resident 48 had become increasingly aggressive and combative and discharged resident 48 to an inpatient psychiatric treatment facility. On 2/17/03, resident 48 was readmitted to the nursing facility. A review of resident 48's discharge orders from the psychiatric facility revealed that resident 48 was to receive the following medications when he returned to the nursing facility: Lasix 20 mg daily, KCL (potassium) 10 meq daily, Colace 200 mg twice daily, Aspirin 81 mg daily, Zyprexa 2.5 mg daily, Topamax 200 mg daily, Celebrex 200 mg daily and Mevacor 20 mg daily. (It should be noted that Zyprexa is an antipsychotic medication, used to control aggressive behavior, Topamax is a mood stabilizer and Celebrex is used for arthritic pain.) Further review of resident 48's medical record revealed a "Medical Consultation" for resident 48 done on 1/31/03, by a physician on admission to the psychiatric facility. The medications listed on the consult were Haldol 5 mg IM or po every 2 hours as needed, Depakote 250 mg twice daily for 2 days then three times daily (used as a mood stabilizer), Zyprexa 5 mg daily and 2.5 mg every 4 hours (prn) as needed, Colace 200 mg twice daily, Aspirin 81 mg daily, Lasix	F 329	reported daily to the DON on the facility 24-hour report and will also be reported to the primary care physician as they occur.	

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F 329	Continued From page 19 20 mg daily, KDur 10 mcg daily and Mevacor 20 mg daily. When resident 48 was readmitted to the nursing facility on 2/17/03, a copy of the consultation was sent with resident 48's admission paperwork. Based on record review, the facility nurse that admitted resident 48 to the nursing facility on 2/17/03, used the medications listed on a medical consult dated 1/31/03 rather than the admission physician medication orders listed on the psychiatric facility discharge instruction sheet (dated 2/17/03). There were significant medication differences between the 2/17/03 discharge orders and the medications on the 1/31/03 medical consult. Due to this error, resident 48 was administered: Zyprexa 5 mg daily instead of Zyprexa 2.5 mg daily that was ordered, and Depakote 250 mg three times daily, which was not ordered. Additionally, the medications which were ordered on the discharge instruction sheet, but not received by resident 48 were: Topamax 200 mg daily, and Celebrex 200 mg daily. There was no evidence in the medical record of resident 48 that facility staff had contacted the physician to clarify the orders. (There was a physician telephone order dated 2/17/03, to discontinue the Haldol and the prn Zyprexa.) A 5 day Minimum Data Set assessment dated 2/21/03, completed by facility staff for resident 48, documented that resident 48 was not on any	F 329		

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F 329	Continued From page 20 antipsychotic medication. A nursing care plan dated 2/18/03, completed by facility staff for resident 48, documented as a problem that resident 48 was at increased risk for fall episodes related to decreased mobility and psychotropic drug use. There were two goals identified under the problem. The first goal documented that the resident would not have injuries or falls daily through the next review. The approaches for the first goal for resident 48 were to provide a clutter free environment, to keep frequently used items easily accessible for the resident, to assist with all transfers, and if a fall or injury should occur, to notify the physician and the family and take vital signs. The second goal documented that resident 48 would present maximum effect of psychotropic medication with least amount of dosage. The approaches to the second goal were to give medication as ordered , to review in quarterly psychotropic drug committee meeting and monitor behaviors. A review of resident 48's medication administration sheet for 2/17/03, through 2/22/03, revealed per documentation, that resident 48 received Depakote 250 mg three times daily and Zyprexa 5 mg daily. There was no evidence on the medication administration sheet that the facility nursing staff were monitoring resident 48 for effectiveness of the medication or if resident 48 was experiencing any side effects from the medications. The 23rd Edition of Nursing 2003 Drug Handbook , Lippincott, William and Wilkins (page 429), indicates that some of the side effects of Depakote include, but are not limited to, "sedation...muscle weakness... ataxia... dizziness." The same drug handbook indicates (page 483) that some of the side effects of Zyprexa include, but are not limited to, "somnolence...dizziness...articulation impairment...	F 329		

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F 329	Continued From page 21 orthostatic hypotension... increased salivation." The following medical record notations document: a. A nurses note for resident 48, dated 2/18/03 at 7:00 AM, stated, "he has been drooling @ (at) times and speaking lowly, (sic) sometimes unintelligibly (with) slurred speech. Report given to day nurse." b. On 2/19/03, a facility staff nurse documented on the "Medicare Daily Charting" sheet that resident 48 had slurred speech. c. On 2/22/03, a facility day shift nurse documented on the "Medicare Daily Charting" sheet, " has (decreased) activity tolerance, fatigues easily upon exertion (decreased) safety awareness...". d. On 2/22/03, a facility night shift nurse documented on the "Medicare Daily Charting" sheet, "...Continues to drool and his speech continues to be slurred and less intelligible compared to how it was (before) he was last a patient @ this facility...". On 2/23/03, a facility night shift nurse documented that resident 48 had been found on the floor between a wheelchair and the bed. The nurse documented that resident 48 was experiencing pain in his right hip and that resident 48's right lower extremity was externally rotated and was shorter by 1 to 2 inches than the left lower extremity. Resident 48 was sent to the hospital for evaluation. Resident 48 was diagnosed in the hospital with a right hip fracture. An interview was held on 8/11/03 at 3:30 PM with a facility staff nurse who was familiar with resident 48. The facility nurse stated that they had provided care for resident 48 previous to the discharge to the psychiatric facility and after he was readmitted. The	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 22 facility nurse stated that resident 48 had a history of combative and resistive behaviors. The facility nurse stated that in January 2003, resident 48's behaviors increased and he was striking out at staff and other residents. The staff nurse stated that resident 48 hit his physician and that resident 48 was discharged to a phychiatric facility for evaluation and medication management. The nurse stated that resident 48 had previously been tried on anti-depressants but had not been on any antipsychotic medications previous to the discharge on 1/31/03. The facility nurse stated that when resident 48 was readmitted to the facility, he was not as independent as he had been during his prior admission and was lethargic. The facility nurse stated that resident 48 may have fallen because of the medication he was on. An interview was held on 8/12/03 at 7:30 AM with another facility nurse who was familiar with resident 48. The facility nurse stated that thye had provided care for resident 48 previous to the discharge to the psychiatric facility on 1/31/03, and after resident 48's readmission on 2/17/03. The facility nurse stated that resident 48 had an increase in combative behaviors. The nurse stated that resident 48 was hitting staff and other residents and had hit his physician and was discharged to a psychiatric facility. The nurse stated that resident 48 was in the other facility for a while, and when he returned he was not the same. The nurse stated that resident 48 was lethargic and his speech was slurred. There was no evidence in the medical record that the physician had been contacted by anyone in the facility to inform him of resident 48's change in condition prior to the fall on 2/23/03 which resulted in him fracturing his hip.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 23	F 371	F – 371	
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 interview, 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 tour completed on August 11, 2003 from 8:00 AM until 8:30 AM. In the walk in refrigerator: 1. There were 6 mighty shakes on a tray, which were not dated with a thaw date. 2. There was a box which contained 10 mighty shakes, the date on the box was 7/14/03 (14 days old). 3. There were two metal containers of red Jell-O, which were not covered, dated or labeled. 4. There was a plastic container of cream cheese frosting, which was dated 7/29/03 (13 days old). 5. There was a plastic container of cookie dough, which was dated 5/13/03 (90 days old). Ready to eat, potentially hazardous food prepared and held refrigerated for more than 24 hours in a food establishment shall be clearly marked at the time or preparation to indicated the date by which the food shall be consumed which is, including the day of preparation: 4 calendar days or less from the day the	F 371	All items in the walk-in refrigerator, walk-in freezer and dry storage room were examined to ensure that all food items were not outdated on 18 August 2003. An audit tool will be developed by the Dietary Manager or designee for monitoring the walk-in refrigerator, walk-in freezer and dry storage room by 22 September 2003. Dietary staff will receive in-service training by 26 September 2003 regarding the use of the audit tools and the importance of labeling, dating and covering left over or pre-prepared food items in either the walk-in freezer or walk-in refrigerator as well as items placed for thawing in the walk-in refrigerator. Bi-weekly audits using the audit tools and monitoring the walk-in freezer, walk-in refrigerator and dry storage room will be conducted by 29 September 2003 by the dietary manager, or designee X 2 and once a week thereafter. Audits will be reviewed in QA meeting beginning no later than 3 October 2003 X 2 and randomly thereafter to ensure compliance. The consultant Dietitian will conduct an in-service on maintaining sanitation standards in the dietary department and will review regulations for labeling, dating, and covering food items in the walk-in refrigerator and freezer and the timelines for the thawing and serving of thawed meats and poultry for dietary employees by 15 October 2003.	8/18/2003 9/22/2003 9/26/2003 9/29/2003 10/3/2003 10/15/2003

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 _____	8/13/2003

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

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F 371	Continued From page 24 food is prepared, if the food is maintained at 45 degrees Fahrenheit or less. Reference Guidance: US Public Health Service FDA 1999 Food Code, page 64. In the dry storage room: 1. There was a container of mustard, which had a manufacture date of 10/26/00. 2. There was 8 bags of dry yeast, which had manufacture date of 6/22/02. 3. There was a bag of wheat germ, with no manufacture date or delivery date. On 8/12/03 at 12:40 PM, the facility dietitian stated based on the code at the bottom of the package of wheat germ, it had been packaged around 1/6/03. She later told a surveyor that wheat germ was good for 6 months.	F 371		

Plan of Correction Addendum for F-312

F – 312 Resident 27 has been assessed and found to be appropriate for a toileting program by 2 September 2003.

Resident 27 will be placed on an individualized Incontinence Care program. He will have a care plan for Incontinence Care developed and implemented by October 10, 2003.

Resident 5 has been assessed and found to be inappropriate for participation in a toileting program. Resident 5 will have a care plan for Incontinence Care developed and implemented by October 10th, 2003.

Any resident determined to be inappropriate for the toileting program will receive incontinence care Q 2 hours and PRN.

Assignment sheets will be developed that identify residents on Toileting and Incontinence Care Programs. The assignment sheets will be provided to each nursing aide on a daily basis and will be updated weekly as new residents are admitted and as resident conditions change.

The DON or designee will conduct compliance rounds to monitor the incontinence care program daily X's 2 weeks then 3 X's a week X's 2 weeks then 1 X a week X's 2 weeks and randomly thereafter to ensure compliance is maintained.

A nursing assistant will monitor the halls for call lights and other resident needs during meal times to ensure residents get the care they need in a timely manner.

Facility administration will perform random call light audits 3 X's a week for 2 weeks, 2 X's a week for 1 week and randomly thereafter each month.

Nursing administration will report to the QA committee the results of the compliance rounds and call light audits by October 10, 2003. The QA Committee will monitor the effectiveness of the incontinence program and the call light answering program at least quarterly until the next annual survey.

Addendum to completion dates for survey compliance for all F- Tags cited will be changed to 10 October 2003.