STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465128	A. BUILDING _____ B. WING _____	11/09/2005

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) COMPLETION DATE
F 275 SS=B	483.20(b)(2)(iii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility did not submit a comprehensive assessment for 1 of 15 sample residents within 12 months of the previous comprehensive assessment for that resident. Resident 3. Findings included: Resident 3 was readmitted to the facility on 9/3/04 with diagnoses that included: psychosis NOS, schizophrenia, hip fracture, hydrocephalus, and total arthroplasty. Record review of resident 3's chart was done on 11/8/05. Resident 3 had a full comprehensive assessment done as a significant change MDS completed on 9/13/04. There was no annual MDS (Minimum Data Set) in resident 3's chart. Resident 3 should have had a comprehensive assessment within 12 months. An interview was done with the DON (Director of Nursing) on 11/8/05. She confirmed that there was no annual MDS in resident 3's chart.	F 275	12/5/05 POC acceptable Completion date 12/20/05 Buambaugh RN **F 275** [redacted] **(State Health Dept) contacted 11-8-05 to clarify DON understanding of scheduling issues.** **All corrections will be made to resident # 3 MDS on or before 12-20-05** **An audit tool will be developed by Director of Nursing (DON) or designee by 12-15-05 to ensure comprehensive assessments are done no less than once every 12 months.** **Monthly audits will be conducted for 3 months by DON or designee.** **Results of audits will be discussed in the monthly QA meeting with the first QA meeting to be held on or before 12/21/05** 12/29/05 **Utah Department of Health** 631975 **DEC 05 2005** **Bureau of Health Facility Licensing, Certification and Resident Assessment**	
F 276 SS=B	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than	F 276		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Maureen Walker	Administrator	12/5/05

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

EPARTMENT OF HEALTH AND HUMA.. SERVICES
ENTERS FOR MEDICARE & MEDICAID SERVICES

ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 276	Continued From page 1 once every 3 months. This REQUIREMENT is not met as evidenced by: Resident 6 was admitted to the facility June 2004. Resident 6's medical record was reviewed on 11/7/05. There was no quarterly MDS assessment in resident 6's medical record that had been completed within 90 days of the comprehensive MDS. Based on record review and interview it was determined that the facility did not assess a resident using the quarterly review instrument approved by CMS at least every three months. Resident 3 Findings included: Resident 3 was readmitted to the facility on 9/3/04 with diagnoses including: schizophrenia, GERD, and hydrocephalus. Resident 3's chart was reviewed on 11/8/05. The chart was missing MDS quarterly assessments. On 11/8/05, the DON was interviewed. She confirmed that resident 3's chart was missing MDS quarterly assessment which was due 2/28/05.	F 276	**F 276** **A correction will be made to resident 6's MDS by 12-20-05.** **An audit tool will be developed by DON or designee by 12-15-05 to ensure the quarterly review instrument approved by CMS is utilized at least every three months to assess residents.** **Three Monthly audits will be conducted by DON or designee and results of audits will be discussed in the monthly QA meeting with the first QA meeting to be held on or before 12/15/05** 12/29/05	
F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status.	F 278	**F 278** **A correction will be made to residents 4, 6, and 11's MDS by 12-20-05.** **An audit tool will be developed by the DON or designee by 12-15-05 to ensure MDS assessment accurately reflect the resident's status.** **Three monthly audits will be completed DON or designee.** **Results of audits will be discussed in the monthly QA meeting, with the first QA meeting to be held on or before 12/21/05** 12/29/05	

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F 278	Continued From page 2 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility did not accurately complete Minimum Data Set (MDS) assessments for 3 of 15 sample residents, including the appropriate certifications of completion. Residents 4, 6 and 11. Findings include: 1. Resident 4 was admitted to the facility March 2005 with diagnoses that included failed repair of	F 278		

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F 278	Continued From page 3	F 278		

a fractured hip.

Resident 4's medical record was reviewed on 11/8/05. The facility MDS coordinator had signed that an initial comprehensive MDS assessment for resident 4 had been completed 3/16/05. The Resident Assessment Protocols (RAPs) Summary, Section V of the MDS, had not been completed and placed in the resident's medical record.

The facility maintained both a computerized and a hard copy medical record for each resident. The computerized MDS assessment, dated 9/7/05, for resident 4 contained documentation that over the previous seven days the resident had received 1001 cc to 1500 cc of fluid daily through an intravenous (IV) line. Resident 4 had taken all fluids by mouth and had no IV line during the assessment period.

3. Resident 11 was admitted to the facility May 2005 with diagnoses that included dementia.

The computerized MDS assessment, dated 8/11/05, for resident 11 contained documentation that over the previous seven days the resident had received 1001 cc to 1500 cc of fluid daily through an intravenous (IV) line. Resident 11 had taken all fluids by mouth and had no IV line during the assessment period.

The Director of Nursing (DON) was interviewed on 11/9/05 at 9:00 AM. The DON reviewed the computerized records for resident 4 and resident 11. The DON stated the residents had not received IV fluids and she did not understand how the documentation errors had occurred.

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F 278	Continued From page 4	F 278		

3. Resident 6 was admitted to the facility June 2004. Resident 6 was temporarily discharged to the hospital and re admitted to the facility July 2005.

Resident 6's medical record was reviewed on 11/7/05. The facility Interdisciplinary Team (IDT) had completed a comprehensive MDS assessment for resident 6, dated 7/30/05. The MDS was documented as an admission assessment. Resident 6 was not a new admission to the facility. The MDS should have been documented as a significant change assessment for resident 6. As a result of a hip fracture, resident 6 exhibited increased needs for her care. MDS documentation of resident 6's decline included that the resident had gone from being independent with transfers, bed mobility, ambulation, locomotion, and independent with supervision only for toileting without appliances, to maximum assistance in each of those areas and placement of a urinary catheter.

Resident 6's quarterly MDS assessment, dated 6/1/05, was signed by the DON / MDS Coordinator as having been completed on 6/15/05 in section R2B. The attestation, section AA9, was signed by the DON on 6/24/05, nine days after the MDS was documented as complete.

A RAP summary, section V, was documented as having been completed on 3/16/05 by the DON. The "Location and Date of RAP Assessment Documentation", in sections V A4, A5, A6, A11, A16 and A17, revealed the RAPs were completed 4/11/05, over three weeks after the documented completion date. In addition, the location of the documentation referred to resident 6's care plan

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F 278	Continued From page 5 in sections V A2, A4, A5, A7, A8, A11, A16 and A17. The care plan is not a part of the Resident Assessment and it should be completed after the RAI in order to determine how to individualize the resident's care to his/her specific situation. On 11/8/05 at 9:15 AM, the DON was interviewed. The DON stated that she sometimes had to correct MDS documentation after the section R2B completion date. As a result, attestation dates in section AA9 were documented after the MDS completion date. If the changes were significant, a significant correction of an MDS should have been completed. If the changes were minor, there should have been documentation that explained the reason for the changes. The medical records that were reviewed with the DON did not have significant change MDSs nor explanations regarding the corrections that were made to the MDS documents.	F 278		
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that services provided by the facility did not meet professional standards of quality concerning administration of sliding scale insulin. Residents: 1 and 10 Findings included:	F 281	**F 281** ***A correction was made in the administration of sliding scale insulin to resident 1 and 10 on prior to end of survey.*** **An in-service will be held for the licensed nursing staff 12-15-05 on how to correctly utilizing the sliding scale for residents 1 and 10 and on correct charting.** **Audit tool will be developed by the DON or designee by 12-15-05 to ensure continued compliance using the sliding scale for insulin.** **Audits will be completed twice a week for 4 weeks. Once a week for 2 weeks. Once a week for 2 months and randomly over the next 6 months.** **Results of audits will be discussed in the monthly QA meeting, with the first QA meeting to be held on or before 12/21/05**	12/29/05

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F 281	Continued From page 6	F 281		

Resident 1 was admitted to the facility on 9/7/01 with diagnoses including: Insulin-dependent Diabetes Mellitus, seizure disorder, arthritis, and osteoporosis. On 11/7/05 resident 1's medical record and medical administration record were reviewed. A review of resident 1's medical record showed a physician's order on recertification orders dated 10/1/05 through 11/30/05 for sliding scale Humalog insulin if blood glucose (BG) is over 150 as follows: 151-200 give 2 units (u), 201-250=4 u, 251-300=6 u, 301-350=8 u, 351-400=10 u, >400=12 u, sub-Q q.i.d. (four times a day) at 0800, 1200, 1700, 2100 military time. Review of the October and November 2005 MAR revealed sliding scale Humalog insulin was not given in correct amount to resident 1 on the following days in October and November 2005:
On 10/3/05 at 8:00 AM, blood glucose was recorded as 363. The amount of insulin given was documented as 8 u. According to the ordered parameters, 10 units were to be given at this time.
On 10/4/05 at 9:00 PM, resident 1 had a BG of 380. Resident 1 was given 8 u of Humalog insulin, but should have received 10 u.
On 10/6/05 at 8:00 AM, BG was recorded as 383. Resident 1 was given 0 u of insulin, but should have received 10 u.
On 10/15/05 at 8:00 AM, resident 1 had a BG of 276. The amount of insulin given was 8 u, but should have received 6 u.
On 10/20/05 at 8:00 AM, resident 1 had a BG of 543. Resident 1 was given 0 u of insulin, but should have received 12 u.
On 10/24/05 at 9:00 PM, resident 1 had a BG of 395. Resident 1 was given 8 u of insulin, but should have received 10 u.
On 10/31/05 at 8:00 AM and at 11:30 AM, resident 1 had BG's of 250 and 366 respectively.

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Resident 1 was given 0 u at 8:00 AM, but should have received 4 u. Resident 1 was given 8 u at 12:00 noon, but should have received 10 u.
On 11/4/05 at 8:00 AM, resident 1 had a BG of 166. Resident 1 was given 0 u of insulin, but should have received 2 u.
On 11/11/05 at 9:00 PM, resident 1 had a BG of 452. Resident 1 was given 8 u of insulin, but should have received 10 u.
In an interview of a nurse on 11/8/05, she was asked to explain why the units of insulin given did not match the ordered parameters on those dates. She did not know.

Resident 10 was admitted to the facility on 7/25/05 with diagnoses including: Insulin-dependent Diabetes Mellitus, Alzheimer's, and depression.

On 11/9/05 a review of resident 10's medical records showed physician's orders for sliding scale Regular insulin starting 10/2/05 based on BG as follows:
BG 151-200 = 2 u, 2201-250 = 4 u, 251-300 = 6 u, 301-350 = 8 u, 351-400=10 u. , <60 or >400 call MD. 0600, 1200, 1700, 2100.

Review of the October 2005 MAR revealed regular insulin sliding scale was not given in the correct amount to resident 10 on the following days in October:

On 10/2/05 at 11:30 AM, resident 10 had a BG of 202. Resident 10 was given 0 u of insulin, but should have received 4 u.
On 10/5/05 at 8:00 PM, resident 10 had a BG of 151. Resident 10 was given 0 u of insulin, but should have received 2 u.
On 10/6/05 at 8:00 PM, resident 10 had a BG of

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F 281	Continued From page 8 151. Resident 10 was given 0 u of insulin, but should have received 2 u. On 10/7/05 at 11:30 AM, resident 10 had a BG of 168. Resident 10 was given 4 u of insulin, but should have received 2 u. On 10/8/05 at 6:00 AM, resident 10 had a BG of 201. Resident 10 was given 2 u of insulin, but should have received 4 u. On 10/9/05 at 6:00 AM and 8 PM resident 10 had BG's of 163 and 154 respectively. Resident 10 was given 0 u of insulin at each of these times, but should have received 2 u each of these times. On 10/12/05 at 4:30 PM, resident 10 had a BG of 306. Resident 10 was given 6 u of insulin, but should have received 8 u. On 10/13/05 at 8:00 PM, resident 10 had a BG of 151. Resident 10 was given 0 u of insulin, but should have received 2 u. On 10/14/05 at 6:00 AM, resident 10 had a BG of 205. Resident 10 was given 2 u of insulin, but should have received 4 u. At 8:00 PM the same day, resident 10 had a BG of 153. Resident 10 was given 0 u of insulin, but should have received 2 u. On 10/20/05 at 8:00 PM, resident 10 had a BG of 153. Resident 10 was given 0 u of insulin, but should have received 2 u. On 10/22/05 at 6:00 AM, resident 10 had a BG of 152. Resident 10 was given 0 u of insulin, but should have received 2 u. On 10/27/05 at 8:00 PM, resident 10 had a BG of 151. Resident 10 was given 0 u of insulin, but should have received 2 u.	F 281		
F 286 SS=B	483.20(d) RESIDENT ASSESSMENT - USE A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record.	F 286	**F 286** ***Residents 7, 6, and 4's active records were updated to include previous 15 months MDS. Medical Records personnel have been inserviced by consultant during Nov 05 visit.*** **An audit tool will be developed by Medical Records Coordinator or designee by 12-15-05 to ensure 15 months of MDS are in resident's active records.** **Monthly audits will be conducted by Medical Records Coordinator or designee for 3 months and randomly thereafter for 6 months.**	12/29/05

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F 286	Continued From page 9	F 286		

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility did not maintain Minimum Data Sets (MDS) assessments completed within the previous 15 months in the resident's active clinical record for 3 of 15 sample residents. Identifiers 4, 6 and 7.

Findings included:

1. Resident 7 was admitted to the facility on 9/26/05 with diagnoses that included dementia, fibromyalgia, chronic fatigue syndrome, Diabetes, major depression, hypothyroidism, asthma and arthritis.

Resident 7's medical record was review on 11/7/05. The medical record did not have a admission MDS dated 10/6/05 nor were the Resident Assessment Protocols (RAPS) on the medical record. The RAPS are utilized to identify possible causes for each problem area for the resident, and guidance for further assessments and resolutions or intervention.

In an interview with the Director of Nursing (DON), on 11/8/05 at 7:45 AM, the DON confirmed the admission MDS and the RAPS were not on resident 7's medical record.

2. Resident 6 was admitted to the facility June 2004. Resident 6 was temporarily discharged to the hospital and re admitted to the facility July 2005.

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F 286	Continued From page 10 Resident 6's medical record was reviewed on 11/7/05. The facility Interdisciplinary Team (IDT) had documented an "initial" comprehensive MDS assessment for resident 6, dated 7/30/05, which was incomplete. There were no RAPs in resident 6's medical record that coordinated with the 7/30/05 comprehensive MDS assessment. There was no quarterly MDS assessment in resident 6's medical record that had been completed within 90 days of the comprehensive MDS. 3. Resident 4's medical record was reviewed on 11/8/05. The facility MDS coordinator had signed that an initial comprehensive MDS assessment for resident 4 had been completed 3/16/05. The Resident Assessment Protocols (RAPs) Summary, Section V of the MDS, had not been completed and placed in the resident's medical record. On 11/8/05 at 9:15 AM, the DON was interviewed in the conference room by two surveyors. The DON was asked if residents were assessed over a two week look-back from the MDS reference date. The DON stated that they were. The DON then stated she had been using a "rule of sevens" to complete the RAPS seven days after the assessment and to complete the Care Plans seven days after the RAPS.	F 286		
F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose	F 329	**F 329** **Resident drug regiment was reviewed in psychotropic meeting 11-10-05.** **Resident # 8 drug regiment was reviewed with Hospice 11-11-05** **An audit tool will be developed by DON or designee by 12-15-05 to ensure no resident is receiving any unnecessary drugs.** **Audits will be conducted Weekly for 2 weeks, monthly for 2 months and randomly thereafter for 6 months.** **Results of audits will be discussed in the monthly QA meeting, with the first QA meeting to be held on or before 12/21/05**	12/29/05

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F 329	Continued From page 11 should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, it was determined that facility staff failed to ensure that drugs (a hypnotic)are not used for excessive duration. And, the facility staff failed to adequately monitor the dose of medication given. This occurred for one of 14 residents in the survey sample, resident 8. Findings include: Resident 8 was a 51 year old female admitted to the facility on 11/18/04 with the diagnosis of end stage COPD and multiple sclerosis. Resident 8 went to the hospital on 10/7/05 and returned to the facility on 10/14/05. During a review of resident 8's Medication Administration Record (MAR) it was documented that resident 8 was receiving "Dalmane 15-30 mg. PO (by mouth) q.h.s. (every night)" for "insomnia". The MAR documented resident 8 received the Dalmane from 10/14/05 through 11/9/05. This documentation did not specify the dose amount given. During a review of resident 8's Physician Orders dated from May 2005 through September 2005, it was documented that resident 8 had a physician's order for "Dalmane 15-30 mg. PO q.h.s." for "insomnia". Each monthly physician order from May through September 2005 was signed by the physician.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465128	A. BUILDING _____ B. WING _____	11/09/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 12 During an interview with resident 8 on 11/7/05 at 2:20pm, she stated that she sleeps at night and during the day at times. The facility pharmacist completed the monthly Pharmacist Consultant Therapeutic Recommendation form and dated it August 10, 2005. The recommendation documented, "With her routine use of Xanax 1 mg QID, Dalmane may not be very effective for sleep. Consider switching to melatonin, trazodone, or Ambien p.r.n. (as needed) for sleep." During an interview with the Director of Nursing (DON) on 11/8/05 at 10:15am, she stated that resident 8 receives the Dalmane for sleep and that she has been on it "a very long time". The DON did not know how much of the Dalmane dose resident 8 receives due to facility staff documenting their initials on the MAR as opposed to the dose amount. The DON also stated that the documentation of resident 8's hours of sleep stopped on 10/14/05 when resident 8 returned from the hospital.	F 329		
F 430 SS=D	483.60(c)(2) DRUG REGIMEN REVIEW The pharmacist must report any irregularities and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, it was determined that facility staff failed to act upon a pharmacist's recommendation regarding a hypnotic medication. This occurred for one of 14 residents in the survey sample, resident 8.	F 430	**F 430** **Resident drug regiment was reviewed in psychotropic meeting on 11-10-05.** **Resident record and drug regiment reviewed with Hospice RN along with surveyors concerns 11-11-05** **An audit tool will be developed by DON or designee by 12-15-05 to ensure all Pharmacist Consultant Therapeutic Recommendation forms are signed by physician, and have documented agreement or disagreement with recommendation.** **Audits will be conducted monthly for 2 months and randomly thereafter for 6 months.** **Results of audits will be discussed in the monthly QA meeting, with the first meeting on or before 12/08/05** 12/29/05	

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F 430	Continued From page 13	F 430		

Findings included:

Resident 8 was a 51 year old female admitted to the facility on 11/18/04 with the diagnosis of end stage COPD and multiple sclerosis. Resident 8 went to the hospital on 10/7/05 and returned to the facility on 10/14/05.

Resident 8 had a physician's order for "Dalmane 15-30 mg. PO (by mouth) q.h.s. (every night)" for "insomnia". The Medication Administration Record documented resident 8 received the Dalmane from 10/14/05 through 11/9/05.

Resident 8 had Physician Orders dated from May 2005 through September 2005, for "Dalmane 15-30 mg. PO q.h.s." for "insomnia". Each monthly physician order from May through September 2005 was signed by the physician.

The facility pharmacist completed the monthly Pharmacist Consultant Therapeutic Recommendation form and dated it August 10, 2005. The recommendation documented, "With her routine use of Xanax 1 mg QID, Dalmane may not be very effective for sleep. Consider switching to melatonin, trazodone, or Ambien p.r.n. (as needed) for sleep."

During an interview with the Director of Nursing (DON) on 11/8/05 at 10:15 AM, she stated that when the pharmacist makes a recommendation he is to complete the Pharmacist Consultant Therapeutic Recommendation form for the physician to sign. The physician will document if he agrees or disagrees on the form and then sign the form.

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F 430	Continued From page 14 The Pharmacist Consultant Therapeutic Recommendation form dated 8/10/05 was not signed by the physician and did not document whether the physician agreed or disagreed with the pharmacist's recommendation.	F 430	**F 465** **The outlet plate on the special needs unit was replaced during survey** **The missing baseboard was replaced on 11-8-05** **The electrical outlet plate in the dining room was replaced on 11-8-05** **The peeling paint and the area where paint was missing in the room where resident's scale is located will be painted on or before 12-12-05** **The lights in the outside courtyard were repaired during survey.** **The exposed sheet metal by the dishwasher window was repaired during survey.** **The ceiling in resident room # 10 will be repaired on or before 12-12-05** **An audit tool will be developed by the administrator or designee by 12-15-05 to ensure facility continues to be safe, functional, sanitary, and a comfortable environment for residents, staff and the public.** **Audits will be conducted weekly for 4 weeks. Monthly for 2 months and randomly thereafter for 6 months.** **Results of audits will be discussed in the monthly QA meeting with the first QA meeting to be held on or before 12/15/05**	
F 465 SS=B	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation of the facility environment it was determined that facility staff failed to provide a safe, sanitary and comfortable environment in all areas of the facility. Findings include: It was observed during the the entire survey that the following areas of the facility need repairs. 1. In the special needs unit the cable television outlet plate was broken off with pieces of the plate still on the wall. This was repaired during the survey. Also, in this dining room there is food spilled and dried on the wall in the southeast corner. 2. In the main dining room, the baseboard was missing in a six inch section on the south wall. The baseboard was also missing in two sections in the west doorway. This was repaired during the survey. Also, in the dining room on the west	F 465		

12/29/05

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 465	Continued From page 15 wall there is a cracked electrical outlet plate. 3. The room where the resident scale is located and where the residents are weighed has the phone jack pulled off the wall and has the peeled paint attached to it. There is a 3 inch section where the paint is off the wall from where the phone jack was located. 4. In the south outdoor courtyard there are three outdoor lamps hanging off the building by their exposed wires. 5. In the dining room near the dishwasher window on the corner of the wall there is exposed sheetmetal about six inches in length. This was repaired during the survey. 6. The ceiling in resident room #10 has an area where it may have had a privacy curtain track removed. This left the area without paint.	F 465		