accepted 9-26-02 Sharon Jorgensen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A068	A. BUILDING ______ B. WING ______	8/14/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOBBLE CREEK CARE CENTER	469 NORTH MAIN SPRINGVILLE, UT 84663

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 225 SS=D	483.13(c)(1)(ii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility did not report all alleged violations of abuse to the State survey and certification	F 225	F225 On Oct 2001 Resident 8 had won Money in Wendover. Administrator Had encouraged resident numerous Times to have money locked up in Facility safe. Resident refused to do So. Resident was hospitalized twice Once in Dec 2001 and once in Jan 2002, Both times took money with him to hospital. On Feb 14th 2002 it was reported to Administrator that resident was missing $400.00. Administrator interviewed resident, room was searched, resident could not recall when he last saw his money. All he said was the money being in a sock in his chest of drawers. Administrator notified police on Feb 14th, 2002 . Police interviewed resident case number was given to administrator. Administrator was provided police with Schedule of employees. Administrator Failed to call state survey agency and Adult Protective Services. Administrator Had made copy of investigation report. Was turned into survey team on 8-14-02 With numerous other papers. After a Phone conversation with Sharon Jorgenson Report was faxed to state Survey Utah Dept. of Health SEP 1 8 2002 # 499725 #7 Bur. of Medicare/Medicaid Prog. Certification and Res. Assessment	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	administrator	9/9/02

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 aft such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 agency for 1 of 2 allegations investigated by the facility for allegation of theft of a resident's money. Resident 8. Findings include: Resident 21 was a 72-year-old male who was documented on his Minimum Data Set (MDS) Assessment, dated 4/29/02, as having no memory deficit (Section B2 a and b) and as having the cognitive ability to make his own decisions independently, "consistent/reasonable", (Section B4). In an interview with resident 21, on 8/14/02, the resident stated that he had won $400.00 at a casino during the last Wendover outing with the facility staff and other residents. The resident stated he had not given the money to the Administrator to be locked in a safe. The resident stated that the money was taken from his room. During an interview with the facility Administrator, on 8/14/02, the Administrator stated that she had encouraged resident 21to put his money in the safe but that he had refused. The Administrator stated she had become concerned for the safety of the money when resident 21had to leave the facility temporarily for a brief stay at a hospital. The Administrator stated that a facility staff member had turned resident 21's night stand toward the wall so his drawer couldn't be opened and put another piece of furniture against it, as the resident requested before he left. When she learned that resident 21 had left the facility, the Administrator stated that she sent a staff member to get the money so that she could lock it in the safe. The money was not found and the police were called to the facility to investigate. The Administrator stated she had not called the State	F 225	continued from page 1 Inservice was presented to staff on Aug.21.Emphasis was placed on reporting procedure of lost property.Staff member receiving complaint will make incident report.Administrator will investigate comlaint,and report incident to state survey and certification agency,A.P.S, and police department. Resident 8 has kept money in facility safe since 3/14/02. All residents are encourage to keep large amounts of money in facility safe.A written notice will be given to all residents to be signed and kept in residents chart. All incident reports will be reviewed quarterly in Q.A meeting to assure proper procedures are followed for reporting misappropriation of residents property.	9/17/02

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F 225	Continued From page 2 survey and certification agency or Adult Protective Services to report the incident or results of the facility's investigation, but that she had provided personnel schedules for the police investigation. The Administrator could not recall the specific dates of the investigation or the date of the last casino outing the residents had taken, but stated that she thought it was April, 2002. The Administrator was asked for documentation of the facility's investigation, but she was not able to provide it.	F 225		
F 241 SS=G	483.15(a) QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility did not promote care in a manner and an environment that enhanced one resident's dignity and respect for 1 of 10 sample residents whose commode chair was left in her room without being emptied after each use. Resident 3. Findings include: Resident 3 was a 67-year-old female who was admitted to the facility 3/7/01. Resident 3's medical record was reviewed on 8/14/02. It was documented on resident 3's Minimum Data Set (MDS) assessment that her long and short term memory was intact (Section B2 a and b) and as having the cognitive ability to make her own decisions independently, "consistent/reasonable", (Section B4). It was also documented that resident 3 required staff	F 241		

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F 241	Continued From page 3 assistance for transfers, ambulation, dressing and toileting (Section G1A b-g, i, j). During an interview with resident 3 and a family member, on 8/13/02 at 3:30 PM, the resident stated that it bothered her that the staff would not empty or clean her commode chair during the day. The resident stated that the commode chair was left in her room, after it had been used, for the night shift to empty. The resident and her family member stated that, at times, the odor from her chair is "unbearable". Resident 3 stated that she was "humiliated" recently when representatives of her church came into her room and "not only was it [the commode] full, but the lid was up" throughout their visit. Observation of resident 3's room, on 8/13/02 at 3:30 PM, revealed the commode chair was in a corner of the room. The collector pan was visible and contained urine. On 8/14/02 at 1:30 PM, the collection pan in the commode chair in resident 3's room was observed to have been used. Following a discussion with the Administrator and the Director of Nursing, on 8/14/02 at 2:30 PM, regarding resident 3's concern that her commode be emptied and cleaned after use, the Administrator talked with resident 3. When the Administrator returned, she stated that resident 3 always had to be assisted to transfer to the commode and that there was no reason for the commode to be left unclean after use. A nurse aide then entered resident 3's room and was observed to remove and empty the collection pan.	F 241	F241 Administrator approached C.N.A. On shift, 8-14-02. C.N.A. said she Forgot to return to resident #3 Room to empty and clean commode. Because she was called to assist another Resident after she assisted resident #3 After use of commode. Administrator Explained to C.N.A. that commodes must Be cleaned and emptied immediately after Each use. Administrator spoke with resident #3 8-14-02. Resident agreed to use call light and speak to nurse in charge or administrator when staff fails to empty commode after use. So proper action can be taken also on 8-21-02 an In-service was given by D.O.N. and Administrator that nursing staff Must provide care for residents that Maintains each resident dignity and Respect specific emphasis was placed on The use of commode chair and importance That commodes are emptied and cleaned Immediately after each use, D.O.N. and A.D.O.N. and charge nurse Will monitor by random daily observation Also reminder for direct care staff posted In nursing station 9-9-02. **Any issue pertaining to this issue will be addressed in quartely Q.A.meeting**	9-9-02
F 272 SS=E	483.20(b) RESIDENT ASSESSMENT A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State.	F 272		

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F 272	Continued From page 4 The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.	F 272		

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F 272	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility did not complete comprehensive Minimum Data Set (MDS) assessments which included documentation of summary information regarding an additional assessment performed through the Resident Assessment Protocols (RAP) for 4 of 10 residents in the survey sample. Residents: 7, 11, 18, 21 Findings include: The RAPs (Section VA a and b) of the Resident Assessment Instrument (RAI - the combined MDS and RAP assessments) are used to identify areas of a resident's care which have been triggered from the MDS assessment and require further assessment in order to provide an individualized care plan for the resident. Documentation relevant to the assessment information regarding the resident's status should include a description of the nature of the resident's condition, complications and risk factors to use in deciding to proceed with care planning, and factors that must be considered in developing individualized care plan interventions, as well as the possible need for further evaluation by appropriate health professionals. The care planning decision-making column must be completed within 7 days of completing the RAI. Potential problem areas that may trigger on a RAP from an MDS include: 1. Delirium 2. Cognitive loss 3. Visual Function 4. Communication 5. ADL (activities of daily living) functional/rehabilitation potential	F 272	Interdisciplinary team members, As well as members of the quality Assurance committee met and Reviewed all components for Completion of resident's com- Prehensive assessment to insure That all resident's MDSs, RAPs And care plans are coordinated And indicate the resident's current Condition status. All MDSs RAPs Will include the location, date of Documentation and decision to Weather or not to care plan any Triggered problem areas. All resident's care plans will be Reviewed monthly when the Nursing monthly summary is Completed. Any new problem Will be addressed in the care Plan and brought to the attention Of the IDT members as well as The QA committee members for Their review quarterly. ADON/DON will monitor this By doing random weekly audits Of resident's medical records And change of shift reports. so as To ascertain that problems Are being addressed in a proper Manner.	9-9-02

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F 272	Continued From page 6 6. Urinary incontinence and indwelling catheter 7. Psychosocial well-being 8. Mood state 9. Behavioral symptoms 10. Activities 11. Falls 12. Nutritional status 13. Feeding tubes 14. Dehydration/fluid maintenance 15. Oral/dental care 16. Pressure ulcers 17. Psychotropic drug use 18. Physical restraints	F 272		
	1. Review of medical records for resident 11 documented an incomplete RAI assessment, dated 3/10/02, which did not include the location of RAP (Section VAa) assessment documentation and did not include the decision of whether or not to care plan for the triggered problem areas (Section VAb). Problem areas 2, 4, 5, 6, and 8 identified that RAP documentation could be located in "Nurses Notes" but no date was documented to reference any particular note. Further review of the resident's medical record revealed no nurses notes written during the assessment period that provided any summary information regarding the resident's cognitive status, communication, ADLs, continence or mood state.	F272	F272 Resident 11 RAI Assessment of 3-10-02 Reviewed and corrected to include Location and date of RAP assessment documentation as well as decision indicating whether or not to care plan for the triggered problem areas. All problem areas triggered Are assessed in weekly Nurses notes And skin assessment present in Patient chart and overflow charted Completed 9-5-02	9-5-02
	2. Review of medical records for resident 18 documented an incomplete RAI assessment dated 7/12/02, which did not include the dates or location of RAP assessment documentation and did not include the decision of whether or not to care plan for the triggered problem areas. 3. Review of medical records for resident 7	F272	Resident 18 RAI assessment of 7-12-02 Reviewed and corrected to include Dates location of RAP assessment Documentation, as well as including The decision to whether or not to The care plan for the triggered Problem area. All problem areas Triggered are assessed in weekly Nurses notes and skin assessment. Present in patient chart.	9-5-02

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F 272	Continued From page 7 documented an incomplete RAI assessment dated 5/3/02, which did not include the dates of RAP assessment documentation. Problem areas 2, 4, 5, 6, 7, 8, 9 and 11 identified that RAP documentation could be located in "Nurses Notes" but no date was documented to reference any particular note. Further review of the resident's medical record revealed no nurses notes written during the assessment period that provided any summary information regarding the resident's cognitive status, communication, ADLs, continence, mood state, behaviors or falls .	F 272	Resident 7 RAI assessment of 5-3-02 reviewed and corrected to include dates of RAP assessment location in weekly nurses note and skin assessment form sheet, and monthly summery form, Present in patient chart. for the problems areas triggered.	9-5-02
	4. Review of medical records for resident 21 documented an incomplete RAI assessment dated 3/17/02, which did not include the dates of RAP assessment documentation and did not include the decision of whether or not to care plan for the triggered problem areas. Problem areas 2, 5 8, 15 and 16 identified that RAP documentation could be located in "Nurses Notes" but no date was documented to reference any particular note. Further review of the resident's medical record revealed no nurses notes written during the assessment period that provided any summary information regarding the resident's cognitive status, ADLs, mood state, oral/dental care and pressure ulcers.	F272	F272 Resident 21 RAI assessment of 3-17-02 reviewed and corrected to indicate dates of RAP assessment documentation as well as indication Weather or not to care plan for the triggered problem areas. All problems areas triggered are assessed in weekly nurses notes and skin assessment. Present in patient chart.	9-5-02
F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT Within 14 days after the facility determines, or should have determined, that there has been a significant change in the residents physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the	F 274		

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F 274	Continued From page 8 residents status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the residents health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review the facility did not ensure that significant change assessments of residents' needs were completed within 14 days after the facility determined, or should have determined, that there had been a significant change in the resident's physical or mental condition. Significant change assessments were not completed for 1 of 10 sampled residents reviewed. Resident identifier: 21. Findings include: Resident 21 was admitted to the facility on 3/15/01 with diagnoses of Alzheimers dementia with psychotic features, hypothyroidism, hypokalemia, and hypertension. On 8/13/02, and 8/14/02, resident 21's medical record was reviewed. On 3/17/02 an admission comprehensive MDS (Minimum Data Set) was completed for resident 21. On 6/15/02 a quarterly MDS assessment was completed for resident 21. Both of these assessments indicate that resident 21 was independent in ambulation and required limited assistance for eating. Resident 21at time of survey, ambulates short distances with assistance but was mainly using a wheelchair and resident 21 was dependent for eating. These significant changes triggered the need for a comprehensive MDS assessment to be done.	F 274	F274 Resident 's medical record was Reviewed as well as his care Plan and a Significant change In status. Assessment was completed and Submitted to the State resident assessment Dept. His plan of care was updated to Indicate his current condition status. Any significant change in status of Any resident that is identified through Weekly audits of the resident's medical Record and or change of shift reports Will be care planned in that resident's POC. And brought to the attention of Members of the IDT team and QA Committee for their review. A Significant change of status assess-Ment will then be submitted to the State. F 274 In-services presented to nursing staff, IDT Members, as well as Q/A committee members Indicating that a significant change in status Assessment must be submitted to the state Resident assessment dept within 14 days after The facility determines that a significant change In the resident's physical or mental condition has Been determined. The DON and ADON will Ascertain that this is being implemented through Weekly auditing of the resident's medical record Documentation in addition to direct observation Of the resident for any signs or symptoms of a Decline in physical or mental condition 8-21-02	8-21-02

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F 274	Continued From page 9 Resident 21 had a decline in ambulation. A. MDS dated 3/17/02 Section G-1-D (scored as 0, Independent) B. MDS dated 6/15/02 Section G-1-D (scored as 0, Independent) On 8/12/02, 8/13/02, and 8/14/02, resident 21 was observed to be in his wheelchair and recliner chair in his room. He was not observed to be ambulating on the unit. During an interview, on 8/14/02, with DON (Director of Nursing) she stated that resident 21 only walks short distances with help. Resident 21 had a decline in eating. A. MDS dated 3/17/02 G-1-H(scored as 2, limited assistance) B. MDS dated 6/15/02 G-1-H (scored as 2, limited assistance) On 8/12/02, 8/13/02, and 8/14/02, resident 21 was being fed his meals by staff members. Resident 21 was not able to feed himself. During an interview with the LPN (Licensed practical Nurse) working on 8/14/02, she stated that resident 21 hasn't eaten by himself for a very long time, and always requires total assistance to eat. A significant change assessment was not done when resident 21 had a decline in his walking and eating status, as required.	F 274		

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F 279	Continued From page 10	F 279		
F 279 SS=D	483.20(k) RESIDENT ASSESSMENT 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. 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 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). This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility did not ensure that resident comprehensive care plans included services that were to be furnished to attain or maintain the resident's highest practicable physical well being for 1 of 10 sample residents. Resident 21 Findings include: Resident 21 was admitted to the facility on 3/15/01 with diagnoses of alzheimers dementia with psychotic features, hypothyroidism, hypokalemia, hypertension, and benign prostatic hypertrophy. Resident 21's medical record was reviewed on 8/13/02 and 8/14/02 and revealed an annual MDS (minimum data set) dated 3/17/02 and a quarterly MDS assessment dated 6/15/02. The annual MDS resident assessment protocol summary trigger sheet had	F 279	F279 The resident 21 comprehensive care Plan was reviewed and updated so As to clearly indicate any triggered Problem area, care, and services Being provided. Specifically addressed Oral hygiene, need for dental care Including frequent brushing and Brushing especially after every Meal. Also care plan the application Of hand splint to assist in reducing Risk of developing contracture. The DON, ADON Will review and update resident Plan of care on a quarterly basis And or as any problem is identified To assure that all residents receive Appropriate care and services. The QA committee members will Monitor and address any problem Areas Quarterly. CB 9/25/02	8-31-02

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HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 46A068	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 8/14/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOBBLE CREEK CARE CENTER	469 NORTH MAIN SPRINGVILLE, UT 84663

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F 279	Continued From page 11 dentist and that resident 21 had a tooth extracted. On 3/20/02 nurses notes state that resident 21 ..."has severe gum disease"... On 4/3/02 nurses notes state that resident 21 returned from the dentist and one tooth was pulled. On 6/17/02 nurses notes state resident 21 has a swollen right cheek that is bluish with small abrasion marks. On 6/21/02 nurses notes state that resident 21 was transported to the dentist for emergency dental care. Resident 21's care plan does not address resident 21's gum disease, how frequently he needed brushing and flossing provided. On 8/13/02, and 8/14/02, resident 21 was observed to have a contracture on his hand and he had a splint in his room. Resident 21 had an Occupation therapy evaluation on 4/16/02. A hand splint was made. There was no mention of a hand splint in his care plan or giving direction as to when he was to wear the splint and for how long.	F 279		
F 371 SS=D	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 observations made on 8/12/02 and 8/13/02, the facility did not store, prepare, distribute, and serve food under sanitary conditions, as evidenced by kitchen tools, and utensils which were being stored on kitchen cabinet shelves that were worn, water damaged and stained. The outside doors of the kitchen cabinets were, scratched, chipped, worn and unsanitizable. Findings include:	F 371		

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F 371	Continued From page 12 Upper kitchen cabinets: 1. The mixer was being stored on a shelf which was not clean. The bottom of the shelf had a gray buildup visible to the eye. 2. The water flasks were stored on a cupboard shelf which was not clean. The bottom of the shelf had a gray buildup visible to the eye. 3. The food processor was being stored on a shelf which was not clean. The bottom of the shelf had a gray buildup visible to the eye. 4. Kitchen cabinets on the east wall were had dry food spills. When the cabinets were touched by the surveyor to open them, a sticky gray substance was left on her fingers. 5. The kitchen cabinets above the three compartment the doors had cracks and chips. Lower kitchen cabinets: 1. The larger stock pot was being stored on a shelf which had a gray substance on it. 2. Coffee filters were unopened and stored on a shelf which had a gray substance, and food spills and stains on it. 3. Pans were stored on a shelf which had a gray substance, visible to the eye. 4. Cleaning supplies were being stored on a shelf which had spill stains on it. 5. Cabinets below the larger sink were chipped and had dry spills on the doors. The shelves and the south wall had a gray, sticky substance on them. 6. The cabinets along the east wall had a gray, sticky substance on them and the wood was chipped off the doors at the bottom. 7. There was worn particle board shelving in a cabinet along the east wall below the microwave. 8. The cabinets to the east of the kitchen island had a gray, sticky substance and had chipped surfaces along the bottom. 9. The cabinets below the three compartment sink,	F 371	F 371 Food Service Supervisor and Administrator. Consulted with Kitchen staff to point out the Problem areas. On 8-21-02. Kitchen staff started deep Cleaning all kitchen cabinets In and outside. On September 3, 02 QA committee Met. Deficiency presented. Recomm-Endations. Dietician will give in service To kitchen staff 9-9-02. On importance of cleaning kitchen Areas. 2. Cleaning schedule posted in kitchen. Daily cleaning task will be signed off By employee responsible. Monitor By checking schedule and task done Daily. Dietician will do monthly Kitchen inspections. All kitchens Cabinets and shelving will be Refurbished, QA committee will review reports Quarterly.	10/13/02

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F 371	Continued From page 13 were chipped and worn. The cabinet finish was off and unsanitizable. The shelves inside were warped from possible water damage. 10. The cabinet below the coffee preparation area was stained and sticky and the finish was coming off, making the cabinet unsanitizable. 11. The cabinets east of the stove, which wrap around to the open window into the dining room, had a gray, sticky substance and had a worn finish. There were some chipped areas along the bottom. 12. The cabinets on the east wall, below the window, where dirty dishes are returned, had not been washed and had scratch marks from the handle of the garbage can. The doors were chipped and worn. Drawers: 1. The spoon and knife drawers had a visible, sticky gray substance on the inside. When touched by the surveyor, there was a gray material left on her fingers. There were crumbs and spills in the drawer as well. 2. The finish was worn on the outside of the bread drawer. Kitchen Island: 1. Some pots and pans were being stored on shelves that had not been thoroughly washed. 2. Some pots and pans were being stored on a wooden surface that was worn and warped. 2. The outer cabinets were unclean, worn and chipped along the bottom of the doors. Table below the telephone and bulletin board: 1. The legs of the table were unclean, chipped, worn and unsanitizable. 2. The lower shelf of the table had spills and splatters of food substances and stains on it. Stove 1. The bottom portion of the stove, approximately 4	F 371		

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F 371	Continued From page 14 inches high and across the full length of the stove, was not covered. All of the metal, the conduits and the wiring was visible and was covered with a sticky, dusty coating approximately 1/4 inch thick.	F 371	F371 Bottom portion of stove has been cleaned with degreaser New covers are being ordered and will be installed when they are in. CB 9/25/02	9-13-02 10-13-02
F 426 SS=D	483.60(a) PHARMACY SERVICES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview with the director of nursing (DON), it was determined that the facility did not ensure that sliding scale (SS) insulin was documented on the medication administration record (MAR) as being given, as ordered by the physician, for 1 of 2 sample residents on SS insulin. Resident 18 Findings include: Resident 18 was admitted to the facility on 7/16/01 with diagnoses that included insulin dependant diabetes, hypertension and schizophrenia.. A physician order, dated 1/25/02, documented to obtain resident 18's blood sugar (BS) two times daily and administer SS insulin as follows: BS of 150 to 200, 6 units of regular insulin. BS of 201 to 250, 7 units of regular insulin. BS of 251 to 300, 8 units of regular insulin. BS of 301 to 350, 10 units of regular insulin. BS of 351 to 400, 12 units of regular insulin. BS above 400 call MD.	F 426		

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F 426 Continued From page 15

Resident 18's BS for June 2002, that would have required SS insulin and was not documented as being given were as follows:
BS at 4:00 PM on 6/4/02 was 186. BS at 6:00 AM on 6/5/02 was 197 and at 4:00 PM was 195. BS at 4:00 PM on 6/20/02 was 157. BS at 4:00 PM on 6/26/02 was 153.

Resident 18's BS for July 2002, that would have required SS insulin and was not documented as being given were as follows:
BS at 4:00 PM on 7/2/02 was 151. BS at 4:00 PM on 7/3/02 was 163. BS at 6:00 AM on 7/4/02 was 158 and at 4:00 PM was 156. BS at 4:00 PM on 7/5/02 was 158. BS at 4:00 PM on 7/6/02 was 195. BS at 4:00 PM on 7/10/02 was 156. BS at 4:00 PM on 7/11/02 was 191.

Resident 18's BS for August 2002, that would have required SS insulin and was not documented as being given were as follows:
BS at 4:00 PM on 8/6/02 was 159. BS at 4:00 PM on 8/8/02 was 248. BS at 4:00 PM on 8/12/02 was 189.

In an interview with the DON on 8/13/02 at 10:00 AM, she stated that the nurses had been inserviced on the correct administration of SS insulin and that the nurses would document the BS and the amount of SS insulin they gave on the shift report sheets and sometimes would forget to document the SS insulin on the MAR. The DON also stated that the shift report sheets were for her use as an auditing tool and was not part of the residents' medical record.

Review of the shift report sheets for May 2002, June 2002, July 2002 and August 2002, for resident 18, showed the following:

F 426

F426
In-services presented to nursing
Staff indicating policy, procedures,
Expectation require that blood
Glucose levels be done and the
Appropriate sliding scale regular
Insulin dose be administered
As ordered by resident's physician.
Also, that it be properly documented
In the MAR. DON and ADON will
Ascertain that the procedure and document-
Action are being implemented through
Random Daily audits of the MAR
xs 3 weeks. Quarterly review will
also be done by the QA committee.
All nurses received a copy of ad-
Ministration and documentation
Of blood sugar and insulin procedure.
(see attachments)

9/9/02

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F 426	Continued From page 16 May 2002 On 5/25/02 at 4:30 PM, 4 units of SS insulin was documented as being administered for a BS of 162, 6 units should have been administered. On 5/26/02 at 4:30 PM, 4 units of SS insulin was documented as being administered for a BS of 159, 6 units should have been administered. No other documentation was found, for resident 18, on the May 2002 shift report sheets for the missing documentation on the May 2002 MAR. June 2002 No documentation was found, for resident 18, on the June 2002 shift report sheets for the missing documentation on the June 2002 MAR. July 2002 On 7/4/02 at 4:30 PM, 6 units of SS insulin was documented as being administered for a BS of 156. On 7/6/02 at 4:30 PM, 6 units was documented as being administered for a BS of 195. On 7/11/02 at 4:30 PM, 6 units of SS insulin was documented as being administered for a BS of 191. No other documentation was found, for resident 18, on the July 2002 shift report sheets for the missing documentation on the July 2002 MAR. August 2002 On 8/6/02 at 4:30 PM, 4 units of SS insulin was documented as being given for a BS of 159, 6 units should have been administered. On 8/12/02 at 4:30 PM, 4 units was documented as being given for a BS of 189, 6 units should have been administered. No other documentation was found, for resident 18, on the August 2002 shift report sheets for the missing documentation on the August 2002 MAR.	F 426		

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F 494	Continued From page 17	F 494		
F 494 SS=D	483.75(e)(2)-(3) ADMINISTRATION A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of ss483.151-483.154 of this part; that individual has been deemed or determined competent as provided in s483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews and review of employment prescreening records, it was determine the facility used 1 of 5 employees on the sample as a nurse aide for more than 4 months although that individual had not been deemed competent by completing and passing a competency evaluation program. Employee 1 Findings include: The prescreening documentation for new employees was reviewed on 8/13/02. Documentation was reviewed for five of the employees who had been hired between March 2002 and August 2002. It was documented that employee 1 had been employed since 3/27/02. There was no documentation that employee 1 had become a certified nurse's aide. Review of the nurse's aides' schedule from August 4, 2002 until August 17, 2002, documented employee 1 was scheduled as the afternoon aide four days per	F 494	F494 Employee 1 has completed C.N.A. Classes. Has past his skilled test June 2002. Did not pass his written Exam. Retake of written test was Done first part of July 2002, failed Again. Employee 1 took his test Again. Later part of Aug 2002 in Spanish. Currently awaiting re-Sults. Employee 1 was removed From schedule Aug 30 2002. And will not be reschedule Until proof of passing written Test has been acquired. Facility will not hire any direct Care staff that has not Demonstrated competency by Passing the required test for Certification. QA committee Will monitor on a quarterly Basis. CB 9/25/02	9-9-02

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F 494	Continued From page 18 week, August 4, 5, 8 and 10, and then August 11, 13, 14 and 15. The nurse's aides' schedule for the same two weeks documented employee 1 was scheduled eight days, employee 3 was scheduled ten days, employee 4 was scheduled five days, employee 5 was scheduled nine days, employee 6 was scheduled eight days, employee 7 was scheduled nine days, and employee 8 was scheduled nine days. In an interview with the Administrator, on 8/13/02, she stated that she understood the employee had not demonstrated competency by passing the required test. She stated she hadn't considered employee 1 to be a full-time employee because he/she had another primary job.	F 494		
F 496 SS=D	483.75(e)(5)-(7) ADMINISTRATION Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.	F 496	F496 Employee 2 was hired in May 2002 For transportation and restorative. Registry had been called in May Not abuse reported. C.N.A. certification Expired Nov 99. But needed to retake Test. Employee 2 is not performing Restorative duties since 8-19-02 And will not be rescheduled to do So until proof of passing written test Has been acquired. D.O.N. or administrator will Call certification center in Kaysville to verify status Of certification before hiring. Employees data profile is Reviewed by administrator Periodically, Notice is given To staff member before Certification/license will expire. Employees data profile will be Monitored in Q.A. meeting Quarterly. CB 9/25/02	8-19-02

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F 496	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on interviews and review of personnel records, it was determined the facility did not receive registry verification of nurse aide certification for 1 of 5 employees on the sample. Employee 2 Findings include: In an interview with employee 2, on 8/13/02, the employee stated that his/her nurse aide certification had expired and had not yet been renewed. Employee 2 stated that he/she had not been trained or certified as a physical therapy aide, but had previously been trained as a nurse aide. The employee stated that his/her job responsibilities were not related to nurse aide tasks, but that he/she provided restorative and transportation services for the residents. Employee 2 stated the restorative tasks included ambulation and range of motion tasks which required hands on assistance to the residents. Review of a list of employees hired within the previous four months documented that employee 2 had been hired by the facility in May 2002 and that the nurse aide Registry had not been contacted regarding the employees certification prior to his/her active employment. In a call to the nurse aide Registry, on 8/14/02, a registry employee stated that employee 2's certification had expired September 1999. The registry employee stated that employee 2 could not be allowed to perform nurse aide related duties until the employee took and passed the competency test to become recertified.. Review of the regulations for long term care providers documented, 483.75 and "F" tag 493, "Nurse aide	F 496		

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F 496	Continued From page 20 means any individual providing nursing or nursing-related services to residents in a facility who is not a licensed health professional, a registered dietitian, or someone who volunteers to provided such services without pay". Hands-on-care, including range of motion and ambulation training/assistance are nursing related services and must be performed by licensed personnel or nurse aides. In an interview with the facility Administrator, on 8/13/02, she stated that she had not called the Registry before hiring employee 2. She stated that she knew employee 2's certification had expired, but that she had not considered that the restorative tasks were nursing related services.	F 496		