DEPARTMENT OF HEALTH AND HU N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465109	A. BUILDING ___ B. WING ___	10/06/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLADAY HEALTHCARE CENTER	4782 SOUTH HOLLADAY BOULEVARD SALT LAKE CITY, UT 84117

(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 241 SS=E	483.15(a) DIGNITY 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 observations and interviews, it was determined the facility did not ensure care in a manner and a environment that maintained or enhanced resident's dignity and respect in full recognition of his or her individuality. Residents who arrived in dining areas with staff assistance were not served their meals in a timely fashion. These residents were left to wait up to 45 minutes for their meals as residents around them were eating. Findings include: Observations of meal service were made in the, SCU (special care unit) dining room on 10/05/05 and 10/06/05. The following observations were made at the breakfast meals. Residents were observed to enter the dinning room with the assistance of staff. No resident entered independently. Staff was observed to serve the meal to resident tables in random order, without regard to the amount of time residents had been waiting. On 10/05/05 at 7:30 AM, 17 residents were observed seated in the dining room at various tables. Staff members had assisted all of those residents into the dining room. There were no offers of juice or snacks to the residents. At 7:50	F 241 10/31/05 POC acceptable completion date 11/23/05 (Bramburk) RN	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Corrective Action for identified residents** Residents in the SCU dining room are now being served their meals in a timely manner. **Identification of Residents potentially affected** All SCU residents have the potential to be affected **Measures to prevent recurrence** "Hush no Rush" dining (see attached) will be initiated on the SCU by November 14th. Food will be served in the dining room directly from a steam table over a period of 2 hours. Residents will be assisted to the Dining Room at their leisure and receive a hot meal of their choice. The Dietary Services Manager will initiate a Performance Improvement (Quality Assurance) team who will instruct and assist SCU staff in the new dining program. Department managers will supervise the dining room daily. **Monitoring and Quality Assurance** The Dietary Services Manager will audit progress daily for one week and weekly for 3 months and report monthly to the Performance Improvement (Quality Assurance) Committee. Audits and reports may continue as directed by the Committee. Continued compliance will be the responsibility of the Dietary Services Manager.	Nov 23, 2005

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anita J. Stevens — TITLE: Executive Director — (X6) DATE: 10-27-05

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.

Utah Department of Health
PM OCT 27 05

OCT 28 2005
Bureau of Health Facility Licensing, Certification and Resident Assessment

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F 241	Continued From page 1 AM eight more resident were brought into the dining room. Some of the comments made by the residents and over heard by the surveyors included statement such as "I'm hungry", "Is the food frozen to the trees", and "I'm too hungry to eat". In an interview on 10/05/05 with a staff member in the dining room she stated that the breakfast meal usually arrives around 8 AM and "rarely" comes at the time posted. The posted meal times were listed as: SCU-self dining 7:15 AM SCU-assisted 7:30 AM At 7:55 AM there were 29 residents seated in the dining room. The first tray was served at 8 AM. On 10/6/05 at 7:30 AM there were 26 residents seated in the SCU dining room. The first meal tray was served at 7:40 AM.	F 241	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's 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 resident's health status, and	F 274	**Corrective Action for identified residents** Resident 10 has had a Significant Change MDS completed with and ARD of 10/11/05 **Identification of Resident s potentially affected** All residents with a Significant Change of Condition have the potential to be affected	

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F 274	Continued From page 2 requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility did not complete a significant change Minimum Data Set (MDS) assessment for 1 of 15 sample residents (resident 10) who had been documented by the facility as having a significant change in status. Findings include: 1. Resident 10 was admitted to the facility on 11/23/04 and then re-admitted to the facility on 4/11/05 with diagnoses which included rheumatoid arthritis, pain, peptic ulcer and osteoporosis. On 4/8/05, a significant change MDS was completed for resident 10. On 6/18/05, a quarterly MDS was completed for resident 10. A comparison of the two assessments documented a significant change in the resident's condition. These significant changes triggered the need for a comprehensive MDS assessment to be done. The areas that documented significant change included: Resident 10 had a documented decline in Cognitive Skills for Daily Decision Making:	F 274	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Measures to prevent recurrence** The District Director of Utilization Services will in-service the team, responsible for completion of the MDS, on criteria for significant change in the resident's mental and physical condition. **Monitoring and Quality Assurance** For a period of 1 month the Director of Nursing or designee will review and audit all MDS's for accuracy, utilizing the Comparison reports from the facility computer system, to clarify changes that may constitute a significant change in condition. The results of the audits will be brought to the Performance Improvement (Quality Assurance) Committee for review. Audits and reports may continue as directed by the Committee. Continued compliance will be the responsibility of the Director of Nursing Services.	Nov 23,2005

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F 274	Continued From page 3 a. MDS (4/8/05) Section B4 (1= Modified Independence) b. MDS (6/21/05) Section B4 (2= Moderately Impaired) Resident 10 had a documented decline in Mood Persistence: a. MDS (4/8/05) Section E2 (1= Indicators present, easily altered) b. MDS (6/21/05) Section E2 (2= Indicators present, not easily altered) Resident 10 had a documented decline in Socially Inappropriate/Disruptive Behavioral Symptoms: a. MDS (4/8/05) Section E4d (0= Behavior not present OR behavior was easily altered) b. MDS (6/21/05) Section E4d (1= Behavior was not easily altered) On 9/6/05, another quarterly MDS was completed. The MDS indicated the same significant changes as the 6/21/05 MDS. On 10/6/05 at approximately 10:00 AM, the ADON (assistant director of nurse) reviewed resident 10's medical record. She stated that she did not know why resident 10 did not trigger for a significant MDS back on the 6/21/05 MDS. She further stated that they just completed a significant MDS for resident 10.	F 274	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status.	F 278		

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F 278	Continued From page 4 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, it was determined the facility did not ensure the Minimum Data Set (MDS) assessments accurately reflected residents' status for 3 of 15 sampled residents. Specifically, for 2 of the resident's (resident 4 and 7) facility staff documented that the resident's had had a UTI (urinary tract infection) in the last 30 days. In addition, resident 10's MDS was signed	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Corrective Action for identified residents** The MDS for residents 4, 6 (please note resident 7 is entered in the last paragraph on page 5 of the CMS 2567L in error) have been reviewed and Modification MDS's for item coding errors were submitted to the state on 10/14. The RN Coordinator (DNS) will evaluate the MDS completed on resident #10 on 9/6/05 for accuracy of information by disciplines signing on 9/7/05. Any inaccuracies will be corrected by modification MDS with the R2b date corrected to the date of completion of the re-evaluation and signature by RN Coordinator. If there are no inaccuracies identified, only the R2b date will be modified. Validation of correction will be through Validation Report printed verifying acceptance of the Modification MDS. **Identification of Resident s potentially affected** All residents have the potential to be affected **Measures to prevent recurrence** The District Director of Utilization Services will in-service the team, responsible for completion of the MDS, on the criteria for accuracy when completing assessments.	

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F 278	Continued From page 5 by facility staff after the RN (registered nurse) signed the MDS as being completed. Findings Include: 1. Resident 4 was admitted to the facility on 10/19/03 with diagnoses which included diabetes mellitus, congestive heart failure, osteoporosis and chronic UTI. On 10/5/05, resident 4's medical record was reviewed. On 7/26/05, resident 4 had a quarterly MDS completed which documented that resident 4 had had a UTI in the last 30 days. A review of the medical record revealed that resident 4 had not had a UTI since 1/13/05. On 10/5/05 at approximately 11:00 AM, a facility nurse reviewed resident 4's medical record. The facility nurse stated that resident 4's last UTI was 1/13/05. On 10/6/05 at approximately 10:00 AM, the ADON (assistant director of nurses) reviewed resident 4's medical record. The ADON stated that resident 4's last UTI was 1/13/05. 2. Resident 6 was admitted to the facility on 9/26/04, with diagnoses which included neurogenic bladder, deep vein thrombosis, osteoporosis, seizure disorder and renal failure. On 10/5/05, resident 6's medical record was reviewed. On 8/29/05, resident 6 had an annual MDS completed which documented that resident 6 had	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Monitoring and Quality Assurance** For a period of 1 month the Director of Nursing or designee will audit and review all MDS's for accuracy. The results of the audit will be brought to the Performance Improvement (Quality Assurance) Committee for review. Audits and reports may continue as directed by the Committee. Continued compliance will be the responsibility of the Director of Nursing Services.	Nov 23, 2005

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F 278	Continued From page 6 had a UTI in the last 30 days. A review of the medical record revealed that resident 6 had not had a UTI since 5/18/05. On 10/6/05 at approximately 10:00 AM, the ADON reviewed resident 6's medical record. The ADON stated that resident 6's last UTI was 5/18/05. 3. Resident 10 was re-admitted to the facility on 4/11/05 with diagnoses which included rheumatoid arthritis, pain, peptic ulcer and osteoporosis. On 10/6/05 resident 10's medical record was reviewed. On 9/6/05, resident 10 had a quarterly MDS completed. On 9/6/05, under section R2, the RN (registered nurse) signed that the MDS was completed on 9/6/05. Under section AA9, two facility staff signed that they completed their sections of the MDS on 9/7/05, a day after the RN signed the MDS as being completed. On 10/6/05 at approximately 10:00 AM, the ADON reviewed resident 10's medical record. The ADON stated the on the 9/6/05 quarterly MDS two facility staff members signed after the RN signed the MDS as being complete.	F 278	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 371 SS=E	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions.	F 371		

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F 371	Continued From page 7 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 included: The following observations were made on 10/6/05 at 6:55 AM. Refrigerator at Main Floor Nursing Station: 1. Four mighty shakes, which were labeled with a "use by" date of 10/1. 2. A container of apple sauce, which was labeled with a "use by" date of 10/5. 3. Four "baggies" of chips on top of the refrigerator, which were labeled with a "use by" date of 10/4. 4. A "baggie" of animal cookies, which was labeled with a "use by" date of 9/27. Refrigerator at the Second Floor Nursing Station: 1. Two containers of cottage cheese, which were labeled with a "use by" date of 10/4. 2. A container of apple sauce, which was labeled with a "use by" date of 10/4. 3. One mighty shake, which was labeled with a "use by" date of 10/5. 4. An opened bottle of Pepsi, which was not labeled or dated.	F 371	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Corrective Action** All food with expired dates has been removed from both refrigerators. **Identification of Resident s potentially affected** All residents have the potential to be affected **Measures to prevent recurrence** The dietary aides check refrigerators daily for expired food. Each evening when the dietary aide brings newly prepared snacks to the units they remove all foods that will expire by midnight. **Monitoring and Quality Assurance** Refrigerators at the nurse's stations will be audited daily by the Dietary Services Manager or designee for 2 weeks and then weekly for 2 months and spot checks will be performed by department heads monthly for 3 months. The results of the audit will be brought to the Performance Improvement (Quality Assurance) Committee for review. Audits and reports may continue as directed by the Committee Continued compliance will be the responsibility of the Dietary Services Manager.	Nov 23, 2005

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F 426 SS=D	483.60(a) PHARMACY SERVICES - PROCEDURES 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 record review and staff interview it was determined that the facility staff did not ensure that pharmaceutical services, including procedures to assure the accurate dispensing and administering of all drugs were met for 1 of 15 sampled residents (Resident 6). Specifically, residents 6 did not receive an antibiotic for as long as it was ordered and received pyridium longer than it was ordered. Findings Include: 1. Resident 6 was admitted to the facility on 9/26/04, with diagnoses which included neurogenic bladder, deep vein thrombosis, osteoporosis, seizure disorder and renal failure. A review of resident 6's medical record and MAR (medication administration record) was completed on 10/5/05. A physician order from the emergency room, dated 5/18/05, documented the following, "...Amoxicillin 500 mg (milligrams) 1 po (by mouth) [every] 8 hrs (hours) no. (number) 30..." Based on the emergency room order resident 6	F 426	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Corrective Action for identified residents** The Utilization Coordinator reviewed the Medication Administration Record of resident 6 on 10/26. All medications are now being given as ordered. **Identification of Resident s potentially affected** All residents have the potential to be affected **Measures to prevent recurrence** All Licensed Nurses will be inserviced by Nov 3, 2005 by the Director of Nursing or designee on accurate transcription of physician orders. Medical Records will do a daily review of all new orders to check for accurate transcription for 1 month. **Monitoring and Quality Assurance** The Unit Managers will audit new orders weekly for one month and monthly for 3 months. The results of the audit will be brought to the Performance Improvement (Quality Assurance) Committee for review. Audits and reports may continue as directed by the Committee Continued compliance will be the responsibility of the Director of Nursing Services.	Nov 23, 2005

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F 426	Continued From page 9 should have received the Amoxicillin every 8 hours for 10 days. On 5/23/05, the nurse practitioner documented the following in a progress note, "...Amox. (amoxicillin) 500 [every] 8 [hours] [times] 10 d(days)..." Resident 6's May 2005, MAR was reviewed and provided documented evidence that resident 10 had received Amoxicillin every 8 hours, from 5/18/05 at midnight until 5/25/05 at 4:00 PM (6 days). A physician order from the emergency room, dated 5/18/05, documented the following, "...Pyridium 200 mg # (number) 12 [one] PO (by mouth) [every] 6 h (hours) for urinary pain..." Based on the emergency room order resident 6 should have received the pyridium every 6 hours for three days. On 5/23/05, the nurse practitioner documented the following in a progress note, "...Pyridium, 200 [every] 6 [hours] [times] 6 days..." Resident 6's May 2005, MAR was reviewed and provided documented evidence that resident 10 received Pyridium, every 6 hours, from 5/18/05 at midnight until 5/31/05 at 2:00 PM (12 3/4 days).	F 426	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502		

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F 502	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined that the facility did not ensure that timely laboratory services were provided, as ordered by physicians, for 1 of 15 sample residents. Specifically, the facility did not ensure that adequate monitoring of anticoagulation therapy was done as ordered for one sampled resident (resident 6). Coumadin is an oral anticoagulant used to control and prevent blood clotting disorders. Prescribing the dose that both avoids bleeding complications and achieves therapeutic range of clotting times requires monitoring through laboratory tests. The protime (PT) is a laboratory test used to monitor blood clotting in a specific individual. (Reference Guide: Brunner and Sarddarth's textbook of Medical-Surgical Nursing 8th Edition 1996 Lippincott pages 802-803.) Findings include: 1. Resident 6 was admitted to the facility on 9/26/04, with diagnoses which included neurogenic bladder, deep vein thrombosis, osteoporosis, seizure disorder and renal failure. Resident 6's medical record was reviewed on 10/5/05. A review of resident 6's medical record revealed that resident 6 was taking coumadin. On 5/22/05, facility staff obtained a PT/INR lab. The PT was 26.6 which the lab indicated was "High" and the INR was 3.151 which the lab indicated was "critical high".	F 502	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Corrective Action for identified residents** Since 5/23All laboratory tests for resident 6 have been provided as ordered. Results are in the medical record. **Identification of Resident s potentially affected** All residents have the potential to be affected **Measures to prevent recurrence** All nurses will be inserviced by Nov 3, 2005 by the Staff Development Coordinator on the Lab system. The system will assure Physician orders are completed and transcribed appropriately. The Laboratory will be notified and specimens will be collected timely. Receipt of laboratory results will be documented and reported to the physician within the designated time frame. **Monitoring and Quality Assurance** The Laboratory system will be audited by the Director of Nursing or designee daily for 2 weeks and weekly for 3 months. The results of the audit will be brought to the Performance Improvement (Quality Assurance) Committee for review. Audits and reports may continue as directed by the Committee Continued compliance will be the responsibility of the Director of Nursing	Nov 23, 2005

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465109	A. BUILDING ____ B. WING ____	10/06/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 502	Continued From page 11 On 5/23/05, the physician ordered to hold resident 6's coumadin and to "...re[check] PT/INR tonite [sic]..." There was no evidence in the medical record of resident 6 to evidence that the PT/INR was rechecked as ordered by the physician on 5/23/05. On 10/6/05 at 9:30 AM, the ADON (assistant director of nurses) was interviewed. She stated that she was not able to find the Recheck of the PT/INR ordered on 5/23/05.	F 502	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514	**Corrective Action for identified residents** Resident 6's urinary output from the supra pubic catheter is now documented daily in the medical record. **Identification of Resident s potentially affected** All residents with orders for monitoring output have the potential to be affected	

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F 514	Continued From page 12 Based on medical record review, it was determined that the facility did not maintain clinical records on each resident in accordance with accepted professional standards and practices that were complete, accurately documented and readily accessible. Specifically, 1 of 15 sample residents (resident 6) had a medical record that was not readily accessible. Findings include: Resident 6 was admitted to the facility on 9/26/04, with diagnoses which included neurogenic bladder, deep vein thrombosis, osteoporosis, seizure disorder and renal failure. A review of resident 6's medical record was completed on 10/5/05. On 9/26/04, a physician's order was written to monitor resident 6's output every shift and to get a 24 hour total. This order was continued every month on the re-certification orders. The 10/5/05, resident 6's May 2005 "Treatment Record" was reviewed. There was no documentation of any outputs. The "Treatment Record" documented the following regarding shift outputs and 24 hour totals, "...see v/s (vital sign) tracking sheets. On 10/6/05 at 8:00 AM, the ADON (assistant director of nurses) provided the nurse surveyor with the vital sigh sheets from 5/12/05 until 5/17/05. She stated she was not able to locate any other vital sign sheets for the month of May 2005. Upon review of the vital sign sheets from 5/12/05	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Measures to prevent recurrence** The system for maintaining medical records will be reviewed by the Director of Nursing and all information from work sheets will be transcribed into the patient specific medical record daily. **Monitoring and Quality Assurance** All Licensed nurses will be inserviced by November 3, 2005 by the Staff Development Coordinator or designee on appropriate medical record documentation. Audits will be done by the medical records department daily for one week and weekly for two months. The results of the audit will be brought to the Performance Improvement (Quality Assurance) Committee for review. Audits and reports may continue as directed by the Committee Continued compliance will be the responsibility of the Director of Nursing Services.	Nov 23, 2005

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F 514	Continued From page 13 until 5/17/05, it was determined that facility staff were documenting outputs for three residents that were not admitted to the facility until the end of July 2005 and August 2005. On 10/6/05 at approximately 1:45 PM, the documentation of the outputs for the residents in May 2005 was brought to the attention of the DON (director of nurses) and administrator. The administrator stated the following regarding the vital sign sheets, "Appears as though they took a used sheet and added information for your benefit." The DON stated that when she started a bag of medical record papers was handed to her and she took the bag down to medical records to go through.	F 514		

Kindred Healthcare

Hush No Rush Dining Service

Rationale

Hush No Rush Dining Service allows resident to awaken according to their natural biological clock. It may be effective in decreasing challenging behaviors exhibited by resident with dementia and may positively effect ADLs.

Minimum Criteria for Marketing

A minimum of 25% of the total resident population participates in the service or 75% or more on a single nursing unit.

Guidelines

1. Keep the lighting in the Nursing Center or unit dimmed until approximately 9:00 am.
2. Keep the noise on day shift to a minimum through 9:00 am.
3. Arouse residents who have not awakened at approximately 8:00 am.
4. Assist resident with a.m. care in a calm, quiet manner as the resident awakens.
5. Escort the resident to the assigned dining area and offer a beverage (i.e., coffee, tea, juice, etc.), once a.m. care is complete.
6. Notify the Dining Services Department to prepare the resident's breakfast, as the resident enters the dining area.
7. Serve breakfast on the planned menu until approximately 9:00 a.m. Offer an alternate between approximately 9:00 am and 11:30 am.
8. Offer resident a nourishing bedtime snack.
9. Participation in the Hush No Rush dining service is assessed by the interdisciplinary team and documented on the resident's plan of care.
10. Re-assessment and effectiveness of participating in the Hush No Rush dining service quarterly or more frequently as deemed necessary by the interdisciplinary team.
11. If the service is not beneficial to the resident, the service is discontinued.

Adapted from Nampa Care Center.