STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465101	A. BUILDING _____ B. WING _____	6/4/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURRICANE REHABILITATION CENTER Revised 2567 after IDR	416 NORTH STATE HURRICANE, UT 84737

(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 253 SS=E	483.15(h)(2) ENVIRONMENT The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations it was determined the facility did not provide maintenance services necessary to maintain a sanitary interior for two of three common shower rooms. Findings include: On 6/4/03, three shower rooms were observed. The shower heads in the two common showers on the south side of the facility had hoses that were long enough for the shower head to reach the floor. Neither shower had the required vacuum breaker to prevent the back flow of water and bacteria into the shower head.	F 253	Note: I have blacked out a reference to a state official and anywhere that the amendment has superceded the original plan of correction, I have highlighted in grey. F 253 No residents were affected. On 6-09-03 Maintenance Supervisor purchased three shower head vacuum breakers. He installed two breakers and kept one on hand for future use. All long shower hoses are now protected from any back flow into the shower head. NO AMENDMENT NECESSARY	6/9/03
F 278 SS=B	483.20(g) - (h) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. 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	F 278	F278 6-17-03 MDS review form was developed ([redacted]). Nurse on duty to be used at the following times will complete this form: ▪ Upon admission to facility ▪ Upon Re admission to facility ▪ Quarterly ▪ Annually ▪ 5 Day MDS/Medicare Resident ▪ 30 Day – 60 Day – 90 Day Utah Dept. of Health 9-18-3CR SEP 22 2003 Bur of Medicare/Medicaid Certification	7/22/03

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/15/03

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

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F 278	Continued From page 1 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 Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or 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 observation, it was determined the facility did not ensure the Minimum Data Set (MDS) assessments accurately reflected residents' status for 4 of 10 sample residents, (resident 17, 18, 29 and 34). The facility did not ensure that the assessments were accurate before the registered nurse had signed and certified the assessments were complete. Findings include: 1. Resident 18 was an 89-year-old male who was admitted to the facility on 4/19/03 with diagnoses which included cerebrovascular disease, dementia, glaucoma and hypothyroidism. Resident 18 was observed on 6/2/03, 6/3/03 and 6/4/03, nurse aide's, who provided direct care for resident 18, were interviewed, and the resident's medical record was reviewed on 6/4/03. a. Two nurse aide's who provided the direct care for resident 18 were interviewed on 6/4/03. The nurse aides stated that resident 18 had good range of motion and that they worked with him to maintain it. b. The nurse aide's charting for resident 18's activities	F 278	MDS/Medicare Resident MDS Coordinator / DON will review MDS review form on a weekly basis. MDS Coordinator / DON will place a monthly summary of MDS review forms in the IDT book. A copy of the MDS review form will be placed in all resident charts next to the MDS. MDS Coordinator / DON has scheduled a review of the MDS with [redacted] on 6-23-03 at 10:00 am via telephone at which time all sections of the MDS will be reviewed. Therapy will provide a weekly report of minutes and treatments on all residents receiving therapy. The therapy report of minutes and treatments will accompany the MDS in the care plan section of the resident chart. Residents affected will be reviewed following DON meeting with [redacted] The new MDS review forms will be filled out and corrections will be made. As stated earlier all other residents with the potential to be affected will be updated as their next assessment date becomes due.	

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F 278	Continued From page 2 of daily living, dated 4/21/03 through 5/31/03, documented that resident 18 had multiple episodes of urinary incontinence daily. There was no section for documenting if resident 18 was continent of bowel. The nurse aides stated, during the interviews, that resident 18 was basically incontinent of bowel and urine although he did have some response to their efforts to assist him to toilet. c. The nurse's note, dated 4/23/03 at 2:30 AM, documented resident 18 had been found on the floor. d. The physical therapist's records documented that resident 18 had been treated on 4/24/04 for 60 minutes, on 4/25/03 for 50 minutes, on 4/28/03 for 50 minutes, on 4/29/03 for 50 minutes, and on 4/30/03 for 50 minutes, for a total of 5 days and 260 minutes during the assessment period. e. No records were located for the amount of time occupational therapy had worked with resident 18, but there was a physician's order, dated 4/19/03, for the resident to be treated by occupational therapy for 5 days per week for the next 30 days. f. The recreation director was interviewed on 6/3/03. The recreation director stated that if she documented a resident watched television, it would have been for a period of one hour or two hours. It was documented on the recreation director's activity log for resident 18 that, for 3 of the 7 days during the observation period, the resident did not attend any activities, on 4/26/03, 4/27/03, and 4/30/03. It was documented that, on 4/24/03 and 4/25/03, resident 18 watched television and sat passively during an exercise activity. On 4/28/03, resident 18 watched television and participated in an exercise activity. On 4/29/03, it was documented that resident 18 watched television.	F 278	[redacted] A review of the MDS with the MDS Training Coordinator was conducted on 06/23/03 A new MDS review form will be developed, and a schedule will be made by DON or designee by 07/15/03 to review and make corrections as needed on MDS for residents affected in the deficiency. An audit tool will be developed by DON or designee by 07/15/03 for random audits of MDS. Audits will be conducted by DON or designee weekly x 4 and randomly thereafter. Audits will be reviewed in weekly QA meetings x 4 weeks and then randomly thereafter. First QA meeting scheduled 07/22/03.	

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F 278	Continued From page 3 g. The April 2003 medication administration record (MAR) for resident 18 documented the resident had an order for an antipsychotic medication to be given as needed and that none had been given to the resident. h. The April 2003 MAR for resident 18 documented the resident had received an antidepressant medication each of the 7 days of observation. i. The history and physical and the nurses' notes in resident 18's medical record documented the resident was admitted following a hospital stay, but no other hospital stays were documented since he had been admitted to the facility. j. A physician's order, dated 4/30/03, changed resident 18's medication regimen. Three medications were discontinued and a new medication was ordered. The comprehensive MDS assessment for resident 18, dated 4/30/03, documented: a. Section G4, Functional Range of Motion - Resident 18 had impaired range of motion, that interfered with daily functions, of his left and right arms, hands, legs and feet and of his neck and that the resident had other limitations or loss. b. Section H1, Continence in last 14 days - Resident 18 had complete control of bowel and only occasional, less than once per week, incontinence of urine. c. Section J4, Accidents - Resident 18 had not fallen in the past 180 days. d. Section P1 c A and B, Physical Therapy - Resident 18 had been seen by physical therapy only 3 days for a total of 170 minutes e. Section P1 b A and B, Occupational Therapy - Resident 18 had been seen only 2 days for a total of 85 minutes.	F 278		

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F 278	Continued From page 4 f. Section N2, Average Time Involved in Activities - Resident 18 spent most, more than 2/3 of his time in recreational activities. g. Section O4 a, Medications, Antipsychotics - Resident 18 received an antipsychotic on 1 of the 7 days of observation. h. Section O4 b, Medications, Antidepressant - Resident 18 had received an antidepressant only 5 of the 7 days of observation. i. Section P5, Hospital Stays - Resident 18 had been admitted to a hospital once since his last assessment. Resident 18's last assessment was dated 4/19/03. j. Section P8, Physician orders - There had been no physician ordered changes for resident 18 after he was admitted. 2. Resident 17 was an 85-year-old female who was admitted to the facility in October 2000 with diagnoses which included intertrochanteric fracture, hard of hearing, dementia and osteoporosis. a. Resident 17 was observed on 6/3/03, from 12:00 PM to 12:25 PM, to be an independent resident with a kyphotic spine and some limitation of range of motion in her neck. No other contractures were observed as the resident moved about in her room. Resident 17 was observed on 6/4/03 to have functional range of motion of both arms and hands when she was observed propelling her wheelchair in the hallway. b. The medical record for resident 17 was reviewed. The quarterly progress note, dated 4/15/03 and signed by the resident representative and the licensed clinical social worker, documented that the resident stayed in her room most of the time. It was also documented that the resident "does not participate in activities or socialize with anyone." The quarterly MDS assessment for resident 17, dated	F 278		

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F 278	Continued From page 5 4/15/03, documented: a. Section G4, Functional Range of Motion - The resident had impaired range of motion, that interfered with daily functions, of her left and right arms, hands, legs and feet as well as her neck and other limitations or loss (spine). b. Section N2, Average Time Involved in Activities - The resident spent most, more than 2/3 of her time in recreational activities. 3. Resident 29 was admitted to the facility on 2/9/98 with diagnoses of profound mental retardation, seizure disorder and depression. Resident 29's medical recorded was reviewed on 6/3/03. The annual MDS assessment for resident 29, dated 1/3/03, documented: a. SECTION K., ORAL/ NUTRITIONAL STATUS, 2. b. and 3. a., The resident had experienced a 5% or more weight loss over a one month period. Weight for 1/2/03 was 186 pounds and for 3/25/03 it was 184 pounds, which was a 2% weight loss. Nutrition Assessment, dated 3/14/03, documented weight change down 2 pounds, okay and food intake usually good. Observation, on 6/3/03, during lunch resident 29 consumed 83% of the meal. Observation, on 6/4/03, during breakfast the resident consumed 90% of the meal. Resident 29's MDS, Section N., ACTIVITY PURSUIT PATTERNS, 2., 0., average time involved in activities, The resident was involved in activities most-more than 2/3 of time.	F 278		

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F 278	Continued From page 6 Observations of resident 29 as listed; 6/2/03 at 7:30 PM, lying in bed with light off, 6/3/03 at 2:00 PM and 3:15 PM, lying on bed with eyes closed, 6/4/03 at 9:30 AM and 1:45 PM, lying on bed with eyes closed, 6/4/03 at 11:00 AM sitting in wheel-chair in resident room, and at 3:30 PM sitting in wheel- chair at nurses station. 4. Resident 35 was admitted to the facility on 4/19/03 and discharged on 5/13/03. Admitting diagnoses was right leg above the knee amputation (AKA), muscular dystrophy, cerebral vascular accident and diabetes. Resident 35's medical record was reviewed on 6/4/03, The resident was admitted for rehabilitation after having a AKA. Resident 35's admission MDS assessment, dated 4/22/03, documented: a. SECTION K., ORAL/ NUTRITIONAL STATUS, 2. b. and 3. a., The resident's weight was 156 pounds, and 5% or more weight loss over a one month period. A fourteen day Medicare assessment, dated 5/1/03, documented resident weight was 153 pounds, this would be a 3% weight loss. Weight Record and Vital Signs documented on 4/19/03 resident 35 weighted 165 pounds, on 4/27/03 weight was 167 and on 5/03 weight was 171. Activity Assessment and Care Plan, dated 4/19/03, documented resident 35 was weak and not interested in activities or watching T.V. The nurses' notes from admit to discharge documented resident 35 spent most of time in the resident's room visiting with spouse.	F 278		

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F 278	Continued From page 7 5. The charge nurse, who had been overseeing care for all of the residents, was interviewed on 6/4/03. The charge nurse was asked if she actively participated in the MDS assessments. The charge nurse stated that she thought her nurse's notes were used, but that she was not personally asked about the resident's for their MDS assessments. The Director of Nursing (DON) was interviewed on 6/3/03 and 6/4/03. The DON stated that she was the one who documented the MDS assessments. When the DON was asked questions about the residents' status, the DON stated she was not the person to ask because she didn't provide cares for the residents. The DON stated that the charge nurse and the aides were the ones who knew about the residents. The DON stated she got her information about the resident's from their medical records documentation.	F 278		
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations of the kitchen, it was determined the facility did not store food under sanitary conditions. Findings included: On 6/2/03 at 7:30 PM the following items were found in the reach in refrigerator located in the kitchen: 1. a container with whitish colored meat with no label or date 2. a container of noodles in yellow liquid with no label or date 3. a container of coleslaw dated 4/25/03 (38 days)	F 371	F371 No Residents were affected On 6-3-03 both the reach in refrigerator and the walk in refrigerator were cleaned out. All food found in these refrigerators as of 6-3-03 was labeled and dated appropriately. On 6-3-03 all cooks were contacted and in serviced on labeling and dating of food items and regulations relating to safe food storage. [redacted] A fridge cleaning log will be posted in the Kitchen. All items will continue to be labeled and dated per regulations. 6-4-03 Dietary Supervisor will conduct weekly rounds on refrigerators to monitor labeling and dating of food items per regulations. 6-4-03 Administrator will do rounds on refrigerators periodically to monitor labeling and dating of refrigerator per regulations.	7/22/03

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F 371	Continued From page 8 4. a pitcher of red liquid with no label or date 5. a bag of carrots not dated 6. a large container of lemon juice not dated 7. a jar of mustard dated 2/14/02 (1 year and 108 days) 8. a container of parmesan cheese not dated 9. a block of cheddar cheese not dated 10. ¼ head of lettuce not dated 11. ½ loaf of bread with no date 12. 3 eggs sitting on the shelf not labeled or dated 13. a pitcher of prune juice not dated 14. a jar labeled as containing maraschino cherries with a thick purple substance in it not dated or labeled correctly 15. 46 ounce jar of dill pickle chips not dated 16. a container of ketchup not dated 17. a container of lemon juice dated 9/30/02 (9 months) 18. 4 pieces of yellow cheese-half covered in clear wrap not labeled or dated 19. a 30 ounce container with 30 ounces of a yellow jelled substance in it not dated or labeled 20. a container of nondairy dessert topping not dated 21. a plastic bag with ½ of a dried up cucumber in it not dated 22. 4 - 1 pound stacks of yellow cheese covered in clear wrap not labeled or dated 23. ½ green pepper not labeled or dated 24. ½ tomato not labeled or dated 25. 50 individual butter patties left uncovered and undated 26. a container of chocolate pudding dated 3/26/03 (68 days) 27. 1 gallon of Italian dressing not dated 28. 2 opened containers of 32 ounces of dried yeast dated 10/15/01 (2 1/2 years) An interview with the dietary manager was held on 6/3/03 at 09:30 AM. When asked about the labeling	F 371	AMEN[redacted] An audit tool will be developed by Dietary Manager or designee to audit items in fridge for dates and labeling of the food by 06/24/03. Audits will be conducted by Dietary Manager or designee bi-weekly x 2 and weekly thereafter. Audits will be reviewed in weekly QA meeting x 8 and quarterly thereafter in the quarterly QA meeting. First QA meeting scheduled 07/22/03.	

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F 371	Continued From page 9 and dating of food left in the reach in refrigerator the dietary manager stated that she was caught with her "pants down" and that they were short of help in the kitchen lately. When asked about the use of leftover foods in the reach in refrigerator the dietary manager stated that leftovers are suppose to be thrown out after "24 hours." Ready to eat, potentially hazardous food prepared and held refrigerated for more than 24 hours in a food establishment shall be clearly marked at the time of preparation to indicate the date by which the food shall be consumed which is, including the day of preparation: 4 calender days or less from the day the food is prepared, if the food is maintained at 45 degree Farenheit or less. Reference Guidance: US Public Health Service FDA 2001 Food Code, page 69.	F 371		
F 463 SS=D	483.70(f) PHYSICAL ENVIRONMENT The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and interview the facility was not equipped to receive resident calls through a communication system from 2 of 22 occupied residents' rooms. Resident rooms 12 and 21 were missing call lights and resident room 21 had a second call light that was nonfunctioning. Findings include: 1) Observations: a) On 6/4/03 at 10:30 AM room 12 was observed to be occupied by two residents. It was observed that	F 463	F 463 No residents were affected. When administrator was made aware of call lights unavailable for two rooms, resident in B bed was immediately moved (on 6-4-03) to room 17 C bed, which has working call light. On 6-04-03, administrator was able to repair call light in room 21 by replacing the single call light beds B & C shared with a call light splitter so that each bed had a long call light cord available to each bed and each resident. On 6-03-03, administrator had gotten approval from regional vice president to purchase additional upgrades for call light system. The order for parts and supplies was placed on 6-04-03 and the parts were received by Hurricane Rehab. Center on 6-9-03 and installed on 6-10-03. All call lights including the B bed in room 12 are currently installed and functional.	7/22/03

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F 463	Continued From page 10 only one call light receptacle was in the room. There was no call light available for the resident in "B" bed. b) On 6/4/03 at 11:00 AM, the other residents' rooms were checked for working call lights. Room 21 was observed to have four occupants and only three call lights. There was no call light available for the resident in bed C. The resident in room 21, bed B, stated that his call light did not work. The surveyor and a nurse aide attempted to activate the call light for the resident in bed B. The call light did not activate on five of seven attempts. 2) Interview: a) On 6/4/03 at 10:40 AM the facility maintenance manager was interviewed in the hallway outside of room 12. The maintenance manager stated room 12 had only one call light receptacle in the room. In the past room 12 was a private room.	F 463	AMEN [redacted] An audit tool will be developed by Administrator or designee to audit the calling light system by 7/15/03. Weekly audits will be performed weekly x 2, and monthly thereafter by Maintenance Director or designee. Audits will be reviewed weekly x 2 and quarterly thereafter in the QA meeting and changes will be made as needed. First QA meeting schedules 7/22/03	