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

PRINTED: 06/12/2006
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
	465101	A. BUILDING ______ B. WING ______	05/25/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURRICANE REHABILITATION CENTER	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) COMPLETION DATE
F 272 SS=E	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. 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. This REQUIREMENT is not met as evidenced by: Based on chart review and interview it was determined that the facility did not make a comprehensive assessment of residents' needs. Specifically, 2 of 10 sample residents did not	F 272 7/5/06 POC acceptable with addendum Completion date 7/14/06 Busenbark	Hurricane Rehabilitations POC F 272 Section V on the annual assessment dated 03/22/06 for resident 9 will be completed by 06/26/06. Section V on the annual assessment dated 03/23/06 for resident 4 will be completed by 06/26/06. An audit tool will be developed by DON or designee by 06/26/06 to assess comprehensive MDS to ensure section V has been completed. Audits will be conducted by DON or designee bi-monthly x 2, monthly x 2 and randomly thereafter x 6 months. Audits will be presented in the QA meetings and changes will be made as needed to ensure continue compliance. The first QA meeting is to be held by 07/05/06. Addendum: 7/5/06 - Per telephone call call c̄ administrator the DON will attend state agency sponsored MDS training end July 2006 - added with permission Busenbark RN	07/14/06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark E. Peterson
TITLE: Administrator
(X6) DATE: 06/22/06

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 6-22-06 EQ652069708 05
JUN 26 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

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F 272	Continued From page 1 have complete comprehensive minimum data set (MDS) assessments. (Resident identifiers: 4, 9.) Findings included: 1. Resident 9 was originally admitted to the facility in September of 1997 and readmitted in April of 2006 with diagnoses that included malignant neoplasm of the cecum, congestive heart failure, hypertension and presenile dementia with delusional features. On 5/24/06, a review of resident 9's active chart was completed. Resident 9 had the following assessments on the active chart: 2/3/05 quarterly MDS (minimum data set), 08/04/05 quarterly MDS, 3/22/06 annual MDS. Section V of the annual MDS dated 3/22/06 was not completed. The Resident Assessment Protocols were not marked to indicate which triggered items were to be included in the plans of care. Resident 4 was admitted to the facility in November of 2004 with diagnoses that included depression, congestive heart failure, hypertension, peptic ulcer disease, Alzheimer's disease, cerebrovascular accident and constipation. A review of resident 4's medical record was completed on 5/25/06. Section V of the 3/23/06 annual MDS was not completed. The Resident Assessment Protocols were not marked to indicate which triggered items	F 272		

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F 272	Continued From page 2 were to be included in the plan of care. The columns indicating the "Location and Date of RAP Assessment Documentation and the "Care Planning Decision-check if addressed in care plan" were blank. On 5/22/06 at 4:00 PM, the Director of Nursing (DON) was interviewed. The DON stated that he started working for the facility in June of 2005 and that prior to this is has never worked in a nursing home. In addition the DON stated that in March of 2006 an MDS consultant was brought in to help with the MDSs.	F 272		
F 275 SS=E	483.20(b)(2)(iii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on chart review and interview it was determined that the facility did not complete a comprehensive resident assessment every 12 months. Specifically, 5 of 10 sample residents did not have comprehensive assessments completed in the 12 month time frame. Resident identifiers 1, 2, 3, 4, 7, 9. Findings included: 1. Resident 3 was originally admitted to the facility in August of 1987, then readmitted in April of 2006 with diagnoses that included multiple	F 275	F 275 A Comprehensive Medicare 14 day Assessment completed 04/14/06 was found in resident 3's chart on 06/21/06. An annual assessment was completed with an ARD of 03/22/05 for resident 9 on 06/22/2006. An annual assessment was completed with an ARD of 01/18/05 for resident 1 on 06/22/2006. An annual assessment was completed with an ARD of 03/21/05 for resident 2 on 06/21/06. An annual assessment was completed with an ARD on 01/04/06 for resident 7 on 06/21/06. An annual assessment was completed with an ARD off 11/29/05 for resident 4 on 06/21/06. An audit tool will be developed by DON or designee by 06/26/06 to assess annual assessment to ensure comprehensive assessments are	07/14/06

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F 275	Continued From page 3 sclerosis, urinary tract infection, methicillin resistant staph aureus and hypertension. A review of resident 3's active chart was completed on 05/23/06. Resident 3 had the following minimum data set (MDS) assessments on the active chart: 9/20/04 quarterly, 11/02/04 quarterly, 1/30/05 annual, 5/1/05 annual, 07/31/05 quarterly, 10/30/05 quarterly. Based on the last annual assessment date of 05/01/05, resident 3 should have had an annual MDS assessment completed by 4/30/06. No other annual assessments were found dated after 5/1/05. 2. Resident 9 was originally admitted in February 1997, and readmitted in April of 2006 with diagnoses that included malignant neoplasm of the cecum, congestive heart failure, hypertension, presenile dementia with delusional features. A review of resident 9's active chart was completed on 5/24/06. Resident 9 had the following MDS assessments on the active chart: 2/3/05 quarterly, 8/4/05 quarterly, 3/22/06 annual. Based on the last annual assessment date of 3/22/06, resident 9 should have had an annual assessment completed by 3/22/05. No other annual assessments were found dated between 2/3/05 and 3/22/06.	F 275	completed in the 12 months time frame. Audits will be conducted by DON or designee bi-monthly x 2, monthly x 2, and randomly thereafter x 6 months. Audits will be presented in the QA meetings and changes will be made as needed to ensure continued compliance. The first QA meeting is to be held by 07/05/06.	

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F 275	Continued From page 4 3. Resident 1 was admitted to the facility in September 2001 and readmitted in October of 2002 with diagnoses that included of a brain condition, osteroarthritis and fractured femur. Resident 1's medical record was reviewed on 5/23/06. Resident 1 had the following quarterly MDS assessments on the chart; 4/4/05, 7/4/05, 10/6/05 and 4/13/06. An annual assessment was done on 1/18/06. Based on the annual assessment date there should have been an annual assessment done on 1/18/05. There were no annual assessments noted in the chart prior to 1/18/06. 4. Resident 2 was admitted to the facility in July of 2003 with diagnoses that included alcoholism, gastrointestinal bleed and diabetes. Resident 2's medical record was reviewed on 5/24/06. Resident 2 had the following quarterly assessments on his chart; 1/16/05, 4/16/05 and 7/16/05. An annual assessment was done on 3/21/06. Based on the annual assessment date there should have been an annual assessment completed by 3/21/05. There was no annual assessment for the year 2005. 5. Resident 7 was admitted to the facility in May of 2004 and readmitted in May of 2006 (1 day hospital visit) with diagnoses that included fractured femoral condyle, cerebrallar vascular	F 275		

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F 275	Continued From page 5 disease, diabetes and atrial fibrillation. Resident 7's medical record was reviewed on 5/23/06. Resident 7 had the following quarterly assessments on his chart; 4/4/05, 7/4/05, 10/3/05. A significant change assessment was completed on 3/21/06. An annual assessment was not found on the chart for 1/4/06. 6. Resident 4 was admitted to the facility in November of 2004 with diagnoses that included depression, congestive heart failure, hypertension, peptic ulcer disease, Alzheimer's disease, cerebrovascular accident and constipation. A review of resident 4's medical record was completed on 5/25/06. Resident 4 had the following MDS assessments on the active chart: 12/2/04 annual MDS, 2/28/05 quarterly MDS, 5//30/05 quarterly MDS and a 3/23/06 incomplete annual MDS. An annual assessment was due on or about 12/4/05. No such assessment was found. On 5/22/06 at 4:00 PM, the Director of Nursing (DON) was interviewed. The DON stated that he started working for the facility in June of 2005 and that prior to this he has never worked in a nursing home. In addition the DON stated that in March of 2006 an MDS consultant was brought in to help with the MDSs because he realized that there was a problem. The DON stated that there were no other MDSs that were done for the above residents except for those found on the medical charts.	F 275		

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F 276 SS=E	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on chart review and interview it was determined that the facility did not assess residents, using the quarterly review instrument, not less frequently than once every 3 months. Specifically, 4 of 10 sample residents did not have quarterly assessments at least every 3 months. Resident identifiers 2, 3, 4, 9. Findings included: 1. Resident 3 was originally admitted to the facility in August of 1987, then readmitted in April of 2006 with diagnoses that included multiple sclerosis, urinary tract infection, methicillin resistant staph aureus and hypertension. A complete review of resident 3's active chart occurred on 5/23/06. Resident 3 had the following Minimum Data Set (MDS)assessments on the active chart: 9/20/04 quarterly, 11/2/04 quarterly, 1/30/05 annual, 5/1/05 annual, 7/31/05 quarterly, 10/30/05 quarterly. Based on the last quarterly assessment date of 10/30/05, resident 3 should have had a quarterly assessment completed on or about 1/31/06.	F 276	F 276 A Quarterly Assessment with an ARD 01/31/06 was completed on 06/21/06 for resident 3 A quarterly assessment with an ARD 04/28/05 was found in resident 9's overflow chart on 06/21/06. A quarterly assessment with an ARD 11/04/05 was completed 06/21/06 for resident 9. A quarterly assessment with an ARD of 10/16/05 was completed 06/21/06 for resident 2. A quarterly assessment with an ARD of 01/16/06 was competed on 06/21/06 for resident 2 A quarterly assessment with an ARD of 08/30/05 for resident 4 was found in resident's chart on 06/21/06 A quarterly assessment with an ARD of 02/28/06 for resident 4 was completed on 06/21/06 An audit tool will be developed by DON or designee by 06/26/06 to assess quarterly assessments to ensure residents are assessed no less than once every 3 months. Audits will be conducted by DON or designee bi-monthly x 2, monthly x 2, and randomly thereafter x 6 months. Audits will be presented in the QA meetings and changes will be made as needed to ensure continued compliance. First QA meeting to be held by 07/05/06	07/14/06

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F 276	Continued From page 7 No quarterly assessment was found dated between 10/30/05 and 1/31/06. 2. Resident 9 was originally admitted to the facility in February of 1997, and readmitted in April of 2006 with diagnoses that included malignant neoplasm of the cecum, congestive heart failure, hypertension, presenile dementia with delusional features. A review of resident 9's active chart was completed on 5/23/06. Resident 9 had the following MDS assessments on the active chart: 2/3/05 quarterly, 8/4/05 quarterly, 3/22/06 annual. Based on the above assessment dates, Resident 9 should have had quarterly assessments completed on or about 5/3/05, and 11/4/05. No quarterly assessments were found dated on or before 5/3/05 or 11/4/05. 3. Resident 2 was admitted on July of 2003 with diagnoses that included alcoholism, gastrointestinal bleed and diabetes. Resident 2's medical record was reviewed on 5/23/06. Resident 2 had the following quarterly MDS assessments on his chart 1/16/05, 4/16/05 and 7/16/05. An annual assessment was done on	F 276		

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F 276	Continued From page 8 3/21/06. There were no quarterly assessments between the quarterly MDS dated 7/16/05 and the annual MDS dated 3/21/06. A quarterly assessment was due on or about 10/16/05 and 1/16/06. There were no other quarterly assessments found on the chart. Resident 4 was admitted to the facility in November of 2004 with diagnoses that included depression, congestive heart failure, hypertension, peptic ulcer disease, Alzheimer's disease, cerebrovascular accident and constipation. A review of resident 4's medical record was completed on 5/25/06. Resident 4 had the following MDS assessments on the active chart: 12/2/04 annual MDS, 2/28/05 quarterly MDS, 5/30/05 quarterly MDS and a 3/23/06 incomplete annual MDS. On or about August 30th a quarterly MDS should have been completed. No such assessment was found in the resident's chart. On 5/22/06 at 4:00 PM, the Director of Nursing (DON) was interviewed. The DON stated that he started working for the facility in June of 2005 and that prior to this he has never worked in a nursing home. In addition the DON stated that in March of 2006 a MDS consultant was brought in to help with the MDSs because he realized that there was a problem. The DON stated that there were no other MDSs that were completed for the above	F 276		

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F 276	Continued From page 9 residents except for those found on their medical charts.	F 276		
F 278 SS=D	483.20(g) - (j) 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 willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and observation, it was	F 278	F 278 A significant change will be completed by 06/26/2006 in section P-4 on Quarterly MDS dated 05/30/05, Quarterly MDS dated 08/29/05 and Annual MDS dated 03/23/06 to accurately reflect resident 4's status A significant change was completed on 06/21/06 in section C-1 on Admission MDS dated 03/18/06 to accurately reflect resident 5's status. An audit tool will be developed by DON or designee by 06/26/06 to assess accuracy of MDS. Audits will be conducted by DON or designee bi-monthly x 2, monthly x 2, and randomly thereafter x 6 months. Audits will be presented in the QA meetings and changes will be made as needed to ensure continued compliance. First QA meeting to be held by 07/05/06	07/14/06

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F 278	Continued From page 10 determined that the facility's minimum data sets (MDS) were inaccurate for 2 out of 10 sampled residents. (Resident identifiers: 4,5) Findings included: 1. Resident 4 was admitted to the facility in November of 2004 with diagnoses that included depression, congestive heart failure, hypertension, peptic ulcer disease, Alzheimer's disease, cerebrovascular accident and constipation. A review of resident 4's medical record was completed on 5/25/06. A review of resident 4's annual MDS dated 3/23/06 documented that in section P-4 pertaining to "Devices and Restraints" that resident 4 had "0" trunk restraints. Observations of resident 4 on 5/23/06, 5/24/06 and 5/25/06 revealed that when the resident was observed in a wheelchair a lap buddy was in place. On 5/23/06 at approximately 1:30 PM resident 4's daughter was interviewed. Resident 4's daughter stated that resident 4 needs to utilize a lap buddy because the resident will attempt to stand and then fall. The daughter stated that resident 4 has had a lap buddy in use for a long time. A review of the physician's recertification orders dated 4/1/2006 revealed that on 3/31/05, resident 4 was originally ordered a "lap buddy to remind (the resident) not to stand up and for positioning help."	F 278		

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F 278	Continued From page 11 2. Resident 5 was admitted to the facility in March of 2006 with diagnoses that included congestive heart failure, hypertension, diabetes and pneumonia. A review of resident 5's admission MDS dated 3/18/06 documented that in section C-1 that the resident hears adequately (normal talk). On 5/23/06, during the lunch meal, resident 5 was asked in a normal voice if he liked his lunch. Resident 5 replied,"What?" A second time using a loud voice resident 5 was asked again, if he liked his lunch. He replied,"No." Resident 5's "Resident Assessment-Data Collection Form" dated 3/10/06 documented that resident 5's hearing was "poor" and that his hearing aide was lost at the hospital. A review of a nursing note dated 3/12/06 documented that resident 5 was HOH (hard of hearing).	F 278		

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	465101	A. BUILDING ______ B. WING ______	05/25/2006

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F 279 SS=E	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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 services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on chart review it was determined that the facility did not develop, review or revise the residents comprehensive plan of care, including measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs. Specifically, 5 of 10 sample residents did not have care plans based on the assessment, or the plans of care were incomplete. Resident identifiers 3, 4, 5, 7, 8. Findings included: 1. Resident 3 was originally admitted to the	F 279	F 279 The facility revised and updated care plan for resident 3 on 06/21/06 The facility revised and updated care plan for resident 4 on 06/21/06 The facility revised and updated care plan for resident 5 on 06/21/06 The facility revised and updated care plan for resident 7 on 06/21/06 The facility revised and updated care plan for resident 8 on 06/21/06 To include measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. An audit tool will be developed by DON or designee by 06/26/06 to assess accuracy of care plans. Audits will be conducted by DON or designee bi-weekly x 2, monthly x 2, and randomly thereafter x 6 months. Audits will be presented in the QA meetings and changes will be made as needed to continue compliance. The first QA meeting is to be held by 07/05/06	07/14/06

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F 279	Continued From page 13 facility in August of 1987, then readmitted in April of 2006 with diagnoses that included multiple sclerosis, urinary tract infection, methicillin resistant staph aureus and hypertension. A complete review of resident 3's active chart occurred on 05/23/06. Resident 3 had the following RAPs (Resident Assessment Protocol) generated by the annual assessment completed on 5/1/05: Cognitive loss Communication ADL (Activities of Daily Living) function/Rehabilitation potential Urinary incontinence/Catheterization Falls Nutrition Pressure ulcers Psychiatric drug use Resident 3 had the following plans of care on the active chart: History of hypertension Potential for skin breakdown R/T (related to) decreased mobility Alteration in neurological function Falls Alteration in ability to do ADLs Skin breakdown stage II pressure ulcer on buttocks Nutritional status Alteration in speech Cognitive or disordered thinking MRSA (methicillin resistant staph aureus)-urinary tract infection pneumonia dx (diagnosis) Risk for infection related to indwelling catheter	F 279		

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F 279	Continued From page 14 History of depression R/T chronic medical conditions Alteration in resp (respiratory) status R/T pneumonia The following plans of care for resident 3 did not include target dates, and therefore no timetable to meet residents needs: History of hypertension Potential for skin breakdown R/T decreased mobility Alteration in neurological function Falls Alteration in ability to do ADLs Skin breakdown stage II pressure ulcer on buttocks 2. Resident 8 was originally admitted to the facility in June of 2000 with diagnoses that included hypothyroidism, pneumonia and hemiplegia. A complete review of resident 8 was completed on 5/25/06: Resident 8 had the following RAP's (Resident Assessment Protocol) generated by the annual assessment completed on 3/23/06: Cognitive Loss Communication ADL Functional/Rehabilitation Urinary Incontinence and Indwelling Catheter Psychosocial Well-Being Mood State Behavioral Symptoms Falls Resident 8 had the following plans of care on the chart.	F 279		

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F 279	Continued From page 15 Mood/Psycho Social - 5/7/06 Alteration in Ability to do ADL's - 11/13/05 Bladder Incontinence - 11/13/05 Falls - 11/13/05 Alteration in Bowel Function - 11/13/05 Psychotropic Medication - 11/13/05 History of Depression - 11/13/05 Potential for Skin Breakdown - 11/13/05 Altered Thought Processes - 11/13/05 The care plan "Mood/Psycho Social" is the only care plan on the chart that was active from January to April, 2006. All other care plans did not reflect the current RAP status. They had not been updated or discontinued since 3/23/06. 3. Resident 7 was admitted on 5/12/04 and readmitted on 5/9/06 (1 day hospital visit) with diagnoses of fractured femoral condyle, cerebral vascular disease, diabetes and atrial fibrillation. A complete review of Resident 7 active chart occurred on 5/23/06. Resident 7 had the following RAPs (Resident Assessment Protocol) generated by a significant change assessment completed 3/21/06: Delirium Cognitive Loss Communication Alteration in Ability to do ADL's Mood State Behavioral Symptoms Activities Falls Psychotropic Drugs	F 279		

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F 279	Continued From page 16 Resident 3 had the following plans of care on the active chart: Alteration in ability to do ADL's - 3/06 Risk for Injury related to Falls - 3/06 Altered Thought Processes Related to Cognitive Memory - 3/06 Impaired Verbal Communication - 8/03/06 The care plan "Impaired Verbal Communication" is the only care plan on the chart that is active after the month of March, 2006. All other care plans had not been updated or discontinued after 3/06 but were RAP generated for the period before and after 3/06. Resident 4 was admitted to the facility in November of 2004 with diagnoses that included depression, congestive heart failure, hypertension, peptic ulcer disease, Alzheimer's disease, cerebrovascular accident and constipation. A review of resident 4's medical record was completed on 5/25/06. Resident 4 had the following RAP's (Resident Assessment Protocols) generated by the annual assessment: Cognitive Loss Communication ADL (Activities of daily living) Function Urinary Incontinence Psychosocial Well-Being Mood State Behavioral Symptoms Activities Falls	F 279		

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F 279	Continued From page 17 Nutritional Status Pressure Ulcers Psychotropic Drug Use Physical Restraints Resident 4 had the following plans of care on the chart. However, the following plans of care for resident 4 did not include target dates, and therefore no timetable to meet residents needs: Cognitive or Disordered Thinking Hospice Care- Failure to Thrive Hypertension Anxiety CHF (Congestive Heart Failure) Constipation Incontinence ADLs Altered thought Processes Nutritional Status Weight Loss The care plans did not reflect the current RAP status. They had not been updated or discontinued since March of 2006.	F 279		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility did not provide service that met professional standards of quality for 1 of	F 281	F 281 An in-service will be conducted for the licensed nursing staff by DON or designee on catheter irrigation as per the Lippincott Manual of nursing Practice eight edition 2006, pg 756 by 06/23/06 An audit tool will be developed by the DON or designee by 06/26/06 on irrigation of indwelling catheters. Audits will be conducted on procedure	07/14/06

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F 281	Continued From page 18 10 sample residents. Specifically, one resident received a catheter irrigation that did not meet professional standards of quality. (Resident identifier: 3.) Findings included: 1. Resident 3 was originally admitted to the facility in August of 1987, then readmitted in April of 2006 with diagnoses that included multiple sclerosis, urinary tract infection, methicillin resistant staph aureus and hypertension. An observation of scheduled catheter irrigation, for resident 3, occurred on 5/24/06 at 10:40 AM. RN 1 washed her hands, applied clean gloves, and began removing resident 3's clothing and positioning resident 3, while explaining the activity to the resident. RN 1 inspected the catheter and drainage system, then began repeatedly pushing the catheter, that was already in place, into resident 3's urethra, stating that it was to "check placement." No cleansing of the catheter was done prior to the "check placement" procedure. RN 1 obtained a sterile large volume syringe and aspirated a quantity of sterile saline. RN1 stated that the syringes were reused and changed on a daily basis. RN1 separated the junction between the catheter and the drain tubing, no cleansing was conducted prior to separation, inserted the syringe into the catheter and instilled the sterile saline. The drain tubing and catheter were then reconnected and	F 281	by DON or designee bi-weekly x 2, monthly x 2, and randomly thereafter x 6 months. Audits will be presented in the QA meeting and changes will be made as needed to continue compliance. The first QA meeting is to be held by 07/05/06	

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F 281	Continued From page 19	F 281		

the nurse observed for return.

RN1 aspirated the remaining sterile saline, using the same large volume syringe, separated the junction between the catheter and the drain tubing, no cleansing was conducted prior to separation, inserted the syringe into the catheter and instilled the sterile saline (total of 100 milliliters of saline). The drain tubing and catheter were then reconnected and the nurse observed for return.

Per the Lippincott Manual of Nursing Practice, eighth edition 2006, pg. 756:
To irrigate the catheter
1. Wash hands. Put on gloves.
2. Using aseptic technique, pour sterile irrigating solution into sterile container.
3. Clean around catheter and drainage tubing connection with sterile gauze pads soaked in providone-iodine solution.
4. Disconnect catheter from drainage tubing. Cover tubing with a sterile cap.
5. Place a sterile drainage basin under the catheter.
6. Connect a large-volume syringe to the catheter and irrigate catheter using prescribed amount of sterile irrigant.
7. Remove syringe and place end of catheter over drainage basin, allowing returning fluid to drain into basin.
8. Repeat irrigation procedure until fluid is clear or according to physician's directives.
9. Disinfect the distal end of the catheter and end of drainage tubing; reconnect the catheter and tubing. Remove gloves. Wash hands.

According to facility policy for urinary catheters:

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F 281	Continued From page 20 "If irrigation is necessary, disinfect tubing junction before disconnecting. Using aseptic technique, irrigate with a sterile syringe and sterile solution. Discard unused solution." Aseptic technique was not utilized, the tubing junction was not disinfected and per the RN's statement, a sterile syringe is not utilized during each irrigation.	F 281		
F 367 SS=D	483.35(e) THERAPEUTIC DIETS Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and observation, it was determined that the facility did not give 1 out of 10 sampled residents their physician ordered prune juice every day (QD). (Resident identifiers: 4) Findings included: Resident 4 was admitted to the facility in November of 2004 with diagnoses that included depression, congestive heart failure, hypertension, peptic ulcer disease, Alzheimer's disease, cerebrovascular accident and constipation. A review of resident 4's medical record was completed on 5/25/06. A review of the physician's recertification orders	F 367	F 367 Residents will receive therapeutic diets as per MD order. An in-service will be conducted for the kitchen staff by the dietary manager or designee on therapeutic diets by 06/23/06. An audit tool will be developed by dietary manager or designee by 06/26/06 to compare meals with therapeutic diets. Audits will be conducted by dietary manager or designee bi-weekly x 2, monthly x 2, and randomly thereafter x 6 months. Audits will be presented in the QA meeting and changes will be made as needed to ensure continued compliance. The first QA meeting is to be held by 07/05/06	07/14/06

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F 367	Continued From page 21 dated 4/1/2006 revealed that resident 4 had an order for "Prune juice 8 oz. (ounces) by mouth every day." A review of resident 4's diet card revealed that the resident was to be served "8 oz. prune juice" at breakfast everyday. Observations of the breakfast meal on 5/23/06 and 5/24/06 revealed that resident 4 was not served prune juice as ordered by the physician.	F 367		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility did not store, prepare, distribute, or serve food under sanitary conditions. Specifically, bulk foods were stored in bags that had not been approved for food storage, outdated foods were being stored, cross-contamination of dishes occurred and there was potential for contamination of food due to unclean surfaces. Findings included: Observations of the kitchen/food service area took place 5/22/06 to 5/24/06.	F 371	F 371 Food being stored in bags that were not approved for food storage was thrown out on 05/24/06. New food was purchased in small quantities. New approved ingredient bins were ordered and received by 06/09/06.The serving area identified was cleaned immediately on 05/25/06. An in-service will be conducted for the kitchen staff by dietary manager or designee on storing, preparing, distributing, and serving of food under sanitary conditions on 06/23/06. An audit tool will be developed by dietary manager or designee by 06/26/06 to ensure continued sanitary conditions in the kitchen. Audits will be conducted by dietary manager or designee bi-weekly x 2, monthly x 2, and randomly thereafter x 6 months Audits will be presented in the QA meeting and changes will be made as needed to ensure continued compliance. The first QA meeting is to be held by 07/05/06	07/14/06

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F 371	Continued From page 22 1. Observations of the dishwashing area took place on 5/22/06 and 5/23/06. On 5/22/06 at 2:45 PM, the day shift cook was observed using the automatic dishwasher. The day shift cook was observed wearing yellow dishwashing gloves as dirty dishes were placed into the washing machine. At 2:50 PM, the day shift cook removed a garbage bag full of refuse while wearing yellow gloves, then was observed sanitizing a cart tray and handling clean dishes without sanitizing or changing the gloves. On 5/23/06 at 1:00 PM, the day shift cook was observed loading dirty dishes into the diswasher while wearing yellow gloves. The day shift cook then began putting away clean dishes and silverware with the same gloves, without sanitizing or changing gloves. 2. Observation of the outdoor pantry occurred on 5/22/06 at 2:00 PM. Two 8 pound 10 ounce plastic containers of Casa Solana enchilada sauce were observed with expiration dates of September 5, 2005. Eight 15 ounce boxes of Imperial Raisins were found with best before dates of April 1, 2006. Five garbage cans, utilized as bulk food storage containers, were observed to be lined with black plastic garbage type bags. The containers held sugar, flour and powdered milk. An interview with the the dayshift cook occurred on 5/22/06 at 2:00 PM. The day shift cook stated that she did not know where the packaging for the	F 371		

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F 371	Continued From page 23 bags, or documentation regarding approved uses for the bags could be found. An interview with the evening shift cook occurred on 5/22/06 at 5:56 PM. The evening shift cook stated that she did not know where the black bags came from. She also stated that she did not know where the packaging or documentation regarding approved uses for the bags could be found. An interview with the administrator took place on 5/24/06 at 5:00 PM. The administrator stated that he did not know where the packaging for the bags was, and had been unable to find documentation regarding approved uses for the bags. As quoted in Food Safety News (A cooperative extension service of US department of Agriculture, Kansas State University) June 1999 Volume 2, number 3: "Containers not approved for food use are trash or garbage bags, paint or solvent cans, industrial plastics, galvanized container, and fiber barrels that have been used for nonfood purposes." 3. An observation of the kitchen tray line took place on 5/22/06 at 5:55 PM. A cupboard, overhanging the right side of the steam table that food was being served from, was observed to have dust "bunnies" along it's top edge.	F 371		

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(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 387 SS=E	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that 4 of 10 sample residents were not seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days as required. (Resident Identifiers: 3, 4, 6, 8.) Findings included: 1. Resident 8 was admitted to the facility on February of 2003 with diagnoses that included hypothyroidism, pneumonia and hemiplegia. A review of resident 8's medical record revealed the resident had been seen by a physician on 5/6/05, 3/29/06, 4/25/06 and 5/11/06. Per documentation there was no evidence that Resident 8 was seen by her attending physician on or around 7/6/05, 9/6/05, 11/6/05 and 1/6/05 as required. There was no documentation in the medical record to provide evidence that resident 8 had been seen by a physician on or about 8/6/05,	F 387	F 387 Documentation was found in resident 4's chart to support a MD visit on 02/08/06. A physician's visits schedule will be developed by medical records or designee by 06/26/06. Primary Physicians will be provided with a list of residents to be seen each month. If a resident has not been seen by his/her primary physician in a timely manner, arrangements will be made for them to be seen by the Medical Director. An audit tool will be developed by medical records or designee by 06/26/06 to ensure continued compliance with physician visits. Audits will be conducted by medical records or designee bi-monthly x 2, monthly x 2, and randomly thereafter x 6 months. Audits will be presented in the QA meeting and changes will be made as needed to ensure continued compliance. The first QA meeting is to be held by 07/05/06.	07/14/06

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

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FORM APPROVED
OMB NO. 0938-0391

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	465101	A. BUILDING ______ B. WING ______	05/25/2006

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F 387	Continued From page 25 11/6/05 or 2/6/06. 2. Resident 3 was originally admitted to the facility in August of 1987, then readmitted in April of 2006 with diagnoses that included multiple sclerosis, urinary tract infection, methicillin resistant staph aureus and hypertension. A complete review of resident 3's active and discharge charts occurred on 05/23/06. Resident 3's charts had physician progress notes indicating physician visits for 5/19/05, 6/30/05, 9/15/05, 12/15/05, and 3/23/06. Between 6/30/05 and 9/15/05 resident 3 went 77 days without a physician visit. Between 12/15/05 and 3/23/06 resident 3 went 98 days without a physician visit. Resident 3 should have had physician visits on or about 8/29/05 and 2/13/06. No documentation was found on the chart indicating physician visits occurred on or about 8/29/05 or 12/13/06. 3. Resident 6 was admitted to the facility in June of 2005 with diagnoses that included osteoporosis and hypothyroidism. A complete review of resident 6's chart occurred on 5/22/06. Resident 6 had physician progress notes indicating physician visits for 06/30/05, 08/26/05, 09/15/05, 9/16/05, 12/15/05, 1/19/06 and 3/23/06.	F 387		

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F 387	Continued From page 26 Following admission on 6/1/05, resident 6 should have had physician visits every 30 days for 90 days. The resident should have had another physician visit on or about 07/30/05. No documentation was found on the chart indicating a physician visit occurred on or about 07/30/05. An interview with the Director of Nursing (DON) occurred on 5/23/06 at 1:45 PM. The DON stated that there was no other documentation of physician visits for resident 6. 4. Resident 4 was admitted to the facility in November of 2004 with diagnoses that included depression, congestive heart failure, hypertension, peptic ulcer disease, Alzheimer's disease, cerebrovascular accident and constipation. A review of resident 4's medical record revealed the resident had been seen by a physician on 6/24/05 and on 5/11/06. Per documentation there was no evidence that Resident 4 was seen by her attending physician on or around August of 2005, October of 2005, December of 2005, February of 2006 and April of 2006 as required. On 5/23/06, the DON was interviewed. The DON stated that the only time that the resident had been seen by the primary physician in the past year was on 6/24/05 and on 5/11/06.	F 387		

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F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM 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 observation of resident rooms, it was determined that 10 out of 42 bedside call lights the facility staff did not ensure the nurses's station was equipped to receive resident calls through a communication system from resident rooms and toilet facilities. Findings included: On 5/23/06 at 2:00 PM a tour was made of all resident rooms, 10 out of 42 bedside call bells tested were either inoperative or had to be held in the down position by the resident to work properly and register on the call board at the nurse's station. It was observed in rooms 14 A, 18 B and 18 C the call bells did not function. In rooms 15 B, 17 A, 19 B, 21 A, 21 C and 24 A the call bell only worked if the button was held in the down position. On 5/23/06 at 2:15 PM, in an interview with the Administrator, he stated that monthly checks were done on the system and that the system had passed all checks in April. During the interview with the Administrator, he stated that the call system would be worked on that evening (5/23/06).	F 463	F 463 The communication system between the nurse's station and resident rooms, toilet, and bathing facilities was in working condition by the end of 05/26/06. An audit tool will be developed by administrator or designee by 06/26/06 to ensure a continued working communication system. Audits will be conducted by administrator bi-weekly x 2, monthly x 2, and randomly thereafter x 6 months. Audits will be presented in the QA meeting and changes will be made as needed to ensure-continued compliance. The first QA meeting is to be held by 07/05/06.	07/14/06

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