STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465100	A. BUILDING _____ B. WING _____	3/13/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINIA AT ALTA	4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107

(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 151 SS=B	483.10(a)(1)&(2) EXERCISE OF RIGHTS The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on a confidential group meeting held with residents on 3/12/03 at 9:30 AM and staff interviews it was determined that the facility did not inform residents of their right to vote and did not assist residents to exercise their right to vote. Findings include: During a confidential group meeting held on 3/12/03 at 9:30 AM, 5 of 10 actively participating residents stated that the facility had not informed them of their right to vote. These residents stated that they wanted to vote in the last election, however, they were not given the opportunity. On 3/12/03 at 2:45 PM, the facility social worker was interviewed. She stated that she had been employed at the facility since September 2002 and since that time; she had not helped residents with registering to vote, with obtaining absentee ballets or with helping residents to vote but that she could. She stated that since she started in September 2002, she had not been there long enough for an election to take place. The election the residents were interested in voting in took place in November 2002, 2 months after the social worker was employed. On 3/13/03 at approximately 8:30 AM, the facility	F 151 OK 4/11/03 DD	F151 Residents right to vote (exercise right as citizen) will be discussed in April's Resident Council meeting by SSW. S.L.C. By-Mail Voter Registration forms have been obtained by S.S.W. All residents will be asked if they wish to vote and SSW will provide assistance in registering. Absentee ballots will be obtained prior to the next local or national election. SSW will meet with residents in a group meeting or one on one prior to an election and assist residents who desire to vote at a booth or by absentee ballot. SSW will monitor each residents voting status monthly through Quality Assurance Committee. [illegible] APR 10 2003 [illegible] #507537	5/15/2003

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jerry Lemmons — TITLE: Admin. — (X6) DATE: 4/10/03

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 151	Continued From page 1 activity director was interviewed. He stated that he had helped residents with voting in the past but he had not assisted any residents to vote in the most recent election. He further stated that he had not helped any residents register to vote or obtain absentee ballets.	F 151		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal	F 157 OK 4/1/03 AA	F157 Resident 13's physician will be notified by licensed nurse regarding the Sliding parameters. Inservice will be given by D.O.N. on Blood Sugar/Sliding Scale policies and importance of calling Dr. if resident refuses or only wants to take part of their insulin. Dr. does sign weekly Insulin Record. Nurses will call Dr. when treatment needs altered or resident refuses treatment and document in nurses notes and/or by Fax for all residents with Blood Sugar monitoring & Sliding Scale. The D.O.N. will monitor weekly proper documentation & dr. notification for the next 30 days and then monthly through Quality Assurance Program.	5/15/2003

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F 157	Continued From page 2 representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interviews and review of resident medical records, it was determined that for 1 additional resident, not included in the original sample of 15, the facility did not immediately inform the residents's physician when there was a need to alter treatment significantly. Resident identifier: 13. Findings include: Resident 13 was a 76 year old male who was admitted to the facility on 10/15/96. Resident 13 was an insulin dependent diabetic who had physician's orders to have his blood sugar (BS) monitored four times a day and then receive regular insulin based on the following sliding scale: BS 151 - 200 = 3 units (u) BS 201 - 250 = 5 u BS 251 - 300 = 7 u BS 301 - 350 = 9 u BS 351 - 400 = 11 u > 400 call MD Resident 13's March 2003 blood glucose monitoring record was reviewed on 3/13/03. Between 3/1/03 and 3/13/03, thirteen errors in insulin administration were noted. (Please also see F - 426 for medication error specifics.) In addition to the errors in the amount of insulin given to resident 13, there were two instances in March 2003 (from documentation from the March 2003 blood glucose monitoring record) when facility nurses gave sliding scale insulin based on what resident 13 would "allow".	F 157		

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F 157	Continued From page 3 A facility nurse was questioned regarding this practice on 3/13/03 at 10:30 AM. The nurse stated that if she gave the full amount, "he'll bottom out, so I give part of it." The nurse also stated that resident 13 occasionally refuses his insulin. The surveyor asked if it was because he "bottoms out". The facility nurse replied "that's part of it". When asked if the physician had been made aware of the practice of not giving all the ordered insulin, the nurse stated "I don't know if she's been made aware. I haven't called her." When asked how long this practice had been going on, the nurse stated "since October". On 3/13/03 at 11:17 AM, the facility's director of nurses (DON) was asked if she was aware that her nurses were adjusting the sliding scale insulin of resident 13. The DON stated she was not aware. In addition, 3/8/03 at 4:30 PM, resident 13's BS was 406. Based on the physician's orders, facility nursing staff should have called the physician. There was no documentation in the medical record of resident 13 to evidence that the physician was notified of this high blood sugar. Instead, the facility nurse gave 5 units of regular insulin. On 3/13/03 at 11:30, the resident's physician was interviewed. She stated she was not aware that the nurses were adjusting the sliding scale insulin based on what resident 13 would allow. She stated that no one at the facility had notified her of this.	F 157		
F 174 SS=D	483.10(k) TELEPHONE The resident has the right to have reasonable access to the use of a telephone where calls can be made	F 174		

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F 174	Continued From page 4 without being overheard. This REQUIREMENT is not met as evidenced by: Based on a confidential resident group interview, held 3/12/03 at 9:30 AM, it was determined that the facility did not ensure that residents had access to a telephone where they could make calls without being overheard. Findings include: During a confidential resident group interview, held 3/12/03 at 9:30 AM, 3 of 10 actively participating residents stated that they do not have access to a telephone where they could make private calls. The residents stated the phones that they could use to make personal calls were a phone across from the east nurses' station and a phone in the recreation/social service office, which is also used for facility meetings. The residents stated that other residents and staff are always in the area of the phone across from the east nurses' station. They stated that they have been told that they can use the recreation/social services office to make private phone calls, however, facility staff that are conducting meetings often occupy this room. They stated that when the recreation and social service personnel are not working, mainly during nights and on weekends, the office is locked. They were unsure who had a key to this office during those times so that they could use the phone privately. On 3/12/03, one alert and oriented resident who was participating in group stated that on one occasion he was feeling depressed and wanted to use the phone in the recreation/social service office to make a private call because he felt the need to speak with someone. He stated that the office was being used for a meeting and he felt he could not use the phone there and he	F 174 OK 4/11/03 DD	F174 Resident phone will be moved into the Day room to provide residents privacy during phone calls. SSW will inform Resident Council of this change and monitor monthly through Quality Assurance Committee and Resident Council input to assure compliance. Residents will be informed by SSW that alternate phones for privacy can be made available in Social Service, Marketing office and physician office.	5/15/2003

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F 174	Continued From page 5 did not want to use the phone across from the east nurses desk because it was not private.	F 174		
F 241 SS=E	483.15(a) QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on a confidential group interview held with residents on 3/12/03 at 9:30 AM and individual resident interview, it was determined that the facility did not always care for residents in a manner that maintains or enhances each resident's dignity by not answering call lights timely or providing services timely according to the needs of the residents. Findings include: 1. On 3/12/03, at 9:30 AM, a confidential interview was held with a group of residents. Eight (8) of 10 residents actively participating in the group discussion stated that they have had to wait too long for their call light to be answered. One resident stated that sometimes his call light is not answered. Other residents stated that they have had to wait 45-60 minutes for their call light to be answered. They stated that this is a problem on all shifts.	F 241 OK 4/11/03	**F241** **Nursing Inservice will be held on Call lights and services being provided in a timely manner to all residents.** **The Director of Nursing will set up a Quality Assurance program on random call light tests and monitor response time on each shift 5 x's week for the next 45 days. SSW will discuss call call light response time monthly in Resident Council. Call light response will be discussed and monitored weekly in QA/Standard of Care meeting by Director of Nursing.**	5/15/2003
F 248 SS=E	483.15(f)(1) QUALITY OF LIFE The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the	F 248		

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F 248	Continued From page 6 physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, the confidential group interview, staff interview and review of resident medical records, it was determined that for 3 of the 15 sample residents and 7 of 10 residents in the group interview, the facility did not provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental and psychosocial well-being of each resident. Resident identifiers: 9, 13 and 24. Findings include: 1. The confidential group interview was held on 3/12/03 at 9:30 AM. There were 10 residents in the group who were actively participating. When asked about the activities in the facility, 7 of the 10 residents stated that half the things on the monthly activity board (schedule) were not done. They stated that they did not know what some of the things were on the schedule and only found out while state survey was in the building. Additionally, the 7 residents stated that facility staff does not go get (from their rooms) residents who are unable to take themselves down to the activities. The activity assistant was interviewed on 3/13/03. He was asked if staff went and helped the residents who could not get to the activities on their own. The activity assistant replied that they helped "some of them". 2. Resident 9 was a 94 year old male who was admitted to the facility on 7/12/96.	F 248 OK 4/11/03 JD	F248 Residents 9, 13, & 24 Activity Plan will be reviewed and updated by the TRT to reflect resident needs & interests. Residents 9, 13 & 24 require assistance to and from activities will be targeted by Activity staff to assure staff assist to activities they wish to participate in & Activity staff will document on the attendance record refusals. Activity Progress Notes will address reason for refusals. Activity Planning Committee will be set up monthly & minutes kept to identify activities residents would like on the Activity Calendar. The Activity calendar will provide activities for Higher functioning, basic and low function residents so all resident activity needs are met. Residents not participating in activities will be identified and activity & nursing staff will remind & assist to Act. Inservice will be held for all staff reminding them of the importance of assisting & reminding residents to activities & targeted resident list is at the nurses station. Activity staff will follow the monthly calendar and give copies to each resident. Changes in the calendar will be posted on the Activity Board and a general announcement made of the change by Activity staff. Quality Assurance audit on attendance records will be done by Activity Director weekly to assure accuracy of attendance, to target residents not attending or refusing activities and to monitor and assure effectiveness of the Activity Plan of Action. Issues & problems will be addressed weekly in QA/Standard of Care meeting.	5/15/2003

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F 248	Continued From page 7 Resident 9 was observed on 3/11/03 and 3/13/03 for involvement in activities. On 3/11/03 at 9:20 AM, resident 9 was observed in his wheelchair being wheeled into his bedroom. Resident 9 was pushed next to his bed, facing the wall. Staff then left. Resident 9 remained sitting in his room (while in the wheelchair) from 9:20 AM through 10:40 AM. There were no lights on in the room, the room was very dim. There was no television or radio on. Resident 9 was not observed to be involved in any activity or interaction, but was observed to be awake. On 3/13/03, from 8:24 AM to 8:54 AM, resident 9 was observed sitting next to his bed in his wheelchair which faced the corner wall. The room was dim, there were no lights on. There was no television or radio turned on. From 8:54 AM to 9:19 AM, nurse aides were observed to perform some personal cares for resident 9. Then from 9:20 AM through 11:04 AM, resident 9 was observed to be in his bed laying on his left side. Resident 9 was not observed to be involved in any activities. Review of the March 2003 attendance roster kept by activity personnel for resident 9 revealed that on 3/11/03, he received only a "morning greeting". When the activity director was questioned on 3/13/03, as to what the "morning greeting" was, he stated that he went from room to room and said hello and let the resident know what activities were planned for the day. 3. Resident 13 was a 94 year old female who was admitted to the facility on 12/17/93. Resident 13 was observed on 3/13/03, from 8:34 AM to 11:04 PM, for involvement in activities.	F 248		

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F 248	Continued From page 8 At 8:34 AM, resident 13 was observed next to her bed, sitting in her wheelchair and faced toward the corner. Resident 13 was observed to remain this way until 9:20 AM when staff placed her in bed on her back with the side rail up. Resident 13 continued to lay on her back until approximately 9:45 AM when a nurse aide took her into the bathroom and showered her. Resident 13 was back in her room, sitting in her wheelchair at 10:08 AM and remained there without involvement in activities through 11:04 AM. Review of the March 2003 attendance roster kept by activity personnel for resident 13 revealed the following: March 1 - no activity March 2 - no activity March 3 - morning greeting only March 9 - no activity March 10 - morning greeting only March 11 - morning greeting only 4. Resident 24 was an 84-year-old female who was admitted to the facility on 6/8/02. Resident 24 was observed on 3/13/03, from 8:31 AM to 11:00 AM, for involvement in activities. At 8:31 AM, resident 24 was observed next to her bed, awake sitting in a Geri-chair and facing the wall. Resident 24 was observed to remain this way until 9:20 AM when staff placed her in bed,awake on her back with the side rail up. Resident 24 continued to lie on her back in bed awake without involvement in activities until 11:00 AM. Review of the March 2003 attendance roster kept by activity personnel for resident 24 revealed the	F 248		

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F 248	Continued From page 9 following: March 1 - no activity March 2 - no activity March 3 - morning greeting only March 4 - morning greeting only March 7 - morning greeting only March 8 - morning greeting only March 9 - no activity March 11 - morning greeting only 5. On 3/12/03 at 1:50 PM, a confidential family interview was conducted. The family member was asked if their loved one, who, through observations had not been assisted to or been involved in activities, was ever assisted to attend facility activities. The family member stated that the resident did not attend activities and that no one from the activities department or other facility staff visited them in the room. The family member stated that when the facility held ice cream or other social activities that sometimes a CNA (certified nurses aide) would bring some food down and feed the resident in the room but the resident did not attend. The family member also stated that the resident was often in bed when they were not visiting.	F 248		
F 252 SS=E	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility did not maintain water	F 252 OK 4/11/03 DD	F252 Temperatures on water heaters was turned up so that hot water is between 110-120 degrees by Maintenance Supervisor. Water temperatures will be tested weekly for the next 30 days & then monthly thereafter and documented temperatures will be placed on Maint. Quality Assurance Checklist Log & discussed weekly in QA meeting. Showers will be included in the test following shower schedule.	3/31/2003

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F 252	Continued From page 10 temperatures at a comfortable temperature in the common shower areas for 5 of 10 alert and oriented residents who were interviewed in a confidential group meeting. Findings include: On 3/12/03 at 10:30 AM, a confidential group meeting was conducted with a group of residents. Ten alert and oriented residents actively participated in the discussion. Six of the ten residents had complaints that the water was too cold for showers. On 3/11/03 at 2:30 PM, the water temperature in the showers was checked. The water temperature in the east wing woman's shower tested to be 96 degrees Farenheit. The water temperature in the west wing woman's shower tested to be 92 degrees Farenheit. The water temperatures tested to be below the normal body temperature of 98.6 degrees Farenheit, and would have felt cool to the bathers.	F 252		
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 and a confidential group interview, it was determined the facility did not provide housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior. Findings include: Observations were made of the facility on 3/10/03,	F 253		

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F 253	Continued From page 11 3/11/03, 3/12/03 and 3/13/03. Observation of resident room 7, on the morning of 3/11/03, revealed a brown substance to be smeared over an area of the wall approximately 18 inches from the South East corner. The brown smears were covering an area approximately 18 inches wide and starting 3 inches from the floor to about 20 inches from the floor. The substance remained on the wall through 3/12/03, until the administrator was advised by the surveyors at 4:45 PM on 3/12/03. Observation of the east wing women's tiled shower revealed the shower head to be dangling from a hose to the floor with a continuous trickle of water running from it on 3/10/02, 3/11/02, 3/12/02, and 3/13/02. A four inch baseboard tile by the shower was broken and chipped and five and a half one inch floor tiles were missing in front of the third bathroom stall, making the floor non-sanitizable. The east wing men's bathroom had two stalls. Floor tiles were missing from in front of the second toilet leaving a seven inch by five inch area that could not be sanitized. The shower heads in the women's shower on the east wing was observed resting against the shower floor on 3/10/03, 3/11/03, 3/12/03 and 3/13/03. The shower head in the women's shower on the west wing was long enough to reach the floor. Neither shower had the required breaker to prevent the back flow of water and bacteria into the shower head. The men's tile shower on the west wing had a crack in the floor across the width of the shower. The crack was approximately one inch deep. On 3/12/03 at 10:30 AM, a confidential group	F 253 DLC 4/11/03 DD	**F253** **Brown substance on wall in Room 7 was cleaned by housekeeping during survey. Housekeeping supervisor will utilize the facility Quality Assureance Room Check list to monitor and assure that rooms are being cleaned properly by housekeeping staff checking each room at least weekly before an admission and after discharge. Issues addressed weekly by the House keeping supervisor in QA meeting.** **East Women's shower head will be repaired. Vac Breakers will be placed on each shower. Shower tiles will be repaired so floors can be sanitizable in both Men & Women showers by Maint.** **West Wing Men's room urinal will be repaired. Maintenance will utilize facility Quality Assureance Rounds Check list to monitor maintenance repairs wkly & discuss issues in wkly QA meeting to assure ongoing compliance.** **The Director of Nursing will monitor the specimen fridge weekly to assure that no food items are in this fridge & log compliance in wkly QA meeting. D.O.N will inservice licensed nurses that no food items are to be placed in this fridge.**	4/30/2003

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F 253	Continued From page 12 interview was conducted with ten alert and oriented residents. One of the five male participants in the group stated that the only urinal in the men's room on the west wing had been broken for a week and could not be used. In an interview with the administrator, on 3/12/03 at 4:09 PM, the administrator stated the men's urinal on the west wing had been reported out of order to her on Monday, 3/10/03, and it had been covered over the previous weekend to prevent use The administrator stated that maintenance had not been able to get to it yet. The specimen fridge, at the west nurses station was observed, on 3/13/03, to contain a melted ice cream sandwich and ten culture swab kits which should have been stored separately.	F 253		
F 281 SS=G	483.20(k)(3)(i) RESIDENT ASSESSMENT 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, interviews with the Director of Nurses (DON) and the wound nurse, and record review, it was determined the facility did not provide services that met professional standards of quality for 1 of 15 residents in the sample who was cut twice during dressing change procedures. Resident 46. Findings include: Resident 46 was an 81-year-old female who was admitted to the facility on 11/13/00 with diagnoses that included diabetes, dementia and deep vein	F 281 ok 4/14/03	F281 Resident 46 dressings will only be cut off using bandage scissors. Treatment nurse will be counciled by the Director of Nursing not to use pointed scissors for treatments and use bandage scissors. Treatment nurse will be counciled on notifying the Administrator immediately if ordered supplies do not come within 3-5 days & to communicate with the D.O.N. who keeps a pair of bandage scissors on hand in her office. New bandage scissors arrived The D.O.N. and Administrator will monitor follow-up on all incidents involving nursing standard of practice through weekly QA/ standard of Care meeting.	3/14/2003

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F 281	Continued From page 13 thrombosis. Resident 46"s medical record was reviewed on 3/10/03 and 3/11/03. Nursing notes, dated 12/11/02 at 12:15 PM documented that, during a dressing change procedure, resident 46's left leg "was nicked [with] scissors, sustaining 1 cm [centimeter] superficial laceration. Wound cleaned [and] dressed." An incident investigation report, dated 12/11/02, documented, "Nurse reported the small cut. Orders written for daily Tx [treatment], first aid done at time." Under "Course of Action" it was documented, "Nurses will now be using bandage scissors only for dressing changes." Bandage scissors have a smooth, flat rounded end that slips between a bandage and a resident's skin to protect the resident from being cut when the bandage needs to be cut off. There was no documentation to evidence that the facility had followed up with this incident and obtained bandage scissors for the nurses who performed treatments. Two months later, resident 46 was cut a second time during a dressing change on 2/12/02, leaving a 1.5 cm superficial laceration. The bleeding was stopped and the wound was cleaned and dressed. In her report, the wound nurse documented a request to "Have C/S [central supply] order decent bandage scissors." The report was signed by the medical director and the administrator. Again, there was no documentation to evidence that the facility had followed up with this incident or obtained bandage scissors for the nurses who performed treatments. The wound nurse was observed during treatment	F 281		

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

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F 281	Continued From page 14 rounds on 3/11/03 from 9:45 AM until 10:30 AM. The nurse was observed to use a pair of short pointed scissors to cut a different resident's bandage. The nurse was not observed to use bandage scissors during the observation. In an interview with the wound nurse, on 3/11/03 at 3:40 PM, the nurse stated that the pointed scissors she had used earlier that day during treatments were the same scissors she had used when resident 46 was cut. The nurse stated that she had previously lost two pair of her own bandage scissors at the facility and the pointed ones were all she had left to use. The nurse stated she had been waiting for the facility to get some bandage scissors in. In an interview with the DON on 3/11/03 at 3:20 PM, the DON stated she had ordered bandage scissors for the nurses but she had not received them. "The basic types of risks to safety within the health care environment are falls, client-inherent accidents, procedure-related accidents, and equipment -related accidents. The nurse learns to recognize factors associated with these problem areas and to take steps to prevent or minimize accidents in the institution. An accident necessitates the filing of an incident report . . . collected by risk managers who monitor trends and frequencies of incidents in the workplace. Repeated occurrences will lead managers to take preventive actions." (.Potter, Patricia A. RN, MSN, and Anne G. Perry, RN, MSN, ANP, EdD. Basic Nursing Theory and Practice Second Edition. Mosby - Year Book, Inc, 1991., pg 650.)	F 281		

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F 309 F 309 SS=D	Continued From page 15 483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on review of resident medicals records, it was determined that for 2 of the 15 sample residents, the facility did not provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being. Resident identifiers: 9 and 21. Findings include: 1. Resident 9 was a 94 year old male who was admitted to the facility on 7/12/96. The medical record of resident 9 was reviewed on 3/10/03 and 3/11/03. During the review, the following was found in a nurse's note dated 10/10/02: ...Pt. (patient) remain in bed with several times attempted to climb over the bed. CNA (certified nurse aide) tried to teach him to use the urinal. Pt. refused. Protective brief worn..." There was no documented reason in the medical record of resident 9 why he could not be assisted to the restroom by staff. Instead, when resident 9	F 309 F 309 OK 4/11/03 DS	**F309** **Resident 9 will have a Bowel & Bladder assessment updated to reflect accurate incontinence level and a management program & care plan developed to provide necessary care & services to meet this residents needs by a licensed nurse. A Bowel & Bladder Assessment will be completed with the MDS/IDT process when to assure that all residents B&B programs are meeting the residents needs and level of assistance to be assisted to the bathroom and brief applied. Weekly in IDT meeting ADL & Bowel & Bladder status changes will be discussed on all residents and residents that could benefit from a toileting program plan of care will be updated. All nursing staff will be inserviced on the necessity to assist residents maintain their dignity by establishing an appropriate Bowel and Bladder program, & selecting appropriate type of brief, & assistance to the bathroom. The QA/ Standard of Care Committee will monitor effectiveness of this Plan of Action weekly. Resident 21- A Resident Identification card will be placed in front of all residents Medication Record (Medication Book) Clearly identifying Allergies clearly identifying Allergy Alerts. Inservice will be held for licensed nurses to reinforce the need to check Allergies for all new drugs ordered especially by other health care professionals such as Dentist & assuring that Physician Referal has the Allergies clearly identified. The Director of Nursing will provide the inservice and monitor effectiveness of this Plan of Action weekly in QA/Standard of Care meeting.**	5/15/2003

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F 309	Continued From page 16 refused to use the urinal to relieve himself, staff applied a "protective brief". Two nurse aides and one registered nurse were interviewed on 3/12/03 regarding resident 9's condition in October of 2002. They all stated that he made an effort to use the restroom, but that occasionally he would have an incontinent episode. Less than 2 months later, on 12/2/02, a nurse's note documented "...Incont. (incontinent) of B&B (bowel and bladder). Wears adult briefs..." There was no documentation in the medical record of resident 9 to evidence that staff had provided the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being for this resident who was attempting to remain continent by using the restroom. The director of nurses (DON) was interviewed on 3/12/03 regarding the 10/10/02 nurses note where instead of staff assisting resident 9 to the restroom, they let him use an protective brief. The DON stated "they should have taken him to the bathroom". 2. Resident 21 was an 85-year-old female with diagnoses including esophageal reflux, rheumatoid arthritis, gastric ulcer, congestive heart failure and depressive disorder. Resident 21's medical record was reviewed on 3/12/03. On the front of resident 21's record and on her "Resident Admission Information Sheet", it was documented that resident 21 was allergic to penicillin and morphine sulfate. On 10/2/02, resident 21 was seen by the dentist and	F 309		

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F 309	Continued From page 17 was found to have an abscess tooth, which was extracted. The dentist ordered Amoxicillin 500 milligrams (mg) 1 twice a day (BID). Amoxicillin is classified as a penicillin. According to the "Nursing 2003 Drug Handbook", page 70, the use of Amoxicillin is contraindicated in patients hypersensitive to drug or other penicillin's. A review of resident 21's nurses' notes was completed on 3/12/03. The following was documented: 10/2/02 at 11:00 AM: "Pt. [patient] came back from dentist [with] tooth extraction-orders for ABX [antibiotics] to be given ASAP [as soon as possible] d/t [due to] absess." 10/2/02 at 12:00 PM: "ABX [antibiotic] given per LPN [licensed practical nurse] to pt [patient]". 10/2/02 at 1:00 PM: "Was found on chart pt [patient] allergic to "PCN" [penicillin] MD [medical doctor] called stat, pt [patient] assessed stat. Pt [patient] pale [without] cyanosis. Resp [respiration] even, unlabored...states does not feel good". Per the nurses' notes, on 10/2/02, at 12:00 PM, the nurse contacted the facility's medical director to inform her about the resident receiving a form of penicillin to which she was allergic. At 1:15 PM the medical director called and told the facility that resident 21 was not her patient. At 2:00 PM, resident 21's dentist was called. At 3:30 PM, resident 21's dentist returned that facility's call and a telephone order was written to discontinue the Amoxicillin and start EES (erythromycin ethylsuccinate) 500 mg BID.	F 309		

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F 320 F 320 SS=D	Continued From page 18 483.25(f)(2) QUALITY OF CARE A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern is unavoidable. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review it was determined that the facility assessed 1 of 15 sampled residents has having a mood decline with increased verbalizations of sadness, increased negative statements and becoming more tearful and withdrawn when review of the medical record did not evidence that this mood decline was unavoidable. Further, there was no documented evidence that the resident's physician was notified of her mood decline and her antidepressant medications were discontinued. Resident identifier: 23. Findings include: Resident 23 was an 85-year-old female with diagnoses including depressive disorder, esophageal reflux, rheumatoid arthritis, gastric ulcer and congestive heart failure. Resident 23's medical record was reviewed on 3/12/03. Resident 23 had a quarterly MDS (minimum data set) assessment completed with the reference date of 11/10/02. Section E1. Indicators of depression, anxiety and sad mood documented that resident 23 had none of these indicators exhibited in the last 30 days. Section E2. Mood persistence documented that	F 320 F 320	F320 Resident 23's physician will be called & informed of her mood decline since anti-depressant discontinued. This resident will be reviewed by our Psychotropic Drug Committee physician for a recommended antidepressant drug to control mood. The facility has hired a Psychiatric physician (MD) to be part of our Psychotropic Drug Committee to assure that all residents on Psychotropic medications are monitored monthly for appropriate and effective doses of medication. The Director of Nursing will inservice licensed nurses on the importance of notifying the physician of any change in resident status as the result of discontinuing or changing a medications and documentation of follow up in nurses notes. The DON will monitor during weekly Quality assurance meeting. OK 4/4/03 SD Added per Terry Lemmon by phone 4/11/03 9:30 AM Helmdl RN	5/15/2003

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F 320	Continued From page 19 there were no mood indicators present. A review of resident 23's "Care Plan Conference Summary", dated 11/14/02 was completed. The following was documented in the "Summary of Care Plan Conference Discussion" section, "Resident states she still feels "awful" r/t [related to] depression." Resident 23 had a significant change MDS assessment completed with the reference date of 2/9/03. Section E1. Indicators of depression, anxiety and sad mood documented that resident 23 made negative statements, had sad, pained, worried facial expression, had experienced withdrawal from activities of interest and experienced reduced social interaction which was exhibited daily or almost daily (6,7 days a week) and exhibited crying and tearfulness up to 5 days a week. Section E2. Mood persistence documented that the mood indicators exhibited by resident 23 were not easily altered. Section E3. Change in mood documented that resident 23's mood status had deteriorated over the past 90 days. A review of resident 23's "Care Plan Conference Summary", dated 2/12/03 was completed. The following was documented in the "Summary of Care Plan Conference Discussion" section, "Resident expresses sadness [and] having no reason to live". A review of resident 23's plan of care was completed on 3/12/03. A mood care plan initiated in 1999 and most recently reviewed 2/12/03 documented that resident 23 had an alteration in mental health related to depression and declining group and personal therapy. One of the approaches for this identified problem was that resident 23 would have no decline in mood as	F 320		

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F 320	Continued From page 20 evidenced by MDS indicator comparison. One of the documented interventions to address the identified mood problem was to notify the doctor with any status change. On 2/13/03, facility staff developed a care plan for resident 23 for the identified problem of ineffective individual coping related to mood patterns manifested by negative statements, crying, tearfulness and sad appearance. The documented goal for this identified problem was that resident 23 would show bright affect, smiles and positive statements the majority of any given day. A review of resident 23's "Monthly Summary" forms, completed by facility nursing staff was completed on 3/12/03. The "Monthly Summary" form for January 2003 documented the following under the "Progress Towards Nursing Care Plan Goals", "cont [continues] to cry [and] be neg [negative] [at] [times]". The "Monthly Summary" form for February 2003 documented the following under the "Progress Towards Nursing Care Plan Goals", "continues to cry [and] be negative [at] times". An "Comprehensive Pain Assessment General Information" sheet, dated 3/5/03, completed by facility nursing staff for resident 21 and kept in the medication administration record (MAR) was reviewed on 3/12/03. Under the comments section of this form the following was documented, "Pt [patient] has been depressed lately and for a short time stopped eating so that she could die". A review of resident 23's social service progress notes and progress notes from the mental health clinic were	F 320		

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F 320	Continued From page 21 reviewed on 3/12/03. On 10/1/02, the physician from the mental health clinic saw resident 23 and documented that she had been treated with antidepressants for more than 30 years and that she had been started on the anti-depressant Effexor in January 2001 or perhaps before. He recommended the antidepressant Zoloft be decreased to 25 mg a day for 7 days and then to discontinued and the Effexor XR 150 mg twice a day be continued. On 11/14/02, the social worker documented, "[resident 23] stated that she continues to feel very depressed [and] feels she is getting worse". The social worker documented that she would ask the doctor from the mental health clinic to see resident 23 during his next visit. On 12/3/02, 19 days later, the physician from the mental health clinic again saw resident 23. He documented that she appeared much more depressed and assessed that the increase in depression correlated with the taper of the low dose Zoloft that he recommended two months prior. His recommendation was to restart Zoloft 25 mg every day for 7 days then increase to 50 mg every day and to continue the Effexor XR 150 mg twice a day. On 2/12/03, the social worker documented that resident 23 was, "recently moved to monitored dining room in an effort to encourage her to eat as resident is giving up [and] refusing to eat... over the past 30 days [resident 23] made negative statements about wanting to die [and] having nothing to live for daily or almost daily. [Resident 23] has a sad expression daily [and] crying or tearfulness up to 5 days per week. [Resident 23] has withdrawal of activities of interest [and] social interaction. Also during the last	F 320		

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F 320	Continued From page 22 30 days, these mood indicators are not easily altered." She documented that resident 23 had a significant change noted in cognitive, communication and mood areas. An additional note, written by the social worker on 2/12/03, documented that resident 23, "admitted to 'giving up' [and] feeling like she has 'not one thing to live for'". It was also documented that resident 23's family member, who attended the interdisciplinary care plan (IDT) meeting, stated that her doctor had reduced her antidepressants. The family member was noted to be "visibly upset by [resident 23's] hopelessness". A review of resident 23's physician progress notes was completed on 3/12/03. On 6/4/02, the physician documented that resident 23 was more depressed and wrote, "stimulate her -take her out!" He also started her on Ritalin 5 mg twice a day. On 7/8/02, the physician documented that resident 23 had increasing depression. He recommended resident 23 continue her antidepressant Effexor, and start Zoloft 25 mg a day for 1 week then increase to 50 mg a day. He discontinued the Ritalin. On 10/8/02, the physician recommended that the same antidepressants be continued. On 1/3/03, the physician recommended that resident 23 begin Effexor XR 150 mg every day and Zoloft 100 mg every day. On 2/4/03, the physician documented that resident 23 was still mild to moderately depressed. He recommended that her Zoloft be decreased to 50 mg a	F 320		

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F 320	Continued From page 23 day for 2 weeks then 25 mg a day for 2 weeks then stopped. On 3/6/03, the physician documented that resident 23's moods were still variable. He recommended that her Effexor be decreased to 75 mg a day for 2 weeks then discontinued and to stop the Zoloft. Resident 23's "Anti-Depressant Monthly Records" from January 4, 2003 to January 31, February 1, 2003 to February 28, 2003 and from March 1, 2003 to March 12, 2003 were reviewed. These forms were used to track the number of times per shift resident 23 verbalized sadness or made negative comments about herself or others. The following was documented for January 2003 during the 7:00 AM to 7:00 PM shift: Resident 23 verbalized sadness 4 times on the following days: 4, 5, 6, 7, 8, 9, 10, and 11; 3 times on the following days: 12, 13, 15, 16, 17, 18, 24, 25, 26, 27, 28, 29,30 and 31 and 2 times on the following days: 19, 20, 21 and 22. Resident 23 made negative statements 4 times on the 4th and 2 times on the 14th. The following was documented for January 2003 during the 7:00 PM to 7:00 AM shift; Resident 23 verbalized sadness 1 time on the following days: 22, 23, 24, 25, 26, 27, 28, 29 and 30. Resident 23 made negative statements 1 time on the following days: 22, 23, 24, 25, 26, 27, 28, 29, 30 and 31. The following was documented for February 2003	F 320		

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F 320	Continued From page 24 during the 7:00 AM to 7:00 PM shift: Resident 23 verbalized sadness and made negative statements 3 times on the following days: 23, 24, 25,26, 27, and 28. The following was documented for March 2003 during the 7:00 AM to 7:00 PM shift: Resident 23 verbalized sadness 5 times on the following days: 9, 10, 11; 4 times on the 4th, 3 times on the following days: 2, 3, 5, 6, 7; 2 times on the 8th and 1 time on the following days 1, and 12. Resident 23 made negative statements 5 times on the following days: 9, 10, 11; and 2 times on the following days 1, 8 and 12. Resident 23 had an increase in the number of documented times she verbalized sadness in March 2003, after her antidepressant was discontinued, versus February 2003 when she was still receiving her antidepressant medications. On 3/13/03 at 9:05 AM, a nurse familiar with resident 23's care was interviewed. She stated that she had noticed a decline in resident 23's mood that she was more tearful at times and had made negative statements of wanting to die. On 3/13/03 at 9:55 AM, the facility social worker was interviewed. She stated that resident 23 had been more "in a funk" recently. She stated that resident 23 expressed to her that she did not like the physician from the mental health clinic and was not interested in group therapy. The social worker stated that she was unsure if resident 23's doctor had been notified of the mood decline but that she had had not called to inform him and the doctor had not called her to check	F 320		

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F 320	Continued From page 25 on her mood status. On 3/13/03 at 10:10 AM, the facility director of nurses (DON) stated that resident 23's doctor had only called the facility on one occasion because he was upset that she was late for an appointment. On 3/13/03 at approximately 1:15 PM, the DON stated that she was unaware that resident 23's doctor had discontinued her antidepressant medications on 3/6/03 until 3/11/03 when the facility held a psychotropic drug review meeting. There was no documented evidence in the medical record that resident 23's physician was called to inform him of her mood decline with increased verbalizations of sadness, increased negative statements and becoming more tearful and withdrawn identified in February 2003. Resident 23's antidepressant medications were discontinued 3/6/03.	F 320		
F 364 SS=E	483.35(d)(1)&(2) DIETARY SERVICES Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on a confidential resident interview, a confidential group interview held with residents on 3/12/03 at 9:30 AM and temperatures obtained from a test tray during the lunch meal on 3/12/03, it was determined that the facility did not serve food which was at the proper temperature and palatable to the residents.	F 364 OK 4/4/03 DB	F364 The Dietary Manager will implement a test tray tempature log for each meal 3 x's a week for the next 30 days and weekly thereafter. The Dietary Manager will inservice dietary staff on the importance of serving out the food hot. Resident Council will be ask at each meeting if meals are served hot. The Dietary Manager will discuss food temperature weekly in QA/ Standard of Care meeting for effectiveness of Plan of Action and compliance.	5/15/2003

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F 364	Continued From page 26 Findings include: On 3/11/03 at approximately 10:00 AM, a confidential resident interview was conducted. The resident was asked how she liked her breakfast. The resident stated that her food was always served cold. She asked, "Why do you think I have a microwave in my room?" During a confidential group meeting, held 3/12/03 at 9:30 AM, 10 of 10 residents actively participating in the group discussion stated that they were served cold food and the food was not palatable because of this. One resident stated that the food was bad and not served hot. On 3/12/03, a test tray was requested during the lunch meal. It was the last tray served from the kitchen after all resident trays had been served in the main dining room. At 1:04 PM, the test tray was received and the temperatures were taken. The chicken potpie was 104 degrees Fahrenheit and the potatoes were 110 degrees Fahrenheit. The chicken potpie and the potatoes tasted cold and were not palatable.	F 364		
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 observation and staff interview, it was determined that the facility did not store, prepare, distribute and serve food under sanitary conditions as evidenced by: 1. Residents receiving regular and mechanical soft consistency diets were served fried	F 371		

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F 371	Continued From page 27 eggs with yolks that were not congealed during the breakfast meal on 3/11/03 2. In the kitchen, the strip below the freezer, which covers the insulation, was missing and the strip covering the insulation below the walk-in refrigerator was not properly secured and there was a scoop in a box of thickener 3. A resident who received his nutrition via gastrosotomy tube had his tube feeding formula stored on the floor of his room. Finding include: 1. On 3/11/03 observations of the breakfast meal were made in the assist/restorative dining room and the main dining room. All residents receiving regular and mechanical soft consistency diets were served fried eggs, which had yolks that were not congealed. On 3/11/03, at 8:25 AM, regular shell eggs, not pasteurized shell eggs were observed in the walk-in refrigerator. On 3/11/03 at 8:25 AM, the cook who prepared the eggs was interviewed. When asked what type of eggs she prepared for breakfast, she indicated she used shell eggs. She was asked if the facility ever used any other type of egg and she stated that at times they would use liquid eggs in the carton or frozen omelets. She was unsure if the facility ever ordered pasteurized shell eggs. On 3/11/03, at 8:57 AM, the acting food service supervisor submitted a food invoice which, documented that liquid scrambled eggs had been received on 3/11/03, however, there was no evidence provided to the survey team that pasteurized shell eggs were being used by the facility.	F 371 OK 4/11/03 DD	F371 Residents in this facility request fried eggs. The Dietary Manager will implement and follow the facility Fried Egg policy. Dietary staff will be inserviced on the Fried Egg policy. Residents requesting soft fried eggs will be informed by the Dietary Manager the facility policy on Fried Eggs. Dietary Manager will monitor cooks compliance to policy and discuss effectiveness of Plan of Action in weekly QA meeting. Maintenance will repair the strip below the freezer & walk-in-fridge. Scoop in box of thickener was removed. The Dietary Manager will monitor weekly to assure that the scoop is stored properly and not in the thickener box as part of Quality Assurance program. This topic will be covered in a staff meeting by the Dietary Manager. The feeding formula was removed from the floor in residents room. Tube feeding formula will be appropriately stored in the med. Rm. The Director of Nursing will monitor during weekly Quality Assurance rounds to assure compliance.	4/25/2003

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F 371	Continued From page 28 In a food establishment that serves a highly susceptible population: The following food may not be served or offered for sale in a ready-to-eat form: A partially cooked animal food such as lightly cooked fish, rare meat, soft cooked eggs that are made from raw shell eggs and meringue. Reference guidance: U. S. Public Health Service, FDA 2001 Food Code, page 79. 2. Observations during the initial tour of the kitchen on 3/11/03 from 1:06 PM to 1:32 PM revealed the following: a. The strip beneath the walk-in freezer, which was supposed to cover the freezer insulation, was missing. This exposed the freezer insulation making this area unsanitizable. b. The strip beneath the walk- in refrigerator, which was supposed to cover the refrigerator insulation, was coming loose and the insulation was not fully covered. This exposed the refrigerator insulation making this area unsanitizable. c. There was a scoop in a box of food/beverage thickener with the handle in the product. The handle is considered contaminated because staff handles it. 3. On 3/10/03, at 4:20 PM, a resident who received his nutrition via a gastrostomy tube (g-tube) had tube had 7 boxes of tube feeding formula stored on the floor of his room. Food shall be protected from contamination by storing the food...where it is not exposed to splash, dust or other contamination and at least 6 inches above the floor. Reference guidance: U. S. Public Health Service, FDA 2001 Food Code, page 55.	F 371		

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F 426 SS=D	483.60(a) PHARMACY SERVICES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on review of resident medical records and interviews, it was determined that for 1 of 1 residents who was an insulin dependent diabetic receiving sliding scale insulin, the facility did not ensure the accurate administration of insulin. Resident identifier: 15. Findings include: Resident 15 was a 76 year old male who was admitted to the facility on 10/15/96. Resident 15 was an insulin dependent diabetic who had physician's orders to have his blood sugar (BS) monitored four times a day and then receive regular insulin based on the following sliding scale: BS 151 - 200 = 3 units (u) BS 201 - 250 = 5 u BS 251 - 300 = 7 u BS 301 - 350 = 9 u BS 351 - 400 = 11 u > 400 call MD Resident 15's March 2003 blood glucose monitoring record was reviewed on 3/13/03. Between 3/1/03 and 3/13/03, thirteen errors in insulin administration were noted and are listed below. On 3/3/03 at 4:00 PM, resident 15's BS was 343.	F 426 ok 4/11/03 DD	**F426** **Resident 15's (?13) Correct dosage of insulin will be administered by licensed nurses according to B/S sliding scale orders by physician. All licensed nurses will be skills tested on administering insulin according to physician orders and proper documentation & dr. notification. Nurses will call Dr. when treatment needs altered or resident refuses treatment and document in nurses notes and/or by Fax for all residents with Blood Sugar monitoring & Sliding Scale. The D.O.N. will monitor weekly proper documentation & dr. notification for the next 30 days and then monthly through Quality Assurance Program all residents on B/S sliding scale insulin orders.**	5/15/2003

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F 426	Continued From page 30 Facility nurses should have given 9 units of sliding scale insulin, but instead gave 11 units. On 3/3/03 at 9:00 PM, resident 15's BS was 313. Facility nurses should have given 9 units of sliding scale insulin, but instead gave only 3 units. On 3/4/03 at 6:00 AM, resident 15's BS was 270. Facility nurses should have given 7 units of sliding scale insulin, but instead gave no sliding scale insulin. On 3/5/03 at 6:00 AM, resident 15's BS was 397. Facility nurses should have given 11 units of sliding scale insulin, but instead gave only 7 units. On 3/5/03 at 4:30 PM, resident 15's BS was 236. Facility nurses should have given 5 units of sliding scale insulin, but instead gave 8 units. On 3/6/03 at 11:00 AM, resident 15's BS was 323. Facility nurses should have given 9 units of sliding scale insulin, but instead gave none. On 3/7/03 at 11:00 AM, resident 15's BS was 353. Facility nurses should have given 11 units of sliding scale insulin, but instead gave none. On 3/7/03 at 9:00 PM, resident 15's BS was 323. Facility nurses should have given 9 units of sliding scale insulin, but instead gave 7 units. On 3/9/03 at 6:00 AM, resident 15's BS was 197. Facility nurses should have given 3 units of sliding scale insulin, but instead gave none. On 3/10/03 at 6:00 AM, resident 15's BS was 224. Facility nurses should have given 5 units of sliding scale insulin, but instead gave none.	F 426		

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F 426	Continued From page 31 On 3/10/03 at 8:50 PM, resident 15's BS was 362. Facility nurses should have given 11 units of sliding scale insulin, but instead gave only 9 units. On 3/11/03 at 6:00 AM, resident 15's BS was 160. Facility nurses should have given 3 units of sliding scale insulin, but instead gave none.	F 426		
F 494 SS=D	483.75(e)(2)-(3) ADMINISTRATION A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of ss483.151-483.154 of this part; that individual has been deemed or determined competent as provided in s483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility personnel files, it was determined that 1 of 3 nurse aides hired within the past 8 months was not certified prior to the four month anniversary of her hire date. Employee identifier: 1. Findings include:	F 494 OK 4/11/03 DS	**F494** **Employee 1 was terminated as an aide doing direct patient care. All Nursing Aide files will be reviewed to assure that aides are certified, certificates are current and aide registry is called and documented on Background/Registry log by HR Director. The Director of Nursing will monitor non-certified aides for certification within 4 mo. of hire date and terminate if certification is not completed within 4 months of hire. HR Director will discuss and monitor in weekly QA meetings for compliance. The Admin. will review weekly the new hire Background Registry log to assure compliance.**	5/15/2003

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F 494	Continued From page 32 Employee 1 was hired as a nurse aide on 11/6/02. The personnel file of employee 1 was reviewed on 3/12/03. The personnel file did not contain any documentation to evidence that employee 1 had become a certified nurse aide. The State nurse aide registry was called on 3/12/03 at 9:35 AM. The person at the aide registry confirmed that employee 1 was not yet certified. Review of the facility's employee schedule for March 2003 revealed that employee 1 continued to work as a nurse aide after her four month anniversary date.	F 494		
F 496 SS=D	483.75(e)(5)-(7) ADMINISTRATION Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.	F 496 OK 4/11/03 DM	**F496** **Employee 1 was terminated as an aide doing direct patient care. All Nursing Aide files will be reviewed to assure that aides are certified, certificates are current and aide registry is called and documented on Background/Registry log by HR Director. The Director of Nursing will monitor non-certified aides for certification within 4 mo. of hire date and terminate if certification is not completed within 4 months of hire. HR Director will discuss and monitor in weekly QA meetings for compliance. The Admin. will review weekly the new hire Background**	5/15/2003

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F 496	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on interviews and review of facility personnel files, it was determined that for 1 of 3 nurse aides hired in the past 8 months, the facility did not seek information from the State nurse aide registry. Employee identifier: 1. Findings include: Employee 1 was hired as a nurse aide on 11/6/02. The personnel file of employee 1 was reviewed on 3/12/03. The personnel file did not contain any documentation to evidence that the facility had sought information from the State nurse aide registry regarding employee 1 prior to allowing her to serve as a nurse aide. The Administrator was interviewed on 3/12/03 at approximately 9:00 AM regarding employee 1. She was told that the surveyor could not find evidence that the facility had called the State nurse aide registry regarding employee 1. The administrator replied that employee 1 was not certified when they hired her. The surveyor explained that whether an aide was certified or not did not matter and that the facility had to call the State nurse aide registry before hiring any nurse aide. The administrator stated that they had called the nurse aide registry for employee 1. The surveyor asked if the facility had documentation to that effect. The Administrator said "yes" and left the room. The Administrator returned to the room with a piece of paper which documented that the aide registry had been called on 11/6/02 to inquire regarding employee 1. At 9:35 AM, the survey nurse called the State nurse	F 496		

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F 496	Continued From page 34 aide registry and inquired regarding employee 1. The person at the registry stated "a lady called from Infinia at Alta, today, just a few minutes ago to inquire whether (employee 1) had a history of abuse. She was also told she wasn't certified."	F 496		