DEPARTMENT OF HEALTH AND HUM[illegible] SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465142	A. BUILDING _____ B. WING _____	9/21/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINIA AT GRANITE HILLS, INC	**950 EAST 3300 SOUTH SALT LAKE CITY, UT 84106**

(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 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 representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined that for 2 of 14 sampled residents, the facility did not notify the family member of one resident or the physician of another resident when the residents required emergency room treatment. (Residents 30 and 35.) Findings include:	F 157	<See attached>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 11-5-00

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 157	Continued From page 1 Findings include: 1. Resident 35 was a 45 year old female who was admitted to the facility on 5/28/97 with diagnoses including multiple sclerosis, urinary tract infections, pressure ulcers, constipation, and cauda equina injury. Review of the 8/23/00 Minimum Data Set assessment (MDS), for resident 35, documented the resident to have impaired range of motion to her neck and all extremities. The MDS documented resident 35 required total assistance for transfers and bed mobility and limited assistance for locomotion on and off the unit. Review of the nurse's notes, dated 5/29/00, documented resident 35 had suffered a sunburn and dehydration. The nurse's note documented resident 35 required rehydration via an intravenous line (IV) and the resident was sent to an emergency room to have the IV placed. The nurse's notes did not document that resident 35's family had been notified of the incident. Review of resident 35's active record documented the resident's daughter was the facility's contact person. Resident 35's daughter had expressed that she had not been notified of the incident. In interviews on 9/27/00 with resident 35's mother and two sisters, the family members stated the facility had not notified any of them of the 5/29/00 incident. In an interview with resident 35, at 1:30 PM on 9/27/00, the resident was unable to recall the incident. When resident 35 was asked if there was any reason she would request the facility not to notify her family of any unusual incident, resident 35 stated, "I've never thought about it".	F 157		

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F 157	Continued From page 2 2. Resident 30 was a 39 year old female who admitted to the facility 2/6/97 with diagnoses including hemiplegia, cerebral vascular accident, depressive disorder, seizures, and joint pain. Review of the 9/17/00 nurse's note for resident 30 documented, "Resident traveled to 7-11 unassisted and was hit by a truck. No injuries assessed by paramedic at scene. She was not knocked out of her chair [wheelchair]. Transported to [hospital] by ambulance." The nurse's note documented resident 30's family had been notified, but did not document the resident's physician had been notified. In an interview with resident 30's physician on 9/27/00 at 9:45 AM, the physician stated that he had not been notified of the accident which had occurred on 9/17/00..	F 157		
F 164 SS=E	483.10(d)(3)FREE CHOICE The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and	F 164 JB 11/30/00		

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	clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. This REQUIREMENT is not met as evidenced by: [redacted] Based on observations and a confidential group interview, the facility failed to ensure that residents' personal privacy was maintained during personal cares and medical treatments. Specific observations and interviews involved 2 of 14 sampled residents, 8 of 15 residents in a confidential group interview, and 3 additional residents. (Residents 1, 20, 21, 22, 30, 37.) Findings include: 1. An observation of a nurse performing a dressing change to resident 22's pressure sore was made on 9/21/00 at 10:50 AM. The resident's pressure sore was located on his right foot. The facility's acting Director of Nursing (DON) and a nurse aide were assisting the nurse throughout the treatment. Resident 22 resided in a room with two other residents. During the observation, resident 21, a roommate of resident 22, was lying in bed. Resident 21's bed was located directly across from resident 22's. While performing the dressing change to resident 22's pressure sore, the staff did not pull the privacy curtain or otherwise ensure his privacy. 2. Observation from the hallway of the north shower room on 9/27/00 at 3:00 PM revealed that resident 1 was receiving a shower. The door to the shower room was propped open with a large metal trash can. Resident 1 was observed to be sitting in a shower chair facing the hallway. The person assisting resident 1			

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was a family member. The family member had draped towels over resident 1. The towels did not cover all of resident 1's body, exposing his chest and groin area to the hallway.
Although resident 1 was routinely bathed by family members, facility staff would be responsible to ensure that cares were provided in a manner that ensured the resident's privacy.

3. Resident 37 was a 42 year old female who admitted to the facility 7/29/93 with a diagnosis of multiple sclerosis. Resident 37's 7/21/00 Minimum Data Set assessment (MDS) documented the resident to be totally dependent for mobility and the resident had limited range of motion of all extremities.

Observation from the east hallway near room 206, on 9/21/00 at 7:30 AM, revealed that resident 37 was sitting in a wheelchair wearing a hospital gown. The hospital gown covered resident 37's front torso and shoulders. Resident 37 was positioned facing the hallway with her thighs and lower legs exposed. Resident 37's buttocks and sides were exposed as a nurse aide pushed the resident's wheelchair out of her room. Resident 37 spoke quietly to the aide and the aide immediately provided a blanket to cover the resident's lap and legs. As she was being wheeled past a staff member, who was mopping the floor outside resident 37's room, the resident again spoke quietly to the aide. The aide stated, "Oh, it's just [staff member]." Resident 37 was wheeled past the male staff member and the surveyor toward the shower room on the west hall. No attempt was made to cover resident 37's buttocks or sides.

4. Observation from the hallway into the north shower room, on 9/20/00, at 10:00 AM, revealed that resident 22 was receiving a shower. The shower door was

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F 164	Continued From page 5 propped open and two nurse aides were assisting him with his shower. From the hallway, resident 22 was observed in a shower chair, facing the south wall in full side vision. Observation revealed resident 22 to be unclothed and uncovered. 5. Observation from the west hallway, on 9/20/00 at 9:35 AM, revealed resident 30 was being taken through the hall and into the shower room by a nurse aide. Resident 30 had a white blanket wrapped around her torso. The resident had bare legs from mid thigh down and she had bare shoulders. Resident 30 was continually calling out, "My blanket, my blanket". The aide did not respond. 6. Residents 20, 21, and 22, share room 107. Observations were made of room 107 on 9/25/00 and 9/26/00. There was no curtain or privacy covering for the window which opened to an enclosed patio. 7. A confidential interview was held with a group of residents on 9/20/00 at 1:30 PM. Fifteen (15) residents participated in the group interview. Eight (8) of the 15 residents indicated that facility staff do not ensure the residents' privacy during cares. Five (5) of the 15 residents stated that staff leave the door open when they assist residents with dressing or other personal cares. Five (5) of the 15 residents stated that staff routinely leave the door open to the shower room when residents were in the shower. [redacted] [redacted] [redacted]	F 164		

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F 253 SS=F	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: [redacted] Based on observations of the facility's resident rooms; the toilet/bathroom areas, the east, west, north and south hallways, and the dining area; interviews with facility staff, and facility record review, it was determined that the facility had failed to provide building maintenance (repairs to damaged walls, floors, doors, window screens, and equipment/fixtures) and general housekeeping practices (routine and deep cleaning to walls, floors, baseboards, doors, and equipment/fixtures), to afford a sanitary, orderly, and comfortable environment for the facility's residents (25 of 29 resident rooms, 16 of 17 bathroom/bathing areas, and all common areas). Findings include: Observations of the facility's resident rooms, bathroom/bathing rooms, hallways, and the dining area were made throughout the survey; 9/19/00, 9/20/00, 9/21/00, 9/25/00, 9/26/00 and 9/27/00. Areas of concern included: 1. Missing or non-adhering wall baseboards throughout the facility were observed in resident rooms, bath/shower rooms, hallways, and in the downstairs dining area. 2. Walls, ceilings, floors, resident room doors, and resident toilet/bathroom doors, were observed to have one or more of these listed conditions; holes of various sizes and depth, dented areas, gouges in wood or plaster, splintered wood, roughed in plastered	F 253 JB 11/30/00		

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F 253	Continued From page 7 patches, unfinished wallboard, flaking, peeling, scraped paint surfaces, scuff marked areas, chipped and/or missing tiles, mildew appearing areas, brownish/red rust type areas around fixtures, dried food/drink splatters, tape adhesive remnants, missing curtain attachments leaving non-painted areas visible, severely worn areas, and grey/black visibly soiled surfaces, were observed in the facility in the following areas: RESIDENT ROOMS: Room 109: South wall, west of BR (bathroom) door (3" x 3") hole. South wall, east of BR door peeling & flaking paint in area just above coving, an area of (8' X 3'). South wall, had an area (8" X 3") that revealed that some type of item had previously been on the wall and when removed left an area without the current paint. The south wall was noted to have two ¾" holes. Resident's closets were observed to be covered with areas where tape, and tape adhesive remnants, remained on the front surface of the closet door. Door (room entry) had 9 areas of worn and/or splintered wood surfaces. Room 110: Door (room entry) had 8 areas of worn and/or splintered wood surfaces. Room 111: Resident room corner, next to the closet had peeling and flaking paint over a (7" X 1") area. Resident room walls (4) had painted surfaces that had been scraped causing discolored and worn areas. Heater/air conditioner unit had areas where the paint was scraped and was soiled.	F 253		

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F 253	Continued From page 8 Room 112: Resident room walls (4) and the ceiling had peeling and flaking paint. Paint was noted to have been worn off an area just above a resident's bed mattress. West wall area had a plaster patched area that was not painted. South wall area had a (4' X 4') area that was covered with tape adhesive and/or where tape had been pulled off the wall along with the wall's paint. Resident room walls (4) had additional areas where tape, tape adhesive, and nail holes were noted. Resident room area base boards had been removed and were missing from room. Door (room entry) had 6 areas of worn and/or splintered wood. Door (bathroom entry) had 2 areas of worn and/or splintered wood. Room 114: South wall, east and west of the bathroom door, had areas of peeling and flaking paint. Resident room walls had several dents, three ½" dents in wall west of bathroom door, and a (2" X 2") area east of the bathroom door. South wall, east of the bathroom door, had a plaster patched area (16" X 51") that had not been painted, and an area where the plaster board had not been painted. Door (room entry) had worn and splintered wood from the floor to 2 feet above the floor, in the area of the door knob, and on 2 other areas of the door. Room 115: Resident room area, north wall, east and west of the bathroom door, had paint peeling and flaking along a 1 foot area up from the floor. Door (room entry) had worn and splintered areas from	F 253		

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the floor to 2 feet above the floor, in the area of the door knob, and 1 other area of the door.
Door (bathroom) had worn and soiled areas, more pronounced at the area from the floor to 1 foot above the floor.

Room 210:
Room walls had 3 areas where the paint was peeling and flaking.
Ceiling area had previously had a privacy curtain track removed, and the area under it had not been painted.

Room 211:
Resident room area baseboards were missing and in one area of the wall that was now exposed, was a hole that entered into the space between walls.
Room walls had paint damaged areas on the south wall and in the southwest corner of the room.
Door (bathroom) had 7 areas where the wood is worn and splintered.

Room 212:
Wall behind the entry door had an area (12" X 4 1/2 ") that had been plaster patched (area was dry, cracked, and sunken in) and was not painted. There was also peeling/flaking paint and a hole in the wall in this area.
Ceiling area had previously had a privacy curtain track removed and the area under it had not been painted.
Door (room entry) had a splintered area (3/4" X 2"), and 2 other areas that were worn with wood damage.

Room 214:
South wall had an area (2" X 7") that had not been painted over when an item that had been attached to the wall had been removed. The area contained three nail holes.
Door (room entry) had 2 areas where the wood was splintered and worn (3/4" X 26") and an area from the

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F 253	Continued From page 10 floor to the doorknob. Room 215: East wall area had scuff marks, had 2 1/2" paint scrape, and 2 nail holes. Room 217: West wall of room had scraped areas of paint, and had a soiled appearance. The window area was missing some brackets and had not been repainted. East wall of the room had paint scraped areas, and a soiled appearance. Baseboards in the room were loose and had started pulling away from the wall at the area behind the entry door. Splatter type marks were observed on the ceiling of the room. Door (bathroom) had wood damage in a (2" X 3") area where a section had been broken off. Door (room entry) had an area of damage (3" X 1 1/2") in the area of the doorknob. Room 209: East wall and north wall had missing baseboards. Window sill area (2' X 4") had several tiles missing and broken. West wall area (2" X 10") above the baseboard had flaking paint. Door (room entry) had a worn and splintered area (2 1/2" X 32"). Room 207: North wall above baseboard had a (8 1/2 " X 2 3/4") dented area. Door (room entry) had worn and splintered wood along edges and in one other area. Room 206:	F 253		

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F 253	Continued From page 11 South wall edge where it meets the bathroom metal door edge had loose and chipped paint running from the floor to just above the doorknob. Window screen was bent causing an opening of (1" X 10") area. Door (room entry) had an area (6" X 1 1/2") where the wood was splintered along it's edge. Door (bathroom) was observed to be worn and splintered in the area around the doorknob. Room 204: South wall, east of the bathroom door had an area (26 1/2" X 1/1/2") where paint was peeling and flaking. Room 203: North wall had an area (4" X 1/2") where the wallpaper was torn. Door (bathroom) had an area of 16" where the wood was splintered along it's outer edge. Room 202: East wall, north of the entry door had 6 areas where paint was loose and flaking off. South wall, behind the entry door had an area (5 1/2" X 2 1/2") where wallpaper and wall board had been torn off. Room 201: Area just above the resident's mattress had a painted area that was damaged/worn. Wall near the door magnet had 2 areas (9" X 10") (5" x 3") where the wall had been plaster patched, but had not been sanded or painted. West wall had areas where the paint was peeling and flaking. Door frame (bathroom) observed to have a section 17" long where it had not been painted.	F 253		

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F 253	Continued From page 12 Room 106: Wall behind the entry door had an area (46" X 7') that was not painted and had been plaster patched in several areas. Wall east of the bathroom door had an area (3/4" X 9") that had not been painted. Walls and baseboards had splatter type markings, and dry stained areas with run lines going down the wall. Ceiling area had soiled and splatter type markings. Areas that were clean were very visible next to soiled areas. Peeling and flaking paint area (4" X 1/2") was on the wall above and to the right of the light switch. Door (room entry) had 3 areas that were worn and splintered. Room 105: Walls in the room generally had areas that were worn and/or had loose flaky paint. Room 104: Walls on the south side of room were visibly soiled. Ceiling had 5 holes located between the window and the privacy track. Door (room entry) had an area (2" X 10") where the wood is worn and splintered along the outer edge. Door frame (bathroom) was painted on the left and top side, but not on the right side. Room 103: Three areas of floor tile were missing, worn, and/or broken (1" X 1"), (11/2" X 1"), and (2 1/2" X 1"). Door (room entry) was observed to have an area (13" X 1 1/2") that was worn and splintered. The area by the doorknob was worn and splintered on both sides of the door. Room 102:	F 253		

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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) COMPLETE DATE
F 253	Continued From page 13 Door (room entry) had an area (8' X 2 1/2") along the backside of the door that was worn and splintered. There were 4 other areas where the wood was worn and splintered along the outer edges of the door. Room 101: Northeast corner wall had an area with plaster and paint damage. Ceiling, outer corner abutment had a (1" X 1") crack type opening in the painted surface. Baseboards removed and missing in several areas of the room. Room 107: West wall near bed (d) had a hole (15" X 11"), and near bed (c) a dented type hole (10" X 8"). Northeast corner of room, behind the entry door had a (55" X 5 1/2") area where the baseboard was missing. Towels were placed in the void left by the missing baseboards and were 4" deep. These towels were soaked with water. Room walls (4) had several areas where paint was flaking off, and there were splatter type marks on both the walls and the ceiling (more pronounced on the west wall area). Door (room entry) was observed to have an area (21" X 3") on the inside surface that was worn and splintered. WOOD DOORS: All wood doors had scuff marks and light - dark soiled areas (medium to dark was average). This soiled area of the doors was located from the bottom edge up 1 to 2 feet, and was on the outside of the door that faces out to the hallway. TOILET/BATHROOMS (SHARED OR PRIVATE):	F 253		

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	465142	A. BUILDING _____ B. WING _____	9/21/00

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F 253	Continued From page 14 Bathroom 109: Bathroom had a toilet seat covered with chipped and flaking paint. Bathroom floor had black mildew type areas between the tiles, edges, and corners. Bathroom (shared) 110 - 111: Bathroom had a crusty brown ring on the floor surrounding the toilet . Bathroom (shared) 112 - 113: Bathroom wall, behind the sink had paint peeling and flaking off. Bathroom ceiling had 2 large areas where the paint had bubbled out from the surface. Three holes (1" X 1") were noted on the ceiling. Bathroom toilet was twisted 5 inches toward the wall. Bathroom area had paint that had been scraped off from the west wall from the floor to the top of the sink, and was 28 inches wide. Bathroom had broken and missing tiles, the floor had soiled and brown stained areas. Bathroom (shared) 114 -115: Bathroom's south wall by the toilet had greater than twelve round holes, 1/16" to ½" in size. Bathroom wall coving, and area around the toilet and tub, had dark brown/black soiled and/or mildew areas. Bathroom (shared) 210-211: Bathroom had a 4" hole on the wall above the light switch. Bathroom had blackened mildew type areas running along edges and crevices. Bathroom (shared) 214-215: Bathroom had no toilet tank lid. Bathroom's toilet had a brown colored edge that ran	F 253		

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F 253	Continued From page 15 around the fixture. Bathroom floor had grey colored, dirty appearing areas around the edges and corners. Bathroom (shared) 216-217: Bathroom had a brown, soiled appearing area on the baseboards and on the edges and cracks in the floor. The floor corner behind the toilet was especially dirty in appearance. Bathroom's wall tiles (17) located behind the sink and toilet had surfaces chipped. Bathroom ceiling had a (6' X 1") dark marking. Bathroom's baseboards loose on the south and west walls. Bathroom (private) 209: Bathroom's south wall had a (21" X 3") area where paint was peeling and flaking. The area behind the toilet and above the coving had flaking paint. Bathroom's toilet had a brown crusty ring around it. Bathroom (shared) 204-205: Bathroom's toilet had a brown crusted ring (1/2" wide) around it's base. Bathroom's shower area had black mildew appearing edges and surfaces. Bathroom (shared) 202-203: Bathroom had no baseboards for a wall area of (35" X 3"). Painted surfaces in same area peeling and chipped. Indented area (6" X 3") within the walls without baseboard had an area that opened into the space between the walls. Bathroom's painted walls behind the toilet and toilet paper holder had areas of peeling and flaking. Bathroom had peeling and flaking paint at the base of the light box fixture.	F 253		

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F 253	Continued From page 16 Bathroom (shared) 106-201: Bathroom's shower area had black mildew appearing edges and cracks. Bathroom (shared) 104-105: Bathroom's bathtub had a pinkish/orange smeared substance that was dry, and adhered to the tub's bottom surface. Bathroom 103: Bathroom had no lid for the toilet's tank. A plastic tray was placed over tank, not covering the total open area. Bathroom 102: Bathroom's north wall had areas where the paint had been scraped partially off. Bathroom 107: Bathroom had paint and plaster board damage behind the toilet. HALLWAYS (EAST, WEST, NORTH, and SOUTH): Hallways identified as the East, West, North, and South hallways all had areas where baseboards had been removed. Along these hallways were various dents, scraped painted areas, areas with black scuff marks, splatter type markings, paint worn areas, and visibly soiled areas. These type of problems were more pronounced in the area between the floor and the handrails. On the north wall between a front office and the facility entrance, an open, recessed metal wall box was observed on 9/19/00 from 7:30 AM until 4:45 PM. The box contained several bare tipped electrical wires that entered the box from inside the wall.	F 253		

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F 253	Continued From page 17 The electrical outlet by the time box, next to the "day room" was observed to have had no outlet cover plate on 9/19/00, 9/20/00, and 9/21/00. DINING ROOM (DOWNSTAIRS): East wall (farthest east) had a 10 foot section of coving loose and seperated from the wall. North wall had several areas with missing tile pieces. Northwest corner had an area (8" X 2") that had not been painted. West wall area had loose, chipped, and flaking paint. Tile was missing in an area (3' X 2") in front of the door that leads outside. South wall, east and west of the kitchen entrance had 3 areas where tiles were either missing or broken. The wall edges of the dining room were predominately with dark, coffee ground appearing substance along sides of the dining room baseboards. On 9/19/00 and 9/20/00, the wall between the elevator and the resident bathroom (downstairs off the dining room) had four holes where the handrail had been attached. There was no handrail. HOUSEKEEPING: The facility's resident rooms, hallways, doorways, and the dining room area, were noted to have dirty splattered surfaces and/or areas where fluid had run down the surfaces of walls, baseboards, and glass entryways. Facility water fountains were observed on 9/19/00 and 9/20/00. The water fountain across from the south nurses station had spotted areas of a brown substance over the drain area. It also had white crusted mineral type deposits under the water spout and over much of the drain basin.	F 253		

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F 253	Continued From page 18 HEATER/AIR CONDITIONERS: Heater/air conditioners with one or more of the following problems; nonfunctioning heat and/or air conditioner, missing control knobs, dark brown/black soiled areas (especially in crevices and on vent fins) were noted in resident rooms: 111, 112, 115, 211, 212, 214, 217, 209, 204, 203, and 107. Room 111 equipment had scrape type marks and was dirty in appearance. Room 112 did not have the left control knob. Room 115 did not have the left control knob. Room 211 had 2 control knobs missing. Room 212 had 1 control knob missing. Room 214 had 1 control knob missing. Room 217 did not have the front panel secured on the right side of unit. Room 209 had a dirty appearance. Room 204 equipment was not plugged into electrical outlet, had no control knobs, and had dirty appearance. Room 203 equipment was not plugged into electrical outlet and had 2 control knobs missing. Room 107 equipment had no control knobs. FURNITURE/EQUIPMENT: Furniture/equipment with one or more of these noted problems; broken and/or non-functioning devices, tape repairs not adhering to equipment and/or appearing unsightly, soiled furniture and equipment from stains and dried food: Resident rooms: Room 109 - closets with tape adhesive. Room 111 - night stand's 2nd and 3rd drawers broken. Room 115 - night stand with 2 broken drawers. Room 210 - plastic cover on the north wall electrical outlet was broken, exposing wiring where pieces of the outlet were missing.	F 253		

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F 253	Continued From page 19 Room 211 - over bed white metal light fixture soiled resulting in grey appearance. Room 212 - call light fixture on wall covered with duct tape and had a window valance without a curtain). Room 215 - night stand with the front of the bottom drawer broken off and no cover on bathroom toilet tank. Room 217 - blue chair with spotted areas such as from something dripping on it and television soiled with dried food. Room 206 - window screen bent exposing 10 inch long open area. Room 204 - orange chair with duct tape repairs. Room 203 - night stand drawer broken - resident stated it was very difficult to open and close it. Room 202 - green chair with tears in the covering fabric. Room 105 - night stand with 2 of the drawer's front sections broken. Room 103 - no cover over the bathroom toilet tank. Room 107 - brown, fecal smelling stain on an eggcrate mattress propped against the north wall and torn and stained privacy curtains. East hallway, between rooms 106 and 201, the handrail was observed to be broken on the north end, leaving a sharp edge. Review of facility records, regarding ongoing and future interventions, did not focus predominantly on resident areas of daily use, ie. bedrooms, bathrooms, halls, and the dining area. The repair of a severe water drainage problem in the northwest shower room, where water is leaking into an adjacent resident room, and into the dining area, was addressed in a service bid on 9/1/00. At the time of the survey no repairs in this area had been started. Baseboards in the hallways were generally missing when the survey began. Staff indicated that they had been removed over a month	F 253		

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F 253	Continued From page 20 earlier. Problems with the individual room heaters/air conditioners have been ongoing, and records indicate that recently the facility has been doing repairs in this area. As noted in the observations, this is an area that continues to need further action to correct functional and sanitary problems. Interviews with administrative staff indicated that the facility had been at times without a maintenance supervisor over the past several months. Administrative staff indicated that they were aware of many of the previously noted problems, but had not been able to actively address many of them. Interviews with administration indicated that the lack of deep cleaning and sanitation was not an area that had been addressed as a problem. Surveyor: JORGENSEN, SHAREN	F 253		
F 278 SS=E	483.20(g) - (h)RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly-- Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not	F 278 JJB 11/30/00		

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	more than $1,000 for each assessment; or Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Surveyor: JORGENSEN, SHAREN Based on record review, it was determined that for 3 of 14 sampled residents plus one additional resident, the facility failed to ensure that Minimum Data Set (MDS) assessments were done accurately and completely. (Residents 9, 24, 35, and 48.) Findings include: 1. Resident 9 was admitted on 11/27/95 with diagnoses including traumatic brain injury, seizure disorder, organic personality disorder and hypertension. Review of resident 9's Minimum Data Set (MDS) quarterly assessment, dated 6/29/00, documented the resident had been free of falls for the past 180 days (section J4). Review of nurse's notes for resident 9 documented the resident had been injured in falls on 5/17/00 and 5/29/00. The 6/29/00 MDS documented resident 9 did not wear a restraint (P4). Resident 9 was observed on 9/19/00, 9/20/00, 9/21/00 to wear a seat belt when in his wheelchair. A physician's order dated 9/16/99 ordered, "Self-releasing seat belt when up in wheelchair". The comprehensive MDS assessment dated 3/8/00 documented that resident 9 did wear the trunk restraint daily. Resident 9's care plan documented the resident "wears self-releasing seat belt			

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F 278	Continued From page 22 in wheelchair". The 6/29/00 quarterly MDS for resident 9 was incomplete. Required sections that had been left blank included: AA6 - facility provider number; AAa - date and signature persons completing section AA; A2 - residents room number; A4a - date resident reentered the facility from most recent temporary discharge; A6 - residents medical record number; and R2 - signature of registered nurse (RN) Assessment Coordinator. The 3/8/00 comprehensive MDS for resident 9 was incomplete. Required sections that had been left blank included: AA3 - resident's birthdate; AB1 - date of entry; AB11 - date background information completed; A2 - room number, and A4a - date of reentry. 2. Resident 24 was admitted 8/4/00. His diagnoses included traumatic brain injury, motor vehicle accident, and aspiration pneumonia. Resident 24's admission MDS, dated 8/17/00, was incomplete. Required sections that had been left blank included: AA6 - provider number; AA7 - medicaid number; AB4 - zipcode of prior primary residence; AB11 - date of background information completed; AC1 - eating patterns and activities of daily living pattern; ADa - signatures and titles; A6 - medical record number; F1 and F3 - psychosocial well-being; G1gb - staff support for dressing; I1 - diagnoses; I2 - infections; and N1 through N5 - activity pursuits. 3. Resident 35 was admitted 5/28/97. Her diagnoses included multiple sclerosis, pressure ulcers, gastro-intestinal bleed, cauda equina injury, and	F 278		

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F 278	Continued From page 23 insomnia. Resident 35's significant correction MDS, dated 5/23/00, was incomplete. Required sections that had been left blank included: AA6 - provider number; AA7 - medicaid number; AB4 - zipcode of prior primary residence; AB6 - occupation; A2 - room number; and A4a - date of reentry. In addition, the resident had two quarterly MDS assessments dated 8/23/00. Although these assessments had the same date, the resident's condition was inconsistent between the two assessments. The inconsistencies were; cognition, memory, delerium, communication, mood, modes of transfer, infections, and pressure ulcers. These quarterly MDS assessments were dated as complete and signed by interdisciplinary team members, but were not signed by a registered nurse coordinator. 4. Resident 48 was admitted 8/1/00. His diagnoses included traumatic brain injury, obstructive hydrocephalous, and insomnia. Resident 48's comprehensive MDS dated 8/14/00 was incomplete. Required sections that had been left blank included: AB1 - date of entry; AB4 - zip code of prior primary residence; AB6 - occupation; AB10 - any MR/DD status; AB11 - date background information completed; AD - signatures and dates section; A3 - assessment reference date; A5 - marital status; A6 - medical record number; A8 - reason for assessment; A10 - advanced directives; C1 hearing; C2 - communication devices; F1, 2, and 3 - psychosocial well-being; J4 - accidents; and R2a - signature of RN coordinator.	F 278		

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F 281 SS=D	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: Surveyor: BATEMAN, GREGORY Based on observations, staff interviews and record review, for 2 of 14 sampled residents, the facility failed to ensure that nursing staff provided wound treatment in accordance with professional standards of practice. (Residents 4 and 22.) Findings include: 1. Resident 22 was admitted to the facility on 5/5/97. His diagnoses included traumatic brain injury with depressive and agitated features, muscle spasms, hypertension, bladder spasms and a history of a deep vein thrombosis. The resident had a stage III pressure sore to the outer portion of his right foot. An interview with the facility's acting Director of Nursing (DON) was held on 9/19/00 at 10:10 AM. The DON stated that resident 22 had a stage III pressure sore to his right foot. She stated that the current treatment to the resident's pressure sore was to apply Silvadene and wrap with gauze. On 9/21/00 at 11:00 AM, the DON estimated resident 22's pressure sore to be approximately 2.5 centimeters round. A review of resident 22's medical record was done. On 9/4/00, a telephone order was obtained to apply a Silvadene dressing to the resident's right lateral foot pressure sore two times a day. An observation of a nurse performing a dressing change to resident 22's right foot pressure sore was done on 9/21/00 at 10:50 AM. The nurse was assisted	F 281 JB 11/30/00		

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F 281	Continued From page 25 by the facility's DON and a nurse aide and was done in the resident's room. The nurse, while wearing gloves, removed the old dressing from the resident's right foot. She then removed the gloves, washed her hands, then applied clean gloves. The nurse did not bring supplies to cleanse the resident's pressure sore. The nurse performing the dressing change asked the nurse aide to get a wet wash cloth. The nurse aide left, then returned to the room with a wash cloth. She then went into the resident's bathroom and placed the washcloth under running tap water. The nurse aide then gave the wet wash cloth to the nurse. The nurse wiped the stage III pressure sore with the wet wash cloth, then without changing gloves or washing her hands, applied Silvadene ointment to a 2 x 2 gauze dressing and applied it to the pressure sore. The nurse then wrapped the resident's entire right foot with a Kerlex gauze roll. The nurse did not wash her hands after cleansing the stage III pressure sore and prior to applying a clean dressing. In addition, a wash cloth would not be considered a clean dressing supply appropriate to cleanse a stage III pressure sore. 2. Resident 4 was readmitted to the facility on 9/8/00. His diagnoses included traumatic brain injury, seizure disorder, pressure sores, and neurogenic bladder. An interview with the DON was held on 9/19/00 at 10:10 AM. The DON stated that resident 4 had pressure sores on his feet and that staff were doing wet to dry dressings to them using normal saline. A review of resident 4's medical record was done. On 9/8/00, the physician had ordered wet to dry dressing	F 281		

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F 281	Continued From page 26 changes to both heel pressure sores. An observation of a nurse performing dressing changes to resident 4's right and left foot was made on 9/21/00 at 10:00 AM. The nurse wore gloves to remove the old dressing from the resident's left heel. The resident had a scabbed pressure sore on his heel. The nurse removed her gloves, applied clean gloves then applied a 2 x 2 gauze dressing saturated with normal saline. The nurse then applied a dry 2 x 2 gauze dressing and taped the dressing in place. The nurse washed her hands when she completed the dressing to the left foot. The nurse did not provide any cleansing to the pressure sore between removing the old dressing and applying the new dressing. The nurse then removed the old dressing from the resident's right heel. The resident was noted to have a scabbed pressure sore to his right heel. The nurse then applied a 2 x 2 gauze dressing saturated with normal saline, followed by a dry 2 x 2 gauze dressing. Again the nurse did not provide any cleansing to the pressure sore between removing the old dressing and applying the new dressing. In addition, the nurse did not wear gloves or wash hands while performing the dressing change to the resident's right heel. The U.S. Department of Health and Human Services, Pressure Ulcer Treatment Clinical Practice Guidelines, Number 15, page 18, documents, "Stage II, III, and IV pressure ulcers are invariably colonized with bacteria. In most cases, adequate cleansing and debridement prevent bacterial colonization from proceeding to the point of clinical infection....Minimize pressure ulcer colonization and enhance wound healing by effective wound cleansing and debridement...."	F 281		

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F 287 SS=E	483.20(f)(1-4)Resident Assessment Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: Admission assessment; Annual assessment updates; Significant change in status assessments; Quarterly review assessments; A subset of items upon a resident's transfer, reentry, discharge, and death; Background (face-sheet) information, if there is no admission assessment; Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by HCFA and the State. A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month, including the following: Admission assessment; Annual assessment; Significant change in status assessment; Significant correction of prior full assessment; Significant correction of prior quarterly assessment;	F 287 JSB 11/30/00		

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Quarterly review;

A subset of items upon a resident's transfer, reentry, discharge, and death;

Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

The facility must transmit data in the format specified by HCFA or, for a State which has an alternate RAI approved by HCFA, in the format specified by the State and approved by HCFA.

This REQUIREMENT is not met as evidenced by:
Surveyor: JORGENSEN, SHAREN

Based on review of the Health Care Finance Administration's (HCFA) State Report error details, Facility's Data Submission Summary and resident clinical records for 7 of 14 sample residents and 17 additional residents, it was determined that the facility had not transmitted Minimum Data Set (MDS) information on a monthly basis as required. Residents 9, 20, 22, 24, 25, 30, 32, 35, 45, and CR1, CR3, CR4, CR5, CR6, CR7, CR8, CR10, CR11, CR12, CR13, CR14, CR15, CR16, CR17, CR18, CR19.

Findings include:

1. A review of the HCFA's Missing Assessment Report for the facility documented that the facility had not electronically transmitted MDS discharge information to the State for 17 residents who are no longer at the facility.

a. Resident CR3's last MDS transmission was dated 2/16/00 and there was no transmission between 8/18/99 and 2/16/00.

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F 287	Continued From page 29 b. Resident CR4's last MDS transmission was dated 7/6/98 and had an incorrect social security number c. Resident CR5's last MDS transmission was dated 6/16/99 and there was no transmission for a required December, 1998 MDS. d. Resident CR6's last MDS transmission was dated 3/24/99. e. Resident CR7's last MDS transmission was dated 11/10/99. f. Resident CR8's last MDS transmission was dated 10/14/98. g. Resident CR10's last MDS transmission was dated 6/16/99. h. Resident CR11's last MDS transmission was dated 2/3/99. i. Resident CR12's last MDS transmission was dated 5/7/99. j. Resident CR13's last MDS transmission was dated 6/23/99. k. Resident CR14's last MDS transmission was dated 3/16/00. l. Resident CR15's last MDS transmission was dated 10/29/99. m. Resident CR16's last MDS transmission was dated 4/24/00. n. Resident CR17's last MDS transmission was dated 1/26/00. o. Resident CR18's last MDS transmission was dated 4/3/00. p. Resident CR19's last MDS transmission was dated 5/18/00. 2. Individual Resident Records a. Resident 9 did not have an encoded MDS transmitted to the State for the five months between 1/26/00 and 6/29/00.	F 287		

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F 287	Continued From page 30 b. Resident 20 did not have an encoded MDS transmitted to the State for the six months between 12/29/00 and 6/28/00. Resident 20 was temporarily discharged from the facility 6/21/99. No MDS Reentry Tracking form was transmitted to the State. c. Resident 22 did not have an encoded MDS transmitted to the State for the six months between 8/18/99 and 2/16/00. d. Resident 24 was admitted to the facility on 8/4/00. Resident 24 did not have an encoded MDS transmitted to the State from this facility. e. Resident 25 did not have two required encoded MDS assessments transmitted from the facility for the eight months between 5/20/99 and 1/26 /00. An MDS temporary discharge tracking and an MDS re-entry tracking form were transmitted in October, 1999. f. Resident 30 did not have an encoded MDS transmitted to the State for the six months between 11/17/99 and 5/18/00. g. Resident 32 did not have an encoded MDS transmitted to the State for the six months between 6/9/99 to 12/1/99. h. Resident 35 did not have an encoded MDS transmitted to the State for the five and a half months between 6/2/99 and 11/24/99. i. Resident 45 did not have an encoded MDS transmitted to the State for the six months between 1/19/00 and 7/21/00. j. Resident CR1 did not have an encoded MDS transmitted to the State for the nine months between	F 287		

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F 287	Continued From page 31 6/16/99 and 3/8/00.	F 287		
F 316 SS=D	483.25(d)(2)QUALITY OF CARE A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Surveyor: JORGENSEN, SHAREN Based on observations, interviews, and record review, it was determined the facility did not provide appropriate, timely services for continence cares for 2 of 14 sample residents and 1 additional resident who required staff assistance for toileting and hygiene tasks. (Residents 9, 20, and 49.) Findings include: 1. Resident 9 was admitted to the facility on 11/27/95 with diagnoses including traumatic brain injury, seizure disorder, hypertension, organic brain disease, organic personality disorder, and insomnia. Observations of resident 9 were made on 9/19/00. At 2:30 PM, resident 9 was observed in his wheelchair as he was being taken, by a recreation aide, across the parking lot to an activity in an adjacent building. Resident 9 was wearing navy blue sweat pants which were wet from his perineal area to his knees. No staff offered assistance with incontinence care to the resident. At 5:20 PM, resident 9 was observed sitting in his wheelchair, at a dining room table. He was still wearing the same sweat pants. A restorative aide was seated at the table assisting and cuing resident 9 with	F 316 JB 11/30/00		

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his meal, but did not offer continence cares. Resident 9 was observed to be wearing the wet sweat pants for 2 hours and 50 minutes.

Observations of resident 9 on 9/20/00, at 11:25 AM, revealed resident 9 to be propelling his wheelchair through the hallway to the elevator. Resident 9's tan pants were visibly wet at his perineal area and between his legs. At 11:45 AM, resident 9 was sitting in his wheelchair, at a dining room table, wearing the same tan pants. At 1:00 PM, resident 9 was observed to be in the hallway, near the northeast nurses station, wearing the tan pants which were visibly wet in the perineal area. At 2:40 PM, resident 9 was observed to be in the hallway wearing the wet tan pants. At 3:15 PM, an aide assisted resident 9 to the bathroom and into dry pants. Resident 9 was observed to wear the same wet pants for a period of 3 hours and 50 minutes before staff assisted him with incontinence cares.

Review of resident 9's Minimum Data Set assessment (MDS) dated 6/29/00 documented the resident required extensive assist of staff for dressing and hygiene cares, and required limited assist of staff for toileting. Resident 9 was documented as having gone from occasionally incontinent, on the 3/8/00 MDS, to multiple daily episodes of bladder incontinence on the 6/29/00 MDS.

Resident 9's care plan, originally dated 7/27/99 and reviewed 4/25/00, documented the resident had a deficit in performing activities of daily living (ADLs) and was occasionally incontinent. Resident 9's care plans, dated 7/27/99 and 1/21/00, documented the facility was to "check for incontinence every two hours and as needed", "assist with toileting every two hours", and "assist with peri care after every incontinent episode."

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Surveyor: BATEMAN, GREGORY

2. Resident 20 was admitted to the facility on 6/21/99. His diagnoses included a traumatic brain injury with aggressive features, seizure disorder and hypertension.

Observations of resident 20 were made on 9/20/00. At 11:05 AM, the resident was transferring himself from his bed to his wheelchair. There was no staff in the room. The resident's grey sweat pants were wet on both inner legs from the perineal area to below his knees. In addition, the seat of his pants was wet. When seated in the wheelchair, his wet pants remained visible.

The resident propelled himself into the hallway near the north nursing station. There were licensed staff and nurse aide staff in the area of resident 20. No staff offered assistance to the resident to change his wet clothing. The resident remained in his wheelchair and propelling himself throughout the hallway until 11:50 AM.

At 11:50 AM, a nurse aide assisted resident 20 to the dining room. The resident's pants remained visibly wet. The nurse aide brought and set up the resident's lunch meal and placed a clothing protector around the resident's neck. The resident remained in the dining room until 12:48 PM, at which time he propelled himself to the elevator and returned to the main floor of the facility. The resident continued to propel himself through the hallway until 2:00 PM, at which time a nurse aide assisted the resident back to his room to provide incontinence cares.

An interview with a nurse aide was held on 9/19/00 at 2:00 PM. The nurse aide stated that resident 20 was incontinent. She stated that resident 20 needed incontinence cares about every two hours. This nurse

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aide stated that resident 20 was not resistive to incontinence cares.

An interview with one of the facility's restorative nurse aides (RNA) was held on 9/27/00 at 3:10 PM. The RNA stated that resident 20 was incontinent of urine when staff do not assist him to the bathroom. She stated that the resident should be toileted every one to two hours in order to keep him dry.

A review of resident 20's medical record was done. On 6/28/00, facility staff completed a full, annual MDS assessment. The resident was assessed as having complete control of bladder continence. Resident 20 had no toileting programs or appliances assessed as being necessary to maintain continence.

A review of resident 20's comprehensive care plan was done. The care plan identified a problem of, "Incontinent of urine frequently". The goal for this identified problem was, "Resident will be clean, dry, odor free, and free of skin irritation thru next review." Approaches for this identified problem included, check every two hours and as needed for incontinence, toilet every two hours and as needed and assist with peri care with each incontinent episode. The date of this care plan problem was not present, however, the target date identified for completion was 3/28/00.

There was an additional care plan problem of, "Incontinent of B/B [bowel and bladder]." The goal for this identified problem was, "Will be clean, dry [and] odor free till next review." Approaches for this identified problem included, peri care after each incontinent episode and to monitor for incontinence during group activities and report to nurse. This care plan problem was dated 6/13/00.

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F 316	Continued From page 35 An additional care plan problem indicated resident 20 was, "Incontinent of B/B." The goal for this identified problem also stated the resident would be clean, dry and odor free through the next review. Approaches for this identified problem also included, encourage to use bathroom as needed, peri care after each incontinent episode, and to monitor for incontinence during group activities and report to nurse. The target date for completion of this identified problem was 9/13/00. Surveyor: KUHN, REGINA 3. Resident 49 was a 48 year old male admitted on 9/6/00. His diagnoses included organic brain syndrome with a history of traumatic brain injury and seizure disorder. Observations of resident 49 were made on 9/19/00 at 7:45 AM. At that time, the resident was standing near the entrance to the facility. He was wearing olive green pants which were wet from his perineal area to below his knees. Both licensed nursing and nurse aide staff were in the area, however, no staff offered assistance with incontinence care to the resident. At 8:20 AM, resident 49 was in the dining room. He was still wearing the olive green pants which remained wet at the perineal area. Both licensed nursing and nurse aide staff were in the area, however, no staff offered assistance with incontinence care to the resident. Resident 49 was again observed at 3:35 PM that same day. The resident remained in the same olive green pants which were again visibly wet. A review of resident 49's medical record was done. On 9/20/00, facility staff completed a full MDS assessment. The resident was assessed as being occasionally incontinent of bladder. The MDS documented the resident was on a scheduled toileting	F 316		

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F 316	Continued From page 36 plan.	F 316		
F 324 SS=G	483.25(h)(2)QUALITY OF CARE The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: BUSENBARK, LESLEE Based on observation, interview and record review, it was determined that for 2 of 14 sampled residents, the facility did not provide necessary assistance or supervision to assist one resident out of the sun which resulted in the resident suffering heat stroke and to prevent one resident from leaving the facility without supervision which resulted in an accident with a motor vehicle. (Residents 30 and 35.) Findings include: 1. Resident 35 was readmitted to the facility on 11/13/97 with diagnoses that included, multiple sclerosis (MS), urinary tract infection, gastro-intestinal bleed, pressure ulcer, and neurogenic bladder. Review of resident 35's medical record on 9/27/00, revealed the following: A nursing note dated 5/29/00 at 12:00 PM, documented, " Pt. [patient] became heat stroke [sic], had been outside in sun to long. Pt. was red and became unresponsive. Unable to hear B.P. [blood pressure], P [pulse] 96, R [respirations] very rapid. Called [physician] orders to start IV [intravenous] D5 1/2 N.S to hydrate pt. Cold clothes applied [with] ice to body and forehead. T [temperature] [down] 99.6	F 324 SB 11/30/00		

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within 10 minutes. Pt. became more responsive. Orders to send pt to emergency room if unable to start IV. Unable to start IV. Called transport."

A nursing note dated 5/29/00 at 7:00 PM, documented, "Returned from [care facility]. D/C [discontinue] IV fluid when finished."

A nursing note dated 5/29/00 at 8:00 PM, documented, "IV fluid complete. D/C IV line [no] problems. Pt. A/O [alert and oriented] has sunburn to arms [and] face."

A nursing note dated 6/6/00 documented, "Wkly sum. [weekly summary]. [No] further complication to sunburn. Dehydration on day of occurence. Hydration adm [administration] via PIV [peripheral intravenous] [without] complications...."

A physician's telephone order dated 5/29/00 documented, " Start IV D5 1/2 N.S. to hydrate pt., if unable, send to emergency room."

Facility staff completed an MDS assessment for resident 35 on 5/23/00. Resident 35 was assessed as having short and long term memory problems and some difficulty in new situations with cognitive skills for daily decision making. The resident was also assessed as being totally dependent on staff for transfers both to and from bed, chair, and wheelchair. In addition, resident 35 was not ambulatory and required the physical assistance of one person with locomotion both on and off the unit of the facility. Resident 35 was also assessed as requiring an application of ointment or medication to her skin.

Review of resident 35's comprehensive plan of care revealed the following:

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F 324	Continued From page 38 Care plan problem # 3, originally dated 1/14/00, revealed the problem "Resident dependent on staff for all ADL's [activities of daily living] d/t [due to] MS". The interventions included that the facility staff was to "provide all transfers". Review of the May, 2000 treatment record for resident 35 revealed that the resident had a physician's order for sunblock SPF 30 every day as needed. There was no documentation which would indicate that sunblock had been applied to resident 35's skin on 5/29/00. Surveyor: JORGENSEN, SHAREN 2. Resident 30 was a 39 year old female who admitted to the facility 2/6/97 with diagnoses including hemiplegia, cerebral vascular accident, depressive disorder, seizures, and joint pain. Resident 30 was three feet ten inches tall, non-ambulatory, and she used a fitted, low wheelchair for locomotion. Observation of resident 30 on 9/19/00, 9/20/00, 9/21/00, 9/25/00, 9/26/00 and 9/27/00 revealed the resident to use the fitted, low wheelchair for locomotion both in and out of the facility. No wheelchair flag was observed during that time (as was identified as an approach on the resident's care plan). On 9/26/00 at about 4:30 PM, resident 30 was observed to be alone at a bus stop, attempting to get on a city bus. A facility staff member who had just arrived on another bus saw resident 30 and ran to take the resident back to the facility. On 9/27/00 at 1:45 PM, resident 30 was observed being returned from a nearby bakery by a bakery staff member. Resident 30 did not have a wheelchair flag, was not accompanied by a responsible person, and had not signed out in the facility sign out book.	F 324		

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Review of the 9/17/00 nurse's note for resident 30 documented, "Resident traveled to [convenience store] unassisted and was hit by a truck. No injuries assessed by paramedic at scene. She was not knocked out of her chair [wheelchair]. Transported to [hospital] by ambulance."

In an interview with the Administrator, on 9/26/00 at 10:30 AM, he expressed concern regarding the safety of the resident. The Administrator stated that resident 30 usually goes out of the facility each afternoon, often to the bakery nearby. He further stated that the bakery personnel will frequently help her get back to the facility.

An interview was held with a facility social service employee on 9/27/00 at 8:00 AM. She said she was aware that some residents were allowed to come and go from the facility independently, but she did not know who they were. She said there is no list identifying the residents who can leave as they wish.

In an interview, on 9/27/00 at 10:20 AM, two nurse aides were interviewed about which residents could be allowed to leave the facility unsupervised. Together they named six residents and added, "Most of the time they'll sign out." One of the aides stated, "Those are it", and the other aide agreed. Resident 30 was not named by either of the aides.

An interview was held with resident 30's physician on 9/27/00 at 9:45 AM. He stated that resident 30 used to be able to go out on her own safely. He stated that recently she has not been safe.

Review of resident 30's MDS assessments was done. Facility staff documented resident 30's short and long

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F 324	Continued From page 40 term memory had declined between 5/18/00 and 8/13/00. Comparison of the two MDSs further documented resident 30 had declined from "modified independence" in cognitive skills for daily decision-making to "moderately impaired - decisions poor, cues/supervision required". Review of resident 30's care plan, dated 5/18/00 and reviewed by the interdisciplinary team on 8/18/00, documented the resident had, "Alteration in thought process related to personality change manifested by unsafe in community." The care plan goal was, "Resident will sign out when leaving building every day through next review." The approaches on resident 30's care plan included, "Offer her a wheelchair flag; Remind of traffic safety rules i.e.: cross at corners, avoid dark colors, use sidewalks; Ensure sign out book is available;" and "If she forgets, explain importance of signing out to her." Review of the physician's orders dated 6/28/00, documented resident 30 could have a "therapeutic LOA [leave of absence] with responsible person according to facility policy as needed." Review of the sign out/release of responsibility for leave of absence book documented resident 30 had been signed out by family members 1 to 3 times a month since May, 2000. Review of the sign out book documented resident 30 signed herself out on 6/19/00 at 2:20 PM and back in at 4:10 PM. The only other time resident 30 had signed herself out was at 2:40 PM on 9/18/00, this was the day following the motor vehicle accident.	F 324		
F 325 SS=G	483.25(i)(1)QUALITY OF CARE Based on a resident's comprehensive assessment, the	F 325		

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facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.

This REQUIREMENT is not met as evidenced by:

Surveyor: KUHN, REGINA

Based on interviews and medical record review, for 1 of 14 sample residents, the facility did not ensure that a resident maintained acceptable parameters of nutritional status, such as body weight, as evidenced by: a resident lost 8.87% of his body weight during his original admit stay, while his only nutrition was by gastric tube feeding. (Resident 24)

Findings include:

Resident 24 was a 31 year old male admitted to this facility with diagnoses of aspiration pneumonia, traumatic brain injury from a motor vehicle accident, and constipation. Resident 24 required placement and continued use of a gastric feeding tube to maintain nutrition.

On 9/19/00, review of resident 24's medical record, revealed that he had been admitted to this facility on 8/4/00, and had been discharged to an acute care hospital on 9/9/00, to rule out aspiration pneumonia with an increased temperature of 104 degrees Faranheit and increased lethargy.

Review of resident 24's original admit orders, revealed that the resident had a physician's order to be given a bolus of Isosource (an enteral feeding supplement) of 500cc (cubic centimeters) four times every day, amounting to 2000cc over a twenty four hour period. Resident 24 had a physician's order for a free water bolus of 150cc four times a day and after medications.

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F 325	Continued From page 42 Review of the nursing enteral flow sheet on 9/20/00, revealed that the boluses of Isosource 500cc, to be given at 9:00 PM, were not documented as being given on 8/5/00 through 8/10/00. The nursing enteral flow sheet documented that 5 of 30 boluses were missed. These boluses would amount to 2500ccs of Isosource feeding. On 9/20/00, review of resident 24's medical record, revealed that a new physician's order had been written on 8/11/00 to change resident 24's enteral feeding. The order stated that the enteral feeding would be changed to Isosource 100cc an hour for 10 hours from 8:00 PM until 6:00 AM with Isosource bolluses of 250ccs twice a day. There was no change in the orders on the free water boluses from the original admit orders. Review of the nursing enteral flow sheet on 9/20/00, evidenced that on 8/11/00, 8/12/00, 8/14/00, 8/15/00, 8/16/00, 8/18/00, from 8/20/00 through 8/28/00, 8/30/00 and 8/31/00, there was no documentation that the 5:00 PM bolus of Isosource 250cc had been given. The enteral flow sheet documented that 17 of 31 boluses were missed. These boluses would amount to 4250cc of Isosource feeding. On 9/20/00, review of the nursing enteral flow sheet for resident 24, revealed that on 9/1/00, the two boluses at 8:00 AM and at 5:00 PM, of 250cc of Isosource, were not documented as being given. On 9/8/00, there was no documentation that the 5:00 PM bolus of Isosource 250cc was given. The enteral flow sheet documented that 3 of 16 boluses were missed. These missed boluses would amount to 750cc of Isosource feeding.	F 325		

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On 9/20/00, review of resident 24's weight monitoring sheet, revealed that resident 24 had been admitted to this facility on 8/4/00 without an admit weight obtained. The facility documentation recorded the resident's weight to be 169 pounds during the first week in August. The facility documentation recorded the resident's weight to be 154 pounds the first week in September. There were no other weights documented. The difference in the two weights indicated that resident 24 had an 8.87% decrease in body weight, or 15 pound weight loss from admit to this facility until he was discharged to an acute care hospital on 9/9/00.

The dietary assessment and resident 24's care plan recommended weekly weights to be done. A nurses note, dated 8/21/00, stated TO (telephone order) for weekly weights. There were no weekly weights documented.

On 9/21/00, at 1:45 PM until 3:00 PM, an interview was conducted with the acting DON (director of nursing), the former DON, the Staff Developer, the dietary supervisor, the Adminstrator and the Corporate Administrator, to gain information concerning resident 24's significant weight loss, hospitalization, and lack of documentation on resident 24's enteral flow sheets.

During this interview, the acting DON stated that she has been assigned to work during the graveyard shift. She stated that there were times that resident 24 would have episodes of nausea and/or vomiting during the continuous night feedings. She stated that she would discontinue the Isosource feeding due to the resident's intolerance. She stated that she assumed the day shift nurse would make up for any loss of feeding due to the inturruption of the continous feeding.

There was one nurses note, on 8/21/00 that

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F 325	Continued From page 44 documented the tube feeding was discontinued related to emesis. There was no documentation to support that either the night or day shift nurses gave resident 24 additional tube feedings to make up for the amount missed related to intolerance. When asked about the lack of documentation on the enteral flow sheet for resident 24, the acting DON said she did not believe the tube feedings were missed, just not documented. The acting DON said that the floor nurses were very aware that resident 24 was their most acute (seriously ill) resident. During the interview, the dietitary supervisor stated that she had voiced a weight concern prior to resident 24's transfer to the hospital. She stated that she had done the nutritional assessment on 8/8/00 on resident 24, but the dietary consult was not done until 8/24/00.	F 325		
F 327 SS=G	483.25(j)QUALITY OF CARE The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Surveyor: KUHN, REGINA Based on interviews and medical record review, for 1 of 14 sampled residents, the facility did not provide fluid intake to maintain proper hydration as evidenced by: a resident, whose only source of hydration was by a gastric tube, did not receive sufficient fluid, as prescribed by his physician. (Resident 24.) Findings include: Resident 24 was a 31 year old male admitted to this facility with diagnoses of aspiration pneumonia,	F 327 JSB 11/30/00		

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traumatic brain injury from a motor vehicle accident, and constipation. Resident 24 had required, and continued to require a gastric feeding tube to maintain nutrition and hydration.

Review of resident 24's medical record, revealed that he had been admitted to this facility on 8/4/00, and had been discharged to an acute care hospital on 9/9/00, to rule out aspiration pneumonia with an increased temperature of 104 degrees Faranheit and increased lethargy.

Review of resident 24's original admit orders, on 9/19/00, revealed that the resident had physician's orders to be given a bolus of Isosource (an enteral feeding supplement) of 500cc four times every day. A 500 cc bolus of Isosource provided 388cc of water. Over a twenty four hour period, the resident would have received 1940 cc of water from the bolus feedings. Resident 24 had physician's orders for a free water bolus of 150cc four times a day and after medications.

Review of the nursing enteral flow sheet on 9/20/00, revealed that the boluses of Isosource 500cc to be given at 9:00 PM, were not documented as being given on 8/5/00 through 8/10/00. These six missed bolus feedings would amount to 2328cc of water. The nursing enteral flow sheet documented that from 8/5/00 through 8/10/00, resident 24 missed 22 of 24 free water boluses. The missed boluses of free water would amount to 3300cc of water.

On 9/20/00, review of resident 24's medical record, revealed that a new physician's order had been written on 8/11/00 to change the resident's enteral feeding. The physician's order stated that the enteral feeding would be changed to Isosource 100cc an hour for 10

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hours from 8:00 PM until 6:00 AM, with Isosource bolluses of 250cc twice a day. There was no change in physician's orders on the free water boluses from the original admit orders. The new orders would provide 1164 cc of water from tube feedings.

Review of the nursing enteral flow sheet on 9/20/00, revealed that on 8/11/00, 8/12/00, 8/14/00, 8/15/00, 8/16/00, 8/18/00, from 8/20/00 through 8/28/00, 8/30/00, and 8/31/00, there was no documentation that the 5:00 PM bolus of Isosource 250cc had been given. These missed boluses of Isosource were 17 of 41 boluses to be given. The missed boluses of Isosource amounted to 3298cc of water. The nursing enteral flow sheet documented that 31of 84 free water boluses of 150cc each had not been given. These missed free water boluses amounted to 4650ccs of water.

On 9/20/00, review of the nursing enteral flow sheet for resident 24, revealed that on 9/1/00, the bolus of 250cc of Isosource at 8:00 AM and 5:00 PM, were not documented as being given. On 9/8/00, there was no documentation that the 5:00 PM bolus of Isosource 250cc was given. These three missed boluses of Isosource would amount to 582cc of water. Between 9/1/00 and 9/8/00, the nursing enteral flow sheet documented that 12 of 32 free water boluses of 150cc were missed. These free water boluses would amount to 1800cc of water.

On 9/21/00, at 1:45 PM until 3:00 PM, an interview was conducted with the former DON (director of nursing, the acting DON, the Staff Developer, the dietary supervisor, the Administrator and the Corporate Administrator, to gain information concerning resident 24's significant weight loss, hospitalization and the lack of documentation on resident 24's enteral flow sheets.

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F 327	Continued From page 47 During the interview, the former DON stated, and the two other licensed nurses agreed, that the facility protocol was 60-120ccs of free water before and after medications as a flush with gastric tube feedings. The former DON stated that their facility protocol was different from the original admit orders for free water boluses for resident 24, and would require a physician's order to change it. The former DON stated that the nurses and practitioners just assumed that every one followed the facility's protocol. The acting DON stated that she has been assigned to work during the graveyard shift. She stated that there were times that resident 24 would have episodes of nausea and/or vomiting during the continuous night feedings. She stated that she would discontinue the Isosource feeding due to the resident's intolerance. She stated that she assumed the day shift nurse would make up for any loss of feeding due to the inturruption of the continous feeding. There was one nurses note, on 8/21/00 that documented the tube feeding was discontinued related to emesis. There was no documentation to support that either the night or day shift nurses gave resident 24 additional tube feedings to make up for the amount missed related to intolerance. When asked about the lack of documentation on the enteral flow sheet for resident 24, the acting DON, and the other licensed nurses, said they did not believe the enteral feedings and free water boluses were missed, just not documented. The acting DON also said that the floor nurses were very aware that resident 24 was their most acute (seriously ill) resident. On 9/25/00, at 11:00 AM, a review of the	F 327		

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F 327	Continued From page 48 hospitalization record at an [acute care hospital] was done. The emergency room medical record, on 9/9/00, stated that resident 24 had a temperature of 104 degrees Faranheit and increased lethargy. A lab draw (blood test) was done in the emergency room. Lab values indicated sodium at 160 and the BUN (blood urea nitrogen) to be 39. Normal lab range for sodium is 136-144 and normal lab range for BUN is 7-20. An increase in sodium and BUN could be indicative of dehydration. Review of the hospital discharge summary on 9/12/00, revealed that the physician attending resident 24 stated that resident 24 was admitted to the [acute care hospital] for aspiration pneumonia and hypernatremia secondary to dehydration.	F 327		
F 371 SS=F	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: Surveyor: KUHN, REGINA Based on observation and interviews, the facility did not store, prepare, distribute, and serve food under sanitary conditions, as evidenced by: the facility kitchen and storage room were not kept clean for preparation of food and four dietary staff had potential for cross contamination during meal preparation. Findings include: Kitchen tour 1. During the initial tour of the facility kitchen on 9/19/00, at 7:35 AM, observation revealed crumbs on the tubing of the orange juice dispenser, coffee	F 371 JB 11/30/00		

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F 371	Continued From page 49 grounds present in the bottom of the coffee maker on the table, debris and crumbs on 4 of 5 trays that clean pitchers were stored on, and hard, old dish soap collected on the sanitizer below the pipe. There were five ladles and several food processor attachments stored above the center food preparation table with dust and grease present on the top surfaces. The hood over the stove had large areas of grease collected along the edge in the back. The top of the oven had grease and stains present. There was an open plastic container, on the bottom shelf of the second preparation table, that had opened containers of jello, powdered sugar, brown sugar and several unidentifiable containers with no dates noted. Observation revealed a container of chicken base substance, partially opened, with the lid to one side and undated. On the bottom shelf of the first preparation table, was a large container of opened margarine that was not dated or refridgerated. There were several flies in the food preparation area. 2. During the intial tour of the storage room on 9/19/00, at 8:00 AM, observation revealed a two shelf rolling tray with a box of potatoes uncovered and a large bag of onions open with several onions laying on the top shelf. Observation revealed that there was debris and onion skins present around the bag of onions. A clear, plastic plate was on top of one box of potatoes, with grease and hardened food on it. A white chest freezer had ice cream remnants on the inside of the lid which were present until 9/27/00. The freezer, labeled #1, had dark colored smears on each shelf and around the edges of the inside of the door. The shelves inside the freezer had a collection of ice on them. The top two shelves had approximately three inches of collected ice on the top and bottom of each shelf. There were six empty boxes stacked on the north side of the white chest freezer with dirt and	F 371		

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F 371	Continued From page 50 paper in the bottoms. There were several flies in the food storage room. Food preparation 1. Observation of breakfast preparation on 9/19/00, at 7:30 AM, revealed a dietary assistant set up trays for residents with unwashed, ungloved hands. He placed napkins and utencils on resident trays and touched the rim of each plate with contaminated hands. 2. Observation of breakfast preparation on 9/20/00, at 7:40 AM, revealed the cook preparing the breakfast trays with gloves on. She left the food area and opened a drawer to the food preparation table. With the same contaminated gloves, she returned to the preparation table and used a knife to cut toast for a resident tray. She then placed the toast on the resident tray with the same contaminated gloves. The cook was observed to pick up a container of cinnamon and sprinkle it on residents' toast with the same gloves. She held the residents' trays at the rim and touched each residents' trays with the same contaminated gloves. The cook was observed to cough over the food preparation table two times. She placed her gloved hand on her chest and returned to the food preparation table. Observation revealed that the cook did not wash her hands or reglove at any time during breakfast preparation when going from a dirty area to a clean area. 3. Observation of breakfast preparation on 9/20/00, at 7:50 AM, revealed that the dietary assistant prepared resident trays with ungloved, unwashed hands. She turned the tray cart with ungloved hands and returned to the tray preparation line. Observation revealed that the dietary assistant did not wash her hands or glove between touching the tray cart and returning to the	F 371		

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F 371	Continued From page 51 food preparation line. She was observed to place sugar packets and containers of fluid on resident trays. Observation revealed that the dietary assistant did not wash her hands or glove during the process of tray set-up or when going from a dirty area to a clean area. 4. Observation of breakfast preparation on 9/21/00, at 8:00 AM, revealed that the dietary assistant opened the door to the dishroom with gloved hands. He returned to the tray preparation line and continued to set up resident trays with the same contaminated gloves. He was observed to go into the dish room and remove an additional spoon. He returned to the tray preparation line. The dietary assistant was not observed to wash his hands or reglove. He removed a tray cart from the dishroom and returned to the tray preparation line to set up resident trays with the same contaminated gloves. Observation revealed that the dietary assistant touched an egg on two different resident trays with the same contaminated gloves. Observation revealed that the dietary assistant did not wash his hands or reglove when going from a dirty area to a clean area. 5. Observation of breakfast preparation on 9/21/00, at 8:30 AM, revealed a dietary assistant placed her gloved hands on her legs several times then leaned on the food preparation table with the contaminated gloves. She proceeded to place fluids on resident trays with the contaminated gloves. Observation revealed that the dietary assistant did not was her hands or reglove when going from a dirty area to a clean area. 6. Observation on 9/19/00, at 3:40 PM, revealed the dietary assistant sweeping a two shelf tray containing potatoes and onions. The dietary assistant used the same broom that she had previously used to sweep the storage room floor. Review of the facility infection control policy on	F 371		

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	465142	A. BUILDING _____ B. WING _____	9/21/00

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F 371	Continued From page 52 9/21/00, revealed there was only one inservice given on infection control by the facility dated May, 2000. Interview: On 9/21/00, at 2:00 PM, an interview was conducted with the dietary supervisor concerning inservices provided for the kitchen staff. The dietary supervisor stated that she meets with her staff two to three times a week but that she did not always keep minutes of those meetings. There was no written documentation of inservices given on hand washing, cross contamination or infection control specific to the dietary staff. During the same interview, the dietary supervisor obtained copies of the cleaning schedule for the nurse surveyor. The cleaning schedule had multiple spaces that were left blank where employees were to sign for completion of cleaning tasks. In addition, the cleaning schedule had multiple areas that were crossed off. When the dietary supervisor was asked what these meant, she stated that when there were missing initials or spaces crossed off on the schedule, it meant it was not done.	F 371		
F 469 SS=E	483.70(h)(4)PHYSICAL ENVIRONMENT The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Surveyor: JORGENSEN, SHAREN Based on observations and interviews, it was determined the facility did not maintain an effective pest control program to contain a pervasive fly infestation. Specific observations and interviews involved 4 of 14 sample residents, 15 of 15 residents	F 469	JB 11/30/00	

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in a confidential group interview, and 5 additional residents. (Residents 13, 16, 20, 28, 30, 35, 37, 39, and 43.)

Findings include:

Observations:

1. On 9/19/00 at 3:15 PM, resident 35 was observed lying in her bed. Two flies were observed flying around resident 35's face and walking on the resident's eyelids, lips, and hair. Resident 35 was observed to have impaired movement of her hands and arms and the resident could not brush the flies away.

2. On 9/19/00 at 7:30 AM, two dumpsters were observed to be at the south end of the facility's parking area. A large, uncovered construction dumpster was observed to be over filled with plastic bags of trash stacked two to three feet above the rim of the dumpster. A smaller dumpster was over filled with similar bags of trash. The smaller dumpster had a two-sectioned lid. The left section of the lid was open and resting on the trash bags approximately 1 1/2 feet above the rim of the dumpster. The right section of the lid was open and resting on trash bags approximately six inches above the rim of the dumpster.

3. On 9/20/00 at 7:15 AM and at 12:00 PM, the two full dumpsters were observed. Both sections of the lid to the smaller dumpster were open and resting on trash bags which were stacked approximately 2 1/2 feet above the rim of the dumpster.

4. On 9/20/00 at 7:15 AM, a clear plastic bag of soiled, disposable briefs was observed to be on the floor, four feet inside the facility's entrance door. It

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was observed for 15 minutes before a staff member carried the bag outside.

5. On 9/20/00 at 7:15 AM, two window screens were observed to be bent open and away from the window frames. The windows were at the south end of the facility and opened facing the dumpsters, a possible entrance for flies.

6. On 9/20/00 from 1:00 PM to 1:30 PM, flies were observed hovering around the northeast nurse's station and also hovering over resident 30.

7. On 9/20/00 at 2:40 PM, resident 16 was observed to be swinging his arms while standing outside the nurse's station and shouting, "These f-----g flies."

8. On 9/21/00 from 7:40 AM to 7:48 AM, resident 39 was observed to be sleeping in her wheelchair in the hallway just outside room 204. Resident 39's head was bowed and four flies were observed to be crawling over her neck, shoulders and back. At that same time, resident 30 was in her wheelchair in the hallway across from resident 39. A fly was observed to be crawling in resident 30's hair. There was a strong odor of urine coming from the bathroom shared by rooms 204 and 205. Three urinals were setting on the back of the toilet. Two of the urinals had dried, yellow-orange stains on them.

9. On 9/19/00, 9/20/00, 9/21/00, 9/25/00, 9/26/00 and 9/27/00, observations were made of the outside entrance to the facility's kitchen. There were two plastic garbage containers without lids near the door. At each observation, there was garbage in the containers.

10. On 9/19/00, 9/20/00, 9/21/00, 9/25/00, 9/26/00

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F 469	Continued From page 55 and 9/27/00, observation revealed many flies present in the kitchen and storage room areas throughout the entire day. 11. Observations of the dining room were made on 9/20/00 during the lunch meal. Resident 20 was observed to be swatting at flies that were crawling on his food. The facility's Staff Developer approached resident 20 and also swatted at the flies. Resident 37 was also observed to be in the dining room. Resident 37 was seated in a geri-chair and was observed to have limited mobility in her upper extremities. There were three flies crawling across the resident's chest. A nurse aide made frequent attempts at swatting the flies away, but flies continued to land on resident 37. Interviews: 1. On 9/19/00 at 7:45 AM, resident 43 asked to speak to a State surveyor. Resident 43 stated, "Something needs to be done about the flies." Resident 43 stated, "They are everywhere". Resident 43 further stated that the facility had "put a fly strip at each nurse's station", but that it was "ineffective". Resident 43 was observed to be swatting at flies in the dining room as he spoke. 2. On 9/19/00 at 7:50 AM, resident 13 was observed to be seated at a table in the dining room. Resident 13 stated to a surveyor, "The flies are terrible." 3. An interview with a nurse aide was held on 9/19/00 at 2:15 PM. The nurse aide stated that she had seen "tons of flies" throughout the facility for the past two to three weeks. She stated that she sees the flies crawling on residents, in resident rooms and in the	F 469		

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F 469	Continued From page 56 dining room. When asked why she thought there may be more flies in the facility, she stated that she felt the extra garbage dumpster was contributing. As the nurse aide was talking to the surveyor, she brushed several flies away from her. She stated that the residents have to swat the flies away when they eat their meals. 4. An interview with resident 28 was held on 9/19/00 at 3:00 PM. The resident asked, "What can they do about all of these flies?" She stated that the problem with too many flies in the facility had been going on for about a month. 5. A confidential group interview was held with residents on 9/21/00 at 1:30 PM. Fifteen (15) residents participated in the interview. Fourteen (14) of the 15 residents stated the number of flies in the facility have been bothersome to them. The residents stated the flies have been a problem for the past month but that they have increased in the past few weeks. Fifteen (15) of the 15 residents stated the facility's dumpsters were not emptied routinely. Several of the residents expressed that if the facility did a better job of emptying the dumpster, and changing residents when they were incontinent, the fly problem would go away. Surveyor: KUHN, REGINA Surveyor: BATEMAN, GREGORY	F 469		
F 490 SS=F	483.75ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 490	JSB 11/30/00	

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This REQUIREMENT is not met as evidenced by:

Surveyor: BATEMAN, GREGORY

Based on observations of resident rooms, bathrooms, shower facilities, hallways, the dining room, the kitchen and food storage room, it was determined the facility was not administered in a manner that effectively and efficiently utilized resources to ensure that each resident attained or maintained their highest practicable well-being.

Findings include:

Observations of the facility's interior were made on all days of survey; 9/19, 9/20, 9/21, 9/25, 9/26 and 9/27/00. Areas observed included resident rooms, bathrooms, shower facilities, hallways, and the dining room. Each of these areas were accessible to residents and required extensive maintenance services. Areas of concern included:

1. Missing or non-adhering wall baseboards throughout the facility were observed in resident rooms, bath/shower rooms, hallways, and in the downstairs dining area.

2. Walls and ceilings with one or more of these listed conditions; holes of various sizes and depth, dented areas, gouges, flaking, peeling, scraped surfaces, scuff marked areas, dried food/drink splatters, tape adhesive remnants, missing curtain attachments leaving non-painted areas visible, worn out areas, and visibly soiled surfaces were observed in the facility in the following areas:

a. Resident rooms: 109, 111, 112, 114, 115, 210, 211, 212, 214, 215, 217, 209, 207, 206, 204, 203, 201, 106, 105, 104, and 101.

b. Toilet/Bathrooms (shared or private): 112--113,

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F 490	Continued From page 58 114--115, 210--211, 216--217, 209, 203--202, 102, and 107. c. Hallways: East, West, North and South. d. Dining room: Downstairs. 3. Walls with plaster patched areas, and unfinished wall board surfaces, were observed to have not been painted in these resident rooms: 112, 114, 201, 106, and 101. 4. Resident's room doors and bathroom doors were observed to have at least one or more damaged areas where the wood is either gouged, splintered, severely worn, scuff marked, and/or had dark soiled surfaces in the following areas of the facility: a. Resident entry doors: 109, 110, 112, 114, 115, 212, 214, 217, 209, 207, 206, 106, 104, 103, 102, and 107. b. Toilet/Bathroom doors: 112, 115, 211, 217, 206, and 203. c. All wood doors had scuff marks and light - dark soiled areas (medium to dark was average). This soiled area of the doors was located from the bottom edge up 1 to 2 feet. 5. Floor surfaces in various areas of the facility were observed to have one or more problems, such as broken or missing tiles, dark crusted areas along edges, corners, and around fixtures, and dark mildew appearing areas in crevices and along edges of the shower/bath, in the following noted areas:	F 490		

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F 490	Continued From page 59 a. Resident rooms: 217, 209, and 103. b. Toilet/Bathrooms: 109, 111, 113, 114, 115, 210, 214, 215, 217, 209, 204, and 201. c. Dining room: Tile missing or broken at the north wall, west wall, the south wall that is immediately outside the north kitchen doors, and the far south wall. Wall edges had dark, coffee ground appearing substance along sides of the dining room baseboard edges. 6. Heater/air conditioners with one or more of the following problems; nonfunctioning heat and/or air conditioner, missing control knobs, dark brown/black soiled areas (especially in crevices and on vent fins) were noted in resident rooms: 111, 112, 115, 211, 212, 214, 217, 209, 204, 203, and 107. 7. Furniture/equipment with one or more of these noted problems; broken and/or non-functioning devices, tape repairs not adhering to equipment and/or appearing unsightly, soiled furniture and equipment from stains and dried food: a. Resident rooms: 109 - closets with tape adhesive; 115 - night stand with 2 broken drawers; 210 plastic cover on the north wall electrical outlet was broken, exposing wiring where pieces of the outlet were missing; 211 - overbed white metal light fixture soiled resulting in grey appearance; 212 - call light fixture on wall covered with duct tape; 215 - night stand with the front of the bottom drawer broken off and no cover on bathroom toilet tank; 217 - blue chair with spotted areas such as from something dripping on it and television soiled with dried food; 206 - window	F 490		

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F 490	Continued From page 60 screen bent exposing 10 inch long open area; 202 - green chair with tears in the covering fabric; 204 - orange chair with duct tape repairs; 105 - night stand with 2 of the drawers' front sections broken; 103 - no cover over the bathroom toilet tank; and 107 - brown, fecal smelling stain on an eggcrate mattress propped against the north wall, and a torn and stained privacy curtain near bed 1. b. Throughout the facility several resident rooms, hallways, doorways, and the dining room area, were noted to have dirty splattered surfaces and/or areas where fluid had run down the surfaces of walls, baseboards, and glass entryways. Refer to F-253. A review of the facility's regulatory compliance between 8/1/96 and 9/27/00 was done. During this time frame, five recertfication surveys were conducted. The recertification survey dates were: 8/1/96, 6/16/97, 9/10/98, 11/23/99, and 9/27/00. This facility has had repeat deficiencies in the areas of housekeeping, maintenance and food service sanitation. The repeat deficiencies were as follows: a. For each of the five recertification surveys, the facility failed to provide a safe, clean, comfortable and homelike environment for residents. The deficiencies cited were: i. 8/1/96, Tag F-252. Specific items addressed included dirty resident rooms and bathroom, mold in a shower, and persistent offensive odors. ii. 6/16/97, Tag F-252 and F-253. Specific items addressed included persisent offensive odors, dirty	F 490		

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F 490	Continued From page 61 resident rooms and bathrooms, dirty floors, dirty furniture in resident rooms and common areas, holes in the walls and ceiling of the dining room, holes in the walls of resident rooms, missing base boards in the dining room, dirty and unrepaired resident equipment, and a heating/air conditioning unit pulled away from the wall in a resident room. iii. 9/10/98, Tag F-252. Specific items addressed included bathrooms with dirty air vents (some of which not working), bathrooms with missing floor tiles and dispensers, unrepaired wall boards, holes in walls in common areas an resident rooms, missing kick boards, a bathroom sink pulled away from the wall, dirty bathrooms, missing ceiling tiles, and dirty furniture in common areas as well as resident rooms. iv. 11/23/99, Tag F-257. Specific items addressed included 10 heating/air conditioning units in resident rooms that were not functioning properly. v. 9/27/00, current findings at Tag F-253. b. For 4 of the 5 recertification surveys, the facility failed to store, prepare and distribute food under sanitary conditions. The deficiency cited was: i. 6/16/97, Tag F-371. Specific items addressed included lack of chemical sanitizer in the dishwasher, hot food temperatures less than 140 degrees Farhenheit at serving time. ii. 9/10/98, Tag F-371. Specific items addressed included chipped and rusted shelves in the store room, floors in the kitchen and store room worn and unclean, holes in the kitchen ceiling with water leaking, and black mold on the walls of the food storage room.	F 490		

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F 490	Continued From page 62 iii. 11/23/99, Tag F-371. Specific items addressed included different type meats stored on the same tray and placed on shelves higher than other food items, temperature in walk-in refrigerator too warm, and dirty cooking equipment. iv. 9/27/00, current findings at Tag F-371.	F 490		
F 521 SS=F	483.75(o)(2)&(3)ADMINISTRATION The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. This REQUIREMENT is not met as evidenced by: Surveyor: BATEMAN, GREGORY Based on observations of the housekeeping and maintenance needs of the facility and a review of the facility's quality assurance records, it was determined that the facility's quality assessment and assurance committee failed to implement appropriate plans of action to correct identified quality deficiencies. Findings include: 1. The facility's quality assessment and assurance committee failed to implement action to maintain substantial compliance and to ensure that	F 521 KB 11/30/00		

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housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior were provided. The housekeeping and maintenance services that had not occurred in the facility were found to be widespread and led to a determination of Substandard Quality of Care.
Refer to Tag F-253.

2. The facility's quality assessment and assurance committee failed to implement action to maintain substantial compliance for quality deficiencies cited during previous recertification surveys. Between 8/1/96 and 9/27/00, five recertification surveys were completed. The recertification survey dates were: 8/1/96, 6/16/97, 9/10/98, 11/23/99, and 9/27/00. This facility has had repeat deficiencies in the areas of housekeeping, maintenance and food service sanitation. The repeat deficiencies were as follows:

a. For each of the five recertification surveys, the facility failed to provide a safe, clean, comfortable and homelike environment for residents. The deficiencies cited were:

i. 8/1/96, Tag F-252. Specific items addressed included dirty resident rooms and bathroom, mold in a shower, and persistent offensive odors.

ii. 6/16/97, Tag F-252 and F-253. Specific items addressed included persisent offensive odors, dirty resident rooms and bathrooms, dirty floors, dirty furniture in resident rooms and common areas, holes in the walls and ceiling of the dining room, holes in the walls of resident rooms, missing base boards in the dining room, dirty and unrepaired resident equipment, and a heating/air conditioning unit pulled away from the wall in a resident room.

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INFINIA AT GRANITE HILLS, INC	950 EAST 3300 SOUTH SALT LAKE CITY, UT 84106

(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 521	Continued From page 64 iii. 9/10/98, Tag F-252. Specific items addressed included bathrooms with dirty air vents (some of which not working), bathrooms with missing floor tiles and dispensers, unrepaired wall boards, holes in walls in common areas an resident rooms, missing kick boards, a bathroom sink pulled away from the wall, dirty bathrooms, missing ceiling tiles, and dirty furniture in common areas as well as resident rooms. iv. 11/23/99, Tag F-257. Specific items addressed included 10 heating/air conditioning units in resident rooms that were not functioning properly. v. 9/27/00, current findings at Tag F-253. b. For 4 of the 5 recertification surveys, the facility failed to store, prepare and distribute food under sanitary conditions. The deficiency cited was: i. 6/16/97, Tag F-371. Specific items addressed included lack of chemical sanitizer in the dishwasher, hot food temperatures less than 140 degrees Farhenheit at serving time. ii. 9/10/98, Tag F-371. Specific items addressed included chipped and rusted shelves in the store room, floors in the kitchen and store room worn and unclean, holes in the kitchen ceiling with water leaking, and black mold on the walls of the food storage room. iii. 11/23/99, Tag F-371. Specific items addressed included different type meats stored on the same tray and placed on shelves higher than other food items, temperature in walk-in refrigerator too warm, and dirty cooking equipment. iv. 9/27/00, current findings at Tag F-371.	F 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465142	A. BUILDING _____ B. WING _____	9/21/00

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINIA AT GRANITE HILLS, INC	950 EAST 3300 SOUTH SALT LAKE CITY, UT 84106

(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 521	Continued From page 65 Surveyor: GLENDE, SHAUNA 3. A review of the previous years quality assurance minutes was done on 9/27/00. There was documentation that a quality assurance meeting was conducted in April, 2000. A "Q.A. Monthly Review" form was dated 4/27/00. There was no documentation of the facility's housekeeping or maintenance services addressed. There was documentation that a quality assurance meeting was held in September, 2000. A "Quality Assurance Meeting" form was dated 9/15/00. On this form was an agenda item labeled, "Environment Report". This agenda item was checked but contained no description of what was discussed regarding the environment. There was no documentation of corrective action plans to address the facility's housekeeping and maintenance needs. There were no other quality assessment and assurance committee minutes available to review. An interview was held with the facility's Administrator on 9/27/00. The Administrator stated that he could not find all the meeting minutes and could not remember the dates that the quality assurance meetings had been held.	F 521		

INFINIA
HEALTH CARE

Infinia at Granite Hills

N3
11/30/00

PLAN OF CORRECTION

REVISED 11/30/00

RESPONSE TO SURVEY DATED 27. SEPTEMBER 2000

STATE-DIRECTED ITEMS RE: MAINTENANCE/HOUSEKEEPING

1) Infinia at Granite Hills has employed [redacted] an independent consultant with expertise in housekeeping and maintenance services. He has already begun services and will begin submitting reports, effective 17. November 2000. [redacted] information will be submitted by this date to the State of Utah, Department of Health, Bureau of Health Facility Licensure, to the attention of [redacted]. The name will also be submitted to the State of Utah, Department of Health , Bureau of Medicare/Medicaid Program Certification and Resident Assessment, to the attention of [redacted]

2) The above mentioned consultant will monitor the facility housekeeping and maintenance services at least weekly and submit written reports to the Administrator each visit identifying facility repairs and items which still need repair. The Administrator will submit the consultant's findings weekly to the State of Utah agencies listed above, and to Infinia Health Care Group, Inc., beginning 17. November 2000.

3) This consultant will be appointed to and participate on the Quality Assessment and Assurance Committee.

4) Though the plan to achieve substantial compliance is contained in this Plan of Correction, the methodology to maintain compliance will be developed by the Administrator, Environmental Services Director and Consultant, submitted to the Quality Assurance Committee and implemented by 10. December 2000.

5) The consultant's services will be retained until substantial compliance has been achieved and systems in place and followed. Upon achievement of substantial compliance, the Quality Assessment and Assurance Committee will continue to review compliance on a quarterly basis.

GENERAL PLANNED CORRECTIVE MEASURES

From the survey, it is clear to this new Administrator that certain systems and personnel have not be in place or functional in order for the facility to provide consistent, continuing effective patient care. Establishing better communications and reporting systems will insure ongoing compliance. Hiring an effective DON, Maintenance Director and Medical Records Coordinator, training them, retaining them, and providing them the tools for success are all part of this Plan of Correction. Increased expectations and a more proactive management approach will insure that the elements addressed in this Plan of Correction will successfully be achieved and maintained, so the next survey will be a breath of fresh air for all of us.

Staffing issues will be resolved by 30. November 2000, and all training issues for new staff will be addressed by 31. December 2000. Specific dates for tagged items noted in the Plan of Correction as appropriate.

F 157
SS=D

1) To prevent incidents where residents with limited mobility are left exposed to hazardous conditions, such as the weather related condition cited in this tag, CNA rounds are now extended to include all areas where patients gather, such as patios, dining areas, activity areas, etc. These rounds are conducted at least once each half hour and will be logged by the CNA staff, immediately following a 24. November 2000 inservice on the matter. The DON will review the log weekly and report to the Quality Assessment and Assurance Committee on this matter quarterly.

   Physician orders in place, indicating all patients on psychotropic medications must receive sunblock prior to leaving building. Charge Nurse responsible to insure that this is applied. To be charted by CNA's, charts to be reviewed weekly by DON, problems reported to Administrator, ongoing problems addressed in quarterly Q & A meeting.

   Date of completion: 24. November 2000

2) On 24. November 2000, all staff will receive inservice training on the policy regarding contacting the families or responsible parties of patients who have been involved in an incident affecting their health or well-being. The policy is that when such an incident occurs, an incident report is to be filed for review by the Administrator, DON, and medical director. Families or responsible parties must be notified by the manager on duty during the same business day of the incident. In the event such parties are unreachable, this will be noted on the incident report and the Administrator will continue contact efforts. The reports will be reviewed on a weekly basis by the DON. Problems immediately reported to the Administrator for resolution. Ongoing problem areas reported and reviewed during a quarterly Quality Assessment and Assurance Committee meeting.

   Date of completion: 10. November 2000 - already done.

3) In the event an incident has the potential for medical complications, as in the case of the sunburn or the resident being hit by a truck, the medical director will be contacted by the Charge Nurse immediately following the incident, this will be logged in the incident report, the DON will track this upon receiving the incident report (at least by the DON's next work day following the incident), and the Administrator will follow up on any missed contacts. This process will be explained and implemented individually prior to November 24th, and a topic in the 24. November 2000 inservice. The incident reports will be reviewed for this each week by the DON. Problems reported to the Administrator as they happen. Any continuing problems tracked and resolved as part of the quarterly Quality Assessment and Assurance Committee meeting.

   Date of completion: 24. November 2000

F 164
SS=E

1) All staff to receive inservice training on 24. November 2000 regarding patient privacy including the following items:

   a) Privacy curtains pulled when procedures performed.
   b) Doors to restrooms and showers not propped open. Shower room exhaust fans repaired to make environment more conducive to shutting the doors. Doors to be shut when dressing, bathing or toileting patients.
   c) Assistance to families providing care to patients, to help them maintain the privacy and dignity of all patients.
   d) Discussions concerning patients' conditions, behaviors, etc. to be held away from patients or others who are not required or authorized to know such information.
   e) Staff to maintain patient dignity and modesty, regardless of who is or isn't watching.
   f) Sensitivity and customer service training to all staff, to help them be aware and sensitive of patient needs and wishes. How to respond to these needs.

2) By 24. November 2000, blinds and other privacy features will be installed, to ensure dignity and privacy in all patient rooms, treatment areas, etc.

3) By 24. November 2000, all residents will be given opportunity to participate in a resident meeting to be informed of the facility grievance and reporting process, so they may know how to report incidents where they feel their privacy, dignity or other rights are compromised. The Social Services worker will be the contact person for grievances, with the TRT as backup. These contact persons will be inserviced on logging, reporting and resolving grievances by the 24. November date. The Administrator will review the log of grievances weekly, to insure adequate follow-up.

4) Resident 1's family to be educated on privacy assurance, while patient is showering or other care given. Staff receives inservice training on privacy during cares as outlined above. Nurses to assure compliance during rounds. The staff inservice and direction will also address the issue with patients 22, 30 & 37.

   Resident 20, 21 and 22's room to receive blinds on or before 27. November 2000.

   As outlined above, staff to receive inservice training on privacy including information on pulling privacy curtains when performing cares, as in the case with patient 22.

All inservice completed by 24. November 2000.

All other items completed by 27. November 2000.

F 253
SS=F

1) As outlined earlier, an independent consultant, with maintenance and housekeeping expertise, has been contracted to monitor the facility's maintenance and housekeeping needs as follows:
   a) Monitor progress at least weekly.
   b) Identify facility repairs that have occurred and areas still in need of repair.
   c) Participate in the Quality Assessment and Assurance Committee.
   d) Assist in developing a plan to achieve and remain in substantial compliance in the areas of maintenance and housekeeping.
   e) Report findings to the Administrator on a weekly basis, for submission to the state agencies referenced earlier and the corporate offices.

   The consultant will remain until the facility has achieved substantial compliance in the areas of maintenance and housekeeping.

   All efforts will be maintained in a Q/A log in addition to the maintenance log and reviewed at least weekly by the Administrator until substantial compliance has been achieved, and quarterly thereafter by the Quality Assessment and Assurance Committee.

2) Items referenced in the 21. September 2000 Life Safety Code Survey to be corrected on or before 10. November 2000 and are summarized as follows:
   a) Inservice relating to keeping doors free of impediments.
   b) Door closers and latches repaired, with weekly monitoring.
   c) Door repairs made to insure smoke seal and fire barrier adequacy. Weekly inspection and logging.
   d) Fire drills conducted and logged quarterly as required by NFPA.
   e) Inservice on fire response plan with monthly follow-up, as well as inclusion of this subject in employee orientation.
   f) Sprinkler heads inspected, with functionally compromised heads replaced.
   g) Fire extinquishers tested by AAA Fire and Safety & Alarm Co.
   h) Kitchen hood fire suppression system tested and inspected by AAA Fire and Safety & Alarm Co.
   i) No items stored in hallways or entry ways.
   j) Extension cords taken out of service, and inservice to inform staff of applicable wiring requirements of the UFC. Weekly monitoring and logging by maintenance director.
   k) Power taps plugged directly into wall socket. Weekly monitoring and logging by maintenance director.
   l) Soiled, oily wiping cloths removed from elevator control room.
   m) Obstructions and combustible items, including a wooden table removed from stairwells. Maintenance director to monitor and log weekly.
   n) Lint filters cleaned daily. Instructional signage posted in English and Spanish.

   The above items are being addressed in response to the Life Safety Code Survey and more detail is included in that plan of correction, which is attached.

3) ALL **Resident Rooms** are being refurbished at a rate of two per week, including the adjoining bathrooms. This effort, conducted by [redacted], began 23. October 2000. All work to be completed on or before 26. March 2001. Items to be completed include:

a) Cleaning and repair, as needed, to insure adequate operation of the rooms' HVAC units.
b) Repair or replacement of doors, to insure fire and smoke barrier, as well as smooth, safe finish.
c) Patching of walls, to eliminate holes, dents and other structural problems.
d) Painting of walls and ceilings, to eliminate flaking, discoloration, and to improve aesthetics.
e) Coving replaced or reattached as needed, to better seal the seam between the floor and the wall for sanitation, safety and aesthetics.
f) Baseboards reinspected, repaired or reattached as needed.
g) Window sills repaired or replaced as needed.
h) Door latches and knobs inspected and repaired or replaced as needed.
i) Repair or replacement of window screens, etc. as needed.
j) Damaged wallpaper and borders removed, and area repainted.
k) Outlets inspected and repaired, replaced and covers attached as needed.
l) Other items as needed.

In addition to the refurbishing efforts, a minimum schedule for cleaning and routine maintenance will be developed by the Administrator, with input from the maintenance director and consultant. The required frequency will be adapted to individual patients' needs and revised as needed. The determination of need may be made by the housekeeper, the DON, the Resident Services Director and/or the Administrator. There will be a log for the housekeeping staff to complete, indicating completion of required items, by room. There will be a weekly review by the maintenance director, who will log and report deficiencies to the Administrator on a weekly basis and to the Quality Assessment and Assurance Committee on a quarterly basis. This system will be in place no later than 30. November 2000.

4) ALL **Wood Doors** will be repaired, cleaned, refinished and fitted with a kick plate by 26. March 2001. Doors which present an imminent hazard, such as those that do not close or latch properly, or those that do not provide adequate smoke or fire barrier, will be repaired no later than 30. November 2000. This will be reviewed and logged as outlined above in 3).

5) ALL **Toilet/Bathrooms (shared or private)** will be refurbished per the list of items in 3) above, and put on the housekeeping schedule as outlined. Additional items to include:
   a) Toilet seats repaired or replaced as needed.
   b) Toilets reset as needed.
   c) Tank covers replaced as needed.
   d) Broken/missing tiles replaced as needed.
   e) Other items outlined in 3) or as otherwise required.

   Work to be completed no later than 26. March 2001, except in the case of broken or missing toilet seats, tank covers and unstable toilets, which will be repaired or replaced as necessary no later than 10. December 2000. This will be reviewed and logged as outlined above in 3).

6) ALL **Hallways (East, West, North and South)** will be refurbished as outlined above in 3) and work completed on or before 26. March 2001. Special and immediate attention paid to outlet cover plates, wiring and other life safety issues, which will be repaired as needed on or before 30. November 2000, or already have been as addressed in the Life Safety Code Survey. This will be reviewed and logged as outlined above in 3).

7) The **Dining Room (downstairs)** will be refurbished as outlined in 3), including the following additions:
   a) Missing or damaged ceiling tiles replaced.
   b) Handrail reattached.
   c) Damaged or missing floor tiles replaced.
   d) Housekeeping issues addressed as above.
   e) Other items as needed.

   The work will be finished on or before 26. March 2001, with sanitation and housekeeping issues addressed immediately. This will be reviewed and logged as outlined above in 3).

8) All **Heaters/Air Conditioners** cleaned, repaired or replaced (as needed) and fully functioning in occupied patient areas on or before 30. November 2000. Units in vacant areas to be completed on or before 26. March 2001. This includes the replacement of missing or broken control knobs. This will be reviewed and logged as outlined above in 3).

9) All **Furniture/Equipment** cleaned prior to 30. November 2000, repaired as possible by 31. December 2000, or replaced as needed on or before 26. March 2001. Efforts to include the following:
   a) Tape adhesives removed and items actually repaired.
   b) Scrape marks refinished and equipment cleaned.
   c) Broken drawers repaired.
   d) Outlet receptacles and covers replaced as needed.
   e) Fixtures cleaned or repaired as needed.
   f) Window treatments repaired or replaced for privacy.
   g) Call lights repaired and in good working order.
   h) Toilets repaired as needed (mentioned above).
   i) Furniture clean from debris, stains, etc.
   j) Window screens repaired and replaced as needed.
   k) Torn fabrics appropriately repaired or replaced.
   l) Privacy curtains repaired or replaced as necessary.
   m) Hand rails repaired as needed.
   n) Shower area completely repaired and renovated.

10) All of these areas will be inspected, logged and maintained as outlined in 3). Maintenance director with extensive background has been hired to correct existing problems and provide ongoing preventive maintenance. Systems for reporting and correcting problems as they come up will be in place on or before 10. December 2000. A preventive maintenance schedule is in place and will be adapted to meet the needs outlined in the survey and Plan of Correction on or before 30. November 2000. Additionally, a log specific to this Plan of Correction will be developed and implemented prior to 30. November 2000. Records and logs will be reviewed weekly by the Administrator and consultant during the Plan of Correction, and quarterly by the Quality Assessment and Assurance Committee thereafter.

11) In addition to the maintenance and housekeeping schedules listed above, a scheduled program of deep cleaning will be developed and implemented on or before 31. December 2000. The log will be reviewed weekly by the Administrator and consultant during the Plan of Correction, and quarterly by the Quality Assessment and Assurance Committee thereafter.

Items to be completed as outlined above, with final completion date of 26. March 2000

F 278
SS=E

1) All MDS assessments to be completed accurately and completely within the time frames outlined by Medicare and Medicaid. During the week of 23. October 2000, the MDS Coordinator has received inservice training to assure compliance with this requirement. The DON is assigned to review all MDS for accuracy and completeness and will follow up with all departments to insure disciplines have been covered. The Medical Records clerk is responsible that all portions are complete and submitted to the corporate office, who transmits the data to the state, in a timely fashion. The Medical Records clerk will maintain and keep current a schedule of IDT meetings and MDS submissions. The Administrator will review submission records and schedules with DON on a monthly basis to insure continued compliance.

2) Infinia Health Care, Inc. has supplied an RN and Medical Records specialist to review all MDS and medical records for accuracy and make corrections as appropriate. These individuals have already reviewed, corrected and completed the 3/8/00 and 6/29/00 assessments for resident #9. The same for the 8/17/00 assessment for resident #24, the 5/23/00, 8/23//00 and second 8/23/00 assessment for resident #35, and the MDS for resident #48. All other resident assessments are being reviewed, completed and corrected as part of this process, to be complete on or before 27. November 2000.

   Ongoing accuracy and timely submission will be assured by the process mentioned above, reviewed, as stated, by the Administrator and DON on a monthly basis.

As mentioned above, the date of completion for this item is 27. November 2000.

F 281
SS=D

1) All licensed personnel to participate in an inservice training session, concerning wound care, pressure sore prevention, care of pressure sores, and infection control, including during dressing changes. This will take place on or before 27. November 2000.

   Step by step instructions for dressing changes will be developed and placed in the treatment book for residents 22 and 4, as well as others where applicable by 27. November 2000. The following of the outlined procedure will be a line item on the CNA flow sheet and signed as part of the charting process. Additionally, visual monitoring will be conducted by the nursing staff.

   The DON or Charge Nurse, as designated by DON, will monitor all dressing changes until satisfied that compliance is 100%. Compliance will be reported weekly to the administrator, monthly to the Quality Assessment and Assurance Committee during the Plan of Correction period, and quarterly to this committee when substantial compliance is reached.

All items will be finished by 27 November 2000.

F 287
SS=E

The RN and Medical Records specialist referenced earlier are reviewing and correcting all patient MDS assessments and will have accurate and complete assessments for ALL patients transmitted no later than 27. November 2000. This includes patients 9, 20, 22, 24, 25, 30, 32, 35, 45, CR1, CR3, CR4, CR5, CR6, CR7, CR8, CR10, CR11, CR12, CR13, CR14, CR15, CR16, CR17, CR18, & CR19.

To insure that this problem does not get repeated, a stable medical records person and DON have just been hired, are being trained by the above mentioned personnel, and are receiving additional training and resources through the state, software suppliers and fiduciary intermediary. These are people who have been hand selected and recruited for past performance with the current administrator and who have shown stability and interest in providing great patient care, with attention to detail and documentation.

As mentioned above, the date of completion is 27. November 2000.

F 316
SS=D

Continence cares will be provided for all residents at a minimum of every two hours, with frequency increased, as needed (determined and charted by Charge Nurse or DON, or added to the care plan through the IDT process), for individual patients. This to begin immediately through informal on-the-spot training, and to formally commence following an inservice on the matter 24. November 2000. This training will include peri-care training, bowel and bladder retraining concepts and charting procedures, to insure compliance in this area. The DON or Charge Nurse will be responsible to assess whether all residents, including 9, 20 and 49 are dry and clean and that appropriate care is being provided to prevent UTI's, skin breakdowns, odor problems or other quality of life issues. Resident 20's MDS, dated 6/28/00 will be reviewed for accuracy and corrections made as needed. All corrections to be completed on or before 27. November 2000.

F 324
SS=G

1) All residents, including 30 and 35, will be reassessed and their care plan updated at least quarterly to determine whether increased supervision is required in order to avoid accidents or injuries. The IDT will be responsible to assess all residents and document findings. The Medical Records Coordinator will submit a report to the Administrator and DON, indicating whether or not this has taken place.
2) A list will be provided at both nurse stations, in a binder for privacy, to inform staff about which patients require supervision outside the facility. Nurses responsible to ensure that all residents sign in and out, and that other appropriate documentation (eg: "leave of absence" form or "against medical

advice" form) is complete when a patient leaves the facility. In the event that a patient refuses to complete such documentation, or allow supervision, it will be charted by the nurse on duty, an incident report filed, with family/responsible party and physician notified. The DON will review records and incidents weekly and report problems to Administrator as they occur. DON will also make a quarterly report to the Quality Assurance and Assessment Committee. Inservice to be provided 24. November 2000.

3) The sunburn issue with patient 35 was addressed in the Plan of Correction for Tag F 157. In addition, documentation will be reviewed by DON for this patient and others on a weekly basis to assure that care plans are being followed.

4) Patient 30 will be provided a wheelchair flag upon leaving the facility, effective immediately. A responsible person will be available to take her on a scheduled basis, to the bakery or other nearby locations as practicable. Since this patient has a fairly regular routine of going to the bakery, and since there are staff who frequent this establishment as well, the Resident Services Director will arrange a scheduled escort each day, as desired by this patient.

In the case of this patient, who often is non-compliant on signing out, using wheelchair flags, or accepting supervision, comprehensive documentation, notification and care planning as noted above will result in additional interventions, to be determined by the DON and/or IDT.

Tagged items will be completed no later than 27. November 2000, as outlined above.

F 325
SS=G

1) This facility will ensure that all residents will remain within acceptable parameters of nutritional status by monitoring all weights at least monthly. Weekly, if patient has skin breakdown, low protein/albumin lab results, when the patient has a history of poor nutritional intake, or when food intake is other than by mouth. Patients will be evaluated by dietician (food percentages), and there will be a weekly skin and weight evaluation for those patients deemed at higher risk in the monthly skin and weight meeting conducted for all residents.

2) On 27. November 2000, an inservice will be held to educate care givers on documentation of nutritional intake, nutritional needs of residents, and the policies and procedures for documenting intake to effectively implement the plan outlined above.

3) Resident 24's weight to be monitored at least weekly to ensure his nutritional needs are met. The Registered Dietician will be notified in order to adjust caloric intake if patient is unable to tolerate all of his feedings.

4) The DON and dietary director will review the enteral flow sheet, dietary percentages flow sheet and other documentation for accuracy and compliance, noting any problems. Weekly reports to administrator, monthly reports to the Quality Assessment and Assurance Committee during Plan of Correction period, and quarterly reports to the committee thereafter will insure proactive intervention in this matter.

5) The Registered Dietician will also be notified of any admission or new tube feeding orders within 24 hours. The DON will be responsible for completion of this requirement.

All items completed on or before 27. November 2000.

F 327
SS=G

1) Resident 24's hydration needs have been addressed by implementing a weekly monitoring of enteral flow sheets, dietary percentage flow sheets, better staffing, and education of staff, to ensure that no feedings or opportunities for hydration are missed. Additionally, this resident's skin turgor has been monitored on a weekly basis.
2) All residents will be assisted with maintaining proper hydration. Fluids will be offered with each medicine pass. Enteral flow sheets will be reviewed weekly by DON, to ensure the hydration needs are being met and that care givers are following the proper procedures and meeting the individual hydration needs as outlined on this form.
3) For patients, such as patient 24, whose only source of fluid is via a feeding tube, intake and output documentation will be mandatory. Documentation to be reviewed by DON on a weekly basis, with problems reported to the Administrator and a quarterly report made to the Quality Assessment and Assurance Committee.
4) CNA assignment sheets will include residents that require assistance or cueing in order to maintain sufficient hydration states. The DON will be responsible for monitoring the hydration process in the facility and will report to the Quality Assurance and Assessment Committee on a quarterly basis.
5) On or before 27. November 2000, an inservice will be held addressing the importance of hydration and individual resident needs.

All items completed on or before 27. November 2000.

F 371
SS=F

1) The dietary staff, under the director of the Dietary Director, shall set and maintain high standards of sanitation in the food service working and storage areas at all times. Checklists are created to assist the Dietary Director in assuring completion of all tasks. These will be reviewed by the Dietary Director at least weekly and reported to the Quality Assessment and Assurance Committee at least quarterly.
2) Monthly departmental meetings and inservice trainings are held with the dietary staff by the Dietary Director and Registered Dietician to discuss and review job descriptions, explain policies, show procedures, cleaning schedules, assignments, and any changes that involve an action to improve sanitation or safety and protect food and patients from contamination.
3) Sanitation and contamination control will be monitored in focus rounds which will be completed each morning by the Dietary Manager, each evening by P.M. manager, weekly by the Registered Dietician, and Monthly by the Administrator. Results reported quarterly to Quality Assessment and Assurance Committee.
4) General cleanliness and care of the storeroom will be maintained and monitored through a daily cleaning schedule, reviewed in the above-mentioned focus rounds.
5) On or before 24. November 2000, all dietary staff to receive inservice training on basic food handling principles, use of gloves, sanitation and Public Health Services standards and guidelines found in its Food Services Sanitation Manual.

6) All applicable forms attached. Completed forms reviewed on a monthly basis by the Administrator.

All items completed on or before 24. November 2000.

F 469
SS=E

Pest control will be improved no later than 27. November 2000 as follows:

1) Large, uncovered dumpster already removed from premises. Existing dumpster is emptied more frequently, eliminating overflow and stench, which would attract flies.
2) Soiled briefs immediately removed from building and placed into dumpster. Monitored in rounds two times each shift by Charge Nurse.
3) Window screens repaired or replaced as needed in order to be pest resistant.
4) Standards of cleanliness will be enforced to reduce odors in the building. Maintenance Director to monitor cleanliness daily as supervisor of the Housekeeping crew. Charge nurse to monitor also during each shift. Urinals emptied and cleaned as used, briefs removed from building, soiled areas cleaned as needed.
5) Bowel and Bladder training program improved as outlined in the Plan of Correction for tag F 316.
6) Existing exhaust fans repaired and additional fans added to pull odorous air from bathrooms and other areas and to pull fresh air in.
7) Grease trap in kitchen cleaned on a regular weekly schedule to eliminate odors and back up. To be performed and logged by the maintenance director.
8) Other measures as identified by the Maintenance and Housekeeping Consultant.

All items completed, as noted above, on or before 27. November 2000.

F 490
SS=E

1) To administer the building in a manner which enables it to uses its resources effectively to ensure patient well-being, the Administrator will track the items addressed in the Plan of Correction for F 253, F 371 and other tags on a weekly basis. The Administrator will also lead a Quality Assessment and Assurance Committee review of all items of all tags in the Plan of Correction. Items will be reviewed daily by department heads in applicable areas, weekly between department heads and Administrator, monthly between Administrator and Quality Assessment and Assurance Committee during the period of the Plan of Correction, and quarterly by the Quality Assessment and Assurance Committee upon achievement of significant compliance.
2) The Administrator will assure staffing, training and retention to guarantee continued, ongoing compliance to all regulations and quality patient care. The staffing will be accomplished by having in place effective leadership in the facility to recruit, train and maintain staffing. These leaders have been identified, hand picked and recruited by the Administrator. Administrator, with department heads, will be involved in new employee orientation and staff development. Staff development will be documented and reviewed by Quality Assessment and Assurance Committee on a quarterly basis, to ensure patient, employee and regulatory needs are being met. The proper training and leadership of staff are the two things which have been missing and have resulted in the turnover of key positions. By providing the above, along with

continued industry networking and participation, turnover and vacancies will be reduced, ensuring continuity of systems, operations, compliance and staffing.

3) Visible, proactive administrative involvement within the facility, to assure that standards of care, cleanliness and safety are monitored.
4) Administrator, as indicated in several of the above tags to develop systems, communication and reporting mechanisms to assure adequate follow-up and tracking of compliance and care issues.

Staffing issues, of course, are ongoing, but the date of completion to have the systems and staffing in place is 27. November 2000.

F 521
SS=F

1) The Quality Assessment and Assurance Committee will meet quarterly, beginning on or before 27. November 2000 and every third month thereafter, to assess progress toward correcting deficiencies noted in tag F 253, F 371 and other tags. Additionally, this committee will address ongoing and new items, to maintain compliance and to prevent new problems from cropping up. As indicated above, the department heads will evaluate their departments for compliance and other issues on a daily basis, to be reviewed with the Administrator on a weekly basis, and by the Quality Assessment and Assurance Committee on a monthly basis during the Plan of Correction and quarterly upon the achievement of significant compliance.
2) Logs and schedules to be developed and implemented by the Administrator, with input and assistance from the consultants and department heads. These schedules and logs will all be in place no later than 27. November 2000. They will be reviewed on an ongoing basis: daily by the department heads, weekly by the Administrator (and DON where applicable) and monthly by the Quality Assessment and Assurance Committee during Plan of Correction, quarterly thereafter.
3) Again, and probably the key to the success of every item listed in the above Plan of Correction: The Administrator will develop and implement systems of communication and reporting to insure that compliance is tracked and progress made.

All items completed on or before 27. November 2000.