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 _____	08/07/2001

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 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 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: Based on observations and interviews, it was determined that the facility did not ensure residents' personal privacy was maintained during insulin administration, skin checks and personal cares. Specific observations and interviews involved 6 of 13 sample residents and 11additional residents . (Residents 1, 4, 6, 12, 13, 16, 17, 21, 24, 26, 28, 29, 40, 41, 42, 45, 46.) Findings include: 1. Resident 29 was admitted to the facility on 4/13/01,	F 164	**Free Choice** All residents receiving blood glucose tests, insulin or other treatments or cares are taken to rooms for privacy with door closed and/or privacy curtain drawn. Nurses have passed skills tests for this procedure. In service training sessions on 8/10 for all staff, 8/13 for the licensed nurses and further inservices for review or as needed for all care staff covered blood glucose testing procedures, insulin administration, cares, treatments and other issues were held with all staff. Individual in service training with skills tests conducted by Janice Schorr, R.N. Nurse Consultant, Jay Pease, L.P.N. and Elaine Jones, R.N., D.O.N. These training sessions included privacy for all cares. Privacy curtains replaced/repaired as needed to provide for privacy during patient cares. Privacy screen available for those who prefer to receive some cares, such as blood glucose checks or insulin administration outside of their rooms. New track installed for privacy curtains between shower heads to allow for additional privacy during showers, in addition to the shower curtain already installed in the doorway. Residents 1, 4, 6, 12, 16, 17, 26, 24, 28, 29, 40, 41, 42, 45, 46 and all other residents have their privacy in cares assured due to the above efforts. Those residents who desire and are able to self administer insulin or other medications, as in the case of resident 29, have care plans reflective of this and have been instructed on privacy issues. The family of resident 4, who provide much of his personal cares, have been instructed on patient dignity and privacy issues. Resident 13 self discharged, against medical advice during the survey. Resident 21 was on hospice care and has passed away since survey. Monitoring rounds conducted by D.O.N. and A.D.O.N. implemented to assure continued compliance. These rounds will continue daily until substantial compliance is reached and weekly thereafter. Deficiencies found in the monitoring rounds will be reported to the administrator , corrections and repairs made as needed, and deficiencies reviewed by QA.	8/16/01

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tony Lemmon — TITLE: Adm — (X6) DATE: 2/16/02

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 aft 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 164	Continued From Page 1 with diagnoses of insulin dependant diabetes mellitus, traumatic brain injury, hypertension, and seizure disorder. A physician's order, dated 4/13/01, indicated the resident was to have blood sugar (BS) monitoring four times daily at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. A physician's order, dated 7/9/01, indicated the resident was to receive NPH insulin 14 units, and regular insulin 6 units every AM, and NPH insulin 14 units every PM. On 8/1/01 at 7:45 AM, resident 29 was observed to check her own blood sugar per the facility's blood glucose monitor while standing at the south hall nurse's medication cart in the hallway. The resident then was observed (with supervision from the nurse) to draw up and self-administer the insulin. Three other residents were observed to be standing in the hallway, near the resident, as she self-administered the insulin. The nurse was not observed to take the resident to a private area of the facility to check her blood sugar and administer the insulin. On 8/2/01 at 7:50 AM, resident 29 was observed standing in the hallway at the south hall medication cart. With the nurse's supervision, the resident was observed to check her own blood sugar and self-administer her insulin. Other residents were observed to be standing in the hallway and walking by resident 29 as she self-administered the insulin. On 8/7/01 at 12:20 PM, resident 29 was observed to stand in the hallway at the nurse's medication cart. The resident was observed to check her blood sugar and administer her insulin, with the nurse's supervision. Visitors and residents were observed to be standing in the hallway and walking by resident 29, as she self-administered the insulin injection.	F 164		

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On 8/7/01 at 12:35 PM, resident 29 was interviewed. When asked if she felt the facility provided privacy for her when she wanted it, the resident stated she felt uncomfortable checking her blood sugar and giving her insulin in the hallway. The resident stated she would prefer to do this in her room.

2. Resident 45 was readmitted to the facility on 1/31/01, with diagnoses of insulin dependant diabetes mellitus, hepatitis C, end stage renal disease with dialysis, seizure disorder, hypertension, paranoid schizophrenia, asthma, and anemia.

A physician's order, dated 1/31/01, documented the resident was to have BS monitoring by the facility 1/2 hour before each meal, 3 times daily. A physician's order, dated 1/31/01, indicated resident 45 was to receive Humalog insulin 6 units, 1/2 hour before meals 3 times daily at 7:00 AM, 11:00 AM, and 4:00 PM.

On 8/1/01 at 7:55 AM, the facility's van driver was observed to enter resident 45's room, wake him up, and ask him to get ready to go to his dialysis appointment. At 8:05 AM, the resident was observed to start to leave the facility with the van driver. The nurse caring for the resident was observed in the basement dining room passing the morning medications at that time. The nurse surveyor asked if the nurse knew the resident was leaving the facility, and the nurse stated,"No". The nurse surveyor asked if the resident's blood sugar had been checked and if his morning insulin had been administered. The nurse stated, "No". At 8:10 AM, the nurse was observed to stop the resident from leaving the building. While standing in the hallway of the facility, the nurse was observed to check resident 45's blood sugar. The resident was then observed to leave the facility and go out into the facility's parking lot. At 8:15 AM, the nurse was

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F 164	Continued From Page 3 observed to go out into the facility's parking lot and administer the resident's insulin. Other residents and visitors were observed to walk by the resident as the nurse checked his blood sugar and administered his insulin. The nurse was not observed to provide for the resident's privacy while checking his blood sugar or administering the resident's insulin. 3. Resident 46 was admitted to the facility on 3/29/00, with diagnoses of insulin dependant diabetes mellitus, blindness, and hypertension. A physician's order, dated 10/4/00, indicated the resident was to have blood sugar monitoring by the facility 4 times daily, at 6:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM. A physician's order, dated 7/16/01, indicated the resident was to have NPH insulin 30 units every AM and NPH insulin 10 units every PM. During an observation of a medication pass on 7/31/01 at 5:00 PM, a facility nurse was observed to check a blood sugar on resident 46 in the dining room, at the table where resident 46 ate his meals with other residents. The facility nurse administered resident 46's insulin in his abdomen in the dining room at the resident's table. The nurse did not provide privacy for resident 46. On 8/1/01 at 6:15 AM, and 8/2/01 at 6:50 AM, the nurse was observed to check the resident's blood sugar and administer the resident's insulin while the resident was standing in the hallway at the south hall medication cart. Other residents were observed standing near the resident when the nurse checked his blood sugar and administered the insulin. The nurse did not provide privacy for resident 46 while checking his blood sugar and administering his insulin.	F 164		

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F 164	Continued From Page 4 4. On 8/1/01, at 6:00 AM, a surveyor was walking past the north end of the facility, facing the street, to enter the facility on the east side. Resident 12 could be seen from the outside of the north end of the facility, through his room window. The light was on in the room, the window blinds were open and the privacy curtains were not drawn. Resident 12 was completely unclothed and ambulating about his room. When the surveyor entered the facility, resident 12 could be seen from the front door in the same condition. The north nurses station was just inside of the front door to the facility. A facility staff nurse and a lab technician, not a facility employee, were standing at the nurses station. The facility nurse made no attempt to assist resident 12 or to provide privacy for him. Resident 12 remained unclothed until 6:20 AM when a nursing assistant entered his room and helped him dress. On 8/1/01 at 12:45 PM, resident 12 was observed for ten minutes, from the hallway, to be by his door to his room wearing only his underwear. Two staff members were observed to pass the resident's room and gather supplies from the closet next to the residents room. A third facility staff member was observed to enter the residents room, walk by resident 12 who was still in his underwear, and tell his roommate that there was a telephone call for him. None of the facility staff members were observed to offer the resident assistance with closing his door for privacy. Resident 12 finished getting dressed by 12:55 PM. 5. On 7/31/01 at 2:30 PM, resident 4 was observed sitting unclothed in the west shower room. The shower room door was fully opened. The shower curtain did not cover the entry way, leaving an opening of about 18 inches at the north end. Resident 4 sat directly behind the opening, with his torso facing the hallway, fully exposed.	F 164		

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6. On 8/1/01 at 6:25 AM, resident 40 was observed from the hallway while an aide provided cares. The door to resident 40's room was fully opened. The room had no privacy curtain to close around the resident's bed. Four residents shared the room with resident 40 and there was only one partial privacy curtain observed hanging in the room. All four residents were in the room during the observation. Resident 40 was observed from the hallway to be wearing only a blue incontinence brief.

7. On 8/1/01 at 7:25 AM, resident 13 was observed from the hallway to be sitting unclothed in the west shower room. The door was fully opened. The shower curtain was open about 18 inches at the north end. Resident 13 sat directly behind the opening, with his torso facing the hallway, fully exposed, as he washed his groin area.

8. On 8/1/01 from 5:30 AM until 8:30 AM, skin checks on 12 residents were performed by facility nursing staff at the surveyors request. While observing skin checks the surveyor noted the nursing staff did not close any of the resident's room doors. The following was observed:

a. Resident 1's door to his room was not closed nor was a privacy curtain used while his buttocks were exposed.

b. Resident 42's door to his room was not closed nor was a privacy curtain used while his buttocks were exposed.

c. Resident 26's door to her room was not closed nor was her privacy curtain pulled while her pants were pulled down and her incontinence brief was showing.

d. The nursing staff did not close resident 41's bathroom door while a nursing staff helped resident 41on the toilet. Two of his roommates were awake and in the room. The door to their room was open.

e. Resident 40 was laying in bed and a nursing staff

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F 164	Continued From Page 6 did not close the door to his room nor was the privacy curtain pulled while his buttocks were exposed. One of resident 40's roommates was present in the room while his buttocks were exposed. f. Resident 21's door was not closed nor was his privacy curtain pulled as his buttocks were exposed. g. Resident 17's privacy curtain was not pulled nor was his door closed when his buttocks were exposed. h. Resident 16's door was not closed nor was his privacy curtain pulled while his buttocks were exposed. i. Resident 24's door was not closed nor did the nursing staff pull the privacy curtain when her buttocks were exposed. j. Resident 28's door to her room was not closed nor was her privacy curtain pulled when her buttocks were exposed. k. Resident 6's door to his room was not closed nor was his privacy curtain pulled when his buttocks were exposed. l. Resident 4's door to his room was not closed when his buttocks were exposed.	F 164		
F 167 SS=D	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was	F 167	**Examination of Survey** Results of Surveys conducted within the past twelve months are posted near the main entry way and at the North nurse's station. A flyer directing residents to this is posted on the Resident Information Board, near the residents' public phone. Compliance monitored by D.O.N. on a daily basis until substantial compliance is reached and weekly thereafter. Deficiency in this area reported to administrator and corrected as appropriate. Reviewed by QA committee.	8/7/01

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F 167	Continued From Page 7 determined that the facility did not ensure the results of the most recent survey were available for examination in a place that was readily accessible to the residents. Findings include: On 8/6/01 at 3:00 PM, observation revealed that the most current survey was not posted. There was not a sign directing anyone interested in the survey results to it's location. The survey results were located in a binder, filed in the medical record cart behind the north nurses station. On 8/6/01 at 3:55 PM, an interview was conducted with two residents in regards to where the survey results were located. The two residents stated that they had no idea where the survey results were located and would like to have access to the results. The two residents stated they would try to find the survey results location. On 8/7/01 at 2:00 PM, the two residents stated they were unable to find the survey results from last year.	F 167		
F 204 SS=G	483.12(a)(7) TRANSFER AND DISCHARGE REQUIREMENTS A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review and on interviews with the facility administrator, facility social services staff member, a registered nurse with the Utah Department of Health, an independent living	F 204	**Transfer and Discharge Requirements** To prevent instances where a resident is inappropriately discharged, as in the case of Resident 18, the facility has adopted a policy whereby all discharges are reviewed by the IDT prior to discharge. The reason for discharge, the appropriateness of discharge, and the appropriateness of placement will all be reviewed for the safety and health of the resident, compliance with resident rights,	8/21/01

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F 204	Continued From Page 8 apartment manager, and an employee of the Social Security Administration, it was determined that the facility did not ensure a safe and orderly discharge for one sample resident (resident 18). Findings include: Resident 18 was a 60 year old male admitted to the facility on 4/18/01 with diagnoses including dementia, delusions, agitation, depressive features secondary to a cerebral vascular accident, hypertension, insomnia and headaches. On 7/13/01, resident 18 was discharged by the facility to a local homeless shelter for men. That same day, the resident returned on his own to the facility. On the afternoon of 7/14/01, resident 18 was transported by the facility to a "rescue mission" and was signed in by facility staff to stay for the night. According to facility documentation, the resident returned to the facility later that same day, was not allowed to enter the building and spent the night "outside". Facility documentation indicates that resident 18 was readmitted to the facility on 7/16/01 after the facility's interdisciplinary team had reviewed the resident's level of independent functioning and found that the previous assessment information had been inaccurate . 1. During an interview conducted on 8/9/01, a facility employee who had been the van driver on 7/13/01 and 7/14/01, stated that on Friday, 7/13/01, he was instructed to take resident 18 to the men's shelter because the resident had been discharged. The van driver stated that resident 18 refused to be dropped of at the shelter and had asked the driver to take him to another location. After leaving the resident, the van driver returned to the facility. The van driver stated that he was "surprised" to see resident 18 back in the facility that same day at	F 204	compliance with applicable regulations, and whether or not the resident's needs are more appriopriately met in the new setting. Any member of the IDT can place a hold on the discharge pending further review of any concern. The past two MDS assessments will be reviewed as part of the process. If a significant change is found between the two quarterly assessments, a review will be performed by the IDT to determine the accuracy of the information. Any corrections or significant changes will be immediately communicated to Resident Assessment. Final discharge decisions will lie with the administrator or director of nurses. In the case that a question exists, it will be addressed by consulting with Resident Assessment, prior to a transfer or discharge. Additionally, the Long Term Care Ombudsman may be consulted for additional input regarding discharges. IDT received inservice on the above policy as a committee on August 21, 2001. Compliance to this policy will be reviewed by the physician (through discharge order process), the IDT and the administrator during and immediately following each discharge, with frequency of monitoring dictated by frequency of discharges. All discharges for each quarter will be reviewed by the QA committee.	

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F 204	Continued From Page 9 approximately 2:00 PM. He further stated that on Saturday, 7/14/01, he was instructed to take resident 18 to the rescue mission. He stated that he drove resident 18 to the rescue mission in the afternoon and took resident 18 inside the mission and registered him to stay for the evening. 2. Nurse's notes in resident 18's medical record were reviewed on 8/2/01. The nurse's notes dated 7/13/01 stated "Pt (patient) discharged to shelter with belongings et (and) medication." The next notes dated 7/14/01 document, "Pt (patient) came to front entrance et (and) started banging et hitting glass door for me to let him in. Opened the door for pt (to) come in, et (he) wanted to know why he got dropped off @ (at) the shelter. Informed him that he was no longer a resident, et that he doesn't live here anymore. Pt doesn't remember that he was discharged to the shelter, he also stated, the shelter did not let him in, he also does not know if he took his meds (medications) or not, he does remember that he handed his meds to the person at the shelter. Pt spent the rest of the noc (night) outside across the parking lot, notified SSW (social services) about situation." 3. A facility social service staff member was interviewed on 8/2/01, 8/6/01, and 8/7/01. The staff member indicated that resident 18 had been denied Medicaid reimbursement for his stay at the facility by the Resident Assessment Section (RAS) of the Bureau of Medicare/Medicaid Program Certification and Resident Assessment; a medical eligibility determination program of the Utah State Medicaid Agency. The denial was based on information contained in the resident's Minimum Data Set (MDS) that indicated that the resident did not require the level of medical care of a nursing facility based on his independence in aides of daily living.	F 204		

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F 204	Continued From Page 10 The social service staff stated she had spent 1 month working with resident 18 to locate an appropriate place for him to stay and to prepare him for discharge from the facility on 7/16/01 to new living arrangements at an independent living complex. The discharge services provided included working with the Social Security Administration and acquiring dishes, furniture etc. She also confirmed that resident 18 had been discharged on 7/13/01 to the shelter. 4. On 8/8/01, an interview was conducted with the Social Security Administration (SSA) employee who had worked with resident 18. They confirmed that arrangements were made on 7/12/01 to send resident 18's benefit checks to his new apartment in his own name. The SSA employee stated, "a few days later" the facility's social services called to cancel the arrangements. 5. On 8/9/01, an interview was conducted with the apartment manager who was responsible for services provided in the independent living complex that the facility's social services had arranged for resident 18 to be discharged to on 7/16/01. The apartment manager stated, "(Resident 18) came in on 7/12 and signed papers." He further stated that he had expected resident 18 would move into his new apartment on 7/16/01. 6. On 8/7/01 at 2:45 PM , the facility's administrator was interviewed. He stated he made the decision to discharge resident 18 to a shelter on Friday 7/13/01 because Medicaid payments had been denied and he wasn't certain that resident 18 was going to be admitted to the apartments on Monday 7/16/01. 7. An interview was conducted with the registered nurse from the Resident Assessment Section (RAS). The RAS nurse stated that based on the facility's	F 204		

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F 204	Continued From Page 11 Medicaid pre-admission documents which included resident 18's MDS assessment dated 4/30/01, resident 18 had not qualified for Medicaid coverage for placement at a long term care facility.	F 204		
F 241 SS=E	483.15(a) QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, a confidential group interview, individual interviews, and an interview with a family member, it was determined the facility did not promote care for residents in a manner and in an environment that enhances each resident's dignity and respect in full recognition of his or her individuality. The facility did not answer call lights timely, knock on doors before entering resident rooms and a staff member did not treat residents with respect. (Room identifiers: 104, 106, 109, 111, 113, 114, 205, 209, 210, 213, and 214.) Findings include: The following observations were made during the survey: CALL LIGHTS On 7/31/01 at 8:05 AM, a resident in room 209 turned on the call light. The nursing staff answered the call light at 8:18 AM. 13 minutes. On 7/31/01 at 2:10 PM a resident in 106 turned on the call light. The nursing staff answered the call light at	F 241	**Quality of Life** Call light system overhauled so that it is audible in all portions of the nursing floor. System repaired so that some lights which were incorrectly wired will now register correctly. Pull cord added to resident restroom in lower level. Staff inservice held September 10, 2001 to cover the "no pass rule", meaning that no staff member, regardless of assignment, is to pass a room with an active call light without checking on the resident. Inservice to include information on maximum length of time a resident should wait for an answer (3 minutes) to a call light, that staff should always knock/identify selves before entering a resident's room, and what constitutes good customer service, resident respect and dignity. Employees number 1 & 2 have received one on one counseling on August 17, 2001 regarding quality of life issues, including knocking, patient respect, and overall dignity of residents. A call light was added to the downstairs resident restroom. 208 and 209's wiring	9/24/01

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	465142	A. BUILDING _____ B. WING _____	8/7/01

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F 241	Continued From Page 12 2:26 PM. 16 minutes. On 8/1/01at 6:30 AM, a resident in room 214 turned on the call light. The nursing staff answered the call light at 6:39 AM. 9 minutes. On 8/1/01at 6:32 AM, a resident in room 113 turned on the call light. The nursing staff answered the call light at 6:40 AM. 8 minutes. On 8/1/01at 6:32 AM, a resident in room 109 turned on the call light. The nursing staff answered the call light at 6:41 AM. 9 minutes. At 6:42 AM, a resident in 109, turned on the call light. The nursing staff answered the call light at 6:55 AM. 13 minutes. On 8/1/01at 6:45 AM, a resident in room 104 turned on the call light. The nursing staff answered the call light at 7:01 AM. 16 minutes. On 8/1/01 at 6:30 AM, a resident in room 114 was heard from the hallway to be repeatedly calling out, "Bathroom, bathroom". At 6:35 AM, the call light in room 114 was turned on. The nursing staff answered the call light at 6:52 AM. 22 minutes. KNOCKING ON RESIDENT ROOM DOORS On 7/31/01 at 1:30 PM , a nurse was overheard telling two nursing assistants that she had watched them not knock on doors to resident rooms. She told the nursing assistance that the State survey team was here and that staff need to knock on resident doors prior to entering their room. On 8/1/01 at 9:30 AM, a confidential group interview was conducted. Ten of ten residents stated that facility staff do not knock on the door prior to entering their room. The following comments were made by the	F 241	was repaired so that the correct light registers when the button is pushed. The rest of the system was tested to assure that each push station registered correctly when activated. To assure continued operation of the call light system, it will be tested monthly by the maintenance supervisor. Problems will be reported to the administrator and repairs initiated in a timely fashion. Timely answering of call lights, knocking/identifying self before entering residents' rooms and respect/dignity issues will be observed as part of daily compliance rounds by administrator and nursing administration until substantial compliance is reached, at which time these monitors will occur on a weekly basis Monitoring reports are maintained in a monitor log book, which will be reviewed by the QA committee on a quarterly basis. Signs placed on each patient room door reminding caregivers and visitors to knock prior to entering the room.	

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F 241	Continued From Page 13 residents: 1. One resident stated if the facility staff knocked, the staff would reply it's just me. He/she felt that identification was needed due to his/her disabilities. The resident was upset because sometimes people entered his/her room without identifying themselves. 2. Another resident stated that employee 1 would intrude into his/her room without knocking or identifying themselves. The resident did not want that facility staff member seeing him/her especially because he/she was not on nurse or a nurse aide. The resident further stated that he/she would be in the bathroom and the nurse aides would come in without knocking. The nurse aides would ask him/her to stop what he/she was doing because another resident needed to use the bathroom. He/she felt that the staff made him/her feel like his/her needs did not matter. 3. Ten of ten residents stated they felt uncomfortable when Employee 1 entered their rooms without knocking. On 8/1/01 from 6:15 AM to 7:17 AM, a medication pass was observed with the charge nurse. During the medication pass, the nurse did not respect the resident's dignity as evidenced by observations of the nurse entering resident rooms 111, 114, 205, 210, and 213, without knocking on the door or asking the resident's permission to enter. LACK OF RESIDENT RESPECT On 8/1/01at 9:30 AM, a confidential group interview was held. Ten of ten residents identified a nursing staff member, Employee 2, who did not treat residents in a dignified manner. The following was said about employee 2: 1. One resident stated that employee 2 had repeatedly told residents that he/she did not want to be there, did not care about the residents and told residents how	F 241		

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F 241	Continued From Page 14 much he/she hates his/her job. 2. Another resident stated that employee 2 talked down to him/her, and was not very nice or considerate of his/her feelings. On 8/7/01at 1:00 PM, an interview was conducted with a family member of a resident. The family member felt that there were some staff in the facility that did not treat residents in a dignified manner.	F 241		
F 242 SS=G	483.15(b) QUALITY OF LIFE The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interviews, and record review, it was determined the facility did not allow the residents to continue to participate in activities of their expressed interests and to interact with members of the community in a setting of their choice for 2 residents who had been receiving Specialized Rehabilitation Services (SRS) at a site away from the facility. (Residents 4 and 6) Findings include: The facility was being reimbursed a higher daily rate so that residents 4 and 6 could attend an outside SRS program. On 8/15/01, an interview was conducted with a	F 242	**Quality of Life** Arrangements are complete for programming options which allow for choice, are consistent with plans of care and assessments, and allow for interaction with members of community both inside and outside of the facility. These alternatives are in place for residents 4 & 6, according to their needs and abilities and other residents as indicated above. Additionally, there is a job coaching program in place for those residents who are able and qualify to do so. The residents mentioned above, and one other began going to the outside SRS program on September 4, 2001. Continued compliance tracked by social services worker who will contact SRS providers each month to verify that resident programs are remaining in place. Deficiencies reported to the administrator and QA committee.	9/4/01

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representative from the SRS program. The representative of the SRS program stated residents 4 and 6 had been coming from the facility to receive SRS services. The representative of the SRS program stated the facility had been informed that they could not send the residents to the SRS program after 5/30/01, unless payment was received from the facility for the services. On 5/30/01, the residents were denied continued service due to the facility's lack of response to the SRS representative's request for payment. The residents from the facility were contracted to attend three days a week, Monday, Tuesday and Wednesday, from 9:00 AM until 1:00 PM. The representative at the SRS stated the residents usually arrived early and often were allowed to stay until 2:30 PM because the residents enjoyed being there. The SRS representative stated the residents were very upset and the residents actually cried when they learned they would not be coming back to the program.

On 8/7/01 a facility social service staff member was interviewed regarding the SRS programs for the residents who had been involved. The staff member stated the facility was planning to implement their own SRS program, but at that time, the facility did not have a program in effect that would qualify.

In the interview with the social service staff member, the staff member stated the facility had attempted to place the residents into another SRS program but that SRS provider would only accept one of the residents into the program. The staff member stated the facility has not been able to find another SRS provider that would take all the residents.

When the social service staff member was asked if she had observed any change in the mood or behaviors of any of the residents since they had stopped going to the SRS, the staff member said, "Yes." She stated they

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had declined in mood.

THE RESIDENTS

1. Resident 6 was a 38 year old male who had been attending SRS. He had been admitted to the facility 2/9/00 with diagnoses including mild mental retardation and seizure disorder.

Resident 6 was interviewed regarding his daily routine. Resident 6 stated that he and two other residents used to go to SRS. He stated, "We loved it." The resident stated they had to stop going, "because the State or the Corporation stopped paying. They just didn't want to pay any more."

Resident 6 stated, "We are very, very upset because we enjoyed going out so much." The resident began to cry and stated, "I really miss it. It was just something for us to do, to keep us busy." Resident 6 stated that he and resident 4 especially enjoyed going out to SRS. He stated, "[resident 4] isn't as happy as he was, like we used to be." Resident 6 stated, "Now its day to day, it's just nothing."

Resident 6 further stated when he was attending SRS, "At the end of each day, about 7:00 each day, I'd call my mother and that was the main topic of discussion. We always talked about what I did at SRS." The resident also stated, "Now there is no comparison. I sit around and mostly do nothing."

Resident 6 stated the facility had talked of finding another program, or starting their own, but they have never done anything about it. He stated he was feeling totally discouraged.

On 8/15/01 during an interview with the representative of the SRS program, they stated that resident 6 was

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F 242	Continued From Page 17 highly involved with the program and was able to earn a little spending money while he worked. The representative stated that resident 6 seemed to enjoy working on meaningful projects and interacting with the other people he had met at the SRS site. The representative stated, "He was probably our best." The representative further stated that resident 6 was especially upset about not getting to continue the program and he wanted to know why. 2. Resident 4 was readmitted to the facility on 2/20/01 with diagnoses that included, closed head injury, seizure disorder, and mental retardation. A review of the resident's medical record was done on 8/7/01. A review of physician orders revealed an order, dated 3/5/01, for resident 4 to receive SRS. The annual comprehensive care plan for resident 4, dated 3/6/01, documented a care plan problem for, "Specialized Rehabilitation Service R/T (related to) Developmental disability M/B (manifested by) need for more normalized living." The interventions for this care plan problem included the following: 1. Staff to assist resident to SRS three times a week. 2. Review program goals three times a month. 3. Document progress. 4. Assist with transportation and lunches. 5 .Educate family, friends, of program. 6. Praise all efforts. 7. Encourage resident to do as much for self as resident can do. 8. Meet with long-term social work monthly to review program. On 8/7/01 at 1:00 PM, during an interview with resident 4's family, they stated that they felt that resident 4 had experienced a decline in his functional	F 242		

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F 242	Continued From Page 18 abilities since resident 4 had stopped attending the SRS program. The family member defined the decline as resident 4 had become more depressed and had a decrease in his motor skills and he had become more stiff in his range of motion. Furthermore, the family member stated that he/she was told that the facility wanted to develop their own program six months ago but nothing has happened. The family member stated that resident 4 had told them that he misses the program. Resident 4's last two quarterly MDS's, dated 5/4/01 and 7/26/01, were compared. Resident 4's MDS assessment, dated 5/4/01, documented that resident 4 had no mood indicators for being depressed, sad, or anxious. Resident 4's MDS assessment, dated 7/26/01, indicated that resident 4 had one or more mood indicators that were present and not easily altered. The 7/26/01 assessment documented that the resident had experienced a decline in his mood. On 8/15/01 in an interview with a representative of the SRS program they stated that resident 4's individualized program involved fine motor and gross motor skills. The representative stated resident 4 responded well to the therapy. The representative stated resident 4 had been working with eating utensils to feed himself and was making progress. The representative stated, "He liked it here, resident 4 did really well."	F 242		
F 278 SS=D	483.20(g) - (h) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each	F 278	**Resident Assessment** This matter had been resolved prior to survey. Resident 18's MDS had been reviewed, corrected and resubmitted to Resident Assessment 7/21/01.	9/20/01

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F 278	Continued From Page 19 assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly-- Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interviews with the facility social services staff member and the attending physician and record review, it was determined the facility did not provide a Minimum Data Set (MDS) assessment that accurately reflected the resident's status in the areas of memory and activities of daily living (ADL) for 1 of 18 residents. (Resident 18.) Findings include: Review of resident 18's medical record documented the resident was a 60 year old male who was readmitted to the facility on 4/18/01 following a temporary discharge. Resident 18's Preadmission Screening Resident Review, dated 4/18/01 by the	F 278	To assure that this problem does not repeat, the following process is implemented: • All quarterly reviews will include a review of the prior MDS and care plans to assure that any changes are recognized as such, and that if there is a change in condition, it is addressed in the care plan and thoroughly reviewed by team members. • The medical records clerk will audit the MDS following the IDT meeting and submission of updated MDS to assure that any changes in condition have indeed been addressed. • Any member of the IDT can question changes, requiring further documentation or study to validate the new MDS. • If a significant change is noted prior to the quarterly or annual review, an IDT meeting will be held when the change is noted, and a significant change MDS will be submitted. • The medical records consultant will audit these issues on a quarterly basis for compliance. Inservice training held with IDT on August 21, 2001 to review this policy and procedure. MDS and care plans will be done and reviewed during IDT meeting. Any changes or additions will be completed and discussed during this meeting. The medical records clerk will audit and place in charts in a timely manner following each IDT. The medical records consultant will conduct a	

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F 278	Continued From Page 20 DON, documented the resident's diagnoses to be, "Hypertension, S/P [status post] CVA [cerebral vascular accident] [with] depressive features, insomnia, Hx [history of] hematuria, H.A, [headache] Dementia, Alcohol abuse." Review of resident 18's history and physical report (H and P), dated 2/8/01 and initialed by the facility's Medical Director on 4/20/01, documented resident 18 had progressively declined over the past two years and on one occasion had to be hospitalized for a medication overdose. The H and P also documented that resident 18 "underwent neuro-psychologic testing at [hospital] with a picture of memory deficits and probable dementia." It also documented that resident 18 had undergone another psychological evaluation, on 12/8/98, and, "At that time, he was felt to have dementia with depression and possible schizo and personality disorder." The H and P also documented that, "[Resident 18] knows what month it is but does not know the year. He cannot perform simple subtraction except the first sequential 7 (100 minus 7). He cannot remember three words sequentially." The H and P further documented that resident 18's, "Cognition: Markedly impaired, particularly for judgement, high reasoning and new learning." Review of the social progress note, dated 4/18/01 and signed by the Licensed Clinical Social Worker (LCSW) corporate consultant, documented, "[Resident 18] has experienced several CVAs and subsequently has been place in 24 hour skilled nursing facilities for the last 10-12 years. He requires intensive supervision and cues with his activities of daily living." Review of resident 18's last full MDS assessment, dated 4/30/01, documented the resident had no short term or long term memory deficit (section B2a and b),	F 278	full audit on a quarterly basis, with all findings reported to the QA committee. Any discrepancies or omissions will be immediately reported to D.O.N. and administrator, immediately addressed as appropriate and will be logged and reviewed by the QA committee.	

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F 278	Continued From Page 21 was completely independent with his activities of daily living (ADLs) (section G1-8) and had no overall change in self sufficiency as compared to status of 90 days ago or to the last MDS assessment (section Q2). Resident 18's most recent prior MDS, a quarterly assessment dated 1/27/01, and most recent prior full MDS, dated 11/7/00, had documented that he had a short term memory deficit. The facility completed an MDS, dated 7/21/01, that was a "Significant Correction of Prior Full Assessment" for resident 18. The MDS correction documented resident 18 had both short and long term memory deficit (section B2a and b). The prior full assessment that was being corrected was the 4/30/01 MDS which documented resident 18 had no short term or long term memory deficit. The MDS correction documented that, resident 18 required supervision for activities of daily living (ADLs) for locomotion off his care unit (G1f), for dressing (G1g) and for bathing (G2a) and he required limited assistance for personal hygiene (G1j). The 4/30/01 MDS documented he was totally independent in all ADLs. Resident 18's most recent assessment prior to 4/30/01 was dated 1/27/01 and documented that the resident had a short term memory loss and that he had required supervision in the ADLs of eating (G1h) and hygiene. A review of resident 18's plan of care and interviews with the facility social service staff member and the attending physician revealed the following: The facility's plan of care for resident 18 documented, three times, "Resident exhibits poor short term memory and requires some assist with decision making D/T [due to] Dementia R/T [related to] CVA." The goals documented for resident 18 included, "Resident will be alert and oriented QD [every day]", "Resident will respond positively to redirection away from anger	F 278		

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outburst any given day," and "Will make decisions on own at least 1X [one time] daily." The target date for the resident to reach the goals was 7/18/01. Interventions the staff were implement in order to help resident 18 reach the goals included, "Reality orientation QD and PRN [as needed]," "Encourage to make all decisions" and "Coach through process and assist PRN," and "Clarify reality when not making sense."

During interviews with the facility social service staff member, on 8/2/01, 8/6/01, 8/7/01, the social service staff member stated that she had worked closely with resident 18, almost daily for a full month, in order to assist him with his transfer into his own apartment. The social service staff member stated that resident 18 demonstrated a serious short term memory deficit that had became more apparent to her as she spent more time with him. The staff member stated, "He [resident 18] could eat but needed cues to do it. He could take meds [medications] but needed supervision."

The attending physician, who had provided care for resident 18 prior to his temporary discharge, was interviewed by telephone on 8/9/01. The physician stated that the MDS assessment, which documented resident 18 had no memory deficit, was incorrect.

Review of the facility's Self-Administration of Medications assessment for resident 18, dated 4/18/01, documented the resident wanted to self-administer his own medications. It was also documented that resident 18 was not a candidate for self-administering his medications because of his confusion. The assessment was signed by resident 18 and by the social services.

Resident 18 had been considered for Flexcare, an option for placement in a less restrictive setting than

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F 278	Continued From Page 23 long term care for residents who function at a high level of independence. The Flexcare Notice of Decision for resident 18, dated 4/27/01, documented "Your current medical conditions indicate that your care needs are most appropriately met in a nursing facility at this time." The specific reasons for the decision included concerns regarding resident 18's behaviors and his poor cognitive abilities.	F 278		
F 314 SS=J	483.25(c) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, it was determined that for 5 of 13 sample residents, the facility did not ensure that residents with pressure sores received the necessary treatment and service to promote healing. The facility did not provide pressure reliving devices, provide nutritional support, reposition as assessed and careplanned, or provide treatment as per the physician order. Resident identifiers: 6, 24, 35, 40, and 42. Findings include: Interviews On 7/30/01 at 9:05 AM, the Director of Nursing	F 314	**Quality of Care** All residents are evaluated using the Braden Scale upon admission, then quarterly and annually. An RN has been designated as the skin nurse and will conduct all evaluations, to assure consistency. All residents who are identified as "at risk" (score 12 is the break point), will have care plans reviewed to address pressure sore prevention. Care plans will include pressure relief cushioning in beds and wheelchairs. It will also include turning schedules where appropriate. To track potential skin breakdown in the facility, a Clip Board Body Audit form will be completed by shower aides to mark suspicion or development of wounds, and shower aides will notify Wound Care Nurse or Charge nurse of skin problems or potential skin problems. The skin nurse will chart progress on those residents identified as having skin breakdown on a weekly basis. **F 314** Pressure relieving devices, such as bed and	8/20/01

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F 314	Continued From Page 24 (DON) was interviewed regarding routine skin assessment documentation. The DON stated her assistant had developed a form which included a body chart skin assessment that the nurse aides were to complete when they performed resident showers. The DON stated the aides were to document if the resident had no skin problems, or if there were, the aides were to document and illustrate the location of the problem on the body drawing. An interview with the DON and the Assistant Director of Nursing (ADON) was held on 8/1/01. They stated that the nursing assistants were supposed to do a skin check on residents when they were bathing. If the nursing assistants found skin breakdown, they were to report it to the charge nurse. The charge nurse was to assess the resident, obtain treatment orders and then do weekly skin assessments and documentation. Both the DON and the ADON stated that they could not get the facility nursing staff to follow through with the process. An interview with two facility nurses was held on 8/2/01, at 7:25 AM. The nurses stated that the nursing assistants usually would tell the nurses if a resident had a skin breakdown. They both stated that they were not aware of a facility protocol for the prevention and treatment of skin breakdown. Both the nurses stated they were unaware of the form that was identified by the DON and ADON. On 7/30/01 at 9:15 AM, a certified nurse aide (CNA) was asked about the skin assessment form, identified by the DON. The CNA stated, "We don't use body charting." The CNA stated that he/she did not know anything about the form. The DON reminded the CNA of the form, at which point the CNA stated, "Oh yeah, I don't know where it is."	F 314	wheelchair cushions, heel protectors, etc. are in place for the "at risk" residents. Progress will be charted in a Wound Care Book, which will include Braden Scale Sheets, Body Audits and weekly tracking sheets. This book will be audited for completeness by the medical records clerk on a weekly basis until substantial compliance is reached, and monthly thereafter. All residents have been assessed as of August 20, 2001. Whenever a resident's skin is compromised, or a resident is "at risk", the dietary supervisor will be notified by skin nurse or D.O.N. Appropriate dietary adjustments will be recommended to physician for his/her approval. Weights will be done weekly and dietary intake monitored closely by restorative aides. This information. Nursing staff will date and initial all dressings, so they may be compared and tracked with the charting. Treatment records are monitored daily by medical records clerk to assure treatments are being performed as ordered. Following the determination of substantial compliance, these audits will continue on a weekly basis. Any deficiencies are reported to the D.O.N. and administrator. Audit forms are maintained in a QA log book, and the process is reviewed quarterly by the QA committee.	

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F 314	Continued From Page 25 On 7/30/01 at 9:30 AM, a different nurse aide was interviewed. This nurse aide stated she had been at the facility seven months. The nurse aide was asked is he/she was aware of the shower day body charting form. The nurse aide stated, "I've never heard of body charting." Interviews were held with the facility's Food Service Supervisor (FSS) on 7/31/01 at 2:15 PM and 8/1/01 at 9:20 AM. On 7/31/01, the FSS stated the facility had a weight and skin meeting, which was held weekly, following interdisciplinary team (IDT) meetings. On 8/1/01, the FSS clarified that the facility had a weight meeting that was held on Thursdays, following the IDT meetings. She stated, "there is no actual skin meeting." The FSS stated she participated in the weight meetings. The FSS stated she thought nursing staff would communicate with the dietary staff when a resident had a newly identified pressure sore. The FSS was unable to identify which of the facility's current residents had pressure sores which would require nutritional interventions. An interview was held with a facility nurse on 8/1/01 at 9:25 AM. The FSS was present during the interview. The surveyor asked the nurse who would be notified if a resident were to have a newly identified pressure sore. The nurse stated she would inform the resident's physician. The FSS asked the nurse if she would notify the dietary staff. The nurse stated, "No, should I?" An interview was held with a night shift nurse aide, on 8/1/01 at 6:00 AM. The nurse aide stated that he/she could not remember who needs to be turned at night. The nurse aide stated that residents 36 and 42 were not turned or repositioned at night. The nurse aide further stated that resident 35 was not turned in bed, only pulled up and a pillow placed between her legs. The	F 314	The above items are in place for residents 6, 24, 35, 40, 42, and other residents who have been identified by the facility nursing staff. Care staff inserviced on the forms, systems, policies and procedures as they relate to wound care on 8/14/01. Additionally, these policies are included a communication log found at each nurse's station.	

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nurse aide stated he/she could only remember one resident who was turned and repositioned at night; resident 21.

An interview was held with another night shift nurse aide on 8/1/01 at 6:15 AM. The nursing assistant stated he/she was busy answering call lights at night and did not have time to turn and reposition residents in bed. The nurse aide stated that resident 36 and 42 were not turned or repositioned at night.

On 8/2/01 at 3:05 PM, a different facility nurse was interviewed. The nurse stated she had worked for the facility before, but this time she had been working for eight months. The nurse stated facility nursing staff used to complete weekly skin assessments and document the results of treatments and wound progress. The nurse stated that the weekly skin assessments had stopped because, "People with pressure ulcers went to the wound clinic for treatment." The nurse said she still checks resident 36, who has a big sore. When identifying residents with skin problems, the nurse stated, "I rely heavily on the aides for information." The nurse further stated, "I think the aides have a skin sheet they document on," but that she had not seen the sheet used.

On 8/2/01 at 4:36 PM, a different staff nurse was interviewed. This nurse stated that when a resident was identified as having a pressure sore, the pressure sore was measured. The nurse stated the pressure sore was not measured again until the resident was discharged.

Residents:

1. Resident 42 was readmitted to the facility on 6/23/01, with diagnoses of diabetes mellitus, hypertension, coronary artery disease, legally blind,

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schizo-effective disorder and bipolar disorder.

Review of resident 42's clinical record on 8/1/01, revealed an admission MDS assessment completed 7/5/01, which documented resident 42 required extensive assistance with bed mobility. The assessment also documented that resident 42 had a stage III (full thickness of skin lost, exposing the subcutaneous tissues) pressure ulcer, and required pressure relieving devices for the bed, a turning and repositioning program, and nutrition or hydration intervention to manage skin problems.

The care plan for resident 42, dated 6/23/01, documented, under problem 14, that resident 42 had an alteration in skin integrity, related to decubitus on buttocks, stage II, (a partial thickness loss of skin layers that presents clinically as an abrasion, blister or shallow crater), and decubitus on right heel, stage III, manifested by broken layers of skin. The intervention documented to turn every two hours and position with pressure off the decubitus, and encourage protein snacks.

Resident 42 was observed at various times on 7/31/01, 8/1/01, and 8/2/01. The following observations were made:

a. On 7/31/01 at 7:50 AM, resident 42 was observed to be up in a wheelchair, sitting in his room, next to his bed. Resident 42 had protective booties on both feet. The bed had been stripped and the mattress was observed to be a tan plastic mattress.

At 9:30 AM, resident 42 was observed to be lying on his bed, on his back, with his legs elevated on a wedge cushion. Protective booties were on both feet.

At 10:45 AM resident 42 was observed to be lying on

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F 314	Continued From Page 28 his bed, on his back,with his legs elevated on a wedge cushion. Protective booties were on both feet. At 12:30 PM resident 42 was observed to be lying on his bed, on his back, with his legs elevated on a wedge cushion. Protective booties were on both feet. At 2:00 PM resident 42 was observed to be lying on his bed, on his back, with his legs elevated on a wedge cushion. Protective booties were on both feet. At 3:45 PM resident 42 was observed to be lying on his bed, on his back, with his legs elevated on a wedge cushion. Protective booties were on both feet. Resident 42 had a bag of potato chips to the right side of him on the bed. Resident 42 had dropped broken chips on the right side of his chest, just below his clavicle. At 5:50 PM resident 42 was observed to be lying on his bed, on his back, with his legs elevated on a wedge cushion. Protective booties were on both feet. The bag of potato chips was to the right side of him and appeared to be empty. Resident 42 still had the broken chips on his chest. b. On 8/1/01 at 6:00 AM, resident 42 was observed to be lying on his bed, on his back, with his legs elevated on a wedge cushion. Protective booties were on both feet. The empty bag of potato chips was still to the right side of him and the broken chips were still on his chest. At 7:30 AM, resident 42 was observed to be lying on his bed, on his back, with his legs elevated on a wedge cushion. Protective booties were on both feet. The empty bag of potato chips was still to his right side and the broken chips still on his chest.	F 314		

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At 8:25 AM, resident 42 was observed to be lying on his bed, on his back, with his legs elevated on a wedge cushion. Protective booties were on both feet. The empty bag of potato chips was still to his right side and the broken chips still on his chest.

At 9:30 AM, resident 42 was observed to be lying on his bed, on his back, with his legs elevated on a wedge cushion. Protective booties were on both feet. His shirt had been changed and the empty bag of potato chips removed.

At 12:20 PM, an observation of resident 42's skin condition was made. A facility nurse accompanied the surveyor during the observation. Resident 42 was observed to have two open wounds on his buttocks; one on his right buttock and one on his left buttock. The facility nurse stated that both wounds were stage II pressure sores and both approximately two centimeters in size. There were no dressings on either wound. Additionally, the nurse stated that the mattress that resident 42 was on was not pressure relieving or pressure reducing. Resident 42 was observed to have gauze dressing roll covering his right heel. The wound under the dressing was not observed. The nurse stated that resident 42 had a large black area on his right heel. She stated the right heel wound was being treated two times a day and that a wedge cushion and booties were used to prevent pressure to the heel.

At 1:15 PM, resident 42 was observed to be lying on his bed, on his back, with his legs elevated on a wedge cushion. Protective booties were on both feet.

At 2:30 PM resident 42 was observed to be lying on his bed, on his back, with his legs elevated on a wedge cushion. Protective booties were on both feet.

c. On 8/2/01 at 5:30 AM, resident 42 was observed to

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be lying on his bed, on his back. His head was one foot from the headboard. His legs were bent at the knees and were resting on the siderails. His legs were not elevated on the wedge cushion and his protective booties were on the floor.

At 6:15 AM, resident 42 was observed to be lying on his bed, on his back. His head was one foot from the headboard. His legs were bent at the knees and were resting on the siderails. His legs were not elevated on the wedge cushion and his protective booties were on the floor.

At 6:45 AM, resident 42 was observed to be lying on his bed, on his back. His head was one foot from the headboard. His legs were bent at the knees and were resting on the siderails. His legs were not elevated on the wedge cushion and his protective booties were on the floor.

At 7:10 AM, resident 42 was observed to be lying on his bed, on his back. His head was one foot from the headboard. His legs were bent at the knees and were resting on the siderails. His legs were not elevated on the wedge cushion and his protective booties were on the floor.

At 7:45 AM, resident 42 was observed to be up in the wheelchair. There was a pillow and blue foam pad observed in the wheelchair. Protective booties were on both feet.

At 9:35 AM, resident 42 was observed to be lying on his bed, on his back, with his legs elevated on a wedge cushion. Protective booties were on both feet.

At 10:50 AM, resident 42 was observed to be lying on his bed, on his back, with his legs elevated on a wedge cushion. Protective booties were on both feet.

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At 12:35 PM, resident 42 was observed to be lying on his bed, on his back, with his legs elevated on a wedge cushion. Protective booties were on both feet.

An interview was held with a night shift nursing assistant on 8/1/01, at 6:15 AM. The nursing assistant stated that they had cared for resident 42 during the night but had not turned or repositioned resident 42 during the night.

At 2:35 PM on 8/1/01, an interview was held with the nursing assistant who had cared for resident 42 on the day shift from 7:00 AM to 3:00 PM. She stated that she had fed resident 42 his breakfast and lunch, in his room and in bed. She stated he had not wanted to get out of bed. She also stated that she had not turned him off of his back during the shift.

A review of resident 42's clinical record on 8/1/01 revealed the following:

A nurse's note, dated 6/29/01 at 3:50 PM, documented,"...Redness noted on buttocks..."
A nurse's note, dated 7/4/01 at 10:30 PM, documented,"Turned him and inspected his skin, He had 3 lrg[large] areas of broken skin. Cleaned & transparent drsg[dressing] applied."
A nurse's note, dated 7/10/01 at 10:30 PM, documented, "Has 2 2nd st. [stage] DQ [decubitus] on buttocks. Duoderm applied."
A nurse's note, dated 7/15/01 at 12:35 AM, documented,"Pt. [patient] continues to have tx [treatment] done to heel, et[and] buttock."

A physician order, dated 7/10/01 at 11:00 PM, documented,"duoderm to to DQ on buttocks." No other treatment orders could be found in resident 42's clinical record for treatment to pressure sores on the

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resident's buttocks.

Nursing staff utilized treatment records to document when pressure sore dressing changes were completed. A review of resident 42's July 2001, treatment record was done. The physician ordered pressure sore treatment was not identified on the treatment record. Additionally, there was no other documentation in resident 42's medical record to demonstrate the treatments to the resident's pressure sore was completed, as ordered on 7/10/01.

2. Resident 35 was admitted to the facility 4/27/96 with diagnoses of multiple sclerosis, dyspepsia, insomnia, pressure ulcer, neurogenic bladder depressive features and calcium metabolism disorder.

Review of resident 35's clinical record on 7/31/01, revealed a quarterly MDS assessment completed on 3/26/01, which documented resident 35 was totally dependant for bed mobility. The assessment also documented that resident 35 had one stage II pressure ulcer, and required pressure relieving devices for the bed, a turning/repositioning program, and nutrition or hydration intervention to manage skin problems.

The care plan for resident 35, dated 2/27/01, documented under problem 10, that resident 35 had alteration in skin integrity. Interventions for this identified problem included nutritional supplement to increase protein density, protein snacks tid (three times daily), reposition every two hours with air bed. Pad all pressure areas to prevent further breakdown, and dressings per physician's order.

Resident 35 was observed at various times on 7/31/01, 8/1/01, and 8/2/01.

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a. On 7/31/01, at 7:45 AM, resident 35 was observed to be lying on a low airloss bed, on her back, positioned slightly to her right. The head of the bed was elevated 30 degrees. Her legs were bent at the knees and both legs were to her right. There was no pillow under her head. Her arms were bent at the elbows and across her abdomen.

At 8:45 AM, resident 35 was observed being fed breakfast by a nursing assistant. The nursing assistant stated that resident 35's bed was broken and the head of the bed would not go up or down. The nursing assistant stated she had to prop resident 35 up with pillows to feed her. Resident 35 was observed to be lying on a low airloss bed, on her back, positioned slightly to her right. The head of the bed was elevated 30 degrees. Her legs were bent at the knees and both legs were to her right. There was a pillow under her head. Her arms were bent at the elbows and across her abdomen.

At 9:30 AM, resident 35 was observed to be lying on a low airloss bed, on her back, positioned slightly to her right. The head of the bed was elevated 30 degrees. Her legs were bent at the knees and both legs were to her right. There was no pillow under her head. Her arms were bent at the elbows and across her abdomen.

At 10:30 AM, resident 35 was observed to be lying on a low airloss bed, on her back, positioned slightly to her right. The head of the bed was elevated 30 degrees. Her legs were bent at the knees and both legs were to her right. There was no pillow under her head. There was a pillow between her knees. Her arms were bent at the elbows and across her abdomen.

At 12:00 PM, resident 35 was observed being fed lunch. Resident 35 was observed to be lying on a low airloss bed, on her back, positioned slightly to her

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right. The head of the bed was elevated 30 degrees. Her legs were bent at the knees both legs were to her right with a pillow between her knees. There was no pillow under her head. Her arms were bent at the elbows and across her abdomen.

At 1:30 PM, resident 35 was observed to be lying on a low airloss bed, on her back, positioned slightly to her right. The head of the bed was elevated 30 degrees. Her legs were bent at the knees both legs were to her right with a pillow between her knees. There was no pillow under her head. Her arms were bent at the elbows and across her abdomen.

At 4:00 PM, resident 35 was observed to be lying on a low airloss bed, on her back, positioned slightly to her right. The head of the bed was elevated 30 degrees. Her legs were bent at the knees both legs were to her right. There was no pillow between her knees. There was no pillow under her head. Her arms were bent at the elbows and across her abdomen.

b. On 8/1/01 at 6:30 AM, resident 35 was observed to be lying on a low airloss bed, on her back, positioned slightly to her right. The head of the bed was elevated 30 degrees. Her legs were bent at the knees both legs were to her right. There was no pillow between her knees. There was no pillow under her head. Her arms were bent at the elbows and across her abdomen.

At 7:00 AM, resident 35 was observed to be lying on a low airloss bed, on her back, positioned slightly to her right. The head of the bed was elevated 30 degrees. Her legs were bent at the knees both legs were to her right. There was no pillow between her knees. There was no pillow under her head. Her arms were bent at the elbows and across her abdomen.

At 9:15 AM, resident 35 was observed being fed

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F 314	Continued From Page 35 breakfast by a nursing assistant. Resident 35 was observed to be lying on a low airloss bed, on her back, positioned slightly to her right. The head of the bed was elevated 30 degrees. Her legs were bent at the knees both legs were to her right. There was no pillow between her knees. There was no pillow under her head. Her arms were bent at the elbows and across her abdomen. At 11:30 AM, resident 35 was observed to be lying on a low airloss bed, on her back, positioned slightly to her right. The head of the bed was elevated 30 degrees. Her legs were bent at the knees both legs were to her right. There was no pillow between her knees. There was no pillow under her head. Her arms were bent at the elbows and across her abdomen. At 2:00 PM, resident 35 was observed to be lying on a low airloss bed, on her back, positioned slightly to her right. The head of the bed was elevated 30 degrees. Her legs were bent at the knees both legs were to her right. There was no pillow between her knees. There was no pillow under her head. Her arms were bent at the elbows and across her abdomen. c. On 8/2/01, at 7:05 AM, resident 35 was observed to be lying on a low airloss bed, on her back, positioned slightly to her right. The head of the bead was elevated 30 degrees. There was no pillow under her head. Her arms were bent at the elbows and across her abdomen. Her legs were bent at the knees and both legs were to her right. There was no pillow between her knees. At 8:10 AM. resident 35 was observed to be lying on a low airloss bed, on her back, positioned slightly to her right. The head of the bead was elevated 30 degrees. There was no pillow under her head. Her arms were bent at the elbows and across her abdomen. Her legs	F 314		

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were bent at the knees and both legs were to her right. There was no pillow between her knees.

At 9:15 AM, resident 35 was observed being fed breakfast by a nursing assistant. Resident 35 was observed to be lying on a low airloss bed, on her back, positioned slightly to her right. The head of the bead was elevated 30 degrees. There was no pillow under her head. Her arms were bent at the elbows and across her abdomen. Her legs were bent at the knees and both legs were to her right. There was no pillow between her knees.

At 10:30 AM,resident 35 was observed to be lying on a low airloss bed, on her back, positioned slightly to her right. The head of the bead was elevated 30 degrees. There was no pillow under her head. Her arms were bent at the elbows and across her abdomen. Her legs were bent at the knees and both legs were to her right. There was no pillow between her knees.

An interview was held with resident 35 on 7/31/01. The surveyor asked resident 35 how often nursing staff repositioned her bed. She stated the only time staff repositioned her was when they were changing her wound dressings. She stated she did not get out of bed except to shower two times a week.

An interview was held with a night shift nursing assistant on 8/1/01, at 6:15 AM. He stated that he had been assigned to provide cares to resident 35 during the night. He stated that he had pulled resident 35 up in the bed but that he had not turned her.

An interview was held with a different nursing assistant on 8/1/01, at 1:35 PM. The nursing assistant was assigned to provide resident 35's cares on that day. She stated that she had not turned resident 35 except to help the facility nurse change the resident's dressing.

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A review of resident 35's clinical record on 8/1/01 revealed the following:

On 3/8/01, a skin and weight meeting note documented that resident 35 had a stage II pressure sore and recommended turning, increased protein meals, increased protein snacks, health shakes, increased fluids and to obtain orders for vitamin C, zinc and multiple vitamins.

On 4/5/01, a skin and weight meeting note documented that resident 35 had a stage III pressure sore and had a weight loss but to continue the same plan.

On 4/12/01, a skin and weight meeting note documented that resident 35 had a stage III pressure sore and to encourage fluids, encourage dietary intake, and supplement with Novasource 2.0 (a high protein liquid supplement) twice daily.

On 5/31/01, a skin a weight meeting note documented that resident 35 had a stage III pressure sore and to continue with turning, treatment to pressure sore and air mattress.

On 6/7/01, a skin and weight meeting note documented resident 35 had a stage III pressure sore and to increase fluids as much as possible, increase dietary intake, continue treatment to the pressure sore as ordered, turn every two hours and that resident 35 was on an air mattress.

On 7/5/01, a skin and weight meeting note documented resident 35 had a stage III pressure sore and to order ProMod (a powder protein supplement) 2 scoops twice daily with medications, and to continue health shakes three times daily, turning every 2 hours, treatment to the pressure sore as ordered and keep on air mattress.

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F 314	Continued From Page 38 Review of resident 35's weight record revealed the following: February 2001, 142 pounds. March 2001, 140 pounds April 2001, 137 pounds May 2001, 134 pounds June 2001, 132 pounds July 2001, 129 pounds August 2001, 128 pounds. No documentation could be found in the clinical record that any of the recomendations made during the weight and skin meetings, including ordering vitamin C, zinc, multivitamins, or protein supplements, had been done to promote wound healing or prevent weight loss for resident 35. An interview was held with a licensed nurse on 8/7/01. The nurse stated that nursing staff documented giving health shakes on resident 35's treatment record. The nurse stated that resident 35 had never received Novasource or ProMod. The nurse stated that the only supplement resident 35 received was the health shakes. A review of resident 35's June 2001, treatment record was done. The treatment record listed a health shake to be given to resident 35. Per documentation, resident 35 was not given the health shake at anytime, during the month of June 2001. A review of resident 35's July 2001, treatment record was done. Per documentation, resident 35 was given the health shake 32 out of 90 times during the month. A physician progress note for resident 35, dated 6/3/01 documented,"Under her left ischial tuberosity, there is a sore of approximately five centimeters in diameter	F 314		

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F 314	Continued From Page 39 which is foul-smelling and there are speckled black points in the wound. The surrounding tissue is somewhat indurated though this is not extensive. PLAN: left buttock sore with a necrotic, foul smell. Wet-to-dry Betadine twice today and again in the morning. Then switch to wet-to-dry TID (three time daily) with Gentamicin and Saline. Continue to do this until it is cleaner and improving...Continue her air mattress overlay. Avoid any pressure on this area until this is improving..." Review of the June, 2001, treatment record for resident 35 revealed that the treatment ordered on 6/3/01 for the Betadine dressing was only documented as being done two of the three times ordered. The Gentamicin dressing ordered to be done three times daily, was only documented as being done 12 out of 29 times it should have been done per physician order. On 6/14/01, a physician order for resident 35 documented to change the Gentamycin dressing to twice daily. Review of the June, 2001, treatment record for resident 35 revealed that the treatment ordered on 6/14/01 for Gentamycin dressing changes twice daily, was only documented as being done 15 out of 34 times it should have been done per the physician order. Review of the July, 2001, treatment record for resident 35 revealed the the treatment ordered on 6/14/01 for Gentamycin dressing changes twice daily, was only documented as being done 31 out of 60 times it should have been done per the physician order. Review of the August, 2001, treatment record for resident 35 revealed that the treatment ordered on 6/14/01 for Gentamycin dressing changes twice daily, was not documented as being done on 8/5/01 and	F 314		

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F 314	Continued From Page 40 8/6/01 at 8:00 PM. During an interview with a facility nurse on 7/31/01, the facility nurse stated that treatments have not always been done as ordered. The facility nurse stated that dressings that were to be changed twice daily, were to be done once on the day shift and once on the evening shift. The nurses work 8 hour shifts, 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM. The nurse stated that frequently when he changes a dressing that was ordered to be changed twice daily, the dressing that was done by him the day before would still be on the wound. He stated that the nurse's date and initial dressings for that reason. An observation of resident 35's dressing change was done on 8/7/01 at 1:45 PM. The old dressing had the date 8/6/01 on it and initials of a facility nurse. The facility nurse doing the dressing change stated that the initials belonged to the nurse that had worked the day shift on 8/6/01. 3. Resident 24 was an 87-year-old female who was admitted to the facility on 1/27/99, with diagnoses that included, hypocalcaemia, anemia, arthritis, degenerative joint disease, spinal stensosis and probable cancer. Resident 24's physician orders included an order, dated 7/10/01, for resident 24 to have a duoderm dressing to the pressure sore on her right ankle. Observation of resident 24 were made at various times on 7/31/01, 8/1/01 and 8/6/01. The following was observed: a. On 7/31/01 at 9:00 AM, resident 24 was observed leaning over forward in her wheelchair. She was in her room facing her bed with her back towards the	F 314		

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door. Resident 24 had a light brown mattress on her bed.

At 9:30 AM, 10:00 AM, and 11:00 AM, resident 24 was observed leaning over forward in her wheelchair and her position in the wheelchair not changed.

At 12:30 PM, resident 24 was observed to be leaning forward over in her wheelchair next to her bed.

At 2:30 PM, resident 24 was observed to be leaning forward over in her wheelchair next to her bed. A few minutes later, a facility staff member entered the room and lifted resident into her bed.

b. On 8/1/01 at 6:00 AM, resident 24 was laying in bed with her legs bent and her right ankle against her mattress.

At 8:00 AM, an observation of resident 24's skin condition was made. A facility nurse aide was present during the observation. Resident 24 was observed laying in bed with her legs bent and her right ankle against the mattress. Resident 24's left leg was resting on her right leg. The nurse aide was observed to straighten resident 24 's left leg to uncover resident 24's right ankle. At that time, no pressure relieve devices were observed on resident 24's feet or on her bed. Resident 24 was observed to be wearing a pair of white socks on both feet. When the nurse aide removed the sock on resident 24's right foot, the sock was observed to have yellow drainage. The drainage was visiable on the outside of the sock. Resident 24's right ankle was observed to have a blister like area with a partial loss of the top layer of skin. This exposed the second layer of skin. There was no dressing on resident 24's right ankle.

c. On 8/6/01 at 2:09PM, resident 24 was observed

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laying in bed on her back with her left leg on top of her right leg. Resident 24 had no pressure relief device applied to her bed or on her right ankle.

An interview was held with a facility nurse on 8/7/01. The surveyor asked the nurse how resident 24's pressure sore, to the right ankle, developed. The nurse stated that resident 24 acquired the pressure sore to her ankle from laying on her right side.

Review of resident medical record was done on 8/1/01. Facility staff completed an annual comprehensive Minimum Data Set (MDS) assessment for resident 24 on 3/20/01. Staff assessed resident 24 as requiring limited assistance with her bed mobility and with her activity of daily living (ADL) cares. Staff further assessed that resident 24 was not on a turning program and did not have any pressure sores. No further MDS assessments were found in resident 24's medical record.

Facility staff completed a Braden Scale pressure sore risk assessment on 3/20/01. Resident 24's risk assessment score was 14. The Braden Scale assessment documented that a score of 18 or below was considered high risk for skin breakdown.

The comprehensive care plan, for resident 24, dated on 3/20/01, documented a care plan problem, "At Risk for Skin impairment ". The interventions for the care plan problem included the following: Reposition frequently while in wheelchair. Turn and position every 2 hours and as needed. Weekly skin checks to be done, and to provide preventive skin care. The care plan did not include the use of any pressure relieving or reducing devices.

Resident 24's care plan also identified that the resident required extensive to total assistance with ADL's. This

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care plan problem was dated 3/20/01. Interventions for this care plan problem included; assist with all transfers, assist with dressing, perform all personal grooming and hygiene for resident.

A review of resident 24's CNA flow sheet for the month of July 2001, documented resident 24 was independent with turning and positioning.

A review of the nurse's notes section of resident 24 's medical record on 7/31/01 revealed the following:
a. A note dated on 7/10/01 at 10: 00 PM, documented that resident 24 had a pressure sore on her right ankle and was starting to complain of pain.
b. A note dated on 7/12/01 at 9:00 PM, documented that resident 24 was complaining of pain in right ankle. The note further stated that the resident had an intact duoderm dressing on the pressure sore and there was no redness, swelling, heat, or other signs of infection.
c. A note dated on 7/13/01 at 8:00 PM, documented that resident 24 "complains of pain in her right ankle. The note further documented that the duoderm dressing was removed and that resident had edema in her ankle with some purple discoloration.

There were no nursing notes after 7/13/01, which documented the presence of a pressure sore on the resident's ankle. There was no size or stage documented in resident 24's medical record. Resident 24's medical record did not include documentation that nursing staff provided preventive skin care.

A review of the dietary section revealed a dietary note was made on 3/20/01. This note documented a care plan problem for "Alternation in nutrition below ideal body weight, potential deficiency of protein/difficultly chewing."

A review of the facility's skin and weight records for

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F 314	Continued From Page 44 the month of July 2001 was done on 8/9/01. There was no documentation on the records to indicate resident 24 had skin breakdown. On 8/9/01 at 1:10 PM, an interview with the FSS was conducted. The FSS was asked when she became aware resident 24 had a pressure sore. The FSS stated she was not made aware resident 24 had a pressure sore until 8/4/01. This was 28 days after the pressure sore had been identified by the facility nursing staff. 4. Resident 6 is a 38 year old male, who was admitted to the facility with diagnoses that included, obesity, venous thrombosis, seizure disorder, apnea, and mild retardation. At 7/31/01 at 2:20 PM, resident 6's room was observed as he was being interviewed. Resident 6 had a trapeze on his bed and an air mattress on his bed. Resident 6 was observed to be sitting in his wheelchair with an "egg-crate" cushion on the seat of the wheelchair. On 8/1/01, during an observation of resident 6's skin, with facility staff present, resident 6 was observed to have no skin breakdown at the present time. Review of resident 6's medical record on 8/9/01 revealed the following: a. A nurse's note, dated 5/1/01, documented that resident 6 had a stage II pressure sore on his right buttock. The note documented that the sore measured approximately 2 centimeters in diameter. The note further documented that the nurse had applied a dressing to the sore and reminded the resident to keep pressure off the area. There was no documentation found that resident 6's physician was notified of resident 6's stage II pressure sore on his right buttock.	F 314		

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b. A physician's progress note, dated 5/10/01, documented "The resident was sitting in a wheelchair with two thin pieces of egg foam mattress stacked on top of each other. However, he easily bottoms through this. His mid, medial buttock is slightly pink and there are two, one centimeter shallow pressure sores. The physician further documented, "Left buttock sores. His wheelchair cushioning system is sub optimal. I will order a proper wheelchair cushion."

c. A physician order, dated 5/10/01, documented that resident 6 needed a wheelchair cushion, which was not an egg-crate cushion and to consult a vendor to determine what type of cushion was best to use for resident 6. The order further documented that the pressure sore on resident 6's left buttock was to be cleaned, and a dressing applied daily until the pressure sore was healed.

d. A nurse's note, dated 5/21/01, documented that resident 6 had a stage II pressure sore on his left buttock. The note documented that the pressure sore was the size of a "pencil eraser" and that resident 6 refused to have a dressing applied to the sore. There was no documentation regarding a pressure relieving cushion for resident 6's wheelchair found.

e. A nurse's note, dated 5/24/01, documented that resident 6 had stage II pressure sore on his left buttock that was 0.25 centimeters in diameter. The nurse further documented that resident 6 refused to have a dressing applied to the pressure sore.

f. A physician's progress note, dated 6/3/01, documented, "He wonders what the statue of his wheelchair cushion is...I reviewed his chart with him and I had ordered a new wheelchair cushion on May 10th."

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g. A physician order, dated 6/3/01, documented that the resident was wandering where the new wheelchair cushion was and to please let the resident know the status of the new cushion.

h. The significant change MDS assessment, dated 2/12/01,documented resident 6 had been assessed as having no skin breakdown. The assessment further documented that resident 6 was assessed as needing a pressure relieving device while in a chair, a turning and positioning program and nutritional and hydration intervention to manage skin problems.
The quarterly MDS assessment dated, 5/10/01, documented resident 6 had been assessed as having two stage I pressure sores [a persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.], one stage II pressure sore and two stage III pressure sores. The assessment further documented that resident 6 was assessed as needing a pressure relieving device for his chair, a pressure relieving device for his bed, a turning and positioning program, a nutritional or hydration intervention to manage skin problems, and ulcer care.

i. The comprehensive care plan the facility had developed for resident 6, on 2/14/01 and updated on 5/8/01, documented a care plan problem of, "Alteration in skin integrity". The interventions for this problem included, encouraging the resident to be compliant with treatments and cares, remind and assist the resident to turn and position every two hours while in his bed or wheelchair, treatments as ordered, to measure and document the wound progress or the skin sheets every week, include zinc and increased protein in his diet. There was no documentation that the interventions included the pressure relieving devices for his bed and wheelchair which resident 6 had been assessed as needing on his 2/12/01 comprehensive

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assessment.

In an interview, on 7/31/01 at 2:20 PM, with resident 6, he stated that he did not think he currently had any skin breakdown. Resident 6 stated that he did have a pressure sore in May of this year. Resident 6 stated it took a week after he had developed the pressure sore on his buttock for the staff to place some kind of padding on his wheelchair. He stated that first the staff placed a pillow in his wheelchair. He stated the staff then tried an egg crate and a pillow. He stated that currently the staff had placed two sections of an egg crate mattress in his wheelchair. He stated that the physician had ordered a pressure relief cushion for his wheelchair, but he had never received the pressure relief cushion because the facility told him it was too expensive to purchase.

In an interview, on 7/31/01 at 2:30 PM, a facility nurse stated that they could not remember a problem, with getting a wheelchair cushion for resident 6. The nurse stated that the resident was very verbal and would make his needs known to the staff.

5. Resident 40 was a 33 year old male who admitted to the facility on 5/5/97 with diagnoses including traumatic brain injury with depressive and aggressive features, hemiplegia, and muscle spasms.

A review of resident 40's medical record was done. On 4/19/01, facility staff completed a comprehensive MDS assessment. At that time, facility staff assessed resident 40 as having no pressure sores or sores on the resident's feet. Facility staff completed another MDS assessment for resident 40 on 7/5/01. At that time, resident 40 was assessed as having one stage II pressure sore and that he had an open sore on his foot.

On 4/12/01, a physician's note for resident 40

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documented, "Right lateral foot callous. This was previously an open sore. He is at risk for current sores because of the position of his foot and his use of wheelchair, which positioned this callous near the floor. He has a foot support but it is not adjustable. (This is despite several orders over several months.) Reorder an adjustable right leg support so it can help keep his toes off the ground."

An additional physician's note, dated 4/29/01, documented, "It was medically necessary to see [resident 40] today to check his right foot. I spoke with [DON] yesterday and asked if he had gotten a new leg support because his right foot had been dragging. She said that still had not been done and we reviewed that it was initially ordered back in November of 2000 and then again more recently. She said that efforts had been made but she did not know why it had not been done." In addition, the physician's note documented, "She [DON] called back to say that he [resident 40] had a wound that needed debriding. I asked her to obtain a scalpel and suture removal kit and other supplies for potential debriding. She called back later saying that the facility did not have supplies nor could it obtain supplies on the weekend."

A physician note, dated 6/11/01, documented, 'Right lateral foot recurrent sore, healing well. -Keeping his foot elevated is helping tremendously."

The July 2001, treatment record for resident 40 included an intervention to have the resident wear, "Heel protector(s) every shift to right foot at all times." Per documentation, nursing staff failed to ensure resident 40 wore the heel protector for 31 shifts.

Multiple observations of resident 40 were made on 8/1/01, between 6:25 AM and 2:30 PM. During the observations, resident 40 did not have a heel protector

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F 314	Continued From Page 49 to his right foot. At 1:30 PM, resident 40 had a band of tape around the calf of his right leg and around the foot support of his wheelchair. His leg was not resting on the foot support, but was dragging along the floor. At 2:30 PM, the surveyor requested the DON to observe the position of resident 40's leg. The DON promptly removed the tape band around the resident's right leg and placed the resident's heel protector to his right foot. Multiple observations of resident 40 were made on 8/2/01, between 5:50 AM and 3:30 PM. Resident 40 did not have the heel protector to his right foot when he was in the wheelchair.	F 314		
F 322 SS=D	483.25(g)(2) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined the facility did not ensure that a resident who was fed by a gastrostomy tube (G-tube) received the appropriate treatment and services to prevent vomiting or aspiration pneumonia for one of two residents receiving G-tube feedings, when a nurse did not check for gastric residual or proper placement of the resident's G-tube prior to administering a scheduled bolus feeding, and the nurse did not allow the bolus feeding to be given by gravity, which put the	F 322	**Quality of Care** Inservice held September 10, 2001 to retrain nursing staff on the procedure for bolus feeding as follows: • Use gloves • Allow formula to come to room temperature • Position patient in a high semi-Fowler's position • Unclamp the tube • Assess the abdomen and auscultate for bowel sounds • Check G-tube for proper placement • Measure the volume of gastric contents to assess gastric retention. If gastric residual is less than 100 ml, replace the contents and then irrigate the tube with 50 ml water.	9/24/01

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F 322	Continued From Page 50 resident at risk for complications from the G-tube feeding. (Resident 48) Findings include: Resident 48 was a 32 year old male who admitted to the facility with diagnoses including traumatic brain injury, aspiration pneumonia, hypernatremia, constipation and bladder spasm. Resident 48's physician orders included orders for resident 48 to have bolus nutrition feedings per the resident's gastrostomy tube. On 8/6/01 at 11:30 AM, a facility nurse was observed to give resident 48 a scheduled bolus feeding of Nova-Source 2.0 (prepared nutritional formula). The nurse was observed to connect a 60 cc (cubic centimeter) syringe of clear water to the gastrostomy tube. The nurse was observed to push approximately 40 cc of water into the resident's G-tube. The nurse was then observed to remove the syringe plunger out of the 60 cc syringe and fill the syringe with 60 cc of the Nova-Source. The nurse then elevated the syringe to allow the Nova-Source to gravity flow into resident 48's G-tube. The formula did not flow from the syringe. The nurse was observe to reposition the syringe and tubing to try to get the Nova-Source to flow into the G-tube, but the Nova-Source remained in the syringe. The nurse was then observed to put the syringe plunger back in the syringe and push the Nova-source into resident 48's G-tube. The nurse continued to refill the syringe with the Nova-Source and push the Nova-Source into resident 48's G-Tube until the nurse had pushed a total of 237 cc of Nova-Source into resident 48's G-tube. After giving the resident the Nova-Source, the nurse was observed to flush resident 48's G-tube with a total of 100 cc of water. The feeding and flushes took approximately two minutes.	F 322	• Give bolus feeding by gravity, not to exceed 50-60 cc per minute-DO NOT PUSH Skills testing and monitoring will be conducted by D.O.N. and A.D.O.N. to assure that all nurses know and follow this procedure. Monitoring will occur daily until consistent adherence is noted, and weekly thereafter. Any deficiencies immediately addressed by one to one inservicing conducted by the D.O.N. and A.D.O.N. Skills testing sheets and monitor forms maintained in a QA log book and reviewed by the QA committee on a quarterly basis. This process will be tracked for resident 48 and all other applicable residents.	

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Observation of resident 48 immediately after this bolus feeding revealed that resident 48's abdomen had become visibly round and distended. At 1:10 PM, resident 48 was observed to be sitting in his wheelchair, in his room. A white curd like substance was observed on the front of resident 48's shirt. This white curd like substance was also observed on resident 48's chin and at the left corner of resident 48's mouth.

The following procedure for administering tube feedings is documented in the Illustrated Manual of Nursing Practice, Springhouse Corp, 1991: pg 831:
1. First allow the formula to come to room temperature. Then position the patient in a high semi-Fowler's position. Next, unclamp the tube. Assess the abdomen and auscultate for bowel sounds. Check feeding tube placement.
2. Measure the volume of gastric contents to assess gastric retention. If gastric residual is less than 100 ml (milliliters) replace the contents and then irrigate the tube with 50 ml of water.
3. You'll administer the feeding by one of several methods... For a bolus feeding, use a 50 ml or 60 ml syringe to administer the ordered amount of formula every 3 or 4 hours by gravity....the rate of administration should not exceed 50 cc to 60 cc per minute.

The "Encyclopedia and Dictionary of Medicine, Nursing and Allied Health", Fourth Edition, W.B. Saunder Co., 1987, pages 1268-1269, documented the following:
Common complications of tube feeding include aspiration pneumonia, nausea/vomiting, cramping, abdominal distention, gastric retention, and constipation or diarrhea. Common contributing factors to these complications include displaced feeding tubes,

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F 322	Continued From Page 52 too rapid administration of formula, gastric retention and reduced gastric motility.	F 322		
F 323 SS=E	483.25(h)(1) QUALITY OF CARE The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility did not maintain the Biohazard sharps containers, in a manner that prevented used needles and other sharps from being accessible to the residents. This put the residents at risk for injury and exposed the residents to hazardous materials. This potentially effected all residents in the facility. Findings include: 1. During an observation of blood sugar monitoring, and insulin administration on 8/7/01 at 12:20 PM, a resident was observed to stand in the hallway by the south hall medication cart. The sharps container on the medication cart was observed to have used syringes protruding from the top rim of the sharps container. The resident was observed to check her blood sugar and self-administer her insulin, with the nurse's supervision. After checking her blood sugar and self-injecting her insulin, the resident was observed to put the used lancet and insulin syringe into the sharps container on the medication cart. In doing so, the resident's fingers were observed to slip inside the sharps container. This increased the resident 's risk of injury or contamination to her fingers by direct contact with the soiled items in the sharps container.	F 323	**Quality of Care** To maintain a hazard free environment with regard to biohazard sharps containers, the facility will use only those sharps containers which are connected to the medicine carts, are wall mounted or otherwise secured to prevent tipping. These containers will be emptied as needed, but in all cases prior to filling to the point of overflowing. The maintenance supervisor will monitor daily for compliance and submit a compliance report to the administrator each day in connection with his other daily tracking assignments. Full containers will be stored in a locked container until picked up by the biohazard disposal company. Daily reporting maintained in a QA log and reviewed by the QA committee on a quarterly basis. Staff received inservice training on this policy on September 10, 2001.	9/24/01

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F 323	Continued From Page 53 2. On 7/31/01, at 5:25 PM, during an observation of a medication pass, the facility nurse was preparing medications to administer to a resident. The nurse was observed to knock the sharps container off of the medication cart. Two disposable razors and two insulin syringes were observed to fall out of the container onto the dining room floor. The facility nurse picked up the used razors and used syringes and placed them back into the container. She then continued to set up the medications and administered them to the resident without washing her hands. 3. On 7/30/01 at 2:20 PM, the west shower room door was fully open and accessible to all residents and staff. Two sharps containers were observed inside the bathing area. One container was laying on a counter top. The lid on the container had fallen open about 1 1/2 inches. The container had been filled to the top, of the container, and the shaving razors were exposed. The razors could be accessible to anyone reaching inside the lid. On 7/31/01 at 10:15 AM, observation of the the west shower room revealed that the two filled sharps containers were in the same locations as the previous day. 4. On 7/31/01 at 3:45 PM, a small sharps container was observed to be on top of the south hall medication cart and was accessible to all residents. The medication cart was observed to be unattended. The sharps container was observed to have 2 razor handles protruding almost two inches above the top rim of the container. 5. On 8/2/01 at 4:40 PM, a small sharps container was observed to be on top of the south hall medication cart, which was in the hallway and accessible to all residents. The medication cart was observed to be	F 323		

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F 323	Continued From Page 54 unattended. The sharps container was observed to have the handles of three injection syringes protruding from one and a half inches above the top rim of the container. 6. On 8/7/01 at 4:00 PM, a small sharps container was observed to be on top of the south hall medication cart, which was in the hallway and accessible to residents. The medication cart was observed to be unattended. The sharps container was observed to have the handles of two injection syringes protruding approximately one inch above the top rim of the container.	F 323		
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: Based on observation, resident and staff interview, and record review, it was determined that the facility did not offer sufficient fluids to 2 sample residents and 1 additional resident, who were not able to obtain fluids on their own . (Residents 33, 35 and 42.) Findings include: 1. Resident 35 was admitted to the facility 4/27/96, with diagnoses of multiple sclerosis, dyspepsia, insomnia, pressure ulcer,neurogenic bladder depressive features and calcium metabolism disorder. Review of the most recent MDS, a quarterly assessment, in the record for resident 35, dated 3/26/2001, documented that resident 35 was totally dependant on staff for all cares, including eating and drinking.	F 327	**Quality of Care** To assure and maintain adequate hydration for all residents, including residents 33, 35 and 42, the facility has implemented a hydration cart, increased fluids at meals and has improved tracking of intake and output as follows: • In addition to fluids offered at med pass, insulated pitchers of ice water are offered after breakfast and after lunch. Ice water is available at nurse's stations during the evening and night hours. The insulated pitchers are color coded to facilitate a visual check to assure changing b i d. • Fluids offered at night to those residents who are awake or otherwise request such. • The registered dietician has ordered additional fluids to be included with meal trays. • Intake and output to be charted daily for those residents on catheters.	9/24/01

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F 327	Continued From Page 55 Review of the plan of care for resident 35 dated 2/5/2001, documented under problem one, that resident 35 required total assist with all ADL's (activities of daily living) due to the multiple sclerosis. Problem 14 documented that resident 35 required maximum assistance to eat. The goal for problem 14 documented that resident 35 would maintain a fluid intake of 2000 cc's a day. The interventions documented that the facility was to record resident 35's intake and output daily, and report decreased fluid intake to the charge nurse and/or physician. The interventions also documented the facility was to encourage the resident to take 100% of all fluids served, and to provide as much assistance as necessary. On 7/31/01 at 7:50 AM, the surveyor entered resident 35's room. The window blinds were shut and the privacy curtain was pulled to the foot of the bed. Resident 35 was lying on her back with her arms across her abdomen and both legs bent at the knees and to her right. An opaque plastic water mug was on the bedside stand out of resident 35's reach. The water mug had measures printed on the side in milliliters/ cubic centimeters and the water level was visible without opening the mug. The fluid level in the mug was at 400 cc. The surveyor asked resident 35 how she was doing and she stated, "I'm extremely thirsty." The surveyor then asked how often staff offered her fluids and resident 35 stated, "Not often enough." Resident 35 was observed at various times on 7/31/01. Resident 35 was observed at 7:50 AM, 8:45 AM, 9:30 AM, 10:35 AM, 12:00 PM, 1:30 PM and 4:00 PM. At each observation time the water mug was on the bedside stand and the water level was at the 400 cc.	F 327	• All residents have been evaluated by A.D.O.N. or D.O.N. for dehydration risk on or before September 24, 2001. • Care plans updated to address hydration needs for those residents at risk for dehydration. • "At risk" residents include those who have skin breakdown, are totally dependent on staff for cares, are on feeding tubes, superpubic catheters and foley catheters. These will be identified by the A.D.O.N. • Nurses will check I & O and skin turgor on a daily basis to ensure that residents are showing signs of adequate hydration. • Night nurses are to total the I & O for each day, chart the totals, and replace the tracking sheet in the room of each resident who is so tracked. The medical records clerk will monitor I & O documentation on a daily basis, as will the A.D.O.N. and D.O.N, until substantial compliance is reached, at which point the medical records clerk will continue monitoring on a monthly basis. • Audit and compliance rounds records maintained in a QA log. All deficiencies reported daily to D.O.N. or A.D.O.N. The QA committee will review quarterly. An inservice held to address hydration matters on August 14, 2001 and reviewed September 10, 2001.	

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Resident 35 had a foley catheter. Observation of the urine in the urine drainage bag on 7/31/01, revealed that resident 35's urine was very dark amber.

A nursing assistant caring for resident 35 on 7/31/01, was observed assisting the resident with her lunch at 12:45 PM. There was an empty glass observed on the tray. The nursing assistant stated she had also assisted resident 35 with her breakfast. The nursing assistant stated she had given the resident a glass of juice, a glass of milk and a health shake for the morning meal and a glass of juice and a health shake for the noon meal. She stated the resident had taken about 50% of her diet at both meals. The surveyor asked the nursing assistant if she had given resident 35 any other fluids besides the fluids served with the meals and she stated she had not.

Review of the intake and output record for resident 35 for 7/31/01, documented that the resident 35 had 360 cc intake and 250 cc output for the 24 hour period.

On 8/1/01at 6:00 AM, an interview was held with two nursing assistants that work the night shift. Both of the nursing assistants stated that they do not routinely offer fluids to any residents during the night. They also stated that they do not pass fresh water to the residents during the night. They stated that if a resident asked for a drink they will give them one. The surveyor asked if resident 35 had been offered fluids during the night. Neither nursing assistant stated that they had offered resident 35 fluids that night.

On 8/1/01, resident 35 was observed at 6:30 AM. The water jug was on the bedside stand. The water level was at 60 cc. The water level was observed to be 60 cc at 9:15 AM and 10:20 AM. At 10:30 AM, a nursing assistant was observed to be passing ice and water to

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F 327	Continued From Page 57 all the resident rooms. At 11:30 AM, resident 35's water jug was on the bedside stand and observed to be full. At 2:00 PM resident 35's water jug was observed to still be full. On 8/2/01, resident 35 was observed at 7:00 AM, 8:05 AM, 9:15 AM and 10:30 AM. On each observation the water jug was on the bedside stand and the water level was 200 cc. No documentation could be found by the facility for resident 35's intake or output for 8/1/01 or 8/2/01. 2. Resident 42 was readmitted to the facility on 6/23/01, with diagnoses of diabetes mellitus, hypertension, coronary artery disease, legally blind and schizo-effective disorder and bipolar disorder. Review of the admission MDS for resident 42 dated 7/5/2001, documented that the resident required extensive assistance with ADL's including eating and drinking. Review of the plan of care for resident 42 dated 6/23/2001, documented under problem 8, that there was an alteration in fluid /electrolyte balance related to dehydration manifested by thirst. The goal for problem 8 documented that resident 42 would have adequate fluid intake every day. Interventions were to encourage fluids on trays and offer fluids between meals. Resident 42 was observed at at various times during the day on 7/31/01. At 7:50 AM, resident 42 was up in the wheel chair in the middle of his room. A water mug was observed on the bedside stand out of resident 42's reach. The mug contained 220 cc of water. Resident 42 was observed at 9:30 AM, 10:45 AM, 12:30 PM, 2:00 PM, 3:45 PM, and 5:30 PM. During	F 327		

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F 327	Continued From Page 58 each observation resident 42 was observed to be lying on the bed on his back with his legs elevated on a wedge cushion. The water mug was observed to be on the bedside stand, out of reach of resident 42, and the water level remained at 220 cc at each observation. On 8/1/01 at 6:00 AM, an interview was held with two nursing assistants that work the night shift. The surveyor asked if resident 42 had been offered fluids during the night. Neither nursing assistant stated that they had offered resident 42 fluids that night. An interview with the nursing assistant caring for resident 42 on 7/31/01, was done at 9:45 AM. She stated that she had fed resident 42 his breakfast and he had taken all of his juice and milk and had consumed 50% of the meal. She also stated that she gave fluids to residents when they asked for them. Resident 42 was observed on 8/1/01 at 6:00 AM, 7:30 AM, 9:35 AM, 11:05 AM, 12:30 PM, 1:15 PM and 2:20 PM. Resident 42 was lying on his bed, on his back with his legs elevated on a wedge cushion. There was no water mug in resident 42's room. Resident 42 was observed on 8/2/01 at 6:15 AM, 7:30 AM, 7:45 AM, 8:30 AM and 9:45 AM. Resident 42 had no water mug in his room. 3. Resident 33 was readmitted to the facility, on 7/23/01, after a hospitalization for urosepsis. Resident diagnoses included multiple sclerosis, dysphagia, quadripareses, gastrointestinal hemorrhage, neurogenic bladder and insomnia. On 8/7/01 at 9:35 AM, resident 33's bedside table contained three water bottles without handles and a one liter water container with a handle. Two water bottles were full of liquid . The third water bottle was	F 327		

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F 327	Continued From Page 59 three quarters of the way full. The one liter water container with a handle was observed to be less than one fourth full of water. All four containers contained no ice. At 9:45 AM resident 33 wheeled herself into her room. Resident 33 told the surveyor that she could not hold the water bottles without handles very well. She further stated that the water container she could hold, was the liter water container with the handle. She stated that for her to be able to use the water container with the handle, it could only be filled 1/4 full and had to have a straw placed in the container. She stated no one offered her fluids throughout the day. She did not know what the liquid was in the three water bottles without handles, and stated she never used them. At 9:50 AM the facility food service supervisor was observed to enter resident 33's room to talk with her. She was observed to not offer the resident a drink of water. A nursing assistant brought resident 33 's roommate into the room. The nursing assistant did not offer resident 33 a drink of water. At 10:10 AM, a facility staff nurse and the assistant director of nursing (ADON) were observed to walk into resident 33's room after the call light had been pushed. The two facility staff members assessed resident 33's roommate. The two staff members did not offer resident 33 any fluid to drink. Resident 33's water levels from all four water containers did not change. From 10:15 AM to 10:20 AM, three facility nursing staff members were observed to enter resident 33's room and were not observed to offer resident 33 any fluids. At 10:30 AM, the ADON was observed to enter	F 327		

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F 327	Continued From Page 60 resident 33's room to make her bed. The facility staff member did not offer resident 33 any fluids. At 1:30 PM, resident 33 was observed in the dining room being assisted with her fluids by a nursing assistant. The nursing assistant was interviewed. The nursing assistant stated that resident 33 had a half of a cup of water mixed with her cranberry juice. At 1:45 PM, resident 33's water containers were observed to contain the same amount of liquid that was observed at 9:35 AM. At 2:50 PM, resident 33 was placed in bed. Resident 33's water container levels had not changed. A review of the residents meal consumption log was done. The meal consumption logs did not contain any place for tracking the residents fluid intake during their meals. In an interview with a facility nursing assistant, on 8/7/01, they stated that there were only two residents that the nursing assistants tracked for fluids and resident 33 was not one of them A review of resident 33's intake and output record for July, 2001, and August, 2001, revealed that the facility staff had not documented any intake or output. Resident 33 had a gastrostomy tube which was used to supplement dietary and fluid intake on a daily basis if resident 33's intake was not at least 80% for meals. Resident 33 was to receive three cartons of Novasource at bedtime if the dietary intake was below 80%. Resident 33 was also to receive 50 cc of water via the gastrostomy tube every 8 hours. A review of the enteral flow sheet for resident 33 revealed that from 7/23/01 through 7/31/01, the 50 cc of water was only documented as being given 6 out of	F 327		

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F 327	Continued From Page 61 27 times that resident 33 should have received the water. During an interview with a facility staff nurse on 8/6/01, he/she stated that the nursing assistants were to keep track of the residents intake and output on sheets that were in the resident bathrooms. The nurse stated that it was the night nurses responsibility to total the amount in order to know if someone was not getting enough fluids. The nurse stated the only way he/she knows if the residents were not getting enough fluids, was if the nursing assistants reported it to the nurse. The facility nurse stated that the intake and output records were often incomplete.	F 327		
F 329 SS=K	483.25(l)(1) QUALITY OF CARE Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined that for for review of the medical record, review of the medication administration record, and staff interview, it was determined that for 4 of 5 sample residents, the facility did not ensure adequate monitoring of resident's medications. Specifically, nursing staff were not consistently documenting blood sugar monitoring per physician orders. (Residents 29, 42, 45, and 46.)	F 329	**Quality of Care** An inservice on proper administration of medication, proper documentation of medication, proper procedures and documentation of blood sugar monitoring proper administration of insulin (including sliding scale), and facility policies and procedures when omissions are noted was held with all licensed nurses on August 13, 2001 and with all staff on August 10, 2001. Pool nursing will be inserviced on the above information prior to working the nursing floor, and an orientation book containing these and other policies is available. Each licensed nurse will sign that they have received the inservice training. Proper medication administration and documentation policies reviewed, updated, and inserviced to all licensed nurses on August 10 & 13. Pool nursing staff will be required to read and sign to acknowledge	8/20/01

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F 329	Continued From Page 62 Findings include: 1. On 8/1/01 at 6:00 AM, the nurse was interviewed regarding the facility's policy and procedure for performing quality control checks for the facility's glucose monitors. The nurse stated that he/she was unaware of a written policy regarding quality control checks for the facility's glucose monitors. The nurse stated the night shift nurse performed a high and low quality control check on the facility's 2 glucose monitors each night, to assure the glucose monitors were accurate and functioning properly. When asked if there were written parameters that were used to compare the results of the high and low quality check to, the nurse said there were none. When asked where documentation of the quality control checks for the 2 glucose monitors were located, the nurse stated they were not documented anywhere. 2. The DON was interviewed on 8/1/01 at 1:00 PM regarding the facility's policy and procedure for performing quality control checks for the facility's glucose monitors. The DON stated there was no written facility policy regarding quality control checks, but that the night nurse was to perform and document the quality check results on the 2 facility glucose monitors, using a high and low solution daily. The DON stated there was a documentation sheet in the front of the north and south hall MAR's for the results of the daily quality control checks to be documented. 3. The facility's quality control documentation flow sheets for June and July 2001 were reviewed by the nurse surveyor on 8/1/01. Review of the facility's quality control check flow sheets revealed documentation that high and low quality control checks were not being performed and documented daily. There was no documentation to evidence the	F 329	they understand facility policies, and that they will follow the policies. The facility has put into place a policy and procedure for Glucometer calibration, which is to occur daily. An inservice was held August 10 & 13 to explain this policy. The A.D.O.N. will monitor the calibration checks daily through QA. Resident 45 will receive breakfast, blood sugar check and prescribed insulin as ordered before dialysis. The charge nurse will give resident insulin per physician order and check blood sugar prior to breakfast and assure that this process is done in time for the resident to have breakfast prior to dialysis. To address the accuracy of medicine administration for all residents, including insulin administration for residents 29, 42, 45 and 46, licensed nurses have received inservice training August 10 & 13 on the policies for ordering, receiving and administering medications, as well as documentation of administration and blood glucose testing. Blood glucose test results are charted on a sheet according to the physician orders which is updated daily and faxed to the physician. Abnormal results (blood sugar lower than 50 or higher than 400) are immediately called in to the physician. Nurses have received inservice training on this procedure August 10 & 13. Nursing administration to conduct daily compliance rounds to assure correct	

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F 329	Continued From Page 63 facility had performed a quality control check for the north hall glucose monitor on 6/5/01, 6/6/01, 6/7/01, 6/12/01, 6/13/01, 6/14/01, 6/19/01, 6/20/01, 6/21/01, 6/26/01, 6/27/01, 6/28/01, 7/3/01, 7/4/01, 7/5/01, 7/6/01, 7/7/01, 7/9/01, 7/10/01, 7/11/01, 7/17/01, 7/18/01, 7/19/01, 7/24/01, 7/25/01, 726/01, and 7/31/01. There was no documentation to evidence the facility had performed a quality control check for the south hall glucose monitor on 6/5/01, 6/6/01, 6/7/01, 6/12/01, 6/13/01, 6/14/01, 6/19/01, 6/20/01, 6/21/01, 6/26/01, 6/27/01, 6/28/01, 7/3/01, 7/4/01, 7/5/01, 7/6/01, 7/7/01, 7/8/01, 7/9/01, 7/10/01, 7/11/01, 7/12/01, 7/17/01, 7/18/01, 7/19/01, 7/24/01, 7/25/01, 7/26/01, and 7/31/01. Documentation on the days that the glucose monitors were checked, revealed both high and low quality control results. However, there was no documentation of a parameter to compare these results to in order to determine if the glucose monitor was accurate and functioning properly. The DON stated the parameter range for comparing the results of the quality control checks to, should be documented on the facility's flow sheet. The DON stated the parameter information was on the box of test strips used for testing the glucose monitors. The DON was unable to locate the test strip boxes with the parameter information required to accurately perform the quality control checks on the facility's glucose monitors. The lack of daily quality control checks using the proper procedures resulted in the facility not being able to determine if the facility's glucose monitors were calibrated to accurately assess the resident's blood glucose levels. 4. Resident 45 was readmitted to the facility on 1/31/01 with diagnoses of insulin dependant diabetes	F 329	administration of medications. Reports maintained in a QA log and reviewed by the QA committee. To assure the availability of all medications and supplies, the night charge nurse will audit both medicine carts and supply rooms for completeness of inventory twice a week, make corrections as needed and report findings to A.D.O.N. To assure proper charting of administered medications, the medical records clerk will conduct a daily audit until substantial compliance is reached and a weekly audit thereafter. Medical records clerk will review the medicine administration record and treatment record to assure that all medications and treatments are being given as ordered. This will occur on a daily basis until substantial compliance is reached, and weekly, thereafter. Deficiencies reported to the D.O.N. and administrator following each audit for immediate correction. Compliance reports maintained in a QA log for review each quarter by the QA committee.	

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F 329	Continued From Page 64 mellitus, hepatitis C, end stage renal disease with dialysis, seizure disorder, hypertension, paranoid schizophrenia, asthma, and anemia. The resident's medical record and medication administration records (MAR) for July, and August 2001 were reviewed. A physician's order, dated 1/31/01, documented the resident was to have blood sugar (BS) monitoring by the facility 1/2 hour before each meal, 3 times daily. Based on the blood sugar results, the facility was to administer sliding scale Novolin R (regular) insulin as follows: If the blood sugar was above 200 give 2 units, above 250 give 4 units, and if above 300 give 6 units. The July and August 2001 MAR's were reviewed and indicated no documentation that the facility had monitored resident 45's blood sugars, per the physician's orders, at 7:00 AM on 7/7/01, 7/10/01, and 7/13/01; at 11:00 AM on 7/13/01, and 7/14/01; and at 4:00 PM on 7/2/01, 7/5/01, 7/6/01 and 8/3/01. The night shift nurse, caring for resident 45, was interviewed on 8/1/01 at 5:30 AM. The nurse stated resident 45 was scheduled to have blood sugar monitoring and insulin administration at 7:00 AM daily as per the physician's order. The nurse stated this was to be done by the night shift nurse. Observation from 5:30 AM through 7:25 AM evidenced the resident did not receive his blood sugar monitoring or his insulin administration at 7:00 AM, as per the physician's order. At 7:25 AM, the night shift nurse was observed to enter resident 45's room and attempt to wake him up to check his blood sugar. The nurse stated he was unable to wake the resident up and that this information would be passed on to the day shift nurse in report.	F 329		

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F 329	Continued From Page 65 Observations from 7:25 AM through 7:55 AM evidenced resident 45 continued to sleep and he did not have his blood sugar monitored or insulin administered by the facility staff. At 7:55 AM, the facility's van driver was observed to enter resident 45's room, wake him up, and ask him to get ready to go to his dialysis appointment. The resident complied, but was heard to say he had not had his breakfast yet. The van driver arranged to have the facility provide a breakfast for the resident to take with him to his dialysis appointment. At 8:05 AM, the resident was observed to start to leave the facility with the van driver. The nurse caring for the resident was observed in the basement dining room passing the morning medications at this time. The nurse surveyor asked if the nurse knew the resident was leaving the facility, and the nurse stated,"No". The nurse surveyor asked if the resident's blood sugar had been checked and if his morning insulin had been administered. The nurse stated, "No". At 8:10 AM, the nurse was observed to stop the resident from leaving the building. The nurse was observed to check the resident's blood sugar in the hallway by the front doors of the facility. The nurse was then observed to go back downstairs to the medication cart, draw up the resident's insulin, go back upstairs and outside the facility to the parking lot where the resident was standing. The nurse was then observed to administer the resident's insulin at 8:15 AM. This was 1 hour and 15 minutes after the resident's blood sugar monitoring and insulin administration was scheduled per the physician's order. Documentation on the MAR for 7/27/01 at 7:50 AM, indicated the resident had not received his blood sugar monitoring, insulin or calcium medication because he had left the facility for his dialysis appointment.	F 329		

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F 329	Continued From Page 66 5. Resident 29 was admitted to the facility on 4/13/01 with diagnoses of insulin dependant diabetes mellitus, traumatic brain injury, hypertension, and seizure disorder. The resident's medical record and medication administration records for July 2001 and August 2001 were reviewed. A physician's order, dated 4/13/01, indicated the resident was to have blood sugar monitoring by the facility four times daily at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. The July and August 2001 MAR's were reviewed and indicated no documentation that the facility had monitored resident 29's blood sugars, per the physician's orders, at 12:00 PM on 7/31/01, at 4:00 PM on 7/6/01, 7/9/01, 7/11/01, and 7/31/01, and at 8:00 PM from 7/2/01 through 7/17/01 (16 days), 7/22/01, 7/24/01, 7/31/01 and 8/3/01. Documentation on the MAR on 8/6/01 at 12:00 PM, indicated the resident's blood sugar was 465. A nurse's note, dated 8/6/01 at 12:15 PM documented, "BS (at) noon (at) 465. Called (MD). Awaiting call back." At 12:25 PM, "Unable to reach (MD). Placed page to (nurse practitioner), awaiting for call back." There was no further documentation in the medical record regarding if the physician was notified regarding resident 45's abnormal blood sugar monitoring results. 6. Resident 46 was admitted to the facility on 3/29/00 with diagnoses of insulin dependant diabetes mellitus, blindness, and hypertension. The resident's medical record and medication administration records for June, July and August 2001 were reviewed on 8/6/01.	F 329		

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F 329	Continued From Page 67 A physician's order, dated 10/4/00, indicated the resident was to have blood sugar monitoring by the facility 4 times daily at 6:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM. The June 2001 MAR was reviewed and indicated no documentation that the facility had monitored resident 46's blood sugars, per physician's orders, at 11:30 AM on 6/12/01 and 6/29/01; at 4:30 PM on 6/14/01, 6/17/01, 6/18/01, 6/29/01 and 6/30/01; at 9:00 PM on 6/2/01, 6/5/01, 6/6/01, 6/8/01, 6/9/01, 6/10/01, 6/12/01, 6/13/01, 6/14/01, 6/15/01, 6/17/01, 6/18/01, 6/19/01, 6/20/01, 6/21/01, 6/22/01, 6/24/01, 6/26/01, 6/27/01, 6/28/01, 6/29/01, and 6/30/01. The July and August 2001 MAR's were reviewed and indicated no documentation that the facility had monitored resident 46's blood sugars, per physician's orders, at 6:30 AM on 7/7/01; at 11:30 AM on 7/27/01; at 4:30 PM on 7/6/01, 7/14/01, and 7/22/01; at 9:00 PM from 7/2/01 to 7/20/01 (19 days), 7/22/01, 7/24/01 and 8/4/01. A physicians's telephone order, dated 7/16/01, changed resident 46's sliding scale Humalog insulin as follows: If blood sugar is 150 to 219 give 3 units, 220 to 279 give 5 units, 280 to 339 give 8 units, 340 to 399 give 12 units, 400 and over give 18 units and call the physician. The order also stated if the fasting blood sugars were over 250, the facility staff was to recheck the resident's blood sugar in 3 hours and repeat the Humalog insulin according to the sliding scale. Review of the July and August 2001 MAR's revealed no evidence that the facility rechecked the resident's blood sugars in 3 hours if they were over 250,and repeated the Humalog insulin according to the sliding	F 329		

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F 329	Continued From Page 68 scale at 6:30 AM on 7/17/01 (BS 403), 7/18/01 (BS 349); at 11:00 AM on 7/18/01 (BS 376), 7/24/01 (BS 400), 7/25/01 (BS 257), 7/26/01 (BS 274), 8/4/01 (BS 349), 8/5/01 at 11:30 AM (BS 283), and 8/6/01 (BS 296); at 4:40 PM on 7/20/01 (BS 294), 7/25/01 (BS 298), 7/27/01 (BS 324), 7/28/01 (BS 276), 7/30/01 (BS 339), 8/2/01(BS 400), 8/3/01(BS 396), and at 9:00 PM on 7/21/01 (BS 314), 7/23/01 (BS 263), 7/29/01 (BS 501), and 8/1/01 (BS 350). 7. Resident 42 was readmitted to the facility on 6/23/01 with diagnoses diabetes mellitus, hypertension, coronary artery disease, legally blind and schizo-effective disorder and bipolar disorder. Resident 42 had a physician order dated 6/23/01, to monitor his blood sugars before meals and at bedtime. Review of the June 2001, MAR indicated that the BS to be done at 11:00 AM was not documented on 6/24/01, 6/25/01 and 6/29/01. The BS to be done at 5:00 PM was not documented on 6/24/01, 6/25/01, 6/26/01, 6/29/01, and 6/30/01. The BS to be done at 8:00 PM was not documented on 6/26/01, 6/27/01, 6/28/01, 6/29/01, and 6/30/01. Review of the July 2001, MAR indicated that the BS to be done at 6:30 AM was not documented on 7/7/01. The BS to be done at 12:00 PM was not documented on 7/9/01, 7/11/01, and 7/28/01. The BS to be done at 5:00 PM was not documented on 7/31/01. The BS to be done at 8:00 PM was not documented on 7/2/01, 7/3/01, 7/4/01, 7/5/01, 7/6/01, 7/10/01 through 7/22/01, 7/24/01, and 7/31/01. During an interview with the DON on 8/1/01, she stated that she was aware that a lot of the BS were not being done, especially the BS to be done at bedtime. She stated that the nursing staff told her that the	F 329		

DEPARTMENT OF HEALTH AND HUM . SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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

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F 329	Continued From Page 69 residents got angry if they are awakened for a bedtime BS. The DON also stated that she had told the nursing staff to contact the physicians and inform them of the problem and get the BS times changed but they have not done it.	F 329		
F 361 SS=E	483.35(a)(1)-(2) DIETARY SERVICES The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs. This REQUIREMENT is not met as evidenced by: Based on interviews with the Food Service Supervisor, the former registered dietician, the Administrator and record review, it was determined the facility had not employed a qualified dietitian. Findings include: The Food Service Supervisor (FSS) was interviewed on 7/30/01. The Food Service Supervisor could not remember when the previous registered dietitian had stopped working with the facility, but did say it was before May, 2001.	F 361	**Dietary Services** Registered Dietician has been contracted on August 9, 2001and is providing consultation. Continued compliance monitored by administrator, who will receive monthly consultation report, which will be reviewed by the QA committee..	8/9/01

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F 361	Continued From Page 70 In an interview with the Food Service Supervisor, on 8/1/01, the FSS stated she had reviewed her regulations and realized she should have been working under a qualified Dietitian. In an interview, on 8/16/01, the Registered Dietitian, who had been the former dietary consultant, stated he/she could not say for certain how long ago he/she last worked for the facility. The RD estimated it had been approximately six months since he/she had worked at the facility. In an interview with the facility Administrator, the Administrator stated they had not had a Registered Dietitian working with the facility since April, 2001.	F 361		
F 426 SS=K	483.60(a) PHARMACY SERVICES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of medical records, and review of the medication administration records (MAR), it was determined the facility did not provide adequate pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals) to meet the needs each resident. The facility did not administer sliding scale insulin as per the physician's order for 5 of 5 insulin dependant sample residents. Residents 16, 29, 42, 45, and 46. The facility did not have a system in place to obtain	F 426	**Pharmacy Services** An inservice on proper administration of medication, proper documentation of medication, proper procedures and documentation of blood sugar monitoring proper administration of insulin (including sliding scale), and facility policies and procedures when omissions are noted was held with all licensed nurses on August 10 & 13. Pool nursing will be inserviced on the above information prior to working the nursing floor, and an orientation book containing these and other policies is available. Each licensed nurse will sign that they have received the inservice training. Proper medication administration and documentation policies will be reviewed, updated, and inserviced to all licensed nurses on August 10 & 13. Pool nursing staff will be required to read and sign to	10/21/01

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F 426	Continued From Page 71 medications in a timely manner for 5 of 13 sample residents and 10 additional residents. (Residents 3, 12, 13, 16, 24, 26, 27, 28, 29, 31, 32, 34, 35, 40, and 44.) 1. Resident 45 was readmitted to the facility on 1/31/01 with diagnoses of insulin dependant diabetes mellitus, hepatitis C, end stage renal disease with dialysis, seizure disorder, hypertension, paranoid schizophrenia, asthma, and anemia. The resident's medical record and MAR's for July, and August 2001 were reviewed. A physician's order, dated 1/31/2001, documented the resident was to have blood sugar (BS) monitoring by the facility 1/2 hour before each meal, 3 times daily. Based on the 7:00 AM, 11:00 AM and 4:00 PM blood sugar monitoring results, the resident was to receive sliding scale Novolin R (regular) insulin as follows: If the blood sugar result was above 200 give 2 units, if above 250 give 4 units, and if above 300 give 6 units of Novolin R insulin. There was no documentation on the July and August 2001 MAR's that the facility staff had administered the resident's sliding scale insulin as per the physician's order, on 7/20/01 (BS 236), 7/23/01 (BS 205), 7/25/01 (BS 202), 7/26/01 (BS 302), 7/30/01 (BS 264), and 8/6/01 (BS 208); and at 4:00 PM on 7/4/01 (BS 300), 7/15/01 (BS 221), 7/16/01 (BS 249), 7/31/01 (BS 204), and 8/5/01 (BS 268). A physician's order, dated 1/31/01, indicated resident 45 was to receive Humalog insulin 6 units, 1/2 hour before meals 3 times daily at 7:00 AM, 11:00 AM, and 4:00 PM. The order stated to hold the insulin if the blood sugar was below 100. There was no documentation on the July and August	F 426	acknowledge they understand facility policies, and that they will follow the policies. The facility has put into place a policy and procedure for Glucometer calibration, which is to occur daily. An inservice was held August 10 & 13 to explain this policy. The night time nurse performs the alibration of the Glucometer. The A.D.O.N. will monitor the calibration checks daily through QA. Resident 45 will receive breakfast, blood sugar check and prescribed insulin as ordered before dialysis. The charge nurse will give resident insulin per physician order and check blood sugar prior to breakfast and assure that this process is done in time for the resident to have breakfast prior to dialysis. To address the accuracy of medicine administration for all residents, including insulin administration for residents 29, 42, 45 and 46, licensed nurses have received inservice training August 10 & 13 on the policies for ordering, receiving and administering medications, as well as documentation of administration and blood glucose testing. Blood glucose test results are charted on a sheet according to the physician orders which is updated daily and faxed to the physician. Abnormal results (blood sugar lower than 50 or higher than 400) are immediately called in to the physician.	

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F 426	Continued From Page 72 2001 MAR's that the facility had administered the resident's Humalog insulin, as per the physician's order, at 7:00 AM on 7/11/01; at 11:00 AM on 7/13/01 and 7/14/01; and at 4:00 PM on 7/6/01, 7/13/01, and 8/1/01. There was also no documentation that the facility held the Humalog insulin when the resident's blood sugar was below 100, as per the physician's order, on 7/7/01 at 4:00 PM. Resident 45's blood sugar was documented as 88 at this time, and it was documented that the Humalog insulin was administered. Documentation on the July 2001 MAR from 7/1/01 through 7/31/01, indicated the resident had refused his Humalog insulin at 7:00 AM and at 11:00 AM, 10 times. Documentation also indicated the resident had refused his Humulin N insulin, 6 units daily, 13 times. There was no documentation in the resident's medical record that the physician had been notified or interventions had been made regarding the resident's refusal of the insulin. On 8/1/01 at 6:00 AM, a nurse caring for resident 45 was interviewed. The nurse stated resident 45 was scheduled to have dialysis outside of the facility 3 times weekly, on Mondays, Wednesdays, and Fridays. The nurse stated the resident left the facility for dialysis a little before 8:00 AM, and returned to the facility at approximately 12:30 PM. By scheduling the resident's blood sugar monitoring and insulin administration daily at 11:00 AM, the facility did not meet resident 45's needs on the 3 days he attended dialysis treatments. On 8/1/01 at 7:55 AM, the facility's van driver was observed to enter resident 45's room, wake him up, and ask him to get ready to go to his dialysis appointment. At 8:05 AM, the resident was observed to start to leave the facility with the van driver. The nurse caring	F 426	Nurses have received inservice training on this procedure August 10 & 13. To assure the availability of all medications and supplies, charge nurses are to order refills when the number of medications in a card is eight or below. "Out of Stock" is not to be charted. The medications are to be ordered. The night charge nurse will audit both medicine carts and supply rooms for completeness of inventory twice a week, make corrections as needed and report findings to A.D.O.N. To assure proper charting of administered medications and reporting to the physician, the medical records clerk will conduct a daily audit until substantial compliance is reached and a weekly audit thereafter. To assure that all residents, including residents 3, 12, 13, 16, 24, 26, 27, 28, 29, 31, 32, 34, 35, 40, 42, 44, 45 and 46 receive their medications on time, we have: Changed the times of medicine pass to better avoid events in the facility such as meals and shift changes which have the potential to delay the pass. We have shifted the nursing load to better equalize stations and have implemented skills tests and monitoring to assure proper procedure and timing. The monitoring will occur daily until substantial compliance is reached, and on a weekly basis thereafter. The monthly pharmacy report will be reviewed and responded to each month by the A.D.O.N. . The D.O.N. will verify completion of this task monthly. Prior to a finding of substantial compliance, the	

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F 426	Continued From Page 73 for the resident was observed in the basement dining room passing the morning medications at this time. The nurse surveyor asked if the nurse knew the resident was leaving the facility, and the nurse stated,"No". The nurse surveyor asked if the resident's blood sugar had been checked and if his morning insulin had been administered. The nurse stated, "No". At 8:10 AM, the nurse was observed to stop the resident from leaving the building, and to check the resident's blood sugar. The nurse was then observed to administer the resident's insulin at 8:15 AM. This was 1 hour and 15 minutes after the resident's blood sugar monitoring and insulin administration was scheduled, per the physician's order. Documentation on the July 2001 MAR for 7/27/01 at 7:50 AM also indicated the resident had not received his blood sugar monitoring, insulin or calcium medication because he had left the facility for his dialysis appointment. 2. Resident 29 was admitted to the facility on 4/13/01 with diagnoses of insulin dependant diabetes mellitus, traumatic brain injury, hypertension, and seizure disorder. The resident's medical record and MAR's for July and August 2001 were reviewed. A physician's order, dated 4/13/01, indicated the resident was to have blood sugar monitoring by the facility four times daily at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. Based on the 12:00 PM and 4:00 PM blood sugar monitoring results, the resident was to receive a sliding scale Humulin regular insulin as follows: If blood sugars were 200 to 250 give 2 units, 251 to 300 give 7 units, 301 to 350 give 10 units and over 350 give 14 units.	F 426	administrator will review as well. The QA committee will review the responses quarterly, under the direction of the administrator. An inservice was held August 10 & 13 regarding proper documentation of physician orders and telephone orders to assure that ordered medications are available, that information is available and passed along and that the charting reflects all orders for medications and treatments. The medical records clerk will perform a daily audit to assure that treatments, medications and charting reflect the physician's orders. This will continue until substantial compliance is reached, and will be performed monthly thereafter. Deficiencies are reported following the audit to the D.O.N. and administrator. Monitor sheets are maintained in a QA log and results reviewed quarterly by the QA committee.	

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F 426	Continued From Page 74 A physician's order, dated 7/9/01, indicated a change in resident 29's sliding scale order for Humulin regular insulin as follows: If the blood sugars were below 60 call the physician, 60 to 200 give no sliding scale insulin, 200 to 250 give 1 unit, 250 to 300 give 3 units, 300 to 350 give 5 units, 350 to 400 give 7 units, and if over 400 call the physician. This order required immediate clarification by the facility staff with the physician, because it documented two different doses of sliding scale Humulin regular insulin to be administered for the blood sugar results of 200 (no insulin or 1 unit), 250 (1 unit or 3 units), 300 (3 units or 5 units), or 350 (5 units or 7 units). On 8/3/01 at 12:00 PM, documentation on the MAR indicated the resident's blood sugar was 300. The facility staff documented that they administered 5 units of Humulin regular insulin. There was no evidence in the medical record or on the MAR's that the facility staff clarified the physician's order, (to give 3 units or 5 units), before administering the insulin. Review of resident 29's July and August 2001 MAR's also indicated the facility failed to document administration of the sliding scale Humulin regular insulin as per the physician's orders, at 12:00 PM on 7/1/01 (BS 281), 7/11/01 (BS 238), 7/14/01 (BS 314) and 7/22/01 (BS 228); and at 4:00 PM on 7/14/01 (BS 319). There was no documentation in the resident's medical record or on the July and August 2001 MAR's that the facility notified the physician or provided treatment when the resident's blood sugar was below 60 or above 400, as per the physician's order, at 8:00 AM on 7/20/01 (BS 421), 8/4/01 (BS 495), and on 8/5/01 (BS 500); at 12:00 PM on 7/10/01 (BS 458), 7/15/01 (BS 520), 7/18/01(BS 50), 7/19/01 (BS 435), 7/24/01	F 426		

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(BS 453); and at 4:00 PM on 7/17/01 (BS 54), 7/19/01 (BS 35), 7/26/01 (BS 54), 7/27/01 (BS 49), and 8/4/01 (BS 51).

On 8/6/01 at 12:00 PM, there was documentation on the MAR that the resident's blood sugar was 465. A nurse's note, dated 8/6/01 at 12:15 PM documented, "BS (at) noon (at) 465. Called (MD). Awaiting call back." At 12:25 PM, "Unable to reach (MD). Placed page to (nurse practitioner), awaiting for call back." There was no further documentation in the medical record regarding notification of the resident's physician as per the physician's order.

Documentation on the MAR, for 8/6/01 at 12:00 PM, indicated the facility staff administered 7 units of the sliding scale Humulin regular insulin. There was no documentation in the medical record of a physician's order for the facility to administer 7 units of sliding scale insulin at this time.

On 8/6/01 at 4:00 PM, there was documentation on the MAR that the resident's blood sugar was 197 and that the staff administered 3 units of sliding scale Humulin regular insulin at 5:00 PM. The nurse's note, dated 8/6/01 at 4:00 PM, documented, "BS 197. 16 U (units) NPH (insulin) given..." There was no documentation in the medical record of a physician's order for the staff to administer the sliding scale insulin or 16 units of NPH insulin.

3. Resident 46 was admitted to the facility on 3/29/00 with diagnoses of insulin dependant diabetes mellitus, blindness, and hypertension.

A physician's order, dated 10/4/00, indicated the resident was to have blood sugar monitoring by the facility 4 times daily, at 6:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM.

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F 426	Continued From Page 76 A physician's order, dated 6/17/01, indicated the resident was to receive sliding scale Novolin R insulin as follows: If the blood sugar is 150 to 219 give 3 units, 220 to 279 give 5 units, 280 to 339 give 8 units, 340 to 399 give 12 units, 400 and over give 18 units and call the physician. There was no documentation on the July 2001 MAR that the resident received the sliding scale Novolin R insulin, per the physician's order, at 6:30 AM on 7/2/01 (BS 249), 7/4/01 (BS 343) and 7/8/01 (BS 321); at 11:30 AM on 7/8/01 (BS 326), 7/9/01 (BS 287), 7/10/01 (BS 384), and 7/11/01 (BS 279); at 4:30 PM on 7/4/01 (BS 151), 7/8/01 (BS 304), 7/9/01 (BS 173), and 7/11/01 (BS 215). A physicians's telephone order, dated 7/16/01, changed the sliding scale insulin to Humalog insulin as follows: If blood sugar is 150 to 219 give 3 units, 220 to 279 give 5 units, 280 to 339 give 8 units, 340 to 399 give 12 units, 400 and over give 18 units and call the physician. The order also stated if the fasting blood sugars were over 250, the facility staff was to recheck the resident's blood sugar in 3 hours and repeat the Humalog insulin according to the sliding scale. There was no documentation on the July and August 2001 MAR's that the resident received the sliding scale Humalog insulin, per the physician's order, at 6:30 AM on 7/16/01 (BS 335) and 7/18/01 (BS 349); at 11:30 AM on 7/16/01 (BS 186), 7/22/01 (BS 227), 7/26/01 (BS 154), 7/28/01 (BS 171), 7/29/01 (BS 196), 8/2/01 (BS 210) and 8/7/01 (BS 155); at 4:30 PM on 7/17/01 (BS 190), 7/19/01 (BS 206), 7/26/01 (BS 161), 7/27/01 (BS 324), 7/28/01 (BS 400), and 8/3/01 (BS 394); at 9:00 PM on 7/27/01 (BS 172), 7/29/01 (BS 501), and 8/2/01 (BS 200).	F 426		

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Review of the July and August 2001 MAR's revealed no evidence that the facility rechecked the resident's blood sugars in 3 hours if they were over 250, and repeated the Humalog insulin according to the sliding scale, as per the physician's order, at 6:30 AM on 7/17/01 (BS 403), 7/18/01 (BS 349); at 11:00 AM on 7/18/01 (BS 376), 7/24/01 (BS 400), 7/25/01 (BS 257), 7/26/01 (BS 274), 8/4/01 (BS 349), at 11:30 AM on 8/5/01 (BS 283), and 8/6/01 (BS 296); at 4:40 PM on 7/20/01 (BS 294), 7/25/01 (BS 298), 7/27/01 (BS 324), 7/28/01 (BS 276), 7/30/01 (BS 339), 8/2/01(BS 400), 8/3/01(BS 396), and at 9:00 PM on 7/21/01 (BS 314), 7/23/01 (BS 263), 7/29/01 (BS 501), and 8/1/01 (BS 350).

4. Resident 16 was readmitted to the facility on 5/31/01 with diagnoses of insulin dependant diabetes mellitus, peripheral vascular disease, congestive heart failure, anemia, dementia, Tourette's syndrome, and chronic obstructive pulmonary disease.

The resident's medical record and June, July and August 2001 MAR's were reviewed.

A physician's admission order, dated 5/31/01, indicated the resident was to receive NPH insulin 12 units and Regular insulin 5 units every AM. The order also indicated the resident was to receive NPH insulin 8 units every PM.

There was no documentation on the June 2001 MAR to indicate the resident received the NPH insulin 12 units every AM, as per the physician's order, on 6/5/01, 6/6/01, 6/7/01, 6/18/01, 6/25/01, 6/27/01, and 6/30/01.

There was no documentation on the June, July, and August 2001 MAR's to indicate resident 16 received

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the Regular insulin 5 units every AM, as per the physician's order, on 6/5/01, 6/6/01, 6/7/01, 6/18/01, 6/25/01, 6/27/01, 6/29/01, 6/30/01, 7/1/01 through 7/31/01 (31 days), and 8/1/01 through 8/6/01. There were no physician's orders found in the resident's medical record to discontinue the resident's regular insulin 5 units every AM.

There was no documentation on the June, July and August 2001 MAR's to indicate resident 16 received the NPH insulin 8 units every PM, as per the physician's order, on 6/25/01 through 6/28/01, 7/31/01, and 8/5/01.

A physician's order, dated 5/31/01, indicated the resident was have blood sugar monitoring 3 times daily, at 6:30 AM, 4:30 PM, and 9:00 PM. Another physician's order, dated 5/7/01, indicated the resident was to receive Novolin R sliding scale insulin as follows: If the blood sugar is 151 to 200 give 4 units, 201 to 250 give 7 units, 251 to 300 give 10 units, and over 300 give 13 units.

There was no documentation on the resident's June and July 2001 MAR's that the resident received the sliding scale Novolin R insulin, as per the physician's order, at 6:30 AM on 6/1/01, (BS 187), 6/9/01 (BS 296), 6/10/01 (BS 192), 6/13/01 (BS 303), 6/23/01 (BS 178), 6/30/01, (BS 246), 7/6/01 (BS 202), 7/12/01 (BS 159), 7/15/01 (BS 157), 7/16/01 (BS 155), 7/20/01 (BS 168), 7/24/01 (BS 233); at 4:30 PM on 6/4/01 (BS 192), 6/9/01 (BS 200), 6/15/01 (BS 159), 6/19/01 (BS 151), 6/20/01 (BS 175), 6/23/01 (BS 184), 7/2/01 (BS 233), 7/4/01 (BS 214), 7/5/01 (BS 200), 7/6/01 (BS 214), 7/8/01 (BS 201). 7/12/01 (BS 200), 7/15/01 (BS 201), 7/18/01 (BS 191), 7/19/01 (BS 277), 7/20/01 (BS 160), 7/23/01 (BS 221), 7/24/01 (BS 259), 7/29/01 (BS 201); at 9:00 PM on 6/11/01 (BS 151), 6/19/01 (BS 256), 7/5/01 (BS 189), 7/7/01 (BS

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

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F 426	Continued From Page 79 216), 7/15/01 (BS 189), 7/19/01 (BS 222), 7/21/01 (BS 200), 7/23/01 (BS 236), 7/28/01 (BS 281) and 7/30/01 (BS 201). 5. Resident 42 was readmitted to the facility on 6/23/01 with diagnoses diabetes mellitus, hypertension, coronary artery disease, legally blind and schizo-effective disorder and bipolar disorder. Resident 42 had a physicians order, dated 6/23/01, to receive Novolin N insulin 24 units every day at 6:00 AM. Review of the July, 2001, MAR revealed that Novolin N 24 units was not documented as being given as ordered on 7/2/01, 7/6/01, 7/7/01, 7/10/01, 7/29/01, and 7/30/01. In addition to regularly scheduled insulin doses, resident 42 was to receive extra regular insulin (sliding scale) at 6:30 AM, 12:00 PM, 5:00 PM and 8:00 PM as follows: Blood sugar (BS) 151-200, 2 units BS 201-250, 4 units BS 251-300, 6 units BS 301-350, 8 units BS 351-400, 10 units BS 401-450, 12 units BS over 400 to call the physician Resident 42's BS for June 2001, that required sliding scale insulin, were documented as follows: BS on 6/26/01 at 6:00 AM was 335. BS on 6/26/01 at 11:00 AM was 341. BS on 6/27/01 at 11:00 AM was 300. BS on 6/28/01 at 6:00 AM was 410 and at 11:00 AM was 300. BS on 6/30/01 at 6:00 AM was 273. There was no documentation to indicate that resident 42 received the sliding scale insulin as ordered on	F 426		

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F 426	Continued From Page 80 those dates. Resident 42's BS for July, 2001, that required sliding scale insulin were documented as follows: BS on 7/4/01 at 5:00 PM was 215. BS on 7/6/01 at 6:30 AM was 223, BS on 7/11/01 at 5:00 PM was 211. BS on 7/17/01 at 6:30 AM was 230. BS on 7/25/01 8:00 PM was 297. There was no documentation to indicate that resident 42 received the sliding scale insulin as ordered on those dates. 6. A review of all the residents MAR's for July, 2001, revealed that medications and dietary supplements were not available to administer to residents per the physician's order as follows: a. Resident 3 had a physician order to receive Oyster Shell Calcium 500 mg twice daily. On 7/24/01, the 5:00 PM dose was circled on the MAR and it was documented on the nurse's medication notes that the medication was out of stock. b. Resident 12 had a physician order to receive L-thyroxin .05 mg every morning. On 7/11/01, the dose was circled on the MAR and it was documented on the nurse's medication notes that the medication was out of stock. c. Resident 13 had a physician order to receive Celebrex 100 mg twice daily. On 7/11/01, the 8:00 AM dose was circled on the MAR and it was documented on the nurse's medication notes that the medication was out of stock. d. Resident 16 had a physician's order, dated 5/7/01, for a dietary supplement of Resource Diabetic Liquid, 1 carton 3 times daily. On the August 2001 MAR, the dates of 8/3/01 through 8/6/01 at 8:00 AM, were initialed and circled, indicating the resident did not	F 426		

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F 426	Continued From Page 81	F 426		

receive the supplement at these times. On the back of the August 2001 MAR, the facility staff documented for the dates 8/4/01, and 8/5/01, and 8/6/01, "Resource Diabetic OOS (out of stock). CS (central supply) has been told to order more."

e. Resident 24 had a physician order to receive a Duragesic patch every third day. On 7/6/01, the dose was circled on the MAR and it was documented on the nurse's medication notes that the medication was out of stock.

f. Resident 26 had a physician order for Potassium Chloride 40 meq twice daily. On 7/24/01, the 8:00 PM dose was circled and on 7/27/01 the 8:00 AM dose was circled on the MAR and it was documented on the nurse's medication notes that the medication was out of stock.

g. Resident 27 had a physician order for Docusate Sodium 250 mg every day. On 7/6/01, the dose of medication was circled on the MAR and it was documented on the nurses's medication notes that the medication was out of stock.

h. Resident 28 had a physician order for a Fentanyl patch change every 72 hours. On 7/16/01, the dose was circled on the MAR and it was documented on the nurse's medication notes that the medication was not in from the pharmacy.

i. Resident 29 had a physician order for Calcium Carbonate 650 mg three times daily with meals. On 7/10/01, the 5:00 PM dose was circled on the MAR and it was documented on the nurse's medication notes that the medication was out of stock.

j. Resident 31 had a physician order for Zyprexa 20 mg at bedtime. On 7/26/01, the dose was circled on

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F 426	Continued From Page 82 the MAR and it was documented on the nurse's medication notes that there was none in the cart. k. Resident 32 had a physician order for Propantheline 15 mg three times daily. On 7/4/01, 7/5/01, and 7/6/01, all three doses for all three days were circled on the MAR and it was documented on the nurse's medication notes that the medication was out of stock. l. Resident 34 had a physician order for Tums 500 mg twice daily, and Docusate Sodium 100 mg twice daily. On 7/6/01, the 8:00 AM dose of Tums was circled on the MAR and on 7/20/01 the 5:00 PM dose of Docusate Sodium was circled on the MAR. It was documented on the nurse's medication notes that the medications were out of stock. m. Resident 35 had a physician order for Zanaflex 4 mg two tablets three times daily. On 7/20/01, the 12:00 PM dose was circled on the MAR. It was documented on the nurse's medication notes that the medication was out of stock. n. Resident 40 had a physician order for Zanaflex 4 mg, two tablets, three time daily. On 7/25/01, and 7/28/01, the 4:00 PM doses were circled and it was documented on the nurse's medication notes that the medication was out of stock. o. Resident 44 had a physician order for Tegretol 200 mg three time daily. On 7/6/01, the 8:00 AM and 12:00 PM doses were circled on the MAR and it was documented on the nurse's medication notes that the medication was out of stock. 7. The monthly pharmacy consultant report for March, 2001, identified lack of documentation of medication administration as a problem. The facility	F 426		

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F 426	Continued From Page 83 did not respond to this report. 8. On 7/31/01at 8:00 AM, a staff nurse was interviewed in regards to who was responsible for ordering medication. The nurse stated there was no individual staff member assigned to be responsible for ordering the resident's medication.	F 426		
F 430 SS=E	483.60(d)(2) PHARMACY SERVICES The pharmacist must report any irregularities and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interviews with facility nursing staff and record review, it was determined that the facility did not act upon the monthly pharmacist reports from March 2001 through June 2001. Findings include: During an interview with the facility director of nursing (DON) on 8/6/01, the surveyor asked to review the monthly pharmacist consulting reports. The DON handed the surveyor a three ring binder that she stated contained the monthly reports. Upon review of the contents of the notebook, it was noted that the last pharmacy report in the book was dated 1998. The DON stated that she knew she had the most recent reports but was not able to locate them at that time. During a meeting with the administrator on 8/6/01 at 4:30 PM, he stated that he had copies of the pharmacy reports in his office and would give them to the team the following morning. On 8/7/01, the administrator gave the surveyor copies	F 430	**Pharmacy Services** The monthly pharmacy report will be reviewed and responded to each month by the A.D.O.N. . The D.O.N. will verify completion of this task monthly. Prior to a finding of substantial compliance, the administrator will review as well. The QA committee will review the responses quarterly, under the direction of the administrator.	9/24/01

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F 430	Continued From Page 84 of the monthly pharmacy reports for March of 2001, through June 2001. A review of the clinical records of the residents identified on the monthly pharmacy reports was done on 8/7/01. No documentation could be found in the clinical records that the recommendations made by the pharmacist for the months of March 2001, through June 2001 had been addressed by the facility or the physicians. On 8/7/01, a facility nurse was asked by the surveyor if they had seen a pharmacy report recently. The nurse stated, "not for a long time." During an interview with the facility DON on 8/7/01, she stated that she had not addressed the recommendations made by the pharmacist on the reports from March 2001 through June 2001, and had not assigned any facility nursing staff to follow through with the recommendations.	F 430		
F 441 SS=J	483.65(a)(1)-(3) INFECTION CONTROL The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility did not implement an infection control program to provide a safe and sanitary environment . This included identification of residents with infections, investigating origins of	F 441	**Infection Control** Staff inserviced on residents who have serious infectious diseases. These residents will be identified by the A.D.O.N. and an updated list placed in the communication book. Ongoing, a QI list tracking infections will be maintained in the medicine administration record by the D.O.N. after review by the infection control committee each Friday. It will be updated at least weekly by the D.O.N., more often as required, and will be audited weekly by the medical records clerk to ensure completeness and accuracy. Any new staff, including those from the pool, will be	8/20/01

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F 441	Continued From Page 85 infections, prevention of spread of infection, proper handling of linen, and the use of universal precautions when performing blood glucose monitoring and administering insulin on residents with known infectious disease. (Residents 17, 24, 25, 26, 33, 42,and 46) Findings include: 1. Interviews During an interview with the director of nursing (DON) on 8/1/01, she stated that she had not implemented an infection control program in the facility, including the tracking of infections since she started employment on 5/21/01. She could not produce any records that were more recent than December of 1999 that documented any type of infection monitoring. On 8/2/01, the DON gave the surveyors the facility policy and procedure manual for infection control and general nursing practices. The DON stated that she was not aware that the facility had these manuals. Review of the manuals on 8/2/01, revealed that they had not been reviewed by the quality assurance committee. A review of the facility Quality Assurance Committee meeting minutes was done on 8/6/01. Meetings had been held on 11/30/00, 12/11/00, 3/6/01 and 6/25/01. None of the meeting minutes addressed any infection control issues. On 8/2/01 at 7:30 AM, a night shift nurse was interviewed. The nurse stated he/she was a new employee and had worked for the facility about 3 months. When asked if the facility had provided any orientation or inservicing regarding infection control policies, the nurse stated, "No". The nurse was asked if the facility had any infection control policy available	F 441	oriented to the communication book and weekly QI list identifying residents with infectious diseases. The Infection Control Committee meets with the skin nurse to determine progress of any wounds, monitors antibiotic therapy and follow up labs as needed, and meets weekly to assure that effective infection control practices are reflected in policy and practice. Members of this committee consist of the D.O.N, the A.D.O.N, the wound care nurse, and the business office manager. All direct care/nursing employees received inservice training on Universal Precautions, conducted August 6, August 7, August 10 and August 13. In addition to the care staff, all staff attended the meeting on August 10. All staffing from the pool will receive inservice and will sign that they have received inservice on facility infection control policies. All licensed nurses received inservice training on wearing gloves while administering insulin and doing blood sugar checks. They and the other direct care staff received inservice training on glove useage when changing briefs, handling body fluids, etc. in addition to the training cited above. These inservice meetings were conducted August 6, August 7, August 10 and August 13. All licensed staff received one on one training, and have been skills tested and monitored to assure the ability to follow the policies surrounding Universal Precautions, glove usage, blood sugar testing and insulin/medication administration. Compliance monitoring will continue daily	

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F 441	Continued From Page 86 to the staff for reference, and the nurse stated,"No". The nurse was asked if the facility had an Infection Control program in place. The nurse stated, "No." When asked how the staff would know which residents had been identified with an infectious disease, the nurse stated they would know by the medication (antibiotics) or treatments ordered by the physicians. When asked how the staff were made aware of resident's with infectious diseases, the nurse stated this was done by "word of mouth" during report at the change of shift. The DON stated that a facility nurse that was also employed in May, 2001, had been concerned about residents he suspected had urinary tract infections and would infections. The DON stated that this facility nurse obtained wound cultures and collected urine specimens and sent them to the laboratory without physician orders. She stated that when the laboratory results were returned to the facility, the physicians were notified of the results and antibiotics were started for the residents that required treatment. She also stated that one resident had been identified as having MRSA (methicillin resistant staphylococcus aureus) in her urine and became so ill she was discharged to the hospital for treatment. On 8/2/01, an interview was held with two facility staff nurses at 9:30 AM. They stated that if they suspected a resident had an infection, the would call the physician for orders for a chest x-ray, urine or wound culture, what ever they suspected was wrong. If the physician gave them an order for a procedure, the procedure would be done. If the physician ordered antibiotics, they were ordered from the pharmacy, written on the MAR and treatment sheet and followed as ordered. They stated that they do not fill out an infection report or tracking form of any kind. The information would be passed on in report to the next	F 441	until substantial compliance is reached, and on a weekly basis thereafter. Compliance rounds reports are turned in to administrator and maintained in a QA log, to be reviewed by the QA committee on a quarterly basis. All inservice includes the following instruction: • Because all patients with bloodborne pathogens cannot necessarily be identified at time of care, Universal Precautions are always used. • Appriopriate barrier precautions used routinely for all patients, determined by the likelihood that the caregiver will be exposed to blood or bloody secretions rather than the likelihood that the patient is infected. • Because of concerns about transmission of diseases other than bloodborne diseases, gloves are recommended when touching feces, nasal secretions, sputum, urine, vomitus, and saliva • Handwashing is essential before cares, after cares, before and after meals, after using the restroom, etc. etc. • Clean towels and linens are not to be stored in shower room. • Dirty linens are never left on the floor, but placed in a bagged hamper and sent frequently to the laundry room (before the bag overflows or sits for a long period). Rolling hampers have been purchased for each aide station and are in use to facilitate disposal of dirty linens in an appropriate fashion.	

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F 441	Continued From Page 87 shift. They stated that they do not report the information to any of the administrative staff. On 8/2/01, an interview was held at 7:45 AM, with a nursing assistant working the 7:00 AM to 3:00 PM shift She stated that she was not aware of any residents having a condition or infection that she needed to take special precautions with. She stated that she was aware of one resident that had a urinary tract infection. On 8/2/01, an interview was held at 8:05 AM, with a nursing assistant working the 7: 00 AM to 3:00 PM shift. The nursing assistant was transporting dirty linen, not bagged and she was not wearing gloves. When asked if she was aware of any resident that she need to take precautions with due to infections, she said no. When asked if she knew what universal precautions were she said no. On 8/2/01, an interview was held at 8:25 AM, with a nursing assistant working the 7:00 AM to 3:00 PM shift. She stated that she was only aware of one resident that she needed to use universal precautions with. She also stated that she had not been inserviced on infection control issues since she had been hired in May, 2001. On 8/2/01, an interview was held at 9:05 AM, with a facility staff nurse working the 7:00 AM to #:00 PM shift. She stated that she was not aware of any residents that she needed to use special precautions with. She stated that she had been employed in the facility since September 2000, and had not been inserviced on universal precautions or infection control procedures. A review of the facility inservice log on 8/6/01, revealed that the facility had provided one inservice on	F 441	Infection control policies are in place. Infection control committee to meet weekly until substantial compliance is reached, after which it will meet at least quarterly and report to the Quality Assurance Committee. In addition, weekly Standard of Care meeting will be held to discuss, among other things, infections and to review the facility infection control tracking logs. Resident 45, 46 and other residents as appropriate to receive blood glucose checks and insulin administration in accordance with the above information. Aides instructed to change gloves and wash hands after handling dirty clothes or linens and between patients. This addresses the issue cited in the survey between residents 42 and 26, as well as all other residents in the facility. Residents 17, 24 and 33's catheter tubing and collection bags checked q shift to assure no tubing or bags are touching the floor. All other residents with catheters have tubing and bags checked as well. Daily monitoring by D.O.N., A.D.O.N and charge nurses to assure this standard is met. Included in compliance rounds. Staff also inserviced on the importance of maintaining a free flow of urine through the tubing and never raising the bag and collecting tubing above bladder level. Inserviced that if bag or tubing touches the floor, it must be changed. Inserviced that the bag is emptied at least every eight hours and more frequently if there is a large volume of urine. The catheter is never disconnected from the	

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F 441	Continued From Page 88 universal precautions on March 9, 2001, previous to the employment of the current DON. The minutes of the inservice did not include or identify residents with known infectious disease as a precaution for the facility staff. A review of the MAR's for all residents for the month of July 2001, was done on 8/2/01. Seven residents were identified as being treated for infections during the month of July, 2001. During the interview with the DON on 8/1/01, she could not identify who had been treated for infections during the month of July, 2001. 2. Resident 45 was readmitted to the facility on 1/31/01 with diagnoses of insulin dependant diabetes mellitus, hepatitis C, end stage renal disease with dialysis, seizure disorder, hypertension, paranoid schizophrenia, asthma, and anemia. On 8/2/01 at 7:30 AM, a night shift nurse was interviewed. The nurse was asked if resident 45 had been identified as having any infections. The nurse stated the resident had hepatitis C. Resident 45's MDS, dated 5/20/01, was reviewed . Documentation under section I.Q., k. Infections, identified the resident had viral hepatitis. The resident's care plan was reviewed and there was no evidence found that the facility had identified the resident's viral hepatitis C infection as a problem, or implemented a plan of care. Resident 45's medical record and medication administration records for July, and August 2001 were reviewed. A physician's order, dated 1/31/2001, documented the resident was to have blood sugar (BS) monitoring by the facility 1/2 hour before each meal, 3 times daily. A physician's order, dated 1/31/01,	F 441	tubing to obtain urine samples, irrigate the catheter or ambulate or transport the patient.	

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F 441	Continued From Page 89 indicated resident 45 was to receive Humalog insulin 6 units, 1/2 hour before meals 3 times daily at 7:00 AM, 11:00 AM, and 4:00 PM. On 8/1/01 at 7:55 AM, the facility's van driver was observed to enter resident 45's room, wake him up, and ask him to get ready to go to his dialysis appointment. At 8:05 AM, the resident was observed to start to leave the facility with the van driver. The nurse caring for the resident was observed in the basement dining room passing the morning medications at this time. The nurse surveyor asked if the nurse knew the resident was leaving the facility, and the nurse stated,"No". The nurse surveyor asked if the resident's blood sugar had been checked and if his morning insulin had been administered. The nurse stated, "No". At 8:10 AM, the nurse was observed to stop the resident from leaving the building, and to check the resident's blood sugar. The nurse was not observed to wear gloves while checking the resident's blood sugar. The nurse was not observed to wash his/her hands after checking the resident's blood sugar. The nurse was observed to go downstairs to the medication cart, draw up the resident's insulin and go back upstairs to administer the insulin. The resident had left the facility, and was observed to be standing outside, in the facility's parking lot. The nurse was observed to leave the facility, go to the parking lot, and administer the resident's insulin. The nurse was not observed to wear gloves while administering the resident's insulin. By not following the guidelines of universal precautions regarding gloving and performing appropriate handwashing, the nurse increased his/her risk of direct exposure to resident 45's blood. The nurse who was observed to check resident 45's blood sugar and administer the resident's insulin on the morning of 8/1/01, was interviewed on 8/2/01 at 8:00 AM. When asked regarding the facility's infection	F 441		

DEPARTMENT OF HEALTH AND HUM. SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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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 441	Continued From Page 90 control policy and universal precautions policy, the nurse stated he/she had not been oriented or received inservice training by the facility. When asked if he/she knew where these policy's were located in the facility and if he/she had access to them, the nurse stated, "No". The nurse was asked if he/she was knowledgeable about the use of universal precautions, the nurse stated, "Yes, I know I should have worn gloves when I checked [resident 45's] blood sugar, I was just in a hurry." Review of the facility's Blood Sugar Monitoring policy indicated the following: "Purpose: To monitor blood glucose level. General Infection Control Guidelines: 1. Observe (standard) universal precautions. 2. Wash your hands before and after all procedures... Equipment: 1. Tissues 2. Disposable gloves. 3. Alcohol wipes. Procedure...2. Put on gloves..." 3. During an observation of a medication pass on 7/31/01 at 5:00 PM, a facility nurse was observed to perform a blood glucose on resident 46 in the dining room at the table where resident 46 ate his meals with other residents. The facility nurse did not wear gloves to obtain the blood sugar. The facility nurse then administered resident 46's insulin in his abdomen in the dining room at the table. At 5:25 PM, while the facility nurse was preparing medications to administer to another resident, she knocked the sharps container off of the medication cart. Two disposable razors and two insulin syringes were observed to fall out of the container onto the dining room floor. The facility nurse picked up the used razors and used syringes and placed them back into the container. She then continued to set up the medication and administer it to the next resident	F 441		

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	465142	A. BUILDING _____ B. WING _____	8/7/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From Page 91 without washing her hands. 4. On 8/1/01, one aide was observed removing resident 42 clothes with gloves on. Without changing his/her gloves the aide went from resident 42 to resident 26. The facility aide helped stand and pull down resident 26's incontinence briefs. Resident 42 was identified as having MRSA on 8/5/01. " The textbook of Medical-Surgical Nursing, eighth edition, Brunner and Suddarth, 1996; page 1960, states, "...Universal Precautions. Universal precautions were first described by the CDC (Centers for Disease Control). These precautions are a strategy for protecting health care workers from occupational transmission of bloodborne organisms...The premises of universal precautions are: (1) all of the patients with bloodborne infections cannot be identified at the time care is provided for them, and (2) appropriate barrier precautions should be used routinely for all patients. The barrier precautions are determined by the likelihood that the nurse will be exposed to blood or bloody secretions rather than the likelihood that the patient is infected...Body Fluids. When following universal precautions, the nurse recognizes that blood is the most important potential source of bloodborne pathogens such as HIV (human immunodeficiency virus), HBV (hepatitis B virus), and HCV (hepatitis C virus)... Barrier Precautions. Because of concerns about transmission of diseases other than bloodborne diseases, gloves are recommended when touching feces, nasal secretions, sputum, urine, vomitus, and saliva. 5. During the survey, there were multiple observations of dirty linen and bed pads on the floor in resident rooms. This was observed especially during the morning hours when the nursing staff were stripping and changing resident beds.	F 441		

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F 441	Continued From Page 92 6. During the entire survey, the shower room on the north west end of the facility was observed to have stacks of clean towels and wash cloths on a shower bench just inside the door. Next to the shower bench where the clean towels and wash cloths were stacked, was a barrel where dirty linen was placed that did not have a lid. The Photo Altas of Nursing Procedures, Third Edition, Swearingen and Howard, 1996 page 9, states, "...handle, transport, and process used linen in a manner that prevents skin and mucous membranes exposure, contamination of clothing, and environmental soiling." 7. On 7/31/01 at 7: 30 AM, resident 17's catheter tubing was observed dragging on the floor as he wheeled himself down the hall. Six inches of catheter tubing was observed touching the floor. 8. On 8/1/01 at 8:30 AM, resident 24's catheter tubing was observed dragging on the floor as she wheeled herself down the hall. A review of resident 24's medical record documented that resident had a history of recurrent urinary tract infections. 9. On 8/1/01 from 7:35 AM until 7:55 AM, resident 33 was observed to be sitting in her wheelchair just outside the west shower room, with her catheter tubing laying on the floor. Resident 33's medical record documented a history of urinary tract infections, including hospitalization for urinary sepsis. Brunner and Suddarth's Textbook of Medical-Surgical Nursing, Eighth Edition, Lippincott-Raven Publishers, 1996, Smeltzer and Bare, page 1147, states "When catheters are used, microorganisms may gain access to	F 441		

DEPARTMENT OF HEALTH AND HUM SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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F 441	Continued From Page 93 the urinary tract... the most common way, by migrating to the bladder along the internal lumen of the catheter after the catheter has become contaminated." Page 1149, states " A preassembled and sterile closed urinary drainage system is necessary and should not be disconnected before, during, or after insertion of the catheter. To prevent contamination of a closed system, the tubing is never disconnected. No part of the collection bag or drainage tube should ever be contaminated. The bag is never raised above the level of patient's bladder because this will cause flow of contaminated urine by gravity into the patient's bladder from the bag. Urine should not be allowed to collect in the tubing because a free flow of urine must be maintained to prevent infection. .. The drainage bag must never touch the floor. The bag and collecting tubing are changed if contamination occurs...The bag is empty at least every eight hours through the drainage valve., and more frequently if there is a large volume of urine, to lessen the risk of bacterial proliferation...The catheter is never disconnected from the tubing to obtain urine samples, irrigate the catheter, or ambulate or transport the patient." Davis, Mary Jackson, Shilo Jorgensen, Sharen Jackson, Shilo Jorgensen, Sharen Jorgensen, Sharen	F 441		

DEPARTMENT OF HEALTH AND HUM. . SERVICES
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F 460 SS=E	483.70(c)(1)(iv&v) PHYSICAL ENVIRONMENT Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation and resident interview it was determined that the facility did not assure full visual privacy for each resident. Thirteen of thirty resident rooms did not have privacy curtains that would provide complete visual privacy. Room identifiers 102, 104, 109, 112, 114, 201, 206, 209, 210, 212, 214, 215, 216 Findings included In resident room 104 bed A, one curtain was observed to be tied together with tape. On 7/31/01, at 1:20 PM, resident of 104 bed A was interviewed, he stated that he never used the privacy curtain because it was tied up with tape. The taping of the curtain would allow visualization of the resident from the hallway and roommate when receiving cares. In resident room 104 bed B, one curtain was observed missing which would not provide the resident privacy from his roommate. On 7/31/01 at 1:20 PM, resident of 104 bed B stated that the privacy curtain had been pulled down. In room 112 bed A, there was no privacy curtain which would allow visualization of the resident	F 460	**Physical Environment** Curtains and tracks repaired to provide total visual privacy for residents in the facility's semi-private rooms. Hooks and grommets installed where needed to hold curtains close to wall where lighting canopies create a 12" gap between wall and curtain. The repairs will be made in 102, 104, 109, 112, 114, 201, 206, 209, 210, 212, 214, 215, 216 as noted in the survey and other rooms where deficiencies are identified by facility staff. Weekly monitoring by maintenance supervisor to assure continued compliance. Monitor reports maintained by administrator in QA book, for quarterly review by QA committee. Deficiencies addressed as they occur.	9/20/01

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F 460	Continued From Page 95 receiving cares. In room 114 bed A, there was a privacy curtain that had a gap of 12 inches between the wall and the privacy curtain, which could have allowed visualization of the resident receiving cares. In room 212 bed B, there were privacy curtains that were tied together. Bed A, in room 212 did not have tracking for a privacy curtain. The lack of privacy curtains would allow visualization of the resident receiving cares. In room 214 bed A , there was a privacy curtain that had a gap of 12 inches between the wall and the privacy curtain, which allowed visualization of the resident receiving cares. In room 215 bed A, there was a privacy curtain that had a gap of 12 inches between the wall and the privacy curtain, that would allow visualization of the resident receiving cares. In room 102, bed A, there was a 12 inch gap between the wall and the curtain which would allow visualization of the resident receiving cares. In room 109, a four bed ward, there were no privacy curtains around the C and D beds which were occupied. This would allow visualization of the residents receiving cares and would not allow the residents privacy from each other. In room 206, bed A, there was a 12 inch gap between the wall and the curtain which would allow visualization of the resident receiving cares. In room 209, there were no privacy curtains around any of the four beds. This would allow visualization of the four residents receiving cares and would not	F 460		

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F 460	Continued From page 100 bed. This would allow visualization of the resident receiving cares. In room 216 the privacy curtain for bed A would not slide to the end of the track due to a screw which prevented the curtain from moving to the end of the track. This would allow visualization of the resident receiving cares.	F 460		
F 490 SS=K	483.75 ADMINISTRATION 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. This REQUIREMENT is not met as evidenced by: Based on a annual survey with subsequent extended survey, conducted July 30, 2001, through August 7, 2001, and resultant finding of Immediate Jeopardy to resident health and safety, it was determined that the facility was not being administered in a manner that enabled it to use its resources either efficiently of effectively to ensure that residents were provided the opportunity to attain or maintain their highest practicable well-being. Immediate Jeopardy area identified in the facility were in regards to accurate and timely administration of medications, in the prevention and treatment of pressure sores and lack of an infection control program and the use of universal precautions when performing blood glucose monitoring and the administration of insulin to residents identified with infectious disease. Additionally, during the extended survey, the facility	F 490	**Administration** 1) Systems have been implemented to ensure that residents of the facility are provided with required medications in accordance with their physician orders and to ensure that medications are available and administered to residents in a timely manner. Administrative oversight, including supervision and monitoring of facility staff in identifying, correcting and preventing medication errors is in place to ensure that delivery of services is done in accordance with acceptable professional standards of practice, and in such a manner that residents' needs are being met. a) Refer to Tag F-329 b) Refer to Tag F-426 2) Refer to Tag F-314 3) Refer to Tag F-441 4) Systems in place for administration to effectively use its resources to assure that each resident attains or maintains their highest practicable, physical,	

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F 490	Continued From Page 97 an infection control program and the use of universal precautions when performing blood glucose monitoring and the administration of insulin to residents identified with infectious disease. Additionally, during the extended survey, the facility was found to be non-compliant in the areas of personal privacy, timely answering of call lights and staff not speaking respectfully to residents, allowing residents to participate in activities of choice, lack of accurate assessments of residents, management of tube feedings, provision of fluids to maintain hydration,lack of resident orientation for discharge,lack of providing an accident free environment, lack of registered dietitian consulting, lack of follow through with pharmacy consultant reports, privacy curtains did not provide full visual privacy, lack of nurse aide verification, failure to obtain laboratory tests ordered by physicians, mechanical problems in call light system,and survey results not accessible to residents. This had the potential to effect all residents in the facility. Findings include: On 7/30/01 , an annual survey was initiated. On 8/2/01, facility administration was noticed of the elements of Immediate Jeopardy to resident health and safety and Sub-Standard Quality of Care. The determination of Immediate Jeopardy was based on the findings of significant non-compliance in the areas of Quality of Care/Pressure Sores [42 Code of Federal Regulations (CFR) 483.25 (c) (1) (2) Tag F 314], Quality of Care/Medication Administration [42 CFR 483.25 (l) (l) (iii), Tag F-329], Pharmacy Services [CFR 483.60 (a), Tag F-426] and Infection Control [42 CFR 483.65(a), Tag F-441].	F 490	mental and psychosocial well-being are outlined below: a) Refer to Tag F-164 b) Refer to Tag F-241 c) Refer to Tag F-242 d) Refer to Tag F-278 e) Refer to Tag F-322 f) Refer to Tag F-327 g) Refer to Tag F-204 h) Refer to Tag F-323 i) Refer to Tag F-361 j) Refer to Tag F-430 k) Refer to Tag F-460 l) Refer to Tag F-496 m) Refer to Tag F-502 n) Refer to Tag F-463 o) Refer to Tag F-167 As outlined in the above referenced tags, these items will be monitored and the records maintained in a QA log, for review and appropriate action by the QA committee.	

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F 490	Continued From Page 98	F 490		

1. Facility administration failed to have systems in place that would ensure that residents of the facility were provided with required medications in accordance with their physician orders, and to ensure medications were available and administered to residents in a timely manner. There was a lack of sufficient administrative oversight, supervision and monitoring of the facility staff in identification, correction and prevention of medication errors and ensuring that the delivery of the services was done in accordance with acceptable professional standards of practice and in such a manner that residents' needs were being met.

a. Facility nursing staff failed to employ nursing assessment when medications may have been contraindicated. For resident with diabetes mellitus, blood glucose monitoring did not occur in accordance with physician's orders or in conjunction to the administration of insulin.
(Refer to Tag F-329.)

b. Facility nursing staff failed to accurately document when medications were administered. Medication administration records were completed in a manner that did not enable others to determine what doses had been administered nor what time they had been administered. Facility staff failed to ensure that all physician ordered medications were ordered timely from the pharmacy resulting in medications being unavailable when doses were due.
(Refer to Tag F-426.)

2. Facility administration failed to provide oversight to ensure that residents' assessed needs were being met and that necessary services were provided to residents for the prevention of pressure sores or to promote healing for residents with pressure sores.

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F 490	Continued From Page 99 (Refer to Tag F-314.) 3. Facility administration failed to ensure that policies and procedures were implemented to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility failed to have an effective infection control program in place, including the use of universal precautions when performing invasive procedures on residents with known infectious disease. (Refer to Tag F-441.) 4. In addition to the areas of Immediate Jeopardy stated above, the facility administration failed to effectively and efficiently use its resources to ensure that each resident attained or maintained their highest practicable, physical, mental and psychosocial well-being in the following areas of deficient practice cited during the extended survey completed 8/7/01. a. Facility administration failed to ensure that residents were provided privacy during personal cares (Refer to Tag F-164) b. Facility administration failed to ensure that the facility promoted care for resident in a manner and in a manner and in an environment that maintained or enhanced the resident's dignity and respect. (Refer to Tag F-241) c. Facility administration failed to ensure residents were able to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care. (Refer to Tag F-242) d. Facility administration failed to ensure that the assessment accurately reflected the resident's status. (Refer to Tag F-278)	F 490		

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F 490	Continued From Page 100	F 490		

e. Facility administration failed to ensure that a resident who is fed by a gastrostomy tube received the appropriate treatment.
(Refer to Tag F-322)

f. Facility administration failed to ensure residents were provided with sufficient fluid intake.
(Refer to Tag-327)

g. Facility administration failed to provide sufficient preparation and orientation to a resident to ensure a safe and orderly discharge from the facility.
(Refer to Tag-204)

h. Facility administration failed to provide an environment as free from accident hazards as possible.
(Refer to Tag-323)

i. Facility administration failed to ensure that the director of food service received frequent scheduled consultation for a qualified dietitian.
(Refer to Tag F-361)

j. Facility administration failed to act on the monthly pharmacy consultant reports.
(Refer to Tag F-430)

k. Facility administration failed to ensure that residents were provided with full visual privacy in resident rooms.
(Refer to Tag F-460)

l. Facility administration failed to ensure that the facility received registry verification that a nurse aide has met competency evaluation requirements prior to allowing the nurse aide to work at the facility.
(Refer to Tag F-496)

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F 490	Continued From Page 101 m. Facility administration failed to ensure that laboratory services met the residents needs. (Refer to Tag F-502) n. Facility administration failed to ensure the resident call system functioned properly form toilet facilities. (Refer to Tag F-463) o. Facility administration failed to make the survey results readily accessible to the residents. (Refer to Tag F-167)	F 490		
F 496 SS=E	483.75(e)(5)-(7) ADMINISTRATION Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and phone	F 496	**Administration** All nurses and aides to have their licenses and certificates checked prior to beginning service as a nurse or nurse's aide. This is done by the A.D.O.N. All nurses and aides currently employed have been checked or rechecked as part of this correction. To assure continued compliance, the Business Office Manager will conduct a quarterly audit to verify documentation, and file a report with the administrator, who maintains a record in the QA log. The QA committee reviews the report quarterly.	9/20/01

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F 496	Continued From Page 102 interview with an employee at the state nurse aide registry, it was determined that the facility failed to contact the registry before allowing newly hired nursing assistants to perform patient care. Findings include: On 8/7/01, five randomly selected employee records were reviewed for verification that the facility had contacted the state nurse aide registry on new nursing assistants. No documentation could be found in the records that this had been done. During an interview with the assistant director of nursing on 8/7/01, he stated he called on the Certified nursing assistants but was not aware that he was required to call on non-certified nursing assistants. The state nurse aide registry was contacted by phone and the registry employee stated that the facility had not contacted them on those five employees whose records were reviewed.	F 496		
F 502 SS=E	483.75(j) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview with facility staff and record review it was determined that the facility did not have in place a system to ensure that laboratory values ordered by physicians were completed. (Residents 22, 37, and 45.)	F 502	**Administration** A system is in place to ensure that laboratory values ordered by physicians are completed for all residents, including Resident 22, 37 and 45. All policies and systems have been reviewed and updated. A protocol for handling lab work has been developed and implemented, to assure that all ordered lab work is performed and that paperwork is not lost. It is located in the lab book, with the lab policy.	9/24/01

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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 502	Continued From Page 103 Findings include: 1. An interview was held with two facility nurses on 8/2/01. The nurses stated that if laboratory tests are ordered, the nurse that notes the order is responsible to make out the laboratory request slip and place it in the lab box on the desk at the north nurses station. The nurses stated that the information is also written on the resident's treatment sheet. Routine laboratory tests are printed on the treatment sheets every month. The nurses stated that there is no one assigned to make out the laboratory request slips. Usually the nurse working the night before the tests are due, will make out the request slips. If laboratory test results come into the facility while they were on shift they would call the results to the physician. They stated that there was not a particular procedure they were aware of to make sure that all the laboratory tests were completed and the results were called into the physicians. 2. Resident 45 was readmitted to the facility on 1/31/01 with diagnoses of insulin dependant diabetes mellitus, hepatitis C, end stage renal disease with dialysis, seizure disorder, hypertension, paranoid schizophrenia, asthma, and anemia. Resident 45's medical record was reviewed and was found to have a physician's order for a laboratory test, dated 5/7/01, for a stool for leukocytes, C-diff, O+P (ova and parasites), and occult blood. There was no documentation in the resident's chart that the laboratory tests had been performed, or that the physician had been notified of the laboratory results. 3. Resident 22 was admitted to the facility on 7/19/00 with diagnoses of diabetes mellitus, schizophrenia, and insomnia. The resident's medical record was reviewed and was found to have a physician's order for a laboratory test,	F 502	Nursing staff inserviced on the policies and protocols September 10, 2001. The medical records clerk audits the Record of Lab Draws and resident charts on a weekly basis to assure that all labs are drawn, the results are recorded, the physician has been notified, the lab sheets are signed, and the orders are in place. The monitoring conducted by the medical records clerk will be recorded and kept in a QA log, maintained by the administrator. Deficiencies will be immediately addressed, and the QA log reviewed and addressed on a quarterly basis by the QA committee. These practices will ensure that the values for residents 22, 37 and 45 are complete, accurate and followed, as well as for other residents. All resident charts have been audited to assure that all ordered labs have been completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 502	Continued From Page 104 dated 6/20/01 for a urine drug screen. There was also an order, dated 6/30/01, for a complete metabolic panel, hemoglobin A1c, and valproic acid level. There was no documentation in the resident's chart that these laboratory tests had been performed, or that the physician had been notified of the laboratory results. On 8/2/01, the DON and the medical records staff were asked for a copy of resident 45 and 22's laboratory results for these dates, but they stated they were unable to find them. The medical records staff then called the facility's laboratory service. The medical records staff stated the laboratory service had no record that these laboratory tests had been done. 4. Resident 37 was admitted to the facility on 03/13/97 with the diagnoses of seizure disorder, hypothyroidism, dyspnea, obsessive disorder, hypertension, and a vitamin deficiency. A review of the physician's re-certification orders dated June 2001, documented that resident 37 was prescribed phenobarbital (an anticonvulsant medication), since 3/13/97. The physician's re-certification orders dated June 2001 further documented that resident 37 was to have a phenobarbital level drawn by the facility's laboratory services, every March, June, September, and December. A review of laboratory results in the medical record revealed no documentation that resident 37 had a phenobarbital level done in March 2001. 5. Resident CR3 was a 49 year old female who admitted to the facility on 7/19/00 with diagnoses including chronic obstructive pulmonary disease, Hepatitis C, anxiety, alcohol dependency, and borderline personality disorder.	F 502		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 502	Continued From Page 105	F 502		

Nurses notes dated, 1/21/01 at 10:00 PM, and social service notes, dated 1/22/01, documented the resident had ingested an unknown quantity of alcohol on 1/22/01. A physician's order was obtained by the nurse for the resident's psychotropic and narcotic medications to be held until 3:00 PM, and for the facility's laboratory to draw a blood alcohol level. There was no blood alcohol laboratory result, dated on or near 1/22/01, found in resident CR3's medical record.

The DON was interviewed on 8/6/01. She said the facility did not have a copy of the laboratory result, but she would contact the laboratory for a copy.

On 8/7/01 a representative of the laboratory was in the facility and spoke with the surveyor. The representative stated he would look through all the records and find the results if a test had been requested or completed.

On 8/7/01 the DON stated she had heard back from the laboratory representative and that the laboratory had not received a request to draw a blood alcohol level on resident CR3.