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	465142	A. BUILDING _____ B. WING _____	08/08/2005

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

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F 167 SS=B	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 comments from facility staff on 8/03/05 , it was determined that the facility did not make the results of the most recent state survey and complaint investigations available for examination and posted in a place readily accessible to residents. Findings include: On August 3, 2005 at 2:00 PM, the staff at the North nursing station were asked to locate a copy of the previous survey results. Several of the nursing staff members sitting at the nursing station did not know what this surveyor was referring to; however, one of the social services staff and the dietary manager were standing at the station and both said "it used to be right here on the counter". These two staff members began looking through the various books located at the nursing station and found the information in a book labeled "State Survey Results". The staff were asked if they were aware that the results of the State survey had to be accessible to the residents without the residents requesting permission to review. The staff stated the reason the book had been relocated was because the	F 167	Public notices were posted at both nurses stations and at the administrative office indicating that the most recent rurvey results are available on the counter oif the North Nursing Station. The survey binder is made available to all without having to ask. It is kept at the North Nurse Station so as to be easily accessible to all, and still monitored by the nursing and office staff daily to ensure it stays available. The administrator reviewed the survey binder to ensure that it is up to date. The administrator will review weekly to ensure that the survey binder is in place and complete. The administrator shared this procedure with all staff in a General Staff meeting on 9/9/05. QA 9/24/05	10/15/05 7

Acceptable POC 9/20/05

Per phone conversation with Dorothy over Admin

Completion Date 10/7/05

Utah Department of Health
631923
SEP 15 2005
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: administrator | (X6) DATE: 09/15/05

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 167	Continued From page 1 residents had the tendency to pick up the book and take it to their rooms which meant other residents did not have access to the information. On August 4, 2005 at 2:00 PM the State Survey results book was still located in the same place as the previous day.	F 167		
F 224 SS=D	483.13(c)(1)(i) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (Use F224 for deficiencies concerning mistreatment, neglect or misappropriation of resident property.) This REQUIREMENT is not met as evidenced by: Based on record review and confidential interview, it was determined that the facility did not ensure that 1 additional sample resident with wandering behaviors was protected from leaving the facility without supervision. This could have resulted in harm to the resident. (Resident 15) Findings include: The facility policies and procedures for Elopement, Exit Door Alarm, Elopement Assessment and Prevention, and Facility Physical Environment Risk were reviewed on 8/9/05 and included the following: Policy: Elopement	F 224	An inservice training was held on 8/25/05 (see A) regarding Policy & Procedure on Care Plan for Elopement (see B), IDT Care Plan for Elopement (see C), IDT Care Plan for Wandering Behavior (see D), Elopement Risk Assessment (see E), State Guidelines regarding Elopement (see F), and Wind Chill Index (see G). All current residents have been re-assessed as of 9/2/05. DON (or designee) will report findings in QA. "Alert Charting" (see H) was instituted ensuring a system of at least 72 hours of nursing documentation after each incident involving resident #15, or other residents as designated. Findings are reported to the QA committee. Interdisciplinary Team (IDT) will ensure compliance by reporting in the daily "Standards of Care" meeting. Administrator will ensure compliance with Elopement Policy & Procedure in daily Department Head meeting, Weekly IDT meeting, and monthly review in Quality Assurance (QA) meeting.	10/5/05

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F 224	Continued From page 2 Elopement of a resident is defined as the leaving of a facility without the knowledge of staff, a resident who has impaired decision making ability, is oblivious to own safety needs, and those at risk for injury outside the confines of the facility. Pertinent excerpts from the policies and procedures review were: The facility Administrator is responsible for ensuring that effective policy and procedures are developed and consistently implemented to reduce the risk of elopement by residents. The facility will identify those residents who are at risk for elopement prior to or at the time of admission and throughout their stay. The facility will assess and develop a plan of care along with specific interventions for residents identified as being at risk for elopement. Elopement Risk Assessment will be done on admission and updated with the MDS (minimum data set) [significant change, quarterly and annual reviews] and reviewed by the interdisciplinary team. Nursing personnel must report and investigate all reports of resident elopement. It is the responsibility of all personnel to report to the Charge nurse as soon as possible any resident leaving the premises, or suspected of being missing... Purpose 1. To reduce the risk of elopement. 2. To maintain a safe environment for residents with impaired decision-making ability, oblivious to	F 224		

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F 224	Continued From page 3 own safety. 3. To reduce risk for injury outside the confines of the facility... Missing Residents: ... 2. Employee observes a resident is unaccounted for or missing, he or she should: a. The Charge nurse shall be notified immediately ... b. The Charge nurse will alert all available staff to initiate a facility search..and identify where the resident was last seen and the time. c. The Charge nurse will coordinate all search efforts ... 4. Notification of Authorities: b. If the resident is not found within 60 minutes the Search Coordinator will notify local authorities... to participate in the search. c. The Charge nurse will notify the legal representative or family of the resident within 60 minutes... f. The Administrator/Director of Nursing is responsible for determining whether the elopement occurred as a result of neglect and reporting the incident to the Utah Department of Health... 5. Missing Resident Return Procedure: a. Upon return of resident a total body assessment shall be completed (head to toe, vital signs, temperature, and skin condition)... b. Notify the following upon return... - Administrator/Director of Nursing will notify the Utah Department of Health ... ...d. Charge nurse shall chart all pertinent information in the resident's Medical Record. Include the following:	F 224		

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F 224	Continued From page 4 Follow-up charting every shift (including behavior problems) for 48 hours. The Director of Nursing will conduct a complete investigation of the incident and implement corrective action. e. Interdisciplinary Care Plan will reassess the resident, problem addressed on the overall Plan of care and revised as necessary. 8. Incident report: An incident report shall be completed and referred to the Safety Committee for review and recommendations. Documentation the Department of Health ... was notified and name of person spoke to will be placed on the incident report. 9. Documentation Guidelines: All pertinent details of search and notification of authorities, physician, Department of Health..., and resident's representative shall be documented in the Medical Record... Elopement problem discussed in a specially scheduled Interdisciplinary Care Plan meeting Exit Door Alarms Policy: This facility maintains a Code Alert alarm system on all exit doors. Purpose: 1. To provide a safe environment for residents 2. To prevent the risk of resident elopement Procedure: 1. Door Alarm System: The facility indicated by	F 224		

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F 224	Continued From page 5 an "X", that two systems were in use and those were a Code Alert and Wander Guard. Elopement Assessment and Prevention Policy: Resident (sic) who are wander/elopement risks should be identified prior to or at the time of admission. Identified wander/elopement risk residents shall be observed and supervised to minimize their risk wandering away from the facility. Purpose: To provide procedures for an assessment, documentation, observation and supervision of residents at risk for wondering (sic) away from the facility. To provide a safe environment for residents. Procedure: Prior to or at the time of admission and quarterly thereafter a resident will be evaluated for wondering (sic) behavior. 1. Prior history of wandering... 2. Indicate whether the resident has impaired decision making and/or impaired cognition and the ability to be mobile... 3. Plan of Care should be developed on the day of admission and quarterly, more often if necessary, of a resident with a known history of wandering 4. C.N.A.'s (certified nursing assistants) shall identify Residents who wander at start of their shift	F 224		

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F 224	Continued From page 6 5. Residents who develop wandering behavior after admission to the facility should be reassessed and appropriate interventions included in the plan of care within seven (7) days of identification of behaviors, which include wandering. 6. Plan of care interventions should address resident's specific behavioral patterns... 12. Residents shall be assess (sic) upon admission and quarterly thereafter for wondering (sic) behavior. Facility Physical Environment Risk This facility described their assessment of risk is High Risk due to the location of: Facility sits along 33rd south, which is a very busy main traffic area. Speed limit is 35 miles per hour. Residents like to walk to the local 7-11 and Albertson's which requires crossing a busy traffic area. Resident 15: Resident 15 was admitted to the facility 3/14/05 with the diagnoses of Brain injury, Hyperthyroidism, Other conditions of the brain, Myoclonus, Mixed drug abuse, Depressive Type Psychosis. Resident 15's medical record was reviewed 8/2/05. The admission assessment completed 3/7/05 by a facility nurse, revealed that resident 15's cognitive status was severely impaired with cognitive defects. Resident 15 exhibited altered perceptions of awareness of surroundings, had periods of restlessness and exhibited wandering	F 224		

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F 224	Continued From page 7 behaviors on a daily basis. On 8/01/05 at 3:20 PM, during an interview with a facility CNA. This surveyor asked, as part of the environmental review, what the CNA would do in case a resident had wandered away from the facility. The CNA was able to site appropriate measures for conducting a search. The CNA was asked at this time if there were any residents who had wandered away from the facility recently. She stated "yes, last week [resident 15] crawled over the fence and we caught him and brought him back". She stated the police were called to assist with getting resident 15 down from the fence. Review of the facility incident reports was completed on 8/3/05, and it was noted there were three (3) incident reports filed for resident 15. Two of the reports were related to elopement and one was for attempted elopement. 1. 5/02/05 "at 1200 (12:00 PM) it was noted [Resident 15] was not in the building. Refer to elopement form. Admin (administrator), ADON (assistant director of nursing), sheriff, family notified. Returned at 2230 (10:30 PM) by sheriff - sunburned face, amb (ambulatory), tired, alert, helmet on." Based on information provided in this report, resident 15 was missing from the facility for ten and one half hours (10 1/2) from noon until 10:30 PM. 2. 7/03/05 at 1700 (5:00 PM) "resident [resident 15] had stated several times during the day wanted to get out. @ (at) approximately 1700 (5:00 PM) [resident 15] went to locked doors in	F 224		

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attempts to leave and began shaking the door vigorously when this failed to release the doors [resident 15] backed up and began kicking the door at level of handle. CNA put himself between pt. (patient/resident 15) and doors. Resident became more upset stated would break the glass so it would cut him and he could sue this place".

3. Resident 15 "left facility @ 1500 (3:00 PM) on 7/16/05. Unknown how he did we found him @ 700 South 3900 East [9 blocks from facility]. After much investigation I found back gate fence open where any one can go and come as please (sic)". Maintenance "called at 10:30 (10:30 AM) on 07/17/05, no response. Administrator notified. Borrowed $40.00 to pay for chain and lock, three slurpies and gas for CNA buying items. The slurpies are to celebrate been (sic) alive". Incident report had a comment "No injuries, thanks (sic) God!"

Review of resident 15's medical record for 5/2/05 revealed the following documentation. Around noon the nurse was looking for resident 15 for a medication pass. The nurse could not find the resident and instructed two (2) CNA's to look for resident 15. A search of the facility and grounds were conducted. During the search a food supply truck was at the facility and the delivery driver had apparently left the gate opened to deliver the supplies. Further documentation revealed that the facility staff had attempted to notify family that resident 15 was missing. The ADON searched the food truck but resident 15 was not there so a call was placed to the local Sheriff's department. No other documentation was noted on 5/2/05.

On 5/3/05 a nurse's note from 6:00 AM to 6:00 PM stated resident 15 was in the facility, no

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injuries noted, and that resident had no complaints and was cooperative. Nurse documented will continue to monitor.

On 5/3/05 at 2200 (10:00 PM), it was documented in the nurse's notes that resident 15's former wife had called and wanted to explore the use of Ativan to control resident 15's behavior of, "increased agitation and anxiety with multiple intentions of AWOL (absent without leave)."

On 5/4/05 at 8:55 AM, a nurse's note was documented as a late entry stating resident 15 returned from a local hospital where resident 15 was located at 2230 (10:30 PM). Resident 15 was noted to have "sunburn on his face and the back of his neck" but denied any discomfort.

On 6/20/05, the Social Services consultant documented a note for the quarterly review which indicated resident 15 had short and long term memory problems, indications of delirium, short attention span, disorganized speech, paces up and down halls, in and out of other resident's rooms and resident 15's mood was not easily altered. Further documentation stated behavioral symptoms included "wandering daily with no redirection for first of 1-2 attempts".

A behavior tracking sheet dated 7/28/05, documented resident 15 tried to escape outside from the dining area. The notes stated "he was hanging out from the fence and try to lift his body go from this high. While the 911 coming to help him don't fall we tied him with sheets to the fence and the new nurse was helping us while the aid was calling inside. 911 came and help us to get him down "(written as documented on behavior tracking sheet). An incident report could not be

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F 224	Continued From page 10 located for this attempt at elopement. An interview with a facility CNA was conducted on 8/03/05 at 8:45 AM. The facility CNA was asked if there were any residents who had been identified who required frequent checks. The facility CNA gave the names of five (5) residents that were to be checked every 15 minutes. Resident 15 was included in the list for 15 minute checks. A confidential interview was conducted on 8/3/05 at 2:00 PM regarding resident 15. It was stated that resident 15 had been in a couple of other facilities and had been "kicked out" because the other facilities could not handle him due to his history of falls and behaviors. It was further stated that a couple of months ago resident 15 had eloped from the facility and was gone for seven (7) hours and that resident 15 had gone back to his old neighborhood. Resident 15 had been recognized by a former neighbor who had notified the police and the police had picked up resident 15 and taken him to a hospital. It was stated the facility had notified the family about the incident but that last week he had been caught trying to escape over the fence. There was no evidence that the facility had put any interventions in place such as a personal body alarm or a wander guard to try and track resident 15. It was stated that the facility did not do enough to assure resident 15 did not wander. The interviewee stated that resident 15 had some real behavior problems but that the facility could do more to address resident 15's behaviors to keep him safe. Resident 15 was identified upon admission and	F 224		

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F 224	Continued From page 11 additional MS assessments as a daily wander risk. Only two care plans could be found on resident 15. Both care plans were identified as being copied on 4/14/05 at 3:53 PM and 3:55 PM respectively. The care plans addressed Alteration in Thought Processes and Impaired Social Interaction related to resident 15's traumatic brain injury. Neither of the care plans addressed the wandering behaviors or addressed any interventions to be put in place which would keep resident 15 safe because of the specific behavior of wandering. No additional documentation was found to indicate resident 15 was under observation every 15 minutes. The facility identified resident 15 as a high risk for elopement on two MS assessments, one on 3/27/05 and again 6/20/05. Resident 15 had several episodes in which wandering behaviors had been exhibited with elopement from the facility. The facility had policies and procedures in place to address assessment and plan of care for elopement, development of specific interventions, and interdisciplinary care plan to reassess the resident and revise the plan of care as necessary. There was no evidence of a care plan or interdisciplinary team meeting to demonstrate that the facility assured resident 15 would be safe from his elopement behaviors. Based on interviews conducted with CAN's, resident 15 was known to be an elopement risk and was on their list for 15 minute checks. Nursing and social services had documented resident 15 had wandering behaviors. No	F 224		

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F 224	Continued From page 12 interventions had been put in place to prevent resident 15 from continuing to try to elope. Documentation from nursing, after resident 15 returned from elopement, showed vital signs were taken and resident 15 was noted to have been sun burned. Facility policy specified documentation was to include a "head to toe assessment" which was not documented as being done. A call was placed to the Department of Health to inquire if the facility had reported any elopement activities on resident 15. Review of the State Agency entity report log on 8/3/05, revealed the facility had not reported resident 15's elopements from the facility on 5/2/05, 7/3/05, 7/16/05, and 7/28/05.	F 224		10/15/05
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 observations, confidential resident interviews, and record review, it was determined the facility did not promote care to maintain or enhance each resident's dignity and respect. Specifically, call lights were not answered timely, staff conversed among themselves in Spanish while providing cares to residents who spoke only English, and residents were not provided privacy during cares. This has the potential to affect all residents.	F 241	An inservice was held on 8/25/05 (see A) regarding, among other topics, Call Lights. Protocol was reviewed. A goal/guideline of 3 minutes max west set for call light response time. It was further reiterated that any member of staff can initially answer call lights to assess needs and respond appropriately. Nursing Administration and Administrator will monitor daily. Findings are reviewed and evaluated in QA.	

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F 241	Continued From page 13 Findings included: On 8/4/05 at 9:21 AM, a call light was observed to be on above the door of room 110. A corresponding alarm was heard to be audible from the halls and nurses' station on the main floor of the facility. At 9:26 AM, someone announced overhead that the nursing assistants should answer the call lights. At 9:29 AM, after 8 minutes of continuous observation, the call light was turned off by a nursing assistant who was observed to enter room 110. On 8/2/05 at 9:00 AM, a confidential interview was conducted with 7 alert and oriented residents. The residents, who required staff assistance to complete some of their activities of daily living, stated they had to wait too long for their call lights to be answered. The residents stated the most troublesome times were during the mornings, at meal times, and at change of shifts. The residents stated they were uncomfortable with Spanish speaking staff conversing among themselves in the facility. The residents stated they knew the staff were talking about the residents and making rude comments about the residents in Spanish. On 8/2/05 at 8:30 AM, Resident Council minutes were reviewed. The minutes revealed residents had communicated their concerns, in June 2005, regarding staff being slow to answer resident call lights. In addition, the residents had communicated their concerns, in June and July 2005, regarding staff	F 241		

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F 241	Continued From page 14 conversing among themselves in Spanish while they were in the presence of residents and while they were providing cares for the residents. It was not noted that any staff or facility representative had accepted responsibility to resolve the issue. On August 2, 2005 at 9:00 AM, while standing at the North nursing station conducting chart review and monitoring call lights, a call bell was activated. The audible sound and tone continued until 9:15 AM at which time it stopped ringing. This was a total of fifteen (15) minutes. On 8/3/05 an observation was made that a call light was activated at 4:15 PM. At 4:22 PM, a resident from room 208 was seen exiting the room and yelling " I need your help in here now, he's standing here naked...." A CNA approached the resident, and the resident was pulled into the room. Upon entering the room the CNA was told by the resident that the roommate needed a brief in order to have his cares performed. The CNA then exited the room and returned at 4:26 PM along with another CNA to attend to the roommate.	F 241		
F 250 SS=D	483.15(g) SOCIAL SERVICES The facility must provide medically-related social services 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 observation, interviews and medical records review, it was determined that the facility	F 250	An inservice was held on 8/25/05 regarding, among other topics, Suicidal Tendencies Policies & Procedures. (See A) Care Plans were reassessed for those residents with suicidal tendencies. Crisis Hotline contact numbers are now posted at nursing stations. This information was reviewed also in the inservice.	

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F 250	Continued From page 15 did not ensure medically-related social services were provided, through the assessment and care planning process, to maintain the highest practicable physical, mental and psychosocial well-being for 2 of 14 sampled residents. Specifically, the facility did not assess and document the resident's behavior in the detail required to either plan for the resident's care or manage their behaviors. Residents 5 and 7. Findings include: Resident 5's medical record was reviewed on 8/2/05. Resident 5 was admitted to the facility January 2, 2004 with the diagnoses of Anoxic Brain Damage, Bipolar Disorder, seizures, substance abuse, Attention Hyperactive Deficit Disorder, and failed attempts of suicide. Resident 5 had a history of depression with three previous attempts of suicide with an overdose of medications and two attempts at hanging himself. H first attempt at hanging occurred in 2003 which resulted in anoxic brain injury and one month after admission to the facility resident 5 was found with a sheet wrapped around h neck. Resident 5 was subsequently sent to a local hospital with a psychiatric department where he was evaluated over a period of several days. His treatment plan consisted of continuing his Depakote for seizures and consideration of placing him on Wellbutrin and possibly Lithium because of its abilities to help reduce suicidality (sic). During the psychiatric evaluation the physician documented that resident 5 had threatened suicide over a period of time, most of them attention seeking; however, "this time he had to be taken seriously". Resident 5 improved and was transferred back to	F 250	At daily Standards of Care (SOC) meeting with IDT members, there is now a review of behaviors, concerns and incidents, with minutes taken as to the person responsible for follow-up. Results & findings are reported at next day's SOC meeting to ensure follow up is occurring. Pharmacist consultant met with Nursing Administration and Administrator. Reviewed, evaluated and planned regarding drug reviews and recommendations for labs. Nurses were inserviced on 8/28/05 regarding Med Pass Protocol. (see I & J) Policy on disposable straight-edged razors reviewed. CNA will check out a disposable shaver for each requesting resident, observe the resident shaving, and then retrieve razor for disposal by CNA. Results of inservice to CNAs & Nurses were evaluated and are on the agenda for next QA on 9/29/05. SSW consultant brought in to evaluate residents #5 #7 for psycho-social interaction and appropriate Care Plan. We will continue to monitor the effectiveness of our interventions at the daily Standards of Care meeting.	10/5/05

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F 250	Continued From page 16 the long term care facility. Resident 5's current medications were: Depakote Sprinkles 125 mg (milligram) capsules, eight (8) capsules per day Trileptal 150 mg tabs (tablets), three (3) tabs BID (twice a day) Wellbutrin SR (sustained release) 150 mg BID Zyprexa 15 mg, one (1) tab qhs (every night at bedtime) Haldol 2 mg tabs one (1) PRN (as needed) Trazodone 50 mg, one (1) PRN Resident 5's 2/24/05 and 5/19/05 MDS (minimum data set for resident assessment) for cognitive/decision making was assessed as "3" meaning Resident 5 was severely impaired. Resident 5's assessment also indicated he had wandering behaviors and was socially inappropriate. Resident Assessment Protocol's (RAP'S) triggered for cognitive loss, communication, ADL (activities for daily living), rehabilitation, psychosocial mood state, behaviors, falls, dehydration and psychotropic drugs. Resident 5 was also assessed as a high risk for elopement. Behaviors: Nursing/Social Service documentation Documentation in Nurse's notes revealed that resident 5 continued to express thoughts of suicide and to exhibit behaviors of stealing from other residents throughout March and April of 2004. 3/13/05 Nurse's notes revealed that resident 5 was involved in a sexually inappropriate behavior	F 250		

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F 250	Continued From page 17 with another resident. 3/21/05 Social Services notes revealed that resident 5 was involved in an incident with another resident involving sexually inappropriate behaviors. Resident 5 was interviewed and had no recall of the incident. 4/5/05 Nurse's notes revealed suspicious activity between resident 5 and a visitor. A CNA reported that resident 5 and his visitor were locked in the shower room together. Nurse's notes indicated "will continue to monitor activities". Adult protective services were notified. Interviews with CNA's indicate that resident 5 was no longer to be left alone with visitors. 4/6/05 Social Services notes revealed they had received reports that suspicious activity was occurring between resident 5 and a visitor. Social Services documented resident 5 was approached twice regarding the alleged behavior and resident 5 denied and/or did not recall incident. Social Services documented Adult Protective Services (APS) would be notified. On 4/7/05, Social Services documented a recommendation to send resident 5 to a local hospital to be evaluated for evidence of possible sexual abuse. Resident 5 was sent to a local hospital and findings were documented by a physician as negative. 4/8/05 Nurse's notes indicated another episode where a visitor and resident 5 were witnessed by staff to display inappropriate sexual behavior. 4/9/05 Nurse's notes documented resident 5's roommate requested a room change because of resident 5's inappropriate sexual behavior.	F 250		

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F 250	Continued From page 18 During active chart review on 8/2/05, an entry was noted in the Behavior Complex Program documentation log. On 7/6/05 the Social Services assistant had documented a note stating that resident 5 was in the dining room during breakfast and was seen putting a butter knife down his throat. He was asked three times to stop and continued to put it down his throat. He finally threw the knife down and when asked why, he had indicated that he didn't do that and said why would he do that. The note stated that nursing and the social worker were notified and that resident 5 was to get only a fork and spoon and was to be monitored closely at meal times. On 7/11/05 the Social Services assistant documented that resident 5 was caught with a lighter in th room. When the CNA walked in and asked what he was doing, resident 5 replied that the was trying to start a fire. On 8/2/05 at 11:00 AM, the Social Services consultant was at the facility and was asked if he was aware of incidents with a butter knife and cigarette lighter for resident 5. The Social Services consultant stated, "No", and that he had not been in the facility during the month of July. He stated that if he had been called specifically to check on resident 5 he would have responded. He was asked if he knew of any evaluations on resident 5 and he stated evaluations were in the medical record. He was informed that none could be found and he stated he would fax an annual evaluation to the Department of Health. On 8/2/05 at 12:20 PM, an interview was conducted with the Social Services assistant who	F 250		

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F 250	Continued From page 19	F 250		

had documented the "knife and lighter" incidents. She stated that the CNA's had given her the information and it was her responsibility to follow up with resident 5 to determine what type of action would be necessary for resident 5. She stated she did not feel it was an attempt to do any harm and did not feel that either incident was a problem. She stated that resident 5 did not have the knife down his throat; he was just putting it in his mouth and taking it out. When asked if resident 5 had a psychiatric consult or a change in his medications she stated she did not know about any psychiatric consults or any change of medications to control behavior. She stated that resident 5 "just needs to be redirected". She stated that resident 5 had been placed with the restorative aides to monitor his behaviors during meals. The Social Services assistant was asked what her credentials were for evaluating residents and she replied she had worked as a CNA for over 10 years and had let her certification lapse so she was working to assist the social worker with the residents. Her responsibilities were to review the behavior log book and follow up with residents. If there were problems she reported to nursing and always talked with the Social Services director. She stated she had suggested possible 15 minute checks to supervise resident 5 more closely.

On 8/2/05 at 1:05 PM, the ADON (assistant director of nursing) was interviewed regarding the incidents with the knife and the lighter. The ADON stated she was aware of the knife incident but this was the first she had heard about the lighter. She stated that this would cause her a great deal of concern because the risk of fire something that would always cause her concern. She was asked if resident 5 was on 15 minute

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F 250	Continued From page 20 checks. She stated that she had not been made aware of the problem and to her knowledge, he was not on 15 minute checks. The ADON stated that resident 5 was supervised for his smoke breaks. On 8/2/05 at 1:15 PM, the lead CNA was interviewed specifically regarding resident 5 and the instances involving the visitor and the instances around the knife and the lighter. She stated she knew about the instances and resident 5 was under increased supervision during visits from outside visitors, but was not aware of resident being on 15 minute checks. The lead CNA stated that she was not aware that the Social Services assistant had recommended the 15 minute checks. On 8/2/05 at 1:25 PM, the Social Services director was interviewed regarding the incidents with resident 5 and the knife and lighter. The Social Services director had the Behavior Tracking book in her office and turned to the pages and read them aloud. Documentation from the Behavior Tracking book revealed the following regarding resident 5: 7/6/05 " [resident 5] was down eating breakfast. He took his butter knife into his mouth and down into his throat leaving approximately 2 (two) inches of the handle hanging out... I asked him to give me the knife and he ignored my requests 3 x's (three times). I demanded the knife and [resident 5] threw it. I spoke with [ADON, SSW and RN charge nurse]. [RN charge nurse] was asked to get Dr.(doctor) orders to have plastic utensils used during meal times. No metal utensils." A note was observed in the margin written by the Social Services assistant which	F 250		

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F 250	Continued From page 21 states " not to get a knife, only fork and spoon". 7/12/05 "I walked in to give him [resident 5] snack and he was playing with a lighter. I asked him what he was doing he told me trying to start a fire". The Social Services director was asked if she knew if the information regarding increased supervision, i.e. every 15 minutes, had been communicated to nursing. She stated the chain of command was to discuss the behaviors with the ADON and lead CNA and it was up to nursing how they wanted to implement measures. She stated she was not aware that the ADON and lead CNA were not aware of the recommendation for increased monitoring. She was asked if she felt resident 5 was a risk for suicide based on his previous history of multiple attempts. She stated she did not feel either of these incidents were significant. She stated that the team had talked about using plastic utensils for resident 5, but felt the same dangers were present as with the metal ones. She stated they decided to just take his knife away. She stated as far as the lighter incident was concerned, she felt that all teenagers at some time try to start fires and that resident 5 would not have started a fire. She said that from time to time a resident will acquire cigarette lighters and pass them out to other residents so the CNA's were always checking the rooms to confiscate lighters. She also stated that resident 5 seemed to exhibit behaviors around the times he had outside visitors. On 8/3/05 at 8:45 AM, a facility CNA was interviewed to determine the names of residents who were being monitored every 15 minutes. The CNA stated resident 5 was not on the list and	F 250		

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F 250	Continued From page 22 the CNA was unaware that resident 5 needed increased monitoring. On 8/3/05 at 9:55 AM, the CNA in charge of the restorative program was interviewed regarding resident 5 being monitored in the dining room by the restorative aides. She stated that resident 5 was not being observed by restorative aides. Resident 5 was observed in the dining room on 8/2/05 for breakfast and 8/3/05 at lunch and was not observed to be eating with a restorative aide. Behavior tracking documentation: 2004/2005 Stealing 8/9/04-Food off trays 8/15-Unknown item another resident room 8/21-Cigarettes from another resident 8/21-Crackers from another resident 9/15-Yelling demanding food from another resident's tray 9/16-Money from another resident 9/21-Soda from nursing station 10/2-Cigarettes from another resident 10/6-Soda from another resident 10/7-Batteries from Blood pressure machine 11/1-Fruit punch from recreational office 11/1-Another resident's electronic game 11/8-Another resident's DVD player 11/10-Soda from another resident 11/15-Cigarettes from another resident 11/17-Soda from nursing station 11/17-Cigarettes from another resident 11/18-Cigarettes from another resident twice this day 11/26-Cigarettes from another resident 11/26-Soda from South nursing station	F 250		

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F 250	Continued From page 23 11/26-Soda from North nursing station 11/26-Soda from another resident (13 epodes of stealing in November) 12/5-Root beer from resident's lap 24 epodes of stealing documented for 2004 1/10/05-Food 1/23-Soda and food (2 separate epodes) 5/17-Candy 6/13-Soda 7/17-Item off med cart 8/6-Video game (7 epodes of stealing to present) Fighting 2/28/05-Picking on another resident 5/8-Struck in head with tape recorder by another resident Harmful Behavior 9/21/04-Smoking in room/had a lighter 10/20-Climbing out window in room 11/2-"Got outside" 11/8-Hanging around door attempting to leave 6/2/05-Tried burning hand with cigarette on smoke break 7/6-Placed a butter knife down h throat 7/12-Playing with a lighter in h room Other behaviors 12/6/04-Urinating on the patio 12/13-Urinating on the patio 3/13/05-Inappropriate sexual behavior with another resident 4/5-Suspicious behavior (locked in shower room) with visitor 4/8-Suspicious behavior with visitor	F 250		

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F 250	Continued From page 24 The last IDT meeting found in the medical record was dated 2/24/05. Based on the documentation, the IDT meeting covered residents 5's compliance with medications, coordination and sleep patterns. There was no mention of increased or decreased behaviors, and no interventions mentioned regarding behaviors. Social Services documented no changes. Resident 5 had two psychotropic drug reports. One began in January and ended in August; however, this report was not dated and was not signed by the DON (director of nursing), team leader or attending physician. The second report began in March and was signed by DON, team leader and attending physician; however, there was no date to indicate when the review was conducted. The behaviors being tracked were "anxious, verbally abusive, number of hour slept, suicidal ideation, and self abuse". The psychotropic drug review was dated 3/12/04 as the last adjustment for use of Trazodone. It was signed by the attending physician on 3/2/05. An interview was conducted with a facility RN on 8/4/05 at 2:00 PM regarding resident 5's Trazodone. The facility RN was asked how often resident 5 used the PRN dose of Trazodone. She stated that resident 5 did not take the Trazodone. The last documented use of Trazodone was November of 2004 and a total of 22 PRN's were documented. According to a pharmacy note of April 2005, there was a recommendation that resident 5 try a reduction of the Zyprexa to 10 mg. A discharge care plan dated 5/2/05 was also reviewed and current behaviors were listed as sexually inappropriate, elopement risk, stealing,	F 250		

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F 250	Continued From page 25 seeking money for cigarettes, confusion and forgetfulness and the level required for discharge was none or decrease in all behavioral areas and the feasibility of attaining the level was listed as poor. Functionally, resident 5, was currently listed as having no suicidal ideation or attempts at suicide and the level required for discharge was that there would be no talk of attempting suicide and the feasibility of attaining the level for discharge was listed as poor. Physician documentation dated 3/2/05 indicated that resident 5 was presently stable in behavior and regarding suicide attempts. The plan was to continue to monitor and continue with current care plan and follow up as necessary. Resident 5's current behavioral care plan dated 5/12/05 listed AWOL risk, inappropriate sexual behaviors, stealing, seeking cigarettes, and repetitive questioning. Triggers for the behaviors were listed as diagnoses (Anoxic Brain damage), boredom (denial of cigarettes), sexual inappropriateness, no money (family sends limited amount), confused, forgetful, still believes he is a teenager-following with "teen appropriate" behaviors. The plan of action/interventions were listed as: redirect, contact family regarding cigarettes and money, fight guardianship, re-orient times 3, stimulate thinking process. Outcomes were to be none or decreased epodes of AWOL, none or decreased epodes of sexual inappropriate behavior, no epodes of stealing/cigarette seeking, and decreased questioning. On 8/8/05 at 12:30 PM, a telephone call was	F 250		

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F 250	Continued From page 26 made to the Consultant Clinical Social Worker. He was asked if he felt resident 5 needed any interventions because of increasing behaviors of stealing, sexual inappropriateness or possible attempts at self harm. He stated he knew about the alleged inappropriateness of resident 5's visitors, but resident 5 was an adult with the ability to say no and if the facility felt resident 5 needed him to intervene with therapy he would be more than happy to supply that service. The Consultant Clinical Social Worker stated no one at the facility had indicated a need for intervention for resident 5. On 8/8/05 at 1:30 PM, the facility Social worker was interviewed for a second time regarding resident 5. She was asked to describe what the facility does to monitor resident's who have had multiple attempts at suicide and had escalating behaviors that might indicate those behaviors were not under control. She stated that those individuals who have psychiatric diagnose could be referred to a local mental health professional, but for those residents who have an organic problem there have been no services available to the facility in the State of Utah. She stated the facility would observe the residents and redirect them to try to reduce the behaviors. The residents could also have a one to one and she had an assistant who would visit with the residents and try to determine the resident's needs. It was explained to the Social worker that there was a specific concern for resident 5 regarding previous attempts at suicide. Resident 5 had been sent to the psychiatric division of a local hospital in February of 2004, and that was the last time resident 5 had been exposed to mental	F 250		

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F 250	Continued From page 27 health care by a professional. It was explained to her the concern was, since resident 5's admission to the facility, he had made multiple threats and, until the actual attempt was made, his behaviors were thought to be attention seeking. It was explained that resident 5 had several behaviors recently that could be viewed as attempts to harm himself. Specifically the episode of burning his hand with a cigarette, the knife episode and the latest episode with the lighter in his room. The Social Services director was asked if she was responsible to evaluate resident 5 and make recommendations to have resident 5 followed up with a mental health evaluation. She stated she could make recommendations but it was up to nursing to monitor the resident and to call the physician to see if resident 5 would benefit from an adjustment of his medications or to be seen by a mental health professional. It was explained to her the concern was that no evidence could be found that resident 5 has had any kind of follow up since 2004. It was also explained to her that there no evidence of any psychotropic drug blood levels to determine if resident 5's medication regime was therapeutic. There was no indication in the medical record to determine if resident 5 was stable and in view of his behaviors around stealing, inappropriate sexual encounters and areas of self abuse that there was a concern for his well being. She stated that she could call a local mental health professional and see if they could take resident 5 to evaluate. Resident 7 was admitted to the facility July 2004 with diagnoses that included diabetes, seizure disorder, depression, and history of alcohol	F 250		

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F 250	Continued From page 28 abuse. A lead CNA was interviewed on 9/2/05 at 12:57 PM. The lead CNA stated that, on 6/1/05, resident 7 had been lethargic and the nurse had called her to double check the resident's vital signs. The lead CNA stated she entered resident 7's room and "found him drinking from a lotion bottle." The lead CNA stated she took the bottle, saw that it contained a number of pills, including 25-30 Trazodone. The lead CNA stated she had seen a lot of Trazodone and could recognize it easily. Trazodone had been one of resident 7's routine medications. The lead CNA stated that other medications, such as over-the-counter sleeping medications, had been found in resident 7's room in a subsequent search. A nurse's note, dated 6/1/05 at 10:45 AM revealed resident 7 was drinking from a bottle which was found to contain more than 25 pills of six different types. A Resident Transfer Form, documented by a facility nurse on 6/1/05, revealed resident 7 was transferred from the facility to a hospital emergency room. The nurse had documented that a CNA had entered resident 7's room at 10:15 AM on 6/1/05. The nurse documented that the CNA, "saw (resident 7) trying to drink out of lotion bottle, took it away (and) noticed it was filled (with) pills." The nurse documented the resident's room was checked and more pills were found. The nurse documented that seven different medications had been found. The nurse documented that the physician ordered resident 7 to be transported to the hospital. On 7/4/05, nursing staff's documentation on a	F 250		

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F 250	Continued From page 29 Behavioral Tacking Sheet for all residents revealed that resident 7 had asked for a razor. The resident was told he would have to ask his CNA. It was documented that resident 7 stated, "I want to cut my (expletive deleted) throat I will I have razors in my room." On 7/4/05, the Social Services assistant documented that resident 7 stated he was going to cut his throat and that the resident was sent to the hospital for suicide evaluation. There was only nurse's note, dated 7/4/05, in resident 7's medical record. The nurse's note, documented as having been written between 10:00 PM and 6:00 AM, revealed the resident made verbal sexual advances to a nursing assistant. There was no mention of the razor incident or that resident 7 had been transferred to the hospital. Resident 7's physician's Progress Notes, dated 7/13/05, revealed the resident "Took a handful of tablets he had been hoarding in an apparent suicide attempt - Depressed due to med (medical) condition." The physician documented the resident had been to the emergency room because of a change of level of consciousness and that Dilantin toxicity had been a problem. The physician documented, "Also was threatening suicide, started Zoloft." The physician's Progress Notes for resident 7, dated 7/20/05, revealed the resident "hordes meds, then tries to take as overdose." Resident 7's Physician's Orders revealed orders, dated 9/9/04, for the resident to receive the antidepressants Trazodone 100 mg (milligrams)	F 250		

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F 250	Continued From page 30	F 250		

each evening at bedtime for insomnia, and Lexapro 20 mg daily for situational depression. An order to discontinue resident 7's Trazodone was documented, 6/11/05, on the resident's referral form when he returned from the hospital.

The Nursing 2005 Drug Handbook, Lippincott Williams and Wilkins, page 470, cautions that residents who take Trazodone , an antidepressant, should be monitored for suicidal tendencies. Nurses should monitor the resident for mood changes and allow only a minimum supply of the drug. In addition, caregivers should be instructed how to recognize signs and symptoms of suicidal tendencies or suicidal thoughts. On page 455, it revealed that Lexapro, an antidepressant used to treat major depressive disorders, should be used cautiously in patients with a history of seizure disorders and suicidal ideations. It cautioned that residents at high risk for suicide should be monitored closely. Residents taking Lexapro should be evaluated for history of drug abuse and observed for signs of misuse or abuse of the medication.

The facility Social Services director was interviewed on 8/2/05 at 2:09 PM. The Social Services director stated that she was on vacation at the time of resident 7's first alleged suicide attempt and that she knew nothing about it.

After returning from vacation, the Social Services director did not document any action taken regarding the incident. The Social Services director documented a Progress Note, dated 6/13/05, that resident 7 had returned from the hospital and had no problems. The Social Services director documented a Progress Note,

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F 250	Continued From page 31 dated 6/17/05, that resident 7 was becoming verbally abusive with other residents and that staff were keeping an eye on him to deter potential conflicts with others. In a fourteen day review, dated 6/24/05, the Social Services director documented the resident 7 was being monitored by staff in his room due to his recent overdose and that he was seen as a significant change due to decreased socialization and increased behaviors such as verbal aggression. The Social Services director did not document anything regarding the statements resident 7 made on 7/4/05 about cutting his own throat. The next Social Service Progress notes, dated 7/19/05, revealed resident 7 was "arguing about a transfer" to another facility in another location. The other facility had refused the transfer because of resident 7's attempted overdose. The Social Services director was interviewed on 8/3/05 at 8:45 AM. The Social Services director stated she talked with resident 7 regarding updating his medical treatment plan. The Social Services director stated, "He still wanted to be full code, even though we explained suicide attempts and full code are like oil and vinegar. They don't mix." A nurse documented the conversation took place on 7/21/05. The Licensed Clinical Social Worker (LCSW) was interviewed by two surveyors on 8/2/05 at 11:00 AM. The LCSW stated he had not been in the facility during July 2005. In addition, the LCSW stated he had not been made aware of resident 7's suicide attempt by overdose (OD) in June 2005 or the resident's suicide threat in July 2005. The LCSW stated that he would have come to see the resident if he had been called by the facility.	F 250		

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F 250	Continued From page 32 Resident 7's History and Physical, dated 4/8/04, revealed, "There apparently have been suicide attempts in the past.". Resident 7's Psychosocial Assessment, dated 4/30/04, revealed the resident "denies depression or any suicide ideation recently. Affect is flat. He has had both in the remote past. He is also a recovering alcoholic." The assessment revealed resident 7 should be observed for signs and symptoms of depression or suicide ideation. Resident 7's Psychosocial Assessment, dated 8/3/04 by the LCSW, revealed the resident was pleasant and cooperative, tended to self-isolate, had problems with depression and anxiety, and had problems adjusting to being placed in a care facility. Resident 7's history of alcoholism was documented but there was no documentation regarding the resident's history of suicide attempts. Resident 7's quarterly MDS assessment, dated 6/24/05, was reviewed on 8/1/05. The interdisciplinary team (IDT) had documented in the MDS assessment that daily, or almost daily, resident 7 made negative statements such as "Nothing matters; Would rather be dead, What's the use; Regrets having lived so long; Let me die". The IDT documented that resident 7 was verbally abusive, socially inappropriate and resisted care. Resident 7's care plan, dated 6/28/05, revealed a plan for the resident's Behavioral Symptoms / Problems. One of the behavioral concerns for resident 7 had been documented by the LCSW as "recent OD (suicide) attempt. The Desired	F 250		

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F 250	Continued From page 33 Outcomes/Goals for the Behavioral concerns for resident 7 included "no suicide/overdose attempts." The five approaches the staff were to implement to assist resident 7 to achieve the listed goals, were: (1) encourage to attend activities, (2)education on social efficacy and diet regimen, (3) reminders and cues to previous conversations, (4) education on appropriate ways to handle disagreements with others, and (5) give options as a "redirective". Resident 7's care plan did not include approaches regarding ways to reduce his risk for suicide attempts, to keep his environment safe, to monitor for extreme mental distress or despair, to identify possible precipitators, or to handle possible suicide attempts. A nurse's note, dated 7/705 at 2:30 PM, revealed that a local mental health agency was in to see resident 7, but that the resident needed a referral completed by the Social Services director before they could assume mental health care. There was no documentation that such a referral had been made. On 8/10/05, a representative from the records department of the local mental health agency was interviewed by telephone. The representative stated that there had not been any referral for the agency to evaluate or treat resident 7. The Social Services director and LCSW did not document or state that they had assessed and intervened with resident 7 as a suicide risk.	F 250		
F 279	483.20(k) RESIDENT ASSESSMENT	F 279		

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F 279 SS=E	Continued From page 34 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under s483.25; and Any services that would otherwise be required under s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, and record review, it was determined that the facility did not develop comprehensive care plans with measurable objectives and time tables, that met the medical, nursing, mental and psychosocial needs for 5 of 14 sample residents and one additional resident. Residents: 5, 6, 7, 8, 10 and 15. Findings include: 1. Resident 8 was admitted to the facility on 2/16/05 with diagnoses that included Depressive disorder, Alcohol dependence, Hemiplegia, Cerebrovascular accident and Sleep apnea. Record review revealed that resident 8's annual MDS (minimum data set) assessment triggered	F 279	An inservice training was held on 8/25/05 (see A & J) where Care Planning Standards (see M), Charting, Late Entry Protocol (see N) was reviewed & discussed. Plan of Care for all residents were reviewed as of 9/2/05. MDS/RAI Policy & Procedures (see O) reviewed with Nursing Administration, Medical Records Clerk, and SOC Team (IDT). Daily Standards of Care meeting: findings reviewed, evaluated and care planned. Findings reported, reviewed and evaluated at each QA. (see K – Change in Resident Status). Psychotropic Drug Review will be monitored by Nursing Staff, evaluated by DON (or designee), Pharmacy Consultant, and LCSW. Results reviewed, evaluated and care planned at QA and Psychotropic Drug Review. Social Work Consultant / RN Consultants were brought in, and all comprehensive Care Plans, MDS Assessments, RAPs, on all patients. Care Plan will be reviewed during IDT meetings for evaluation of appropriate interventions.	10/7/05

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F 279	Continued From page 35 the following RAPs (resident assessment protocols) concerns: Cognitive loss, ADL (activities of daily living)/rehab program, Mood state, Falls risk, Dehydration risk, and Dental care. All of the triggered RAPs were checked by the facility (IDT) interdisciplinary team to be care planned. Resident 8's medical record contained the following care plans: Risk of ineffective management of therapeutic regimen for depression, Impaired physical mobility, Constipation due to increased immobility, Impaired gas exchange related to COPD, Risk for seizures, and Altered peripheral tissue perfusion due to venous stasis. There was no documentation in resident 8's clinical record that the RAP's triggered for cognitive loss, falls, or dental had been care planned. The care plan for resident 8 was incomplete. 2. Resident 6 was admitted to the facility on 1/6/04 with the following diagnoses: Traumatic brain injury, Left sided hemiparalysis, and Depression. Review of Resident 6's MDS assessment identified the following RAP concerns were triggered: Cognitive loss, Communication, ADL/Rehabilitation potential, Psychosocial well-being, Mood state, Dehydration/Fluid maintenance, Oral/Dental care. The IDT had documented that all triggered concerns needed to be care planned. Resident 6's clinical record contained the following care plans: Disturbed sleep pattern r/t	F 279		

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F 279	Continued From page 36 (related to) insomnia, Need for minimal assistance with ADL's, Expressions of suicide, Identification with past roles and life status causing feeling of loss r/t placement in SNF (skilled nursing facility), Risk for falling r/t hemiparalysis, Planned weight change program r/t ... ideal body weight. There was no documentation in Resident 6's chart that the triggered RAP's for Cognitive loss, Communication, Dehydration,or Dental were care planned. Resident 6's care plan was incomplete. 3. Resident 7 was admitted to the facility July 2005 with diagnoses which included diabetes, depression, and history of alcohol abuse. Resident 7's quarterly MDS assessment, dated 6/24/05, was reviewed on 8/1/05. The interdisciplinary team (IDT) had documented that daily or almost daily resident 7 made negative statements such as "Nothing matters; Would rather be dead, What's the use; Regrets having lived so long; Let me die". The IDT documented that resident 7 was verbally abusive, socially inappropriate and resisted care. Review of Resident 7's comprehensive MDS assessment, dated 4/21/05, identified RAP problem areas that included: Cognitive loss, Communication, ADL/Rehabilitation potential, Urinary incontinence, Psychosocial well-being, Mood state, Behavioral symptoms, Falls, Nutritional Status, Dehydration/Fluid maintenance, Pressure ulcers, and Psychotropic Drug use. The RAP summary revealed the facility IDT had determined resident 7's care plan	F 279		

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needed to include the resident's Nutritional Status and his Psychosocial well-being, Mood state, and Behavioral symptoms. A care plan had been written for resident 7 and it included the concerns listed below.

The care plan in resident 7's active clinical record, dated 6/13/05,addressed the identified concerns of:
a. Resident is at Nutritional Risk with multiple factors including non-compliance with diabetic diet. Eleven approaches were listed for the nursing and dietary staff to implement in order to help the resident reach the goal of maintaining his weight.
b. Resident is at risk for dehydration. The only approach for nursing and dietary to implement in order to help resident 7 maintain moist mucous membranes and have no tenting of skin, was to monitor for signs and symptoms of dehydration.
c. Alteration in skin integrity secondary to surgery, with no goals or approaches listed.

The only other care plan contained in resident 7's active clinical record was dated 6/28/05 had been prepared by the Licensed Clinical Social Worker. The care plan revealed the RAP problem area of: Behavioral Symptoms/Problems. The identified concerns were, in the order listed: non-compliant with diet; manipulative; argumentative; verbally abusive; potential for physical abuse; recent attempt to overdose/suicide hospitalized, denies this attempt; socially inappropriate; refuses redirection; and isolative tendencies.

Possible precipitators to the behaviors were identified as: short term memory problems, diagnoses, unhappy with people in general, decompensation from hospital stay (significant

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F 279	Continued From page 38 change), and environment. The Desired Outcomes/Goals for the Behavioral concerns included, decreased/no manipulation, arguing, isolation, increased diet compliance, acceptant of redirection, no suicide/overdose attempts, and improvement on social efficacy skills. There was no explanation of "social efficacy skills" or measures to determine if the goal had been reached. No time table was documented for the desired behavioral outcomes. The approaches the staff were to implement to assist resident 7 to achieve the listed goals, were: encourage to attend activities, education on social efficacy and diet regimen, reminders and cues to previous conversations, education on appropriate ways to handle disagreements with others, give options as a "redirective". Resident 7's care plan did not include approaches regarding ways to prevent, recognize, or handle potential suicide attempts. In addition, the IDT documented on the RAP summary that resident 7's care plan included concerns regarding his ADLs, incontinence and psychotropic drug use. Those concerns were not addressed in resident 7's care plan. The IDT documented on the RAP summary that they decided not to care plan triggered RAP problems for resident 7 in the areas of cognition, communication, falls, hydration, and skin. The IDT documented that reasons for their decisions, other than dietary issues, had been documented prior to the designated assessment period and that were revealed in notations that were not in the resident's active record and not readily accessible.	F 279		

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F 279	Continued From page 39 4. Resident 5 was admitted to the facility 1/2/04 with the diagnosis of Anoxic Brain damage, Bipolar disorder, Seizures, and Substance Abuse. A review of resident 5's annual MDS showed RAPS triggered for cognitive loss, communication, ADL (activities of daily living), rehabilitation, psychosocial mood state, behaviors, falls, dehydration and psychotropic drug use. Resident 5 was noted to have a Behavior Care Plan dated 5/12/05 in the medical record. Resident 5's care plan described symptoms/problems as AWOL (absent without leave) risk, inappropriate sexual behaviors, stealing, seeking cigarettes, repetitive questioning. Resident 5's care plan interventions listed redirection, contacting family regarding cigarettes and money, re-orient, stimulate thinking process and SRS (specialized rehabilitation services) programing. Resident 5's care plan did not address the elopement risk, psychotropic drug use or specific interventions to reduce the behaviors other than redirection. Resident 5's possible precipitators were listed that resident 5 "still believes he is a teenager-following through with teen appropriate behaviors". There were no planned interventions that addressed specific needs of "age appropriate interventions" that would meet the needs of resident 5. 5. Resident 10 was admitted to the facility 2/24/92 with the diagnosis of Syphilitic Endocarditis, Dementia, Obsessive-Compulsive Disorder, polysubstance dependence (alcohol, cocaine), non-specific Psychotic Brain Syndrome,	F 279		

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F 279	Continued From page 40 Chronic Airway Obstruction and Decubitus Ulcers. Current documentation for care planning for resident 10 included: risk for skin impairment dated 11/20/2003 with target date of 02/12/04. No resolution dates were documented. There was a notation on the care plan that it was reviewed on 1/13/05. Care plans were initiated for balance, ADL's, extensive assistance with bathing, verbal expressions of grief, socially inappropriateness, poor decisions, covert open conflict with staff, teeth loss, and moderate risk for elopement. The care plans were signed as having been reviewed by the IDT on 11/20/03 with target dates set to achieve the goals for resident 10 by 2/12/04. There was no indication that the goals were reached and no indications that the IDT had readdressed the effectiveness of the care plan, with two exceptions. One of the care plans was updated on 5/6/04 for Toileting when resident 10 had a urinary catheter placement. There was no additional care planning noted which addressed topics of care such as how often to change resident 10's urinary catheter, catheter care or monitoring of signs and symptoms of urinary traction infections. A recreational care plan was dated 1/25/04. 6. Resident 15 was admitted to the facility 3/14/05 with diagnoses of Brain injury, Hyperthyroidism, Other conditions of the brain, Myoclonus, Mixed drug abuse, and Depressive type Psychosis. A review of resident 15's admission assessment completed 3/7/05 by a facility nurse, revealed that	F 279		

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F 279	Continued From page 41 resident 15's cognitive status was severely impaired with cognitive defects; resident 15 exhibited altered perceptions of awareness of surroundings, had periods of restlessness and exhibited wandering behaviors on a daily basis. The facility identified resident 15 as a high risk for elopement on two (2) MDS assessments, one done 3/27/05 and again 6/20/05. Resident 15 had several episodes in which wandering behaviors had been exhibited as well as elopement from the facility. The facility had policies and procedures in place to address assessment and plan of care for elopement, development of specific interventions, and interdisciplinary care plan to reassess the resident and revise the plan of care as necessary. No evidence of a care plan or interdisciplinary team meeting could be located to demonstrate that the facility was assuring resident 15 was safe from his elopement behaviors. Based on interviews conducted with CNA's, resident 15 was known to be an elopement risk and resident 15 was on their list for 15 minute checks. Nursing and social services had documented resident 15 had wandering behaviors; yet, no interventions had been put in place to prevent resident 15 from continuing to elope. Resident 15 was identified upon the admission MDS assessment and on the quarterly MDS assessment as being a daily wander risk. Resident 15's active medical record contained two (2) care plan problems. The care plans addressed Alteration in Thought Processes and Impaired Social Interaction related to resident 15's traumatic brain injury. Neither of the care	F 279		

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F 279	Continued From page 42 plans addressed the resident's wandering behaviors or addressed any interventions to be put in place which would keep resident 15 safe because of the specific behavior of wandering.	F 279		
F 280 SS=E	483.20(k)(2) RESIDENT ASSESSMENT A comprehensive care plan must be: Developed within 7 days after the completion of the comprehensive assessment; Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and Periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility Interdisciplinary Team (IDT) did not develop a comprehensive care plan within seven days after the comprehensive assessment and did not review and revise the care plan after each subsequent assessment for 4 of 14 sample residents and 1 addition resident. Residents: 4, 7, 10 and 15 Findings included: 1. Resident 4 was admitted to the facility January	F 280	An inservice was held with Nursing Staff on 8/25/05 (see J) re: resident assessments. Daily Standards of Care meeting was instituted on 9/1/05. Care Plan protocol, Policy & Procedure and Reporting was reviewed (see K, O, L, M, N). Daily review at SOC meeting of incidents, behaviors, Physician Orders and concerns. DON (or designee) responsibility for assigning monitor and follow up at SOC and QA meetings. Medical Records Clerk instituted an Audit Sheet on 9/1/05 to monitor charging and Care Plan entry dates and completion protocol within 24 hours of admission. Comprehensive Care Plans will be reviewed for accuracy and make appropriate corrections. Care Plans will be reviewed/audited at each resident's IDT review and at every Change of Condition. IDT and Medical Records will be responsible for this procedure, and will report to QA Committee.	10/15/05

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F 280	Continued From page 43 2001 and readmitted September 2003 with diagnoses that included schizophrenia, diabetes mellitus and dementia. Resident 4's medical record was reviewed on 8/3/05. The facility's IDT had completed a comprehensive Minimum Data Set (MDS) assessment for resident 4 on 9/9/04. The Resident Assessment Protocol (RAP) summary triggered 10 problem areas for resident 4 that potentially required a care plan. The IDT determined resident 4 needed a care plan to address his cognition, mood state, behavioral symptoms, psychosocial well-being, activities of daily living (ADLs), recreational/therapeutic activities, falls, communications, nutrition, and psychotropic medications. The IDT determined fall risk did not need to be addressed in resident 4's care plan dated 9/9/04. Resident 4's care plan should have been reviewed and updated with each of three quarterly MDS assessments since 9/9/04, on 12/2/04, 2/24/05 and 5/19/04. The problem of Nutrition for resident 4 was reviewed and updated on 5/19/05. Resident 4's participation in Activities was addressed in a care plan dated 6/20/05. Resident 4 had a Behavioral care plan dated 2/22/05 which was revised 7/29/05 and a separate Elopement Risk care plan was most recently updated 12/4/04. The remaining problems addressed on resident 4's care plan were: Poor decision making, dated 10/15/03 with no revision or review dates.	F 280		

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F 280	Continued From page 44 Motor agitation that interferes with functional ability, dated 10/15/03 with no revision or review dates. Requires assistance with ADLs, dated 10/15/03 with no revision or review dates. Receiving psychotropic medications, dated 10/15/03 with no revision or review dates. Disturbance in personal identity related to Schizophrenia, dated 10/15/03 with no revision or review dates. Resident 4's 5/19/05 MDS assessment revealed the resident had an unsteady gait and had fallen within 30 days but there was no care plan to address the resident's risk for falls. 2. Resident 7 was admitted to the facility July 2004 and readmitted June 2005 with diagnoses that included diabetes mellitus, seizure disorder, alcoholism, anemia and dysuria. Resident 7's medical record was reviewed on 8/1/05 and 8/2/05. The facility's IDT had completed a comprehensive MDS assessment for resident 7 on 4/22/05. The RAP summary triggered 12 potential problem areas for resident 7 that required a care plan. The IDT determined resident 7 needed a care plan to address his mood state, behavioral symptoms, psychosocial well-being, ADLs, incontinence, nutrition, and psychotropic medications. The IDT determined fall risk, fluid maintenance, pressure ulcer risk, cognitive loss and communication did not need to be addressed in resident 7's care plan. The care plan in resident 7's active medical record was reviewed. Resident 7's care plan	F 280		

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F 280	Continued From page 45 included a problem, dated 6/13/05, that related to his nutritional and dehydration risk and a behavior care plan dated 6/28/05. Resident 7's active medical record did not include any additional care plan problems, goals, or approaches for ADLs, incontinence, fall risk, although the resident had multiple factors that could increase his risk for falls and, in fact, the resident had fallen within 30 days of the quarterly assessment date. There were two forms in the record entitled "Initial Care Plan". As of 8/1/05, none of the blanks on the forms, including resident 4's name, had been filled in. 3. Resident 15 was admitted to the facility on 3/14/05. Based on the MDS admission assessment, Resident 15 was identified as a wander risk. No evidence of a care plan could be found in resident 15's medical record to address elopement or interventions to prevent elopement for the resident. According to facility policy for elopement assessment and prevention, residents who develop wandering behavior after admission to the facility should be reassessed and appropriate interventions included in the plan of care within 7(seven) days of identification of behaviors, which include wandering. The plan of care should be developed on the day of admission and quarterly, more often if necessary, of a resident with a known history of wandering. Care plans should be prepared by an interdisciplinary team, which includes the attending physician, a registered nurse and other appropriate staff in disciplines determined by the resident's needs. 4. Resident 10 was admitted to the facility 2/24/92 with the diagnoses of Syphilitic	F 280		

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F 280	Continued From page 46 Endocarditis, Dementia, Obsessive-Compulsive Disorder, polysubstance dependence (alcohol, cocaine), non-specific Psychotic Brain Syndrome, Chronic Airway Obstruction and Decubitus Ulcers. Current documentation for care planning for resident 10 included: risk for skin impairment, dated 11/20/2003, with a target date for resolution of 02/12/04. No resolution dates were documented. There was a notation on the care plan that it was reviewed 1/13/05. Care plans for balance, ADL's, extensive assistance with bathing, verbal expressions of grief, socially inappropriate, poor decisions, covert open conflict with staff, teeth loss, and moderate risk for elopement were documented. Each of the care plans were activated 11/20/03 with target goals for resolution listed as 2/12/04. There was documented review to indicate that the targeted goals were resolved or of the need to readdress the effectiveness of the care plan. Another care plan was updated on 5/6/04 for toileting when a urinary catheter was placed. There was no indication of care planning which addressed areas of concern with a urinary catheter such as how often to change the catheter, catheter care and recognition of signs and symptoms of urinary tract infections related to urinary catheter placement. Resident 10's most recent care plan for recreation was dated 1/25/04.	F 280		
F 281 SS=E	483.20(k)(3)(i) RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based on inspection of the facility medication refrigerator and interview with the Assistant Director of Nursing (ADON), it was determined that the facility did not ensure medications were administered in accordance with professional standards of practice in that the facility did not ensure medications administered by vials were not expired. Textbook of Basic Nursing, Seventh Edition, Caroline Bunker Rosdahl, RN-C, BSN, MA, page 746 under section of Setting up Medications, bullet point 5 states "Check the medication to make sure it is not spoiled or outdated. (Rationale: The medication may lose its effectiveness or become toxic.)" Findings included: On August 1, 2005 at 2:55 PM, the facility medication refrigerator was inspected and findings included: 1. One Hospice Comfort Kit which was unopened with the expiration date of 6/6/05. 2. One box containing nine (9) vials of Lorazepam injectables of 2 mg/ml (milligrams per milliliter). One of the vials was observed to be missing the security seal and there was no date as to when the medication vial was opened. 3. A plastic bag containing a vial of Lorazepam 2 mg/ml for a discharged resident. The vial was observed to be missing the security seal and there was no date as to when the medication was opened. 4. One vial of the facility house supply of Tetanus -Diphtheria Toxin was observed to be missing the	F 281	On 8/25/05 Nursing Staff had an inservice training (see J) session re: Policy & Procedure on Opening & Labeling of Medications (see R). Administrator and ADON met with Pharmacy Consultant on 8/29/05 and reviewed responsibilities & expectations re: Drug Policy & Procedures. An inservice was held on 8/25/05 where all staff informed again that no personal items are to be stored in the Medication Refrigerator. DON (or designee) is responsible, and will spot-check med frig daily, thoroughly reviews dating of opened meds weekly, and reports in daily SOC meeting and at monthly QA.	10/15/05

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F 281	Continued From page 48 security seal and there was no date as to when the medication was opened. 5. One vial of the facility house supply of Pneumovax was observed to be missing the security seal and there was no date as to when the medication was opened. 6. One vial of the facility house supply of PPD (tuberculin testing solution) was observed to be missing the security seal and there was no date as to when the medication was opened. 7. One plastic bag containing an employee's lunch. The nurse who opened the refrigerator was observed to remove the bag when the refrigerator was opened and said that's just my lunch. On 8/04/05 at 10:55 AM the ADON was interviewed regarding facility policy for dating vials of medication when opened. The ADON stated the facility policy was to date the vials the day they were opened and to discard them within 30 days. If the medication was insulin, the expiration date would be within 28 days of opening the vial.	F 281		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by:	F 309		

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F 309	Continued From page 49 Based on interviews and record review, it was determined that the facility did not provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being for 1 of 14 sample residents. (Resident 12) Specifically: 1. The facility did not provide physician ordered treatment for a resident's pressure sores. 2. Facility staff did not monitor a resident for signs and symptoms of a urinary tract infection as per the plan of care. 3. Facility nurses did not assess a resident's condition when a nursing assistant reported a change in condition, which resulted in the resident requiring hospitalization. Findings include: Resident 12 was readmitted to the facility in March of 2005 with diagnoses that included paraplegia, decubitus ulcer, wound infection and sepsis from a urinary tract infection. Resident 12 also had penile dehiscence from foley catheter use. The resident had been seen by a urologist and it was recommended that a suprapubic catheter be placed. The resident and the resident's guardian refuse to have the suprapubic catheter placed. A review of resident 12's medical record was completed on 8/8/05. Upon readmission to the facility, resident 12 was on the antibiotic Levaquin 500 mg (milligrams) daily for 7 days for a urinary tract infection.	F 309	**F309** **Nurses were thoroughly inserviced on Skin Assessment Protocol on 8/25/05 (see J).** See also attachment L: Accident & Skin Assessment and Reporting Protocol. ADON is responsible for Skin Assessment program, and assigns those residents with wounds to Charge Nurses for assessment. ADON will coordinate all Lab Orders and report findings at daily SOC meeting. Nurses were inserviced on 8/25/05 (see J) on Catheter Protocol (see Q). Charge Nurse will distribute copies of Lab Results various disciplines, who will report and follow up at SOC, IDT and QA meetings. Facility will implement Exception Charting Protocol to track and monitor for changes in condition and appropriateness of treatments and interventions. Medical Records Clerk will audit Treatment Sheets weekly for completion of prescribed treatments. END	10/6/05

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F 309	Continued From page 50 A quarterly Minimum Data Set (MDS) assessment dated 7/13/05, was completed by facility staff for resident 12. Facility staff documented on the MDS assessment the following: Resident 12's cognitive skills for daily decision making was moderately impaired. Resident 12 would resist cares. Resident 12 required limited assistance with bed mobility and transfers. Resident 12 had had a urinary tract infection in the last 30 days. Resident 12 had one stage 3 and one stage 4 pressure ulcer. Resident 12 required pressure relieving devices for the chair and the bed, a turning and repositioning program, ulcer care and application of dressings. An "Initial Care Plan" dated 7/19/05, was completed by facility staff for resident 12. Facility staff documented the following on the care plan: Problem with urinary tract infection and skin infection. The goals were no decline in condition, no further infections. The approaches were treatments as ordered including treatment at a local hospital wound clinic. Problem with catheter and potential for UTIs (urinary tract infections). The goal was no further UTIs. The approaches were to monitor for signs and symptoms of UTIs and report to the physician. Problem with breakdown on coccyx and sacral area and refuses to be up 50 % of the day and	F 309		

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F 309	Continued From page 51 refuses care and treatments 1 to 3 times a week. The goal was no further breakdown and will have healing as evidenced by decrease in decubitus size. The approaches were to provide pressure relief in the bed and in the chair and provide treatments as ordered. In two physician progress notes dated 4/27/05 and 6/8/05, resident 12's physician documented that resident 12 had a neurogenic bladder and had recurrent UTIs and sepsis with catheter use. The physician also documented that resident 12 had recurrent decubiti on the buttocks, chronically. A review of resident 12's nurses' notes, clinic visits and laboratory test results revealed the following documentation regarding resident 12's treatment and status of resident 12's decubitus ulcers and urinary status: Nurses Notes: 3/20/05 at 2:45 PM, the day of readmission, resident 12's foley catheter was in place, the urine was clear and the dressing on resident 12's coccyx was loose so the dressing was changed. There was no description of the wound on resident 12's coccyx in the nurse's note. 3/22/05 from 6:00 AM to 6:00 PM, resident 12's catheter was patent (draining) and clear yellow urine noted. 3/23/05 at 2:30 AM, resident 12 pulled the catheter out and had to be sent to a local hospital to have it replaced. Resident 12 returned to the facility at 4:30 AM.	F 309		

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F 309	Continued From page 52 3/23/05 from 6:00 AM to 6:00 PM, resident 12's catheter was draining clear yellow urine. 3/24/05 from 6:00 AM to 6:00 PM, resident 12's catheter was intact and resident 12's coccyx dressing was changed. There was no description of the wound in the nurse's note. 3/26/05 at 4:30 AM, resident 12's catheter was patent and the urine was clear light yellow. 3/27/05 at 6:00 AM, resident 12's catheter was patent draining clear yellow urine and the resident refused to have treatment done to decubitus ulcer. 3/28/05 at 2:45 AM, resident 12 refused to have the treatment done. 3/28/05 from 6:00 AM to 6:00 PM, resident 12 refused to have the treatment done to the decubitus ulcer. The catheter was patent with clear yellow urine. 3/29/05 (not timed) a dressing change was completed for resident 12. The decubitus ulcer had signs and symptoms of infection with foul smelling discharge. 4/14/05 at 2:30 PM, resident 12 pulled the catheter out and was sent to a local emergency room to have it replaced. 4/22/05 (weekly note not timed) resident 12 had a decubitus on the coccyx and his urine was clear. 4/29/05 (weekly note not timed) resident 12 had a stage four decubitus.	F 309		

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F 309	Continued From page 53 5/6/05 at 9:00 PM, resident 12 pulled the catheter out and a facility nurse was able to replace it. 5/7/05 at 5:00 AM, resident 12 had clear yellow urine draining from the catheter. 5/19/05 at 12:00 PM, resident 12 pulled the catheter out and was sent to a local hospital to have it replaced. 6/5/05 (weekly note not timed) resident 12 had a sacral decubitus wound and his urine was yellow and clear. 6/12/05 (weekly note not timed) resident 12 had a sacral decubitus wound and his urine was yellow and clear. 6/15/05 (not timed) resident 12 had a dressing applied to the coccyx decubitus with slight foul odor noted. 6/19/05 (weekly note not timed) resident 12 had a sacral decubitus and a right gluteal decubitus and his urine was yellow and clear. 6/20/05 at 10:30 PM, resident had a dressing change. "New open area...5 inches in diameter and 2 inches deep to R (right) gluteus...". The physician was notified. 6/26/05 (weekly note not timed) sacral and gluteus decubitus stage 2 and stage 4 and resident 12's urine was yellow and clear. 6/27/05 at 12:30 PM, an order was obtained to send resident 12 to a local hospital wound clinic for evaluation of the gluteal wound. An appointment was set up for 8/1/05.	F 309		

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F 309	Continued From page 54 6/29/05 from 6:00 AM to 6:00 PM, resident 12 had foul smelling discharge out of decubitus on coccyx. The physician was notified and the antibiotic "Augmentin 875" was ordered two times daily for 14 days. The wound was cleansed and dressed. A wound culture was ordered and obtained. Also a urinalysis was ordered due to resident 12's urine being concentrated with sediment present. The physician ordered to give resident 12 Rocephin intramuscular, which was done. Laboratory Results: The wound culture was obtained on 6/29/05 and showed abundant mixed flora. There was no sensitivity report to indicate that the antibiotic the physician had ordered was appropriate. The urinalysis was obtained on 6/30/05 and reported to the facility on 7/2/05. The urinalysis showed pseudomonas in the urine. The physician was contacted on 7/6/05. There was no change in the antibiotic that the physician had started on 6/29/05. Nurses Notes: 6/30/05 at 5:00 PM, the wound clinic called the facility and cancelled the appointment for 7/1/05 stating, " He had seen resident 2 mo (months) ago and he recommended (the house physician) assume care for resident for wounds." Clinic Visit Record: Resident 12's medical record contained a	F 309		

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F 309	Continued From page 55 "Referral to Physicians and Clinics" dated 4/13/05. A physical therapist had evaluated resident 12's sacral wound. The physical therapist documented that resident 12's wound was, " 4.5 by 2.4 by 3 cm (centimeters) with 1 to 4.4 cm of undermining. Base yellow with red slough. Purulent bloody odiferous exudate. Periwound maceration." The physical therapist recommended an absorbent antibacterial dressing or VAC (a continuous vacuum suction to the wound) trial to sacral wound. It is unclear when the facility began treating resident 12's wound with an absorbent antibacterial dressing. From the documentation it appears the treatment was initiated around 5/5/05. Nurses Notes: 7/1/05 (not timed), a new appointment was made with another local hospital wound clinic for 7/8/05 to continue with antibiotics and dressing changes as ordered. 7/2/05 10:00 AM, "Residents (sic) condition remains fair...Old dressing remains intact. Removed (with) moderate amt (amount) discharge with foul smell. DQ (decubitus) Coccyx shows little (change)... Gluteus DQ with necrotic tissue edges appear to be breaking away from wound bed... again (with) foul odor...continues on Abx (antibiotic) therapy for Tx (treatment) of wound infection...". 7/8/05 from 6:00 AM to 6:00 PM. Resident 12 was seen in the wound clinic. New treatment orders were given for resident 12's wounds.	F 309		

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F 309	Continued From page 56 There was also a telephone order that was obtained from the wound clinic on 7/8/05, for a wound VAC for the coccyx area and eventually to the ischial area. The nurse documented that she placed the order through a local distributor for the wound VAC. Clinic Visit Record: On 7/8/05, the wound clinic described the wounds, "Coccyx wound is 5.4 L (long) X 3.5 W (wide) X 2.4 D (deep (with) undermining. R (right) ischium wound is 9.4 L X 7.2 W X 3.2 D (with) undermining present. Nurses Notes: 7/10/05 (weekly note not timed) a new treatment to wounds will monitor progress. Urine yellow and clear. 7/11/05 at 2:00 PM, " Residents (sic) wounds are making great improvement. Coccyx wound much cleaner. Tissue pink healthier. 2nd wound also show much improvement with most of necrotic tissue gone..." 7/12/05 9:00 AM, resident 12 went to the wound clinic, returned. Coccyx wound showed some granulating tissue. The ischial wound had some darkened muscle which indicated additional injury from pressure. On 7/12/05 an order was faxed to the facility from the wound clinic to start the VAC therapy to the coccyx "now". On 7/13/05 from 6 :00 AM to 6:00 PM, a call was placed to the local distributor to inquire why the	F 309		

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F 309	Continued From page 57 wound VAC had not been delivered. The distributor stated that the order had been canceled by facility administration. 7/18/05 at 3:30 PM, the facility notified the wound clinic that the wound VAC was not available and the wound clinic changed the treatment orders. The facility did not notify the wound clinic that the VAC was not available until 6 days after it was ordered. On 7/20/05, resident 12 was again seen in the wound clinic. The wound VAC still had not been obtained by the facility. The wound clinic progress notes indicated that the ischial wound had additional necrotic tissue present and a foul odor. The wound clinic recommended surgical intervention. There was no further nursing documentation in resident 12's nurses' notes until 7/25/05, when a facility nurse documented that resident 12's father was contacted and told that resident 12's wounds were not healing and would possibly require hospitalization. On 7/26/05 at 1:00 PM a facility nurse documented in resident 12's nurses notes, "CNA (certified nursing assistant) reporting s/s (signs and symptoms) of sepsis...Transfer to (local) hospital..." Resident 12 was transported to a local hospital for evaluation on 7/26/05, due to fever, chills and oxygen desaturation. The admitting diagnoses according to the hospital was urinary tract infection with urosepsis. A review of the hospital History and Physical	F 309		

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F 309	Continued From page 58 dated 7/26/05 was done on 8/8/05. The History and Physical indicated that resident 12 had a temperature of 102.9 Farenheit and a blood pressure of 90/50 in the emergency room. (It should be noted that resident 12's usual average temperature was 97 and usual average blood pressure was 114/70 as documented in resident 12's nursing facility medical record.) The History and Physical also indicated that upon arrival at the emergency room, resident 12's foley catheter was changed and noted to have a gross purulent, foul smelling drainage. On 8/2/05 at 2:30 PM, an interview was held with a facility nursing assistant that had frequently provided care to resident 12 while at the nursing facility. The nursing assistant stated that she was aware that resident 12 had frequent urinary tract infections and that he had severe pressure sores. The nursing assistant stated that approximately 3 days before resident 12 had been sent to the hospital, she had reported to a facility charge nurse that she thought resident 12 had a infection either in his urine or pressure sores. The nursing assistant stated that resident 12 had a foul strong odor about him and reported it to the charge nurse every day until 7/26/05. The nursing assistant stated that on 7/26/05, she noticed that there was a definite change in resident 12's condition. The nursing assistant stated that resident 12 had a temperature, was very shaky, and his color appeared dusky. The nursing assistant stated that she could not get the charge nurse to listen to her. The nursing assistant stated that she was unable to obtain resident 12's blood pressure because he was shaking so much. She also stated that resident 12's hands were cold but dry. The nursing assistant stated "I am not a nurse but I know the	F 309		

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F 309	Continued From page 59 signs of possible shock." The nursing assistant stated she sought assistance of the nurse responsible for the residents at the other nurses station in the building, and the social service worker also came to help. They obtained an oxygen saturation, which fluctuated between 74 and 88, and placed 3 liters of oxygen on resident 12. They then called 911 and resident 12 was transported to a local hospital emergency room. An interview was held with the facility social service worker (SSW) on 8/2/05 at 3:10 PM. She stated that on 7/26/05, she heard a facility CNA page the nurse from the other side to come to resident 12's room. The SSW stated she went to resident 12's room to see if she could help. The SSW stated that resident 12 was really shaky and his fingertips and lips were slightly blue. She stated that the other nurse started oxygen on resident 12. The SSW stated that she was not sure who had called 911, but resident 12 was transported to the hospital emergency room.	F 309		
F 323 SS=D	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 two observations, it was determined that the facility did not ensure their environment remained as free of accident hazards as possible. Specifically a gallon container labeled as bleach concentrate was found stored in the common shower area in which residents can enter	F 323	All Kitchen, Laundry, and Maintenance staff were inserviced regarding the use of household bleach in the facility. Bleach will not be used at all. All bleach was removed from the facility by 8/8/05. Locked was replaced on shower room cabinet, and all cleaning chemical are locked up. Maintenance Supervisor will spot check daily to review chemicals in use.	10/17/05

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F 323	Continued From page 60 unsupervised. Findings included: On 8/1/05 at 1:00 PM during the initial tour of the building, the common shower area was observed. A gallon container of concentrated bleach was observed to be located on the floor under the wooden bench where residents could sit. On 8/2/05 at 10:00 AM, this surveyor entered the shower and the container of concentrated bleach was observed to be in the same location.	F 323	Administrator will review weekly on Facility Tour Sheet to ensure that no bleach is in use, and that all cleaning chemicals are locked in appropriate cabinets. Maintenance Supervisor, as Safety Office of IDT, and Administrator will report at QA.	10/19/05
F 331 SS=E	483.25(l)(2)(ii) QUALITY OF CARE Based on a comprehensive assessment of a resident, the facility must ensure that residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview with the assistant director of nursing (ADON) it was determined that the facility did not assess residents for gradual dose reductions and behavioral interventions for 3 of 14 sample residents who received antipsychotic medications. Resident identifiers: 2, 5, and 10. Findings included: 1. Resident 2 was admitted to the facility 6/8/02 with the diagnoses of Organic Brain Syndrome, Psychological Stress, Chronic Viral Hepatitis B	F 331	Administrator and ADON met with Pharmacy Consultant regarding policy of consultant involvement in Drug Review and QA. Both meetings are scheduled for 9/26/05. Pharmacy consultant will follow-through on drug-reduction recommend-ations to facility physician. (See J – nursing inservice, A – general inservice, L – Incident & behavior reporting, P – Psychotropic Drug Review, and M – Charting) Medical Records Clerk will coordinate with DON (or designee) to ensure complete Care Plan entries & documentation. DON (or designee) will report findings at IDT and QA.	10/19/05

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F 331	Continued From page 61 and C, HIV, Brain Injury, Convulsions and Blindness of Left eye. Resident 2 was placed on Zoloft 100 mg. (milligrams) PO (by mouth) QD (every day), Remeron 30 mg. PO QHS (hour of sleep each day), and Zyprexa 15 mg. QHS. Resident 2 was recently seen by his attending physician and orders were renewed. Based on medical record review, there was no documentation to show attempts had been made to reduce the dosage of resident 2's medications. There was no documentation of a recent psychotropic drug review or IDT (interdisciplinary team) meeting to discuss if the medication regime was appropriate for resident 2. The last documentation of psychotropic drug review was dated 4/03 which was not readily accessible and located in the department of medical records. There was no evidence that resident 2 was being monitored for adverse consequences or complications of drug therapy. 2. Resident 5 was admitted to the facility 1/2/04 with the diagnosis of Anoxic Brain Damage, Bipolar Disorder, Seizures, Substance Abuse, and ADHD (attention deficit hyperactive disorder). Resident 5 was placed on Wellbutrin SR (sustained release) 150 mg. PO QD, Zyprexa 15 mg. QHS and had orders for PRN (as needed) medications of Haldol 2 mg. PO and Trazodone 50 mg. PO at bedtime for sleep. Resident 5 routinely took the Wellbutrin and the Zyprexa. Resident 5 was recently seen by his attending physician and orders were renewed. There was no Pharmacy review documentation in Resident 5's medical record. The consultant	F 331	A Mental Health Specialist has been contracted to review appropriateness of Behavioral Interventions, need for gradual Dose Reductions or Medication Changes on those residents identified in the survey. It is planned to retain this mental health specialist to review all residents on an ongoing basis.	10/19/05

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F 331	Continued From page 62 Pharmacist was contacted 8/2/05 and he supplied documentation that a reduction of Zyprexa was recommended in April of 2005. There was no documentation of a psychotropic drug review or IDT meeting to discuss if the Zyprexa regime was still appropriate for resident 5. There was no evidence that resident 5 was being monitored for adverse consequences or complication of drug therapy. According to a pharmacy note of April 2005, there was a recommendation that resident 5 try a reduction of Zyprexa from 15 mg. to 10 mg. Resident 5 had two psychotropic drug reports in his medical record. One of the reports began in January 2005 and ended in August 2005. The report was not dated or signed by members of the interdisciplinary team (IDT). The second report began in March of 2005 and was signed by the IDT. There was no date to indicate when the review was conducted. The behaviors listed as being tracked were "anxious, verbally abusive, number of hour slept, suicidal ideation, and self abuse. A psychotropic drug review was dated 3/12/04 (sic) as the last adjustment for use of Trazodone. It was signed by the attending physician on 3/2/05. An interview was conducted with a facility RN on 8/4/05 at 2:00 PM regarding resident 5's use of Trazodone. The facility RN was asked how often resident 5 used the PRN dose of Trazodone. She stated that resident 5 did not take the Trazodone. The last documented use of Trazodone was November of 2004 when a total of 22 PRN doses	F 331		

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F 354	Continued From page 64 nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interviews with the facility Administrator and the Acting Director of Nursing, it determined that the facility did not designate a registered nurse to serve as the Director of Nursing on a full time basis. Findings include: On 8/1/05 at 2:00 PM, an interview was held with a facility RN that the facility had indicated was the "Acting Director of Nursing" (acting DON). The acting DON stated that she had signed an agreement with the previous Administrator that she would be the interim/acting DON until the facility could hire a Director of Nursing. She also stated that around the end of June 2005, she had told the previous administrator that she no longer would be the acting DON but would continue to work shifts on the floor and would assist with the Minimum Data Set Assessments. The facility employed a new administrator around the first part of July 2005. During the same interview with the facility RN, that the facility had stated was their acting DON, the RN stated that she had told the new administrator that she would no longer be the acting director of nursing. An interview was held with the facility administrator on 8/9/05 at 10:30 AM. The administrator stated that he had asked the same facility RN if she would accept the Director of Nursing position when he first came to the facility. He stated that she had declined the offer and	F 354	ADON had been acting DON while the administrator(s) had attempted to hire a new DON. An RN had been working in step with ADON to review and sign appropriate RN-only documentation. This RN had been attending IDT and other care planning meetings. She was offered the position of DON by current administrator and declined. A new search was begun, and during this time two different company senior RNs have been at this facility to consult and direct nursing services. The search culminated in the procuring of an RN, from outside this facility, who has accepted the offer to become the DON. The new DON will begin working at this facility on 10/01/05. During the interim, the company consulting RN will continue to be the Acting DON.	10-1-05

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F 354	Continued From page 65 informed him she would no longer be the acting DON.	F 354		
F 460 SS=D	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 observations, the facility did not have resident rooms equipped to assure full visual privacy for each resident. Three of 31 occupied resident rooms did not have privacy curtains for residents, in the beds positioned closest to the door, that provided the residents with full visual privacy. Findings include: During initial tour of the facility on August 1, 2005 at noon, resident rooms 114, 213 and 214 were observed to not have a privacy curtain around each of the resident's beds. Each of the beds were located closest to the entrance door to the resident's room. On August 3, 2005 at 9:43 AM,a resident in room 110 was observed by two surveyors to be changing his underwear at his bedside without a curtain pulled or the door closed. A facility CNA (certified nursing assistant) was observed to enter	F 460	**Missing privacy curtains were located in the laundry and replaced in resident rooms.** Curtains are in poor repair. New replacements were ordered on 9/1/05. Maintenance Supervisor will review facility weekly to check for privacy curtains and report to Administrator. Housekeeping Supervisor will have housekeepers review each room daily and report. Administrator will monitor weekly on Facility Tour Sheet to ensure compliance.	10-9-05

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F 460	Continued From page 66 the room and told the resident she needed to close the door. She pulled the curtain instead, which left a two foot space in which the resident could still be seen from the hallway as he stood to change his underwear. The CNA walked out of the room without closing the door.	F 460		
F 514 SS=E	483.75(l)(1) ADMINISTRATION The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. This REQUIREMENT is not met as evidenced by: Based on observation, and record review, it was determined that the facility did not maintain clinical records in accordance with professional standards that were complete, accurately documented, readily accessible and systematically organized for 7 of 14 sample residents and one additional resident. Residents: 2, 5, 6, 7, 8, 10, 12 and 15 Findings included: 1. Resident 7 had resided at the facility since 7/28/04. Resident 7's medical record was reviewed on 8/1/05 and 8/2/05. a. On 8/1/05, two Anti-Anxiety Monthly Record Sheets documenting Klonopin administration and resident behavior tracking were located in resident 7's current medical record. One page	F 514	Nursing / Medical Records Consultant reviewed and instructed Med Rec Clerk on system for filing, thinning, tracking medical records. DON (or designee) will review new Physician Orders each morning in SOC (for both visits and phone orders). A new Medical Records Consultant will be contracted. Administrator will ensure that a competent consultant is available to Med Rec Clerk. Medical Records Clerk will perform an in-depth Chart Audit on an ongoing basis under the direction of the MR Consultant. Med Rec Clerk will report at SOC, IDT and QA regularly. Nurses were inserviced on 8/25/05 (see J) regarding appropriate protocol for Late Entries and "Alert Charting" (see M & N). IDT makes assignments of person responsible for specific portion of MDS to be completed.	10-19-05

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F 514	Continued From page 67 was dated "Current Month April 2005". The other page was dated "Current Month 2005" without reference to a specific month. Resident 7 had not been prescribed Klonopin. The tracking sheets should have been filed in the closed medical records of a former resident who had been discharged from the facility since 5/3/05. b. On 8/1/05 and 8/2/05, resident 7's Medication Administration Record (MAR), dated July 2005, was not located in the resident's medical record. On 8/1/05, the Medical Records Director and the Assistant Director of Nursing (ADON) were asked to locate resident 7's July MARs. On 8/2/05, the Medical Records Director provided two pages of resident 7's MAR and one page of the resident's Treatment record dated July 2005. In leu of the missing MAR pages, the ADON provided a Physician's Orders History Report. The history report did provide a history of the physician's orders but did not provide medication administration information. In addition, resident 7's medical record included June 2005 MARs documenting the medications administered on 6/1/05. There were no June 2005 MARs in resident 7's active or closed records from 7/11/05 through 7/28/05. A set of June 2005 MARs documented medications administered on 6/29/05 and 6/30/05. A physician's order, dated 5/31/05, changed resident 7's Dilantin dosage, but the change was not reflected on the 6/1/05 MAR. Resident 7 had Dilantin orders dated 7/28/04 for Dilantin 200 mg (milligrams) every morning and every evening at bedtime. A nurse's note, dated 5/31/05 at 11:00 AM, revealed resident 7 was to receive an immediate dose of 200 mg of Dilantin	F 514	MAR & TAR forms will be monitored by Med Red Clerk, who will coordinate and report to daily SOC meeting. 10-19-05 DON (or designee) will monitor reports and the nurses' follow through, and report the QA. (See Elopement P & P: B, C, D, E, F, G)	

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F 514	Continued From page 68	F 514		

and the resident's routine Dilantin was to be changed to 430 mg every evening, to begin on 5/31/05. There was no mention of the morning dose of Dilantin and no MAR to reveal what had been given from 6/11/05 through 6/28/05 in resident 7's medical record. Resident 7 had been in the hospital from 6/1/05 to 6/11/05. The MAR dated the end of June 2005 revealed resident 7 was administered Dilantin, 200 mg at 8:00 AM and 200 mg plus 300 mg at 8:00 PM. A physician's telephone order, dated 6/30/05, revealed that resident 7's order for Dilantin had been changed to 300 mg Dilantin every evening at bedtime, and the morning dose was ordered to be discontinued.

On 8/4/05, a missing July 2005 MAR had been located and provided to the surveyors by the Medical Records Director. Documentation on the MAR revealed that physician's orders for resident 7's Dilantin administration had not been documented accurately, resulting in inaccurate delivery of the medication. The MAR revealed resident 7's physician's order, dated 6/30/05, had not been transcribed to the July 2005 MAR. The Dilantin orders on the July 2005 MAR were: 200 mg every morning and 300 mg every evening at bedtime. A laboratory test, dated 7/7/05 revealed resident 7's Dilantin level was high at 28.5. High therapeutic range was 20.0.

Resident 7 had an order for an anti-anxiety medication, Ativan 0.5 mg to be administered every three hours as needed for agitation. Resident 7's medical record included nurses' documented behavior tracking and side effect tracking records for March 2005, April 2005, May 2005 and June 2005. There was no nurses' documented behavior tracking / side effects

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F 514	Continued From page 69 record found for resident 7 for July 2005. The Medical Records Director and the ADON stated they were not able to locate any behaviors / side effects tracking dated July 2005. Resident 7 had been receiving two antidepressant medications, Lexapro 20 mg each morning for depression and Trazodone 100 mg each evening at bedtime to help him sleep. Resident 7 did have behaviors that may have been related to his depression. Resident 7 had threatened suicide in July 2005 as documented in a CNA's report dated 7/4/05. Irregularities were revealed in resident 7's nurses notes. A nurse's note dated 6/13/05 at 1:15 PM began on one page and was completed on a second page. The 6/13/05 nurse's note was followed by nurses' notes dated 6/14/05 and 6/15/05. Between the two pages of continuous documentation, a half page of nurse's notes had been added. The nurse's documentation was dated 6/14/05 at 11:00 PM. The nurse did not document that the extra page of notes was a late entry or why it was out of sequence. The second half of the notes page and the back side of the notes page had been crossed through to prevent additional documentation. A CNA's documentation, dated 7/4/05 and not part of the resident's medical record, revealed resident 7 had threatened to commit suicide with a razor. A note by the Social Services Assistant, dated 7/4/05 that was not with resident 7's medical record, was provided to the surveyors on 8/4/05. The Social Services note documented that resident 7 had threatened to commit suicide with a razor and was sent to a hospital for evaluation. There was no nurses's note or any	F 514		

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F 514	Continued From page 70 other entry in the resident's medical record to document resident 7's threat, to document any immediate action the facility may have taken, or that resident 7 was transported to the hospital for evaluation. 2. Resident 12 was most recently readmitted to the facility March 2005 with diagnoses that included paraplegia, decubitus ulcer, and wound infection. A review of resident 12's medical record was completed on 8/8/05. Resident 12's medical record did not contain complete information regarding the resident's decubitus ulcers. A nurse's note, dated 3/20/05 at 2:45 PM, revealed resident 12 had a wound on his coccyx that required a dressing change. There was no description of the wound size or appearance. On 3/24/05, the day shift nurse documented that a dressing had been changed to resident 12's coccyx wound. There was no description of the wound size or appearance. Nurse's notes, dated 3/27/05 at 6:00 AM, revealed resident 12 had refused to have treatment done to his decubitus ulcer. Nurses' notes, dated 3/28/05 at 2:45 AM and from 6:00 AM to 6:00 PM, refused to have treatment done to his decubitus ulcer. A nurse's note, dated 3/29/05 revealed the decubitus ulcer had developed signs and symptoms of infection with foul smelling discharge.	F 514		

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F 514	Continued From page 71 There were no nurses' notes that mentioned resident 12's decubitus ulcer wound again until 4/22/05. A weekly nurse's summary, dated 4/22/05 mentioned that resident 12 had a decubitus on his coccyx. There was no description of the wound size or appearance. The next weekly nurse's note, dated 4/29/05, revealed resident 12's decubitus ulcer was Stage IV. The next mention that resident had a decubitus ulcer was in weekly nurses' notes, dated 6/5/05 and 6/12/05. There was no description of the wound size or appearance. A nurse's note, dated 6/15/05, revealed resident 12's decubitus ulcer had a slight foul odor and had a dressing on it. There was no further description of the wound size or appearance. A weekly nurse's note, dated 6/19/05, revealed resident 12 two decubiti, one on his sacrum and one on his right gluteus. There was no description of the size or appearance of the wounds. The nurse's note, dated 6/20/05 at 10:30 PM, revealed the new open area that had been discovered on resident 12's right gluteus, was 5 inches in diameter and 2 inches deep. Resident 12's medical record contained a "Referral to Physicians and Clinics" dated 4/13/05. A physical therapist documented that resident 12's wound was, " 4.5 by 2.4 by 3 cm (centimeters) with 1 to 4.4 cm of undermining. Base yellow with red slough. Purulent bloody odiferous exudate. Periwound maceration." The	F 514		

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F 514	Continued From page 72 physical therapist recommended an absorbent antibacterial dressing to resident 12's sacral wound. From the facility nurses' documentation, it was unclear when the facility began treating resident 12's wound with the dressing that had been ordered. From the documentation, it appears the treatment was initiated around 5/5/05. There was no routine wound tracking documentation in resident 12's medical record. The documentation that mentioned resident 12's decubitus ulcers continued to be sporadic and incomplete until the resident was discharged to the hospital on 7/26/05. (see F309) 3. Resident 2 was admitted 6/2/02 with the diagnoses of Organic Brain Syndrome, Psychological Stress, Chronic Viral Hepatitis B and C, HIV (human immune virus), Brain Injury, Convulsions and Blindness of the Left eye. Resident 2 was seen for a clinic appointment on 5/19/05 and a PPD (tuberculin test) was placed and orders were written for the staff to read the test within 48-72 hours and call the results to the clinic. Resident 12 had a Immunization Record in the active medical record. No documentation was found that the test was read or that the results of the test was called to the clinic. The ADON (assistant director of nursing) was asked on 8/4/05 at 11:00 PM to locate the information. At 1:00 PM the ADON was asked if she had located the information and she stated "no, it was not done, it was not read and the results were not	F 514		

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F 514	Continued From page 73 called into the clinic". Resident 2's MDS (minimum data set) annual assessment dated for 4/30/04 The assessment completed on 4/30/04 was not signed by the MDS coordinator. 4. Resident 5 was admitted to the facility 1/02/04, with the diagnoses of Anoxic brain damage, bipolar disorder, seizures and substance abuse. Resident 5's MDS for 2/24/05 was reviewed and revealed that resident 5 had 7 (seven) days of diuretic therapy during this assessment period. No physician's order could be found for diuretic therapy on resident 5. 5. Resident 10 was admitted to the facility 2/24/92 with the diagnoses of Syphilitic endocarditis, Dementia, Obsessive-Compulsive disorder, Substance abuse ... MDS assessment done on 10/21/04 listed resident 10 as having tooth loss with out dentures as well as having tooth loss with dentures or a removable bridge. Resident 10 was observed to have no upper teeth and "snags of teeth" in his lower jaw. MDS assessment done on 7/2/05 for resident 10 assessed resident 10 as having no oral problems. Resident 10 has no upper teeth and only snags for lower teeth. Resident 10 had recently seen a dentist who had recommended dentures. 6. Resident 15 was admitted to the facility 3/14/05 with the diagnoses of Brain injury, Status post cardiac arrest , Hyperthyroidism, Other conditions of the brain, Myoclonus, Mixed drug	F 514		

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F 514	Continued From page 74 abuse, Depressive Type Psychosis. Resident 15's medical record was reviewed on 8/3/05. Review of the nurse's revealed inconsistencies. Resident 15 eloped from the facility on 5/2/05. Documentation followed sequentially for 5/3/05 until 2200 (10:00 PM) hours. The next entry was for a late entry and was dated 5/2/05 2206 (10:06 PM). An additional note was added for 5/3/05 after the 5/2/05 noted followed by a note dated 5/4/05. On 5/5/05 a note was written as "05/05/04 (sic) late entry". Late entries are acceptable standard of practice. Nursing and the Law, Sixth Edition, Sheryl A. Futz-Harter, page 6, under Corrections state " corrections can be made in medical records at any time they are realized. ...If the correction or addition of new information is occurring at a date subsequent to the initial entry, the date and time of the new entry must be so indicated. Within the context of the entry, reference is made to the date and time to which the information refers. If it is appropriate, document a brief explanation of why the correction is being made". 7. Resident 8 was admitted to the facility in February 2005 with diagnoses of : Depressive disorder major, Hemiplegia, Convulsions, and Stasis ulcer.	F 514		

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F 514	Continued From page 75 Record review revealed that Resident 8's Annual MDS assessment triggered the following RAP concerns: Cognitive loss, Activities of daily living, Mood state, Falls, Dehydration, and Dental care. All of the triggered RAPs were checked to be careplanned. There was no documentation in Resident 8's clinical record that the RAP's triggered for cognitive loss, falls, or dental care had been careplanned. Resident 8's care plan was incomplete. 8. Resident 6 was admitted to the facility on 1/6/04 with the following diagnoses: Traumatic brain injury, Left sided hemiparalysis, and Depression. Review of Resident 6's annual MDS assessment identified the following RAP concerns triggered: Cognitive loss, Communication, ADL/Rehabilitation potential, Psychosocial well-being, Mood state, Dehydration/Fluid maintenance, Oral/Dental care. There was no documentation in Resident 6's chart that the triggered RAP's for Cognitive loss, Communication, Dehydration, or Dental care were careplanned.	F 514		