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

PRINTED: 11/29/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465142	A. BUILDING _____ B. WING _____	11/16/2006

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

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F 000	INITIAL COMMENTS Complaints were investigated during an annual survey conducted 11/13/06 through 11/16/06. One of the complaints was substantiated. See Recertification 2567.	F 000	12/20/06 POC acceptable completion date 1/3/07 Buxenbaum RN	
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

Utah Department of Health
760871
DEC 21 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	12/20/06

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

Event ID: TW[illegible] Facility ID: [illegible] If continuation sheet Page [illegible]

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility did not inform the resident's physician of a low blood sugar level for 1 out of 13 residents. (Resident Identifier: 1.) Findings included: Resident 1 was admitted to the facility ion 6/17/05 with diagnoses that included congestive heart failure, insulin dependent diabetes and dementia. A review of resident 1's medical records was completed on 11/16/06. The following was documented in a nursing note dated 9/28/06: "The resident came to the nurses station 6:15 PM and was unable to express himself and his thoughts clearly. His blood sugar was checked and found to be 30. (Normal blood glucose levels are between 70 - 100. Panic values are less than 40) The resident was given 4 ounces of a 2.0 supplement with 2 packets of sugar added to it. At 6:25 the resident blood sugar was taken and was 49. At 6:30 PM the resident's blood sugar was taken and was 77...The resident was observed closely for the remainder of the shift." Resident 1's physician orders dated 11/01/2006 were reviewed. It was documented that if resident 1's blood sugar was less than 80 the resident was to be administered "glucose tube+call MD" (physician)	F 157	F 157 Res. 1 blood sugars are with in normal limits. Physician has been made aware of the situation. Nursing staff will monitor blood sugar levels as ordered by the physician and as needed per the nurses' judgment. A copy of proper protocol for how to treat a low blood sugar will be placed on the diabetic residents' MAR. Nursing Staff will be in-serviced on the proper protocol for diabetics, including calling the physician when necessary according to the protocol and physician order. Medical Records staff to audit MAR and chart to ensure protocol is being followed and documented. DON or designee will monitor the audit and ensure all concerns are followed up. Quality Assurance team will monitor process and will make additional changes or institute new policy and procedure as needed. F 157 Medical Records to audit the MAR's weekly and the DON will monitor the audits weekly.	11/17/06 11/17/06 12/29/06 12/29/06 12/29/06 12/29/06 12/29/06

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F 157	Continued From page 2 It was also documented that if the resident was not reacting to the glucose 15 oral gel, he was to be given Glucagon 1 mg (milligram) intramuscular as needed. On 11/15/06 at 12:05 PM resident 1's physician was interviewed. The Physician read the 9/28/06 nursing note and stated that "staff should have given resident 1 an injection of glucagon and then called me." The physician stated that she was not notified about the low blood sugar.	F 157		
F 161 SS=E	483.10(c)(7) ASSURANCE OF FINANCIAL SECURITY The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's current surety bond and residents' trust account balance report, it was determined that the facility did not have a surety bond which would assure the security of all personal funds of residents deposited with the facility. Findings included: The facility's Administrator was asked to provide to surveyors a copy of the facility's current surety bond. Review of the facility's surety bond as of 11/15/06, revealed it to be for $3,800. The Administrator was then asked for a copy of the resident trust account. As of 11/14/06, the	F 161	F 161 Facility is aware that the Surety Bond amount is $3800 and that resident trust needs to be at or below that amount. Trust was spent down to below the surety bond amount. 12/15/06 Business Office Manager will monitor the amount in the resident trust weekly and will make sure the resident trust amount does not exceed the bond limit. The resident trust balance sheet will be printed out weekly and given to the administrator for follow-up. 12/15/06 Quality Assurance will monitor the process and make changes as necessary.	

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F 161	Continued From page 3 resident trust account total was $4,998.16. The facility's surety bond was not sufficient to assure the security of all personal funds of residents deposited with the facility. During an interview with the Administrator on 11/15/06, he stated that he knew that the surety bond did not cover the total sum of the residents' accounts.	F 161		
F 241 SS=D	483.15(a) DIGNITY 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, it was determined that for 1 of 13 sampled residents, the facility utilized signage in a resident's room that did not maintain or enhance the resident's dignity. Resident 5. Findings include: Resident 5 was admitted to the facility on 11/5/03, with diagnoses that included: hypertension, diabetes mellitus, intracranial injury, mood disorder, anxiety, and an allergy to briefs. Observations of resident 5's room were made on 11/14/06 at 11:45 AM, 12:10 PM, and 4:15 PM. At each observation, an incontinence brief was taped to the wall, near resident 5's bed. There note attached to the incontinence brief that direct that the brief was not to be used for resident 5	F 241	F 241 The incontinence brief and note that was taped to the wall was removed. The staff was in-serviced on resident dignity and on not using signs for care reminders. Staff was also instructed to remove signs immediately when found on walls for reminders of care for the residents. Care reminder signs are not to be used by anyone. This will be monitored by the Manager on Duty when filling out the MOD checklist. Any concerns will be brought to Q.A. Quality Assurance Team will discuss and make changes as necessary. Manager on Duty will monitor and complete the checklist at least 5-days a week. The checklists will be reviewed monthly.	11/17/06 12/29/06 12/15/06 12/29/06

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F 241	Continued From page 4 due to an allergy.	F 241		
F 252 SS=E	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview with the facility maintenance supervisor, it was determined that the facility did not provide a safe, sanitary and comfortable environment for the residents. Findings Included: A general tour of the facility was conducted on 11/15/06 at 9:50 AM and at 2:00 PM with the maintenance man. The following concerns were found: 1. The bathroom between residents' room 202 and 203 was observed. The light fixture over the sink had an empty-exposed light bulb socket and another light bulb was burned out. 2. The bathroom between resident's rooms 104 and 105 was observed. Around the base of the entire toilet was a half inch wide area of a brown substance. There was a 4 foot section of coving next to the toilet that was pulling away from the wall. The linoleum flooring was curling up at both entrance ways of the bathroom. 3. The bathroom between residents' room 106 and 201 was observed. There was an uncovered	F 252	F 252 1. Bathroom between 202-203 the light bulbs were replaced. 2. Bathroom between 104-105 the brown substance was removed from around the toilet and the toilet was re-caulked. The old flooring was removed and replaced with new flooring and new coving. 3. Bathroom between 106-201 the light bulb was replaced.	11/20/06 1/3/07 11/20/06

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F 252	Continued From page 5 light bulb in the light fixture over the sink. 4. The bathroom between residents' room 204 and 205 was observed. The linoleum next to the shower stall, measuring 52 inches was curling up away from the floor. 5. The bathroom between residents' room 206 and 207 was observed. There was an uncovered light bulb in the light fixture over the sink. 6. The bathroom between residents' room 115 and 114 was observed. There was a sink with a porcelain support pedestal in the bathroom. The porcelain support pedestal had a crack that ran the entire length of the pedestal. There were sharp edges present. The wall behind the porcelain support pedestal had numerous brown spots and a 8 inch section of buckling paint. The design on the linoleum floor was worn away and there were brown areas on the linoleum floor where the top layer of the linoleum was missing. There was also a strong odor of urine present in the bathroom. 7. The bathroom between residents' room 110 and 111 was observed. There were three uncovered light bulbs in the light fixture over the sink. There was a large amount of water covering the floor. Resident 1 was present when the bathroom was observed. Resident 1 stated that he told staff the day before that the toilet was clogged. At approximately 1:45 PM, this bathroom was observed again. There was standing water around the toilet only at that time. 8. The following was observed in the shower room located on the north hall:	F 252	F 252 – Continued 4. Bathroom between 204-205 old flooring was removed and new flooring was installed. 5. Bathroom between 206-207 the proper light bulb was installed to make the fixture safe. 6. Bathroom between 114-115 the bathroom was painted, old sink and flooring was removed, and new sink and flooring was installed. 7. Bathroom between 110-111 the proper light bulb was installed to make the fixture safe. The water was mopped up and the toilet was unclogged. 8. Shower room a. Yellow trash can was removed from the shower room b. Shower curtain was replaced with a "homelike" curtain c. All shower curtains were replaced with proper "homelike" curtains. d. Shower head replaced, handrail tightened, tile coving fixed, corner repaired.	1/3/07 11/20/06 1/3/07 11/20/06 11/20/06 11/17/06 11/17/06 11/17/06

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F 252	Continued From page 6 a. There was a yellow trash can used for soiled briefs sitting next to the toilet and in front of the sink. b. There was a white plastic shower curtain dividing the toilet area from the shower area . The shower curtain was torn and partially hanging across the entrance to the shower room. c. There were two shower stalls that were side by side divided by a white plastic curtain. There were no shower curtains across the front of either shower stall. d. The shower stall nearest to the built in wooden cabinets had the following concerns I. a broken shower head II. a loose handrail III. approximately 3 feet of tile coving that was separated from the wall IV. an 18 inch section on the corner of the wall that was separated from the adjacent wall. 9. There were 2 hampers with dirty clothing and blankets in the shower room. 10. There was a plastic shower chair that had 3 sections for seating. Between 2 of the seating sections was a quarter size area of a brownish/ green hard substance consistent with feces. It was observed at 9:50 AM and again at 2:00 PM. 11. There was a screw sticking up from the tile floor approximately 18 inches from the wooden cabinet	F 252	F 252 – Continued 9. The hamper was emptied and the big blue hamper was removed. 10. All shower chairs were cleaned and sanitized. 11. The screw was removed from the tile. Preventative maintenance program will require the Environmental Services Director to monthly observe and document the status of all resident rooms, bathrooms, and shower rooms. The ES Director will complete a room-to-room walk through monthly. Projects will be prioritized and completed by the Maintenance staff. Any concerns will be brought to Q.A. by the maintenance staff. Shower room to be checked daily by the Manager on Duty. All Staff will be in-serviced on the use of the maintenance logs at each nurse's station. What can and cannot be in the shower room. What to do in an emergency. The ES Director will follow-up daily (M-F) on the maintenance logs and daily(S-S) on emergencies. Quality Assurance Team to monitor the preventative maintenance program and maintenance logs.	11/20/06 11/20/06 11/17/06 12/29/06 12/01/06 12/29/06 12/29/06
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS	F 281		

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F 281	Continued From page 7 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the the facility did not follow current professional standards of care when implementing physicians' orders for 2 out of 13 residents. (Resident identifier: 2, 5) Findings included: 1. Resident 2 was readmitted to the facility on 11/11/06 with diagnoses that included: multiple sclerosis,major depression, full thickness skin loss due to burn, and bilateral hip replacement. Resident 2's medical record was reviewed on 11/14/06. Resident 2's had a hospital discharge physician's orders dated 11/11/06 to wear TED hose (anti-embolism stockings) for four week. (Anti-embolism stockings are used to help prevent blood clots and decubitus ulcers from forming in the legs or to help decrease swelling in the legs.) From 11/14/06 to 11/16/06 resident 2 was observed not wearing TED hose. On 11/14/06 at 2:20 PM resident 2 was observed not wearing ted hose. On 11/14/06 at 3:05 resident 2 was interviewed and was not wearing ted hose.	F 281	F 281 1. Res. 2 the TED hose were discontinued. The resident was fitted for a body suit and it was ordered. The resident will be better served by the body suit than by the TED hose due to the residents condition and diagnosis. 2. Res. 5 received a pommel cushion for his wheelchair per the physicians order and care plan. Staff was in-serviced on physician orders and care plans. They were also instructed on documentation, including when treatment is refused. Medical Records dept. to audit charts and physician orders to be sure orders are being followed. Nursing Dept. and Administrator will receive the completed audits and will follow-up with the appropriate nursing staff. All new Dr.'s orders will be reviewed in morning meeting. Any follow-up needed will be assigned in morning meeting. Concerns will be brought to Q.A. Quality Assurance Team will follow-up as needed.	12/15/06 12/22/06 12/29/06 12/29/06 12/29/06 12/18/06

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F 281	Continued From page 8 On 11/15/06 at 7:45 AM resident 2 was observed not wearing ted hose. On 11/15/06 at 8:40 AM resident 2 was observed not wearing ted hose. On 11/15/06 at 9:50 AM resident 2 was observed not wearing ted hose. On 11/15/06 at 1:00 PM resident 2 was observed not wearing ted hose. On 11/15/06 at 3:45 PM resident 2 was observed not wearing ted hose. On 11/16/06 at 8:07 AM resident 2 was observed not wearing ted hose. On 11/16/06 at 9:10 AM resident 2 was observed not wearing ted hose. On 11/16/06 at 11:20 AM resident 2 was observed not wearing ted hose. On 11/14/06 at 3:05 PM, in an interview with resident 2 she stated that the ted hose were taken off on 11/11/2006 in the evening and were not put on again. She stated that the physician at the hospital wanted her to wear them. On 11/15/06 at 1:00 PM, in an interview with resident 2 she stated that they had not put on the ted hose. On 11/16/06 at 9:10 AM in an interview with resident 2 she stated that they still had not put the ted hose on.	F 281		

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F 281	Continued From page 9 On 11/15/06 at 1:35 PM, in an interview the LPN in charge of resident 2 was asked what kind of things were done for resident 2. The LPN interviewed did not mention Ted hose. Resident 5 was admitted to the facility with diagnoses that included: hypertension, diabetes, intracranial injury, mood disorder, anxiety, and an allergy to briefs. Resident 5's medical record was reviewed on 11/14/06. Physician orders dated 11/01/06 to 11/30/06 ordered a pommel cushion. Another physicians order dated 9/18/2006 ordered a pommel cushion in the wheelchair to ensure upright positioning and prevent sliding due to the resident's decreased strength and endurance. The care plan for resident 5 dated 9/30/06 for a physical restraint states that the "resident will be restrained using a pommel cushion to prevent sliding out of the wheel chair." The care plan for a pressure ulcer dated 8/31/2006 includes provision of a pressure relief pad to chair. Resident 5 was observed 11/14/06 through 11/16/06. On 11/14/06 at 9:55 AM resident 5 was observed in the room sleeping on his bed. The wheelchair was next to the bed. There was no cushion in the wheelchair. On 11/14/06 at 11:45 AM resident 5 was observed in the dining room eating lunch seated in the wheelchair. There was no cushion observed in the wheelchair.	F 281		

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F 281	Continued From page 10 On 11/15/06 at 9:00 AM resident 5 was observed in the hallway seated in the wheelchair. There was no cushion observed in the wheelchair. On 11/15/06 at 10:00 AM resident 5 was observed in the TV room sitting in the wheelchair. There was no cushion observed in the wheelchair. On 11/15/06 at 3:20 PM resident 5 was observed in the room sleeping. The wheelchair was beside the bed. There was a cushion on the bedside table. On 11/16/06 at 08:07 AM resident 5 was observed in the wheelchair. There was no cushion observed in the wheelchair. Two certified nursing assistants (CNA) were interviewed on 11/16/06 at 11:10 AM. The surveyor asked if resident 5 had a cushion. One CNA stated "He used to have one, I don't know where it is now." The other aide nodded in agreement.	F 281		
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care This REQUIREMENT is not met as evidenced by: Based on interview and review of a resident's medical record, it was determined that for 1 out of	F 282		

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F 282	Continued From page 11 13 sampled residents, the services provided by the facility were not in accordance with the written plan of care. (Resident identifier: 1.) Findings included: Resident 1 was admitted to the facility on 6/17/05 with diagnoses that included congestive heart failure, insulin dependent diabetes and dementia. A review of resident 1's medical records was completed on 11/16/06. Resident 2's care plan for "Unstable glucose levels and/or significant risk for alterations in blood glucose levels related to Diabetes Mellitus" originally dated 5/16/06 was reviewed. In the intervention section of the care plan the following was documented: a." Report blood sugar that is less than 60... to the physician ASAP (as soon as possible). b. Administer...hypoglycemic meds per physician orders. c. ...If hypoglycemia is suspected or known, give 4-6 oz (ounces) of juice with 1 teaspoon of sugar added followed by a complex carbohydrate source, 3-4 crackers, slice of bread, etc." The following interventions were documented in a nursing note dated 9/28/06: "The resident came to the nurses station 6:15 PM and was unable to express himself and his thoughts clearly. His blood sugar was checked	F 282	F 282 Res. 1 blood sugars were returned to normal. Staff will be in-serviced on the proper protocol interventions to follow for diabetics with low blood sugars. A copy of the proper protocol interventions will be placed on each diabetic residents MAR for easy access and reminders and added to the care plan. This should be followed when low blood sugars are present. Central Supply will ensure that all necessary supplies are available for the nurses to use when needed for the current diabetics. Physician will be notified of low blood sugars as stated in the physician orders, care plan and in the proper protocol interventions for diabetics. Medical records dept. will complete weekly audits to be sure protocol is being followed and documented. DON or designee will follow-up on audits to be sure all needed corrections are completed. DON or designee will bring concerns and reports to Q.A. Quality Assurance Team will monitor and make changes as necessary.	11/17/06 12/29/06 12/29/06 12/29/06 12/29/06 12/29/06

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F 282	Continued From page 12 and found to be 30. (Normal blood glucose levels are between 70 - 100. Panic values are less than 40) The resident was given 4 ounces of a 2.0 supplement with 2 packets of sugar added to it. At 6:25 the resident (sic) blood sugar was taken and was 49. At 6:30 PM the resident's blood sugar was taken and was 77...The resident was observed closely for the remainder of the shift." Resident 1's physician orders dated 11/01/2006 were reviewed. It was documented that if resident 1's blood sugar was less than 80 the resident was to be administered "glucose tube+call MD" (physician). It was also documented that if the resident was not reacting to the glucose 15 oral gel, he was to be given Glucagon 1 mg (milligram) intramuscular as needed. On 11/15/06 at 12:05 PM, resident 1's physician was interviewed at the north nurses' station. The Physician read the 9/28/06 nursing note and stated that staff should have given resident 1 "an injection of glucagon and then called me." The physician stated that she was not notified about the low blood sugar. The facility staff did not follow the care plan nor the physician's orders for resident 1 pertaining to the resident experiencing low blood glucose levels. The facility staff should have notified the resident's physician immediately. They did not The facility staff should have administered the glucose gel and possibly, if needed, the glucagon injection per the physician orders. They did not It was documented in the care plan that resident 1 should have been given 4-6 oz. of juice with 1 teaspoon of sugar added. The facility staff did not	F 282		

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F 282	Continued From page 13 follow physician's orders or the care plan. The facility staff instead gave resident 1 a supplemental drink with 2 packets of sugar added.	F 282	F 309 Both Res 2 and 5 have been evaluated and are receiving therapy treatments.	12/4/06
F 309 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, it was determined that for 2 of 13 sampled residents, the facility did not provide the necessary care and services to attain or maintain the highest practicable physical and mental well-being. Specifically, the facility did not implement services to assist the residents in their ability to ambulate and transfer. (Resident identifiers: 5, 2) Findings included: 1. Resident 5, who was admitted to the facility on 11/05/03, with diagnoses that included: hypertension, diabetes mellitus type II, intracranial injury, mood disorder, pressure sore on the ankle, seizure disorder and anxiety. A review of the October and November 2006 Restorative Therapy Progress Notes for resident 5 was completed on 11/16/06. The following	F 309	Staff will be in-serviced on follow-up for physician orders and therapy orders and documenting refusals. All new orders will be reviewed in morning meeting. Assignments will be made in morning meeting. Administrator, DON, or designee will follow-up on orders in morning meeting. Therapists will meet with Administrator and/or DON weekly to review case load, verify orders, treatments, and new orders. IDT will monitor resident decline/improvement and will follow-up accordingly to correct the decline or continue the improvement. Concerns will be brought to Q.A. Medical Records Dept. will complete an audit on physician and therapy orders weekly. Nursing Dept. will be made aware of necessary changes. DON will monitor that the changes are made. Medical Records Dept. will bring any concerns to Q.A. Quality Assurance Team will review and make changes as necessary.	12/29/06 12/18/06 12/29/06 12/29/06 12/29/06

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F 309	Continued From page 14 entries were made: a. On 10/6/06 a facility staff member documented, "Resident is unable to complete sit to stands [parallel bars]. Notified [name of DON] PT (physical therapy) evaluation sugested (sic) PROM (passive range of motion) to BLE (bilateral lower extremities) Leg extensions flexability (sic) decreasing." b. On 10/12/06 a facility staff member documented, "Resident has had a lot of outburst of discomfort and refused therapy 2x (two times) this week. Resident unable to complete exercises. Need new restorative program developed Transfers from w/c (wheelchair) to mat/bed [with] max [assistance]." c. On 10/18/06, a facility staff member documented, "Resident continues with same restorative program but unable to complete PROM to BLE stretching of LE (lower extremities) dayly (sic) flexability maintaining notified [name of the DON] and requested therapist develops new restorative program for resident." A review of physician orders for resident 5 was completed on 11/15/06. On 10/18/06, a physician telephone order was obtained for a physical therapy (PT) evaluation of resident 5 due to his decline and for staff to discontinue the restorative nursing orders for resident 5. A review of the therapy section of resident 5's medical record was completed on 11/16/06. A physical therapy evaluation from October 2005 was available in resident 5's medical record. There was no documentation to support that resident 5 was evaluated by the physical therapist, due to a declining condition, as was ordered on 10/18/06	F 309		

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F 309	Continued From page 15 On 11/15/06 at 3:00 PM, a telephone interview was attempted with the physical therapist to determine if the physical therapist had completed an evaluation of resident 5's declined status. The surveyor left a message for the physical therapist to return the call. The Director of Nursing (DON) was present at the time of the telephone call. NOTE: The physical therapist did not return the surveyors telephone call. On 11/16/06 at 10:25 AM, the assistant Director of Nursing (ADON) and a licensed practical nurse (LPN) were interviewed regarding resident 5's physical therapy evaluation ordered on 10/18/06. Both of these staff members stated that if the evaluation had been completed, it would be in resident 5's medical record. These staff members reviewed resident 5's medical record and indicated that they were not able to locate a physical therapy evaluation for resident 5 following 10/18/06. A review of Minimum Data Set (MDS) assessments for resident 5 was completed. The last MDS completed for resident 5 was an annual assessment and was dated 8/31/06. On 6/8/06, facility staff had completed a quarterly MDS assessment for resident 5. In comparsion, resident 5 had experienced a decline, from extensive assistance to total dependence in hygiene, eating, dressing, and transfers. A review of resident 5's comprehensive plan of care was completed on 11/16/06. Facility staff had updated resident 5's plan of care on 8/31/06. Following 10/18/06 there were no additions to resident 5's plan of care to address his identified decline	F 309		

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F 309	Continued From page 16	F 309		

2. Resident 2 was readmitted to the facility on 11/11/06 with diagnoses that included multiple sclerosis, major depression, full thickness skin loss due to a burn, and bilateral hip replacement.

On 11/15/06 a review of resident 2's medical record was completed. Facility staff completed an admission Minimum Data Set (MDS) assessment for resident 2 on 8/1/06. Facility staff assessed, in section B item 4, that resident 2 has some difficulty with cognitive skills in new situations only. In section C items 4 and 6, facility staff documented that resident 2 had no difficulty understanding others or making herself understood.

A review of physician orders for resident 2 was completed on 11/16/06. On 11/11/06 there was an order for physical therapy and occupational therapy.

On 11/11/06, a Final Discharge Order form was completed for resident 2 from an acute care hospital. Included on this form was the following order, "Pt (patient) needs comprehensive rehab, PT (physical therapy), [and] OT (occupational therapy). If improves [with] tolerance of therapy please consider transfer to acute rehab." Under the activity section of this form, it was documented that resident 2 was to get up with assistance as tolerated.

On 11/9/06 an "Inpatient Orthopedic Physical Therapy Daily Note" was completed. Included on this form under the assessment section, was the following documentation, "Patient demonstrates increased ambulation distance, decreased pain with activity, increased activity level. Patient tolerates overall treatment well. Patient

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F 309	Continued From page 17 compliance: agreeable and willing. Patient is progressing." Under the Plan/Disposition section, the following was documented, "continue established Physical Therapy plan of care, increase activity as tolerated." A review of resident 2's initial care plan was completed on 11/16/06. There were no care plan interventions that included physical therapy or occupational therapy. Resident 2 was observed on 11/13/06 through 11/16/06. On 11/13/06 at 2:35 PM, resident 2 was observed sitting up in bed, positioned on the back, asleep. On 11/13/06 at 4:35 PM, resident 2 was observed sitting up in bed, positioned on the back asleep. On 11/14/06 at 08:15 AM, resident 2 was observed sitting up in bed eating breakfast. On 11/14/06 at 10:40 AM, resident 2 was observed in bed with the head up positioned on the back, asleep. On 11/14/06 at 11:45 AM, resident 2 was observed in bed with the head up ,positioned on the back, asleep. On 11/14/06 at 12:15 PM resident 2 was observed sitting up in bed eating lunch. On 11/15/06 at 07:45 AM, resident 2 was observed sitting up in bed positioned on the back On 11/15/06 at 08:40 AM, resident 2 was	F 309		

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F 309	Continued From page 18 observed sitting up in bed positioned on the back. An interview was held with a facility licensed practical nurse (LPN)on 11/15/06 at 1:35 PM. The LPN stated, "Now that the facility physician had seen [resident 2], we can get PT orders." Note: upon re-admission to the facility on 11/11/06, resident 2 had orders for both physical therapy and occupational therapy. On 11/15/06 at 9:00 AM, the DON was interviewed. The DON was asked if resident 2 had been assisted out of bed since her return from the hospital on 11/11/06. The DON stated that resident 2 had refused. Resident 2's nursing notes were reviewed from 11/11/06 through 11/14/06. No refusal of treatment was documented. On 11/14/06 at 3:05 PM, resident 2 was interviewed. During the interview, resident stated that the facility staff had not gotten her up to walk or even to sit on the side of the bed. She stated that she was worried that she would lose what progress she had gained in the hospital. Resident 2 stated that she had talked to the DON about her concerns. Resident 2 stated that the DON had told her that she would send the restorative aide into work with her. Resident 2 stated that the restorative aide never did come in.	F 309		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene	F 312		

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F 312	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, and record review it was determined that for 1 of 13 sampled residents, the facility did not ensure that a resident with an assessed need for assistance with dressing and hygiene received necessary services. (Resident identifier: 2.) Findings included: Resident 2 was readmitted to the facility on 11/11/06 with diagnoses that included: multiple sclerosis, major depression, full thickness skin loss due to burn, and bilateral hip replacement. Observations of resident 2 were made at various times from 11/13/06 through 11/16/06. The following observations were made: a. On 11/13/06 at 2:40 PM and at 4:35 PM, resident 2 was observed in bed with a blue and white hospital gown on. Her hair was not combed, meaning that her hair was matted flat against the back of her head and standing on end at the crown. b. On 11/14/06 at 8:15 AM, resident 2 was observed in bed, eating breakfast. She was wearing a blue and white hospital gown. Her hair was not combed. c. On 11/14/06 at 11:00 AM, resident 2 was observed in bed, sleeping. She was wearing a blue and white hospital gown. Her hair was not combed.	F 312	F 312 Res. 2 is on a regular bath schedule, clothes are changed, hair is combed and assistance is given with the needed ADL's. Staff will be in-serviced on assisting with ADL's. Manager on Duty and/or charge nurse will monitor and ensure residents are receiving assistance, when needed, with ADL's. This will be documented on the MOD checklist. Residents that refuse assistance and/or completion of ADL's will be educated on the benefits of good hygiene and potential dangers of poor hygiene. MOD checklists and residents concerns will be reviewed in Q.A. F 312 Manager on Duty/Charge Nurse will monitor the residents ADL's at least 5-days a week.	12/4/06 12/29/06 12/18/06 12/29/06 12/18/06

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F 312	Continued From page 20 d. On 11/14/06 at 2:20 PM, resident 2 was observed during dressing changes to her hips. The resident was wearing a blue and white hospital gown and her hair was not combed. e. On 11/15/06 at 7:45 AM and 8:40 AM, resident 2 was observed in bed. She was wearing a brown and white hospital gown. Her hair was not combed. f. On 11/15/06 at 9:50 AM, resident 2 was observed as she was working with a physical therapist. She was in a brown and white hospital gown. Her hair was not combed. At that time, resident 2 stated that she wanted to get into her wheelchair, but that she needed to be dressed first. She stated, "I have no panties on." g. On 11/15/06 at 1:00 PM, resident 2 was observed in her wheelchair and in the hall. Her hair was not combed. The surveyor asked resident 2 how she was feeling. Resident 2 responded, "at least I'm dressed." h. On 11/16/06 at 8:07 AM, resident 2 was observed in the hall coming up from breakfast in the dining room. Her hair was not combed. i. On 11/16/06 at 9:10 AM, resident 2 was observed in bed. her hair was not combed. An interview with resident 2 was held on 11/14/06 at 3:05 PM. Resident 2 stated that her sheets and her hospital gown had not been changed since her readmission to the facility on 11/11/06. Resident 2 also stated, "No one had even given me a wash cloth to wash my face." On 11/16/06 [illegible] review of resident 2's medical	F 312		

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F 312	Continued From page 21 record was completed. Facility staff completed an admission Minimum Data Set (MDS) assessment for resident 2 on 8/1/06. Facility staff assessed, in section B item 4, that resident 2 has some difficulty with cognitive skills in new situations only. In section C items 4 and 6, facility staff documented that resident 2 had no difficulty understanding others or making herself understood. In section G item 1g and j, facility staff assessed that resident 2 required total dependence for dressing and personal hygiene and that she required the assistance of two personnel. A review of resident 2's comprehensive plan of care was completed on 11/15/06. Facility staff completed a care plan for resident 2 for the identified problem of dressing. This care plan was dated, 11/11/06. Interventions for this identified problem included, assist with weaknesses, help with pants and dress, and full support. A review of the nursing notes for resident 2, between 11/11/06 and 11/15/06 was completed. There were no nursing note entries to document that resident 2 was resistive to having her clothing or bedding changed or that she was resistive to having her hair groomed.	F 312		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (1) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the	F 334		

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F 334	Continued From page 22 immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization: and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following (A) That the resident or resident's legal	F 334	F 334 Pneumococcal Vaccine was ordered and received. It is being offered to all residents. It will be administered to those that consent to receive. 12/11/06 All residents or their guardians have been contacted and have been educated on the benefits and potential side effects. 12/11/06 All residents will have an opportunity to accept or decline the vaccination. It will be documented whether the pneumovax was accepted or declined. This will be kept on file for all residents. 12/29/06 DON or designee will follow-up to ensure all residents have the opportunity to accept or decline. 12/29/06 Tracking sheets will be placed in each residents chart and will be audited by the medical records department to ensure the completion of this process. Medical Records Department will bring any concerns to the DON's attention. DON will follow-up and bring reports to Q.A. 12/29/06 Quality Assurance Team will review and revise as needed. F334 Medical Records will monitor the pharmacy reviews monthly. 12/29/06	

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F 334	Continued From page 23 representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on review of the resident's medical records and interview, it was determined the facility had no documentation that any of the facility residents had either received the pneumococcal vaccine or did not receive the vaccine due to medical contraindications or refusal. Findings include: An interview with the Director of Nursing (DON) was held on 11/14/06 at 10:00 AM. She stated the facility did not have a method of determing which residents may have received the pneumoccocal vaccination, or those residents who have not due to their refusal or medical contraindication. The DON stated that one of the contributing factors in not having a method to track this information was that the facility had	F 334		

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	465142	A. BUILDING _____ B. WING _____	11/16/2006

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F 334	Continued From page 24 recently changed adminstrative staff. She then provided the survey team a form titled, "Immunization Report 2005". The Immunization Report 2005 included documentation that an immunization history would be obtained and kept on file for all residents in the facility. On this form, the number of residents who had received the pneumococcal vaccine was documented as 0. On the bottom portion of the Immunization Report 2005 the DON documented, "Heb B series/Pneumococcal vaccinations may have been given but do (sic) to the change in administrative staff throughout the year, I, the new DON and the new office manager were unable to locate any records regarding the Heb B/Pneumococcal vaccine." On 11/14/06, the DON completed the Form CMS-672, "Resident Census and Conditions of Residents". Included on this form was documentation that 27 of the facility residents had received the pneumococcal vaccination. A telephone interview was held on 11/20/06 at 3:25 PM with the facility Administrator. He stated that none of the residents, admitted to the facility since October 2005, have received the pneumococcal vaccine. The Administrator was not able to identify any residents, admitted prior to October 2005, who had been administered the pneumococcal vaccine. A telephone interview was held with the DON on 11/22/06 at 2:05 PM. regarding the Form CMS-672. The DON stated that when she documented that 27 of the facility residents had received the pneumococcal vaccine, she meant that 27 residents had orders to receive the	F 334		

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F 334	Continued From page 25 vaccine. The DON stated that she was not certain how many of the facility residents had actually received the vaccine, as the nursing staff had not documented the vaccine administration on the residents' Medication Administration Record. NOTE: On 11/16/06 at 10:30 AM, the medication refrigerator at the North Nursing Station was observed to have a vial of Pneumovax with an expiration date of 10/11/06. The protective cover to the vial had been removed.	F 334		
F 426 SS=D	483.60(a) PHARMACY SERVICES - PROCEDURES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on record review it was determined that the facility did not provide pharmaceutical services to meet the needs of one of its residents. Specifically, of the 13 sampled residents, 1 resident was an insulin dependent diabetics and did not always receive his/her insulin according to the physician's orders. (Resident identifiers: 1) Findings included Resident 1 was admitted to the facility in 6/17/05 with diagnoses that included congestive heart	F 426		

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F 426	Continued From page 26 failure, insulin dependent diabetes and dementia. A review of resident 1's medical records was completed on 11/16/06. Resident 1's physician's orders for October 2006 and November 2006 were reviewed. The following orders were documented: 1. Lantus Insulin 100U/ml (U=unit/ ml= milliliter) injection 5 U subcutaneous (SQ) every HS (hour of sleep) 2. Insulin 0 SQ sliding scale (s/s) regular intramuscular QID <80=glucose tube=call MD 0-200=0u (units) 201-240=2u 241-280=4u 281-320=6u blood sugar checks QID (4 times a day) 3 A review of resident 1's September 2006 medication administration record (MAR) revealed the following: At 5:00 PM, Lantus 100U/ML injection 5 units were ordered every day. On September 11th, 12th and 14th, the initial boxes indicating that the Lantus insulin was given were blank. The s/s insulin was ordered every day at 11:00 AM. On September 22nd, the initial boxes indicating that the s/s insulin was given were blank. No blood sugar levels were recorded. The s/s insulin was ordered every evening at 8:00 PM	F 426	F 426 Res. 1 current orders are being followed by the staff. Nursing Staff in-serviced on no blanks on the MAR's, follow orders correctly, follow proper protocol and documentation. At shift change the oncoming nurse will review the MAR's to ensure all meds were given and were signed out. Medical Records department will audit MAR's weekly to ensure there are no blanks and that meds are being given correctly. DON will receive audit and will follow-up as needed. Any concerns will be brought to Q.A. Quality Assurance Team will make changes as necessary.	12/11/06 12/29/06 12/18/06 12/29/06

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F 426	Continued From page 27 On September 16th, the initial boxes indicating that the s/s insulin was given were blank. No blood sugar levels were recorded. The s/s insulin was ordered every evening at 8:00 PM. On September 14th, it was documented that resident 1 had a blood sugar of 242. It was documented that resident 1 received 2 u of s/s insulin. Per the physician's orders resident 1 should have received 4U of insulin per sliding scale (s/s). 4. A review of resident 1's October 2006 MAR revealed the following: At 5:00 PM, Lantus 100U/ML injection 5 units were ordered every day. On October 1st, 2nd and 9th the initial boxes indicating that the Lantus insulin was given were blank. The s/s insulin was ordered every evening at 8:00 PM. On October 2nd, 9th and 11th, the initial boxes indicating that the s/s insulin was given were blank. No blood sugar levels were recorded. The s/s insulin was ordered every evening at 8:00 PM. On October 1st, it was documented that resident 1 had a blood sugar of 260 and the initial box indicating that the s/s insulin was given was blank. The resident should have received 4U of s/s insulin. 5. A review of resident 1's November 2006 MAR revealed the following: At 5:00 PM, Lantus 100U/ML injection 5 units were ordered every day. On November 6th, the initial box indicating that the Lantus was given	F 426		

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F 426	Continued From page 28 was blank. The s/s insulin was ordered every day at 5:00 PM. On November 2nd and 12th, the initial boxes indicating that the s/s insulin was given were blank. No blood sugar levels were recorded. The s/s insulin was ordered every evening at 8:00 PM. On November 2nd and 12 th, the initial boxes indicating that the s/s insulin was given were blank. No blood sugar levels were recorded.	F 426		
F 432 SS=D	483.60(e) STORAGE OF DRUGS AND BIOLOGICALS In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview of facility staff during the annual survey conducted on 11/13/06 through 11/16/06, it was determined that the facility did not store medications properly	F 432	F 432 Expired meds have been discarded. Drugs in the cart and med room will be checked the first week of every month and will be given to DON or ADON to be discarded as necessary. DON and/or ADON will then fill out the appropriate paperwork for destruction of drugs, and discard the drugs appropriately. Staff will be in-serviced on how to check for expired meds in the cart and med room, and how to discard the drugs appropriately. DON and/or ADON will monitor the carts and med room monthly to ensure the proper discarding of expired meds. Quality Assurance Team will be sure this process is occurring.	11/20/06 12/6/06 12/15/06 12/29/06 12/29/06

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F 432	Continued From page 29 and discard medications when they expired. 1. On 11/16/06 at 10:15 AM, the north medication cart was inspected for the proper storage of medications. A vial of Lantus Insulin was found with the open date of 9/06/05. A facility nurse was asked about this date. The nurse stated that, that date could not be correct because it was documented on the label that the date the facility received the Lantus Insulin was 7/10/06. The facility nurse then stated that the insulin was probably opened on 9/06/06 and not 9/06/05. The nurse threw the vial of insulin away. The United States Pharmacopeia Dispensing Information provides the following information on storage of insulin vials: "An insulin bottle in use may be kept at room temperature for up to 1 month. Insulin that has been kept at room temperature for longer than 1 month should be thrown away." 2. On 11/16/06 at 10:15 AM, the medication refrigerator was inspected for the proper storage of medications. The following expired medications were found in the medication refrigerator: a. An unopened vial of Pneumovax with the expiration date of "10/11/06" b. Two bags of Bisacodyl 10 milligram suppositories containing a total of 18 suppositories with the expiration date of 10/11/06.	F 432		
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete:	F 514		

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F 514	Continued From page 30 accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility did not keep clinical records in accordance with accepted professional standards and practices that are complete and accurately documented. Specifically, the facility had no documentation that a pharmacist reviewed the drug regimen for 10 out of 13 sampled residents. (Resident identifiers: 1, 4, 5, 6, 7, 8, 9, 10, 11 and 12.) Findings included: Resident 1, resident 4 , resident 5, resident 6, resident 7, resident 8 resident 9, resident 10, resident 11 and resident 12 , who are each on physician ordered medications and have been in the facility, at least, since April of 2006 had no monthly drug regimen pharmacist review forms in the residents' individual charts On 11/15/06, the Director of Nursing (DON) was asked where these reviews were located. The DON stated that the facility keeps all the residents' drug regimen pharmacy reviews in loose leaf binders. A review of the books	F 514	F 514 All 10 residents did receive drug regimen pharmacist reviews for the 4 months in question. This was verified by the Pharmacy consultant. DON met with the director at the pharmacy and discussed the issues that were holding up progress and got all of them worked out. Drug regimen sheets will be placed in each individual resident chart. The pharmacy consultant will be reviewing each individual resident chart monthly and sign off on the appropriate sheet in each chart. A pharmacy monthly review and report book will be kept but only for reports. Individual drug regimen sheets will be kept in the residents' chart. Medical Records Department will audit the drug regimen sheets monthly to ensure each resident is being reviewed by the pharmacist. DON or designee will monitor the audit and ensure all concerns are followed up. Qualtiy Assurance Team will review and change as necessary.	11/21/06 12/7/06 12/29/06 12/29/06 12/29/06

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revealed that there was no documentation that the required pharmacist reviews were completed for the months of April 2006, May 2006, June 2006, and July 2006 for the above mentioned residents. There was no documentation available that the pharmacist had reported any irregularities to the attending physician and the director of nursing (DON)during April 2006, May 2006, June 2006, and July 2006. There was no documentation available that the attending physician and DON had acted upon these reports during April 2006, May 2006, June 2006, and July 2006 for the above mentioned residents.

On 11/16/06 at approximately 10:00 AM, the DON was interviewed in her office. She stated that all of the residents' drug regimen forms for April, May, June and July of 2006 were missing. She stated that the pharmacist did come on the above mentioned months and that the pharmacist did make recommendations. She stated that she reviews the recommendations and informs the Medical Director (MD) of the recommendations that the MD needs to act on.

On 11/16/06 at 12:00 PM, during exit conference the DON was interviewed. The DON stated that the book that contained the residents' drug regimen pharmaceutical reviews for April, May, June and July of 2006 was missing. She stated that the facility staff have searched every where but were unable to find the missing book.

On 11/21/06 at 2:15 PM, the facility pharmacist was interviewed. He stated that he goes monthly to the facility, usually between the 20th and the end of the month. He stated that he did go to the facility in April, May, June, and July of 2006 but does not recall the exact days. He stated that he

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F 514	Continued From page 32 does make recommendations and suggestions to the DON and the MD. The pharmacist stated that sometimes the DON and the MD follow through with his recommendations and sometimes they do not. He stated that when a resident is on Ambien, he will suggest a drug holiday. He stated that usually the facility will follow through. He also stated that he goes through the medication carts and tell the staff to throw away the expired drugs.	F 514		