DEPARTMENT OF HEALTH AND HUM SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED
FORM /

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	C 11/17/00

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POTOMAC HEALTHCARE OGDEN	524 E 800 N OGDEN, UT 84404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 241 SS=E	483.15(a)QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not always provide care for residents in a manner that maintains each resident's dignity and respect in full recognition of his or her individuality as evidenced by staff failing to answer call lights in resident room's in a timely manner. Findings include: 1. On 11/14/00, at 10:22 AM, observation revealed the call light in room 411 was on above the door outside the resident room. At 10:32 AM, a CNA (certified nurse aide) answered the call light in the resident room. This was 10 minutes after the nurse surveyor observed the light on in the hall. 2. On 11/14/00, at 12:55 PM, observation revealed the call light in room 315 was on above the door outside the resident room. At 1:07 PM, a CNA answered the call light in the resident room. This was 12 minutes after the nurse surveyor observed the light on in the hall. 3. On 11/14/00, at 1:10 PM, observation revealed the call light in room 101 was on above the door, outside the resident room. At 1:17 PM, a CNA answered the call light in the resident room. This was 7 minutes after the nurse surveyor observed the light on in the hall. 4. On 11/14/00, at 11:30 AM, a confidential group interview was conducted which revealed 3 of 8	F 241 Recognition 12/28/00 MDuncan	SEE ATTACHED POC FOR POTOMAC HEALTHCARE of OGDEN	12/05/00 ~~12/15/00~~

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 12/4/00

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 residents had concerns that call lights were not answered in a timely manner.	F 241		
F 246 SS=E	483.15(e)(1)QUALITY OF LIFE A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and medical record review, it was determined that the facility failed to provide services with reasonable accommodations of individual needs and preferences. The facility failed to provide 2 of 7 sample residents and 7 additional supplemental residents with accessible call light cords. (Residents 33, 41, 43, 48, 53, 67, 71, 74, and 79) Medical record review on 11/15/00 and 11/16/00, revealed that there were no assessments in these 8 residents' charts documenting if they were capable of using the call light. Review of the residents' care plans revealed that there was no care plan problem addressing the residents' needs for a call light or that the call light should be within reach for accessibility. 1. On 11/14/00 at 2:10 PM, resident 74 was observed not having a call light cord present in her room. Review of resident 74's quarterly Minimum Data Set (MDS), dated 7/27/00, revealed that resident 74 needed extensive assistance to walk in her room. 2. On 11/14/00, at 2:20 PM, resident 67 in room 403 was observed to not have a call light button available for her to use. Resident 67 was sitting in her recliner,	F 246	accepted 12/3/00 mcurran	

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6 feet away from where her the call light would be accessible for her to use. A review of resident 67's MDS, dated 10/29/00, revealed that resident 67 needed extensive assistance to walk in her room. When asked about having a call light accessible to her, resident 67 stated "I would like one."

3. On 11/15/00, at 2:05 PM, observation of resident 33, in room 301, revealed the resident was seated in a chair on the far wall with no call light accessible to her. Resident 33's MDS, dated 10/24/00, identified her as needing one person assist for transfers. The resident was able to verbalize appropriate use of the call light.

4. On 11/15/00, at 2:08 PM, observation of resident 41, in room 306, revealed the resident in bed. The call light was positioned on the bedside table, unaccessible to the resident. Resident 41's MDS dated, 10/7/00, identified him as needing two person assist for transfers and moderately impaired in decision making. The resident was able to demonstrate appropriate use of the call light.

5. On 11/15/00, at 2:10 PM, observation of resident 43, in room 307, revealed that the call light cord was laying on the bedside table next to the resident's bed and unaccessible to the resident. Resident 43's MDS, dated 8/31/00, identified her as being totally dependent. The resident was able to demonstrate the appropriate use of the call light. The CNA who answered the resident's call light, when the resident demonstrated its use, said that the resident uses the call light.

6. On 11/15/00, at 2:12 PM, observation of resident 48, in room 311, revealed the call light to be on the floor beside the bed. The call light was unaccessible to the resident. Resident 48's MDS, dated 8/27/00,

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F 246	Continued From page 3 identified him as being independent in mobility. However, if the resident were to have an emergency situation, the call light would not be accessible to call for assistance. The resident was able to verbalize the appropriate use of the call light. 7. On 11/15/00, at 2:14 PM, observation of resident 53, in room 313, revealed the call light to be behind the bedside table. The resident was in a wheel chair on the opposite side of the bed. The call light was not accessible to the resident. Resident 53's MDS, dated 8/27/00, identified the resident as being independent in mobility but had difficulties making decisions in new situations. The resident was able to verbalize the appropriate use of the call light. 8. On 11/15/00, at 2:16 PM, observation of resident 71, in room 405, revealed that the call light was on the floor at the end of the bed. Resident 71's MDS, dated 10/31/00, identified her as needing extensive assist with mobility. The call light was unaccessible to the resident. The resident verbalized understanding of the appropriate use of the call light. 9. On 11/15/00, at 2:18 PM, observation of resident 79, in room 408, revealed the resident was seated in a recliner at the end of her bed. The call light was unaccessible to the resident. Resident 79's MDS, dated 8/22/00, identified her as needing extensive assist to total dependence in mobility and severely impaired in decision making. The resident verbalized understanding of appropriate use of the call light.	F 246		
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	F 252	completed 12/28/00 JMC	12/28/00

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possible.

This REQUIREMENT is not met as evidenced by:

Based on readings of the water temperature taken in room 208 and in a restroom by the nurse station, a confidential group meeting with 8 alert and oriented residents, a confidential interview with a resident, interviews with staff, and a review of the resident council minutes, it was determined that the facility did not maintain hot water heating equipment to ensure that water temperatures in hand sinks and bath tubs were within comfortable ranges for residents.

Findings include:

1. In a complaint filed on 5/10/00 with the State Survey Agency, a resident residing in the facility complained that "two out of every three baths are cold. Occasionally the water is warm." The complaint went on to state that "The water temperature was taken today by (the Ombudsman) and it was 78 degrees Fahrenheit." In a telephone conversation on 11/14/00 with the Ombudsman as part of the preparation for the complaint investigation, the Ombudsman cited in the complaint intake confirmed that when they had taken the water temperature, it had measured 78 degrees as was stated in the complaint.

2. On 11/14/00 at 1:10 PM, the water temperature was taken at the hand sink in resident room 208 The temperature was 105 degrees Fahrenheit. Temperatures fluctuated at that time throughout the facility to a high in room 404 of over 120 degrees Fahrenheit. In an unlocked restroom by the nurses station on 11/16/00 at approximately 11:45 AM, the water was run continuously for 3 minutes. The temperature was then taken. It was 75 degrees Fahrenheit.

3. In a confidential group meeting held 11/14/00, at

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F 252	Continued From page 5 11:30 AM, 5 of 8 residents reported that the water temperatures in their hand sinks and baths were often cold. 4. A review of the resident council minutes indicated in the minutes for 9/9/00, residents reported that they were periodically experiencing cold water. Minutes for 10/26/00, indicated that at times, there still was cold water for showering. 5. A resident in a confidential interview held 11/14/00, at approximately 2:00 PM, stated that she bathes in the whirlpool tub. This tub has a water temperature gauge on it. She stated that "The gauge often reads 90 degrees. It takes me 3 to 4 hours to warm up (after bathing)." 6. On 11/15/00, at 2:45 PM, a staff person stated that, "Today I can not give baths because the water is too cold. It was 90 degrees." This staff person stated that the temperature gauge on the tub in the 300 hall was accurate. 7. In a confidential staff interview held 11/15/00, at approximately 2:30 PM, the staff person stated, "If there is no hot water on one hall, they (staff) will take them (residents) to another hall to shower." 8. In a confidential resident interview held 11/15/00, the resident stated, "I have received 4 or 5 baths here at the facility in 2 months. They say the water is too cold. I have my husband bathe me at home."	F 252		
F 329 SS=J	483.25(l)(1)QUALITY OF CARE Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate	F 329		

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therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

This REQUIREMENT is not met as evidenced by:

Based on observations, interviews and medical records review, it was determined that resident's drug regimen was not free from unnecessary doses of Coumadin for 1 of 6 sample residents and 2 additional supplemental residents (residents 41, 67, and 73). An unnecessary drug is any drug when used without monitoring and in the presence of adverse consequences which indicate the dose should be reduced or discontinued.

Coumadin is a oral anticoagulant used to control and prevent clotting disorders. Prescribing the dose that both avoids bleeding complications and achieves therapeutic range of clotting times requires monitoring through laboratory tests. The prothrombin time (PT) is a laboratory test used for monitoring blood clotting time in a specific individual. (Reference Guidance: Brunner and Suddarth's textbook of Medical-Surgical Nursing 8th edition 1996 Lippincott pages 802- 803.)

The International Normalized Ratio (INR), another laboratory test, is used in conjunction with prothrombin time in determining if therapeutic doses of anticoagulant medications are being administered. (Reference Guidance: Physicians' Desk Reference 53 Edition 1999 Medical Economics Company page 932.)

Resident 41, 67 and 73 had physician orders for the medication Coumadin. These residents received prothrombin time (PT) lab results designated as "Panic Results" by the laboratory that when the physician was notified resulted in the physician changing the residents medications orders.

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According to the laboratory that the facility uses, a PT result of greater that 50 is considered a "Panic Result". The PT reference range for an individual not on anticoagulant therapy is 10.7 to 12.5 seconds. An INR of greater than 5.0 is consider a "Critical" value.

1. Resident 41 was a 78 year old male who was admitted on 4/4/00 to the facility with the diagnoses of aphasia, carotid stenosis, hypertension, macrocytosis, hemiplegia, and cerebral vascular accident.

A review of resident 41's medical record showed that the admitting physician on 4/4/00 ordered 5 milligrams of coumadin to be given via the resident gastrostomy tube at 5:00 PM and a PT to be collected every Thursday.

A review of the facility's laboratory requisition forms and laboratory test results, between the dates of 4/4/00 through 9/29/00, showed that blood specimens were not collected on 8/3/00, 9/7/00, and 9/14/00 in accordance with physician's orders for resident 41 to determine prothrombin time. In an interview with the Director of Nursing (DON) on 11/16/00, she stated that the facility did not have laboratory services available for routine tests between the dates of 7/31/00 and 8/15/00. The DON also stated that she could not find the PT results for 9/7/00 and 9/14/00. The DON stated she had called the laboratory. The laboratory reported to her that they had no record of the PT results for the dates of 9/7/00 and 9/14/00.

On 9/22/00, the laboratory identified a "Panic Result" of greater than 50 seconds for resident 41. The laboratory faxed this report to the facility on 9/22/00 at 2:53 PM. The report also noted that the laboratory personnel reported the PT results for resident 41 to a

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facility nurse on 9/22/00 at 2:39 PM via phone according to resident 41's medical record. The physician was not notified of these results by the facility until 9/27/00 according to documentation in a nurse's note (dated 9/27/00) and the documentation on the laboratory test result dated 9/22/00 indicating that the physician had been notified on 9/27/00.

On 11/15/00 an interview was conducted with the facility nurse who received the phone call from laboratory personnel of the 9/22/00 "Panic Result" (PT >50) for resident 41. The facility nurse stated that she could not remember the date that she was notified but that she had asked the laboratory staff person to fax the test results to the facility. The facility nurse stated that the test results were faxed to the administration office and not to the nurses' station.

On 11/15/00 a telephone interview was conducted with a staff person employed by the laboratory. The laboratory staff person confirmed that resident 41's blood specimen was collected on 9/22/00. This staff person stated the laboratory called the facility with the result at 2:39 PM on 9/22/00. The laboratory staff person additionally confirmed during this interview that a critical PT value is anything over 25.0 seconds.

A review of resident 41's Medication Administration Record (MAR) documented that resident 41 received 5 mg of coumadin each day from 9/22/00 through 9/26/00. No change was made in the medication dosage or administration frequency.

On 11/16/ 00 an interview was conducted with the facility nurse who called resident 41's physician on 9/27/00 in regards to 9/22/00 laboratory result. This nurse stated that she had found resident 41's test results on the nurses' desk on 9/27/00 and called the

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physician to notify the physician of the PT results. While on the phone with the physician, the nurse stated that an aide said that the resident had bleeding around the gastric tube site. The nurse also recalled that resident 41 had tarry stools, which she reported to the physician. The nurse stated that on 9/27/00, she held the coumadin until she heard back from the physician.

A review of resident 41's medical record indicated that on 9/27/00, an order was obtained to "hold coumadin until further notice and give Vitamin K 1 mg now, and recheck PT in AM (9/28/00)." On 9/28/00, the laboratory reported a PT of 41.7 seconds and an INR of 12.28 for resident 41.

Documentation indicates that on 9/28/00, the physician ordered that no coumadin be given until further notice. According to a nurse's note dated 9/28/00, resident 41 "had two tarry stools "and "vomited" during the night. The physician was notified on 9/28/00 and the physician "directed to keep patient comfortable." On the morning of 9/29/00 the nurse's note documented that resident 41 was lethargic, that his blood pressure was 60/40 and that his apical pulse was 120. Resident 41's family and physician were notified of his condition.

According to a nurse's note dated 9/29/00, resident 41 was sent to the emergency room by ambulance. The admitting hospital completed a history and physical examination for resident 41 on 9/29/00. According to these records, resident 41 was diagnosed with gastro-intestinal bleeding and anemia.

On 11/15/00 at 3:30 PM, a telephone interview was conducted with resident 41's attending physician in regard to resident 41's elevated PT (>50) on 9/22/00.

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The physician stated "the day I wrote the order [9/27/00] was the day I was notified."

2. Resident 67 was a 93 year old female admitted to the facility on 8/2/00 with diagnoses of Diabetes, Congestive Heart Failure and Atrial Fibrillation. The resident received Coumadin 2.5 mg daily as ordered by the physician.

On 9/22/00 a blood specimen was collected from Resident 67 by the laboratory for a PT to monitor the resident's blood clotting time to ensure that therapeutic levels had been achieved.

During an interview with the Director of Nurses on 11/16/00, she stated critical or panic results of laboratory tests are to be reported to the physician immediately after the facility staff are notified by the laboratory. She stated that the call to the physician is to be documented on the hard copy of the laboratory report and in the nurse's notes.

The results of the 9/22/00 laboratory test indicated that it was considered a "Panic Result". It was documented on the laboratory report (dated 9/22/00) as having been called to a nurse at the facility at 2:39 PM. There was no documentation on the facility copy of the laboratory report that the physician was called with these results. Further, there was no documentation in the resident's medical record nurse's notes that the physician was notified of these results.

The medical record documented the physician became aware of these laboratory results on 9/28/00 (6 days after the report was received). At that time, orders were written by the physician to "hold coumadin x 4 days then restart and check protime (prothrombin time) on 10/2/00 and 10/12/00".

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The medical record documented that resident 67 continued to receive coumadin 2.5 mg daily after the "panic result" of the 9/22/00 laboratory test was called to the facility. The medication administration record in resident 67's medical record documented that she received 2.5 mg of coumadin on 9/22/00, 9/23/00, 9/24/00, 9/25/00, 9/26/00, 9/27/00.

3. Resident 73, an 83 year old female, was admitted to the facility on 11/19/97.

A physician order dated 10/5/00, indicated resident 73 was to receive coumadin 4 mg daily, except on Monday and Friday when she was to receive 5 mg of coumadin. On 10/12/00, a physician order indicated that a blood specimen was to be collected from resident 73 in order to determine PT and INR. This was done on 10/13/00. The laboratory report identified the PT was 24.6 (normal range 10.7 to 12.5 seconds according to the laboratory the facility uses) and the INR was 4.36 (normal range 2.0 to 3.0 according to the laboratory the facility uses). There is no documentation in the resident's medical that the results were called to the physician until 10/18/00, five days after it was drawn.

A review of resident 73's medication record for October 2000, indicated resident 73 received coumadin 5 mg on 10/13/00 and 10/16/00 and coumadin 4 mg on 10/14/00, 10/15/00 and 10/17/00. Resident 73 received additional coumadin for five days before the physician was notified of the abnormal lab results.

F 463 SS=E 483.70(f)PHYSICAL ENVIRONMENT
The nurses' station must be equipped to receive

F 463

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resident calls through a communication system from resident rooms; and toilet and bathing facilities.

This REQUIREMENT is not met as evidenced by:

Based on observation, it was determined that the facility's nurses' station was not equipped to receive resident calls through a communication system from resident toilet facilities. Two bathrooms that were accessible to all residents were not equipped with a call light system. One resident bathroom on the 400 hall had a non-functional call light. (Residents 65, 71, 73)

Findings include:

1. On 11/15/00, at 1:00 PM, observation of the two bathrooms in the front hall of the facility near the administrator's office had no call light system present. In an interview with the administrator on 11/15/00 during the morning, he said that residents had access to those two bathrooms and that they sometimes used them. The administrator said that to install call lights in these two bathrooms would not have been cost effective.

2. On 11/14/00 (time not noted) and on 11/15/00, at 2:00 PM, the residents' call light switch in the bathroom for rooms 403 and 405 was observed to not have the proper equipment to relay a signal to the nurses station (no pull chord or actuation nob). Also on 11/16/00 and 11/17/00, the bathroom was observed to be in the same condition. The bathroom was shared by 4 residents and when 3 residents were asked if they were able to pull the call lights near their beds, they were able to do so demonstrating an ability if there had been a functioning call light in the bathroom (residents 65, 67, and 71).

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F 490 SS=J	483.75ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: As a result of an abbreviated standard (complaint) survey completed 11/17/00 and based on observations, interviews and record review from 11/14/00 through 11/17/00, it was determined that the facility had not been administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Substandard Quality of Care and Immediate Jeopardy to resident health and safety was found concerning a systemic breakdown in the facility's laboratory services including the timeliness of the services and ensuring that physicians are promptly notified of significant laboratory findings and in the administration of medications without adequate monitoring. An additional 6 deficiencies were found and cited in the regulatory groupings of Quality of Life, Physical Environment, and Administration. Findings include: 1. Immediate Jeopardy - The facility was found out of compliance with the requirements of the 42 Code of Federal Regulations, 483.25 (1), as a result of finding that 3 residents received unnecessary doses of the anticoagulant drug Coumadin. The facility failed to establish or monitor for an adequate laboratory services protocol over a period of time which resulted in resident 41 being hospitalized with gastro-intestinal bleeding after continuing to receive Coumadin following a laboratory test revealed a "panic" prothrombin time value. Two other residents	F 490		

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(residents 67 and 73) also continued to receive Coumadin after adverse laboratory findings resulting in the potential for actual harm. (Cross Reference F 329.) This finding additionally constitutes Substandard Quality of Care.

2. Immediate Jeopardy - The facility was found out of compliance with the requirements of the 42 Code of Federal Regulations, 483.75 (j), as a result of findings that 8 residents did not receive laboratory services in a timely manner and as ordered by the physician. Additionally, interviews with facility staff revealed the facility did not provide routine laboratory services for the facility residents when one laboratory terminated their services and the facility failed to contract with another laboratory provider for 15 days (8/1/00 through 8/15/00). (Cross Reference F 502.)

3. Immediate Jeopardy - The facility was found out of compliance with the requirements of the 42 Code of Federal Regulations 483.75 (ii), as a result of findings that the facility failed to notify the physician of significant laboratory results for 4 residents. The failure to notify the physician resulted in actual harm to resident 41 and a potential for harm for residents 2, 67, and 73. (Cross Reference F 505.)

4. Six other regulations were found to be out of substantial compliance in the three general requirement areas; Quality of Life, Physical Environment, and Administration.

a. Quality of Life, 483.15.

i. Residents did not have their call lights answered in a timely manner. (Cross Reference F 241.)

ii. Call lights were not accessible to the residents.

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F 490	Continued From page 15 (Cross Reference F 246.) iii. Water temperatures were not maintained at a comfortable level in resident's hand sinks and bathrooms. (Cross Reference F 252.) b. Physical Environment, 483.70. i. Two bathrooms that were accessible to residents were not equipped with a call light system and 1 resident bathroom serving 4 residents had a nonfunctioning call light system. (Cross Reference F 463.) c. Administration, 483.75. i. The facility employed a non-certified nurse aide full time for more than 4 months to provide resident care. (Cross Reference F 494.) ii. The facility's Quality Assessment and Assurance Committee failed to identify, develop and implement appropriate plans of action to correct identified quality deficiencies in the provision of laboratory services and the administration of medications without adequate monitoring. (Cross Reference F 521.)	F 490		
F 494 SS=D	483.75(e)(2)-(3)ADMINISTRATION A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of ss483.151-483.154 of this part; that	F 494		

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	individual has been deemed or determined competent as provided in s483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. This REQUIREMENT is not met as evidenced by: Based on an interview with the staff person in charge of staff employment records for the facility, it was determined that one nurse aide failed to meet the certified nurse aide requirements for providing resident care. Findings include: One staff person had worked as a full time nurse aide from 4/26/00 continuously to 11/15/00 without completing a training and competency evaluation program, or a competency evaluation program. It is required that the facility must not employ a nurse aide full time in the facility for more than four months unless that person has completed a training and competency evaluation program approved by the State.			
F 502 SS=J	483.75(j)ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of medical records, it was determined that the facility failed to provide or obtain timely laboratory services to meet the needs for 1 of 6 sample residents and 7 additional supplemental sample residents. (Residents identifiers	F 502		

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2, 4 , 41, 57, 67, 73, 84, and 86)

Findings include:

1. Policies and Procedures

On 11/16/00, at 10:50 AM, an interview was conducted with two surveyors and the administrator of the facility. The administrator was asked for a copy of the facility's policy and procedure for laboratory services. The administrator stated that he was not familiar with the laboratory services policies and procedures and referred the surveyors to the DON.

On 11/16/00, at 11:15 AM, an interview was conducted with two surveyors and the DON. The DON was asked for the facility's policy and procedure for laboratory services. The DON responded that there was no laboratory service policy and procedure in the facility's policy and procedure book.

The DON was asked regarding the facility's laboratory service protocols. The DON stated that when laboratory results are within a normal range, the laboratory mails a copy of the results to the facility, and she receives them 4 to 5 days later. The DON stated that if the laboratory results are abnormal or in a critical range, the laboratory notifies the facility per telephone and faxes a copy of the results to the facility. The DON stated that all laboratory results are given to the nurse who is assigned to provide care for the resident and that it is that nurse's responsibility to notify the physician. The nurse who notifies the physician is then responsible to document this information in the resident's medical record in the nurse's notes, according to the DON.

The DON stated that the laboratory results were to be

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On 11/16/00 at 11:20 AM, an interview with a second nurse was done. The nurse stated the laboratory services are provided routinely on Monday, Wednesday, and Friday. The nurse stated that the laboratory requisitions for the specimens to be drawn are done by the night shift nurses. She further stated that the night shift nurses are to document on the treatment sheet or MAR for laboratory specimens that have been drawn. She stated that the night shift nurses are responsible to know what laboratories have been done and what laboratories have not been done. The nurse stated that the DON received the laboratory results. She stated that the nurses must call and ask the laboratory to fax the laboratory results. The nurse identified that when the laboratory faxes results to the facility, sometimes the fax works and sometimes is does not. The nurse furthered mentioned that sometimes the laboratory sends the laboratory results by mail, and sometimes they do not.

A third facility nurse was interviewed on 11/16/00 at 11:00 AM. The nurse was asked to describe the facility's process for handling laboratory orders. The nurse stated that when she received an order from the physician for a resident to have laboratory tests done, she wrote a physician's telephone order, filled out a laboratory requisition slip, and documented the order on the MAR and in the nurses notes. The nurse stated that the laboratory services were scheduled for Monday, Wednesday, and Friday. If there was a "stat" (immediate) laboratory draw ordered by the physician, the laboratory services would be provided at any time. The nurse stated that laboratory results were faxed to the facility that day or the next day. The nurse stated she was not sure who picked up the faxed laboratory results, but that a copy was given to her to act on. The nurse stated she would then call the

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physician with the laboratory results, receive new orders, and fax a copy of the laboratory results to the physician if he wanted them. The nurse stated she would document the physician's notification of the laboratory results on the laboratory slip and in the nurses notes. The nurse stated she would then put the laboratory slip in a tray for the medical records staff to file.

2. Resident 41

Resident 41 was a 78 year old male who was admitted to the facility on 4/4/00 with diagnoses of aphasia, carotid stenosis, hypertension, macrocytosis, hemaplegia, and cerebral vascular accident.

Resident 41's medical record was reviewed on 11/15/00.
According to admission orders dated 4/4/00, resident 41 was to receive coumadin 5 mg at 5:00 PM each day via the resident's gastrostomy tube and have a PT checked every Thursday.

A review of 8/00 and 9/00 treatment sheet was conducted for resident 41 which revealed several blanks where PT results should have been marked as completed. On 8/3/00, 8/11/00, 8/31/00, 9/7/00, 9/14/00, 9/21/00 and 9/28/00, the dates were blank on the treatment sheets with no nursing signature stating the PT results were done. An interview with the nurse on 11/15/00 revealed that the blanks did not mean laboratories tests were not done.

A review of the resident laboratory results and laboratory requisitions as compared with the physician orders revealed that resident 41's PT results for 8/3/00, 9/7/00, 9/14/00 were missing.

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In an interview with the DON conducted on 11/16/00, she stated that the facility did not have laboratory services available for routine tests between the dates of 7/31/00 and 8/15/00. The DON also stated that she could not find the PT results for 9/7/00 and 9/14/00. When the DON called the laboratory, they had no record of the PT results for 9/7/00 and 9/14/00.

A blood specimen was not collected for resident 41's PT until 9/22/00. On 9/22/00 the PT was a "panic result" that was greater than 50 seconds. A review of the medical record revealed that the laboratory service faxed and called the facility on 9/22/00 with resident 41's test result.

The physician was not notified of these results by the facility until 9/27/00 according to documentation in a nurse's note (dated 9/27/00). The laboratory test report, which was dated 9/22/00, documented that the physician had been notified on 9/27/00.

A review of resident 41's MAR documented that resident 41 received 5 mg of coumadin each day from 9/22/00 through 9/26/00. No change was made in the medication dosage or administration frequency.

On the morning of 9/29/00 the nurse note documented resident 41 was lethargic and his vital signs were abnormal. He was sent to the hospital emergency room for evaluation. According to the history and physical examination from the hospital on 09/29/00, resident 41 was diagnosed with gastro-intestinal bleeding and anemia.

On 11/15/00 at 3:30 PM a telephone interview was conducted with resident 41's attending physician in regard to resident 41's elevated PT (> 50). The physician stated that he was not always notified of the

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laboratory results for resident 41. He stated that he is usually notified by the nurses at the facility of critical laboratory results.

3. Resident 67

Resident 67 was a 93 year old female admitted to the facility on 8/2/00 with diagnoses of diabetes, congestive heart failure and atrial fibrillation.

The resident received coumadin 2.5 mg daily as ordered by the physician. On 9/22/00 blood was drawn from resident 67 by the laboratory for a PT. The results of this laboratory test indicated a "panic result". The laboratory report dated 9/22/00 documented that a facility nurse was notified at 2:39 PM. There was no documentation on the facility laboratory report that the physician was called with these results. There was also no documentation in the nurses notes that the physician was notified of these results. The medical record documented the physician became aware of these laboratory results on 9/28/00, 6 days later, when orders were written by the physician to recheck the PT on 10/2/00 and 10/12/00. The medical record documented that resident 67 continued to receive coumadin 2.5 mg daily after the 9/22/00 "panic result" was called to the facility. Resident 67's MAR documented that she received coumadin 2.5mg on 9/22/00, 9/23/00, 9/24/00, 9/25/00, 9/26/00, and 9/27/00.

4. Resident 86

Resident 86, an 89 year old male, was admitted to the facility on 5/19/99 with diagnoses of Alzheimer's disease, hypertension and recurrent urinary tract infections. He was admitted with a suprapubic

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catheter in his bladder.

The physician's admission note documented "Pt. (patient) has suprapubic catheter which results in chronic UTI (Urinary Tract Infection)". From May, 2000 through October, 2000, there were monthly physician's orders for resident 89 to have urinalyses due to chronic urinary tract infections.

Review of resident 86's laboratory reports documented that urinalyses had been done in May, 2000 through September, 2000. There was no documentation in the medical record for a urinalysis in October, 2000.

During an interview with the DON, on 11/17/00, she stated she had called the laboratory on 11/16/00, at surveyor request, to obtain documentation for the urinalysis that was to be completed in October, 2000. The laboratory reported to the DON that a urinalysis had not been done on resident 86 in the month of October, 2000.

5. Resident 73

Resident 73, an 83 year old female, was admitted to the facility on 11/19/97.

A physician's order dated 10/5/00, documented resident 73 was to receive coumadin 4 mg daily, except on Monday and Friday when she was to receive coumadin 5 mg. On 10/12/00, there was a physician's order to check resident 73's PT and INR. This was done on 10/13/00. The PT was 24.6 and INR was 4.36. There was no documentation in resident 73's medical record to indicate that the physician was called with the results untill 10/18/00, five days after it was drawn, at which time orders were recieved to hold

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the coumadin for three days, and then restart the coumadin at 3mg daily.

A review of resident 73's MAR for October, 2000 documented resident 73 received coumadin 5 mg on 10/13/00 and 10/16/00 and coumadin 4 mg on 10/14/00, 10/15/00 and 10/17/00. Resident 73 continued to receive the same dose of coumadin for five days before the physician was notified of the abnormal laboratory results on 10/18/00. Resident 73's PT and INR were to be checked in 10 days (on 10/28/00), according to physican's order. As of 11/18/00, there was no documentation to indicate that the PT and INR ordered to be done on 10/28/00 had been done.

6. Resident 57

Resident 57, a 71 year old female, was admitted to the facility on 6/11/99 with diagnoses of hip fracture and atrial fibrillation.

A review of resident 57's clinical record documented that she was receiving coumadin 2 mg daily. The record also documented that she was to receive PTs and INRs on a monthly basis. A routine PT and INR was collected on 7/17/00, documenting a PT of 23.7 and an INR of 4.3. A physician order dated 7/17/00, documented to hold the coumadin for three days and recheck the PT and INR in one week. The recheck should have been done on 7/24/00. Resident 57's next PT and INR were done on 8/16/00. The PT and INR recheck due on 7/24/00, and a routine monthly PT and INR due 10/00, could not be found by the facility or the laboratory.

7. Resident 84

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Resident 84, a 94 year old female, was admitted to the facility on 6/28/00 with diagnoses of congestive heart failure, diabetes and deep vein thrombosis.

A review of resident 84's medical record revealed that she had physician's orders for lanoxin (Digoxin) 0.25mg every day. Digoxin is used to make the heart pump more effectively by slowing the heart rate down.

A blood specimen was collected on 9/25/00 for a Digoxin level to determine the level of Digoxin in resident 84's blood. The results of the laboratory test documented that the resident's Digoxin level was 2.4 (high). A physician's telephone order was written on 9/29/00, four days later, to hold lanoxin for two days due to the high digoxin level. The Digoxin was to be restarted on 10/2/00. The resident's Digoxin level was to be rechecked in 2 weeks (10/13/00).

There was no documentation in resident 84's medical record or the resident's treatment flow sheet, that a Digoxin level had been done on 10/13/00 as ordered.

During an interview with the DON, on 11/17/00, surveyors requested documentation of resident 84's Digoxin level that was to be done on 10/13/00. The DON was unable to obtain results from the laboratory for this test and verified that there were no results available in the resident 84's chart.

8. Resident 4

Resident 4, a 90 year old female, was admitted to the facility on 10/31/00 with diagnoses of chronic renal insufficiency, hypertension, anemia, congestive heart failure and angina.

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Resident 4 had physician's orders for Digoxin 0.125mg every day. On 11/14/00, a nurse's note from the "7a-7p" shift documented that resident 4 had nausea and a pulse of 43 beats per minute. The physician was notified on 11/14/00 and new orders were received to hold the Digoxin until 11/18/00, when the Digoxin was to be resumed at 0.125 mg. However, instead of every day as previsously ordered, it was to only be given every Tuesday and Saturday. The physician ordered that a Digoxin level be done on 11/15/00. There was no documentation on the nursing flow sheet that the Digoxin level was obtained as ordered.

A review of laboratory requisitions at the nurses' station on 11/16/00, at 9:00 AM, revealed that resident 4 had a requisition for a Digoxin level to be done on 11/15/00.

During an interview with a staff nurse, on 11/16/00, at 3:30 PM, the nurse stated that the laboratory technician had been in on the morning of 11/15/00, but she must have missed the lab draw on resident 4.

During an interview with a laboratory technician from the facility contracted laboratory, on 11/17/00, at 12:30 PM, she informed the nurse surveyor that the Digoxin level on resident 4 had not been done on 11/15/00. The laboratory technician stated that due to problems identified in missing some laboratory orders in the facility, laboratory staff had implemented the use of a "lab log" on the evening of 11/16/00. The facility was to document all laboratory orders on this log. Laboratory staff would then sign the log when the specimen was collected.

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9. Resident 2

Resident 2 was admitted to the facility on 12/31/99 with diagnoses of hypertension, pneumonia, chronic obstructive pulmonary disease, depression, and esophageal reflux.

A review of resident 2's medical record revealed a physician's order to obtain a UA (urinalysis) on 8/16/00 for resident 2 due to chronic UTIs (urinary tract infections). A laboratory report for a UA, dated 8/16/00, revealed resident 2 had a urinary tract infection. There was no documentation in the resident's medical record that the facility had informed the physician of these laboratory results.

On 8/24/00, nine days after the UA was completed, the physician ordered Macrobid 100 mg (an antibiotic) to be given resident 2 two times daily for 7 days for treatment of a UTI. 2. Another UA was to be obtained in two weeks (9/7/00), according to the physician's order.

On 9/7/00 resident 2's physician ordered a UA if it was not done as ordered on his orders of 8/24, which was to obtain it on 9/7/00. Review of nurse's notes dated 9/8/00 at 4:00 AM revealed : "Post A/B (antibiotic) UA sent to lab this AM."
Review of laboratory reports revealed there was no copy of the laboratory report in resident 2's chart for the UA which was documented as being obtained on 9/8/00.

The DON was interviewed on 11/17/00 at 2:20 PM. The DON was asked if the facility had a copy of the resident's UA results for 9/8/00. The DON stated she was unable to find an original laboratory report for this UA and had called the laboratory and requested a

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faxed copy of the report. The DON gave the nurse surveyor the faxed copy of a laboratory report for a UA dated 9/8/00. The results of the laboratory report dated 9/8/00 were reviewed by the DON and the nurse surveyor. These laboratory results indicated resident 2 continued to have a urinary tract infection. When asked if the MD was aware of the laboratory results for the UA dated 9/8/00, the DON stated, "No".

There was no further documentation in resident 2's medical record regarding follow up or treatment for the urinary tract infection identified by the 9/8/00 laboratory report.

F 505 SS=J 483.75(j)(2)(ii)ADMINISTRATION
The facility must promptly notify the attending physician of the findings.

F 505

This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and a review of medical records, it was determined that the facility failed to notify the physician in a timely manner of abnormal laboratory values for 1 of 6 sample residents and 3 additional supplemental residents (residents 2, 41, 67 and 73). The results of prothrombin times (PT) for 3 residents were not called to their physician and the results of a urinalysis for1 resident was not called to the physician for identification and treatment. Failure by the facility to promptly notify the physician with laboratory test findings placed these residents in jeopardy of significant harm since appropriate treatment is dependent upon these results.

Findings include:
1. Resident 41 is 78 year old male who was admitted on 4/4/00 to the facility with the diagnoses of aphasia,

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carotid stenosis, hypertension, macrocytosis, hemiplegia, and cerebral vascular accident.

A review of Resident 41's medical record was conducted on 11/15/00 evidenced the following:.

Resident 41 was receiving coumadin, an anticoagulant, for which routine laboratory tests are required to determine of the resident is maintaining therapeutic levels if coumadin. The test required is a prothrombin time (PT). The physician had ordered the PT to be checked every Thursday.

On 9/22/00 a PT was done, as ordered by the physician, for resident 41 by the laboratory. The laboratory identified a "Panic Result" of greater than 50 seconds for resident 41, well above the therapeutic range. The laboratory phoned these results to a facility nurse on 9/22/00 at 2:39 PM and faxed the report to the facility on 9/22/00 at 2:53 PM according to notes on the laboratory report.

The physician was not notified of these results by the facility until 9/27/00, five days later, according to a nurse's note (dated 9/27/00) and the facility's laboratory report (dated 9/22/00) for this resident.

On 11/ 5/00 an interview was conducted with the facility nurse who received the phone call from laboratory personnel of the 9/22/00 "Panic Result" (PT>50) for resident 41. The facility nurse stated that she could not remember the date she was notified but she had asked the laboratory to fax the results to the facility. The nurse stated that the test results were faxed to the administration office and not the nurses' station..

On 11/15/00 a telephone interview was conducted with

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a staff person employed by the laboratory. The laboratory staff person confirmed that resident 41's blood specimen was collected on 9/22/00. This staff person stated the laboratory called the facility with the result at 2:39 PM on 9/22/00. The laboratory staff person stated that a critical PT value is anything over 25.0 seconds. She further stated that the laboratory always notifies the facility of critical abnormalities and will attempt to call the physician when possible.

A review of resident 41's Medication Administration Record (MAR) documented that resident 41 received 5 milligrams of coumadin each day from 9/22/00 through 9/26/00. No change was made in the medication dosage or administration frequency since the physician had not been notified of the PT results. When the physician was notified on 9/27/00, he ordered that the resident not receive coumadin until until another PT could be done.

On 11/15/00 an telephone interview was conducted with the attending physician in regards to resident 41's elevated (PT >50) on 9/22/00. The physician stated, "The day I wrote the order [9/27/00] was the day I was notified."

On 11/16/ 00 an interview was conducted with a facility nurse who called resident 41's physician in on 9/27/00 with the results of the 9/22/00 laboratory PT. The facility nurse stated that she found the panic value laboratory result at the nurses' desk on 9/27/00 and called the physician to notify the physician of the PT results. While on the phone with the physician, the nurse stated the aide said that the resident has bleeding around the gastric tube site. The nurses recalls that the resident also had tarry stools and reported it to the physician. The nurse stated that she held the coumadin until the physician returned her call. The physician

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instructed that vitamin K be administered (to increase resident 41's blood clotting ability) and the coumadin to be held, according to the nurse.

2. Resident 67, a 93 year old female, was admitted to the facility on 8/2/00 with diagnoses of Diabetes, Congestive Heart Failure and Atrial Fibrillation. The resident was receiving Coumadin 2.5 mg daily. On 9/22/00 blood was drawn from Resident 67 by the laboratory for a PT. The results of this laboratory test indicated a "Panic Result" and was documented on the Laboratory report dated 9/22/00 as having been called to a nurse at the facility at 2:39 PM. There is no documentation on the facility laboratory report that the physician was called with these results. There is no documentation in the Resident's medical record nurses notes that the physician was notified of these results. The medical record documented the physician became aware of these laboratory results on 9/28/00, six days later, when orders were written by the physician to "Hold Coumadin x 4 days then restart and check protime (prothrombin time) on 10/2/00 and 10/12/00". The MAR for Resident 67's documented that she continued to be given Coumadin 2.5 mg on 9/22/00, 9/23/00, 9/24/00, 9/25/00, 9/26/00 and 9/27/00.

During an interview with the Director of Nurses on 11/16/00, she stated critical or panic results of laboratory tests are to be reported to the physician immediately after the facility staff are notified by the laboratory and the call to the physician is to be documented on the hard copy of the laboratory report and in the nurse's notes.

3. Resident 73, an 83 year old female, was admitted to the facility on 11/19/97.
A physician order dated 10/5/00, indicated resident 73 was to receive Coumadin 4 mg daily, except on

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Monday and Friday when she was to receive Coumadin 5 mg. There was a physician's order to check resident 73's PT and INR on 10/13/00. The results of this test found the resident's PT to be 24.6 and the INR to be 4.36, both elevated above routine therapeutic levels. The results were not called to the physician until 10/18/00, five days later. A review of resident 73's MAR for October 2000, documented resident 73 continued to receive Coumadin 5 mg on 10/13/00 and 10/16/00 and Coumadin 4 mg on 10/14/00, 10/15/00 and 10/17/00. Resident 73 received additional Coumadin for five days before the physician was notified of the abnormal lab results.

4. Resident 2 was admitted to the facility on 12/31/99 with diagnoses of hypertension, pneumonia, chronic obstructive pulmonary disease, depression, and esophageal reflux.

A review of resident 2's medical record on 11/17/00 revealed that on 8/15/00, the physician had ordered urinalysis (UA, a laboratory test to determine bacterial growth in urine) due to a history of chronic urinary tract infections for resident 2. A review of resident 2's laboratory report for a this UA (dated 8/16/00) revealed resident 2 had a urinary tract infection (UTI). There was no documentation in the resident's medical record that the facility had made the physician aware of these laboratory results on 8/16/00.

On 8/24/00, nine days after the UA was completed, the physician ordered resident 2 be given Macrobid (an antibiotic) 100 mg two times daily for 7 days for treatment of the a UTI.
Another UA was obtained for resident 2 on 9/8/00 as ordered by the physician. There was no evidence in the resident's medical record that this UA had been obtained or if the physician had been notified of the

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F 505	Continued From page 33 results. The DON was interviewed on 11/17/00 at 2:20 PM. The DON was asked if the facility had a copy of the resident's UA for 9/8/00. The DON stated she was unable to find an original laboratory report for this UA and had called the laboratory and requested a faxed copy of the report. The DON gave the nurse surveyor the faxed copy of a laboratory report for a UA dated 9/8/00. The results of the laboratory report dated 9/8/00 were reviewed by the DON and the nurse surveyor. These laboratory results indicated resident 2 continued to have a urinary tract infection. When asked if the MD was aware of the laboratory results for the UA dated 9/8/00, the DON stated , "No."	F 505		
F 521 SS=J	483.75(o)(2)&(3)ADMINISTRATION The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. This REQUIREMENT is not met as evidenced by: Based on interviews and a review of facility records, it was determined that the facility's quality assessment and assurance committee failed to develop and fully implement appropriate plans of action to correct identified quality deficiencies in laboratory services and administration of medications.	F 521	(Accepted 12/28/00 MDwire RN	

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Findings include:

1. An interview was held with the facility's DON on 11/16/00 AM. The DON stated the quality assessment and assurance committee met monthly and reviewed incident reports as part of their process used to identify quality deficiencies. The DON stated that the quality assessment and assurance committee would then develop and implement a plan of action to correct the identified deficiencies.

2. Review of resident 41's medical record revealed the resident had a physician's order for a prothrombin time (PT) to be drawn on 9/22/00. Review of the faxed copy of the laboratory result sheet, dated 9/22/00, revealed documentation that resident 41's prothrombin time result was at the abnormal level of greater than 50 seconds which required immediate intervention by the physician to prevent complications. Documentation on the laboratory sheet revealed the laboratory staff had notified the facility nurse per telephone on 9/22/00 at 2:39 PM regarding resident 41's abnormal prothrombin time results.

Review of the MAR revealed the resident 41 received 5 mg of coumadin from 9/22/00 through 9/27/00.

Review of the nurse's notes revealed documentation that the physician was notified of the abnormal prothrombin time results on 9/27/00 and that he gave an order to discontinue the resident's coumadin. This was 5 days after the PT had been drawn and the result had been faxed and called to the facility. (See F 329 for additional information.)

3. An interview was held with the facility's DON on 11/17/00 at 2:20 PM. The DON stated she became

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aware of the problem identified with resident 41on 9/27/00. She did not express any knowledge of facility responsibility regarding a lack of timely physician notification, treatment for an abnormal PT, and the subsequent administration of unnecessary medications to resident 41.

When asked what corrective action had been taken by the facility for this problem, the DON stated that the problem had been reviewed in their weekly Department Head Meeting. The DON also stated she had talked to the nurse involved in the incident.

When asked if this problem had been reported as an incident or had become part of the facility's quality assessment and assurance process, the DON stated, "No" and that no plan of action was put in place to correct the problem.

4. On 9/15/00, a review of the facility's incident reports revealed no incident report concerning the facility's failure to notify the physician of the abnormal lab findings nor was an incident report found for the administration of unnecessary medications to resident 41.

5. Review of the facility's "Quality Assurance and Assessment Committee Minutes" dated 10/12/00, revealed no documentation that the committee reviewed the problem identified by the facility on 9/27/00 regarding a lack of timely physician notification, any treatment for an abnormal PT, and the administration of unnecessary medications for resident 41. There was no documentation that the committee had developed or implemented a plan of action to correct the identified deficiencies.

PLAN OF CORRECTION

POTOMAC HEALTHCARE OF OGDEN

DECEMBER 13, 2000

F241

Residents who did not have their call light answered timely are now part of the Patient Care Monitoring System. Specific residents were not identified except to be in rooms 101, 315, and 411.

All residents were re-assessed to assure quality care in regards to call light use, irregular labs, restraints, behaviors, accidents, and skin conditions. This was done to assist the residents to reach their highest maintenance level of practical functioning. The residents received updated assessments and additional care planning when the condition of the resident warranted a change. This process will be completed on 12/13/00.

Facility administration implemented the following changes:
Each morning during business days, those members of the interdisciplinary team that are at the facility will be reviewing the twenty four hour report, all lab reports, telephone orders, accident and incident reports, and bath sheets to determine condition changes and resident's complaints and concerns. The charts of the residents that appear on the report will be reviewed to identify changes that are required on the care plan. The care plans will be updated at that time and the patient care log will be updated to reflect the procedure changes that are required to assist the resident.

The Patient Care Log, (Attachment A), will be filled out for all patients and will be used to assist staff in their care and treatment of the resident. This will be updated at the morning meeting when the care plan is updated.

The R-Time Rounds will be conducted on at least a daily basis to monitor the staffing during the care and treatment of the residents, (Attachment B). Care staff will be in-serviced if the residents are missing devices or are not receiving the care that is required for them to reach their highest level of functioning.

As stated prior, the interdisciplinary team will be reassessing the patients for physical devices that will assist them in reaching their highest level of physical functioning and will continue to assess for their devices quarterly or as needed. Call lights are part of the devices that will be reviewed.

All these systems will be in place by 12/13/00.

The director of nurses or designee and the administrator or designee will be responsible to monitor this process and the results of these systems will be reported to the Quality Assurance/Improvement Committee. The monitoring and reporting process will be in place by 12/13/00.

Completion Date for the entire process will be on 12/13/00.

F246

Residents who did not have their call light answered timely are now part of the Patient Care Monitoring System. Further the maintenance director went to these resident's rooms and assessed the length of the call light to assure the resident could reach it. This was provided for residents 33,41,43,48,53,67,71,74, and 79.

All residents were re-assessed to assure quality care in regards to call light use, irregular labs, restraints, behaviors, accidents, and skin conditions. This was done to assist the residents to reach their highest maintenance level of practical functioning. The residents received updated assessments and additional care planning when the condition of the resident warranted a change. Further the maintenance man went to each resident's room to asses the call light to assure all residents could reach it. This process will be completed on 12/13/00.

Facility administration implemented the following changes:
Each morning during business days, those members of the interdisciplinary team that are at the facility will be reviewing the twenty four hour report, all lab reports, telephone orders, accident and incident reports, and bath sheets to determine condition changes and resident's complaints and concerns. The charts of the residents that appear on the report will be reviewed to identify changes that are required on the care plan. The care plans will be updated at that time and the patient care log will be updated to reflect the procedure changes that are required to assist the resident.

The Patient Care Log, (Attachment A), will be filled out for all patients and will be used to assist staff in their care and treatment of the resident. This will be updated at the morning meeting when the care plan is updated.

The R-Time Rounds will be conducted on at least a daily basis to monitor the staffing during the care and treatment of the residents, (Attachment B). Care staff will be in-serviced if the residents are missing devices or are not receiving the care that is required for them to reach their highest level of functioning.

As stated prior, the interdisciplinary team will be reassessing the patients for physical devices that will assist them in reaching their highest level of physical functioning and will continue to assess for their devices quarterly or as needed. Call lights are part of the devices that will be reviewed.

All these systems will be in place by 12/13/00.

The director of nurses or designee and the administrator or designee will be responsible to monitor this process and the results of these systems will be reported to the Quality Assurance/Improvement Committee. The monitoring and reporting process will be in place by 12/13/00.

Completion Date for the entire process will be on 12/13/00.

F252

The maintenance man now monitors water temperatures daily through the preventative maintenance program. Temperature will be monitored daily for the next month and weekly thereafter. Variances to the standard will be reported to the administrator for resolution and monitoring will increase until resolved. This will assure the water temperatures meet proper guidelines for comfort and safety of the residents. This process was put in place on 11/24/00.

The administrator is monitoring complaints closely. The complaints come in through resident council and now through the 24-hour report system implemented. The administrator will log in the complaint and develop an investigation sheet and will share the results of all complaints and investigations to the Quality Assurance/Improvement committee. The maintenance director is required to monitor the water temperatures and assure they're within the proper comfort and safety parameters. The administrator is responsible to monitor the overall process and assure the resident's comfort and safety is assured. This process will be completed on 11/24/00.

F329

Resident 41 upon readmission on 10/03/00 was receiving Coumadin 3mg which was discontinued on 10/12/00. This was replaced with Plavix 75 mg. No dosage adjustment and/or labs are necessary per manufacturer insert.

Resident 67 had Coumadin 2.5mg held on 12/1/00. A repeat pro-time and INR was done on 12/4/00, with a pro-time result of 18.4 and INR of 2.4, which are within therapeutic ranges. Retesting will be done per house physician's protocol.

Resident 73 had an order received to hold Coumadin 3mg X 3days (11/21-11/23) and then restarted on 11/24/00. The next pro-time and INR was drawn on 12/1/00 which was within normal therapeutic limits.

All residents were re-assessed to assure quality care in regards to call light use, irregular labs, restraints, behaviors, accidents, and skin conditions. This was done to assist the residents to reach their highest maintenance level of practical functioning. The residents received updated assessments and additional care planning when the condition of the resident warranted a change. Further the maintenance man went to each resident's room to assess the call light to assure all residents could reach it. Further all resident's present medication regime was reviewed for accuracy and compliance. Incident reports were filled out when medication regime was not followed by the licensed staff and provided to the director of nurses and then the administrator for appropriate investigation and follow up. This process was completed on 11/23/00.

Facility administration implemented the following changes:
Each morning during business days, those members of the interdisciplinary team that are at the facility will be reviewing the twenty four hour report, all lab reports, telephone orders, accident and incident reports, and bath sheets to determine condition changes and resident's complaints and concerns. The charts of the residents that appear on the report will be reviewed to identify changes that are required on the care plan. The care plans will be updated at that time and the patient care log will be updated to reflect the procedure changes that are required to assist the resident.

The Patient Care Log, (Attachment A), will be filled out for all patients and will be used to assist staff in their care and treatment of the resident. This will be updated at the morning meeting when the care plan is updated.

The R-Time Rounds will be conducted on at least a daily basis to monitor the staffing during the care and treatment of the residents, (Attachment B). Care staff will be in-serviced if the residents are missing devices or are not receiving the care that is required for them to reach their highest level of functioning.

The director of nurses will monitor the MAR's and treatment sheets weekly to assure medications are being administered appropriately. The doctor's orders and all labs will be reviewed during the twenty-four hour report and that will assure licensed staff compliance as well. When an order is for periodic administration, the staff nurse receiving orders will block off dates that the medication is not to be administered leaving only the space the medication is to be given. The night shift nurses will review the MAR's to assure that this is done and the director of nurses or designee will follow up all new orders the next business day.

All these systems will be in place by 11/23/00.

The director of nurses or designee and the administrator or designee will be responsible to monitor this process and the results of these systems will be reported to the Quality Assurance/Improvement Committee. The monitoring and reporting process will be in place by 11/23/00.

Completion Date for the entire process will be on 11/23/00. For the Immediate Jeopardy, for all other items 12/13/00.

F463

Locks were installed on the bathroom doors at the front of the building on 11/24/00.

Call lights will be tested weekly for a month and then monthly as part of the preventative maintenance program. When call lights are determined not to be functioning, the maintenance director will get them repaired. If there is a lapse between the identified time and the repair time, the resident(s) without the call light(s) will receive a school bell they can ring until the light is fixed.

The maintenance man is responsible to assure the call light system operates effectively and the administrator is responsible to assure the call lights work as well. The administrator will make monthly round on his own to assure the call lights work properly. Issues with call lights or other complaints will appear on the twenty-four hour report and will be logged in with a complaint investigation sheet, which will review the issue in question for resolution.

The administrator will responsible to report his findings of call light issues to the Quality Assurance/Improvement committee. This process will be implemented by 11/24/00.

F490

All residents were re-assessed to assure quality care in regards to call light use, irregular labs, restraints, behaviors, accidents, and skin conditions. This was done to assist the residents to reach their highest maintenance level of practical functioning. The residents received updated assessments and additional care planning when the condition of the resident warranted a change. This process will be completed on 11/23/00.

Facility administration implemented the following changes:
Each morning during business days, those members of the interdisciplinary team that are at the facility will be reviewing the twenty four hour report, all lab reports, telephone orders, accident and incident reports, and bath sheets to determine condition changes and resident's complaints and concerns. The charts of the residents that appear on the report will be reviewed to identify changes that are required on the care plan. The care plans will be updated at that time and the patient care log will be updated to reflect the procedure changes that are required to assist the resident.

The Patient Care Log, (Attachment A), will be filled out for all patients and will be used to assist staff in their care and treatment of the resident. This will be updated at the morning meeting when the care plan is updated.

The R-Time Rounds will be conducted on at least a daily basis to monitor the staffing during the care and treatment of the residents, (Attachment B). Care staff will be in-serviced if the residents are missing devices or are not receiving the care that is required for them to reach their highest level of functioning.

As stated prior, the interdisciplinary team will be reassessing the patients for physical devices that will assist them in reaching their highest level of physical functioning and will continue to assess for their devices quarterly or as needed. Call lights are part of the devices that will be reviewed.

The director of nurses will monitor the MAR's and treatment sheets weekly to assure medications are being administered appropriately. The doctor's orders and all labs will be reviewed during the twenty-four hour report and that will assure licensed staff compliance as well. When an order is for periodic administration, the staff nurse receiving orders will block off dates that the medication is not to be administered leaving only the space the medication is to be given. The night shift nurses will review the MAR's to assure that this is done and the director of nurses or designee will follow up all new orders the next business day.

Staff members were in-serviced on the following issues that were applicable to their departments: twenty four hour report procedure, lab procedure, medication pass procedure, skin sheets, incident reports, call light issues and water temperatures. In addition, continual in-servicing will be done through daily rounds and through follow up on the twenty four hour report.

Call lights will be tested weekly for a month and then monthly as part of the preventative maintenance program. When call lights are determined not to be functioning, the maintenance director will get them repaired. If there is a lapse between the identified time and the repair time, the resident(s) without the call light(s) will receive a school bell they can ring until the light is fixed.

The maintenance man is responsible to assure the call light system operates effectively and the administrator is responsible to assure the call lights work as well. The administrator will make monthly round on his own to assure the call lights work properly. Issues with call lights or other complaints will appear on the twenty four hour report and will be logged in with a complaint investigation sheet, which will review the issue in question for resolution. The administrator will responsible to report his findings of call light issues to the Quality Assurance/Improvement committee. This process will be implemented by 11/23/00.

The non-certified persons will be logged in on a tickler file to assure they have completed everything that is required and have completed their certification process prior to the four month period.

All lab draws and incident reports were reviewed for the last three months to assure residents received the lab draws ordered and that the results had been reported to the physician.

All these systems will be in place by 11/23/00.

The director of nurses or designee and the administrator or designee will be responsible to monitor this process and the results of these systems will be reported to the Quality Assurance/Improvement Committee. The monitoring and reporting process will be in place by 11/23/00.

Completion Date for the entire process will be on 11/23/00. for the Immediate Jeopardy. For all other items 12/13/00. JB

F494

All nursing assistants hired will be checked through the Nurse Aide Registry and have a background check done. No nursing assistants will be hired until a training class is available or if they are currently enrolled in a class outside the facility. The non-certified persons will be logged in on a tickler file to assure they have completed everything that is required and have completed their certification process prior to the four month period.

The nurse aide training and skills compliance check list was updated on 12/13/00 to assure all new employees receive proper orientation before working on the floor and are certified within the four month period. The director of nurses or designee is responsible to monitor this system. The monitoring sheet is reviewed by the administrator and is presented to the Quality Assurance/Improvement Committee. This process will be in place by 12/13/00.

F502

Resident 41 upon readmission on 10/03/00 was receiving Coumadin 3mg which was discontinued on 10/12/00. This was replaced with Plavix 75 mg. No dosage adjustment is necessary per manufacturer insert.

Resident 67 had Coumadin 2.5mg held on 12/1/00. A repeat pro-time and INR was done on 12/4/00, with a pro-time result of 18.4 and INR of 2.4, which are within therapeutic ranges. Retesting will be done per house physician's protocol.

Resident 73 had an order received to hold Coumadin 3mg X 3days (11/21-11/23) and then restarted on 11/24/00. The next pro-time and INR was drawn on 12/1/00 which was within normal therapeutic limits.

Resident 2 had a UA done on 11/20/00, which was positive for a UTI. On 11/21/00 she was started on antibiotics (cipro X 7 days). A follow up UA will be done on 12/13/00.

Resident 4 had a digoxin level done on 11/22/00, which indicated therapeutic blood level of 1.3. This resident has been discharged.

Resident 57 had a monthly recheck of his pro-time and INR on 11/17/00 which indicated that his INR was within normal therapeutic range (2.91). A tickler file has been set up for monthly labs.

Resident 84 had a digoxin level was drawn 11/20/00 which was within normal therapeutic range (2.0). No new orders were received at this time.

Resident 86 had a UA obtained on 11/20/00, which indicated a UTI. Cipro was started on 11/20/00 X 7 days. A follow up UA was done on 12/1/00, which indicated a positive for a UTI. On 12/4/00 the physician ordered Bactrim X 7 days with a repeat UA due 12/13/00. On 12/7/00 the physician ordered Macrobid QD for prophylactic treatment of the resident's chronic UTI per director of nurses request.

All residents, including residents 2,4,41,67,73,57,84 and 86, were re-assessed to assure quality care in regards to call light use, irregular labs, restraints, behaviors, accidents, and skin conditions. This was done to assist the residents to reach their highest maintenance level of practical functioning. The residents received updated assessments and additional care planning when the condition of the resident warranted a change. This process will be completed on 11/23/00.

Facility administration implemented the following changes:
Each morning during business days, those members of the interdisciplinary team that are at the facility will be reviewing the twenty four hour report, all lab reports, telephone orders, accident and incident reports, and bath sheets to determine condition changes and resident's complaints and concerns. The charts of the residents that appear on the report will be reviewed to identify changes that are required on the care plan. The care plans will be updated at that time and the patient care log will be updated to reflect the procedure changes that are required to assist the resident.

The Patient Care Log, (Attachment A), will be filled out for all patients and will be used to assist staff in their care and treatment of the resident. This will be updated at the morning meeting when the care plan is updated.

The R-Time Rounds will be conducted on at least a daily basis to monitor the staffing during the care and treatment of the residents, (Attachment B). Care staff will be in-serviced if the residents are missing devices or are not receiving the care that is required for them to reach their highest level of functioning.

As stated prior, the interdisciplinary team will be reassessing the patients for physical devices that will assist them in reaching their highest level of physical functioning and will continue to assess for their devices quarterly or as needed. Call lights are part of the devices that will be reviewed.

All these systems will be in place by 11/23/00.

The director of nurses or designee and the administrator or designee will be responsible to monitor this process and the results of these systems will be reported to the Quality Assurance/Improvement Committee. The monitoring and reporting process will be in place by 11/23/00.

Completion Date for the entire process will be on 11/23/00. For the Immediate Jeopardy. For all other items. 12/13/00. JB

F505

Resident 2 had a UA done on 11/20/00, which was positive for a UTI. On 11/26/00 she was started on antibiotics (cipro X 7 days). A follow up UA will be done on 12/13/00.

Resident 41 upon readmission on 10/03/00 was receiving Coumadin 3mg, which was discontinued on 10/12/00. This was replaced with Plavix 75 mg. No dosage adjustment is necessary per manufacturer insert.

Resident 67 receiving Coumadin 2.5mg was held on 12/1/00. A repeat pro-time and INR was done on 12/4/00 with results within therapeutic range (18.4/2.4). Retesting will be done per house physician's protocol.

Resident 73 had an order received to hold Coumadin 3mg X 3days and then restarted on 11/24/00. Next pro-time and INR was drawn on 12/1/00 which was within normal therapeutic limits.

All lab draws and incident reports were reviewed for the last three months to assure residents received the lab draws ordered and that they were provided the physician.

All residents were re-assessed to assure quality care in regards to call light use, irregular labs, restraints, behaviors, accidents, and skin conditions. This was done to assist the residents to reach their highest maintenance level of practical functioning. The residents received updated assessments and additional care planning when the condition of the resident warranted a change. This process will be completed on 11/23/00.

Facility administration implemented the following changes:
Each morning during business days, those members of the interdisciplinary team that are at the facility will be reviewing the twenty four hour report, all lab reports, telephone orders, accident and incident reports, and bath sheets to determine condition changes and resident's complaints and concerns. The charts of the residents that appear on the report will be reviewed to identify changes that are required on the care plan. The care plans will be updated at that time and the patient care log will be updated to reflect the procedure changes that are required to assist the resident.

The Patient Care Log, (Attachment A), will be filled out for all patients and will be used to assist staff in their care and treatment of the resident. This will be updated at the morning meeting when the care plan is updated.

The R-Time Rounds will be conducted on at least a daily basis to monitor the staffing during the care and treatment of the residents, (Attachment B). Care staff will be in-serviced if the residents are missing devices or are not receiving the care that is required for them to reach their highest level of functioning.

As stated prior, the interdisciplinary team will be reassessing the patients for physical devices that will assist them in reaching their highest level of physical functioning and will continue to assess for their devices quarterly or as needed. Call lights are part of the devices that will be reviewed.

All these systems will be in place by 11/23/00.

The director of nurses or designee and the administrator or designee will be responsible to monitor this process and the results of these systems will be reported to the Quality Assurance/Improvement Committee. When lab results are not reported to the physician, the administrator will develop an accident/injury investigation sheet and notify the physician and in-service the nurse. The monitoring and reporting process will be in place by 11/23/00.

Completion Date for the entire process will be on 11/23/00. For the Immediate Jeopardy. For all other items 12/13/00. 18

F521

All residents were re-assessed to assure quality care in regards to call light use, irregular labs, restraints, behaviors, accidents, and skin conditions. This was done to assist the residents to reach their highest maintenance level of practical functioning. The residents received updated assessments and additional care planning when the condition of the resident warranted a change. This process will be completed on 11/23/00.

Facility administration implemented the following changes:
Each morning during business days, those members of the interdisciplinary team that are at the facility will be reviewing the twenty four hour report, all lab reports, telephone orders, accident and incident reports, and bath sheets to determine condition changes and resident's complaints and concerns. The charts of the residents that appear on the report will be reviewed to identify changes that are required on the care plan. The care plans will be updated at that time and the patient care log will be updated to reflect the procedure changes that are required to assist the resident.

The Patient Care Log, (Attachment A), will be filled out for all patients and will be used to assist staff in their care and treatment of the resident. This will be updated at the morning meeting when the care plan is updated.

The R-Time Rounds will be conducted on at least a daily basis to monitor the staffing during the care and treatment of the residents, (Attachment B). Care staff will be in-serviced if the residents are missing devices or are not receiving the care that is required for them to reach their highest level of functioning.

As stated prior, the interdisciplinary team will be reassessing the patients for physical devices that will assist them in reaching their highest level of physical functioning and will continue to assess for their devices quarterly or as needed. Call lights are part of the devices that will be reviewed.

The director of nurses will monitor the MAR's and treatment sheets weekly to assure medications are being administered appropriately. The doctor's orders and all labs will be reviewed during the twenty four hour report and that will assure licensed staff compliance as well. When an order is for periodic administration, the staff nurse receiving orders will block off dates that the medication is not to be administered leaving only the space the medication is to be given. The night shift nurses will review the MAR's to assure that this is done and the director of nurses or designee will follow up all new orders the next business day.

Call lights will be tested weekly for a month and then monthly as part of the preventative maintenance program. When call lights are determined not to be functioning, the maintenance director will get them repaired. If there is a lapse between the identified time and the repair time, the resident(s) without the call light(s) will receive a school bell they can ring until the light is fixed.

The maintenance man is responsible to assure the call light system operates effectively and the administrator is responsible to assure the call lights work as well. The administrator will make monthly round on his own to assure the call lights work properly. Issues with call lights or other complaints will appear on the twenty four hour report and will be logged in with a complaint investigation sheet, which will review the issue in question for resolution. The administrator will responsible to report his findings of call light issues to the Quality Assurance/Improvement committee. This process will be implemented by 11/23/00.

The non-certified persons will be logged in on a tickler file to assure they have completed everything that is required and have completed their certification process prior to the four month period.

All lab draws and incident reports were reviewed for the last three months to assure residents received the lab draws ordered and that they were provided the physician.

All these systems will be in place by 11/23/00.

The director of nurses or designee and the administrator of designee will be responsible to monitor this process and the results of these systems will be reported to the Quality Assurance/Improvement Committee. The monitoring and reporting process will be in place by 11/23/00.

Completion Date for the entire process will be on 11/23/00. For the Immediate Jeopardy. for all other items 12/13/00. JB

Accepted 12/28/00 - M. Davis RN

F241

Rounds will be conducted on at least a daily basis by nurses and/or rehab aides to monitor the staff during the care and treatment of the residents (Attachment A). Care staff will be in-serviced continuously, as needed, if the residents are not receiving the care that is required for them to reach their highest level of functioning. Included in the rounds will be the monitoring of call lights being answered in a timely manner.

The nursing department was in-serviced about answering call lights in a timely manner. Other departments were also in-serviced on answering call lights and what they could and could not do for the residents. These in-services were held between 11/18/00 and 11/21/00.

Call lights will also be monitored at the nurses station at least three times per week times for a month and then at least weekly thereafter. The monitoring will be done by administrative staff or designated staff members. Results of the monitoring and any complaints and concerns will be monitored in the twenty-four hour report.

The director of nurses or designee and the administrator or designee will be responsible to monitor this process and the results of these systems will be reported to the Quality Assurance/Improvement Committee. The Quality Assurance/Improvement Committee will review the results on a monthly basis. The monitoring and reporting process was in place by 12/5/00.

Completion Date for the entire process was on 12/5/00.

F246

Residents 33, 41, 43, 48, 53, 67, 71, 74 and 79 were re-assessed by the interdisciplinary team to assure that call light accessibility needs were met. Residents with mental and/or physical limitations had care plans updated as necessary. These residents will be monitored during rounds that are conducted on at least a daily basis. This process was completed by 12/5/00.

Rounds will be conducted on at least a daily basis by nurses and/or rehab aides to monitor the staff during the care and treatment of the residents (Attachment A). Care staff will be in-serviced if the residents are not receiving the care that is required for them to reach their highest level of functioning. Included in this will be the monitoring of call light accessibility for all residents.

The nursing department was in-serviced on assuring that call lights are within reach of residents. Other departments were in-serviced on the necessity of residents having accessibility to call lights and what they could and could not do for the residents. These in-services were held between 11/18/00 and 11/21/00.

The maintenance man went to each resident's room to assess the call light to assure all residents could reach it. This process was completed on 11/24//00.

The director of nurses or designee and the administrator or designee will be responsible to monitor this process and the results of these systems will be reported monthly to the Quality Assurance/Improvement Committee. The monitoring and reporting process was in place by 12/5/00.

Completion Date for the entire process was on 12/5/00.

F252

The maintenance man now monitors water temperatures daily throughout the building in random locations. This will be done as part of the preventative maintenance program. Temperatures will be monitored daily for the next month and weekly thereafter. Temperatures will be maintained between 105 and 115 degrees Fahrenheit. Any temperatures under 100 degrees or over 120 degrees Fahrenheit will be reported immediately to the administrator for resolution and monitoring will increase until resolved. This will assure that water temperatures meet proper guidelines for comfort and safety of the residents. This process was put in place on 11/24/00.

The administrator is monitoring complaints closely. The complaints come in through resident council and now through the 24-hour report system implemented. The administrator will develop an investigation sheet and will share the results of all complaints and investigations each month to the Quality Assurance/Improvement Committee. The maintenance director is required to monitor the water temperatures and assure they're within the proper comfort and safety parameters. The administrator is responsible to monitor the overall process and assure the resident's comfort and safety is assured. This process was completed on 11/24/00.

F329

Resident 41 upon readmission on 10/03/00 was receiving Coumadin 3mg, which was discontinued on 10/12/00. This was replaced with Plavix 75 mg. No dosage adjustment and/or labs are necessary per manufacturer insert. All labs will be reported to the physician and followed through daily in the twenty-four hour report.

Resident 67 had Coumadin 2.5mg held on 12/1/00. A repeat pro-time and INR was done on 12/4/00, with a pro-time result of 18.4 and INR of 2.4, which are within therapeutic ranges. Pro-time and INR labs will be drawn on a monthly basis and PRN. All labs will be reported to the physician and followed through daily in the twenty-four hour report.

Resident 73 had an order received to hold Coumadin 3mg X 3days (11/21-11/23) and then restarted on 11/24/00. The next pro-time and INR was drawn on 12/1/00 which was within normal therapeutic limits. Pro-time and INR labs will be drawn on a monthly basis and PRN. All labs will be reported to the physician and followed through daily in the twenty-four hour report.

All residents, including residents 41, 67 and 73, had their telephone orders reviewed to ascertain any lab orders. Those lab orders were tracked to assure they were drawn, the reports given to the physician, and follow up labs orders and obtained. The director on nurses followed this process and filled out an abnormal lab report to assure the orders were followed. The director of nurses went back three months in all the residents' medical records. All abnormal labs were reviewed and care plans were updated when there was a history of abnormal labs through a period of different interventions. This was done to assure that all residents were free from potential dangers from receiving unnecessary medications. If issues were discovered the director of nurses, or designee, filled out an incident report and reviewed the situation. This information was also reported to the administrator. Any lacking orders were drawn and the physician was notified on 11/19/00. This was completed by 11/19/00.

Two "tickler" files were developed. One tickler file contains folders for each of the twelve months. The second "tickler file contains daily files (1-31). The quarterly, monthly and yearly labs are put into the lab draw box in the period they are to be done. At the beginning of each month, information from the monthly file goes into the daily file on the appropriated day. A master copy of the request for the lab draw is kept by the director of nurses as a secondary review. The director of nurses will report any concerns with this system, monthly, to the Quality Assurance Committee meeting. This system was completed by 11/19/00.

To assure continued compliance, all physician orders, lab results, accident and incident reports, bath sheets and twenty-four hour reports are all maintained in a writing box at the nurses station. Members of the interdisciplinary

well-being of each resident. Included in these policies is the daily monitoring of labs and the twenty-four hour report, new lab procedures and tracking system, MAR review, rounds procedures, and continual staff in-servicing.

Two "tickler" files were developed. One tickler file contains folders for each of the twelve months. The second "tickler file contains daily files (1-31). The quarterly, monthly and yearly labs are put into the lab draw box in the period they are to be done. At the beginning of each month, information from the monthly file goes into the daily file on the appropriated day. A master copy of the request for the lab draw is kept by the director of nurses as a secondary review. The director of nurses will report any concerns with this system, monthly, to the Quality Assurance Committee meeting. This system was completed by 11/19/00.

To assure continued compliance, all physician orders, lab results, accident and incident reports, bath sheets and twenty-four hour reports are all maintained in a writing box at the nurses station. Members of the interdisciplinary team that are at the facility will review this information each morning during business days. Any accidents, incidents, changes of condition, complaints, and/or other areas of concern will be identified. Care plans will be updated, if necessary, at that time and an appointed member of the interdisciplinary team will follow through any complaints and/or concerns. Further, on non-business days, the weekend manager will review the twenty-four hour report and all labs to assure that the labs were drawn, results were received and the physician notified in a timely manner. This will allow facility administration the opportunity to do a secondary check on the nursing staff and facility consultants. The administrator, director of nurses and/or medical records personnel will also conduct random chart reviews on a monthly basis. This system was completed by 12/5/00.

The director of nurses and administrator have reviewed all labs that were not drawn, abnormal labs and labs not communicated with the physician. These issues were put on incident reports, investigated and assured the physician was notified, the care plan updated and the staff in-serviced. This system was completed by 11/19/00.

The director of nurses will monitor the MAR's and treatment sheets weekly to assure medications are being administered appropriately. The doctor's orders and all labs will be reviewed during the twenty-four hour report to assure licensed staff compliance as well. When an order is for periodic administration, the staff nurse receiving orders will block off dates that the medication is not to be administered leaving only the space the medication is to be given. The night shift nurses will review the MAR's to assure that this is done and the director of nurses or designee will follow up all new orders the next business day. This will be done as a secondary check on the nurses to assure that unnecessary medications are not administered. This system was completed by 12/5/00.

The director of nurses or designee and the administrator or designee will be responsible to monitor this process and the results of these systems will be reported on a monthly basis to the Quality Assurance/Improvement Committee. The monitoring and reporting process was in place by 12/5/00.

Staff members were in-serviced on the following issues that were applicable to their departments: twenty four hour report procedure, lab procedure, MAR reviews, skin sheets, incident reports, call light issues and water temperatures. In addition, continual in-servicing will be done through daily rounds and through follow up on the twenty four hour report. These in-services were completed by 11/21/00. Continual in-services and monitoring will be conducted as needed.

All non-certified aides will be logged in on a tickler file to assure they have completed everything that is required and have completed their certification process prior to the four-month period. The director of nurses or designee will monitor this process.

Rounds will be conducted on at least a daily basis by nurses and/or rehab aides to monitor the staff during the care and treatment of the residents (Attachment A). Care staff will be in-serviced continuously, as needed, if the residents are not receiving the care that is required for them to reach their highest level of functioning. Included in the rounds will be the monitoring of call lights being answered in a timely manner and call light accessibility.

The nursing department was in-serviced about answering call lights in a timely manner and call light accessibility. Other departments were also in-serviced on answering call lights and what they could and could not do for the residents. These in-services were held between 11/18/00 and 11/21/00.

Call lights will also be monitored at the nurses station at least three times per week times for a month and then at least weekly thereafter. The monitoring will be done by administrative staff or designated staff members. Results of the monitoring and any complaints and concerns will be monitored in the twenty-four hour report.

The facility will monitor this process and the results of these systems will be reviewed in the Quality Assurance/Improvement Committee. The Quality Assurance/Improvement Committee will review the results on a monthly basis. The monitoring and reporting process was in place by 12/5/00.

F494

The non-certified nursing assistant that had been identified was taken off of the schedule on 11/16/00. The individual is currently re-taking the written test and will return to work at the facility as a nursing assistant when she has successfully completed her test.

All nursing assistants hired will be checked through the Nurse Aide Registry by the director of nurses and have a background check done. No nursing assistants will be hired until a training class is available or if they are currently enrolled in a class outside the facility. The non-certified persons will be logged in on a tickler file and tracked by the director of nurses to assure they have completed everything that is required and have completed their certification process prior to the four-month period.

The nurse aide training and skills compliance check list was updated on 12/5/00 to assure all new employees receive proper orientation before working on the floor and are certified within the four month period. The director of nurses or designee is responsible to monitor this system. The director of nurses will report the status of non-certified aides monthly to the Quality Assurance/Improvement Committee. This process was in place by 12/5/00.

F502

Resident 41 upon readmission on 10/03/00 was receiving Coumadin 3mg, which was discontinued on 10/12/00. This was replaced with Plavix 75 mg. No dosage adjustment is necessary per manufacturer insert. All labs will be reported immediately to the physician and followed through daily in the twenty-four hour report.

Resident 67 had Coumadin 2.5mg held on 12/1/00. A repeat pro-time and INR was done on 12/4/00, with a pro-time result of 18.4 and INR of 2.4, which are within therapeutic ranges. Pro-time and INR labs will be drawn on a monthly basis and PRN. All labs will be reported immediately to the physician and followed through daily in the twenty-four hour report.

Resident 73 had an order received to hold Coumadin 3mg X 3days (11/21-11/23) and then restarted on 11/24/00. The next pro-time and INR was drawn on 12/1/00 which was within normal therapeutic limits. Pro-time and INR labs will be drawn on a monthly basis and PRN. All labs will be reported immediately to the physician and followed through daily in the twenty-four hour report.

Resident 2 had a UA done on 11/20/00, which was positive for a UTI. On 11/21/00 she was started on antibiotics (cipro X 7 days). A follow up UA will be done on 12/13/00. All labs will be reported immediately to the physician and followed through daily in the twenty-four hour report.

Resident 4 had a digoxin level done on 11/22/00, which indicated therapeutic blood level of 1.3. This resident has been discharged.

Resident 57 had a monthly recheck of his pro-time and INR on 11/17/00 which indicated that his INR was within normal therapeutic range (2.91). A tickler file has been set up for monthly labs. All labs will be reported immediately to the physician and followed through daily in the twenty-four hour report.

To assure continued compliance, all physician orders, lab results, accident and incident reports, bath sheets and twenty-four hour reports are all maintained in a writing box at the nurses station. Members of the interdisciplinary team that are at the facility will review this information each morning during business days. Any accidents, incidents, changes of condition, complaints, and/or other areas of concern will be identified. Care plans will be updated, if necessary, at that time and an appointed member of the interdisciplinary team will follow through any complaints and/or concerns. Further, on non-business days, the weekend manager will review the twenty-four hour report and all labs to assure that the labs were drawn, results were received and the physician notified in a timely manner. This will allow facility administration the opportunity to do a secondary check on the nursing staff and facility consultants. The administrator, director of nurses and/or medical records personnel will also conduct random chart reviews on a monthly basis. This system was completed by 12/5/00.

As stated prior, the interdisciplinary team will be reassessing the patients for physical devices that will assist them in reaching their highest level of physical functioning and will continue to assess for their devices quarterly or as needed. Call lights are part of the devices that will be reviewed.

The director of nurses or designee and the administrator or designee will be responsible to monitor this process and the results of these systems will be reported monthly to the Quality Assurance/Improvement Committee. When lab results are not reported to the physician, the administrator will develop an accident/injury investigation sheet and notify the physician and in-service the nurse. The monitoring and reporting process was in place by 11/23/00.

Completion Date for the entire process was on 12/5/00.

F521

The facility will now monitor and review the following issues in the Quality Assurance/Improvement Committee: Labs, MAR sheets, twenty-four hour report issues, resident's complaints and concerns, non-certified nursing assistant status, water temperatures, all call light issues and any other areas of concern as needed. The director of nurses or designee and the administrator of designee will be responsible to monitor this process and the results of these systems will be reported monthly to the Quality Assurance/Improvement Committee. The Quality Assurance/Improvement Committee will meet together as a whole on a quarterly basis, however, members of the committee will meet monthly to review the preceding issues.

Compliance for all issues was in place by 12/5/00.

Resident 84 had a digoxin level was drawn 11/20/00 which was within normal therapeutic range (2.0). No new orders were received at this time. All labs will be reported immediately to the physician and followed through daily in the twenty-four hour report.

Resident 86 had a UA obtained on 11/20/00, which indicated a UTI. Cipro was started on 11/20/00 X 7 days. A follow up UA was done on 12/1/00, which indicated a positive for a UTI. On 12/4/00 the physician ordered Bactrim X 7 days with a repeat UA due 12/13/00. On 12/7/00 the physician ordered Macrobid QD for prophylactic treatment of the resident's chronic UTI per director of nurses request. All labs will be reported immediately to the physician and followed through daily in the twenty-four hour report.

To assure continued compliance, all physician orders, lab results, accident and incident reports, bath sheets and twenty-four hour reports are all maintained in a writing box at the nurses station. Members of the interdisciplinary team that are at the facility will review this information each morning during business days. Any accidents, incidents, changes of condition, complaints, and/or other areas of concern will be identified. Care plans will be updated, if necessary, at that time and an appointed member of the interdisciplinary team will follow through any complaints and/or concerns. Further, on non-business days, the weekend manager will review the twenty-four hour report and all labs to assure that the labs were drawn, results were received and the physician notified in a timely manner. This will allow facility administration the opportunity to do a secondary check on the nursing staff and facility consultants. The administrator, director of nurses and/or medical records personnel will also conduct random chart reviews on a monthly basis. This system was completed by 12/5/00.

Staff members were in-serviced on the following issues that were applicable to their departments: twenty-four hour report procedure, lab procedure, and MAR protocol. In addition, continual in-servicing will be done through daily rounds and through follow up on the twenty-four hour report. These in-services were completed by 12/5/00. Continual in-services and monitoring will be conducted as needed.

The director of nurses or designee and the administrator or designee will be responsible to monitor this process and the results of these systems will be reported monthly to the Quality Assurance/Improvement Committee. The monitoring and reporting process was in place by 12/5/00.

Completion Date for the entire process was on 12/5/00.

F505

Resident 2 had a UA done on 11/20/00, which was positive for a UTI. On 11/26/00 she was started on antibiotics (cipro X 7 days). A follow up UA will be done on 12/13/00. All labs will be reported immediately to the physician and followed through daily in the twenty-four hour report.

Resident 41 upon readmission on 10/03/00 was receiving Coumadin 3mg, which was discontinued on 10/12/00. This was replaced with Plavix 75 mg. No dosage adjustment is necessary per manufacturer insert. All labs will be reported immediately to the physician and followed through daily in the twenty-four hour report.

Resident 67 receiving Coumadin 7.5mg was held on 12/1/00. A repeat pro-time and INR was done on 12/4/00 with results within therapeutic range (18.4/2.4). Retesting will be done on a monthly basis and PRN. All labs will be reported immediately to the physician and followed through daily in the twenty-four hour report.

Resident 73 had an order received to hold Coumadin 3mg X 3days and then restarted on 11/24/00. Next pro-time and INR was drawn on 12/1/00 which was within normal therapeutic limits. All labs will be reported immediately to the physician and followed through daily in the twenty-four hour report.

All lab draws and incident reports were reviewed for the last three months to assure residents received the lab draws ordered and that they were provided the physician on 11/19/00.

To assure continued compliance, all physician orders, lab results, accident and incident reports, bath sheets and twenty-four hour reports are all maintained in a writing box at the nurses station. Members of the interdisciplinary team that are at the facility will review this information each morning during business days. Any accidents, incidents, changes of condition, complaints, and/or other areas of concern will be identified. Care plans will be updated, if necessary, at that time and an appointed member of the interdisciplinary team will follow through any complaints and/or concerns. Further, on non-business days, the weekend manager will review the twenty-four hour report and all labs to assure that the labs were drawn, results were received and the physician notified in a timely manner. This will allow facility administration the opportunity to do a secondary check on the nursing staff and facility consultants. The administrator, director of nurses and/or medical records personnel will also conduct random chart reviews on a monthly basis. This system was completed by 12/5/00.

As stated prior, the interdisciplinary team will be reassessing the patients for physical devices that will assist them in reaching their highest level of physical functioning and will continue to assess for their devices quarterly or as needed. Call lights are part of the devices that will be reviewed.

The director of nurses or designee and the administrator or designee will be responsible to monitor this process and the results of these systems will be reported to the Quality Assurance/Improvement Committee. When lab results are not reported to the physician, the administrator will develop an accident/injury investigation sheet and notify the physician and in-service the nurse. The monitoring and reporting process was in place by 11/23/00.

Completion Date for the entire process was on 12/5/00.

F521

The facility will now monitor and review the following issues in the Quality Assurance/Improvement Committee: Labs, MAR sheets, twenty-four hour report issues, resident's complaints and concerns, non-certified nursing assistant status, water temperatures, all call light issues and any other areas of concern as needed. The director of nurses or designee and the administrator of designee will be responsible to monitor this process and the results of these systems will be reported monthly to the Quality Assurance/Improvement Committee. The Quality Assurance/Improvement Committee will meet together as a whole on a quarterly basis, however, members of the committee will meet monthly to review the preceding issues.

Compliance for all issues was in place by 12/5/00.

505 - quarterly

Potomac Healthcare of Ogden

This a partial Directed Plan of Correction for the abbreviated survey dated November 17, 2000:

The facility is being directed to include the following items as part of an acceptable plan of correction:

1. The facility must maintain a log with all the routine and incidental lab draws that are to be done including:
   a. Date drawn
   b. Date returned to the facility
   c. Date the physician was notified
   d. Any follow up lab if indicated.

2. Set up a file box, letter size, with dividers for days of the month dated 1 through 31, to be kept at the nurses' station and accessible to the lab. The file box will contain all the lab slips that the lab needs to draw on any given day.

3. Designate a nurse to be in charge of the labs. Duties to include:

   a. Make out all routine monthly lab slips and place them in the file box according to the date they are due.
   b. Review all labs and notify the physician of all lab values.
   c. Review all telephone orders and make sure lab requests are fill out and placed in the lab file under the appropriate date to be drawn.
   d. Make sure all labs to be drawn are entered in the lab log.

4. All labs need to be noted as reviewed or called to the physician. The date, time and the nurse completing the noting must be on the lab slip or fax sheet.

5. A nurses' note must be made in the clinical record stating that the lab was reviewed and whether the physician was notified and any change in order.

6. A policy must be developed with the Medical Director regarding which labs need to be called to the physician and which labs can wait to be reviewed when the physician is in the facility.