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 _____	6/27/01

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

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F 241 SS=B	483.15(a) QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined that for 5 of 9 residents in a confidential group interview plus one resident in a confidential individual interview, the facility did not promote care for residents in a manner that maintained or enhanced each resident's dignity and respect in recognition of his/her individuality by not answering their call lights in a timely manner. Findings Include: A confidential group interview was held with residents on 6/20/01, at 10:30 AM. Nine (9) residents participated in the group interview. Five (5) of the 9 residents stated they have had to wait extended periods of time to have their call lights answered during meal times. A confidential resident interview was held on 6/20/01,at 9:00 AM. The resident stated he/she has had to wait extended periods of time for his/her call light to be answered during meal times. This resident stated he/she had to wait more than fifteen minutes for staff to respond to the call light on several occasions. This resident stated the problem exsisted during almost every meal. He/she stated that the last time he/she had to wait more than fifteen minutes was two days prior, during the lunch meal. This resident stated he/she used a watch to monitor staff response time.	F 241 8/28/01	**F 241** Tray schedule was modified July 2nd to free up one additional aid to answer call lights during the meal times. Response time will be monitored by DON, or other department heads to ensure appropriate response time. Spot checks will be done to ensure appropriate response times are maintained. Information will be communicated to the resident council at their regularly scheduled meetings. It will be a regularly scheduled agenda item for the resident council. Response times will be reviewed in QA meetings on a quarterly basis. Responsible party will be administrator, DON, and recreation director. Alleged date of compliance will be August 31, 2001.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 8/28/01

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 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 A review of the resident council minutes was done on 6/20/01. During the 5/25/01 resident council meeting, residents identified a problem with call lights being answered in a timely manner. On 6/27/01, at 8:30 AM, the call light to room 412 was observed to be signaling. At 8:46 AM, the Director of Nursing (DON) entered room 412. A total of 16 minutes lapsed before the call light was answered. On 6/27/01, at 9:06 AM, the call light to room 318 was observed to be signaling. At 9:16 AM, a staff member entered room 318. A total of 10 minutes lapsed before the call light was answered. On 6/27/01, at 9:18 AM, the call light to room 316 was observed to be signaling. At 9:36 AM, a staff member entered room 316. A total of 18 minutes lapsed before the call light was answered.	F 241		
F 279 SS=D	483.20(k) RESIDENT ASSESSMENT The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under s483.25; and Any services that would otherwise be required under	F 279 MB 8/20/01	**F 279** Care plans for Resident 37 and resident 38 have been reviewed to ensure that identified problems have been care planned. Incident reports have been developed and physician has been notified regarding incidents. All resident care plans will be reviewed at IDT meetings when MDS updates are being made. Issues listed on the MDS will be put on a care plan at that time. A review of all current residents will be completed by September 14, 2001 to ensure that all needs are being met and properly care planned. Twenty-four hour report is reviewed daily to identify additional needs that need to be addressed. New residents will have care plans completed in the same manner within the time frame specified by regulation. DON will be responsible for care plans being completed on time for each identified need. QA committee will review care plan issues on a monthly basis for three months, then quarterly thereafter to ensure that care plans are being done correctly and timely. Responsible party will be Director of Nursing. Alleged date of compliance will be September 14, 2001.	

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	s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined that for 1 of 15 sampled residents plus 1 additional resident, the facility did not develop a comprehensive care plan to address significant care concerns. Specifically, resident 37 had a history of an acute care hospitalization for fecal impaction. A problem of bowel elimination was not included on her care plan. Resident 38 has had multiple instances of injuring her right great toe. Although care of the resultant wounds have been care planned, preventative measures have not been addressed on her care plan. Findings include: 1. Resident 37 was an 88 year old female admitted on 4/11/99 to this facility with diagnoses of anemia, gastrointestinal bleed, dementia, esophagitis, and constipation. On 6/20/01 at 3:35 PM, resident 37 was observed to be telling the wound treatment nurse she had abdominal discomfort and that she felt she needed to go to the hospital to have stool removed. She stated she had been to the hospital before to have that done. On 6/20/01 4:00 PM, an interview was held with resident 37's nurse. The nurse stated she had just provided digital stimulation with removal of stool from resident 37's rectum. She stated the resident had a large amount of stool present in her rectum. The nurse stated the resident was assisted to the toilet and had another large bowel movement.			

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F 279	Continued From page 3 On 6/20/01 at 4:50 PM, an interview was held with the Director of Nursing (DON). The DON stated resident 37 had complained about abdominal discomfort on Monday, 6/18/01. The DON stated she requested a nurse give the resident some Milk of Magnesia. A review resident 37's medication administration record revealed that on 6/18/01, a nurse administered Milk of Magnesia to the resident. On 6/19/01, a review of resident 37's nurses notes dated 1/8/01 revealed documentation that resident 37 was vomiting "blood" and would be transfered to an acute hospital for evaluation. On 6/19/01, a review of the history and physical from the acute hospital revealed that resident 37 had been admitted for a high fecal impaction, which required treatment for forty eight hours after admit, to clear the bowels. On 6/20/01, review of resident 37's comprehensive care plan revealed that there was no care plan problem that addressed resident 37's history of fecal impaction with a goal and approaches to prevent recurrance. 2. Resident 38 was a 73 year old female admitted 12/18/00 with the diagnosis of Alzheimer's disease, hypertension, duodenal ulcer and arthritis. The resident had three incidents of injury to her right great toe. A review of resident 38's medical record was done. On 1/16/01, a nurses note revealed that there was an order to discontinue the dressing changes to the right	F 279		

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F 279	Continued From page 4 great toe. This suggested that an injury had occurred prior to this order. A review of the telephone orders, dated 3/7/01, revealed that there was an order for dressing changes on resident 38's right great toe. During an interview with the Administrator on 6/26/01, it was noted that the incident happened while the resident was being transferred. A review of the nurse's note, dated 6/1/01, revealed that resident 38 possibly bumped her right great toe on the wheelchair. The nurse asssessed the skin tear to be two inches by two inches. A review of resident 38's care plan, dated 6/4/01, revealed that the nurse was to treat the right great toe with antibiotic therapy and dressing changes. No prevention goals, interventions or approaches were noted.	F 279	**F 309** Incident reports will be written for residents 1, 2, 11, 22, 27, 38 and 40 and the physician will be notified of missed treatments. Facility will review all residents with wound care treatment orders to ensure that treatments are being done according to physician orders. When a discrepancy is discovered, incident report will be developed and the physician notified of the discrepancy. Treatments will be monitored by the DON daily for the next 30 days and weekly thereafter to ensure treatments are done according to physician order. New policy is being developed for treatments. Nursing staff was in-serviced July 10th regarding proper protocol for treatments(see attached in-service agenda). Treatments will be audited weekly for the next quarter by Medical Records. Treatments will be addressed on the QA agenda monthly. DON will be responsible to monitor treatments. Alleged date of compliance will be September 14, 2001.	
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined that for 3 of 15 sampled residents	F 309 JSB 8/22/01		

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plus 5 additional residents, the facility did not provide the necessary cares and services to attain or maintain the hightest practicable physical well-being.

Facility staff applied an adherent dressing to a resident with a draining wound which resulted in worsening of a skin tear. (Resident 26)

Facility staff failed to apply dressings to seven residents with skin abrasions or wounds. The dressings were ordered by a physician and incorporated into residents' plan of care. (Residents 1, 2, 11, 22, 27, 38 and 40.)

Findings include:

1. Resident 26 was admitted to the facility on 4/25/01. Her diagnoses included a right hip fracture, chronic obstructive pulmonary disease, and a cerebrovascular accident.

An observation of resident 26 was made on 6/20/01, at 2:15 PM. At that time, the resident had a gauze roll dressing on her right forearm. The wound treatment nurse unrolled the gauze bandage. Sanguineous (bloody) drainage had dried causing the gauze dressing to adhere to the wound. The wound treatment nurse sprayed copious amounts of wound cleanser to the gauze dressing. As the treatment nurse removed the gauze dressing, a triangular section of skin pulled away from resident 26's right forearm. The section was approximately 1.5 centimeters (cm) by . 5 cm. This skin tear bled. Resident 26 cried out and had a grimace on her face as the nurse removed the gauze bandage. The wound treatment nurse applied pressure to the wound for approximately five minutes then applied a non-adhering gauze pad to the wound. The surveyor

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requested the Director of Nursing (DON) observe the resident's right forearm wound. The wound treatment nurse showed the DON the dry gauze roll which had been on the wound that had dried sanguineous drainage. He also showed the DON the skin tear which occurred when the dressing was removed. The wound treatment nurse explained to the DON that he had tried to loosen the dressing from the wound by saturating the dressing with wound cleanser.

An interview with the wound treatment nurse was held on 6/20/01, following resident 26's wound treatment. The nurse stated resident 26 did not have the skin tear to her right forearm on 6/17/01; the last day he worked. The nurse also stated the dressing that was on the resident's right forearm was not an appropriate dressing as it adhered to the wound and caused more damage to the skin tissue. The wound treatment nurse stated the treatment should have included a non-adherent dressing.

An interview with the DON was held on 6/20/01, following resident 26's wound treatment. The DON stated the treatment that had been applied to the resident's right forearm was not appropriate for the wound. She stated the treatment should have included a non-adherent dressing.

An observation of resident 26 was made on 6/26/01, at 3:20 PM. The wound treatment nurse removed a gauze roll dressing from the resident's right forearm. Under the gauze roll, was a gauze 4 x 4 pad. The gauze pad was not a non-adhering pad. The wound treatment nurse saturated the gauze 4 x 4 pad with wound cleanser and removed it. The gauze 4 x 4 pad adhered to the wound, however, no further skin tearing occurred when the pad was removed.

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F 309	Continued From page 7 An interview with the wound treatment nurse was held on 6/26/01, following resident 26's wound treatment. The nurse stated the dressing that had been on the resident's right forearm was not the dressing that had been ordered. He stated there was not a non-adherent dressing covering the wound. A review of resident 26's medical record was done. On 6/20/01, a physician telephone order was obtained to perform a dressing change to resident 26's right forearm everyday until the wound resolved. The treatment ordered was to clean the wound with wound cleanser, apply Bacitracin ointment, cover the wound with a non-adherent gauze 4 x 4 pad, then to wrap the wound with a gauze roll. Prior to 6/20/01, there was no ordered treatment for the skin tear to resident 26's right forearm. 2. Resident 11 was a 95 year old female admitted 6/28/00 with the diagnoses of diabetes mellitis, deep vein thrombosis, polio, and congestive heart failure. A review of resident 11's medical record was done. A nursing note, dated 5/8/01, documented resident 11 had a wound on her right outer ankle. The nursing note also documented the resident's physician had been notified and a wound treatment order had been obtained. A review of physician recertification orders for resident 11 was done on 6/19/01. The recertification orders were signed by the physician on 6/13/01. The recertification orders included a treatment order to clean the resident's right ankle wound daily with wound cleanser, cover with Bacitracin and a 4 x 4 gauze pad, wrap with a gauze roll, and secure with tape.	F 309		

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A review of resident 11's plan of care was done. On 5/8/01, facility staff documented a right ankle sore as a problem. One of the identified approaches for this problem was to provide treatments as ordered.

An observation of resident 11's right foot was made on 6/20/01 at 3:55 PM. The wound treatment nurse accompanied the surveyor during the observation. The resident had a gauze roll to her right foot. The dressing was dated 6/17/01, and initialed by the wound treatment nurse.

A review of resident 11's June 2001, treatment records was done. Per documentation, between June 1st and June 20th, eight dressing changes were not done. The missed treatments were on June 1st, 2nd, 3rd, 9th, 10th, 15th, 18th, and 19th.

3. Resident 22 was a 76 year old female admitted 6/5/01. Her diagnoses included left hemiparesis, left hip fracture, diverticulosis, pulmonary hypertension, atrial fibrillation, congestive heart failure and aortic stenosis.

A review of resident 22's medical record was done. On 6/8/01, a physician's telephone order was obtained to discontinue the staples on her left hip incision and replaced them with steristrips. The dressing was to be changed every day until it was healed. The wound was to be cleaned with betadine, covered with a 4 x 4 gauze and secured with tape. It was to be monitored every day for signs and symptoms of infection.

An interview was held with resident 22 on 6/20/01, at 4:35 PM. The wound treatment nurse was present at the time of the interview. Resident 22 stated she had

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just returned from her physician's office and that the physician removed the hip dressing. Resident 22 stated that her hip dressing had not been changed the previous couple of days. She stated the wound treatment nurse was the last person to change the dressing. The wound treatment nurse stated he had changed resident 22's left hip dressing on 6/17/01.

An observation of resident 22's left hip incision was made on 6/26/01, at 3:40 PM. The incision borders were approximated with three steri-strips intact. There was no seperation or redness along the incision.

Nursing staff documented wound treatments on each residents' treatment record. A review of resident 22's June 2001, treatment record was done. Per documentation, between June 8th and June 20th, four dressing changes were not done. The missed treatments were on June 10th, 15th, 18th and 19th.

4. Resident 27 was an 88 year old male admitted 3/24/00 with the diagnoses of a left rib fracture and cerebral vascular accident with right hemiparesis.

A review of resident 27's medical record was done. On 6/4/01, a physician's telephone order was obtained to apply a dressing to the resident's right shin blister every day until it was resolved. The wound was to be cleaned with wound cleanser, covered with Bacitracin ointment and a 4 x 4 gauze pad, wrapped with a gauze roll and secured with tape.

A review of resident 27's plan of care was done. On 4/14/01, facility staff documented a sore on the resident's right shin as a problem. One of the approaches for this identified problem was to provide

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F 309	Continued From page 10 dressing changes and treatments as ordered. An observation of resident 27's dressing was made on 6/20/01, at 3:50 PM. The wound treatment nurse accompanied the surveyor during the observation. The resident had a gauze roll dressing to his right shin. The dressing was dated 6/17/01, and initialed by the wound treatment nurse. An observation of resident 27's right shin wound was made on 6/26/01, at 9:10 AM. Resident 27 had an abrasion approximately 2.5 cm round. The abrasion had no drainage and no sign of infection. A review of resident 27's June 2001, treatment record was done. Per documentation, between June 4th and June 26th, four dressing changes were not done. The missed treatments were on June 10th, 15th, 18th and 19th. 5. Resident 1 was a 75 year old male admitted on 4/2/01 with the diagnoses of heart disease, legal blindness, Parkinson's disease and dementia. A review of resident 1's medical record was done. On 6/13/01, a physician's telephone order was obtained to apply a dressing to the resident's right great toe on a daily basis until the wound resolved. The wound was to be cleaned with wound cleanser, covered with Bacitracin ointment and a 2 x 2 gauze pad, wrapped with a gauze roll and secured with tape. An observation of resident 1's right foot was made on 6/20/01, at 3:40 PM. The wound treatment nurse accompanied the surveyor during the observation. The resident had a gauze roll over his right foot. The dressing was dated 6/17/01, and initialed by the	F 309		

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F 309	Continued From page 11 wound treatment nurse. A review of resident 1's June 2001, treatment record was done. Per documentation, between June 13th and June 26th, three dressing changes were not done. The missed treatments were on June 15th, 18th and 19th. 6. Resident 38 was a 73 year old female admitted 12/18/00 with the diagnoses of Alzheimer's disease, hypertension, duodenal ulcer and arthritis. A review of resident 38's medical record was done. On 6/4/01, a physician's telephone order was obtained to apply a dressing to the resident's right great toe on a daily basis until the wound resolved. The wound was to be cleaned with wound cleanser, covered with Bacitracin ointment and a 4 x 4 gauze pad, wrapped with a gauze roll, and secured with tape. A review of resident 38's plan of care was done. On 6/4/01, facility staff identified right great toe sore as a problem. Approaches for this identified problem included; provide skin treatments as ordered, and treat right great toe with antibiotic therapy and dressing treatment as ordered per physician. An observation of resident 38's right foot was made on 6/20/01, at 3:45 PM. The wound treatment nurse accompanied the surveyor during the observation. The resident had a gauze roll to her right foot. The dressing was dated 6/17/01, and initialed by the facility's wound treatment nurse. A review of resident 38's June 2001, treatment record was done. Per documentation, between June 4th and June 25th, three dressing changes were not done.	F 309		

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F 309	Continued From page 12 The missed treatments were on June 15th, 18th, and 19th. 7. Resident 40 was readmitted on 6/12/01, following an acute care hospitalization for the surgical repair of her left hip fracture. A review of resident 40's medical record was done. On 6/13/01, a physician's telephone order was obtained to cleanse the incision to the left hip daily with Betadine, cover with a 4 x 4 gauze pad and secure with tape. An observation of resident 40's left hip dressing was made on 6/20/01, at 3:25 PM. The wound treatment nurse accompanied the surveyor during the observation. The resident had a 4 x 4 gauze dressing to her left hip. The dressing was dated 6/17/01, and initialed by the wound treatment nurse. A review of resident 40's June 2001, treatment record was done. Per documentation, between June 13th and 20th, three dressing changes were not done. The missed treatments were on June 15th, 18th and 19th. 8. Resident 2 was admitted 4/10/01, with the diagnoses including schizophrenia and chronic obstructive pulmonary disease. An observation of resident 2 was made on 4/26/01, at 1:05 PM. The facility's staff development coordinator (SDC) accompanied the surveyor during the observation. Resident 2 had a tegaderm and gauze pad dressing to her right knee. She also had a gauze roll dressing to her right shin. Both dressings were dated 6/24/01 and initialed by the wound treatment	F 309		

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F 309	Continued From page 13 nurse. A review of resident 2's medical record was done. On 6/22/01, a phsyician's telephone order was obtained to apply a dressing to the resident's right shin abrasion daily until the wound resolved. The wound was to be cleaned with wound cleanser, covered with Bacitracin and a 4 x 4 gauze pad, wrapped with a gauze roll and secured with tape. A review of resident 2's June 2001, treatment record was done. On June 25th, a nurse documented the wound treatment to the resident's right shin was completed. An interview with the SDC was held on 6/26/01, at 1:30 PM. During the interview, the surveyor reviewed resident 2's June 2001, treatment record with the SDC. The SDC confirmed with the surveyor that the date on resident 2's right shin dressing was 6/24/01, and initialed by the wound treatment nurse. The SDC also confirmed with the surveyor that resident 2's June 2001, treatment record contained documentation that the resident's right shin dressing was changed on 6/25/01. An interview with the facility's wound treatment nurse was held on 6/20/01, at 4:00 PM. The wound treatment nurse stated nursing staff were to document dressing changes on individual resident treatment records. He stated he had observed missing documentation of wound treatments on the treatment records. The wound treatment nurse was asked if he had knowledge that the treatments were not done, or if the documentation was not completed. The wound treatment nurse stated staff were to initial and date a dressing when it was changed. He stated there had been times when he had consecutive days off and	F 309		

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F 309	Continued From page 14 returned to see dressings, ordered to be changed daily, unchanged. He stated that was evident because his initials and his last date of work remained documented on the dressings.	F 309		
F 314 SS=D	483.25(c) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined that for 1 of 15 sampled residents, the facility did not ensure that a resident having a presssure sore received necessary treatment and services to promote healing. Specifically, facility staff did not provide dressing changes to resident 37's resolving stage IV pressure sore as ordered by the physician. Findings include: Resident 37 was an 88 year old female admitted to this facility with anemia, hypothyroidism, gout osteporosis, esphagitis and dementia. On 6/19/01, a review of resident 37's weekly skin sheet revealed that the resident had a healing stage IV pressure sore on her coccyx.	F 314 JSB 6/27/01	**F 314** Incident report will be written for resident 37 and the physician will be notified. Facility will review all residents with wound care treatment orders to ensure that treatments are being done according to physician orders. When a discrepancy is discovered, incident report will be developed and the physician notified of the discrepancy. Treatments will be monitored by the DON daily for the next 30 days and weekly thereafter to ensure treatments are done according to physician order. New policy is being developed for treatments. Nursing staff was in-serviced July 10th regarding proper protocol for treatments(see attached in-service agenda). Treatments will be audited weekly for the next quarter by Medical Records. Treatments will be addressed on the QA agenda monthly. DON will be responsible to monitor treatments. Alleged date of compliance will be September 14, 2001.	

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F 314	Continued From page 15 A review of physician recertification orders for resident 37 was done on 6/19/01. The recertification orders were signed by the physician on 6/13/01. The recertification orders included a treatment order to clean the pressure sore to the resident's coccyx daily with wound cleanser, cover with a hydrogel soaked 2 x 2 gauze pad, and cover with a Composite dressing. An observation of resident 37's pressure sore dressing was made on 6/20/01 at 3:35 PM. The wound treatment nurse accompanied the surveyor during the observation. The resident had a dressing to her coccyx. The dressing was dated 6/17/01, and initialed by the wound treatment nurse. A review of resident 37's June 2001, treatment record was done. Per documentation, between June 1st and June 20th, six dressing changes to the resident's coccyx pressure sore were not done. The missed treatments were on 6/2/01, 6/9/01, 6/10/01, 6/15/01, 6/18/01 and 6/19/01. On 6/25/01, during observation of resident 37's dressing change, the nurse performing the dressing change stated that the dressing was ordered to be changed daily according to the physician's orders. The pressure sore had no sign of infection and had granulation tissue. On 6/26/01, at 11:00 AM, an interview was held with the Director of Nursing (DON) and the Staff Development Coordinator (SDC). Both the DON and SDC stated they had recognized some problems with missed dressing changes when the wound treatment nurse was not on duty.	F 314		

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F 322 SS=D	483.25(g)(2) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined that for 1 of 15 sampled residents (the facility's only resident with a gastrostomy tube), the facility did not ensure that a resident who was being fed by a gastrostomy tube received the appropriate treatment and services to prevent metabolic abnormalities. Two licensed nurses, on different occasions, administered enteral feedings without checking the gastrostomy tube placement first. (Resident 4.) Finding include: Resident 4 was a 79 year old male admitted 9/29/00 with the diagnoses of gastrointestinal bleeding, congestive heart failure, history of pulmonary edema, and a cerebral vascular accident with resultant right hemiparesis, expressive and receptive aphasia. A review of resident 4's medical record was done. On 11/22/00, a physician's order was obtained to administer Fibersource HN, 300 cubic centimeters (cc), six times a day through resident 4's gastrostomy tube. In addition to the enteral tube feedings, resident 4 was to receive water and medications through the gastrostomy tube.	F 322 JSB 8/22/01	**F 322** Incident report will be written for resident 4 and the physician will be notified. Nurses were in-serviced July 10th on the proper procedure for G tube placement (see attached in-service agenda). Practices will be reviewed periodically to ensure continued compliance. DON will monitor the delivery of medications for patients with G tubes on a weekly basis for the next three months and monthly thereafter to ensure that nursing staff is following policy and procedure. QA committee will address this issue on a regular basis to ensure compliance. Responsible party will be DON. Alleged date of compliance will be September 1, 2001.	

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F 322	Continued From page 17 An observation of a nurse administering medications and a tube feeding to resident 4 was made on 6/20/01, at 3:45 PM. The nurse placed a 60cc syringe into resident 4's gastrostomy tube and administered medications to the resident. The nurse then flushed the gastrostomy tube with water and administered the resident's tube feeding. The nurse did not assess the resident's gastrostomy tube for correct placement prior to administering the medications. An observation of a different nurse administering a tube feeding to resident 4 was made on 6/21/01, at 9:32 AM. The nurse placed a 60cc syringe into resident 4's gastrostomy tube and flushed the tubing with 30cc's of water. The nurse then administered the enteral feeding. The nurse did not assess the resident's gastrostomy tube for correct placement prior to administering the enteral feeding. An interview with the Director of Nursing (DON) was held on 6/21/01. The surveyor explained the two observations of enteral feeding administration to the DON. The DON stated the nurses should have assessed the correct placement of resident 4's gastrostomy tube prior to administering any substance through the tube. The DON provided the surveyor a copy of the facility's policy and procedure for enteral feedings. A review of the facility's policy and procedure for enteral feedings was done on 6/21/01. Naso-gastric tube feedings and gastrostomy tube feedings are classified as enteral tube feedings. The policy and procedure for enteral feedings directed nursing staff to ensure correct tube placement by, "checking the length of (the) tube for proper position; Plac(ing a) stethoscope over (the) stomach and instill(ing) a	F 322		

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F 322	Continued From page 18 small amount of air into enteral feeding tube." The nurse is then instructed to, "Listen for air to enter the stomach." "Fundamentals of Nursing" by Kozier, Erb and Olivieri, copywrited 1991, documented that correct tube placement is accurately assessed by aspiration of gastric content (p. 1026).	F 322		
F 364 SS=D	483.35(d)(1)&(2) DIETARY SERVICES Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined, for 1 supplemental sample resident, facility staff have not ensured that the resident received food at the proper temperature. (Resident 49.) Findings include: Observations of meal delivery to resident rooms were made on 6/21/01. At 7:25 AM, a nurse aide began passing trays from a cart to residents on the 100 hall. At 7:40 AM, the same nurse aide transfered the tray cart to the 400 hall and began passing trays to residents. At 7:58 AM, the same nurse aide transfered the tray cart to the 300 hall and began passing trays to residents. The last tray was served to resident 49 at 8:08 AM. At 8:08 AM, a test tray was removed from the cart used to deliver trays to resident rooms. The scrambled eggs on the test tray were 100	F 364 JSB 8/27/01	**F 364** Schedule changes have been made to ensure food is being served at the appropriate temperatures. Specifically, resident 49 will be served first. This will ensure the food is at the proper temperature and will allow the aid to spend the necessary time in feeding her. That aid will then be free to serve the other hall trays after the main dining room has been served. Dietary services manager and social services manager will meet with resident 49 on a weekly basis for the next quarter and monthly thereafter to monitor her satisfaction. Responsible party will be dietary services manager. Alleged date of compliance will be August 1, 2001.	

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degrees and the toast was 86 degrees. At 8:21 AM, a nurse aide began assisting resident 49 with the breakfast meal. Resident 49 was observed to require total assistance with dining, as she was unable to move her upper extremities.

An interview with resident 49 was held on 6/26/01, at 2:30 PM. Resident 49 described her meal service. She stated that a staff member would announce overhead that hall trays were ready to be served. She continued that her tray was generally served last because she required staff to feed her. She stated her tray was usually served about one hour after the overhead announcement.

Resident 49 stated her food has been served cold almost everyday. She expressed that the nurse aides have been willing to reheat her food if she had asked but that she did not like the texture of the food once it had been microwaved. She stated staff had to feed her completely, as she had only minimal movement in her head, and none in her extremities.

Resident 49 stated that only one nurse aide has been assigned to serve trays to residents who eat in their rooms and also to answer call lights during meal times. She stated that when staff get around to serving her, other residents return from the dining room and request assistance from the nurse aides. She stated that has caused an increased time to be assisted with her meals.

On two occasions, resident 49 verbalized permission to the surveyor to speak to facility staff specifically about her concerns of cold food and the amount of time necessary to be served her meals.

Interviews were held with three nurse aides on

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F 364	Continued From page 20 6/27/01, between 9:35 AM and 9:45 AM. Each of the nurse aides stated they had been assigned to pass trays to residents who dine in their rooms. The nurse aides confirmed resident 49's comment that only one nurse aide was assigned to serve trays to residents who eat in their rooms, as well as answer call lights during meal times. Each of the three nurse aides stated they routinely began passing trays on the 100 hall, then the 400 hall and finally to the 300 hall. The nurse aides stated the trays were served in that order because resident 49 required total assistance with her meals. The nurse aides stated that resident 49 was generally served last. Two of the nurse aides stated there had been times when it took in excess of one hour to serve resident 49. The two nurse aides stated resident 49 had expressed concerns that her food was cold on several occasions.	F 364		
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations in the kitchen and the dinette area of the Special Needs Unit (SNU), interview, and dietary record review, the facility did not store, prepare, distribute, and serve food under sanitary conditions. Findings include:	F 371 JGB 8/27/01	**F 371** Identified areas of the kitchen have been cleaned. Cleaning schedule documentation will be checked weekly by the dietary supervisor. Periodic cleanliness checks will be conducted by the dietary supervisor and by the administrator. Dietary and nursing departments have been inserviced regarding labeling and dating food items that are stored in refrigerators. Dietary services manager will conduct random and regular audits of refrigerators in the facility to ensure that all food items are properly stored and labeled. Those without proper labels or covers will be discarded. QA committee will review this on a monthly basis for three months and quarterly thereafter to ensure compliance. Responsible party will be dietary services manager and administrator. Alleged date of compliance will be September 1, 2001.	

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F 371	Continued From page 21 Observations of the kitchen were made during an initial tour on 6/19/01, beginning at 8:10 AM The following was observed: a. There were several packages of formed patty meat and slices of bread, wrapped in plastic wrap. These food items were not labeled or dated. These items were in the walk-in refrigerator. b. There were two large pots stacked one in another, and stored facing upward. This would allow dust or other particles to accumulate in it. c. A wet cloth was inside a dry bucket. There was no cleaning solution. d. The backsplash on the stove had a coating of sticky, black grease. The glass doors and handles on the oven had layers of grease and oil present. There was dust and grease on the top and sides of the oven. There was grease along the back edge of the hood on the stove. The gas outlet, connected to the oven and stove, had dust and grease on the front, sides and top. e. There were crumbs of food on disposable lining papers, stored in an open box, on the shelf under the food preparation table. This was also observed on 6/20/01 at 2:00 PM, and on 6/21/01 at 7:45 AM. f. The motorized section of the blender had a liquid substance around the blades. The substance was brown and orange. This was also observed on 6/20/01, at 2:00 PM. 2. On 6/20/01, at 10:15 AM, an interview was conducted with the dietary supervisor. The dietary supervisor was asked if she had a routine cleaning schedule for the dietary department. The dietary	F 371		

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F 371	Continued From page 22 supervisor stated she had a schedule set up on a weekly and monthly basis. The surveyor requested copies of the dietary cleaning schedule. The cleaning schedule contained multiple holes in documentation. 3. The facility had a small refrigerator in the dinette of the Special Needs Unit (SNU). An observation of the refrigerator's contents were made on 6/19/01 at 3:50 PM. The following was observed: a. An opened package of Suzy-Q dessert. The product was open to air. b. One Hot Pocket in a plastic package. There was no label or date on the product. c. One plastic container with cantalope and watermelon. There was no label or date on the product. d. One product wrapped in aluminum foil. There was no label or date on the product. e. One blue plastic, grocery style bag wrapped around some product. There was no label or date on the product. f. One brown paper bag. There was no label or date on the product.	F 371		
F 521 SS=E	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	F 521 JAB 6/22/01	**F 521** Quality assurance committee will be reestablished and will meet monthly to address overall operational issues relating to quality care and quality operations. Specifically the committee will address issues identified in this survey to ensure compliance with regulations. Committee will also identify other concerns as identified or presented by residents, families and staff that relate to ongoing quality care. Responsible party will be administrator. Alleged date of compliance will be September 1, 2001.	

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	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 observations, interviews and record review, it was determined the facility's quality assessment and assurance committee failed to develop and implement plans of action to correct identified problems with wound treatments. Findings include: 1. An interview with the facility's wound treatment nurse was held on 6/20/01 at 4:00 PM. The wound treatment nurse stated nursing staff were to document dressing changes on individual resident treatment records. He stated he had observed missing documentation of wound treatments on the treatment record. The wound treatment nurse was asked if he had knowledge that the treatments were not done, or only the documentation was not completed. The wound treatment nurse stated staff were to initial and date a dressing when it was changed. He stated there had been times when he had consecutive days off and returned to see dressings, ordered to be changed daily, unchanged. He stated that was evident because his initials and his last date of working were remained on the dressings. The wound treatment nurse stated he had informed the facility's Director of Nursing (DON) that treatments were not being done as well as other licensed nursing staff. He stated dressings continue to be missed, and not completed as ordered.			

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The wound treatment nurse stated he completes all the facility's dressing changes on the days that he works. He stated on his days off, the usually utilized a licensed nurse between approximately 5:00 PM and 9:00 PM. He stated that nurse was usually assigned to complete the dressing changes.

2. An interview with a facility licensed nurse was held on 6/20/01 at 4:05 PM. This nurse stated she usually reviewed the treatment records each day she worked. She stated she had observed missing documentation with dressing changes. She stated she may speak with other nurses about the missed treatments, or may not. She stated it was not her responsibility to contact other staff to determine if a dressing change was done or not. This nurse stated the facility utilized a wound treatment nurse to complete dressing changes. She stated on days the wound treatment nurse was not on duty, another nurse would work from 5:00 PM to 9:00 PM. She stated that nurse was to complete the dressing changes.

3. An interview with another facility licensed nurse was held on 6/20/01 at 4:10 PM. This nurse stated she had observed missing documentation with dressing changes. She stated the facility had a wound treatment nurse to complete dressing changes. She stated if the wound treatment nurse had a day off, another nurse would come in between 5:00 PM and 9:00 PM to complete the dressing changes.

4. An interview with another facility licensed nurse was held on 6/26/01 at 7:30 AM. This nurse stated

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 521	Continued From page 25 she had observed missing documentation with dressing changes. She stated she thought it was only missed documentation, but that the dressings changes were being completed. She stated the facility utilized a wound treatment nurse to complete the dressing changes. She also stated the facility utilized a licensed nurse, between 5:00 PM and 9:00 PM, to complete dressing changes when the wound treatment nurse was not working. 5. On 6/20/01, beginning at 4:45 PM, a meeting with the survey staff and the facility's Administrator, DON, and Staff Development Coordinator (SDC) was held. The DON stated, for several months, there had been problems with dressing changes being completed. She stated she was unaware if the problem was lack of documentation or if the dressings were not being completed. She stated the facility was adressing the problem as a quality assurance measure. 6. On 6/26/01, at 11:00 AM, an interview was conducted with the DON and the staff development coordinator (SDC). The DON and SDC were asked what quality assurance measures had been implemented to address missed dressing changes. The DON and the SDC agreed that they had recognized some problems with dressing changes and approprioate documentation. They stated the problem had exsisted for a few months. The SDC stated an inservice to licensed nursing staff was conducted to address the problem of missed dressing changes. She obtained an inservice roster dated 5/10/01. The inservice roster identified that dressing changes and appropriate documentation was	F 521		

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 _____	6/27/01

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F 521	Continued From page 26 discussed at the inservice. 7. The facility's quality assessment and assurance committee failed to implement measures to correct identified problems of wound treatments. Refer to Tag F-309 and Tag F-314.	F 521		