STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465143	A. BUILDING _____ B. WING _____	C 11/15/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOLOB REG CARE & REHAB CNTR	411 WEST 1325 NORTH CEDAR CITY, UT 84720

(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 325 SS=G	483.25(i)(1)QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the weight records, it was determined that the facility did not assess, care plan or implement interventions for 1 of 14 sample resident's significant weight loss until 3 months after the significant weight loss was identified by the facility consulting dietitian. (Resident 9) Findings include: Resident 9 had a 9 pound weight loss from 4/19/00 to 5/8/00, which was identified by the consulting dietitian. The dietitian recommended weekly weights. There was no documentation that weekly weights were implemented until 8/6/00. Resident 9 had further weight loss, losing another 9 pounds prior to the facility notifying resident 9's physician on 8/6/00. There was no documentation found that the facility notified resident 9's physician prior to that date. The facility did not identify resident 9's significant weight loss on the comprehensive assessment dated 8/2/00. There was no documentation found that the facility care planned resident 9's weight loss. There was no documentation found that the facility implemented intervention prior to resident 9's physician ordering a high calorie supplement on 8/11/00. Documentation revealed that the facility did not always administer the high calorie supplement as ordered by resident 9's physician. 1. Resident 9 was admitted to the facility on 4/19/00,	F 325	POC accepted 12/14/00 LBusenbark RN	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: JEFF CHRISTENSEN - ADMINISTRATOR — TITLE — (X6) DATE: 12/8/00

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 325	Continued From page 1 with diagnoses that included urinary tract infection, congestive heart failure osteoporosis, and depression. Resident 9 expired on 9/12/00. 2. Review of the "Monthly weight and Vital Signs Record", on 11/14/00, for resident 9 revealed that resident 9's admitting weight was documented as 127 pounds. 3. On 11/14/00, the "Nutritional Assessment", was reviewed. The assessment documented a note, dated 5/8/00 and signed by the RD (Registered Dietitian). The note documented, " Wt (weight) in May 118# (pounds) Pt (patient) has lost 9# Need to follow Wt weekly and assess if pt is still losing Wt. Need to assess intakes. Give supplements if needed." 4. On 11/14/00, the "Nutritional Progress Notes" were reviewed. The notes documented the following: a. 6/24/00 - "Wt 112# Last month was 118# - Adm (Admission) Wt 127# Intakes good. IBW (ideal body weight) 100#. Pt should not lose any more Wt - Will get weekly wts. Add to snacks if wt loss continues. No skin problems or problems with intake of meals." b. 8/3/00 - "...90 day review monitor wt. Picked up in NIT (nutritional intervention team) to monitor intake of meals." c. 8/28/00 - "Wt 109# (down) 19#. Resident eats 60 to 70% of meal." d. 8/28/00 - "Question accuracy of wts. they were 112, 111# - Pt eating good. Will give (increased) cal (calorie) meals to (increase) weight." 5. In an phone conversation with the facility	F 325	Resident 9 was discharged from the facility. A 6-month look back audit will be completed on Registered Dietician recommendations to be assured that recommendations are being followed. The Dietary Supervisor will be responsible to review all Registered Dietician recommendations immediately following Registered Dietician visit. This information will be passed on to all necessary entities, i.e., Director of Nursing, or designee, weight/skin team, physician, and the resident/ responsible party.	

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F 325	Continued From page 2 administrator and the director of nursing (DON) on 11/20/00. The DON stated that the facility dietitian did not inform her of resident 9's significant weight loss. 6. On 11/14/00, the "Monthly Weight and Vital Signs Record", for resident 9 was reviewed. The record documented the following weight for resident 9. 4/19/00 127 pounds (admit) 5/07/00 118 pounds 6/04/00 112 pounds 7/06/00 111 pounds 8/06/00 109 pounds 8/11/00 106 pounds 8/20/00 104 pounds This documentation revealed that resident 9 had a 9 pound (7%) weight loss from 4/19/00 (admit) to 5/8/00 and a 6 pound (5%) weight loss from 5/8/00 to 6/4/00. The documentation revealed that resident 9 had a further 3 pound (2.6%) weight loss from 6/4/00 to 8/6/00. The documentation revealed that resident 9 had an 18% weight loss while at the facility. Review of resident 9's entire medical record revealed that no documentation of any weekly weights for resident 9 except the weekly weights documented on the weight record during the month of August 2000. The minimum data set (a comprehensive resident assessment) identifies significant weight loss as a 5% or more weight loss in the last 30 days or a 10% or more in the last 180 days. 7. Further review of the "Monthly Weight and Vital Signs Record" for resident 9 revealed the following documentation:	F 325	Admits will be weighed within 24 hours after admission. Weights will be obtained weekly times 4 then monthly thereafter. Director of Nursing or designee will review all weekly and monthly weights. The Director of Nurses, or designee, will alert weekly weight and skin committee of significant weight variances. Resident identified with significant weight variance will be incorporated into the committee's weekly weight review. Weekly weights, and the committee's review will continue until weight stabilizes, or until the committee deems lesser frequency is appropriate. Physician will be notified, orders noted and resident care plan updated as needed. Director of Nursing, or designee, will be responsible for identifying significant weight trends and reporting these trends to the Quality Assurance team every month, and as needed, until lesser frequency is deemed appropriate.	

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F 325	Continued From page 3 a. Documentation in the "Physician Notified" section, dated 6/6/00, stated that resident 9's physician had been notified by fax of resident 9's weight loss. i. On 11/14/00, the entire physician's orders section of resident 9's medical record was reviewed. No copy of a fax, dated 6/6/00, regarding resident 9's significant weight loss was found. ii. On 11/14/00, the nursing notes dated 4/19/00 through 6/8/00 were reviewed. No documentation was found regarding notification of resident 9's physician of resident 9's significant weight loss. b. Documentation in the "Physician Notified" section, dated 8/6/00, stated that resident 9's physician had been notified by fax of resident 9's weight loss. i. Review of the nursing note section of resident 9's medical record revealed a nursing note, dated 8/6/00 at 3:25 PM, that documented, "Dr. ... faxed re: (regarding) pt. wt. loss of 12 lbs. (pounds) over last 3 mo. (months)." 8. Review of the physician order section of resident 9's medical record revealed a "Clinic Visit and Progress Note" sheet dated 8/11/00. The "Physician's Observations, Progress Notes, and Orders" section documented the following:	F 325	Licensed nurses have been in-serviced by the Director of Nursing on the importance of accuracy of weights, the timeliness of completion, significance of weight loss, (i.e., 5% in 1 month, 7.5% in 3-months, and 10% in 6-months), appropriate interventions to prevent, and documentation that is necessary on said residents. An in-service was also given on importance of supplements and follow through with staff to make sure that they are given and documentation is complete.	
	"Wt down 20 lbs. Appetite O.K. Has rash on eye lids. ? depression. 1. Ensure (a high calorie supplement), one can twice a day. 2. Zoloft 50 mg (milligrams) at h.s. (hour of sleep)...." Review of resident 9's medical record revealed no further documentation that resident 9 was seen by her physician from 4/21/00 through 8/11/00. Review revealed no further documentation that resident 9's			

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F 325	Continued From page 4 physician had been notified of resident 9's significant weight loss prior to 8/06/00. 9. Resident 9's MDS (comprehensive resident assessment) dated 5/2/00, was reviewed. Section G. 1. h. (Physical Functioning-Eating) documented that resident 9 required oversight, encouragement, or cueing provided 3 or more times during the last 7 days. Section K. 4. Oral/Nutritional Status-Nutritional Problems, documented that resident 9 left 25% or more of food uneaten at most meals. Review of the quarterly MDS for resident 9, dated 8/2/00, revealed that Section K.3. (Weight Change) did not identify resident 9's significant weight loss. 10. Review of resident 9's entire comprehensive care plan revealed a care plan problem dated 5/25/00, that documented. "Resident at risk for dietary status R/T (related to) CHF (congestive heart failure)". The goal documented was "Monitor Intakes". The approaches/actions documented were, "1. diet per Dr. order Regular may need NAS diet. Monitor Wt. monthly." There was no further care plan problems regarding resident 9's potential or actual weight loss were found in resident 9's medical record.	F 325		
	11. Review of the medication record for the months of August and September 2000 revealed the following: a. The August 2000 medication record documented a physician's order dated 8/11/00, for Ensure, one can twice a day. Review of the area were the nurse to initials when the Ensure is given revealed that 10 of 40 were not initialed as being given to resident 9.		An audit will be completed for all omitted supplements. Physician notified if applicable.	

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F 325	Continued From page 5 b. Review of the September 2000 medication sheets for resident 9 revealed no order for Ensure one can twice a day. There was no documentation found that resident 9 received the Ensure as ordered by resident 9's physician from 9/1/00 to 9/12/00. 12. In an interview with the facility DON on 11/15/00, she stated that the facility policy regarding weight loss was that the residents were weighted monthly. She stated that the facility nutritional team met weekly and that if a weight loss was identified, the facility would weigh the resident weekly. She stated that if significant weight loss was identified, the facility was to notify the resident's physician. She stated that the facility had problems with their scales and that the scales had been adjusted recently. She stated that she had just assigned a nurse the duty to make sure all the weights were done correctly due to problems with weight accuracy. She stated that the nurse was to inform the nutritional team if there was any weight loss found.	F 325	All facility residents residing in the facility were reweighed and assessed for any significant changes in weight. Physician was notified and orders obtained and care plans updated if applicable. Registered dietician will be consulted if applicable. Residents with weight variance reviewed and addressed by weekly weight committee and patient care plans updated.	ALL F325 COMPLETED 12/15/00
F 387 SS=F	483.40(c)(1)&(2)PHYSICIAN SERVICES The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. ~~A physician visit is considered timely if it occurs not~~ later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: ~~Based on record review and interviews, it was~~ determined that 9 of 14 sample residents, requiring frequent physician intervention, were not seen by a physician as required after admission and periodically during their stay. (Residents 1,2,3,5,8,9,10,11, and	F 387	An audit has been completed on all residents to ensure physician visits per regulation. Physician visits have been scheduled as applicable. New orders will be noted and patient care plans updated as needed.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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F 387	Continued From page 6 12.) Record Review 1.Resident 9, a 91-year-old female, was admitted to the facility on 4/19/00. Her diagnoses include urinary tract infection, congestive heart failure, hypertension, osteoporosis and depression. A physician should have seen resident 9 within 30, 60 and 90 days after admission, and then every 60 days thereafter. A review of resident 9's clinical record revealed that the resident was seen by a physician on 4/21/00 and not again until 8/11/00. During that time period, resident 9 had a weight loss of 18 pounds, 14% of her total body weight. Resident 9 expired on 9/12/00. Refer to tag F325. 2.Resident 1, a 42-year-old female, was admitted to the facility on 5/22/00. Her diagnoses include upper gastrointestinal bleed, anemia with blood loss, organic brain syndrome, paranoid schizophrenia, urinary tract infection and dysphagia (difficulty swallowing) with inability to maintain nutritional status. A physician should have seen resident 1 by 6/30/00. A review of the resident's clinical record revealed that the resident was not seen until 7/21/00. Resident 1 was discharged to the hospital on 7/26/00. 3. Resident 8, an 88-year-old female, was admitted to the facility on 7/6/00. Her diagnoses include congestive heart failure, osteoporosis, shortness of breath, hypertension, degenerative joint disease, angina, arthritis, hypothyroidism and situational depression. Review of resident 8's clinical record indicated a physician had seen the resident on 7/27/00. The resident should have been seen again by 9/5/00. The record indicated she was not seen until 9/12/00 and was discharged to the hospital on 9/13/00.	F 387	Resident 9 discharged from facility 9/12/00. Resident 1 received visit by attending physician on 8/22/00, 9/6/00/, 10/15/00, and 11/2/00. Discharged from facility 11/12/00. Resident 8 admitted 9/17/00. Discharged from facility 9/28/00.	

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F 387	Continued From page 7 4. Resident 3, a 93-year-old female, was admitted to the facility on 2/14/00. Her diagnosis include dementia, syncope, squamous cell cancer of the leg and osteomyelitis. A physician should have seen resident 3 in March, April, May, and July of 2000. Resident 3's clinical record indicated a physician saw her on 3/27/00 and not again until 9/5/00. 5. Resident 5, an 81-year-old female, was admitted to the facility on 4/1/00. Her diagnoses include osteoarthritis, hypertension, organic brain syndrome, hearing loss and backache. A physician should have seen the resident in May and June of 2000. Review of resident 5's clinical record indicated that a physician did not see her until 7/31/00. 6. Resident 5 was admitted to the facility on 4/28/00. His diagnoses include atrial fibrillation, Alzheimer's, and anemia. Review of his clinical record indicated a physician saw him once, on 5/12/00, while in the facility. Resident 5 should have been seen in June and July 2000. Resident 5 expired on 8/31/00. 7. Resident 10 was admitted to the facility on 5/2/00. His diagnoses include hypothyroidism, hypertension, quadriplegia, depression and constipation. Review of his clinical record indicated a physician had seen him on 5/11/00 and 9/27/00. Resident 10 should also have been seen in June, and July of 2000. 8. Resident 11 was admitted to the facility on 1/22/00. Her diagnoses include congestive heart failure, cardio vascular disease, cerebral vascular accident, dementia, anemia, fractured wrist, decubitus ulcer and urinary tract infection. Review of resident 11's clinical record indicated that the resident was seen by a physician February and March of 2000, and on 4/27/00 and	F 387	Resident 3 received visit by attending physician on 12/7/00. Resident 5 discharged 8/31/00. Resident 10 received visit by attending physician on 10/18/00, 11/01/00, 12/05/00. Resident received visit 12/04/00 by pulmonologist. Resident 11 received visit by attending physician on 10/24/00 and 11/30/00.	

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F 387	Continued From page 8 6/29/00. Resident 11 was not seen again until 9/28/00 and should have been seen in August 2000. 9. Resident 12 was admitted to the facility 10/9/99. Her diagnoses include osteoporosis, cardiovascular disease, congestive heart failure, atrial fibrillation, compression fracture of the spine, anorexia and constipation. Review of the clinical record for resident 12 revealed that the resident should have been seen by 1/22/00 for the 90 day visit and was not seen until 2/29/00. The next documented physician visit for the resident was 6/13/00. This was greater than 60 days between visits. Interview During an interview on 11/14/00 at 9:45 AM, with the director of nursing, she stated that the medical records department was responsible for keeping track of the physician visits. She stated that it was discovered that the previous person in that position had not been keeping track of when residents needed to be seen. During an interview with the administrator on 11/15/00, he stated the medical records department was responsible for keeping track of the physician visits. He stated he had not been monitoring them as closely as he should.	F 387	Resident 12 received visit by attending physician on 11/2/00. In-service completed to medical records/licensed nurses that the resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter unless resident is skilled, then it is every 30 days. Physician orders will be reviewed and transcribed as applicable and patient care plans will be updated as applicable. Medical records will be responsible to ensure physician visits are completed per regulation. A running log will be maintained by medical records to ensure physician visits occur in timely fashion. The Director of Nursing, or designee, will review log monthly to ensure compliance and report findings to Quality Assurance team monthly until lesser frequency is deemed appropriate. Follow up letters will be sent to physicians by medical records, as reminders when residents are due to be seen.	ALL F387 COMPLETED 12/15/00