DEPARTMENT OF HEALTH AND HUM. SERVICES
HEALTH CARE FINANCING ADMINISTRATION

acceptable POC 3/5/02 to maintain deficiency PN

PRINTED: 1/25/
FORM APPROVE
2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	1/16/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

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F 176 SS=D	483.10(n) SELF ADMINISTRATION OF DRUGS An individual resident may self-administer drugs if the interdisciplinary team, as defined by s483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview , and medical record review, it was determined that the facility assessed a resident as not being a safe candidate for administering his own medications, then allowed resident to administer his own medications without monitoring. The facility did not monitor for drug safety for 1 of 26 sampled residents. (Resident 25) Findings include: Resident 25 was admitted to this facility on 3/6/01. Resident 25 had diagnoses which include: major depressive disorder, cancer of leg, amputation of leg, osteomyelitis, history of drug abuse, radial nerve palsy, history of seizures, colostomy, contractures, right knee replacement, cholecystectomy, and arthritis. Documentation evidenced that the interdisciplinary team (IDT) completed an evaluation for resident 25 to self administer his own medications on 4/9/01. The evaluation identified that resident 25 " was not a candidate for safe self-administration of medications." The evaluation identified the reasons why resident 25 should not self administer medications, because "patient had a chronic history of substance abuse - most commonly pain management and narcotics." A review of resident 25's medication administration record (MAR) documented that resident 25 self administered some of his medications between the	F 176	The following is a plan of correction and is in reference to F-176 483.10 (n) self-administration of drugs. This will include corrective action for each resident found to have been affected and were named as resident #25. The following plan of correction has been instituted to be in effect on 2/6/02. 1. IDT meeting will evaluate residents' ability to self-medicate. 2. Resident will sign appropriate forms to self-medicate. 3. Lock box with keys and medication record will be provided to resident. Extra key will go to charge nurse for emergency situations. 4. Careplan will designate weekly audit-where charge nurse will evaluate and review medications as ordered. 5. Record on MAR and nurses' notes weekly regarding review with resident regarding capability of self-administration. 6. The nurses will distribute all controlled substances only. 7. In-service regarding above POC was discussed with licensed staff 2/6/02.	2/6/02

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administ. — 2/12/02

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 aft 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 176	Continued From Page 1 months of April, 2001 through December 2001. In June 2001, resident 25's MAR documented that resident 25 had Oxy IR, 5 mg, 1-2 tablets by mouth every 4 hours as needed for pain, ordered. There was "Self Med" written across the individual boxes, where the nurses would initial, as documentation, if the drug had been administered. The other drug name for Oxy IR, is percocet immediate relief. There was no documentation as to whether the drug had been given or not. Nurses notes dated 6/10/01 at 6:00 PM documented the following: "... maintenance man will be in, in the AM to unlock patient medication drawer that contains resident 25's self – meds, including percocet..". Nurses notes dated 6/16/01 at at 6:00 PM, documented the following: "...he went to get his pain pills, and there were no more, he had taken 60...". Further in the entry, "... I took another nurse with me and we told [resident 25] we would have to keep the narcotics in the med cart. He felt like we were blaming him and we explained that was not what we were doing, but that the doctor wanted them kept in the med cart...". A physician's order, dated 7/11/01 reads: "pt able to to continue to self administer medications except narcotics." This was the only physician's order found in resident 25's medical record to allow resident 25 to administer self medications. There was no documentation to show that an original order was received from the physician, to permit resident 25 to administer his own medications. On 01/2/02 at 10:15 AM, an interview with a nursing staff member, who provided care for resident 25, stated that resident 25 was self administering medications with no monitoring by nursing or by	F 176		

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F 176	Continued From Page 2 resident as to which medications were being taken, how many of each medication was being taken, or what time each medication was being taken. The staff nurse stated "resident 25 does not have a medication sheet in his room."	F 176		
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, individual interview and a confidential group interview, the facility did not promote care for residents in a manner and in an environment that maintained dignity and respect as evidenced by: Observation of the request for assistance by residents through use of the call light system revealed that staff did not answer call lights in a timely manner. Findings include: 1. On 12/31/01, at 12:48 PM, the light above the door of room 203 was observed to be on. At 1:04 PM, a nurse assistant entered the room to assist the residents. There was 16 minutes between the time the light was observed to be on until staff entered the room to assist the residents in room 203. 2. On 12/31/01, at 1:20 PM, the light above the door of room 303 was observed to be on. At 1:30 PM, a nurse assistant entered the room to assist the residents. There was 10 minutes between the time the light was observed to be on until staff entered the room to assist	F 241	F-241--The following is a plan of correction and is in reference to F-241 483.15 (a) Quality of Life. This will include corrective action for each resident found to have been affected. The following plan of correction has been instituted to be effect on 2/6/02. 1. The QA committee has determined that responses to call lights in a timely manner will be within 5 min. 2. Employee mandatory in-service for all SVHC employees regarding responsibility to answer call lights within a timely manner throughout the building is scheduled 2/13/02 directed by the administrator. 3. In services regarding call-lights was initiated on 2/6/02 to both licensed staff and the C.N.A.'s-N.A.'s. 4. Spot checks will be done daily until 90% compliance is achieved. 5. QA committee will be involved with resident counsel every month to monitor residents response and progress to call light issues. 6. QA will be monitoring progress q month until compliance met.	3/1/02

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F 241	Continued From Page 3 the residents in room 303. 3. On 1/3/02, at 10:18 AM, the light above the door of room 205 was observed to be on. At 10:20 AM, a nurse aid passed room 205 but did not enter the room to assist the residents. At 10:21 AM, there were observed to be 6 staff members present at the nurses station. The call light above the door of room 205 remained on. At 10:33 AM, a staff member entered room 205 to assist the residents. There was 15 minutes between the time the light was observed to be on until staff entered the room to assist the residents. 4. On 12/31/01, at 8:19 AM, the light above the door of room 303 was observed to be on. At 8:21 AM, a facility nursing assistant was observed to walk past the room while turning her head, she had looked at the room with the light on but continued to walk down the hall. At 8:24 AM, a voice from room 303, stated, "Nurse, would you get in here". A facility nursing assistant was observed to enter room 303 at 8:28 AM. There was 9 minutes between the time the light was observed to be on until staff entered the room to assist the residents in room 303. 5. On 1/02/02, at 8:35 AM, the light above the door of room 313 was observed to be on. A facility nursing assistant was observed to enter room 313 at 8:45 AM. There was 10 minutes between the time the light was observed to be on until staff entered the room to assist the residents in room 313. 6. On 1/3/02, the call light for room 115 was observed to be on at 7:40 AM. The nursing staff answered the call light at 07:50 AM. There was 10 minutes between the time the light was observed to be on until staff entered the room and answered the call light. 7. On 1/3/02, the call light for room 115 was observed to be on at 8:40 AM. The nursing staff answered the call light at 8:50 AM. There was 10	F 241		

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F 241	Continued From Page 4 minutes between the time the light was observed to be on until staff entered the room and answered the call light. A confidential interview was held with a group of residents on 1/2/02 at 9:00 AM. Fourteen residents participated in the interview. Eight (8) of the 14 residents stated that they have had to wait too long for their call light to be answered. Two residents stated they've had to wait up to an hour before a staff member would respond to their call lights.	F 241		
F 252 SS=E	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility did not provide a safe, clean, comfortable and homelike environment for the residents as evidenced by: The facility was observed to be unclean, the building in ill repair, and a leak was present in the ceiling on 1/8/02 that resulted in an employee fall. Findings include: Observation of the environment from 12/31/01 until 1/8/02 revealed the following problems: 1. The tile floor along the coving of the 100, 200, and 300 halls had grey and brown stains and dirt buildup. The special needs unit tile floor along the coving had some areas with grey and brown stains and dirt buildup.	F 252	F-252--The following is a plan of correction and is in reference to F-252 483.15 (h) Environment. This will include corrective action for each resident found to have been affected. The following plan of correction has been instituted to be effect on 2/6/02. There has been new maintenance logs put at each nurse station the maintenance man will check these every morning. There has been put together by plant op, a new preventative maintenance log which QA will look over also plant ops will document every week through out building. 1. Housekeeping supervisor is going to have an in-service on 2/20/02, cleaning of clean covebase on a weekly basis so we no longer have stains and dirt build in the halls. Plant op manager will oversee or audit designated areas and address weekly. 2. Housekeeping supervisor hired a new floor man. The floor man will steam clean and get red stains and brown stains out, clean carpet through out the building. The buffet in the dining room will be recovered by 2/22/02. The table that was unstable is now fixed. Areas of frayed carpet will be repaired and patched. Missing masonite will be replaced as budget allows. 3. Entry doors to resident room that draw wood chips or cracks including the double doors to the unit will be puttied and painted 2/22/02.	3/1/02

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F 252	Continued From Page 5 2. The main dining room carpet had large brown and red stains. There were strips in the carpet under the tables and throughout the carpeted area that were worn and frayed. There was a strong odor of urine present. The buffet tables, that food was served on, had large areas where the masonite was missing and wood was exposed causing it to be unsanitizable. There was one resident table that had paper towels stacked under the legs to maintain stability. 3. All entry doors to the residents' rooms had wood chipped or cracked. The double doors to the units had wood chipped or cracked. 4. The window sills in the hallway from the lobby area had strips of formica missing which exposed the wood underneath, leaving them unsanitizable. There was a broken window that had white tape over the crack. 5. All the windows throughout the building were dirty and difficult to see through. 6. There were areas on all the hallways that had wallpaper on them, where the wallpaper was missing or coming off the wall. 7. The dining room carpet on the 100 hall had large stains that were brown in color. There was a strong odor of urine present. There was a broken window. 8. The brass ring around the door knob of the shower room in the 300 hall was not attached and could be turned easily. 9. There was a used disposable towel on the floor outside room 308 that smelled of urine. 10. There was a hole in the wall above the wardrobe in room 201 that allowed one to see through from the resident room to the outside of the building in the court yard. 11. There were ceiling tiles on the 100, 200, and 300 halls, and throughout the building, that had brown stains, round in shape, that appeared to be water damage. There were several ceiling tiles that were broken or had portions missing.	F 252	4. Windowsills in the hallway from lobby area will have Formica replaced by 6/1/02 and broken window in hallway/lobby area will be replaced by 2/25/02. 5. Housekeeping supervisor has assigned a housekeeper for 1 day a week to clean window throughout the building. Also in the in-service which will be informed to clean those windows. 6. Housekeeping supervisor will go through the building and fix wallpaper. Expected date to be done is 2/25/02. 7. Housekeeping supervisor hired a new floor person who will be cleaning carpets. It will be put on a schedule to do every week. Also housekeeping supervisor will do morning check and if there are stains they will be addressed. Broken window will be replaced by 2/25/02. 8. Replace and fix the brass ring and doorknobs of shower. This will be replaced 2/25/02. 9. Housekeeping supervisor is having in-service on 2/22/02 with housekeeping staff to spot check throughout the building for anything on floors. 10. Hole in the wall of room 201 will be puttied and painted by 2/14/02. 11. Maintenance man has replaced a lot of ceiling tiles. They will be all done by 2/25/02. 12. Shower room water. Maintenance will replace and fix shower room across from unit to turn off water by 2/25/02. 13. Light fixture in room 218 is now on. 14. Room 315 hot water will be repaired 2/25/02. 15. Housekeeping supervisor will have an in-service on 2/22/02 with housekeeping staff. They will be informed to check rooms throughout day for spills and how important it is to clean them up. A mop and bucket with clean water and sanitizer will provide	

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F 252	Continued From Page 6 12. The water in the shower room across from the nurses station, in the special needs unit, would not turn off. 13. There was no light above the mirror in room 218. There were exposed wires instead of a lighting fixture. 14. There was no hot water in resident room 315. 15. There was standing water on the floor in the bathroom of room 308. 16. There were three holes in the wall next to the bathroom on the outside wall of room 206 that were approximately 1/2 inch to 1 inch in diameter. 17. The caulking around the toilet pedestal in room 310 was cracked and had black and dark brown stains present. 18. The dirty utility room on the 100 hall had a large hole in the wall behind the door. There were brown stains on the floor in the hall outside the door. 19. The utility room on the 200 hall, that housed a water heater, had a duct vent that was open into the room from the outside of the roof, which would allow for pest and rodent entrance. 20. There were areas of coving that were broken or missing in the special needs unit in front of the nurses station and outside of room 208 and 310. 21. The refrigerator in the medication room on the 100 hall had broken areas on the bottom of the door that prevented it from sealing and maintaining an appropriate temperature. The water did not work in the sink. There was an old ice machine that was not connected nor being used. The light fixture had no cover. 22. There was a hole in the wall behind the vending machine in the 100 hall. 23. The dirty utility room across from central supply had plastic light fixtures that were hanging down. 24. The shower room on the special needs unit had exposed light bulbs with no light cover. 25. There was water running down the wall outside the physical therapy room on the 100 hall that resulted	F 252	16. for staff at each hall after hours of housekeeping for unexpected spills. 17. The maintenance man has covered the holes in room 206. 18. Housekeeping staff cleaned toilet in room 310. Also maintenance man re-caulked the toilet 19. Maintenance has patched and fixed the hole behind the door. Housekeeping supervisor is having in-service on 2/22/02 with housekeepers to be aware of stains and to spot check throughout day. A maintenance log at each station will also provide information regarding stain and spots to be addressed which plant ops manager will then address., weekly, a log will be maintained with all information above for continue auditing. 20. Utility room will have maintenance will replace duct screen and vent with new equipment by 2/14/02. 21. The maintenance will put cove up and replace broken cove in a timely manner 2/25/02. 22. The water in the sink is now working. Regarding the light fixture a new one has been ordered. The ice machine maintenance is going to look at it try to fix it or it will be removed by 2/25/02. Refrigerator in medication room will be replaced by 2/25/02 23. The hole in the wall behind the vending machine is now fixed. 24. Light fixture has been ordered and will be replaced by 2/25/02 25. Light cover has been ordered and will be replaced in shower room by 2/25/02. 26. This area of water running down wall outside physical therapy room has been repaired by 2/1/02. Record review: Reviewed with maintenance request logs at each station on his responsibilities to resolve and address problems with his initial when completed. Interview	

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F 252	Continued From Page 7 in an employee fall on 1/8/02. Record review: Review of the maintenance request logs at each nurses station revealed that most of the requests for the 100 hall from staff to repair problems in the facility had no documentation that they had been done since the end of October 2001. Some of the request for the 300 hall and the special needs unit had no documentation that the problems had been taken care of since the end of November 2001. Interview: An interview was conducted on 1/8/02, with the administrator and the new plant operations manager concerning the building environment. The administrator stated that they had had a maintenance manager full time until October 2001; and he had taken the routine maintenance logs with him. When the plant operations manager was asked to obtain information about preventive maintenance, she presented the nurse surveyor with a binder with no documentation of maintenance performed and stated that she had developed the binder to begin documentation.	F 252		
F 325 SS=H	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.	F 325		

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F 325	Continued From Page 8 This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by 8 of 26 sampled residents experienced significant weight loss with no dietary interventions implemented to prevent further weight decline. Resident identifiers: 13,20,28,40,50,70,72,74. Calculating weight loss percentages is done by subtracting the current weight from the previous weight, dividing the difference by the previous weight and multiplying by 100. Significant weight losses are as follows: 5% in one month, 7.5% in 3 months and 10% in 6 months. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000). Findings include: 1. Resident 13, a 79 year old female, was admitted to the facility on 10/11/01 with diagnoses of chronic obstructive pulmonary disease, hypothyroidism and bronchitis, urinary tract infection, helicobacter pylori gastritis (h.pylori), anxiety and chronic dizziness. Resident 13 was admitted with physician orders for medications to treat the h. pylori. Review of the physician's order and nursing care referral form, dated 10/11/01, from the discharging hospital to the nursing facility documented that resident 13, "...eats well, but slowly...Pt [patient] is very aware and careful when eating." On 10/15/01 the RD [registered dietitian] completed a nutritional assessment that documented resident 13 was 61 inches tall, weighed 95 pounds, had a small frame and resident 13's ideal body weight range was from 106 to 118 pounds.	F 325	The following is a plan of correction and is in reference to: F-325 483.25 (i) Quality of Care. This will include corrective F-326 483.25 (i) (2) Quality of Care, F-360 483.35 Dietary Services, F-361 483.35 1-2, F-363 483.35 (c) Dietary Services,F-364 483.35 (d) (1) &(2),F-371 483.35 (h) (2). Action for each resident found to have been affected and were identified as 13, 20, 28, 40, 50, 70, 72, 74. 1. Licensed staff will be in-serviced on how to complete the malnutrition/dehydration-pressure sore risk assessment done by the RD, the N progress notes, the dietary intake current weights, and diagnosis an warranted. 2. NIT committee will address any r h-pylori on the residents' careplar residents' physician for medical a interventions. 3. Dietary intake record has been ch percentage of what resident ate is accurately recorded rather than g 4. C.N.A. scheduler will audit dietar weekly to ensure accuracy and co 5. 4 way drug check will be done m QA to ensure that all orders regar will be on residents' MAR's as w percentage documentation. As w diagnosis's to medication and any drug interactions and/or side effects. 6. Licensed staff has been instructed to inform NIT committee of any dietary problems so that other interventions can be implemented as warranted. 7. Monthly weights provided each month upon completion to each hall with current weights to be placed MAR binder so that monthly summaries can address current weights. 8. C.N.A.-N.A will be in-serviced February 20, 2002 regarding interventions for residents' experiencing eating, swallowing, and chewing difficulties. Importance of communicating to nurses so that interventions are implemented as warranted. 9. Speech consultant will report any evaluations, outcomes, and recommendations to the NIT committee. 10. NIT committee will calculate weight loss percentages weekly. 11. Extended menus for the menu cycle is available and currently being followed Dietary staff will be in-serviced by the RD what servings sizes are appropriate and what foods residents on therapeutic diets are to receive. 12. Previous Registered Dietician has been replaced by RD, and whom will assume responsibilities to provide services, support, and supervision, through assessment, monitoring and recommendations, to meet each residents' nutritional needs to prevent significant weight loss. The RD will 2-27-02 ~~2/20/02~~ Some dates modified to reflect original POC mod made by S Hauna RD.	

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F 325	Continued From Page 9 During an interview with a facilty restorative nursing assistant on 1/11/02, she stated that the restorative aides are the only staff members that weigh the residents each month. She stated that the residents are weighed at the end of each month to obtain the weights for the following month. For example, all residents were weighed at the end of December 2001 for January 2002 weights. Review of the weights for resident 13 revealed the following: October 2001 – 95 pounds. November 2001 – 84 pounds. This represents a weight loss of 11 pounds, (11.5%) between the months of October and November 2001. December 2001 – 75.5 pounds. This represents a weight loss of 8.5 pounds, (10%) between the months of November and December 2001. Resident 13 experienced a significant weight loss of 19.5 pounds (20%) between the months of October and December 2001. Review of an assessment written by the RD on 10/15/01 revealed the following: "Intake fair, should be adequate for needs if intake > [greater than] 60% average - otherwise need to consider snacks or supplements. Weight is < [less than] IBW [ideal body weight] range and Pt/family stated she has lost some weight x [times] 1 yr [year] Talked with them about supplements. Said she doesn't like the taste. Monitor intake and weight. Encourage intake." The RD did not address any nutritional management issues in regards to the h.pylori. No further RD assessments could be found in resident 13's clinical record. The RD did not address the November and December 2001 weight loss. Review of an admission Minimum Data Set (MDS)	F 325	ensure that the dietary manager and dietary staff have proper training and systems in place to appropriately monitor the sanitation of the kitchen, ensuring proper storage, preparation and the distribution and serving of foods, following Therapeutic diets as written and serving foods at the proper temperature. 13. Dietary in-service will be held weekly-Tuesday 3pm to discuss all survey issues, training, and any problems with the dietary services. 14. RD will ensure that each resident will receive a therapeutic diet when there is a nutritional problem. The RD will assess in identifying and correct improper serving of therapeutic diets to ensure the dietary needs of the residents. 15. Temperatures are monitored by the dietary cooks daily and recorded. The dietary manager will monitor at random resident's trays for proper food temps and record. 16. The dietary services have a daily cleaning schedule to ensure the sanitation of the kitchen, record to monitor the labeling and dating of foods, temps of the walk-in refrigerator. The dietary manager will audit the above concerns weekly. 17. The RD will be employed by SVHC as a dietary consultant, who will provide adequate supervision to both the dietary manager and dietary staff regarding: 1) Accurately monitoring and assessing residents at risk for weight loss. 2) Monitor the sanitation of the kitchen, ensuring proper storage, preparation, distribution and serving of foods, developing and implementing educational in-services for the dietary staff. 18. A new steam table with 4 wells is being purchased so foods will stay at the appropriate temperature above 140 degrees. 19. The walk-in refrigerator was fixed at temperature have maintained 40 degrees and below. Dietary staff instructed to keep refrigerator door closed going in or out. 20. The dietary staff will be in-serviced February 19, 2002 on how to store, prepare, distribute, and serve food under sanitary conditions. 21. The grease trap was cleaned by a local plumbing company, and was scheduled to come out routinely. 22. The unit manager for out-dated food will check the Alzheimer's unit refrigerator daily.	

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F 325	Continued From Page 10 assessment, dated 10/15/01, for resident 13 revealed under section K. Oral/Nutritional status, 5. Nutritional Approaches c. Mechanically altered diet was marked and e. Therapeutic diet was marked. Review of a "Malnutrition/Dehydration – Pressure Sore Risk Assessment", dated 10/11/01, completed by a facility nurse documented that resident 13 was not a nutritional risk. A nutritional care plan dated 10/15/01, documented that resident 13 was at nutritional risk due to poor intake and appetite, chronic obstructive pulmonary disease and weight loss prior to admit, low body weight and that resident 13 would have no significant weight loss through next review. The approaches were to identify and offer food preferences, monitor intake, weights, and labs as available, diet as ordered and recommend house supplement. The care plan did not address any intervention for the h.pylori. The Brunner and Suddarth's Textbook of Medical-Surgical nursing, Eighth Edition, Chapter 36: Management of Patients With Gastric and Duodenal Disorders (h.pylori), Page 887, documents, " The major goals of the patient may be to reduce anxiety, avoid irritating foods and assure adequate intake of nutrients, maintain fluid balance, increase awareness of dietary management and relieve pain." Review of the nurse's notes for October 2001 revealed no documentation to indicate that resident 13 had a decrease in appetite or complaints of pain or nausea. Review of resident 13's meal intake for October 2001 revealed that the facility was documenting meal intake as good, fair and poor. Out of a possible 63 meals, 2 meals were documented as good intake, 13 meals were documented as fair intake, 11 meals were documented	F 325		

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F 325	Continued From Page 11 as poor intake and 37 meals had no intake documented. Review of an IDT (interdisciplinary team) meeting minutes dated 11/7/01 revealed that resident 13 weighed 84 pounds, a loss of 10 pounds, and the facility would place resident 13 on supplements with meals. A physician order dated 11/7/01 documented that resident 13 was to be given 60 cc of supplement with meals for weight loss. A nurse's note dated 11/7/01 documented to supplement 60cc with meals for weight loss, 10 pounds from admit. Review of the November 2001 medication sheet revealed that the house supplement 60cc TID[three times daily] with meals was not documented as being started until 11/15/01, 9 days after the order had been written. Review of the December 2001 medication sheet revealed that the house supplement was discontinued on 12/2/01 because resident 13 was refusing the supplement stating it made her have mucous in her throat. No evidence could be found to indicate that the facility tried any other kind of supplements or snack. A physician order dated 11/19/01 documented to weigh weekly and record and to obtain a CBC (complete blood count) total protein and albumin (laboratory tests used to determine nutritional status.) No evidence could be found that the physician order had been followed. Review of a resident care plan completed by the dietary management team on 11/19/01 revealed that	F 325		

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F 325	Continued From Page 12 the facility was to assess resident 13's weight weekly until stable, a nutrition/dehydration assessment was to be done weekly by the team, laboratory values to be obtained, Fibersource HN 120cc TID, double portions, resident to be monitored and assessed in the restorative dining program and dietary intake to be monitored and recorded daily. A nurses note dated 11/19/01 documented, " Q [every] week weight and record. CBC, total protein, albumin ordered for weight loss." The facility could not provide any documentation that the care plan written on 11/19/01 had been implemented. Review of the nurse's notes for November 2001 revealed the following: 11/21/01- " Decreased appetite today." 11/25/01- "Eats 50%." 11/26/01- "50% eaten in room." 11/27/01- "Wt. 77.5# concerned about thyroid." 11/28/01- "Encouragement to eat." 11/30/01- "Encouragement to eat." Review of resident 13's meal intake for November 2001 revealed that out of a possible 93 meals, 10 meals were documented as good intake, 36 meals were documented as fair intake, 16 meals were documented as poor intake, 28 meals had no intake documented and 1 meal resident 13 was not in the facility. Review of IDT meeting minutes dated 12/5/01 revealed that the resident's appetite was decreasing and the family was bringing in extra food. Review of resident 13's meal intake for December 2001 revealed that the facility was documenting meal intake in percent of intake. Out of a possible 93 meals, 22 meals were documented in percent and 71 meals had no intake documented.	F 325		

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F 325	Continued From Page 13 Review of the nurses noted for December 2001 revealed the following: 12/3/01- "Pt requested NAS [no added salt] to her food. Diet order written. House supplement given as ordered." 12/4/01- "Pt has been having wt loss. Encouraging eating." 12/5/01-" Pt. not eating well family bringing in special foods..." 12/12/01- "Will continue to monitor and encourage to eat." 12/13/01- "Supplements offered- Family brought in food today pt ate 100%." 12/14/01- "Weight stable. Monthly 75. Dec wk 1 77 week 2 77." 12/15/01- "Encourage to eat." 12/16/01- "Snacks offered." 12/17/01- "Family brings in treats." Resident 13 was weighed on 12/31/01 and weighed 79 pounds, a weight gain of 3.5 pounds from previous weight on the first of December. During an interview with resident 13 on 1/16/01 she stated that when she was admitted to the facility one of the first meals she received, had meat that had made her sick so she would not eat the meat any more. She stated that she would eat most of the vegetables and fruit. Resident 13 stated that she had not discussed this with any facility personnel and that no one had asked her about her meals. She stated that she liked peanut butter and jelly sandwiches and would eat them when the facility had them. Resident 13 also stated that approximately a month ago her family had started bringing snack packs in to her which she kept in her room and would eat them when she was hungry. She also stated that her family had brought her in some Ensure which she would drink when she wanted.	F 325		

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F 325	Continued From Page 14 2. Resident 70, an 83 year old male, was admitted to the facility on 8/10/01 with diagnosis of pneumonia, cerebral vascular accident, dementia, atrial fibrillation, peripheral vascular disease, hypertension, hypothyroidism and mild mental retardation. Resident 70 received intervenous fluids and antibiotics until 8/21/01, then received oral antibiotics until 9/1/01 for the treatment of pneumonia.. Review of the nurses notes from 8/10/01 through 9/1/01,revealed that resident 70's medical condition was stable. Documentation indicated that resident 70 was alert and condition was improving. Resident 70 was being gotten up for meals and dietary intake was good. On 8/15/01 the RD completed a nutritional assessment that documented resident 70 was 67 inches tall, weighed 138 pounds, had a medium frame and resident 70's ideal body weight range was from 142 to 154 pounds. Review of the weights for resident 70 revealed the following: On admission 8/10/01- 138 pounds. September 2001- 127 pounds. This represents a weight loss of 11 pounds (7.9%) between the months of August and September 2001. October 2001- 115 pounds. This represents a weight loss of 12 pounds (9.4%) between the months of September and October 2001. November 2001- 112 pounds. This represents a weight loss of 3 pounds (2.6%) between the months of October and November 2001. Resident 70 experienced a significant weight loss of 26 pounds (18.8%) between the months of September and November 2001.	F 325		

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F 325	Continued From Page 15 Review of an assessment completed by the RD on 8/15/01 revealed that resident 70 was on a puree no added salt, increased protein, increased fat and nectar thick liquids diet. The assessment documented, "Pt with considerable nutritional risk due to low body weight, low albumin, poor intake unable to feed self - dependant on others and swallow deficit. Refer to care plan. Monitor weight, intake and labs." Review of the admission Minimum Data Set (MDS) dated 8/23/01, completed by facility staff, revealed the following: Under section K. Oral/Nutritional status 1. Oral Problems a. chewing problem was marked and b. swallowing problem was marked. 2. height and weight, resident weighed 130 pounds. Under K.4. Nutritional problems c. leaves 25% or more of food uneaten at most meals was marked. Under K.5. Nutritional Approaches nothing was marked. On 8/15/01 resident 70 was evaluated by a speech language pathologist for swallowing problems. The evaluation documented, "Pt. tolerated puree texture with nectar thick liquids without s/s [signs and symptoms] of aspiration while sitting near 90 degrees in bed." Review of a "Malnutrition /Dehydration - Pressure Sore Risk Assessment", dated 8/10/01, completed by a facility nurse documented resident 70 was a high nutrition risk. A nutritional care plan dated 8/15/01 documented that resident 70 was at nutritional risk and would have no significant weight loss through next review. Approaches to the problem on the care plan were to obtain food preferences, feed patient by staff, monitor intake, labs, and weight, diet as ordered puree/thick	F 325		

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F 325	Continued From Page 16 liquids and notify the RD of significant changes. No documentation in the clinical record evidenced that resident 70's weight had been monitored by the RD or the nursing staff or that the RD had been notified of the weight loss. Review of resident 70's monthly recertification orders, signed by the physician on a monthly basis, documented that resident 70 was to receive a puree diet with thickened liquids and snacks three times daily. Review of resident 70's meal intake for August 2001 revealed that the facility was documenting intake as good, fair and poor. Out of a possible 66 meals, 32 meals were documented as good intake, 6 meals were documented as fair intake, 25 meals were documented as poor intake, and 2 meals were marked refused. Under the nourishments offered section, out of a possible 66 times for nourishments to be offered, 11 nourishments were documented as being offered. Review of resident 70's meal intake for September 2001 revealed that out of a possible 90 meals, 45 meals were documented as good intake, 24 meals were documented as fair intake, 4 meals were documented as poor intake, 4 meals were documented as refused and 13 meals had no intake documented. Under th nourishments offered section, out of a possible 90 times for nourishments to be offered, 9 nourishments were documented as being offered, 1 nourishment was documented as being refused. Review of resident 70's meal intake for October 2001 revealed that out of a possible 93 meals, 19 meals were documented as good intake, 51 meals were documented as fair intake, 1 meal refused and 22 meals had no intake documented. Under the nourishments offered section, out of a possible 93	F 325		

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F 325	Continued From Page 17 times for nourishments to be offered, one nourishment was documented as being offered on 10/9/01 and the resident took 100% of that nourishment. Review of resident 70's meal intake for November 2001 revealed that out of a possible 90 meals, 61 meals were documented as good intake, 8 meals were documented as fair intake, 2 meals were documented as poor intake, 1 meal refused and 18 meals had no intake documented. Under the nourishments offered section, out of a possible 90 times for nourishments to be offered, 3 nourishments were documented as 100% taken, 9 nourishments were documented as good intake, a total of 12 nourishments out of 90 were documented as being offered. On 11/26/01 an assessment by the RD documented, "Pt remains at a significant nutritional risk. Intake may not meet needs. Should continue supplements/snacks. Need to continue with current plan - assist with meals, encourage intake." The RD did not address the 26 pound weight loss from August 2001 to November 2001. Review of a quarterly MDS dated 11/7/01, completed by facility staff, revealed the under Section K2. height and weight, resident 70 weighed 112 pounds. Under section K3 weight change a. weight loss was marked 0, indicating that resident 70 had not experienced weight loss of 5% or more in last 30 days; or 10% or more in last 180 days. The MDS did not identify the 26 pound weight loss from August 2001 to November 2001. Further review of the clinical record revealed that resident 70 had not seen by a physician from 8/21/01 to 11/30/01, during the period of time that resident 70 experienced a 26 pound weight loss. No documentation could be found in resident 70's clinical record that the physician had been notified of the	F 325		

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F 325	Continued From Page 18 weight loss. 3. Resident 20 was a 61 year old male admitted to the facility on 7/9/01 with diagnoses of Alzheimer's disease, depression, cerebral degeneration and peptic ulcer disease. On 8/14/01, 36 days after his admission, the RD completed an initial nutritional assessment that documented resident 20 was 6'0" (72 inches) tall, weighed 217 pounds and his ideal body weight range was documented as 157 to 170 pounds. The diet documented was regular with finger foods, double portions. A review of resident 20's admission weight, documented in the initial nurses note, revealed that he weighted 217 pounds on 7/9/01. A review of resident 20's monthly weights, completed by the restorative nurses aides and obtained from the dietary supervisor, documented the following weights for resident 20: August, 2001: 212 pounds. September, 2001: 217 pounds. October, 2001: 214 pounds. November, 2001: 201 pounds. This represents a significant weight loss of 13 pounds, or 6%, between the months of October and November 2001. December, 2001: 201 pounds January, 2002: 195 pounds. On 1/11/02, at the request of the survey team, resident 20 was re-weighed. Resident 20's weight was 191 pounds. This represents a significant weight loss of 10 pounds, or 5% between the months of December 2001 and January, 2002 and a 10.7% significant weight loss between the months of October, 2001 and January, 2002(using the December weight of 201 pounds and the January re-weight of 191 pounds).	F 325		

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F 325	Continued From Page 19 An initial dietary assessment completed by the registered dietitian on 8/14/01 documented, "Intake adequate for needs, current weight 126 % IBW [ideal body weight] [and] considered obese, [question] need for double portions, will need to monitor weight. Pt [patient] [at] nutritional risk [secondary to] obesity, swallow deficit chokes, needs assist [with meals]". This initial assessment identified resident 20 had a good appetite, 75%, that the resident would at times choke and that he required assistance with feeding. The RD's documented nutrition plan for resident 20 was to, " monitor intake, weight (for loss), labs". On 1/2/02 a quarterly nutrition assessment was completed by the RD. The nutritional stress factors documented were obesity and depression with potential for weight loss. The weights documented on this assessment were November 2001, 201 pounds, December 2001, 201 pounds and January 2002, 195 pounds. The 1/2/02 dietary assessment did not identify resident 20's significant weight loss of 13 pounds between the months of October 2001 and November 2001 or his significant weight loss of 19 pounds between the months of October 2001 and January 2002. The January re-weight of 191 pounds had not yet been obtained. A review of resident 20's medical record showed the only dietary evaluations of this resident occurred on 8/14/01 and 1/2/02. No further documented dietary notes were found in resident 20's medical record. A review of the "Nursing Monthly Summary" assessment for November 2001 documented resident 20's current weight was 201 pounds this was followed by a question mark, his diet was documented as regular double portions and his appetite as good. Resident 20's previous month's weight for October 2001 was 214 pounds. This would indicate a 13 pound, or 6%, significant weight loss over 30 days. A review of the nursing summary notes revealed no	F 325		

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F 325	Continued From Page 20 documented evidence that resident 20's significant weight loss was identified as a concern and no interventions were documented as being implemented. A review of the "Nursing Monthly Summary" for December 2001 did not document a current weight but documented resident 20 was receiving a regular diet and his appetite was good. A review of the nursing summary notes revealed no documented evidence that resident 20's 13 pound significant weight loss between the months of October 2001 and November 2001was identified as a concern and no interventions were documented as being implemented. The care plan section of this monthly nursing summary documented "eats 100%, portions [decreased] because of weight gain over IBW [ideal body weight]". A review of the "Nursing Monthly Summary" for January 2002 documented resident 20's current weight was 195 pounds, his diet was regular and his appetite was good. A review of the nursing summary notes revealed no documented evidence that resident 20's significant weight loss of 19 pounds between the months of October 2001 and January 2002 was identified as a concern and no interventions were documented as being implemented. The January re-weight of 191 pounds had not yet been obtained. The care plan section of this summary documented resident 20's weight was maintained. A review of nursing notes from 7/9/01 to 1/2/02 in resident 20's medical record was done. On 10/19/01, the nurse documented that resident 20 had an excellent appetite. On 11/7/01, the nurse documented that resident 20 had a good appetite. On 11/20/01, the nurse documented that resident 20 needed continual encouragement and re-direction but would usually eat 75-100% of meals. On 12/2/01, the nurse documented that resident 20 had a good appetite. On 12/15/01, the	F 325		

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F 325	Continued From Page 21 nurse documented that resident 20, "Eats 100% of meals, d/t [due to] shaking-needs to be fed. Frequently looks for more to eat". A review of resident 20's "Malnutrition/Dehydration-Pressure Sore Risk Assessment", completed by the nursing staff, was done. Resident 20 was assessed on 7/9/01 as having a total score of 9. Resident 20 was assessed on 10/28/01 as having a total score of 11. Per this form, a total score of 10 or higher placed the resident at high nutritional risk. A review of all documented physician assessments completed from resident 20's admission on 7/9/01 through 1/15/02 was done. Resident 20's significant weight loss was not addressed on these assessments. A nutritional care plan, initiated by the RD and dated 8/13/01, documented that resident 20 was at nutritional risk related to obesity, a slight swallowing deficit (as reported by the family) needing assistance with meals and not communicating well and would have no significant weight fluctuations through next review. Approaches to the problem on the care plan included, dietary was to obtain food preferences, weights, meal intakes and labs were to be monitored, resident 20 was to be assisted with meals as needed and his diet was finger foods/double portions. The care plan was not updated to address resident 20's significant weight loss, which occurred between the months of October 2001 and November 2001 and between the months of October 2001 and January 2002. A review of resident 20's meal intakes, documented on the "ADL Flow Sheet Record" for October 2001 revealed the nurse aides were documenting meal intake as good, fair or poor. Out of a possible 93 meals for the month, 58 were documented as good, 1 was	F 325		

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F 325	Continued From Page 22 documented as fair, 12 were documented as poor, 3 were documented as refused and 19 were not documented. A review of resident 20's "Daily Dietary Intake" record for November 2001 revealed the nurse aides were documenting meal intake in percentages. Out of a possible 30 breakfast meals for the month, 8 were documented at 100%, 1 was documented at 60%, 19 were documented at 0% and 2 had no meal intake documented. Out of a possible 30 lunch meals for the month, 26 were documented at 100%, 1 was documented at 0% and 3 had no meal intake documented. Out of a possible 30 supper meals for the month, 14 were documented at 100%, 1 was documented at 90%, 1 was documented at 75%, 1 was documented at 50% and 13 had no meal documented. A review of resident 20's "Daily Dietary Intake" record for December 2001 revealed the nurse aides were documenting meal intake in percentages. Out of a possible 31 breakfast meals for the month, 7 were documented at 100%, 22 were documented at 0%, 1 was documented as refused and 1 had no meal intake documented. Out of a possible 31 lunch meals for the month, 28 were documented at 100%, 2 were documented at 0% and 1 had no meal documented. Out of 31 possible supper meals for the month, 14 were documented at 100% and 17 had no meal documented. A review of resident 20's meal intake record, documented on the "ADL Flow Sheet Record" for January 2002 from 1/1/02 through 1/9/02 revealed the aides were documenting meal intake in percentages. Out of a possible 9 breakfast meals reviewed, 1 was documented at 100%, 6 were documented at 0%, 1 was documented as refused and 1 had no meal documented. Out of a possible 9 lunch meals	F 325		

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F 325	Continued From Page 23 reviewed, 8 were documented at 100% and one had no meal documented. Out of a possible 9 supper meals reviewed, 1 was documented at 75% and 8 had no meal documented. A review of the facility's Dietary Management Team minutes revealed that resident 20 was not identified by the team as at nutritional risk related to his significant weight loss of 13 pounds, or 6% which occurred between the months of October 2001 and November 2001 and 19 pounds, or 8.8% which occurred between the months of October 2001 and January 2002 until 1/2/02. A review of the Dietary Management Team's 1/2/02 minutes documented resident 20 was on the list for review, however, there were no team member comments, recommendations or interventions documented on the monitoring form. Observations on 1/2/02, 1/3/02 and 1/8/02 in the Facility Alzheimer's unit dining room revealed that resident 20 was sent a breakfast tray on the meal cart on these days, however, resident 20 did not receive his breakfast tray. Observation of resident 20 revealed him to be in bed sleeping during the breakfast meals on 1/2/02, 1/3/02 and 1/8/02. Interviews with the certified nurses' aides working on the facility Alzheimer's Unit, who were familiar with resident 20's care, were done on 1/2/02 and 1/3/02 after the breakfast meal was complete. On 1/2/02, the certified nurses' aide stated that resident 20 had not received his tray because he had fallen a few days prior and injured his lip and that he often would not get up for breakfast. The nurse aide was not observed to wake resident 20 to offer his breakfast tray. On 1/3/02, the same certified nurses' aide who was interviewed on 1/2/02 stated that resident 20 had not been offered his tray because of his injured lip. The nurse aide was not observed to wake resident 20 to	F 325		

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F 325	Continued From Page 24 offer his tray. Observation on 1/2/02, 1/3/02, and 1/8/02, and 1/11/02, of the meal portion sizes of resident 20's breakfast trays revealed he received regular portions for breakfast on these days. Review of resident 20's diet card documented he was to get large portions. On 1/11/02, an interview with the food service supervisor was done. She was asked to confirm what diet the kitchen was to send resident 20. She checked and stated that he was to receive a mechanical soft diet with double portions. On 1/11/02, an interview with a certified nurses aide who was familiar with resident 20's care was done. She was asked if resident 20 received large portions at meals. She stated no, that she was unable to "pinpoint exactly" but resident 20 had been receiving regular meal portions for a least a month. She further stated than when he ate meals he needed increased portions because he would eat "a lot". Observation on 1/16/01 revealed that at 8:12 AM, resident 20's tray was taken to his room by a nurses aide. Resident 20 was encouraged to wake up and the aide assisted him with his breakfast meal. He consumed 100%. In a later interview with the nurses aide who assisted resident 20, at 8:30 AM, she confirmed that resident 20 had eaten 100% of his breakfast tray and then consumed 100% of a second tray. 4. Resident 72 was a 78 year old female admitted to this facility on 11/10/00 with diagnoses of congestive heart failure, cerebrovascular accident, deep vein thrombosis, atrial fibrillation, angina, hypothyroidism and gastro-esophageal reflux disorder (GERD). Resident 72 had physician's orders for Prilosec to treat	F 325		

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F 325	Continued From Page 25 GERD on 3/26/01. Resident 72 had physician's orders written on 6/11/01 for Risperdal 1milligram every night, Oxycontin 20 milligrams three times a day for pain, and Percocet 5-325 milligrams every four hours as necessary for pain. Risperdal and Percocet may produce side effects including nausea, vomiting, anorexia and over sedation. The reference for side effects to medications was obtained from the Mosby's Nursing Drug Book, 2000. The registered dietician's nutritional assessment on 11/14/00 documented resident 72's height as 63.5 inches and her weight was 230 pounds. The ideal body weight recommendation was 121-135 pounds. Resident 72's weight history was obtained from the quarterly nutritional reassessment, dated 8/20/01, and was as follows: January 2001-214 pounds February 2001-198 pounds. This represents a weight loss of 16 pounds, (7.5%) between January and February 2001. March 2001-203 pounds April 2001-187 pounds. This represents a weight loss of 16 pounds, (7.9%) between March and April 2001. June 2001-182 pounds July 2001-167 pounds. This represents a weight loss of 15 pounds, (8.3%) between June and July 2001. Resident 72 lost 23.7% of her body weight during a six month period. Review of resident 72's advanced directives revealed that she desired artificial nutrition and hydration, minor surgery, antibiotic treatment orally and intravenously, simple diagnostic tests, and pain medication for comfort. Review of resident 72's MDS (minimum data set),	F 325		

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F 325	Continued From Page 26 dated 5/7/01, 8/4/01, and 11/1/01, revealed that in Section K5, there was no indication that resident 72 was on a planned weight change program. In section K1, the MDS identified that resident 72 had a chewing problems. Review of resident 72's care plan revealed that when resident 72 was admitted to this facility the nutritional care plan, dated 11/00, identified her at nutritional risk with potential for weight loss related to a swallowing deficit and inability to feed herself without assistance. One goal to this care plan problem was that resident 72 would not have a significant weight loss through the next review. A second goal stated that if she did lose weight, the weight loss would be gradual with less that five pounds a month. The approaches to that care plan problem were to assist resident 72 with her meals and monitor weights and intake. Review of resident 72's assessments on admission and quarterly, revealed that there was a malnutrition risk form present in the chart with no documentation present. Review of resident 72's physician's telephone orders, dated 7/30/01, signed by the physician, revealed an order for house formula 60cc for each meal with less than 50% eaten. This order was initiated after the continuous January to July 2001 weight loss had occurred. Review of resident 72's monthly nursing assessment for the month of May 2001, revealed documentation by nursing, that resident 72 had a good appetite and fed herself. The monthly nursing assessment for the month of June 2001, revealed documentation by nursing that resident 72's appetite was fair and "eats and drinks by herself." The monthly nursing assessment for the month of July 2001, for resident 72,	F 325		

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F 325	Continued From Page 27 documented by nursing did not have any documentation in the "appetite" area but documented that she "eats and takes fluid by herself. " Review of resident 72's activity of daily living flow sheet record, documented by the nurse aids, for the month of May, 2001, revealed that of the 90 meals documented in this month, resident 72's intake showed 40 were good, 42 were fair, 5 were poor, 2 were Y (an unknown measurement), and 1 was refused. The activity of daily living flow sheet record for the month of June 2001, revealed that of the 90 meals documented in this month, 25 were good, 21 were fair, 13 were poor, 20 were not documented, and 5 had zero as the amount taken. The activity of daily living flow sheet record for the month of July 2001, revealed that of the 93 meals documented in this month, 52 were good, 26 were fair, 8 were poor, 2 were refused. Review of the nurses notes for June 2001 revealed the following: 6/1/01- "Pt spit up when I gave her noon meds." 6/2/01- "Pt c/o stomach pain, gave tylenol, had small mucousy emesis. IM phenergan with good results." 6/2/01- " Pt has tried to spit up pills all day." 6/3/01- "She only drank part of her nubasic." 6/4/01- "Did not wake up for breakfast." 6/5/01- "MD in to see pt. today. Swallow eval." 6/6/01- "Addendum-watch pts. food intake-if 0 intake over next 2 days, notify MD for feeding tube order." 6/8/01- "Therapy informed me that swallow evaluation was done, but they did not know the results." The results of the swallow study for resident 72 were not in the medical record. There was no indication that the nurses had informed the physician that resident 72's food intake had been zero for breakfast on 6/6/01,	F 325		

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F 325	Continued From Page 28 poor on 6/7/01 and 6/8/01, or that there was no documentation of dinner on 6/7/01 and 6/8/01. During a family interview on 1/2/02, the family member was questioned concerning the care of resident 72. The family member stated that when resident 72 was placed on hospice, August 2001, she began to receive the assistance she had needed with her activities of daily living and assistance with eating. The family member also stated that resident 72 was assisted with her noon meal by a family member throughout the week. 5. Resident 74, a 60 year old male, was admitted to the facility on 10/3/01 with diagnoses of hypotension, protein calorie malnutrition, dehydration, cerebrovascular accident and depression. Resident 74 was admitted with a gastrostomy tube (g-tube) with orders to administer two cans of Ensure three times daily via the g-tube . Resident 74 also had a physician order to receive a puree diet by mouth. On 10/15/01 the registered dietician (RD) completed a nutritional assessment that documented that resident 74 was 70 inches tall, weighed 150 pounds, had a large frame and resident 74's ideal body weight range was from 158 to 180 pounds. Review of resident 74's monthly weights revealed the following: On admission, 10/10/01, 150 pounds. November 2001- 147.5 pounds. This represents a weight loss of 2.5 pounds, (1:6%) between the months of October and November 2001. December 2001-142.5 pounds. This represents a weight loss of 5 pounds, (3.4%) between the months of November and December 2001. January 2001- 140 pounds. This represents a weight	F 325		

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F 325	Continued From Page 29 loss of 2.5 pounds, (1.75%) between the months of December and January 2002. At the request of the survey team, resident 74 was weighed on 1/11/02. Resident 74 weighed 136.5 pounds. This represents a weight loss of 3.5 pounds, (2.5%) between 1/1/02 and 1/11/02. Resident 74 experienced a significant weight lossof 13.5 pounds, (9%) between the months of October 2001 and January 2002. Review of an assessment completed by the RD on 10/15/01 documented, "Intake < 50% usually and pt [patient] not able to meet nutritional needs po [by mouth]. Tube feeding @ 2 cans Nova Source 2.0 TID [three times daily] bolus feedings. This will provide 2844 Kcal and 127 grams protein. This should promote weight gain and may want to decrease amount. Will monitor closely. Monitor intake.....and weekly wts. [weights]." No documentation could be provided by the facility that evidenced resident 74 had been weighed weekly as recommended by the RD. Review of an admission MDS assessment dated 10/23/01, for resident 74 revealed under Section G. Physical Functioning and Structural Problems, h. that resident 74 was totally dependant on one person physical assist to eat. Under section K. Oral/Nutritional Status,1. Oral problems b. it was documented that resident 74 had swallowing problems. K.4. Nutritional Problems, c. resident 74 leaves 25% or more of food uneaten at most meals. K.5. Nutritional Approaches, c. Resident 74 received a mechanically altered diet. K.6. Parenteral or Enteral Intake, a. nothing was marked. A nutritional care plan dated 10/15/01 documented that resident 74 was at significant nutritional risk and would have no significant weight fluctuations through next review. Approaches to the problem on the care	F 325		

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F 325	Continued From Page 30 plan indicated that resident 74 was to receive the tube feedings as ordered, weekly weights and to notify the RD of significant changes. On 10/25/01, the (RD) was asked by the nursing staff to evaluate resident 74's g-tube feeding. The RD recommended, " Fiber Source HN to run at 70/cc an hour to provide 2016 Kcal and 89 grams protein. This should be adequate to maintain weight and replete residual proteins[Albumin] This TF [tube feeding] regimen would provide 1600 cc H20 [water]. Recommend 600cc additional free H20 as 200cc q [every] 8 hours. Will monitor tol [tolerance] to TF and weights." A physicians' order was obtained on 10/25/01 following the RD's recommendation. A nurses note on 10/25/01 documented the following: "Pt. wife informed of new enteral feeding order - she stated she only wants pt. to have 1 can @ [at] qhs [every night at bedtime] - H20 [water] to run rest of day - Dr.....contacted - orders H20 @ 83cc X [times] 24 hours - 1 can of HN Fibersource @ qhs added to water - weight q 2 wks [weeks] - wife informed of possible wt [weight] loss if not eating well - will continue to monitor." On 10/29/001 the RD documented, "Nursing stated family concerned about TF may cause kidney failure? This TF does not provide excess protein and is adequate for needs. I do not have any concerns in regard to this." There was no evidence that this was discussed with the family by the RD or the nursing staff. There was no further documentation by the RD. During a meeting with facility administrative staff and the RD on 1/8/02, the RD stated that he had not done any other assessments on resident 74 since 10/29/01. A review of resident 74's meal intake for October 2001	F 325		

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F 325	Continued From Page 31 revealed that the facility was documenting meal intake as good, fair and poor. Out of a possible 63 meals 18 meals were documented as good intake, 20 meals were documented as fair intake and 25 meals had no intake documented. A review of resident 74's meal intake for November 2001 revealed that the facility was documenting meal intake in percent of intake. Out of a possible 93 meals, 46 meals were documented in percent and 47 meals had no intake documented. A review of resident 74's meal intake for December 2001 revealed that out of 93 meals, 15 meals were documented in percent and 78 meals had no intake documented. Review of resident 74's tubefeeding record revealed that from 10/10/01 to 10/24/01, resident 74 was to receive two cans of Ensure TID at 8:00 AM, 3:00 PM and 11:00 PM. Per documentation resident 74 did not receive two cans of Ensure at 8:00 AM on 10/10/01, 10/13/01 through 10/16/01, 10/18/01 10/20/01, and 10/23/01. Resident 74 did not receive two cans of Ensure at 3:00 PM on 10/10/01, 10/12/01 through 10/16/01, 10/18/01, 10/22/01 and 10/23/01. A physician order dated 10/25/01 documented to give resident 74 HN Fibersource one can every night added to water at 83cc an hour and water to run 24 hours a day. Review of the enteral documentation record for resident 74 from 10/25/01 through 10/31/01 revealed that the resident did not receive per documentation one can of HN Fibersource on 10/25/01, 10/26/01, 10/27/01, 10/29/01, and 10/30/01. On 1/17/02, a telephone interview with resident 74's	F 325		

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F 325	Continued From Page 32 wife was done. She stated that she had not been informed by the facility the resident 74 had lost 13.5 pounds. She stated that she goes to the facility almost every evening around supper time to assist her husband with his meal. She stated that more than once a week she had observed resident 74's lunch tray still on the bedside table in his room and it had not been touched. 6. Resident 40 was a 97 year old female admitted to this facility on 10/9/01 with diagnoses of fractured humerus, dementia, hypertension, hypothyroidism and constipation. Review of resident 40's dietary assessment on 10/6/01 revealed that the dietician had assessed her at the height of 60 inches and a weight of 121 pounds with an ideal body weight recommendation of 113-126 pounds. The registered dietician had identified ill-fitting dentures, the need for resident 40 to be fed, encouragement, and that she had poor intake. The dietary assessment stated that resident 40's intake was poor and might not be adquate for her needs, the facility should consider offering supplements, and recommended Novasource supplements. There was no physician's order found for Novasource and no intervention for resident 40's ill-fitting dentures. Review of resident 40's care plan, initiated by the facility, revealed a nursing care plan problem identifying resident 40 at risk for malnutrion with a score of 21. There were two goals addressed in this care plan problem. One goal was that resident 40 would have no unexpected or unplanned weight loss and the second goal was that resident 40 would have an average intake of 75% with every meal. The approaches for the problem included documentation of percentage that resident 40 ate at each meal, monitor for less that 50% average per meal, and monitor for	F 325		

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F 325	Continued From Page 33 significant unplanned weight loss. The dietary care plan problem initiated on admission for resident 40 identified her at significant nutritional risk related to poor intake and need for assist with her meals. The goal for this care plan problem was that resident 40 would have no significant weight fluctuations. The approaches for this problem were to monitor intake and weight and to assist with meals. The dietitian recommended nutren supplements.. Review of resident 40's IDT meeting comments on 10/10/01 revealed the following information: October 2001- 120 pounds December 31, 2001- 110.5 pounds. This represents a weight loss of 10.5 pounds, (8.7%) between the months of October 2001 and December 31, 2001. January 11, 2002- 107 pounds. This represents a weight loss of 14 pounds, (11.6%) between October 2001 and January 11, 2002. Review of the facility interdisciplinary team meeting notes on 10/17/01, revealed a comment that stated that the resident desired a soft diet. The only dietary communication in resident 40's medical record was for a "select" diet. Continued review of resident 40's dietary history and food preference form, dated 10/17/01, documented that Ensure would be given after meals and at bedtime and would be brought in by the family. There was no documentation in resident 40's chart that she had received Ensure at any time. Review of resident 40's activities of daily living flow sheet record, documented by the nurse aids, from 10/9/01 until 10/31/01, revealed that of the 69 meals offered 4 were documented as good, 8 were fair, 36 were poor, and 21 were left blank with	F 325		

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F 325	Continued From Page 34 no documentation. Of the 69 nourishments offered, 16 were documented as 100%, 14 were documented with a line through the block, 1 was fair, 9 were zero, and 29 were left blank with no documentation. Review of resident 40's activities of daily living flow sheet record for the month of November 2001, revealed that of the 90 meals offered 1 was documented as good, 3 were documented as fair, 52 were documented as poor, 1 was documented as refused, and 33 were left blank with no documentation. Of the 90 nourishments offered 2 were documented as good, 14 were documented as 100%, 2 were documented as 25%, 3 were documented as refused, 22 were documented with zero, 2 were documented with a line through the block, and 44 were left blank with no documentation. Review of resident 40's activities of daily living flow sheet record for the month of December 2001, revealed that of the 93 meals offered zero were documented as good, 9 were documented as fair, 78 were documented as poor, one was documented as refused, and 3 were left blank with no documentation. Of the 93 nourishments offered 3 were documented as fair, 13 were documented as refused, 29 were documented with a line through the block, and 46 were left blank with no documentation. 7. Resident 28 was a 88 year old female admitted to the facility on 7/31/01 with diagnoses of esophageal varices, bleeding ulcers, gastroesophageal reflux, hiatal hernia, hypothyroidism, status post cerebrovascular accident and edema. On 8/14/01, the RD completed an initial nutritional assessment that documented resident 28 was 5'0" (60 inches) tall per the resident, the admit weight section	F 325		

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F 325	Continued From Page 35 was blank, the resident's usual body weight was recorded as 108-115 pounds and her ideal body weight range was documented as 104-115 pounds based on a small frame size. The diet documented was mechanical soft. A review of resident 28's admission weight and height, documented on the "Resident Assessment-Data Collection Form" completed by the nursing staff upon admission, revealed that she weighted 114 pounds and was 5'2" (62 inches) tall. A review of resident 28's monthly weights, completed by the restorative nurses aides and obtained from the dietary supervisor, documented the following weights for resident 28: July 2001: 114 pounds. August 2001: 114 pounds. September 2001: 113 pounds. October 2001: 110 pounds. November 2001: 111 pounds. December 2001: 107 pounds. January 2002: 103 pounds. On 1/11/02, at the request of the survey team, resident 28 was re- weighed. Resident 28's weight was 100 pounds. This represents a significant weight loss of 11 pounds, or 10%, between the months of November 2001 and January 2002, and a 14 pound, or 12%, significant weight loss between the months of July 2001 and January 2002 (using the July 2001 weight and the January re-weight of 100 pounds). An initial dietary assessment completed by the registered dietitian on 8/14/01 documented, "Intake appears to be adequate for nutritional needs, current diet appropriate for needs, pt [patient] would be considered at a nutritional risk [secondary to] GERD [gastroesophageal reflux disease], diarrhea [with] a	F 325		

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F 325	Continued From Page 36 potential for [decreased] intake, advanced age". This initial assessment identified resident 28 had a good appetite (75%) and was able to feed herself. The RD's documented nutrition plan for resident 28 was to, "monitor weight, intake, labs". On 11/1/01, a quarterly nutrition assessment was completed by the dietary supervisor and signed by the RD. There were no nutritional stress factors documented. No further documented dietary notes were found in resident 28's medical record. A review of the "Nursing Monthly Summary" assessment for August 2001 documented resident 28's current weight was 114 pounds and she had a good appetite. The nurse documented that resident 28 had no edema and no abdominal distress. There were no "Nursing Monthly Summary" assessments in the medical record for the months of September, October or November 2001. A review of the "Nursing Monthly Summary" assessment for December 2001 documented resident 28's current weight was 107 pounds and she had a good appetite. The nurse documented that resident 28 had no edema and no complaints of abdominal distress. A review of nursing notes from 7/31/01 to 1/15/02 in resident 28's medical record was done. There was no documented evidence of edema noted during this time. On 9/14/01, the nurse documented that resident 28 did not like the nutritional supplement, Resource, which had been ordered on 8/15/01, and refused to drink it. There was a physician telephone order on 9/16/01 to discontinue the supplement. On 1/4/02, the nurse documented that resident 28 "hates house supplement". On 1/12/02, the nurse documented that resident 28 had a good appetite. There was no	F 325		

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F 325	Continued From Page 37 documented evidence that other types of nutritional supplements or that interventions to increase the calories in resident 28's diet were attempted. A review of all documented physician assessments completed from resident 28's admission on 7/31/01 through 1/15/02 was done. Resident 28's gradual weight loss was not addressed on these assessments. A nutritional care plan, initiated by the RD and dated 9/01, documented that resident 28 was at nutritional risk related to advanced age and periods of diarrhea and would have no significant weight loss through the next review. Approaches to the problem on the care plan included, dietary was to obtain food preferences, meal intakes, weights and labs were to be monitored and the RD was to be notified of significant changes. The care plan was not updated to address resident 28's significant weight loss of 11 pounds, or 10%, between the months of July 2001 and January 2002 (using the July 2001 weight and the original January weight of 103 pounds) and the steady, gradual weight loss between the months of November 2001 and January 2002. A review of resident 28's "Daily Dietary Intake" record for November 2001 was done. On 16 of the days the aides documented that resident 28 ate 100% of her breakfast and 18 days that resident 28 ate 100% of lunch and 1 day that resident 28 ate 100% of supper. Two days documented that resident 28 ate no breakfast and 1 lunch meal which had no meal intake documented. There were no other meal intake records for resident 28 for the month of November 2001. A review of resident 28's "Daily Dietary Intake" record for December 2001 was done. On 2 of the days the nurse aides documented that resident 28 ate 100% of her breakfast and lunch and 15 days which	F 325		

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F 325	Continued From Page 38 had no meal intake documented. There were no other meal intake records for resident 28 for the month of December 2001. A review of the facility's Dietary Management Team minutes revealed that resident 28 was identified as needing nutritional intervention/monitoring during the 1/2/02 meeting. Resident 28 was on the Dietary Management Team list for review 1/2/02, however, there were no team member comments, recommendations or interventions documented on the monitoring form. 8. Resident 50 was an 83 year old female admitted to the facility on 4/4/01 with diagnoses of dementia with depressive features, non insulin dependent diabetes mellitus, osteoarthritis, agitation and generalized pain. The registered dietitian completed an undated initial nutritional assessment that documented resident 50 weighted 145 pounds, was 5'2" (62 inches) tall and her ideal body weight range was 108-121 pounds upon admission. The diet documented was mechanical soft. A review of resident 50's admission weight, documented in the physician's admit note, revealed that she weighted 145 pounds on 4/4/01. A review of resident 50's monthly weights from June 2001 through January 2002, completed by the restorative nurses aides and obtained from the dietary supervisor, documented the following weights for resident 50: June 2001: 140 pounds. July 2001: 142 pounds. August 2001: 142 pounds. September 2001: 139 pounds. October 2001: 137 pounds. November 2001:134 pounds. December 2001: 128.5 pounds.	F 325		

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F 325	Continued From Page 39 January 2002: 131.5 pounds. On 1/11/02, at the request of the survey team, resident 50 was re-weighed. Resident 50's weight was 128 pounds. This represents a significant weight loss of 14 pounds, or 10% between the months of July 2001 and January 2002 (using the July weight of 142 pounds and the January re-weight of 128 pounds). There was steady weight decrease noted from September 2001 to January 2002. An undated "initial dietary assessment" completed by the registered dietitian documented, "Intake/fluids good. Should meet needs...Pt [patient] at nutritional risk m/b [manifested by] senile dementia [with] potential for weight loss". This initial assessment identified resident 50 had a fair appetite (50-75%), good swallowing ability, dentures which fit properly and she could feed herself. The RD's documented nutrition plan for resident 50 was to, "monitor intake, weights, labs". An undated "quarterly nutrition note" not co-signed by the registered dietitian, was completed by the food service supervisor. Resident 50's gradual weight decrease was not identified in this note. A review of resident 50's medical record showed these were the only completed dietary assessments of this resident. The quarterly note for January 2002 had not yet been fully completed but had been partially completed by the food service supervisor. In a telephone interview with her on 1/17/02, she stated that she began to fill out the January 2002 quarterly assessment in November 2001 but had not yet completed it for January. This quarterly note had not yet been reviewed and signed by the dietitian. A review of the "Nursing Monthly Summary" assessment for November 2001 documented resident 50's current weight was 134 pounds. The nurse completing the form documented that resident 50's weight was stable and next to that documented a	F 325		

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F 325	Continued From Page 40 gradual loss of 3 pounds and her appetite was good. A review of the "Nursing Monthly Summary" assessment for December 2001 documented resident 50's current weight was 134 pounds. The nurse completing the form documented no weight changes and that resident 50 had a fair appetite. A review of the "Nursing Monthly Summary" assessment for January 2002 documented resident 50's current weight was 129 pounds, which was a loss of 5 pounds. The nurse completing the form documented that resident 50 had gradual weight loss and her appetite was good. A review of resident 50's "Malnutrition/Dehydration-Pressure Sore Risk Assessment", completed by the nursing staff, was done. Resident 50 was assessed on 4/4/01 as having a total score of 8. Resident 50 was assessed on 7/5/01, 10/1/01, and 1/4/02 as having a total score of 12. Per this form, a total score of 10 or higher placed the resident at high nutritional risk. A review of all documented physician assessments completed from resident 50's admission on 4/4/01 through 1/15/02 was done. Resident 50's gradual weight loss was not addressed on these assessments. A nutritional care plan, initiated by the RD and dated 4/12/01, documented that resident 50 was at nutritional risk related to advanced age and adjustment to the nursing home, senile dementia with potential for weight loss and diabetes and would have no significant weight loss through the next review. Approaches to the problem on the care plan included, dietary was to obtain food preferences, meal intakes, weights and labs were to be monitored and the RD was to be notified of significant changes. The care plan was not	F 325		

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F 325	Continued From Page 41 updated to address resident 50's steady, gradual weight loss between the months of September 2001 and January 2002. A malnutrition/dehydration risk care plan, initiated by nursing, dated 4/10/01 and updated 9/23/01, documented that resident 50 was at nutritional risk related to a total score of 8 on the malnutrition/dehydration assessment, poor ability to take fluids independently or feed self and osteoarthritis. Also documented was that resident 50's average dietary intake was 50-75% and she had good swallowing ability. Documented goals included the following: no unexpected or unplanned weight loss every month, average meal intakes of 75% and evaluate every monthly summary and in the interdisciplinary team meeting. Approaches to the problem of the care plan included document percentage eaten on ADL form every meal, monitor if less than 50% meal average every day, monitor significant unplanned weight loss. A review of resident 50's meal intake record, documented on the "ADL Flow Sheet Record" for November 2001 revealed that the nurses' aides were documenting meal intakes in percentages. Out of a possible 90 meals for the month 10 had no meal percentage documented. A review of resident 50's meal intake record, documented on the "ADL Flow Sheet Record" for December 2001 revealed that the nurses' aides were documenting meal intakes in percentages. Out of a possible 93 meals for the month 26 had no meal percentage documented. A review of resident 50's meal intake record, documented on the "ADL Flow Sheet Record" for January 2002 from 1/1/02 through1/9/02 revealed that	F 325		

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F 325	Continued From Page 42 the nurses' aides were documenting meal intakes in percentages. Out of a possible 27 meals 8 had no meal percentage documented. A review of the facility's Dietary Management Team minutes revealed that resident 50 was identified as needing nutritional intervention/monitoring during the 12/17/01 meeting. Resident 50 was on the Dietary Management Team list for review 12/17/01, however, there were no team member comments, recommendations or interventions documented on the monitoring form. On 1/3/02, from 7:45 AM to 8:15 AM in the Facility Alzheimer's dining room, resident 50 was observed with her breakfast tray. Resident 50 was observed not to be eating her food but was using her spoon to move the foods around on her plate. The nurse aide in the dining room stated, "[resident 50] likes to play with hers, she builds things". The aide was not observed to offer to help resident 50 eat or re-direct her to eat her food. At 7:56 AM, resident 50 was observed to pour half of her glass of juice into her plate. At 8:01 AM, resident 50 continued to manipulate her food around her plate and not eat. The nurse aide asked her if she was having fun and told resident 50 she was supposed to eat. Resident 50 continued to not eat and move the food items around on her plate until 8:15 AM when her plate was removed by a staff member. She was not offered a replacement tray after she poured juice on her food nor was she observed to be offered an alternative breakfast. Resident 50 was not re-directed to eat her breakfast by the certified nurses aide in the dining room or to be offered assistance with eating.	F 325		

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F 326 SS=E	483.25(i)(2) QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and medical record review, it was determined that for 2 of 26 sampled residents, the facility did not ensure that each resident received a therapeutic diet when there was a nutritional problem as evidenced by: one resident did not receive her protein power as ordered by the physician and one resident who does not like meat was not served a protein rich meat alternative during the lunch meal on 1/3/02. Resident identifiers: 35, 42. The facility did not follow therapeutic diets for any resident prescribed these diets per physician orders. Findings include: 1. Resident 35 was a 94 year old female with diagnoses including hemorrhagic cerebrovascular accident, congestive heart failure and anemia. She was also noted to have a history of pressure ulcers. On 1/3/02, resident 35's medical record was reviewed. A review of the January, 2002 re-certification orders, signed by the physician, documented that a puree diet with 1 scoop of Promod (a supplemental protein powder) was ordered on 10/27/01. Observation of the tray line during the lunch meal on 1/3/02 revealed that resident 35 did not receive the ordered Promod. A dietary aide was interviewed on 1/3/02 at 1:30 PM. She stated that the dietary staff usually put the Promod on her tray in a small plastic cup and the nursing staff	F 326	The following is a plan of correction and is in reference to: F-325 483.25 (i) Quality of Care. This will include corrective F-326 483.25 (i) (2) Quality of Care, F-360 483.35 Dietary Services, F-361 483.35 1-2, F-363 483.35 (c) Dietary Services,F-364 483.35 (d) (1) &(2),F-371 483.35 (h) (2). Action for each resident found to have been affected and were identified as 13, 20, 28, 40, 50, 70, 72, 74. 1. Licensed staff will be in-serviced on how to complete the malnutrition/dehydration-pressure sore risk assessment done by the RD, the MDS, the dietary progress notes, the dietary intake records, and the current weights, and diagnosis and medications as warranted. 2. NIT committee will address any medical conditions i.e.: h-pylori on the residents' careplan and consult with residents' physician for medical and nutritional interventions. 3. Dietary intake record has been changed so that percentage of what resident ate is now what is accurately recorded rather than good-fair-or poor. 4. C.N.A. scheduler will audit dietary intake record weekly to ensure accuracy and completion. 5. 4 way drug check will be done monthly by ADON and QA to ensure that all orders regarding house supplement will be on residents' MAR's as warranted and to ensure percentage documentation. As well as to address diagnosis's to medication and any drug interactions and/or side effects. 6. Licensed staff has been instructed to inform NIT committee of any dietary problems so that other interventions can be implemented as warranted. 7. Monthly weights provided each month upon completion to each hall with current weights to be placed MAR binder so that monthly summaries can address current weights. 8. C.N.A.-N.A will be in-serviced February 20, 2002 regarding interventions for residents' experiencing eating, swallowing, and chewing difficulties. Importance of communicating to nurses so that interventions are implemented as warranted. 9. Speech consultant will report any evaluations, outcomes, and recommendations to the NIT committee. 10. NIT committee will calculate weight loss percentages weekly. 11. Extended menus for the menu cycle is available and currently being followed Dietary staff will be in-serviced by the RD what servings sizes are appropriate and what foods residents on therapeutic diets are to receive. 12. Previous Registered Dietician has been replaced by RD, and whom will assume responsibilities to provide services, support, and supervision, through assessment, monitoring and recommendations, to meet each residents' nutritional needs to prevent significant weight loss. The RD will	2-27-02 ~~2/20/02~~

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F 326	Continued From Page 44 would add the Promod to her food. She stated that the kitchen had been out of Promod for 3 or 4 days but that the nurses in the facility should have some and that they'd place a scoop in her food if it was not sent from dietary. An interview with the dietary manager on 1/3/02 at 1:32 PM was done. She stated that they were out of Promod in the kitchen but that it should be available at the nurse's stations. Interviews with nursing staff members on the different halls on 1/3/02 revealed that no Promod was available at the nurse's stations or anywhere else in the facility. An interview with the dietary manager on 1/3/02 at 2:00 PM was done. She stated that she'd been told that they were out of Promod facility wide and had been for at least 3 days. 2. Resident 42 was a 68 year old female with diagnoses including senile dementia, depression and hypertension. On 1/3/02, resident 42's medical record was reviewed. A review of the dietary section of the chart revealed a "Change of Diet" slip, which documented the following, " Regular diet [with] low salt (NAS)[no added salt] (She likes to eat fruits [and] fish) (She doesn't like meat. She also likes lemonade)". Observation of tray line during the lunch meal on 1/3/02 was done. Resident 42's diet card stated as the only food preference, does not like meat. The following was to be served on the menu for lunch that day, meatballs in sweet & sour sauce, fried rice, oriental blend vegetables, bread/margarine and mandarin oranges. Resident 42 received the following food items on her meal tray, mashed potatoes and	F 326	ensure that the dietary manager and dietary staff have proper training and systems in place to appropriately monitor the sanitation of the kitchen, ensuring proper storage, preparation and the distribution and serving of foods, following Therapeutic diets as written and serving foods at the proper temperature. 13. Dietary in-service will be held weekly-Tuesday 3pm to discuss all survey issues, training, and any problems with the dietary services. 14. RD will ensure that each resident will receive a therapeutic diet when there is a nutritional problem. The RD will assess in identifying and correct improper serving of therapeutic diets to ensure the dietary needs of the residents. 15. Temperatures are monitored by the dietary cooks daily and recorded. The dietary manager will monitor at random resident's trays for proper food temps and record. 16. The dietary services have a daily cleaning schedule to ensure the sanitation of the kitchen, record to monitor the labeling and dating of foods, temps of the walk-in refrigerator. The dietary manager will audit the above concerns weekly. 17. The RD will be employed by SVHC as a dietary consultant, who will provide adequate supervision to both the dietary manager and dietary staff regarding: 1) Accurately monitoring and assessing residents at risk for weight loss. 2) Monitor the sanitation of the kitchen, ensuring proper storage, preparation, distribution and serving of foods, developing and implementing educational in-services for the dietary staff. 18. A new steam table with 4 wells is being purchased so foods will stay at the appropriate temperature above 140 degrees. 19. The walk-in refrigerator was fixed at temperature have maintained 40 degrees and below. Dietary staff instructed to keep refrigerator door closed going in or out. 20. The dietary staff will be in-serviced February 19, 2002 on how to store, prepare, distribute, and serve food under sanitary conditions. 21. The grease trap was cleaned by a local plumbing company, and was scheduled to come out routinely. 22. The unit manager for out-dated food will check the Alzheimer's unit refrigerator daily.	

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F 326	Continued From Page 45 gravy, white rice, a bowl of tomato soup, oriental blend vegetables, a slice of bread, mandarin oranges, an 8 ounce carton of fat free milk, and 4 ounces of juice. No high protein meat alternative was served to replace the meat not provided on resident 42's meal tray. 3. On 12/31/01 at 8:48 AM, the food service supervisor was interviewed. She was asked to provide the survey team with the extended menu for the week which would document the appropriate serving sizes to be provided for residents on all diets and document what diet modifications, if any, would need to be made for resident's receiving therapeutic or texture modified diets. She stated she was not sure what I was referring to and stated that since she'd taken over as dietary manager in August, 2001 the facility had not had the extended menus. She stated that all residents are served the same diet. She stated that foods are not cooked with salt and that if a resident is on a renal diet that they don't serve them potatoes. On 12/31/01 at 10:50 AM, the consultant dietitian was interviewed. He was asked whether he knew if the facility had extended menus for the menu cycle currently being followed. He stated he was unaware of any extended menus being used. He stated that the menu being served was low in salt and concentrated sweets. When asked how the staff knew what servings sizes were appropriate or what foods residents on therapeutic diets were to receive if they had no extended menu to specify this, he was unable to provide an answer.	F 326		
F 328 SS=E	483.25(k) QUALITY OF CARE The facility must ensure that residents receive proper	F 328		

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F 328	Continued From Page 46 treatment and care for the following special services: Injections Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and record review, it was determined that for 1 of 26 sampled residents, the facility did not ensure that proper diabetic foot care and treatment was provided. (resident 15) Findings include: Resident 15 was admitted to the facility on 5/7/01. The resident's diagnoses included, multi infarct dementia, weight loss, diabetes mellitus-II requiring insulin, hypertension, hyperlipidemia, onychomycosis, bilateral pedal edema, and proteinuria. Observation of resident 15 was made on 1/8/02 at 9:45 AM. Resident 15's feet had thick yellow, long, jagged toenails. Resident 15's toenail on her left foot great toe was growing upward at approximately an 80 degree angle to the nailbed. Resident 15 made the	F 328	The following is a plan of correction and is in reference to F328 483.25 (k) Quality of Care. This will include corrective action for each resident found to have been affected and were identified as is: 1. A Podiatrist was hired November 2001 to provide podiatry care for all the residents in the facility-prior to hiring the new podiatrist it was noted that podiatry care was lacking. 2. Medical records will maintain current podiatry list so that all residents are seen every 60 days. 3. Licensed staff will inform the podiatrist of any immediate problems. 4. Wound team nurse will assist the podiatrist during rounds.	2/1/02

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F 328	Continued From Page 47 comment, "I've been wanting someone to look at my feet.", while surveyor was observing resident 15's feet. Resident 15's feet were noted to be odorous. A review of resident 15's medical record was done on 1/8/02. There was no documentation available to evidence that a podiatrist had evaluated and treated resident 15. Resident 15's care plan, dated 5/7/01, under the activities of daily living care plan, identified a nursing approach to keep nails clean and trimmed.	F 328		
F 329 SS=E	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 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 medical record review, it was determined that for 4 of 26 sampled residents, the facility did not ensure that resident's insulin regime was monitored. Resident 4 had physician's orders to check blood glucose levels four times a day. Between the months of October and December 2001, blood glucose levels were obtained three times a day or less for 55 of 92	F 329		

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F 329	Continued From Page 48 days. Resident 15 had physician's orders to check blood glucose level three times a day. For the months of October and November, blood glucose levels were obtained two times a day or less for 12 of 61 days . Resident 24 had physician's orders to check blood glucose level two times a day. For the months of October, and November, blood glucose levels were obtained two times a day or less for 9 of 61 days. Resident 76 had physician's orders to check blood glucose level four times a day. Resident 76 attends dialysis every Tuesday, Thursday and Saturday from 10:00 AM to 2:00 PM, therefore, the blood glucose levels before lunch on those days would not be recorded in the MAR (medication administration record). Resident 76 had incorrect insulin administered to him 65 out of 299 possible opportunities, from 10/16/01 (day after admission) to 1/07/02. (Residents 4, 15, 24, and 76) Findings include: Resident 4 was admitted to this facility on 6/23/97 with diagnoses which include the following: hypertension, heart disease, senile dementia, right hip fracture, congestive heart failure, hypothyroidism, osteoarthritis, hypercholesterolemia, small bowel obstruction, and diabetes. The medical record for resident 4 was reviewed on 12/31/01. During this review, it was noted that resident 4 had physicians orders, dated 8/20/01, to check blood glucose levels four times a day, before meals, and at hour of sleep. Resident 4 was to receive sliding scale regular insulin four times a day based on results of blood glucose monitoring. (Sliding scale regular insulin is an amount of insulin which is to be given, based on the results of resident's blood glucose levels). Resident 4's sliding scale insulin orders were: Blood glucose 250-300, give 4 units of regular insulin.	F 329	The following is a plan of correction and is in reference to F-329 483.25 (l) (1) Quality of Care, F-426 483.60 (a)Pharmacy Services. This will include corrective action for each resident found to have been affected and were identified as 4, 15, 24, 76. 1. The house physician ordered standard sliding scale for the diabetic. Residents-who are the house physicians' patients 150-200= 2 units regular 201-250= 4 units regular 251-300= 6 units regular 301-350= 8 units regular 351-400= 10 units regular Call MD if BS < 70 or >450 2. Licensed staff was in serviced regarding missed blood sugars and standard sliding scale insulin for his residents on 2/6/02. 3. Medical records will audit the Diabetic monitoring flow sheet weekly.	2/1/02

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F 329	Continued From Page 49 Blood glucose 301-350 give 6 units of regular insulin. Blood glucose of 351-400 give 8 units of regular insulin. Review of resident 4's MAR (medication administration record), the patient diabetic record flowsheet, and the diabetic monitoring flowsheet identified that resident 4's blood glucose levels were not documented as being done on the following dates and times. 10/02/01: before breakfast, before lunch 10/03/01: before lunch 10/04/01: before lunch, before dinner 10/05/01: before lunch, before dinner 10/06/01: before lunch, before dinner 10/07/01: before lunch, hour of sleep 10/09/01: before dinner 10/10/01: before lunch, before dinner 10/11/01: before lunch 10/13/01: before lunch before dinner, hour of sleep 10/14/01: before lunch, hour of sleep 10/15/01: before lunch,before dinner, hour of sleep 10/16/01: before breakfast, before lunch, before dinner 10/17/01: hour of sleep 10/18/01: before lunch, before dinner 10/21/01: hour of sleep 10/22/01: before lunch, before dinner, hour of sleep 10/15/01: before lunch, before dinner, hour of sleep 10/29/01: before breakfast,before lunch, hour of sleep 10/30/01: hour of sleep 10/31/01: before lunch, hour of sleep 11/01/01: before breakfast 11/03/01: before lunch 11/02/01: before dinner 11/04/01: before lunch, before dinner, hour of sleep 11/05/01: before lunch 11/06/01: before lunch	F 329		

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F 329	Continued From Page 50 11/07/01: before lunch 11/10/01: before lunch, before dinner, hour of sleep 11/12/01: before dinner 11/14/01: before lunch 11/17/01: before lunch 11/18/01: before lunch 11/20/01: before dinner 11/22/01: before lunch, before dinner 11/24/01: before lunch, before dinner, hour of sleep 11/27/01: before lunch, before dinner 12/01/01: before lunch 12/02/01: before lunch, before dinner 12/03/01: before lunch, hour of sleep 12/04/01: before lunch 12/05/01: before lunch 12/06/01: before dinner 12/07/01: before lunch, before dinner 12/08/01: before lunch, before dinner 12/09/01: before lunch, before dinner 12/15/01: before lunch, before dinner 12/16/01: before lunch, before dinner 12/17/01: before lunch 12/18/01: before lunch 12/19/01: hour of sleep 12/23/01: before lunch 12/24/01: before lunch, before dinner 12/29/01: before lunch 12/31/01: before lunch, before dinner, hour of sleep Resident 15 was admitted to this facility on 5/7/01 with the diagnoses which include the following: multi infarct dementia, weight loss, diabetes mellitus (insulin required), hypertension, hyperlipidemia, onychomycosis, bilateral pedal edema, and proteinuria. The medical record for resident 15 was reviewed on 1/8/02. During this review, it was noted that resident	F 329		

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F 329	Continued From Page 51 15 had physicians orders dated 5/7/01 to check blood glucose levels every AM, and every PM, and at hour of sleep. Resident 15 was to receive sliding scale regular insulin three times a day based on the results of blood glucose monitoring. Resident 15's sliding scale insulin orders were: Blood glucose 200-250, give 2 units regular insulin. Blood glucose 251-300, give 4 units regular insulin. Blood glucose 301-350, give 6 units regular insulin. Blood glucose 351-400, give 8 units regular insulin. Blood glucose 401-450, give 10 units regular insulin. Review of resident 15's MAR, patient diabetic record flowsheet, and the diabetic monitoring flowsheet identified that resident 15's blood glucose levels were not documented as being done on the following dates and times. 10/27/01: hour of sleep 10/28/01: hour of sleep 10/29/01: hour of sleep 10/31/01: hour of sleep 11/04/01: before dinner 11/05/01: hour of sleep 11/10/11: hour of sleep 11/13/01: before dinner 11/22/01: before dinner 11/24/01: hour of sleep 11/25/01: before breakfast 11/29/01: before dinner Resident 24 was admitted to the facility on 4/5/01 with diagnoses which include the following: pyelonephritis, insulin dependent diabetes mellitus, pulmonary embolism, infarction, deep vein thrombosis, atrial fibrillation, femur fracture, hypertension, depression, insomnia, anxiety, and anemia.	F 329		

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F 329	Continued From Page 52 The medical record for resident 24 was reviewed on 1/8/02. During this review it was noted that resident 24 had physicians orders dated 4/6/01 to check blood sugar two times a day. Resident 24 was to receive sliding scale regular insulin two times a day based on results of blood glucose monitoring. Resident 24's sliding scale insulin orders were: Blood glucose 151-200, give 2 units of regular insulin. Blood glucose 201-250, give 4 units of regular insulin. Blood glucose 251-300, give 6 units of regular insulin. Blood glucose 301-350, give 8 units regular insulin. Blood glucose 351-400, give 10 units. If blood glucose is greater than 400, give 12 units of regular insulin and check glucose every 2 hours until glucose is less than 150. Review of resident 24's MAR (medication administration record), patient diabetic record flowsheet, and the diabetic monitoring flowsheet identified that resident 24's blood glucose levels were not documented as being done on the following dates and times. 10/12/01: before dinner 10/14/01: before dinner 10/15/01: before dinner 10/16/01: before breakfast 11/02/01: before dinner 11/05/01: before dinner 11/10/01: before dinner 11/29/01: before dinner 11/30/01: before breakfast 1. Resident 76 was a 53 year old male who was admitted to the facility on 10/15/01 with the diagnoses of gastric ulcers, respiratory distress syndrome, IDDM (insulin dependant diabetes mellitus), aspiration pneumonia, CAD (cardiac artery disease), acute renal failure, respiratory failure, gangrenous cholecystitis,	F 329		

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F 329	Continued From Page 53 acute MI (myocardial infarction), and CVA (cerebral vascular accident). A physician's order dated 10/15/01, documented, "sliding scale AC [before meals] and HS [at bedtime]". The sliding scale was ordered as follows: Blood glucose level 150 to 250 give 4 units regular insulin. Blood glucose level 251 to 350 give 6 units regular insulin. Blood glucose level 351 to 450 give 10 units regular insulin. Blood glucose level greater than 450 call the physician. On 1/08/02 at 9:30 AM, an interview with a facility license practical nurse (LPN) was conducted about how to document the sliding scale insulin and glucose monitoring. The facility's LPN stated that the blood sugars should be documented on the "Diabetic Monitoring Flowsheet" with the amount of insulin given. Resident 76's MAR and diabetic monitoring flowsheet was reviewed. The following were a list of days and times during October, November, December, 2001, and January 1, 2002 through January 7, 2002, that resident 76 did not have a blood glucose level documented as being done as ordered. 10/16/01: before breakfast, before dinner 10/17/01: before lunch, hour of sleep 10/18/01: hour of sleep 10/19/01: before lunch, before bedtime 10/20/01: hour of sleep 10/21/01: before breakfast, before lunch, before dinner, hour of sleep 10/22/01: before breakfast, before lunch, hour of sleep 10/23/01: hour of sleep	F 329		

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F 329	Continued From Page 54 10/24/01: before lunch, hour of sleep 10/25/01: hour of sleep 10/26/01: before lunch, hour of sleep 10/27/01: hour of sleep 10/29/01: before lunch, before dinner, hour of sleep 10/30/01: hour of sleep 10/31/01: before lunch, hour of sleep 11/01/01: before breakfast, before dinner, hour of sleep 11/02/01: before lunch, before dinner, hour of sleep 11/03/01: before dinner, hour of sleep 11/04/01: before lunch, before dinner, hour of sleep 11/05/01: before lunch, hour of sleep 11/07/01: before lunch, before dinner, hour of sleep 11/08/01: before dinner 11/09/01: before lunch, hour of sleep 11/10/01: before breakfast, hour of sleep 11/11/01: before lunch 11/12/01: before lunch, before dinner 11/13/01: before dinner 11/14/01: before lunch, hour of sleep 11/16/01: before lunch, hour of sleep 11/18/01: before lunch, hour of sleep 11/19/01: before dinner 11/20/01: before dinner 11/23/01: before lunch, before dinner, hour of sleep 11/28/01: before dinner 11/29/01: before dinner 11/30/01: before lunch 12/01/01: before dinner, hour of sleep 12/03/01: before dinner 12/04/01: before dinner 12/05/01: before dinner 12/07/01: before breakfast, before lunch, hour of sleep 12/09/01: before lunch 12/10/01: before lunch, before dinner, hour of sleep 12/12/01: before lunch 12/14/01: hour of sleep	F 329		

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F 329	Continued From Page 55 12/21/01: before lunch 12/23/01: before lunch 12/24/01: before lunch 12/27/01: hour of sleep 12/28/01: before lunch 12/30/01: before lunch 12/31/01: before lunch 01/02/01: before breakfast, before lunch 01/04/01: before lunch, before dinner 01/06/01: before lunch 01/07/02: before lunch	F 329		
F 360 SS=H	483.35 DIETARY SERVICES The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. This REQUIREMENT is not met as evidenced by: Based on an annual survey with subsequent extended survey, conducted December 31, 2001 through January 16, 2002, it was determined that the facility failed to ensure residents were provided a diet that met their special dietary needs. The consultant dietitian did not provide services, supports and supervision, through assessment, monitoring and recommendations, to meet each resident's nutritional needs to prevent significant weight loss. There was not inadequate supervision and oversight provided by the consultant dietitian to ensure that the dietary manager and dietary staff had proper training and systems in place to appropriately monitor the sanitation of the kitchen, ensuring proper storage, preparation and the distribution and serving of foods, following the therapeutic diets as written and serving foods at the proper temperature.	F 360		

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F 360	Continued From Page 56 This had the potential to affect all residents in the facility. Findings include: 1. The facility did not have a system in place that would ensure that residents of the facility did not have avoidable weight loss. There was a lack of sufficient oversight, supervision and monitoring by the registered dietitian in identification, correction and prevention of weight loss, which resulted in the needs of the residents not being met. Eight residents were identified as having experienced avoidable and significant weight loss due to the breakdown in dietary services. (Refer to Tag F-325) 2. The facility did not have a system in place to monitor that the kitchen was following the approved, written therapeutic menus, including providing consistent food portions, which would allow for variances in the calories, protein and other nutrients provided to each resident. There was lack of sufficient oversight and supervision by the registered dietitian in identifying and correcting the serving of incorrect menus and portions sizes, which would result in the needs of the residents not being met. (Refer to tag F-363) 3. The facility did not have a system in place to ensure that each resident received a therapeutic diet when there was a nutritional problem. This resulted in residents not receiving extra protein as ordered by their physician and all residents receiving the same diet with no modifications made for those residents who had specific therapeutic diet orders. There was a lack of sufficient oversight and supervision by the registered dietitian in identifying and correcting the	F 360	The following is a plan of correction and is in reference to: F-325 483.25 (i) Quality of Care. This will include corrective F-326 483.25 (i) (2) Quality of Care, F-360 483.35 Dietary Services, F-361 483.35 1-2, F-363 483.35 (c) Dietary Services,F-364 483.35 (d) (1) &(2),F-371 483.35 (h) (2). Action for each resident found to have been affected and were identified as 13, 20, 28, 40, 50, 70, 72, 74. 1. Licensed staff will be in-serviced on how to complete the malnutrition/dehydration-pressure sore risk assessment done by the RD, the MDS, the dietary progress notes, the dietary intake records, and the current weights, and diagnosis and medications as warranted. 2. NIT committee will address any medical conditions i.e.: h-pylori on the residents' careplan and consult with residents' physician for medical and nutritional interventions. 3. Dietary intake record has been changed so that percentage of what resident ate is now what is accurately recorded rather than good-fair-or poor. 4. C.N.A. scheduler will audit dietary intake record weekly to ensure accuracy and completion. 5. 4 way drug check will be done monthly by ADON and QA to ensure that all orders regarding house supplement will be on residents' MAR's as warranted and to ensure percentage documentation. As well as to address diagnosis's to medication and any drug interactions and/or side effects. 6. Licensed staff has been instructed to inform NIT committee of any dietary problems so that other interventions can be implemented as warranted. 7. Monthly weights provided each month upon completion to each hall with current weights to be placed MAR binder so that monthly summaries can address current weights. 8. C.N.A.-N.A will be in-serviced February 20, 2002 regarding interventions for residents' experiencing eating, swallowing, and chewing difficulties. Importance of communicating to nurses so that interventions are implemented as warranted. 9. Speech consultant will report any evaluations, outcomes, and recommendations to the NIT committee. 10. NIT committee will calculate weight loss percentages weekly. 11. Extended menus for the menu cycle is available and currently being followed Dietary staff will be in-serviced by the RD what servings sizes are appropriate and what foods residents on therapeutic diets are to receive. 12. Previous Registered Dietician has been replaced by RD, and whom will assume responsibilities to provide services, support, and supervision, through assessment, monitoring and recommendations, to meet each residents' nutritional needs to prevent significant weight loss. The RD will	~~2/20/02~~ 2-27-02

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F 360	Continued From Page 57 improper serving of therapeutic diets, which resulted in the dietary needs of the residents no being met. (Refer to tag F-326) 4. The facility did not have a system in place to monitor food temperatures of foods sent out on resident trays or foods kept under refrigeration. Foods, which are not kept at the proper temperature, pose a possible health risk to residents and can affect the palatability and consumption of foods. There was a lack of sufficient oversight and supervision by the registered dietitian in identifying and correcting improper food temperatures. (Refer to tag F-364) 5. The facility did not have a system in place which would ensure that the sanitation of the kitchen was monitored, which includes, at a minimum, checking the kitchen for general cleanliness, monitoring the labeling and dating of foods and routinely monitoring that temperatures in the walk-in refrigerator were appropriate, on a regular basis. There was a lack of sufficient oversight and supervision by the registered dietitian in identifying and correcting sanitation concerns in the kitchen that would result in the needs of the residents not being met. (Refer to tag F-371)	F 360	ensure that the dietary manager and dietary staff have proper training and systems in place to appropriately monitor the sanitation of the kitchen, ensuring proper storage, preparation and the distribution and serving of foods, following Therapeutic diets as written and serving foods at the proper temperature. 13. Dietary in-service will be held weekly-Tuesday 3pm to discuss all survey issues, training, and any problems with the dietary services. 14. RD will ensure that each resident will receive a therapeutic diet when there is a nutritional problem. The RD will assess in identifying and correct improper serving of therapeutic diets to ensure the dietary needs of the residents. 15. Temperatures are monitored by the dietary cooks daily and recorded. The dietary manager will monitor at random resident's trays for proper food temps and record. 16. The dietary services have a daily cleaning schedule to ensure the sanitation of the kitchen, record to monitor the labeling and dating of foods, temps of the walk-in refrigerator. The dietary manager will audit the above concerns weekly. 17. The RD will be employed by SVHC as a dietary consultant, who will provide adequate supervision to both the dietary manager and dietary staff regarding: 1) Accurately monitoring and assessing residents at risk for weight loss. 2) Monitor the sanitation of the kitchen, ensuring proper storage, preparation, distribution and serving of foods, developing and implementing educational in-services for the dietary staff. 18. A new steam table with 4 wells is being purchased so foods will stay at the appropriate temperature above 140 degrees. 19. The walk-in refrigerator was fixed at temperature have maintained 40 degrees and below. Dietary staff instructed to keep refrigerator door closed going in or out. 20. The dietary staff will be in-serviced February 19, 2002 on how to store, prepare, distribute, and serve food under sanitary conditions. 21. The grease trap was cleaned by a local plumbing company, and was scheduled to come out routinely. 22. The unit manager for out-dated food will check the Alzheimer's unit refrigerator daily.	
F 361 SS=F	483.35(a)(1)-(2) DIETARY SERVICES The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian.	F 361		

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F 361	Continued From Page 58 A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs. This REQUIREMENT is not met as evidenced by: Based on staff interview and observations it was determined that the facility did not utilize their part-time consultant dietitian in a manner which provided adequate supervision to the dietary manager or dietary staff regarding: 1. accurately monitoring and assessing residents at risk for weight loss and 2. monitoring the sanitation of the kitchen , ensuring proper storage, preparation, distribution and serving of foods, developing and implementing educational in-services for the dietary staff. Findings include: 1. Based on clinical record review it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by10 of 26 sampled residents experienced significant weight loss with no dietary interventions implemented to prevent further weight decline. Further, the dietitian did not provide services and supports, through assessment, monitoring and recommendations, to meet each resident's nutritional needs. The facility failed to provide dietetic supports and services which maintained the body weights for each resident as evidenced by: a. Resident 13, a 79 year old female, was admitted to	F 361	The following is a plan of correction and is in reference to: F-325 483.25 (i) Quality of Care. This will include corrective F-326 483.25 (i) (2) Quality of Care, F-360 483.35 Dietary Services, F-361 483.35 1-2, F-363 483.35 (c) Dietary Services,F-364 483.35 (d) (1) &(2),F-371 483.35 (h) (2). Action for each resident found to have been affected and were identified as 13, 20, 28, 40, 50, 70, 72, 74. 1. Licensed staff will be in-serviced on how to complete the malnutrition/dehydration-pressure sore risk assessment done by the RD, the MDS, the dietary progress notes, the dietary intake records, and the current weights, and diagnosis and medications as warranted. 2. NIT committee will address any medical conditions i.e.: h-pylori on the residents' careplan and consult with residents' physician for medical and nutritional interventions. 3. Dietary intake record has been changed so that percentage of what resident ate is now what is accurately recorded rather than good-fair-or poor. 4. C.N.A. scheduler will audit dietary intake record weekly to ensure accuracy and completion. 5. 4 way drug check will be done monthly by ADON and QA to ensure that all orders regarding house supplement will be on residents' MAR's as warranted and to ensure percentage documentation. As well as to address diagnosis's to medication and any drug interactions and/or side effects. 6. Licensed staff has been instructed to inform NIT committee of any dietary problems so that other interventions can be implemented as warranted. 7. Monthly weights provided each month upon completion to each hall with current weights to be placed MAR binder so that monthly summaries can address current weights. 8. C.N.A.-N.A will be in-serviced February 20, 2002 regarding interventions for residents' experiencing eating, swallowing, and chewing difficulties. Importance of communicating to nurses so that interventions are implemented as warranted. 9. Speech consultant will report any evaluations, outcomes, and recommendations to the NIT committee. 10. NIT committee will calculate weight loss percentages weekly. 11. Extended menus for the menu cycle is available and currently being followed Dietary staff will be in-serviced by the RD what servings sizes are appropriate and what foods residents on therapeutic diets are to receive. 12. Previous Registered Dietician has been replaced by RD, and whom will assume responsibilities to provide services, support, and supervision, through assessment, monitoring and recommendations, to meet each residents' nutritional needs to prevent significant weight loss. The RD will	2/20/02

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F 361	Continued From Page 59 the facility on 10/11/01 with diagnoses of chronic obstructive pulmonary disease, hypothyroidism and bronchitis, urinary tract infection, helicobacter pylori gastritis (h.pylori), anxiety and chronic dizziness. Resident 13 was admitted with physician orders for medications to treat the h. pylori. Review of the weights for resident 13 revealed the following: October 2001 – 95 pounds. November 2001 – 84 pounds. This represents a weight loss of 11 pounds, (11.5%) between the months of October and November 2001. December 2001 – 75.5. pounds. This represents a weight loss of 8.5 pounds, (10%) between the months of November and December 2001. Resident 13 experienced a significant weight loss of 19.5 pounds (20%) between the months of October and December 2001. A physician order dated 11/7/01 documented that resident 13 was to be given 60 cc of supplement with meals for weight loss. Review of the December 2001 medication sheet revealed that the house supplement was discontinued on 12/2/01 because resident 13 was refusing the supplement stating it made her have mucous in her throat. A review of dietary notes completed since resident 13's admission did not evidence that the dietitian re-assessed her nutritional needs based on her significant weight loss. There was no documented evidence that alternative dietary interventions were attempted to increase calories in resident 13's diet after she refused the house supplement. Resident 13's weight had been on a downward trend since October 2001. b. Resident 70, an 83 year old male, was admitted to	F 361	ensure that the dietary manager and dietary staff have proper training and systems in place to appropriately monitor the sanitation of the kitchen, ensuring proper storage, preparation and the distribution and serving of foods, following Therapeutic diets as written and serving foods at the proper temperature. 13. Dietary in-service will be held weekly-Tuesday 3pm to discuss all survey issues, training, and any problems with the dietary services. 14. RD will ensure that each resident will receive a therapeutic diet when there is a nutritional problem. The RD will assess in identifying and correct improper serving of therapeutic diets to ensure the dietary needs of the residents. 15. Temperatures are monitored by the dietary cooks daily and recorded. The dietary manager will monitor at random resident's trays for proper food temps and record. 16. The dietary services have a daily cleaning schedule to ensure the sanitation of the kitchen, record to monitor the labeling and dating of foods, temps of the walk-in refrigerator. The dietary manager will audit the above concerns weekly. 17. The RD will be employed by SVHC as a dietary consultant, who will provide adequate supervision to both the dietary manager and dietary staff regarding: 1) Accurately monitoring and assessing residents at risk for weight loss. 2) Monitor the sanitation of the kitchen, ensuring proper storage, preparation, distribution and serving of foods, developing and implementing educational in-services for the dietary staff. 18. A new steam table with 4 wells is being purchased so foods will stay at the appropriate temperature above 140 degrees. 19. The walk-in refrigerator was fixed at temperature have maintained 40 degrees and below. Dietary staff instructed to keep refrigerator door closed going in or out. 20. The dietary staff will be in-serviced February 19, 2002 on how to store, prepare, distribute, and serve food under sanitary conditions. 21. The grease trap was cleaned by a local plumbing company, and was scheduled to come out routinely. 22. The unit manager for out-dated food will check the Alzheimer's unit refrigerator daily.	

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F 361	Continued From Page 60 the facility on 8/10/01 with diagnosis of pneumonia, cerebrovascular accident, dementia, atrial fibrillation, peripheral vascular disease, hypertension, hypothyroidism and mild mental retardation. Review of the weights for resident 70 weights revealed the following: On admission 8/10/01- 138 pounds. September 2001- 127 pounds. This represents a weight loss of 11 pounds (7.9%) between the months of August and September 2001. October 2001- 115 pounds. This represents a weight loss of 12 pounds (9.4%) between the months of September and October 2001. November 2001- 112 pounds. This reprsnte a weight loss o 3 pounds (2.6%) between thre months of October and November 2001. Resident 70 experienced a significant weight loss of 26 pounds (18.8%) between the months of September and November 2001. A review of dietary notes completed since resident 70's admission did not evidence that the dietitian re-assessed his nutritional needs based on his significant weight loss. There was no documented evidence that any dietary interventions were attempted to increase calories in resident 70's diet. Resident 70's weight had been on a downward trend since August 2001. c. Resident 20 was a 61 year old male admitted to the facility on 7/9/01 with diagnoses of Alzheimer's disease, depression, cerebral degeneration and peptic ulcer disease. A review of resident 20's admission weight, documented in the initial nurses note, revealed that he weighted 217 pounds on 7/9/01. A review of resident 20's monthly weights, completed by the restorative	F 361		

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F 361	Continued From Page 61 nurses aides and obtained from the dietary supervisor, documented the following weights for resident 20: August, 2001: 212 pounds. September, 2001: 217 pounds. October, 2001: 214 pounds. November, 2001: 201 pounds. This represents a significant weight loss of 13 pounds, or 6%, between the months of October and November 2001. December, 2001: 201 pounds January, 2002: 195 pounds. On 1/11/02, at the request of the survey team, resident 20 was re-weighed. Resident 20's weight was 191 pounds. This represents a significant weight loss of 10 pounds, or 5% between the months of December 2001 and January, 2002 and a 10.7% significant weight loss between the months of October, 2001 and January, 2002(using the December weight of 210 pounds and the January re-weight of 191 pounds). A review of dietary notes completed since resident 20's admission did not evidence that the dietitian re-assessed his nutritional needs based on his significant weight loss. There was no documented evidence that any dietary interventions were attempted to increase calories in resident 20's diet. Resident 20's weight had been on a downward trend since October 2001. d. Resident 72 was a 78 year old female admitted to this facility on 11/10/00 with diagnoses of congestive heart failure, cerebrovascular accident, deep vein thrombosis, atrial fibrillation, angina, hypothyroidism and gastro-esophageal reflux disorder (GERD). Resident 72 had physician's orders to treat GERD on 3/26/01. Resident 72's weight history was obtained from the quarterly nutritional reassessment, dated 8/20/01, and	F 361		

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F 361	Continued From Page 62 were as follows: January 2001-214 pounds February 2001-198 pounds. This represents a weight loss of 16 pounds, (7.5%) between January and February 2001. March 2001-203 pounds April 2001-187 pounds. This represents a weight loss of 16 pounds, (7.9%) between March and April 2001. June 2001-182 pounds July 2001-167 pounds. This represents a weight loss of 15 pounds, (8.3%) between June and July 2001. A review of dietary notes completed since resident 72's admission did not evidence that the dietitian re-assessed her nutritional needs based on her significant weight loss. There was no documented evidence that any dietary interventions were attempted to increase calories in resident 72's diet. Resident 72's weight had been on a downward trend since March 2001. e. Resident 74, a 60 year old male, was admitted to the facility on 10/3/01 with diagnoses of hypotension, protien calorie malnutrition, dehydration, cerebralvascular accident and depression. Resident 74 was admitted with a gastrostomy tube (g-tube) with orders to administer two cans of Ensure three times daily via the g-tube . Resident 74 also had a physician order to receive a puree diet by mouth. Review of resident 74's monthly weights revealed the following: On admission, 10/10/01, 150 pounds. Novewmber 2001- 147.5 pounds. This represents a weight loss of 2.5 pounds, (1.6%) bewteen the months of October and November 2001. December 2001-142.5 pounds. This represents a	F 361		

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F 361	Continued From Page 63 weight loss of 5 pounds, (3.4%) between the months of November and December 2001. January 2001- 140 pounds. This represents a weight loss of 2.5 pounds, (1.75%) between the months of December and January 2001. At the request of the survey team, resident 74 was weighed on 1/11/02. Resident 74 weighed 136.5 pounds. This represents a weight loss of 3.5 pounds, (2.5%) between 1/1/02 and 1/11/02. Resident 74 experienced a significant weight loss of 13.5 pounds, (9%) between the months of October 2001 and January 2002. The facility was not aware of the weight loss until 1/11/01. On 10/25/01, the (RD) was asked by the nursing staff to evaluate resident 74's g-tube feeding. The RD recommeded, " Fiber Source HN to run at 70/cc an hour to provide 2016 Kcal and 89 grams protein. This should be adequate to maintain weight and replete residual proteins{Albumin} This TF [tube feeding] regimen would provide 1600 cc H20. Recommend 600cc additional free H20 as 200cc q [every] 8 hours. Will monitor tol [tolerance] to TF and weights." A physicians' order was obtained on 10/25/01 following the RD's recommendation. A nurses note on 10/25/01 documented the following: "Pt. wife informed of new enteral feeding order - she stated she only wants pt. to have 1 can @ [at] qhs [every night at bedtime] - H20 [water] to run rest of day - Dr.....contacted - orders H20 @ 83cc X [times] 24 hours - 1 can of HN Fibersource @ qhs added to water - weight q 2 wks [weeks] - wife informed of possible wt [weight] loss if not eating well - will continue to monitor." On 10/29/001 the RD documented, "Nursing stated family concerned about TF may cause kidney failure?	F 361		

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F 361	Continued From Page 64 This TF does not provide excess protein and is adequate for needs. I do not have any concerns in regard to this." There was no evidence that this was discussed with the family by the RD or the nursing staff. There was no further documentation by the RD. A review of dietary notes completed since resident 74's admission did not evidence that the dietitian re-assessed his nutritional needs based on his significant weight loss. There was no documented evidence that any dietary interventions were attempted to increase calories in resident 74's diet via his g-tube or by mouth after the 10/25/01 RD recommendations. Resident 74's weight had been on a downward trend since October 2001. f. Resident 40 was a 97 year old female admitted to this facility on 10/9/01 with diagnoses of fractured humerus, dementia, hypertension, hypothyroidism and constipation. Review of resident 40's IDT meeting comments on 10/10/01revealed the following information: October 2001- 120 pounds December 31.2001- 110.5 pounds. This represents a weight loss of 10.5 pounds, (8.7%) between the months of October 2001 and December 31, 2001. January 11, 2002- 107 pounds. This represents a weight loss of 14 pounds, (11.6%) between October 2001 and January 11, 2002. A review of dietary notes completed since resident 40's admission did not evidence that the dietitian re-assessed her nutritional needs based on her significant weight loss. There was no documented evidence that any dietary interventions were attempted to increase calories in resident 40's diet. Resident 40's	F 361		

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F 361	Continued From Page 65 weight had been on a downward trend since October 2001. g. Resident 28 was a 88 year old female admitted to the facility on 7/31/01 with diagnoses of esophageal varices, bleeding ulcers, gastroesophageal reflux, hiatal hernia, hypothyroidism, status post cerebrovascular accident and edema. A review of resident 28's monthly weights, completed by the restorative nurses aides and obtained from the dietary supervisor, documented the following weights for resident 28: July 2001: 114 pounds. August 2001: 114 pounds. September 2001: 113 pounds. October 2001: 110 pounds. November 2001: 111 pounds. December 2001: 107 pounds. January 2002: 103 pounds. On 1/11/02, at the request of the survey team, resident 28 was re- weighed. Resident 28's weight was 100 pounds. This represents a significant weight loss of 11 pounds, or 10%, between the months of July 2001 and January 2002 (using the July 2001 weight and the original January weight of 103 pounds) and a 14 pound, or 12%, significant weight loss between the months of July 2001 and January 2002 (using the July 2001 weight and the January re-weight of 100 pounds). A review of dietary notes completed since resident 28's admission did not evidence that the dietitian re-assessed her nutritional needs based on her gradual weight loss, which became significant between the months of July 2001 and January 2002. There was no documented evidence that any dietary interventions were attempted to increase calories in resident 28's diet. Resident 28's weight had been on a downward	F 361		

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F 361	Continued From Page 66 trend since September 2001. h. Resident 50 was an 83 year old female admitted to the facility on 4/4/01 with diagnoses of dementia with depressive features, non insulin dependent diabetes mellitus, osteoarthritis, agitation and generalized pain. A review of resident 50's admission weight, documented in the physician's admit note, revealed that she weighted 145 pounds on 4/4/01. A review of resident 50's monthly weights from June 2001 through January 2002, completed by the restorative nurses aides and obtained from the dietary supervisor, documented the following weight for resident 50: June 2001: 140 pounds. July 2001: 142 pounds. August 2001: 142 pounds. September 2001: 139 pounds. October 2001: 137 pounds. November 2001:134 pounds. December 2001: 128.5 pounds. January 2002: 131.5 pounds. On 1/11/02, at the request of the survey team, resident 50 was re-weighed. Resident 50's weight was 128 pounds. This represents a significant weight loss of 14 pounds, or 10% between the months of July 2001 and January 2002 (using the July weight of 142 pounds and the January re-weight of 128 pounds). There was steady weight decrease noted from September 2001 to January 2002. A review of dietary notes completed since resident 50's admission did not evidence that the dietitian re-assessed her nutritional needs based on her gradual weight loss, which became significant between the months of July 2001 and January 2002. There was no documented evidence that any dietary interventions were attempted to increase calories in resident 50's diet. Resident 50's weight had been on a downward	F 361		

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F 361	Continued From Page 67 trend since September 2001. (Refer to Tag F-325) 2. Based on observations, temperature checks and interview it was determined that the facility did not store, prepare, distribute, and serve food under sanitary conditions as evidenced by cleaning rags not being properly stored in sanitizing solution, the florescent kitchen lights not being properly covered, areas of the kitchen in need of cleaning, multiple food items not being labeled and or dated in the walk in refrigerator, outdated food items being stored in the walk in refrigerator, dented cans and unlabeled food items in the dry store room, a scoop was lying in the powdered dry milk, the walk in refrigerator not holding perishable foods at the proper temperature, and the facility grease trap being full of old grease and food debris which caused the facility kitchen floor to flood and smell of sewage when the three compartment dishwashing sink was drained as the water could not properly drain through the grease. (Refer to tag F-371). Based on observation, staff interview and review of documentation, it was determined that the facility did not follow the approved menus and the dietary staff was unaware of the proper amounts of foods to serve residents, which resulted in inconsistent meal servings and variances in the amount of calories, protein and other nutrients provided to each resident. (Refer to tag F-363). Based on food temperature checks during a lunch meal, temperature checks of foods in the walk-in refrigerator and statements made in a confidential group interview with residents it was determined that the facility did not serve food that was at the proper temperature. Hot foods are to be maintained at 140 degrees Fahrenheit or above when served and cold	F 361		

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F 361	Continued From Page 68 foods are to be maintained at or below 41 degrees Fahrenheit when served from tray line. Reference guidance: U.S. Public Health Service FDA 1999 Food Code, page 63. Foods, which are not kept at the proper temperature, pose a possible health risk to residents and can affect the palatability and consumption of foods. An interview with the Dietary Manager was done on 1/8/02 at 9:14 AM. She stated that the consultant dietitian visited the facility 10 hours each month. When asked if the consultant dietitian ever did sanitation checks of the kitchen, monitored the tray line, checked food temperatures or gave in-services regarding any of these or other issues to the dietary staff she stated no. She stated none of the above had been done she she'd taken over as the dietary manager in August 2001. She expressed frustration with the fact that since she'd become the dietary manager in August 2001 she'd received no training regarding how to properly operate the dietary department. An interview with the facility administrator was done on 1/8/02 at 4:15 PM. He confirmed that the consultant dietitian was allowed 10 hours each month to visit the facility. He stated that this was a corporate decision. During earlier interviews with the dietary manager on 12/31/01 at 8:48AM and 1/2/02 at 3:00 PM she stated that she was unsure of exactly what her responsibilities were in regards to running the kitchen. She stated that since she'd taken over she felt as if kitchen operations had improved but still felt like there were many areas where she needed further guidance. She stated that no one had trained her regarding proper sanitation of the kitchen, the need to follow the menus and the extended menus as written. She stated that since she'd been the dietary manager the facility did not have extended	F 361		

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F 361	Continued From Page 69 menus for the dietary staff to follow. She asked if there were any classes that she could take that would help her better perform her duties as the dietary manager. (Refer to tag F-364). Based on observation, interview and medical record review the facility did not follow therapeutic diets for any resident prescribed these diets per physician orders. On 12/31/01 at 10:50 AM, the consultant dietitian was interviewed. He was asked whether he knew if the facility had extended menus for the menu cycle currently being followed. He stated he was unaware of any extended menus being used. He stated that the menu being served was low in salt and concentrated sweets. When asked how the staff knew what servings sizes were appropriate or what foods residents on therapeutic diets were to receive if they had no extended menu to specify this, he was unable to provide an answer. (Refer to tag F-326). Based on observations in the kitchen on 12/31/01, 1/2/02 and 1/3/02 it was determined that the dietary manager and dietary staff lacked supervision and leadership to direct them in proper dietary procedures including sanitation and the storage, preparation, handling and distribution of food. There was no evidence that the consultant dietitian was available as a resource for the dietary manager or to help oversee and manage dietary services. There was no documented evidence, that the facility could produce, which indicated the consultant dietitian made routine sanitation checks, checked meal service or food temperatures or provided the dietary staff with in-service training. There was no evidence that the consultant dietitian had identified and/or attempted to	F 361		

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F 361	Continued From Page 70 correct any of the deficient practices found during the re-certification survey.	F 361		
F 363 SS=E	483.35(c)(1)-(3) DIETARY SERVICES Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of documentation, it was determined that the facility did not follow the approved menus. Findings include: 1. Review of the menu, Week 2 of the fall and winter menu set, revealed that the menu was not followed as written for the breakfast meal on 1/2/02, for the puree lunch meal on 1/2/02, for the breakfast meal on 1/3/02, and for the lunch meal on 1/3/02. 2. Observation of the breakfast meal on 1/2/02 revealed that corned beef hash, toast, 1 slice of bacon, cream of wheat or cold cereal, 4 ounces of juice and an 8 ounce carton of milk was served. The breakfast menu for 1/2/02 documented the following was to be served, orange juice, wheat hearts, poached egg, corned beef hash, toast with margarine and jelly, milk and choice of beverage. No poached eggs were served. No egg of any type or an alternative protein source was offered to the residents. The menu was not followed and the residents were short one protein serving. Observations of all trays also revealed that the serving sizes of corn beef hash varied greatly from	F 363		

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F 363	Continued From Page 71 approximately 2 tablespoons to a ½ cup from resident to resident regardless of what diet they were prescribed. This would allow for variances in both the calories and protein provided to each resident. 3. Observation of the lunch meal on 1/2/02 revealed that residents on puree diets received pureed barbeque chicken, pureed mashed potatoes, pureed bread and pureed dessert. The lunch menu for 1/2/02 documented the following was to be served, barbeque chicken, buttered parsley potatoes, buttered broccoli and pumpkin cake. The residents prescribed puree diets were not served broccoli or any alternative vegetable at the lunch meal. The menu was not followed and the resident's receiving a puree diet were short one vegetable serving. Observations of all trays also revealed that the serving sizes of both the broccoli and the potatoes varied greatly from approximately ¼ of a cup to greater that ½ cup from resident to resident regardless of what diet they were prescribed. This would allow for variances in the number of calories provided to each resident. 4. Observation of the breakfast meal on 1/3/02 revealed that 1 slice of toast, 1 banana, a bowl of oatmeal, 1 sausage link, 4 ounces of juice and 8 ounces of milk were served to residents who ate their meals in their room, the east dining room or the Alzheimer's unit dining room. The resident's who ate in the main dining room were observed to also receive hash browns in addition to the above listed food items. The breakfast menu for 1/3/02 documented that the following was to be served, orange juice, oatmeal, cinnamon French toast, hot buttered syrup, sausage links and milk. French toast and buttered syrup were not served as identified on the menu. This would decrease the calories being provided at the breakfast meal.	F 363	The following is a plan of correction and is in reference to: F-325 483.25 (i) Quality of Care. This will include corrective F-326 483.25 (i) (2) Quality of Care, F-360 483.35 Dietary Services, F-361 483.35 1-2, F-363 483.35 (c) Dietary Services,F-364 483.35 (d) (1) &(2),F-371 483.35 (h) (2). Action for each resident found to have been affected and were identified as 13, 20, 28, 40, 50, 70, 72, 74. 1. Licensed staff will be in-serviced on how to complete the malnutrition/dehydration-pressure sore risk assessment done by the RD, the MDS, the dietary progress notes, the dietary intake records, and the current weights, and diagnosis and medications as warranted. 2/20/02 2. NIT committee will address any medical conditions i.e.: h-pylori on the residents' careplan and consult with residents' physician for medical and nutritional interventions. 3. Dietary intake record has been changed so that percentage of what resident ate is now what is accurately recorded rather than good-fair-or poor. 4. C.N.A. scheduler will audit dietary intake record weekly to ensure accuracy and completion. 5. 4 way drug check will be done monthly by ADON and QA to ensure that all orders regarding house supplement will be on residents' MAR's as warranted and to ensure percentage documentation. As well as to address diagnosis's to medication and any drug interactions and/or side effects. 6. Licensed staff has been instructed to inform NIT committee of any dietary problems so that other interventions can be implemented as warranted. 7. Monthly weights provided each month upon completion to each hall with current weights to be placed MAR binder so that monthly summaries can address current weights. 8. C.N.A.-N.A will be in-serviced February 20, 2002 regarding interventions for residents' experiencing eating, swallowing, and chewing difficulties. Importance of communicating to nurses so that interventions are implemented as warranted. 9. Speech consultant will report any evaluations, outcomes, and recommendations to the NIT committee. 10. NIT committee will calculate weight loss percentages weekly. 11. Extended menus for the menu cycle is available and currently being followed Dietary staff will be in-serviced by the RD what servings sizes are appropriate and what foods residents on therapeutic diets are to receive. 12. Previous Registered Dietician has been replaced by RD, and whom will assume responsibilities to provide services, support, and supervision, through assessment, monitoring and recommendations, to meet each residents' nutritional needs to prevent significant weight loss. The RD will	

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F 363	Continued From Page 72 5. Observation of the lunch meal on 1/3/02 revealed that residents on puree diets received pureed meatballs, pureed mashed potatoes and pureed bread. The lunch menu for 1/3/02 documented the following was to be served, meatballs in sweet and sour sauce, fried rice, oriental blend vegetables, bread and margarine and mandarin oranges. The residents prescribed puree diets were not served oriental blend vegetables or any alternative vegetable at the lunch meal. The menu was not followed and the resident's receiving a puree diet were short one vegetable serving. The residents receiving puree diets received mashed potatoes instead of pureed fried rice. The residents prescribed pureed diets also received either applesauce or vanilla pudding instead of pureed mandarin oranges which would either mean that those residents receiving vanilla pudding were short one fruit serving and one vitamin C serving for the day and those residents receiving applesauce were short one source of vitamin C for the day. The menu was not followed. All residents, regardless of the diet prescribed were served white rice instead of fried rice. Observation of the lunch meal tray line was done 1/3/02. The cook was observed to use a slotted spoon instead of a standardized ½ cup serving utensil to serve the oriental mixed vegetables. This resulted in vegetable servings which were not consistent for residents receiving regular or mechanical soft diets. The cook was overheard asking a dietary aide on the tray line, "How many meatballs should I give?". The cook was then observed to serve 3-6 meatballs to residents receiving regular diets. The cook was observed to use a ½ cup scoop to serve the rice, however, the amount of rice he scooped varied from resident to resident with the scoop at times being under filled and at times overfilled. All of this would allow for variances in the calories and/ or the protein provided to each resident. Some residents prescribed	F 363	ensure that the dietary manager and dietary staff have proper training and systems in place to appropriately monitor the sanitation of the kitchen, ensuring proper storage, preparation and the distribution and serving of foods, following Therapeutic diets as written and serving foods at the proper temperature. 13. Dietary in-service will be held weekly-Tuesday 3pm to discuss all survey issues, training, and any problems with the dietary services. 14. RD will ensure that each resident will receive a therapeutic diet when there is a nutritional problem. The RD will assess in identifying and correct improper serving of therapeutic diets to ensure the dietary needs of the residents. 15. Temperatures are monitored by the dietary cooks daily and recorded. The dietary manager will monitor at random resident's trays for proper food temps and record. 16. The dietary services have a daily cleaning schedule to ensure the sanitation of the kitchen, record to monitor the labeling and dating of foods, temps of the walk-in refrigerator. The dietary manager will audit the above concerns weekly. 17. The RD will be employed by SVHC as a dietary consultant, who will provide adequate supervision to both the dietary manager and dietary staff regarding: 1) Accurately monitoring and assessing residents at risk for weight loss. 2) Monitor the sanitation of the kitchen, ensuring proper storage, preparation, distribution and serving of foods, developing and implementing educational in-services for the dietary staff. 18. A new steam table with 4 wells is being purchased so foods will stay at the appropriate temperature above 140 degrees. 19. The walk-in refrigerator was fixed at temperature have maintained 40 degrees and below. Dietary staff instructed to keep refrigerator door closed going in or out. 20. The dietary staff will be in-serviced February 19, 2002 on how to store, prepare, distribute, and serve food under sanitary conditions. 21. The grease trap was cleaned by a local plumbing company, and was scheduled to come out routinely. 22. The unit manager for out-dated food will check the Alzheimer's unit refrigerator daily.	

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F 363	Continued From Page 73 a no concentrated sweet diet were observed to receive applesauce instead of mandarin oranges which short them a vitamin C serving for the day. On 12/31/01 at 8:48 AM, the food service supervisor was interviewed. She was asked to provide the survey team with the extended menu for the week which would document the appropriate serving sizes to be provided for resident on all diets and document what diet modifications, if any, would need to be made for resident's receiving therapeutic or texture modified diets. She stated she was not sure what I was referring to and stated that since she'd taken over as dietary manager in August, 2001 the facility had not had the extended menus. She stated that all residents are served the same diet. She stated that foods are not cooked with salt and that if a resident is on a renal diet that they don't serve them potatoes. On 12/31/01 at 10:50 AM, the consultant dietitian was interviewed. He was asked whether he knew if the facility had extended menus for the menu cycle currently being followed. He stated he was unaware of any extended menus being used. He stated that the menu being served was low in salt and concentrated sweets. When asked how the staff knew what servings sizes were appropriate or what foods residents on therapeutic diets were to receive if they had no extended menu to specify this, he was unable to provide an answer.	F 363		
F 364 SS=E	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.	F 364		

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F 364	Continued From Page 74 This REQUIREMENT is not met as evidenced by: Based on food temperature checks during a lunch meal, temperature checks of foods in the walk-in refrigerator and statements made in a confidential group interview with residents it was determined that the facility did not serve food that was at the proper temperature. Findings include: On 1/3/02, temperature checks of the lunch meal revealed: At 11:06 AM, the pureed foods for the lunch meal were observed to be sitting on the shelf attached to the steam table but not in the steam table heating wells. At 11:23 AM, a temperature check of the pureed foods half way through tray line, included pureed meatballs at 100 degrees Farenheit, pureed mashed potatoes at 118 degrees Farenheit and juice at 66 degrees Farenheit. At 11:38 AM, a temperature check of the foods after the completion of the tray line included regular meatballs, in the steam table heating well, at 130 degrees Farenheit and ground meatballs, in the steam table heating well, at 100 degrees Farenheit. The puree foods had been used so no temperatures were taken. At 11:26 AM, a temperature check of the food items in the dining room buffet steam table were taken prior to the meal service and included mashed potatoes at 128 degrees Farenheit. The potatoes were not re-heated prior to being served to the residents. Hot foods are to be maintained at 140 degrees	F 364	The following is a plan of correction and is in reference to: F-325 483.25 (i) Quality of Care. This will include corrective F-326 483.25 (i) (2) Quality of Care, F-360 483.35 Dietary Services, F-361 483.35 1-2, F-363 483.35 (c) Dietary Services,F-364 483.35 (d) (1) &(2),F-371 483.35 (h) (2). Action for each resident found to have been affected and were identified as 13, 20, 28, 40, 50, 70, 72, 74. 1. Licensed staff will be in-serviced on how to complete the malnutrition/dehydration-pressure sore risk assessment done by the RD, the MDS, the dietary progress notes, the dietary intake records, and the current weights, and diagnosis and medications as warranted. 2. NIT committee will address any medical conditions i.e.: h-pylori on the residents' careplan and consult with residents' physician for medical and nutritional interventions. 3. Dietary intake record has been changed so that percentage of what resident ate is now what is accurately recorded rather than good-fair-or poor. 4. C.N.A. scheduler will audit dietary intake record weekly to ensure accuracy and completion. 5. 4 way drug check will be done monthly by ADON and QA to ensure that all orders regarding house supplement will be on residents' MAR's as warranted and to ensure percentage documentation. As well as to address diagnosis's to medication and any drug interactions and/or side effects. 6. Licensed staff has been instructed to inform NIT committee of any dietary problems so that other interventions can be implemented as warranted. 7. Monthly weights provided each month upon completion to each hall with current weights to be placed MAR binder so that monthly summaries can address current weights. 8. C.N.A.-N.A will be in-serviced February 20, 2002 regarding interventions for residents' experiencing eating, swallowing, and chewing difficulties. Importance of communicating to nurses so that interventions are implemented as warranted. 9. Speech consultant will report any evaluations, outcomes, and recommendations to the NIT committee. 10. NIT committee will calculate weight loss percentages weekly. 11. Extended menus for the menu cycle is available and currently being followed Dietary staff will be in-serviced by the RD what servings sizes are appropriate and what foods residents on therapeutic diets are to receive. 12. Previous Registered Dietician has been replaced by RD, and whom will assume responsibilities to provide services, support, and supervision, through assessment, monitoring and recommendations, to meet each residents' nutritional needs to prevent significant weight loss. The RD will	2/20/02

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F 364	Continued From Page 75 Fahrenheit or above when served from tray line. Cold foods are to be maintained at or below 41 degrees Fahrenheit when served from tray line. Reference guidance: U.S. Public Health Service FDA 1999 Food Code, page 63. On 1/2/02, observations and temperature checks of foods in the walk-in refrigerator revealed the following: At 2:16 PM, the internal temperature, according to two thermometers in the walk-in refrigerator, was 56 and 58 degrees Farenheit. At 2:45 PM, the internal temperature, according to two thermometers in the walk-in refrigerator, was 58 and 52 degrees Farenheit. Refrigerator temperatures should be maintained at 41 degrees Farenheit or below. Temperatures were taken of random food items through out the refrigerator and included 2% milk at 52 degrees Farenheit, scalloped potatoes from lunch at 120 degrees Farenheit, ground barbeque chicken from lunch at 98 degrees Farenheit, the cook stated the food items from lunch had been in the refrigerator for about one hour, crab salad at 60 degrees Farenheit, banana pudding at 50 degrees Farenheit, patty sausage at 50 degrees Farenheit and yogurt at 52 degrees Farenheit. Potentially hazardous cold foods are to be maintained between 45 degrees Farenheit and 41 degrees Fahrenheit. Reference guidance: U.S. Public Health Service FDA 1999 Food Code, page 63. On 12/31/01, during the initial kitchen tour, observation by this surveyor revealed that 3 of the 5 steam table wells appeared to not be working. On 1/2/02, during an interview with the facility cook he was asked about the steam table wells. He stated that only 2 of the 5 wells in the steam table were working which did not leave him enough room to	F 364	ensure that the dietary manager and dietary staff have proper training and systems in place to appropriately monitor the sanitation of the kitchen, ensuring proper storage, preparation and the distribution and serving of foods, following Therapeutic diets as written and serving foods at the proper temperature. 13. Dietary in-service will be held weekly-Tuesday 3pm to discuss all survey issues, training, and any problems with the dietary services. 14. RD will ensure that each resident will receive a therapeutic diet when there is a nutritional problem. The RD will assess in identifying and correct improper serving of therapeutic diets to ensure the dietary needs of the residents. 15. Temperatures are monitored by the dietary cooks daily and recorded. The dietary manager will monitor at random resident's trays for proper food temps and record. 16. The dietary services have a daily cleaning schedule to ensure the sanitation of the kitchen, record to monitor the labeling and dating of foods, temps of the walk-in refrigerator. The dietary manager will audit the above concerns weekly. 17. The RD will be employed by SVHC as a dietary consultant, who will provide adequate supervision to both the dietary manager and dietary staff regarding: 1) Accurately monitoring and assessing residents at risk for weight loss. 2) Monitor the sanitation of the kitchen, ensuring proper storage, preparation, distribution and serving of foods, developing and implementing educational in-services for the dietary staff. 18. A new steam table with 4 wells is being purchased so foods will stay at the appropriate temperature above 140 degrees. 19. The walk-in refrigerator was fixed at temperature have maintained 40 degrees and below. Dietary staff instructed to keep refrigerator door closed going in or out. 20. The dietary staff will be in-serviced February 19, 2002 on how to store, prepare, distribute, and serve food under sanitary conditions. 21. The grease trap was cleaned by a local plumbing company, and was scheduled to come out routinely. 22. The unit manager for out-dated food will check the Alzheimer's unit refrigerator daily.	

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F 364	Continued From Page 76 place all of the different consistency hot foods in the steam table. On 1/2/02, at 9:00 AM, a confidential interview was held with a group of residents. Fourteen residents participated in this interview. Seven (7) of the fourteen residents complained that the hot foods were often cold when they received their trays.	F 364		
F 371 SS=F	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, temperature checks and interviews it was determined that the facility did not store, prepare, distribute, and serve food under sanitary conditions as evidenced by cleaning rags not being properly stored in sanitizing solution, the florescent kitchen lights not being properly covered, areas of the kitchen in need of cleaning, multiple food items not being labeled and or dated in the walk in refrigerator, outdated food items being stored in the walk in refrigerator, dented cans and unlabeled food items in the dry store room, a scoop was lying in the powdered dry milk, the walk in refrigerator not holding perishable foods at the proper temperature, and the facility grease trap being full of old grease and food debris which caused the facility kitchen floor to flood and smell of sewage when the three compartment dishwashing sink was drained as the water could not properly drain through the grease. Findings include: The following observations were made during the	F 371		

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	465108	A. BUILDING _____ B. WING _____	1/16/02

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F 371	Continued From Page 77 initial kitchen tour done Monday, 12/31/01 from 8:15 AM – 8:35 AM: 1. A cleaning rag was lying on the sink not in proper sanitizing solution. 2. The florescent lights were not properly covered and the bulbs were exposed throughout the kitchen including over food preparation areas. Light bulbs shall be shielded, coated, or other wise shatter-resistant in areas where there is exposed food; clean equipment, utensils, and linens; or unwrapped single-service and single use articles. Reference guidance: U.S. Public Health Service FDA 1999 Food Code, page 142. 3. The hood filters above the stove were dusty and greasy. Observation of the walk-in refrigerator revealed the following: 1. The internal temperature, according to two thermometers in the walk-in refrigerator, was 46 degrees Farenheit. Refrigerator temperatures should be maintained at 41 degrees Farenheit or below. 2. There were two meat patties, which were not labeled or dated. 3. There was a container of pooled, raw eggs which was dated 12/31/01. 4. There was a pan of meatballs, which was not dated. 5. There were three expired containers of sour cream dated 12/13/01. 6. There was a large container of cherry pie filling,	F 371	The following is a plan of correction and is in reference to: F-325 483.25 (i) Quality of Care. This will include corrective F-326 483.25 (i) (2) Quality of Care, F-360 483.35 Dietary Services, F-361 483.35 1-2, F-363 483.35 (c) Dietary Services,F-364 483.35 (d) (1) &(2),F-371 483.35 (h) (2). Action for each resident found to have been affected and were identified as 13, 20, 28, 40, 50, 70, 72, 74. 1. Licensed staff will be in-serviced on how to complete the malnutrition/dehydration-pressure sore risk assessment done by the RD, the MDS, the dietary progress notes, the dietary intake records, and the current weights, and diagnosis and medications as warranted. 2. NIT committee will address any medical conditions i.e.: h-pylori on the residents' careplan and consult with residents' physician for medical and nutritional interventions. 3. Dietary intake record has been changed so that percentage of what resident ate is now what is accurately recorded rather than good-fair-or poor. 4. C.N.A. scheduler will audit dietary intake record weekly to ensure accuracy and completion. 5. 4 way drug check will be done monthly by ADON and QA to ensure that all orders regarding house supplement will be on residents' MAR's as warranted and to ensure percentage documentation. As well as to address diagnosis's to medication and any drug interactions and/or side effects. 6. Licensed staff has been instructed to inform NIT committee of any dietary problems so that other interventions can be implemented as warranted. 7. Monthly weights provided each month upon completion to each hall with current weights to be placed MAR binder so that monthly summaries can address current weights. 8. C.N.A.-N.A will be in-serviced February 20, 2002 regarding interventions for residents' experiencing eating, swallowing, and chewing difficulties. Importance of communicating to nurses so that interventions are implemented as warranted. 9. Speech consultant will report any evaluations, outcomes, and recommendations to the NIT committee. 10. NIT committee will calculate weight loss percentages weekly. 11. Extended menus for the menu cycle is available and currently being followed Dietary staff will be in-serviced by the RD what servings sizes are appropriate and what foods residents on therapeutic diets are to receive. 12. Previous Registered Dietician has been replaced by RD, and whom will assume responsibilities to provide services, support, and supervision, through assessment, monitoring and recommendations, to meet each residents' nutritional needs to prevent significant weight loss. The RD will	~~2/20/02~~ 2-27-02

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F 371	Continued From Page 78 which was not properly covered which could allow for contamination of the food. 7. There was package of bacon, which was opened but not dated. 8. There was large pan of what appeared to be chicken salad, which was not labeled or dated. 9. There were three bowls of salad dressing, which were not labeled or dated. 10. There was a pan of chocolate pudding, a pan of banana pudding and a pan of reduced calorie vanilla pudding, which were not dated. 11. There was a pan of cherry gelatin dated 12/26/01 (5 days old), a pan of sugar free strawberry gelatin dated 12/24/01 (7 days old) and a pan of sugar free raspberry gelatin dated 12/26/01 (5 days old). Leftovers foods should be used or throw away within 72 hours of initial use. 12. There were four 32ounce cartons of expired vanilla yogurt dated 12/27/01. There were 26 small containers of expired mixed berry/strawberry yogurt dated 12/27/01. There were two cases of expired mixed berry/strawberry yogurt one dated 12/6/01 and one dated 12/27/01. There were two cases of expired blueberry/strawberry yogurt dated 11/10/01 and one case dated 12/26/01. Observations in the dry storage room revealed the following: 1. There was a scoop in the dry milk storage container. 2. There was can a sweet potatoes and a can of	F 371	ensure that the dietary manager and dietary staff have proper training and systems in place to appropriately monitor the sanitation of the kitchen, ensuring proper storage, preparation and the distribution and serving of foods, following Therapeutic diets as written and serving foods at the proper temperature. 13. Dietary in-service will be held weekly-Tuesday 3pm to discuss all survey issues, training, and any problems with the dietary services. 14. RD will ensure that each resident will receive a therapeutic diet when there is a nutritional problem. The RD will assess in identifying and correct improper serving of therapeutic diets to ensure the dietary needs of the residents. 15. Temperatures are monitored by the dietary cooks daily and recorded. The dietary manager will monitor at random resident's trays for proper food temps and record. 16. The dietary services have a daily cleaning schedule to ensure the sanitation of the kitchen, record to monitor the labeling and dating of foods, temps of the walk-in refrigerator. The dietary manager will audit the above concerns weekly. 17. The RD will be employed by SVHC as a dietary consultant, who will provide adequate supervision to both the dietary manager and dietary staff regarding: 1) Accurately monitoring and assessing residents at risk for weight loss. 2) Monitor the sanitation of the kitchen, ensuring proper storage, preparation, distribution and serving of foods, developing and implementing educational in-services for the dietary staff. 18. A new steam table with 4 wells is being purchased so foods will stay at the appropriate temperature above 140 degrees. 19. The walk-in refrigerator was fixed at temperature have maintained 40 degrees and below. Dietary staff instructed to keep refrigerator door closed going in or out. 20. The dietary staff will be in-serviced February 19, 2002 on how to store, prepare, distribute, and serve food under sanitary conditions. 21. The grease trap was cleaned by a local plumbing company, and was scheduled to come out routinely. 22. The unit manager for out-dated food will check the Alzheimer's unit refrigerator daily.	

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F 371	Continued From Page 79 shoestring beets with large dents by the top seam of the can. The following observations were made in the kitchen on Wednesday, 1/2/02 from 2:15 PM – 2:45 PM: 1. There were two cleaning rags on the food preparation table, which were not being stored in a proper sanitizing solution. 2. As on 12/31/01, the florescent lights were not properly covered and the bulbs were exposed throughout the kitchen including over food preparation areas. Observations in the walk-in refrigerator revealed the following: 1. At 2:16 PM, the internal temperature, according to two thermometers in the walk-in refrigerator, was 56 and 58 degrees Farenheit. At 2:45 PM, the internal temperature, according to two thermometers in the walk-in refrigerator, was 58 and 52 degrees Farenheit. Refrigerator temperatures should be maintained at 41 degrees Farenheit or below. Temperatures were taken of random foods through out the refrigerator and included 2% milk at 52 degrees Farenheit, scalloped potatoes from lunch at 120 degrees Farenheit, ground barbeque chicken from lunch at 98 degrees Farenheit, crab salad at 60 degrees Farenheit, banana pudding at 50 degrees Farenheit, patty sausage at 50 degrees Farenheit and yogurt at 52 degrees Farenheit. Potentailly hazardous cold foods are to be maintained between 45 degrees Farenheit and 41 degrees Fahrenheit. Reference guidance: U.S. Public Health Service FDA 1999 Food Code, page 63 2. As observed on 12/31/01, there were three expired containers of sour cream dated 12/13/01.	F 371		

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F 371	Continued From Page 80 3. As observed on 12/31/01, there was a pan of cherry gelatin dated 12/26/01 (7 days old) and a pan of sugar free raspberry gelatin dated 12/26/01 (7 days old). Leftovers foods should be used or throw away within 72 hours of initial use. 4. As observed on 12/31/01, there were four 32ounce cartons of expired vanilla yogurt dated 12/27/01. There were 26 small containers of expired mixed berry/strawberry yogurt dated 12/27/01. There were two cases of expired mixed berry/strawberry yogurt one dated 12/6/01 and one dated 12/27/01. There were two cases of expired blueberry/strawberry yogurt dated 11/10/01 and one case dated 12/26/01. 5. There was a container of pooled, raw eggs which was dated 1/1/02. 6. There was a package of Parmesean cheese, which was opened but not dated. 7. There was a package of American cheese slices, which were opened but not dated. 8. There was a package of frozen chicken thawing with a note, which stated, " pulled for Monday lunch". The note was not dated and the next Monday would be 1/7/02, 5 days later. 9. There was a bowl of salad and two bowls of salad dressing, which were not dated. 10. The floor underneath the shelving units was dirty with food debris and grime. Observations in the dry storage room revealed the following:	F 371		

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F 371	Continued From Page 81 1. As observed on 12/31/01, there was a scoop in the dry milk storage container. 2. As observed on 12/31/01, there was can a sweet potatoes and a can of shoestring beets with large dents by the top seam of the can. 3. There was a bag of vanilla pudding and a bag of strawberry gelatin which had been opened but were not dated. 4. There was a box of bread crumbs which were opened but not properly covered. This could allow for contamination of the food. The following observations were made in the kitchen on Thursday, 1/3/02 from 3:15 PM to 3:25 PM: 1. At 3:16 PM a dietary employee was observed to drain the three compartment dishwashing sink. Immediately after the sinks began to drain, water began to flood from around the grease trap and a malodorous smell filled the kitchen. Upon further examination, the grease trap was observed to be full of clotted old grease and food debris. Observations in the walk-in refrigerator revealed the following: 1. At 3:15 PM, the internal temperature, according to two thermometers in the walk-in refrigerator, was 52 degrees Farenheit. Refrigerator temperatures should be maintained at 41 degrees Farenheit or below. On 1/2/02, an interview with the facility cook was done. He stated that the walk-in refrigerator had been too warm for approximately two weeks. He stated the cooler was not working. He further stated, "When I came in this morning, I was afraid the meat had	F 371		

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F 371	Continued From Page 82 spoiled". On 1/2/02, an interview with the food service supervisor was done. She was asked about the improper temperature in the walk-in refrigerator. She stated that the walk-in refrigerator had not been holding the proper temperature for about two weeks. She stated that the system needed to be switched over from the old type of coolant used to a new type of coolant. She further stated that the dietary staff was opening the freezer door, which was attached to the walk-in refrigerator, to try and keep the foods colder in the walk-in and that the dietary staff was trying to not frequently open the refrigerator door to help maintain a cooler temperature. On 1/3/02, the food service supervisor was interviewed regarding the grease trap. She stated that the grease trap did flood each time that all of the compartments of the three compartment sink were emptied at the same time. She stated that the staff were trying to empty one sink at a time to prevent the grease trap from overflowing. The following observations were made 12/31/01 at 1:15 PM in the Alzheimer's unit refrigerator: 1. One expired eight ounce carton of fat free milk dated 10/27/01. 2. Two expired eight ounce cartons of fat free milk dated 11/10/01. 3. Two expired eight ounce cartons of whole milk dated 12/22/01 and two expired eight ounce cartons of whole milk dated 12/29/01. 4. One expired eight ounce carton of whole milk, opened with the carton crushed dated 12/8/01.	F 371		

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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 15 of 26 sample residents, requiring frequent physician intervention, were not seen by a physician as required after admission and periodically during their stay. Residents Findings include: 1. Resident 74 was a 60 year old male who was admitted to the facility on 10/10/01 with diagnoses of hypotension, protein calorie malnutrition, dehydration cerebral vascular accident and situational depression. Resident 74 was seen by a physician on 11/30/01. There was 52 days from the time of admission before resident 74 was seen by a physician. There were no other documented physician visits in resident 74's clinical record. 2. Resident 61 was a 63 year old male who was admitted to the facility on 2/6/01 with diagnoses of end stage chronic obstructive pulmonary disease, depression, and anxiety. Resident 61 was seen by a physician on the following dates: 2/5/01, 2/19/01, 3/5/01, 3/27/01, 5/24/01, 8/12/01, and 12/2/01. There were 58 days between the 3/27/01 and the 5/24/01 physician visits. There were 80 days between the 5/24/01 and the 8/12/01 physician visits. There were	F 387	The following is a plan of correction and is in reference to F-378 483.40 (c) 1 & 2 Physician services. This will include corrective action for each resident found to have been affected and were named as residents 74, 61, 10, 86, 70, 67, 35, 16, 30, 34, 11, 15, c2. 1. A new house physician was hired as SVHC medical director November 2002. 2. Medical records is responsible to provide the doctor with a up-dated list weekly for residents to be seen, to include every 30 days for the first 90 days after admission, and then every 60 days there after. 3. Medical records will audit Dr.'s progress notes monthly to ensure a physician visit. 4. Medical records is to be on the QA committee and this problem will be addressed in QA, February 22, 2002 until compliance is met.	~~2/13/02~~ 2-22-02

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F 387	Continued From Page 84 112 days between the 8/12/01 and the 12/2/01 physician visits. 3. Resident 10 was a 86 year old male who was admitted to the facility on 5/18/99 with diagnoses of cerebral vascular accident, depression, benign prostatic hypertrophy, constipation, osteoarthritis, coronary artery disease, hypertension, gastroesophageal reflux disease and hyperlipidemia. Resident 10 was seen by a physician on the following dates:3/5/01, 8/14/01, 8/21/01 and 11/4/01. There were 162 days between the 3/5/01 and the 8/14/01 physician visits. 4. Resident 86 was an 84 year old male who was admitted to the facility on 8/7/00 with diagnoses of pneumonia, septicemia, senile dementia, renal insufficiency, cerebral vascular accident, hypertension,arthritis, seizure disorder, and depression. Resident 86 was seen by a physician on the following dates: 6/28/01 and 11/11/01. There were 136 days between the physician visits. 5. Resident 70 was an 83 year old male who was admitted to the facility on 8/10/01 with diagnoses of congestive heart failure, hypertension, peripheral vascular disease, hypothyroidism, cerebrovascular accident and emphysema. Resident 70 was seen by a physician on the following dates: 8/21/01 and 11/30/01. There were 101 days between the physician visits. 6. Resident 67 was an 84 year old female admitted to this facility on 6/15/01, with diagnoses of cerebrovascular accident, hypercholesteremia, constipation, diabetes, hypertension, hypothyroidism, and insomnia. Resident 67 had a physician's	F 387		

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F 387	Continued From Page 85 evaluation on 6/27/01 and 11/23/01. There was 118 days between resident 67's first physician's evaluation and her next physician's evaluation. 7. Resident 35 was a 95 year old female admitted to this facility on 4/15/99, with diagnoses of hemorrhagic cerebrovascular accident, hypertension, congestive heart failure and anemia. Resident 35 had a physician's evaluation on 8/26/01 and 11/30/01. There was 94 days between resident 35's last two physician's evaluations. 8. Resident 83 was an 83 year old female admitted to the facility on 6/27/00 with diagnoses including dementia, psychosis and depression associated with dementia, peripheral vascular disease and arthritis. A review of resident 83's medical record was done. It was documented that resident 83 was evaluated by a physician or nurse practitioner on the following dates: 3/12/01, 6/12/01 and 11/11/01. There were 91 days between the 3/12/01 physician visit and the next physician visit on 6/12/01. There were 152 days between resident's 83's 6/12/01 physician visit and the physician visit on 11/11/01. 9. Resident 16 was a 72 year old female admitted to the facility on 10/6/97 with diagnoses including hypothyroidism, Alzheimer's disease and peptic ulcer disease. A review of resident 16's medical record was done. It was documented that resident 16 was evaluated by a physician on the following dates: 4/2/01, 6/27/01, 7/4/01, and 11/11/01. There were 85 days between the 4/2/01 physician visit and the next physician visit on 6/27/01. There were 129 days between resident 16's 7/4/01 physician visit and the physician visit on 11/11/01. 10. Resident 50 was an 83 year old female admitted to the facility on 4/4/01 with diagnoses including dementia with depressive features, diabetes with	F 387		

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F 387	Continued From Page 86 peripheral neuropathy, hypertension, osteoarthritis and generalized pain. A review of resident 50's chart was done. It was documented that resident 50 was evaluated by a physician on the following dates: 4/5/01, 5/5/01, 6/5/01, 10/21/01 and 11/25/01. There were 137 days between resident 50's 6/5/01 physician visit and the next physician visit on 10/21/01. 11. Resident 63 was a 78 year old female who was admitted to the facility on 5/13/97 with the diagnoses of bipolar with psychotic features, hypertension, dementia with aggressive features, lung cancer, diabetes and chronic UTI (urinary tract infection). Resident 63 was evaluated by a physician on the following dates: 3/06/01, 6/19/01, and 10/15/01. There were 105 days between the 3/06/01 and the 6/19/01 physician's visits for resident 63. There were 118 days between the 6/19/01 and the 10/15/01 physician's visit for resident 63. Upon record review for resident 63, on 12/31/01, it had been 77 days since her last physician's visit that was on 10/15/01. 12. Resident 34 was a 79 year old female who was admitted to the facility on 1/15/01 with the diagnoses of DVT (deep vein thrombosis), senile dementia with depressive features, hypothyroidism, iron deficiency anemia, back pain, decubitus ulcer, osteoarthritis, PVD (peripheral vascular disease), and history of cellulitis. Resident 34 was evaluated by a physician on the following dates: 1/15/01, 6/27/01, 7/19/01, 10/09/01, and 12/02/01. There were 163 days between the admission physician's evaluation on 1/15/01 and the next physician's evaluation on 6/27/01, for resident 34. There were 82 days between the 7/19/01 and the 10/09/01 physician's visits for resident 34. 13. Resident 11 was a 70 year old female who was re-admitted to the facility on 11/05/01 with the diagnoses of HTN (hypertension), hypokalemia, COPD (chronic obstructive pulmonary disease), CHF	F 387		

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F 387	Continued From Page 87 (congestive heart failure), diabetes, UTI, right ankle fracture, MI (myocardial infarction), and CAD (cardiac artery disease). Resident 11 was evaluated by a physician on 11/15/01. As of 1/03/01, during record review of resident 11's chart, she had not been evaluated by a physician for 79 days. 14. Resident 15 was a 67 year old female who was admitted to the facility on 5/7/01 with the diagnoses of multi infarct dementia, weight loss, diabetes mellitus insulin required, hypertension, hyperlipidemia, onychomycosis, bilateral pedal edema, and proteinuria. Documentation in the medical record evidenced that resident 15 was evaluated by a physician on 8/25/01, which was 109 days after admission. Documentation further evidenced that resident 15 was seen again on 11/23/01 by a physician, which was 89 days after the physicians first visit. 15. Resident C2 was a 76 year old who was re-admitted to the facility on 6/26/01 and discharged on 8/21/01 with the diagnoses of arthritis, HTN, dysuria, TIA (transient ischemia accident), CHF, macular degeneration, and psoriasis. Resident C2 was evaluated by a physician on 6/27/01. Resident C2 was discharged on 8/21/01 without a physician's note, thus, 55 days had passed since the last physician's visit at the time of discharge.	F 387		
F 426 SS=E	483.60(a) PHARMACY SERVICES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 426		

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	465108	A. BUILDING _____ B. WING _____	1/16/02

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F 426	Continued From Page 88 This REQUIREMENT is not met as evidenced by: 1. Resident 76 was a 53 year old male who was admitted to the facility on 10/15/01 with the diagnoses of gastric ulcers, respiratory distress syndrome, IDDM (insulin dependant diabetes mellitus), aspiration pneumonia, CAD (cardiac artery disease), acute renal failure, respiratory failure, gangrenous cholecystitis, acute MI (myocardial infarction), and CVA (cerebral vascular accident). A physician's order dated 10/15/01, documented, "sliding scale AC [before meals] and HS [at bedtime]". The sliding scale for the following blood glucose levels were ordered as: Blood glucose level 150 to 250 give 4 units regular insulin. Blood glucose level 251 to 350 give 6 units regular insulin. Blood glucose level 351 to 450 give 10 units regular insulin. Blood glucose level greater than 450 call the physician. For the month of October 2001, the facility nurses recorded resident 76's blood glucose levels and sliding scale insulin on a "Diabetic Monitoring Flowsheet" (DMF) and his MAR. The following dates were resident 76's blood glucose levels with the incorrect insulin dosage or elevated blood glucose levels with no insulin documented as being given. DMF 10/17/01 at 6:00 AM, blood glucose level of 173; no insulin documented as being given. 10/20/01 at 6:00 AM, blood glucose level of 220; no insulin documented as being given. 10/20/01 at 12:00 PM, blood glucose level of 168; no	F 426	The following is a plan of correction and is in reference to F-329 483.25 (l) (1) Quality of Care, F-426 483.60 (a)Pharmacy Services. This will include corrective action for each resident found to have been affected and were identified as 4, 15, 24, 76. 1. The house physician ordered standard sliding scale for the diabetic. Residents who are the house physicians' patients 150-200= 2 units regular 201-250= 4 units regular 251-300= 6 units regular 301-350= 8 units regular 351-400= 10 units regular Call MD if BS < 70 or >450 2. Licensed staff was in serviced regarding missed blood sugars and standard sliding scale insulin for his residents on 2/6/02. 3. Medical records will audit the Diabetic monitoring flow sheet weekly.	2/1/02

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F 426	Continued From Page 89 insulin documented as being given. 10/20/01 at 4:30 PM, blood glucose level of 232; no insulin documented as being given. 10/20/01 at 6:00 AM, blood glucose level of 152; no insulin documented as being given. 10/20/01 at 5:00 PM, blood glucose level of 173; no insulin documented as being given. 10/23/01 at 6:00 AM, blood glucose level of 158; no insulin documented as being given. 10/25/01 at 500 PM, blood glucose level of 239; no insulin documented as being given. 10/27/01 at 6:00 AM, blood glucose level of 199; no insulin documented as being given. 10/27/01 at 5:00 PM, blood glucose level of 313; no insulin documented as being given. 10/28/01 at 11:30 AM, blood glucose level of 201; no insulin documented as being given. 10/28/01 at 5:00 PM, blood glucose level of 314; no insulin documented as being given. 10/28/01 at midnight, blood glucose level of 158; no insulin documented as being given. 10/30/01 at 4:30 PM, blood glucose level of 168; no insulin documented as being given. 10/31/01 at 4:30 PM, blood glucose level of 216; no insulin documented as being given. MAR- labeled for 4:00 PM 10/19/01, blood glucose level of 243; no insulin documented as being given. 10/20/01, blood glucose level of 89; 4 units insulin documented as being given. 10/22/01, no blood glucose level documented as being obtained; 4 units insulin documented as being given. 10/23/01, blood glucose level of 256; 4 units insulin documented as being given. 10/28/01; no blood glucose level documented as being obtained; 6 units insulin documented as being given. For the month of November 2001, the facility nurses	F 426		

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F 426	Continued From Page 90 recorded resident 76's blood glucose level on a "Patient Diabetic Record" (PDR) with the sliding scale insulin. The following were dates and times of incorrect insulin doses, documented as being given, for resident 76's blood glucose levels. 6:00 AM blood glucose levels without insulin documented as being given. 11/02/01, blood glucose level of 195. 11/03/01, blood glucose level of 161. 11/06/01, blood glucose level of 217. 11/08/01, blood glucose level of 209. 11/13/01, blood glucose level of 181. 11/14/01, blood glucose level of 208. 11/15/01, blood glucose level of 253. 11/18/01, blood glucose level of 220. 11/19/01, blood glucose level of 152. 11/23/01, blood glucose level of 252. 11/24/01, blood glucose level of 150. 11/27/01, blood glucose level of 178. 11/29/01, blood glucose level of 222. 4:30 PM blood glucose levels with incorrect insulin documented as being given. 11/06/01, blood glucose level of 364, 6 units documented as being given. 11/13/01, blood glucose level of 246, no insulin documented as being given. 11/18/01, blood glucose level of 224, 6 units documented as being given. 9:00 PM blood glucose levels with incorrect insulin documented as being given. 11/06/01, "Re-checked 0400- 199 " no insulin documented as being given. 11/08/01, blood glucose level of 259, no insulin documented as being given. 11/12/01, blood glucose level of 179, no insulin documented as being given.	F 426		

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F 426	Continued From Page 91 11/13/01, blood glucose level of 155, no insulin documented as being given. 11/17/01, blood glucose level of 387, 6 units documented as being given. 11/29/01, blood glucose level of 182, no insulin documented as being given. Resident 76 had sliding scale insulin orders on his November 2001, MAR. The November, 2001, MAR had some days marked with the number of units of insulin documented as being given but no blood glucose level or time was provided. The November 2001, MAR had the following days marked with the number of units of insulin documented as being given, the rest of the days were left blank: 11/07/01-- 6 units of insulin documented as being given. 11/09/01-- 10 units of insulin documented as being given. 11/11/01-- two blocks were marked with 4 units of insulin documented as being given. 11/13/01-- 4 units of insulin documented as being given. 11/14/01-- two blocks were marked with 4 units of insulin documented as being given. 11/15/01-- 0 units of insulin documented as being given. 11/16/01-- two blocks were marked with 6 units of insulin documented as being given. 11/17/01-- 10 units of insulin documented as being given. 11/18/01-- 6 units of insulin documented as being given. 11/19/01-- 4 units of insulin documented as being given. 11/21/01-- 4 units of insulin documented as being given. 11/22/01-- 6 units of insulin documented as being	F 426		

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F 426	Continued From Page 92 given. 11/24/01-- 4 units of insulin documented as being given. 11/26/01-- 4 units of insulin documented as being given. 11/29/01-- 4 units of insulin documented as being given. For the month of December, the facility nurses recorded resident 76's blood glucose level on a "Patient Diabetic Record" (PDR) with the sliding scale insulin. The following were dates and times of incorrect insulin or missed doses documented, for resident 76's blood glucose levels. 6:00 AM blood glucose levels without insulin documented as being given. 12/03/01, blood glucose level of 214 12/06/01, blood glucose level of 189 12/10/01, blood glucose level of 256 12/12/01, blood glucose level of 172 12/14/01, blood glucose level of 240 12/16/01, blood glucose level of 166 12/17/01, blood glucose level of 201 12/19/01, blood glucose level of 275 12/24/01, blood glucose level of 152 11:30 AM blood glucose levels without insulin documented as being given. 12/26/01, blood glucose level of 156, 0 units documented as being not given. 4:30 PM blood glucose levels without insulin documented as being given. 12/06/01, blood glucose level of 317, no insulin documented as being given. 12/07/01, blood glucose level of 229, no insulin documented as being given. 12/13/01, blood glucose level of 192, no insulin	F 426		

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F 426	Continued From Page 93 documented as being given. 12/29/01, blood glucose level of 243, 6 units of insulin documented as being given. 9:00 PM blood glucose levels without insulin documented as being given. 12/13/01, blood glucose level of 156, 0 units documented as being not given 12/16/01, blood glucose level of 227, 6 units of insulin documented as being given. 12/21/01, blood glucose level of 156, 0 units documented as being not given. 12/24/01, blood glucose level of 160, 0 units documented as being not given. 12/28/01, blood glucose level of of 232, no insulin documented as being given. For the month of January, 2002 (from 1/01/02 to 1/07/02), the facility nurses recorded resident 76's blood glucose levels on a "Patient Diabetic Record" (PDR) with the sliding scale insulin. The following were dates and times of incorrect insulin or missed doses of insulin, documented as being given for resident 76's blood glucose levels. 6:00 AM blood glucose levels without insulin documented as being given. 1/07/02, blood glucose level of 181, no insulin documented as being given. 4:30 PM blood glucose levels with incorrect insulin documented as being given. 1/06/02, blood glucose level of 326, 10 units of insulin documented as being given. 9:00 PM blood glucose levels greater than 400, 1/04/02, blood glucose level of 461, 10 units of insulin documented as being given. No nursing intervention documented for glucose greater than 400.	F 426		

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F 426	Continued From Page 94 1/07/02, blood glucose level of 451, 10 units of insulin documented as being given. No nursing intervention documented for glucose greater than 400. Based on medical record review, it was determined that the facility did not ensure that residents received adequate pharmaceuticals services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 4 of 26 sampled residents. Resident Identifier: 4, 15, 24 & 76 Findings include: Resident 4 was admitted to this facility on 06/23/97 with diagnoses which include the following: hypertension, heart disease, senile dementia, right hip fracture, congestive heart failure, hypothyroidism, osteoarthritis, hypercholesterolemia, small bowel obstruction, and diabetes. Resident 4 had physicians orders dated 8/20/01 to check blood glucose levels four times a day, before meals, and at hour of sleep. Resident 4 was to receive sliding scale insulin four times a day based on results of blood glucose monitoring. Resident 4's sliding scale insulin orders were: glucose 250-300 give 4 units regular insulin, 301-350 give 6 units regular insulin, 351-400 give 8 units regular insulin. Resident 4's medication administration record (MAR), patient diabetic record, and the diabetic monitoring flowsheet were reviewed, for the dates of 10/01/01 through 1/07/02. Documentation evidenced the following:	F 426		

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F 426	Continued From Page 95 On 10/10/01 the MAR documented resident 4 's glucose level was 410. Eight units of regular insulin was given. There was no documentation to indicate that resident 4's glucose stabilized, or that the physician was notified. On 10/19/01 the MAR documented that resident 4's glucose level was 279. No regular sliding scale insulin was documented as being given. Resident 4 should have received 4 units of regular insulin according to physician's orders. On 11/15/01 the MAR documented that resident 4's glucose level was 303. No regular sliding scale insulin was documented as being given. Resident 4 should have received 4 units of regular insulin according to physician's orders. Resident 15 was admitted to this facility on 5/7/01 with the diagnoses which include the following: Multi infarct dementia, weight loss, Diabetes Mellitus-II insulin required, hypertension, hyperlipidemia, onychomycosis, bilateral pedal edema, and proteinuria. Resident 15 had physician's orders dated 5/7/01 to check blood glucose levels every AM, every PM, and at hour of sleep. Sliding scale insulin orders were as follows: glucose 200-250 give 2 units regular insulin, 251-300 give 4 units regular insulin, 301-350 give 6 units regular insulin, 351-400 give 8 units of regular insulin, 401-450 give 10 units, if greater than 450, call physician. Resident 15's MAR, patient diabetic record, and diabetic flowsheet were reviewed for the dates of 10/25/01 through 11/30/01, and 1/1/02, through 1/8/02. Documentation evidenced the following:	F 426		

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F 426	Continued From Page 96 On 10/26/01, the MAR documented that resident 15's glucose level was 272. No regular sliding scale insulin was documented as being given. Resident 15 should have received 4 units of regular insulin according to physician's orders. On 10/28/01, the MAR documented that resident 15's glucose level was 207. No regular sliding scale insulin was documented as being given. Resident 15 should have received 2 units of regular insulin according to physician's orders. On 10/30/01, the MAR documented that resident 15's glucose level was 299. No regular sliding scale insulin was documented as being given. Resident 15 should have received 4 units of regular insulin according to physician's orders. On 11/15/01 the MAR documented that resident 15's glucose level was 262. Two units of regular sliding scale insulin was given. Resident 6 should have received 4 units of regular insulin according to physician's orders. On 11/16/01, the MAR documented that resident 15's glucose level was 77. There was documentation to show that juice was given. There was no documentation to show that any further blood glucose monitoring was done. On 11/22/01, the MAR documented that resident 15's glucose level was 42. There was documentation to show that juice was given. There was no documentation to show that any further blood glucose monitoring was done. On 1/6/02, the MAR documented that resident 15's glucose level was 282. No regular sliding scale insulin was documented as being given. Resident 15 should	F 426		

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F 521	Continued From Page 97 5. A review of the quality assurance meeting minutes was done on 1/16/02. The documentation indicated that the meeting was held on 10/9/01. In reviewing the documentation of those minutes, it was noted that no issues involving weight loss had been identified by the facility quality assurance committee according to the meeting notes. 6. The facility's quality assessment and assurance committee did not identify, and subsequently, did not establish corrective action plans to ensure that residents needs were being met and that necessary nutritional services were being provided. The administration did not operationalize and put in place systemic processes to ensure that residents did not have significant weight loss and ensure that each residents nutritional needs were met. (Refer to Tag F-325) 7. The facility's quality assessment and assurance committee did not identify, and subsequently, did not establish corrective action plans to ensure that adequate supervision and oversight by the consultant dietitian was taking place. Consequently, there was not sufficient oversight of the dietary manager and dietary staff to ensure all residents' dietary needs were met. There was no system in place to appropriately monitor the sanitation of the kitchen, ensuring proper storage, preparation and the distribution and serving of foods. There was process for ensuring that residents' therapeutic diets were served as ordered. There was also no effective system in place to ensure that foods were served at the proper temperature. Further, the dietitian did not provide services, supports and supervision, through assessment, monitoring and recommendations, to meet each client's nutritional needs to prevent significant weight loss. (Refer to TAG F-360)	F 521		

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F 426	Continued From Page 98 glucose level was 241. Two Units of regular sliding scale insulin was given. Resident 24 should have received 4 units of regular insulin according to physicians orders. On 11/5/01, the MAR documented that resident 24's glucose level was 161. No regular sliding scale insulin was given. Resident 24 should have received 2 units of regular insulin according to physicians orders. On 11/6/01, the MAR documented that resident 24's glucose level was 168. No regular sliding scale insulin was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders. On 11/7/01, the MAR documented that resident 24's glucose level was 189. No regular sliding scale insulin was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders. On 11/8/01, the MAR documented that resident 24's glucose level was 170. No regular sliding scale insulin was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders. On 11/9/01, the MAR documented that resident 24's glucose level was 72. There was no documentation to evidence that a nursing intervention was implemented. There was no documentation to evidence that resident 24 had further glucose monitoring done. On 11/11/01, the MAR documented that resident 24's glucose level was 72. There was no documentation to evidence that a nursing intervention was implemented. There was no documentation to evidence that resident 24 had further glucose monitoring done.	F 426		

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F 426	Continued From Page 99 On 11/12/01, the MAR documented that resident 24's glucose level was 169. No regular sliding scale insulin was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders. On 11/15/01, the MAR documented that resident 24's glucose level was 156. No regular sliding scale insulin was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders. On 11/15/01, the MAR documented that resident 24's glucose level was 205. No regular sliding scale insulin was documented as being given. Resident 24 should have received 4 units of regular insulin according to physician's orders. On 11/20/01, the MAR documented that resident 24's glucose level was 171. No regular sliding scale insulin was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders. On 11/21/01, the MAR documented that resident 24's glucose level was 185. No regular sliding scale insulin was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders. On 11/22/01, the MAR documented that resident 24's glucose level was 169. No regular sliding scale insulin was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders. On 11/25/01, the MAR documented that resident 24's glucose level was 165. No regular sliding scale insulin	F 426		

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F 426	Continued From Page 100 was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders. On 11/25/01, the MAR documented that resident 24's glucose level was 205 (evening check). Two units of regular sliding scale insulin was given. Resident 24 should have received 4 units of regular insulin according to physician's orders. On 11/27/01, the MAR documented that resident 24's glucose level was 67. There was no documentation to evidence that a nursing intervention was implemented. There was no documentation to evidence that resident 24 had further glucose monitoring done. On 12/2/01, the MAR documented that resident 24's glucose level was 307. Six units of regular sliding scale insulin was given. Resident 24 should have received 8 units of regular insulin according to physician's orders. On 12/7/01, the MAR documented that resident 24's glucose level was 190. No regular sliding scale insulin was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders. On 12/8/01, the MAR documented that resident 24's glucose level was 71. There was no documentation to evidence that a nursing intervention was implemented. There was no documentation to evidence that resident 24 had further glucose monitoring done. On 12/21/01, the MAR documented that resident 24's glucose level was 156. No regular sliding scale insulin was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders.	F 426		

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	465108	A. BUILDING _____ B. WING _____	1/16/02

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F 426	Continued From Page 101 On 12/24/01, the MAR documented that resident 24's glucose level was 73. There was no documentation to evidence that a nursing intervention was implemented. There was no documentation to evidence that resident 24 had further glucose monitoring done. On 12/25/01, the MAR documented that resident 24's glucose level was 79. There was no documentation to evidence that a nursing intervention was implemented. There was no documentation to evidence that resident 24 had further glucose monitoring done. On 1/5/02, the MAR documented that resident 24's glucose level was 151. No regular sliding scale insulin was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders. An interview was conducted with the Director of Nurses (DON)on 1/16/02, regarding the facility's blood glucose monitoring and insulin administration. The DON stated the facility did not have policies to instruct nursing staff on what to do when residents glucose levels are less than 80 or greater than 400.	F 426		
F 490 SS=H	483.75 ADMINISTRATION 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: Based on a recertification survey with subsequent extended survey, conducted December 31, 2001	F 490		

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F 490	Continued From Page 102 through January 16, 2002, and resultant finding of Sub-Standard Quality of Care, it was determined that the facility was not being administered in a manner that enabled it to use its resources either efficiently or effectively to ensure that residents were provided the opportunity to attain or maintain their highest practicable physical well-being. Sub-Standard Quality of Care was identified in the facility in the area of maintaining acceptable parameters of nutritional status including body weight when residents' clinical conditions did not indicate weight loss was unavoidable. Additionally, during the annual and the extended survey, the facility was found to be non-compliant in the areas of assessment of a resident for safe self administration of medications, timely answering of call lights, providing a safe, clean, comfortable and homelike environment, providing therapeutic diets, providing foot care for a resident with diabetes, lack of blood glucose monitoring as ordered by the physician, lack of an effective dietary system including lack of adequate registered dietitian intervention, not following menus, not meeting the nutritional needs of the residents, not holding and serving foods at the proper temperature, lack of storing, preparing, distributing and serving food under sanitary conditions, lack of timely physician visits, lack of proper administration of insulin, lack of nurse aide verification and nurse aides working longer than 4 months without completing a training and competency program, failure to obtain laboratory tests ordered by physicians, and not having an effective quality assurance committee that identified and implemented plans of action to correct quality issues. Findings include:	F 490	The following is a plan of correction and is in reference to F-490, F-495 483.75 (e),F-496, for administration. This will include corrective action for each resident found to have been affected. 1. The facility will not use any individual who has worked more than 4 months as a N.A. unless the individual is a full-time employee in a state-approved training and competency eval. Program and has demonstrated competence through satisfactory participation in a state approved nurse aide training and competency eval. Program or competency eval. Program or has been deemed or determined competent as provided in S483.150 (a) and (b). 2. The C.N.A. scheduler will receive registry verification that the individual has met competency evaluation requirements and seek information from every state registry established under sections 1819 (e) (2) (A) or 1919 (c) (2) (A) of the act the facility believes will include information on the individual. 3. The C.N.A. scheduler will record the staff member-verifying competency of C.N.A.'s with the state registry.	3/1/02

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F 490	Continued From Page 103 On 12/31/01, a recertification survey was initiated. On 1/11/02, facility administration was noticed of the elements of Sub-Standard Quality of Care. The determination of Sub-Standard Quality of Care was based on the findings of significant non-compliance in the area of Quality of Care/Nutrition [42 Code of Federal Regulations (CFR) 483.25 (i) (1) Tag F-325]. 1. Facility administration failed to have a system in place that would ensure that residents of the facility did not have avoidable weight loss. There was a lack of sufficient administrative oversight, supervision and monitoring of the facility staff in identification, correction and prevention of weight loss and that residents' needs were being met. (Refer to Tag F-325) 2. In addition to the area of Sub-Standard Quality of Care stated above, the facility administration failed to effectively and efficiently use it resources to ensure that each resident attained or maintained their highest practicable, physical, mental and psychosocial well-being in the following areas of deficient practice cited during the annual and the extended survey completed 1/16/02. a. Facility administration did not ensure that a resident was safe to self administer medications. (Refer to Tag F-176) b. Facility administration did not ensure that the facility promoted care for residents in a manner that maintained or enhanced the resident's dignity. (Refer to Tag F-241) c. Facility administration did not ensure that the resident environment was clean, safe and comfortable. (Refer to Tag F-252)	F 490	Please refer to corrective actions in reference to tag F-325, F-176, F-241, F-252, F-326, F-328, F-329, F-360, F-361, F-363, F-364, F-371, F-387, F-426, F-495, F-496, F-502, F-521	

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F 490	Continued From Page 104 d. Facility administration did not ensure that residents received therapeutic diets as ordered by the physician. (Refer to Tag F-326) e. Facility administration did not ensure that a resident with diabetes received foot care as needed. (Refer to Tag F-328) f. Facility administration did not ensure that residents with diabetes mellitus received blood glucose monitoring in accordance with physician's orders. (Refer to Tag F-329) g. Facility administration did not ensure that residents were provided with meals that met the nutritional and special dietary needs of each resident. (Refer to Tag F-360) h. Facility administration did not ensure that the registered dietitian provided adequate consultation to provide training to dietary staff and identify dietary needs of the residents. (Refer to Tag F-361) i. Facility administration did not ensure that menus were followed and meals met the nutritional needs of the residents. (Refer to Tag F-363) j. Facility administration did not ensure that food was held and served at the proper temperatures. (Refer to Tag F-364) k. Facility administration did not ensure that foods were stored, prepared, distributed and served under sanitary conditions. (Refer to Tag F-371) l. Facility administration did not ensure that residents	F 490		

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F 490	Continued From Page 105 were seen by a physician in a timely manner. (Refer to Tag F-387) m. Facility administration did not ensure that residents with physician orders to receive sliding scale insulin received the accurate doses. (Refer to Tag F-426) n. Facility administration did not ensure that individuals working a nurse aide in the facility did not work longer than 4 months without completing a training and competency evaluation program. (Refer to Tag F-495) o. Facility administration did not ensure that the nurse aide registry was contacted on new nursing assistants previous to providing patient care. (Refer to Tag F-496) p. Facility administration did not ensure that laboratory services met the resident needs. (Refer to Tag F- 502) q. Facility administration did not ensure that the quality assurance committee identified and implemented plans of action to correct quality issues. (Refer to Tag F-521)	F 490		
F 495 SS=E	483.75(e)(4) ADMINISTRATION A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual is a full-time employee in a State-approved training and competency evaluation program; has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or	F 495		

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F 495	Continued From Page 106 competency evaluation program; or has been deemed or determined competent as provided in s483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on employee records and interview with the facility certified nurse aide (CNA) coordinator, it was determined that 8 of 8 facility nurse aides were not certified and had been working as a nurse aide (NA) for more than four months. Findings include: On 1/02/02 at 3:15 PM, an interview with the CNA coordinator revealed that she was not aware that nurse aides required certification within 4 months of hire. On 1/08/02, a review of 8 facility nurse aide records revealed no documentation of certification. The 8 employees were hired as early as 5/07/01 to the most recent date of 8/20/01.	F 495	The following is a plan of correction and is in reference to F-490, F-495 483.75 (e),F-496, for administration. This will include corrective action for each resident found to have been affected. 1. The facility will not use any individual who has worked more than 4 months as a N.A. unless the individual is a full-time employee in a state-approved training and competency eval. Program and has demonstrated competence through satisfactory participation in a state approved nurse aide training and competency eval. Program or competency eval. Program or has been deemed or determined competent as provided in S483.150 (a) and (b). 2. The C.N.A. scheduler will receive registry verification that the individual has met competency evaluation requirements and seek information from every state registry established under sections 1819 (e) (2) (A) or 1919 (c) (2) (A) of the act the facility believes will include information on the individual. 3. The C.N.A. scheduler will record the staff member-verifying competency of C.N.A.'s with the state registry.	3/1/02
F 496 SS=E	483.75(e)(5)-(7) ADMINISTRATION Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a	F 496		

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F 496	Continued From Page 107 training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on a review of five employee records, interviews with the facility administrator, certified nurse aide coordinator, and a staff member with registry verification, it was determined that the facility had not contacted the nurse aide registry on five of five employees before allowing them to serve as nurse aides. Findings include: A review of five employee records was done on 1/3/02. The review revealed that five employees did not have documentation in their records that the nurse aide registry had been contacted prior to the employees being allowed to serve as nurse aides. On 1/03/02 at 9:10 AM, an interview with the facility administrator revealed that prior to November of 2001, the facility had not been verifying competency of new nurse aides with the state registry. The facility administrator stated that the facility had a new certified nurse aide coordinator that handled calling the state registry. On 1/03/02 at 9:25 AM, an interview with a staff member of the registry verification agency revealed that they had no record of the facility calling to verify competency for the five employees that were reviewed.	F 496	The following is a plan of correction and is in reference to F-490, F-495 483.75 (e),F-496, for administration. This will include corrective action for each resident found to have been affected. 1. The facility will not use any individual who has worked more than 4 months as a N.A. unless the individual is a full-time employee in a state-approved training and competency eval. Program and has demonstrated competence through satisfactory participation in a state approved nurse aide training and competency eval. Program or competency eval. Program or has been deemed or determined competent as provided in S483.150 (a) and (b). 2. The C.N.A. scheduler will receive registry verification that the individual has met competency evaluation requirements and seek information from every state registry established under sections 1819 (e) (2) (A) or 1919 (c) (2) (A) of the act the facility believes will include information on the individual. 3. The C.N.A. scheduler will record the staff member-verifying competency of C.N.A.'s with the state registry.	3/1/02

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F 496	Continued From Page 108 On 1/03/02 at 4:00 PM, the facility's certified nurse aide coordinator stated that she currently calls the registry to verify competency of the CNA's (certified nurse aides). The CNA coordinator stated that she started to verify CNA's with the registry on 11/12/01. One of the five employee record's that were reviewed, was hired on 11/27/01.	F 496		
F 502 SS=G	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 record review, it was determined that the facility did not ensure that laboratory services were provided for a resident per physicians orders to monitor blood clotting time resulting in the resident requiring hospitalization for over anticoagulation. Findings include: Resident C3 was admitted to the facility on 10/12/01 with diagnoses of fractured pelvis, peripheral vascular disease, emphysema,arthritis, gout and gastrointestinal reflux disease. Review of resident C3's clinical record revealed the following: Resident C3 had a physician order dated 10/12/01 for Coumadin 2.5 mg daily. (Coumadin is a medication used to thin the blood which requires monitoring to prevent the blood from becoming too thin and causing bleeding problems.)	F 502	The following is a plan of correction and is in reference to F-502 483.75 (j) administration. This will include corrective action for each resident found to have been affected and were named as resident C3. The following POC has been instituted to be in effect on 2/14/02. 1. SVHC has ensured that the lab will provide lab services per physician's orders to meet the resident's needs. 2. The lab will notify SVHC nursing staff of critical lab values for immediate interventions. 3. The lab will provide SVHC with a logbook to monitor for laboratory draws. 4. QA committee will monitor and audit lab log for accuracy.	2/14/02

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F 502	Continued From Page 109 The treatment sheet for resident C3 for the month of October 2001 documented to obtain a PT/INR, (prothrombin and international ratio, a laboratory test used to measure blood clotting time), every week for three weeks then monthly. The treatment sheet had the dates 10/15/01, 10/22/01, and 10/29/01 marked as the dates the PT/INR was to be drawn. The 10/15/01 and 10/22/01 dates did not indicate that the laboratory tests had been done. The 10/29/01 date was documented as being done. A physician order dated 10/16/01 documented to "Draw P.T INR AM 10/16/01 then call MD [physician] for further lab orders." There was no documentation to indicate that the PT/INR had been done. Review of the laboratory test results for resident C3 revealed that a PT/INR was done on 10/29/01. The results were the PT was 55.3 (normal range 9.5 - 11.5) and the INR was 6.68 (normal 1.0-3.0). A nurses note dated 10/29/01 at 9:00 PM documented," [hospital] called with lab results-PT 55.1, INR 6.8 -Dr.....called with results - V.O. [verbal order] hold Coumadin X [times] 2 days then do PT/INR on Wed. and Friday each week..." A nurses note dated 10/30/01 documented,"Pt. [patient] found with a copious amount of fresh blood in her brief bleeding from her rectum.....pt sent to {hospital} per D.O.N. [director of nursing] direction transported by .....paramedics...." A review of the hospital admission record revealed that resident C3 was admitted to the hospital for the diagnosis of gastrointestinal bleed on coumadin.	F 502		

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F 502	Continued From Page 110 The laboratory used by the facility was contacted on 1/8/02 to obtain the results of the 10/15/01, 10/16/01, and 10/22/01 PT/INR's ordered by the physician. The laboratory had no record that the laboratory tests had been completed. A review of the laboratory log book maintained by the facility on 1/8/02 revealed that the PT/INR's ordered by the physician had not been written in the log for the laboratory to draw.	F 502		
F 521 SS=H	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 a review of the facility quality assurance meeting minutes, facility monitoring systems and interviews with the facility administrator,the director of nursing, and the dietary manager, it was determined that the facility did not ensure that the quality assurance committee effectively identified quality deficiencies and developed and implemented appropriate plans of action to correct the identified quality issues. Findings include: 1. During an interview with the facility administrator	F 521	The following is a plan of correction and is in reference to F521 483.75 (o) (2) and (3) administration. 1. The QA committee has been appointed to meet monthly-the 4th Friday of each month to identify issues with respect to which QA activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies and issues. 2. The QA committee consists of the administrator, ADON, all department heads, pharmacist, and the medical director. The first scheduled meeting is February 22, 2002. 3. The QA committee will identify and establish corrective action plans to ensure the facility was administered in a manner that enabled it to use resources either efficiently or effectively to ensure residents were provided the opportunity to attain or maintain their highest practicable well being.	2/22/02

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F 521	Continued From Page 111 on 1/8/02, he stated that the facility had a quality assurance committee consisting of the administrator, director of nursing,all department heads, a pharmacist, and the medical director. He stated that meetings were held on a quarterly basis. When asked if the facility had discussed weight loss as a concern, the administrator stated that they had not discussed resident weight loss, as a facility concern, in the qaulity assurance committee. The administrator, however, stated he had initiated a weight meeting that met weekly that consisted of the director of nursing, the dietary manager and the registered dietitian. 2. During an interview with the director of nursing on 1/8/02, she stated that the last quality assurance committee meeting was held on 10/9/01. She stated that there were a lot of areas she knew the facility had to work on but they just had not had time to do them all. When asked specifically what the facility had been working on she stated getting fully staffed without having to use pool nurses and getting caught up on the Minimum Data Sets and making sure they were correct. The director of nursing stated that there was a "dietary management team" that consisted of the dietary manager, the director if nursing and the registered dietitian that met weekly. She stated that if a resident was identified as losing weight, the team would implement a specific plan for that resident. 3. During an interview with the facility dietary manager on 1/8/02, she stated that she reviewed all the residents' weights on a monthly basis. She stated if any resident had lost 5 pounds from the previous month they were discussed in the "dietary management team" meeting. She stated that the meeting met weekly and they had started the meetings at the beginning of November 2001. She stated that the registered dietitian would make recommendations and the director of nursing was responsible to follow	F 521		

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F 521	Continued From Page 112 through with the recommendations. 4. A review of the weekly "dietary management team" minutes was done on 1/8/02. Several residents had been identified as losing weight and had been reviewed by the team including residents 13, 20, 28, 40, 50 and 72. Although the team had identified the weight loss, there was no documentation to indicate that the team had followed through with recommendations, if any were made. 5. A review of the quality assurance meeting minutes was done on 1/16/02. The documentation indicated that the meeting was held on 10/9/01. In reviewing the documentation of those minutes, it was noted that no issues involving weight loss had been identified by the facility quality assurance committee according to the meeting notes. 6. The facility's quality assessment and assurance committee did not identify, and subsequently, did not establish corrective action plans to ensure that residents needs were being met and that necessary nutritional services were being provided. The administration did not operationalize and put in place systemic processes to ensure that residents did not have significant weight loss and ensure that each residents nutritional needs were met. (Refer to Tag F-325) 7. The facility's quality assessment and assurance committee did not identify, and subsequently, did not establish corrective action plans to ensure that adequate supervision and oversight by the consultant dietitian was taking place. Consequently, there was not sufficient oversight of the dietary manager and dietary staff to ensure all residents' dietary needs were met. There was no system in place to appropriately monitor the sanitation of the kitchen, ensuring proper	F 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	1/16/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

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F 521	Continued From Page 113 storage, preparation and the distribution and serving of foods. There was process for ensuring that residents' therapeutic diets were served as ordered. There was also no effective system in place to ensure that foods were served at the proper temperature. Further, the dietitian did not provide services, supports and supervision, through assessment, monitoring and recommendations, to meet each client's nutritional needs to prevent significant weight loss. (Refer to TAG F-360) 7. The facility's quality assessment and assurance committee did not identify and subsequently did not establish corrective action plans to ensure that facility was administered in a manner that enabled it to use its resources either efficiently or effectively to ensure that residents were provided the opportunity to attain or maintain their highest practicable well-being. (Refer to Tag F-490)	F 521		

The following is a response to the: Directed plan of correction for the re-certification/extended survey ending 1/16/02 with the finding of sub-standard quality of care in nutrition/weight loss tag F-325 and non-compliance with dietary tags F-360, F-361, F-326, F-363, F-364, and F-371.

1. A new registered dietician has contracted with South Valley Health Care as our registered dietary consultant.
2. The registered dietician will complete nutritional assessments and make recommendations for the residents identified as have significant weight loss. As assessments are completed, nursing will contact the residents' physician and implement the recommendations as indicated and approved by the physician. The residents will be weighed 2 times per week (Monday and Thursday) by restorative and weights will given to the NIT committee members: appointed head of committee: The FSS. The aide scheduler will monitor the daily dietary intake sheets weekly for accuracy. Nourishments scheduled at 10am and 2pm will be charted by the dietary aides on the dietary intake sheets daily and again monitored weekly by the aide scheduler for accuracy. The licensed staff will record House supplement on the MAR's as ordered.
3. NIT committee has been established to include: the registered dietician, restorative aide, the dietary manager, aide scheduler, QA, will meet every Monday at 2pm. The team will monitor and review all weekly weights, dietary intake and supplement intake for all the residents with weight loss and at risk for weight loss as identified, until weight stabilizes. All residents will by weighted and malnutrition/dehydration assessment will be completed within the first 24 hours of admission for baseline information. Minutes of the NIT and weights will be submitted weekly-Wednesday to the Department of Health for review.
4. The registered dietician consultant will perform on site visits weekly to monitor for compliance with tags F-326, F-363, F-364, and F-371. The monitoring will include: 1) ensuring that the facility is accurately serving therapeutic diets as ordered by the physician. 2) That the menu is being followed as written daily with appropriate serving sizes used and if any substitutions are made that they are appropriate and documented accurately. 3) Monitoring will include food temperatures are being taken and accurately recorded for each meal. 4) Monitoring will include kitchen sanitation checks, foods are to be labeled and dated on all expired and outdated foods are disposed of. 5) Monitoring will include checks of the walk-in refrigerator temperatures and will be recorded daily by the dietary staff. The registered dietician consultant will check food temperatures, adherence to the menu, serving of therapeutic diets, walk-in refrigerator temperatures, facility compliance to the labeling and dating of foods and sanitation check personally during the weekly monitoring and document them on a consultant report. The on-site visits will vary in days, to include breakfast, lunch, and supper.
5. The registered dietician consultant will provide at least four mandatory in-services to address the following: 1) the importance of following the menu, as writer, with appropriate portions being served and the correct utensils to be used to ensure the accurately of serving size. 2) Appropriate menu substitutions and the need to accurately document any substitutions made to the menu. 3) Food safety issues

and the importance of serving foods at the proper temperatures. 4) Food temperatures maintenance techniques. 5) The importance of labeling and dating all foods. 6) Any other items that the consultant dietician feels as warranted.
In-services regarding above issues is scheduled for February 19, 2002.

According to Quality Care policy all employees must be able to speak the dominant language-English.
A record of all the in-service will be submitted to the state survey agency with the itemized content of what was discussed as well as a sign-in sheet identifying the employees who attended.

6. The registered dietician consultant will submit written reports to the state survey agency outlining in-service training provided, the facility's movements towards correction and any problems identified by the consultant, which were not previously identified in the "statement of deficiencies" (HCFA-2567) These reports will be submitted weekly
7. The dietary food service manager will attend further training to include participation in which she attended and completed in the "Serve Safe Program"-- February 12, 2002.

POC - Addendum
South Valley

#353390 HH

The following is a addendum to the Directed POC for the re-certification/extended survey ending 1-16-02 for South Valley Health Care. Date of alleged compliance for the POC is 3-7-02.

F-176
Charge nurse will monitor-evaluate and review meds. as ordered on Friday. Medical Records will perform weekly audits to ensure accuracy and completion. QA reviews 4th Friday of each month for compliance.

F-241
Call light check list was developed to be done randomly, at least twice a week, by all dept. heads-QA will review process monthly.

F-252
Areas of frayed carpet were repaired and patched 2-19-02. Formica was replaced in hallway window sills 2-25-02. Maintenance logs are reviewed each morning by maintenance manager. Plant op manager reviews, for completion and/or problem solving of maintenance logs, Tuesdays and Fridays. QA reviews 4th Friday of each month for compliance.

F-325
Resident identified 13, 20, 28, 40, 50, 70, 72, 74 was reviewed with Dr. . for appropriate interventions starting 12-1-01. Licensed staff was in-serviced on how to complete the malnutrition/dehydration-pressure sore risk assessments 2-20-02.
All nursing and dietary staff was in-serviced (Nov 21 and 28 2001) regarding dietary intake record. Dietary intake record was initiated on 12-01-01. NIT committee communication form developed and implemented 2-20-02 to assess NIT committee with dietary and weight issues. If weight loss is identified-the MD will be notified-diet will include enriched-assess for house supplement., speech eval. if warranted-monitor weight 2 times a week until stabilizes. The NIT committee will meet every week on Tuesday at 1 p.m. to include RD, Dietary manager, QA, to assess weight loss that is identified. QA will review above process 4th Friday at 2 p.m. of each month.

F-326
Resident's identified as 35 and 42-Dr. was notified of incidents. The licensed staff was in-serviced on missed blood-sugars on 2-6-02. If blood-sugars are not being done then the process of weekly audits per medical records, the nurses identified will be called in by the DON and counseled-the nurse involved will then call the MD, and an incident report will be written out nurses will notify residents Dr. other than Dr. house for sliding scale orders as warranted. QA will review above process 4th Friday of each month.
The RD is currently reviewing assessments-and is completing annual assessment as scheduled per MDS and/or c.o.c. The RD will monitor resident diets to ensure they are as ordered weekly-The dietary manager will monitor 5 times a week-The cooks will monitor daily. QA will review above process 4th Friday of each month.

F-328
Resident 15 was seen by Dr. 1-8-02 for podiatry care. Medical records will maintain current podiatry list so that all residents are seen every 60 days. Medical records will audit every month for compliance. QA will review above process 4th Friday of each month.

F-329
Residents identified 4, 15, 24, 76-Dr. was informed of incidents-standard sliding scale was generated for all of his residents. If blood-sugars are not being done then the process of weekly audits per medical records, the nurses identified will be called in by the DON and counseled-the nurse involved will then call the MD, and an incident report will be written out nurses will notify residents Dr. other than house MD. for sliding scale orders as warranted. QA will review above process 4th Friday of each month.

F-360 and F-361
QA is involved in the NIT committee weekly and has been ensuring that the conditions of the Directed Plan of Correction. for tags F-325, F-360, F-361, f-326, F-363, F-364, and F-371. The RD is conducting the dietary in-service weekly and report are submitted to the department of Health as required.

F-363
The dietary manager and RD have initiated a daily form to ensure that menus are followed daily-if any substitutions are to be used-the cook will notify either the dietary manager and / or RD for instruction- substitution availability list was provided by RD. Substitutions will be listed on the daily form if altered. Dietary staff was in-serviced 2-26-02 regarding appropriate serving sizes-appropriate utensils were bought to ensure correct serving sizes. QA will review above process 4th Friday of each month.

F-371
Florescent kitchen lights have been covered and filters cleaned by 2-26-02. The RD is monitoring sanitation weekly and copy sent to the Health Department-QA is involved in NIT committee weekly to ensure that sanitation check list is completed. fridg on the unit was removed. QA will review above issues monthly.

F-387
Residents identified 74, 61, 10, 86, 70, 67, 35, 83, 16, 50, 34, 11, 15, C2. Dr. was notified of last physician visits of each resident Dr. is working with medical records to ensure that residents are seen as required after admissions and periodically during their stay (at least once every 30 day for the first 90 days of admission, and at least once every 60 days there after) Medical records have scheduled appointments. for the other residents that are not house MD -again according to regulations. Medical records is on the QA committee and review will be done monthly.

F-426

Residents identified 76, 4, 15, 24. Dr. was informed of missed blood sugars and sliding scale not followed as ordered -refer to F-329

F-490
The QA committee will monitor that administration is effective on a monthly basis. Facility issues will be brought up immediately to the administration for immediate resolution and QA will review for compliance.

F-495
The DON and CNA scheduler will ensure that all NA's are certified within 4 months of hire. They will monitor status monthly and review with QA monthly.

F-496
The CNA scheduler will call registry prior to interview with potential applicant. The DON will meet with potential employee and CNA scheduler to ensure that registry was called DON will monitor this process weekly QA will review monthly.

F-502
Medical records will audit labs on a monthly basis to ensure that they were done as ordered. QA will review monthly.

F-521
The facility administrator has made some changes in the nursing administration and has appointed an RN for QA as it was obvious that the previous QA system was inefficient.
It has been deemed necessary by the administration that QA meet monthly (4th Friday of each month) rather than quarterly to identify issues with respect to which QA activities are necessary; and develop and implement appropriate plans of action to correct identified quality deficiencies and issues and to ensure that the facility is administered in a manner to enable it to use its resources efficiently/effectively to ensure residents are provided the opportunity to attain and maintain their highest practicable well being. (F-490)
Since the survey the Dietary manager has successfully completed the serve safe program. New RD has been hired as the RD for consultant. The NIT committee is meeting weekly and required-reports are being submitted as required to the Dept. of Health for review.
Systems are currently in place to ensure that residents needs are being met and that necessary nutritional services are being met and that necessary nutritional services are being provided and residents nutritional needs are being met. (F-325)
The current RD is providing services, support and supervision, through assessment, monitoring and recommendations to meet each residents nutritional needs to prevent significant weight loss. (F-360)