TN to SG 4-202

Acceptable POC KP 4/9/02

2567

EALTH CARE FINANCING ADMINISTRATION

.TEMENT OF DEFICIENCIES) PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	R 3/14/02

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

X4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 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: This is a repeat deficiency from the annual recertification survey ending 1/16/02. Based on observations on 3/14/02 between 7:30 AM and 4:00 PM, the facility did not provide a safe, clean, comfortable and homelike environment for the residents. The facility was observed to be unclean with stains and dirt built up on the tile floors, and the building in ill repair with wallpaper pealing from the walls and leaking water faucets in the special needs unit shower room. Findings include: A. Dirty: 1. The tile floor in the 300 hall had gray and brown stains and dirt build up, especially noticeable at the entry into room 303, where the floor had a clean area measuring approximately 3 x 3 feet but the rest of the floor had dirt buildup. 2. The floor at the entry into the special needs unit, from the 300 hall, was covered with black stains approximately 7 x 6 feet. 3. The main dining room had a large red stain in the carpet near the west door measuring approximately 8 x 12 inches. 4. All windows throughout the building were dirty and difficult to see through in resident rooms and all dining rooms. 5. The tile floor, in the special needs dining room, had black stains along the tile seams which involved	{F 252} OK KP 4/9/02	The following is a plan of correction in reference to tag {F-252} 483.15 (h)(1) Environment. This will include corrective action for each area that has been found to be affected. The following p.o.c. with be in effect as of 3/31/02. A. Dirty 1. The tile in the 300 hall has been washed, striped and waxed by the floor man, this will be done quarterly and when necessary. This will be monitored weekly by the plant ops manager and reported to the QA team monthly and administrator will follow to make sure compliance is continued. 2. The black stains in the tile on the entry to the special needs unit came up when the floor was striped and waxed, this will be done quarterly and when necessary. This will be monitored weekly by the plant ops manager and reported to the QA team monthly and administrator will follow to make sure compliance is continued. 3. The red stain on the carpet in the main dining room has been cleaned 3 times since survey; the stain is barely noticeable. The carpets will have scheduled cleanings twice monthly and when needed. This will be monitored weekly by the plant ops manager and reported to the QA team monthly and administrator will follow to make sure compliance is continued. 4. All the windows in the building have been cleaned and routine cleaning will be implemented. The plant ops manager, reported to the QA team monthly, will monitor this weekly and administrator will follow to make sure compliance is continued. 5. The black stains in the seams of the tile in the special needs dining room came up when the floor was striped and waxed, this will be done quarterly and when necessary. The plant ops manager, reported to the QA team monthly, will monitor this weekly and administrator will follow to make sure compliance is continued. B. Needs Repair:	

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

Dennis W Nichols — Administrator — 4/2/02

eficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide ient 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 nformation 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 252}	Continued From page 1 most of the floor. B. Needs repair: 1. There were areas on all hallways that had wallpaper on them, where the wallpaper was missing or coming off the wall. The especially noticeable areas were: a. The doorway from the 200 hall into the courtyard, under the window to the left of the door, there appeared to be water damage to the drywall and the wallpaper was peeling off the wall that measured approximately 3 inches in the corner at the top down to the coving. b. Outside room 108 the wallpaper was peeling from the ceiling down about 4 feet with the widest measurement approximately 4 inches. c. In the hallway across from rooms 313 and 315 the wallpaper was peeling from the wall approximately 2-1/2 feet above the hand railing. d. In the special needs unit, on the 300 hall, there was a door frame (apparently a fire door used to be there) where the wall paper was peeling off the wall above the hand railing, approximately 3 feet up the wall. 2. The water in the shower room across from the nurses station, in the special needs unit, would not turn off in the shower stall and in the bathtub. 3. There was no hot water in resident room 315. 4. The floor at the entry into room 214, the carpet to tile seam cover was loose and not attached to the floor by approximately 12 inches, causing a tripping hazard. 5. The refrigerator in the medication room, on the 100 hall, had broken areas on the bottom of the door	{F 252}	1. a. The doorway from the 200 hall into the courtyard, under the window, has been spackled and repaired. This will be monitored on weekly rounds by maintenance, reported to the QA team monthly, the administrator will follow to assure continued compliance. b. Concerning the wallpaper outside room 108. The wallpaper on the entire 100 and 200 hall and the Special Needs Unit has been removed and painted. This will be monitored on weekly rounds by maintenance, reported to the QA team monthly and the administrator will follow to make sure compliance is continued. c. The wallpaper in the hallway across from rooms 313 and 315 has been repaired and painted. This will be monitored on weekly rounds by maintenance, reported to the QA team monthly; the administrator will follow to assure continued compliance. d. Concerning the wallpaper on the special needs unit (the 300 hall). The wallpaper has been removed and painted. These incidents are reported in the maintenance log, which is gone over daily by the maintenance department and will be monitored on weekly rounds by maintenance, reported to the QA team monthly, the administrator will follow to assure continued compliance. 2. Referring to the water in the shower across from the special needs unit, this has been fixed. Checking these fixtures will become part of weekly maintenance rounds. These incidents are reported in the maintenance log, which is reviewed daily by the maintenance department and will be monitored on weekly rounds by maintenance, reported to the QA team monthly, the administrator will follow to assure continued compliance. 3. The hot water in room 315 has been fixed by a local plumbing company. These incidents are reported in the maintenance log, which is gone over daily by the maintenance and will be gone over in the monthly QA meeting and followed up by the administrator to assure a more timely response. 4. The floor at the entry into room 214, the carpet to tile seam cover has been replaced. These incidents are reported in the maintenance	

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{F 252}	Continued From page 2 that prevented it from sealing and maintaining an appropriate temperature. 6. The gate at the nurses station on the special needs unit, from the 200 hall, had a large hole, approximately 8 inches from the bottom, measuring approximately 6 x 8 inches with jagged edges. 7. There was a hole in the floor in the 300 hall dining room, under the window next to the cabinet closet, where a piece of floor tile was missing measuring approximately 6 x 8 inches. The hole was concealed by a trash can.	{F 252}	log, which is gone over daily by the maintenance department and will be monitored on weekly rounds by maintenance, reported to the QA team monthly, the administrator will follow to assure continued compliance. 5. The refrigerator at the Westside nurses station has been replaced. These incidents are reported in the maintenance log, which is reviewed daily by the maintenance department and will be monitored on weekly rounds by maintenance, reported to the QA team monthly, the administrator will follow to assure continued compliance. 6. The gate at the nurse's station on the special needs unit, has been repaired. These incidents are reported in the maintenance log, which is reviewed daily by the maintenance department and will be monitored on weekly rounds by maintenance, reported to the QA team monthly the administrator will follow to assure continued compliance. 7. The tile in the floor on the 300-hall dining room has been replaced. These incidents are reported in the maintenance log, which is reviewed daily by the maintenance department and will be monitored on weekly rounds by maintenance, reported to the QA team monthly, the administrator will follow to assure continued compliance.	3-31-02
{F 326} SS=G	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: This is a repeat deficiency from the annual re-certification survey ending 1/16/02. Based on observation, staff interview and medical record review, it was determined that for 3 of 8 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 who does not like meat was not served a protein rich meat alternative during the lunch meal on 3/14/02, one resident did not receive large portions during the lunch meal on 3/14/01 and one resident did not receive a high protein diet as prescribed by the physician. Resident identifiers 1, 7 and 8. Findings include: 1. Resident 8 was a 68 year old female with diagnoses including senile dementia, depression and hypertension.	{F 326}	OK KP 4/9/02	

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{F 326}	Continued From page 3 In the survey completed, 1/16/02, resident 8 was part of the selected resident sample (resident 42) and was included in the following sample. On 3/14/02, resident 8's medical record was reviewed. A review of the dietary section of the chart revealed a "Change of Diet" slip, dated 1/31/02, which documented the following, "regular diet [with] low salt (NAS) likes to eat: Fruits [and]Fish [and] Lemonaide does NOT like meat". Observation of the tray line during the lunch meal on 3/14/02, from 11:12 AM to 11:36 AM, was done. Resident 8's diet card stated as food preferences, "doesn't like meat". The following was to be served on the menu for lunch steak, O'brien potatoes, mixed vegetables, cornbread and pie. Resident 8 received the following food items on her meal tray, ½ cup of O'brien potatoes, ½ cup mixed vegetables, 1 6oz. Bowl cream of mushroom and noodles soup, 4 crackers, 1 piece of peach pie, 4ounces of apple juice and 4 ounces of water. No high protein meat alternative was served to replace the meat not provided on resident 8's meal tray. This is the same deficient practice noted for this resident in the survey completed 1/16/02. 2. Resident 1 was a 61 year old male with diagnoses including Alzheimer's disease, depression, cerebral degeneration and peptic ulcer disease. On 3/14/02, at 10:30 AM, resident 1's medical record was reviewed. A review of the dietary section of the chart revealed a " Change of Diet" slip, dated 2/26/02, which documented the following, " New Diet Order: Reg [regular]-enriched- lg. [large] portions". Observation of the tray line during the lunch meal on	{F 326}	The following is a plan of correction in reference to tag {F-326} 483.25 (i)(2)Quality of Care. This will include corrective action for each resident found to have been affected. The following p.o.c. will be in effect as of 3/31/02. 1. In reference to Resident 8, March 22, 2002 all dietary staff had a course on protein substitutions, what to do for different diets, food portions, and enriched diets on and then again with the registered dietician on March 26, 2002. On March 26 all dietary staff had an in-service given by the Registered Dietician the discussion included; serving sizes and utensils, menus and substitutions, therapeutic menus, demonstration of proper serving utensils to use in tray line food service, sizes of scoops and ladles and number of ounces each utensil provides, discussion of small, regular, large, and double serving sizes, importance of portion control in determining meeting of nutritional needs of nursing home residents, as well as a brief review of changes in texture as well as dietary modifications for sodium, fat/cholesterol, diabetic diets, and enriched diets. 2. Resident 1 change of diet slip never made it to the kitchen. An in-service for nurses to remind them on procedure for diet slips. (Diet change slips-white copy to in chart and yellow copy to straight to dietary). Medical records will forwards pink copies of telephone orders to dietary as a double check. Any resident that is discussed in NIT meeting will have their medical record checked for diet changes. All weights are being entered into the computer and weight variance reports are being run and are being reviewed in the NIT meeting. Food Services Supervisor will bring the yellow copy of the diet change and make sure it matches with the latest change of diet in the medical record. FSS will audit monthly all medical records to make sure she has received all diet changes, and the accuracy of the diet changes.	

-dates done 2/9/02 + 4/2/02 per DON phone call on 4/9/02

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{F 326}	Continued From page 4 3/14/02, from 11:12 AM to 11:36 AM, was done. Resident 1's diet card documented his diet was large portion, regular, enriched. Resident 1 was served a lunch tray of regular portions which included 3 ounces of steak, ½ cup of mixed vegetables with approximately 1 Tablespoon of extra margarine, ½ c, O'brien potatoes, 1 Tablespoon of gravy, 1 piece of pie, 1 wild berry Magic Cup supplement, 4 ounces of cranberry juice and 8 ounces of whole milk. No large portion of any food on the menu was observed being served to resident 1. Resident 1 had experienced significant weight loss of 13 pounds, or 6%, between the months of October and November 2001, 10 pounds, or 5% between the months of December 2001 and January 2002 and 27 pounds, or 12.6%, between the months of October 2001 and March 14, 2002. Even with monitoring resident 1's weight decline through the Nutrition Intervention Team meetings, the facility failed to implement the therapeutic diet ordered by the physician. 3. Resident 7 was admitted to the facility on 10/31/01 with diagnoses that include type 2 diabetes, congestive heart failure, coronary artery disease and atrial fibrillation. On 3/14/02, resident 7's medical record was reviewed. On 1/3/02 the physician had ordered a diet change from regular NCS (no concentrated sugar), 1800 ADA (American Dietetic Association) diet to NCS, NAS , high protein and lactulose intolerance. The quarterly nutritional re-assessment, written on 2/2/02, stated that resident 7 was on an 1800 ADA regular diet, failing to incorporate the physician change order dated 1/3/02 for a high protein diet. A laboratory test, done 2/11/02, showed resident 7 had	{F 326}	When resident is discussed in IDT meeting the diet will be checked and recorded on the IDT meeting form. 3. Resident 7 change of diet slip never made it to the kitchen. FSS will report to QA monthly on any diet changes that were not reported to the kitchen for follow up with the QA team and the administrator. After review of the NIT meeting notes for 3/12/02, they were not able to complete the residents that needed to be discussed and they finished the NIT meeting on 3/15/02 - resident 7 was discussed and discovered the diet change at that time.	3/31/02

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{F 326}	Continued From page 5 an albumin of 2.9 (normal values are between 3.9 and 5.0) and a total protein of 6.2 (normal values are between 6.3 and 8.2), supporting the need for a high protein diet. Insufficient protein can result in weight loss. Based on a record review done on 3/14/02, resident 7 experienced the following weight loss: 12/29/01 146 2/2/02 143.2 3/14/02 137 Resident 7 experienced a weight loss of 9 pounds in 2-1/2 months after the physician had ordered a change in diet. Resident 7's diet card used in the kitchen, showed that the resident was receiving a regular NCS diet, indicating that a diet change had not been made according to the physician order of 1/3/02. In an interview with the dietary manager, on 3/14/02 at 3:00 PM, she stated that resident 7 had been reviewed in the NIT (nutritional intervention team) meeting held on 3/12/02 because of her weight loss. Review of the NIT minutes, dated 3/12/02, resident 7 was not on the list of residents reviewed. The dietary manager was not aware of the diet change ordered for resident 7 on 1/3/02.	{F 326}		
{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 6 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: This is a repeat deficiency from the annual re-certification survey ending 1/16/02. Based on observation and staff interview it was determined that the facility did not utilize their part-time consultant dietitian to accurately assess the residents identified during the re-certification survey, ending 1/16/02, as having experienced significant weight loss. Resident identifiers 1, 2, 3, 5, and 6. This requirement was included in the Directed Plan of Correction sent to the facility by the survey team. Findings include: 1. On 3/14/02, at 12:30 PM the consultant dietitian was interviewed. She stated that not all of the nutritional assessments had been done. She stated that if the assessments were done they would be in the medical record under the dietary section. She said she was only allowed 6 hours a week in the facility but there was so much to do with dietary that she had to make a judgment call and stated, "I guess there will be a big push for assessment now". 2. On 3/14/02, a review of the dietary section of the medical records of the 5 residents identified in the 1/16/02 re-certification survey as having experienced significant weight loss who are still residing in the facility was completed. The dietitian had not completed a nutritional re-assessment addressing the resident's weight declines or re-assessing their	{F 361}	The following is a plan of correction in reference to tag {F-361} 483.25 (i)(1)-(2) Quality of Care. This will include corrective action for each resident found to have been affected. The following p.o.c. with be in effect as of 3/31/02. 1. All dietary reassessments on patients named in survey. The RD has been given authority to send as much time as necessary to get the building back in compliance and keep it there. The administrator will meet with the RD briefly each week to assure continued compliance and discuss any problems. QA team will go over this during each monthly meeting. 2. Refer to # 1.	3/31/02

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{F 361}	Continued From page 7 nutritional needs after they experienced significant weight loss. A Directed Plan of Correction, sent to the facility by the survey team, documented that the consultant dietitian was to complete nutritional assessments and make recommendations for the residents identified as having significant weight loss during the survey.	{F 361}		
{F 490} SS=G	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: This is a repeat deficiency from the annual recertification survey ending 1/16/02. Based on the results of the follow-up, it was determined that the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Findings include: Seven of the 19 tags which were cited during the annual recertification survey, ending 1/16/02, were not corrected when the survey team performed the follow-up on 3/14/02. The scope and severity of tag F-326 has been changed from the 1/16/02 survey of an "E" to a "G" (actual harm) at the 3/14/02 follow-up survey. The 6 tags which have been re-cited are:	{F 490}	ok KP 4/9/02 The following is a plan of correction in reference to tag {F-490} 483.75 Administration. This will include corrective action for each area that has been found to be affected. The following p.o.c. with be in effect as of 3/31/02. Refer to POC for Tag F-252, F-326, F-361, F-495, F-496, and F-521. At the beginning of each monthly QA meeting each F tag will be gone over to address any problems and assure continued compliance.	3/31/02

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{F 490}	Continued From page 8 F - 252 The facility did not ensure that all environmental issues were corrected. F - 326 The facility did not ensure that 3 of 8 sample residents received therapeutic diets as ordered by the physician. F - 361 The facility did not ensure that all residents that had substantial weight loss were assessed by the registered dietitian. F - 495 The facility did not ensure that 4 of 22 nursing assistants working in the facility had completed a State-approved training and competency evaluation program in less than four months from the date of hire. F - 496 The facility did not ensure that the State Nurse Aide Registry was contacted prior to employment for 11 of 22 employees. F - 521 The facility did not ensure that the QA committee did not identify issues or implement appropriate plans of action to correct the identified quality deficiencies. Please refer to the specific tags within this document (HCFA-2567) for the details of the deficient practice.	{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	{F 495}		

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{F 495}	Continued From page 9 program; has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or 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: This is a repeat deficiency from the annual survey ending 1/16/02. Based on review of the facility's March 2002 nurse aide schedule, review of personnel files, interview with an individual at the State Nurse Aide Registry, and interview with facility staff, it was determined that 4 of the 22 aides reviewed had worked in the facility longer than four months and were not certified. Employee identifiers: 1, 11, 13, 14. Findings include: The facility's March 2002 nurse aide schedule was reviewed on 3/14/02. The Director of Nurses (DON) was asked how she could tell, by looking at the aide schedule, who worked and who called in or did not show. The DON stated that if the someone did not work, she drew a line through their name. The sample of aides reviewed was obtained from March 11, 2002 and included 22 individuals who were confirmed by the DON to have worked that day. Review of the personnel files of those 22 nurse aides (who worked 3/11/02) revealed the following: Employee 1 was hired 6/21/01. There was no documentation in her personnel file to evidence that she was certified. Employee 11 was hired 5/7/01. There was no	{F 495}	The following is a plan of correction in reference to tag {F-495} 483.75 (e)(4)and tag {F-496} 483.75 (e)(5)-(7) Administration. This will include corrective action for each area that has been found to be affected. The following p.o.c. will be in effect as of 3/31/02. 1. The corporation has contracted with a state approved instructional group to assure the competency of the nursing assistants. The facility is not employing any nursing assistant who is pass their statutory limitation of 4 months of employment with out being certified. The State Nurse Aide Registry has been called on all nursing assistants hired since October of 2001. The State Nurse Aide Registry will be called prior to hiring; the DON or designee will fill out The State Nurse Aide Registry form (attached) and give it to the administrator before any decision on hiring is made. This will be reported and followed up with the QA team monthly and reported to the administrator to assure continued compliance.	3/31/02

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 _____	R 3/14/02

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 495}	Continued From page 10 documentation in his personnel file to evidence that he was certified. Employee 13 was hired 5/7/01. There was no documentation in his personnel file to evidence that he was certified. Employee 14 was hired 4/12/01. There was no documentation in her personnel file to evidence that she was certified. During interview with an individual from the nurse aide registry on 3/18/02 at 12:15 PM, she confirmed that employees 1, 11, 13 and 14 were not certified. The facility's plan of correction stated, "The DON and CNA scheduler will ensure that all NA's (nurse aides) are certified within 4 months of hire. They will monitor status monthly and review with QA (quality assurance monthly." The DON could not provide documentation to evidence that nurse aide certification had been monitored. The QA minutes, dated 2/22/02, were reviewed on 3/14/02. They did not contain documentation to evidence that nurse aide certification had been monitored by the QA committee.	{F 495}		
{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.	{F 496}	OK KP 4/3/02	

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{F 496}	Continued From page 11 If, since an individual's most recent completion of a 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: This is a repeat deficiency from the annual survey ending 1/16/02. Based on review of the facility's March 2002 nurse aide schedule, review of personnel files, interview with an individual at the State Nurse Aide Registry, and interview with facility staff, it was determined the facility did not seek information from the State Nurse Aide Registry for 11 of the 22 aides reviewed. Employee identifiers: 1, 2, 6, 7, 10, 11, 12, 13, 14, 16 and 17. Findings include: The facility's March 2002 nurse aide schedule was reviewed on 3/14/02. The Director of Nurses (DON) was asked how she could tell, by looking at the aide schedule, who worked and who called in or did not show. The DON stated that if the someone did not work, she drew a line through their name. The sample of aides reviewed was obtained from March 11, 2002 and included 22 individuals who were confirmed by the DON to have worked that day. Review of the personnel files for those 22 aides revealed the following: Employee 1 was hired 6/21/01.	{F 496}	The following is a plan of correction in reference to tag {F-495} 483.75 (e)(4)and tag {F-496} 483.75 (e)(5)-(7) Administration. This will include corrective action for each area that has been found to be affected. The following p.o.c. will be in effect as of 3/31/02. 1. The corporation has contracted with a state approved instructional group to assure the competency of the nursing assistants. The facility is not employing any nursing assistant who is pass their statutory limitation of 4 months of employment with out being certified. The State Nurse Aide Registry has been called on all nursing assistants hired since October of 2001. The State Nurse Aide Registry will be called prior to hiring; the DON or designee will fill out The State Nurse Aide Registry form (attached) and give it to the administrator before any decision on hiring is made. This will be reported and followed up with the QA team monthly and reported to the administrator to assure continued compliance.	3/31/02

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{F 496}	Continued From page 12 Employee 2 was hired 4/30/01. Employee 6 was hired 1/29/02. Employee 7 was hired 1/29/02. Employee 10 was hired 2/5/02. Employee 11 was hired 5/7/01. Employee 12 was hired 1/29/02. Employee 13 was hired 5/7/01. Employee 14 was hired 4/12/01. Employee 16 was hired 2/20/02. Employee 17 was hired 2/20/02. There was no documentation in the personnel files of the above 11 nurse aides to evidence that the facility had sought information from the nurse aide registry as required. During interview with an individual from the State Nurse Aide Registry on 3/18/02 at 12:15 PM, she confirmed that the facility had not sought information for the above 11 nurse aides. During interview with the individual who had been the CNA scheduler up until 3/1/02, she stated that they were not required to call the registry on individuals who were not certified. The facility's plan of correction stated, "The CNA (certified nurse aide) 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 (quality assurance) will review monthly." The DON was unable to provide documentation that the process of calling the registry had been monitored. The QA minutes, dated 2/22/02, were reviewed on 3/14/02. The QA minutes did not contain documentation that the process of calling the registry	{F 496}		

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{F 496}	Continued From page 13 had been monitored.	{F 496}		
{F 521} SS=G	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 review of the quality assurance (QA) minutes, dated 2/22/02, and the results of the follow-up performed by the survey team on 3/14/02, it was determined that the facility did not identify issues or implement appropriate plans of action to correct identified quality deficiencies. Findings include: A review of the QA minutes, dated 2/22/02, was performed on 3/14/02. The QA minutes failed to address tags F 495 (aide certification) and F496 (nurse aide registry). The directed plans of correction for these two deficiencies were not followed and these tags were re-cited during the follow-up of 3/14/02. There was no documentation to evidence that the QA committee had identified the uncorrected environmental issues. This was re-cited under F - 252.	{F 521}	The following is a plan of correction in reference to tag {F-521} 483.75 (o)(2)&(3) Administration. This will include corrective action for each area that has been found to be affected. The following p.o.c. with be in effect as of 3/31/02. Qa issues identified daily in the department head morning meeting will be included as agenda items for the monthly QA meeting. Items not resolved between the monthly meetings will be part of the agenda for the QA quarterly meeting; the DON or QA designee will monitor these items. Any deficiencies uncovered during survey will be addressed in every monthly meeting and reviewed in the quarterly meeting to assure continued compliance.	3/31/02

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{F 521}	Continued From page 14 There was no documentation to evidence that the QA committee had identified or addressed the concerns of therapeutic diets for residents 1, 7 and 8. This was re-cited under F - 326. There was no documentation to evidence that the QA committee had identified that the dietitian had not completed nutritional re-assessments addressing the residents weight declines or re-assessing their nutritional needs after they experienced significant weight loss. This was re-cited under F - 361.	{F 521}		

THE STATE NURSING ASSISTANCE REGISTRY

A call was made in behalf of the following ---------- ----------

On the day of ---------- --------- 2002

Varification was made by ---------- ------ ---------- title---------- ---

The person contacted was---------- ----------..

Abuse---------- other---------- reported ?

Varified # of certificate is---------- Which is good to ----------

This employee was hired ---------- ---------- ---------- If nursing assistant is not

Certified their last day on the floor will be ---------- ----------

Acceptable POC = addendum attached 5/10/02 [illegible]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 4/25/
FORM APPROVE
2567

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F 203 SS=D	483.12(a)(4)-(6) TRANSFER AND DISCHARGE REQUIREMENTS Before a facility transfers or discharges a resident, the facility must: Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Record the reasons in the resident's clinical record; and Include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when: The health of individuals in the facility would be endangered, under (a)(2)(iv) of this section; The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or A resident has not resided in the facility for 30 days. Contents of the notice. The written notice specified in	F 203 OK = addendum 5/10/02 DS	F 203 Resident #5 was readmitted to the facility on **4/18/02.** The facility will ensure that when it transfers or discharges a resident from the facility, a timely and appropriate written notice will be given to the resident. At a minimum, the following information will be included in the notice: 1. The reason for discharge; 2. The effective date of the proposed transfer or discharge; 3. The location to which the resident is transferred or discharged; 4. A statement that the resident has the right to appeal the action to the State; 5. The name, address, and telephone number of the State long term care ombudsman; 6. The mailing address and telephone number of the Medicaid protection and advocacy agency for persons with various disabilities. Attached is a sample of the notice the facility will use for future discharges that require prior notification. The Administrator will be responsible for monitoring. **This was completed on 5/01/02.**	

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

[signature] ADMINISTRATOR 5/5/02

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 such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 203	Continued From page 1 paragraph (a)(4) of this section must include the following: The reason for transfer or discharge; The effective date of transfer or discharge; The location to which the resident is transferred or discharged; A statement that the resident has the right to appeal the action to the State; The name, address and telephone number of the State long term care ombudsman; For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews it was determined that for one resident (resident 5), the facility did not provide the following discharge notice requirements: 1. The reason for transfer or discharge; 2 The effective date of the proposed transfer or discharge;	F 203		

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F 203	Continued From page 2 3. The location to which the resident was to be transferred or discharged; 4. A statement that the resident had the right to appeal the action to the State; 5. Provide the name, address and telephone number of the State long term care ombudsman; 6. The mailing address and telephone number of the Medicaid protection and advocacy agency for persons with various disabilties; and 7. The facility did not provide notice of transfer to resident 5 at least 30 days before discharge. Findings include: Resident 5 was admitted to the facility on 11/30/01 with diagnoses that include quadriplegia, personality disorder, depression, hypotension and chronic pain. A review of resident 5's closed medical record, on 4/16/02, showed a discharge notice, dated 4/4/02, stating in full; "After long consultations it has been determined by our inter-disciplinary team, that South Valley can no longer meet your needs. As a result please consider this letter as your formal 30-day notice of discharge. Our Social Worker will be more than happy to assist you in finding a new facility that can better and more appropriately meet your needs." The letter was signed by the administrator of the facility. The discharge notice did not contain the following: The reason for discharge; The effective date of the proposed discharge; The location to which the resident was to be discharged; A statement that the resident had the right to appeal the action to the State; The mailing address and telephone number of the Medicaid protection and advocacy agency for persons with various disabilties; and , Provide the name, address and telephone number of the State long term care ombudsman.	F 203		

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F 203	Continued From page 3 A nurses note, dated 4/11/02, stated that the resident was sent to the emergency room via ambulance related to low hematocrit and dehydration. The DON made an entry in resident 5's medical record dated 4/11/02, that a message was left on the hospital discharge planners voice mail stating "we can't take her back, we can't meet her needs...Told nurses not to take this Pt [patient] back," in effect creating a permanent discharge of resident 5 without having received a notice with the required elements.	F 203		
F 206 SS=D	483.12(b)(3) PERMITTING RESIDENT TO RETURN TO FACILI A nursing facility must establish and follow a written policy under which a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident requires the services provided by the facility; and is eligible for Medicaid nursing facility services. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, it was determined that the facility did not readmit resident 5 after an acute hospital admission when the resident was ready to return to the facility and the facility had sufficient available beds to accommodate the resident's readmission. Findings include: Resident 5 was originally admitted to the facility on 11/30/01 with diagnoses that included quadriplegia, personality disorder, depression, hypotension and chronic pain. Resident 5 was discharged to an acute care setting on 4/11/02 and was ready for discharge	F 206 ok c addendum 5/16/02 MD	**F 206** Resident # 5 was readmitted to the facility on **4/18/02**. This facility has established a written policy to ensure that when a resident who is eligible for Medicaid nursing facility services and requires the services provided by the facility, will be readmitted to the facility immediately upon the first availability of a non-private room. Attached is a copy of the policy that will be part of the admission process. The Administrator and Director of Nursing Services will monitor. **This was completed on 5/02/02.**	

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F 206	Continued From page 4 from the hospital on 4/15/02. However, resident 5 was not readmitted until 4/18/02. A review of resident 5's closed medical record on 4/16/02, showed a discharge notice from the facility, dated 4/4/02, stating in full; "After long consultations it has been determined by our inter-disciplinary team, that South Valley Care Center can no longer meet your needs. As a result please consider this letter as your formal 30-day notice of discharge. Our Social Worker will be more than happy to assist you in finding a new facility that can better and more appropriately meet your needs." The notice was signed by the administrator of the facility On 4/16/02 at approximately 3:00 PM, the Director of Nurses (DON) was asked by the surveyor if she could provide the IDT minutes for resident 5. On 4/17/02 at approximately 4:00 PM, the DON stated that the IDT minutes could not be located. While the surveyor was watching, the DON made a late entry in the resident's medical record, dated 4/4/02 and 4/11/02, stating, "Met as a IDT team. Discussed all issues related to [resident's] cares. As a team we can't meet any of her needs. She has been given her 30 day notice for another facility admit". A nurses note, dated 4/11/02, stated that the resident was sent to the emergency room via ambulance. The resident was subsequently admitted as an inpatient in the acute care hospital for a blood transfusion due to low hematocrit and intravenous (IV) hydration resulting from dehydration. The director of nursing (DON) made an entry, dated 4/11/02, that a message was left on the hospital discharge planners voice mail stating, "We can't take her back, we can't meet her needs...Told nurses not to take this Pt [patient] back."	F 206		

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F 206	Continued From page 5 Information received from the hospital discharge planner indicated that resident 5 was ready for discharge on 4/15/02 but the facility had refused to take resident 5 back. Information gathered on 4/16/02 as part of the entrance conference indicated that the facility had 70 residents in this 120 bed facility, therefore, bed availability was not an issue for readmission.	F 206		
F 225 SS=J	483.13(c)(1)(ii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to	F 225 OK c addendum 5/6/02 MS	**F 225** The correction for F225 includes the addition of policy #2034 and #2001. This policy and procedure defines the process for Investigating and Reporting abuse, neglect, and misappropriation of property. The staff will be shown and in-serviced on this policy and procedure on **5/01/02**. The Director of Nursing and Administrator will review all incident reports daily. In reference to resident's #3 and #4, the survey team was contacted on **4/30/02**, to ensure that an investigation will be properly filed. A follow-up call was placed to DOPL for further information regarding the investigation. An "in-house" investigation was conducted based on previous evidence. See investigation form. As part of the Quality Assurance process, every nurse will be given a copy of the investigation form. Each nurse will be given a copy of the investigation policy. Phone numbers for each agency needing to be contacted during an investigation will be placed at the nursing station in the Rolodex.	

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F 225	Continued From page 6 the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of documentation maintained at the state survey agency, facility record review and interviews with the facility administrator and director of nursing (DON), it was determined that the facility did not immediately report to the facility administrator nor the state agency (SA) an incident of misappropriation of resident property (theft of resident medication). Further, the facility did not thoroughly investigate the circumstances surrounding the theft. Resident 3 and 4 Findings include: On 3/16/02, the facility discovered that approximately 143 milligrams of a controlled substance, Schedule III narcotic (hydrocodone, generic Lortab) were missing from residents 3 and 4. Review of a statement made by the DON to the local police on 3/17/02, was reviewed on 4/16/02. The DON's statement indicated that 49, two and one half milligram hydrocodone pills were missing for resident 3 and that 4 five milligram hydrocodone pills were missing for resident 4. Review of resident 3's clinical record was conducted on 4/16/02. A physician order dated 12/1/01 was found for hydrocodone, 5 milligrams one every four hours as needed for pain. A nurses note dated 3/17/02 documented that resident 3 requested pain medication on 3/17/02 at 1:00 PM. The record documented that the medication was taken from the facility "emergency box" due to the fact that resident 3's hydrocodone was	F 225	All incident/investigation reports will be reviewed daily. Follow-up daily. Follow-up by the Director of Nursing or designee will be made to collect further data as needed to ensure the investigation is properly completed. **This was completed on 5/04/02.**	

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F 225	Continued From page 7 missing from the medication cart. Review of resident 4's clinical record was conducted on 4/16/02. A physician order dated 3/17/02 was found for hydrocodone 7.5 milligrams, one or two, every four hours as needed for pain. Resident 4 had not requested any pain medication during the period of time the medication was missing from the cart. In another interview with the DON on 4/16/02, she stated that she contacted the facility pharmacy on 3/21/02 to have the medications replaced. 1. Failure to Report Immediately to the Administrator and to the State Survey Agency: An interview was held with the facility administrator and DON in the afternoon of 4/16/02. Both the administrator and DON stated that on 3/16/02, a facility nurse contacted the DON at home and reported to her that it was discovered at change of shift that evening, that approximately 143 milligrams of a controlled substance, Schedule III narcotic (hydrocodone, generic Lortab) were missing from the medication cart. The administrator indicated that he was first notified of the theft on Monday, 3/18/02 when he returned to the facility after the weekend. The DON stated that the next day, 3/17/02, she contacted the local police department and reported the missing medications. The police went to the facility and took statements from three facility employees having knowledge of the theft. The administrator and DON confirmed that the information given to the police was not reported to anyone but the local police department. During the exit conference on 4/18/02 at 4:00 PM, the facility administrator stated "Do I have to report	F 225		

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F 225	Continued From page 8 everything? What do I have to report?" A review of the documentation maintained by the State Survey Agency was conducted on 4/15/02 as part of the off-site preparation for the survey. No documentation was found that the facility had notified the survey agency of the theft on 3/16/02 of resident 's 3 and 4 pain medication. 2. Failure to Investigate: On 4/16/02, a statement made by the DON to the local police on 3/17/02, was reviewed. The DON's statement indicated that 49, two and one half milligram hydrocodone pills were missing for resident 3 and that 4 five milligram hydrocodone pills were missing for resident 4. Review of resident 3's clinical record was conducted on 4/16/02. A physician order dated 12/1/01 was found for hydrocodone, 5 milligrams one every four hours as needed for pain. A nurses note dated 3/17/02 documented that resident 3 requested pain medication on 3/17/02 at 1:00 PM. The record documented that the medication was taken from the facility "emergency box" due to the fact that resident 3's hydrocodone was missing from the medication cart. Review of resident 4's clinical record was conducted on 4/16/02. A physician order dated 3/17/02 was found for hydrocodone 7.5 milligrams, one or two, every four hours as needed for pain. Resident 4 had not requested any pain medication during the period of time the medication was missing from the cart. An interview was held with the facility administrator and DON in the afternoon of 4/16/02. The administrator and DON stated that the only investigation that was conducted was the one done by	F 225		

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F 225	Continued From page 9 the police. They further stated that no other investigation had been done by the facility to determine what happened to the missing narcotics. The facility failed to investigate the problem in order to put in place a process which could prevent further occurence.	F 225		
F 226 SS=L	483.13(C)(1)(i) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (Use F226 for deficiencies concerning the facility's development and implementation of policies and procedures.) This REQUIREMENT is not met as evidenced by: Based on employee file reviews, interviews with the facility administrator and Director of Nursing (DON) and an employee at the Department of Professional Licensing (DoPL), it was determined that the facility did not have policies and procedures in place to screen potential employees. Subsequently, the facility hired employee 1 to work as a Licensed Practical Nurse (LPN) without the person having licensure as an LPN. The facility did not check with DoPL nor did the facility obtain a copy of the employees license previous to allowing the employee to work in the facility. The facility also allowed two LPN's to work in the facility on expired nursing licenses. (Employees 2 and 3) Findings include:	F 226 ok e addendum 5/6/02 ds	**F 226** Corrective action for F226 includes the addition of policy #2001-Abuse-Prohibiting, Investigation and Reporting, #2029 Abuse Prevention, #4043 Licensure and Registration of Personnel, #5006 Orientation Program. Employee #1 was terminated on **3/18/02**. Employee was apprehended by the West Jordan Police Department on **3/26/02**. Refer to policy #4034 Licensure and Registration of Personnel for current procedures for screening potential staff. Employee #2 and #3: 1. Employee #2 on file in employee record, a copy of her LPN license with an expiration date of 1/31/04. 2. Employee #3 on file in employee record a copy of her LPN license with an expiration date of 1/31/04. Proof of current licensure for the two employees was placed in their employee file on **5/01/02**.	

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F 226	Continued From page 10 On 4/16/02, a review of employee 1's file revealed that the employee had been hired by the facility to work as an LPN on 3/15/02. The facility did not obtain a copy of the employees nursing license nor did the facility contact DoPL to ensure that the employee was licensed. The employee worked in the facility on 3/16/02 and 3/17/02. During the two days that employee 1 worked, the facility discovered that approximately 143 milligrams of a controlled substance, Schedule III narcotic (hydrocodone, generic Lortab) were missing. The medications were missing from the medication cart on the nurses station where employee 1 had been working. The facility reported the incident to the local police department on 3/17/02. On the morning of 3/18/02, the DON contacted DoPL and discovered that employee 1 was not licensed to work as an LPN. As a result of the lack of licensing, employee 1 was terminated by the facility on 3/18/02. The surveyors requested a copy of the facility's policy regarding screening of new employees. The administrator gave a policy titled "Anti-abuse Policy for Residents". A review of the policy showed a section titled "Protocol for Screening New Hires to Help Assure Absence of Abuse in the Facility". This policy discussed criminal background checks and checking various abuse registries at the time of employment but does not address how to ensure professional licensing status. An interview was held with the Administrator and the DON of the facility on 4/16/02 at approximately 2:00 PM. They both stated that the facility did not have a policy in place regarding the screening of licensed staff by contacting DoPL.	F 226	As of **5/01/02**, all licenses and verifications are to be obtained before an employee is allowed to work. Refer to policy #4034 Licensure and Registration and policy #2029 Abuse Prevention (Screening Employees). And #2001 Investigating and Reporting (staff screening). In addition to policy #4034 and #2029, the Director of Nursing will maintain a tracking sheet. This tracking sheet is an "at glance" record of CPR certifications, license expirations, TB tests, Hep B, food handler's permit expirations, and a record of their last BCI check. This nursing checklist will be reviewed by the Director of Nursing monthly. Employees needing to complete licensure, certification, etc. will be notified. **Implemented 5/01/02.**	

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F 226	Continued From page 11 The current DON had been promoted to the DON position on approximately 1/26/02. In an interview on 4/16/02, she stated that as the DON, she had never contacted DoPL previous to hiring a licensed nurse. The DON stated that when she hired a new nurse, she would copy the new employees driver license, Social Security Card, and professional license and place them in a file. This practice was not followed with employee 1 because allegedly the individual was in the process of moving, the verification "was packed" and she would bring them in "later". This verification was not provided even though the individual continued to work two more days. The DON and the administrator stated that if the narcotics had not been missing, the DON would not have contacted DoPL and it would not have been discovered that the individual was not a licensed nurse. On 4/23/02, it was verified with the West Jordan Police Department that during an interview with employee 1, employee 1 stated that she intentionally sought employment as an LPN and she would have continued working had she not been discovered. On 4/17/02 at approximately 4:00 PM, the DON was again interviewed. She stated that she had called DoPL earlier that day (4/17/02) concerning all nurses employed by the facility. She found that two LPN's who were working that day (employees 2 and 3) did not have current licenses. It was determined through DoPL that the licenses had expired on 1/31/02 and that they had not been renewed. Employees 1 and 2 had been working regularly scheduled shifts since 2/1/02 without having current licenses. An interview was conducted with a representative of DoPL, nurse licensing, on 4/19/02. The representative indicated that failure to renew a nursing license was equivalent to the individual being unlicensed and	F 226		

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F 226	Continued From page 12 therefore, the individual would not be allowed to practice as a nurse. The representative additionally stated that both of the employees 2 and 3 had been sent a notice of renewal in November 2001. It was additionally noted that DoPL had not received a change of address on either of the nurses and therefore should have received the notice in sufficient time to renew their license. An interview was conducted with employee 2 on 4/17/02 at approximately 5:15 PM. She stated "I'm so embarrassed. I don't remember getting the notice."	F 226		
{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: This is a repeat deficiency from the annual re-certification survey ending 1/16/02 and a follow-up survey ending 3/14/02. Based on observation, staff interview and medical record review, it was determined that for 1 of 7 sampled residents, the facility did not ensure that each resident received a therapeutic diet when there was a nutritional problem as evidenced by: Resident 1 did not receive large portions during the lunch meal on 4/16/02, the proper serving utensils were not used to serve the appropriate vegetable portions during the lunch meal on 4/16/02, and the facility did not serve therapeutic diets per the facility approved menus. Findings include: 1. Resident 1 was a 61 year old male with diagnoses including Alzheimer's disease, depression, cerebral	{F 326}	ok - addendum 5/6/02 DS **F 326** Tray cards will be rewritten by FSS to ensure they accurately reflect each resident's therapeutic diet and resident's dislikes, allergies and preferences. Completion date: **5/3/02**. FSS to monitor. Portions will be accurately served as ordered by using serving utensils, which accurately reflect the required portion sizes. Kitchen staff in serviced on **5/03/02**. FSS to monitor. Sugar-free dessert mixes are being used for NCS diets. Fruit is now ordered which is canned in own juice rather than a sugar syrup. The extended menu has been in the facility since **4/17/02** and the dietician consultant has made appropriate adjustments.	~~4/17/02~~ AG

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{F 326}	Continued From page 13 degeneration and peptic ulcer disease. On 4/16/02, resident 1's medical record was reviewed. A review of the dietary section of the chart revealed a " Change of Diet" slip, dated 2/26/02, which documented the following, " New Diet Order: Reg [regular]-enriched- lg. [large] portions". Observation of the tray line, during the lunch meal on 4/16/02, from 11:17 AM to 11:43 AM, was done. Resident 1's diet card documented his diet was large portion, regular, enriched. Resident 1 was served the following on his lunch tray: ½ cup mashed potatoes ¼ cup vegetables 1 ounce of gravy 4 ounces of apple juice According to the facilities "Portion Control Chart for Adjusted Portion Sizes", which listed the different portion sizes that were to be served for regular, small, large and double portion diets, the following was to be served to resident 1 rather than what was served: ¾ cup of potatoes 3/4 cup of vegetables 3 ounces of gravy 6 ounces of juice Resident 1 had experienced significant weight loss of 13 pounds, or 6%, between the months of October and November 2001, 10 pounds, or 5% between the months of December 2001 and January 2002 and 27 pounds, or 12.6%, between the months of October 2001 and March 14, 2002. Since 3/18/02, resident 1's weight had stabilized to 188 pounds however, no weight gain to replace previous loss had occurred. On 4/9/02, the Nutrition Intervention Team dropped	{F 326}	Resident 1 has been put back on the NIT review as of **5/02/02**. Residents will continue to be reviewed by NIT until desired weight has been achieved and then has been maintained for two more weeks. FSS will assign a person to check the trays being sent from the kitchen against the individual tray cards to ensure therapeutic diets are being served as ordered effective **5/03/02**. In addition, nursing staff and aides will be in-serviced **5/03/02** on how to double check the meal served against the tray card as they serve the residents their individual trays. FSS and dietary consultant will monitor. In addition, Rocky Mountain Care's quality control administrative designee will monitor for compliance of all above items. All corrections will be completed by **5/03/02**.	

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{F 326}	Continued From page 14 resident 1 from it's review even though the facility failed to consistently implement the therapeutic diet ordered by the physician. 2. Observation of tray preparation service for the Alzheimer's Unit and 300 hall on 4/16/02 from 11:17 AM to 11:43 AM, was done. During this observation, the cook asked the surveyor if he was using the right serving utensil as he was unsure which was the correct size to use. The cook was observed to use a 2 ounce (1/4 cup) serving utensil to serve the Italian mixed vegetables instead of a 4 ounce (1/2 cup) to the 32 residents on these halls who were ordered mechanical soft or regular diets. This would allow for variances in the number of calories and nutrients provided to each resident versus the amount the menu recommended. This observation also revealed that the 8 residents from these halls prescribed no concentrated sweet (NCS) diets were served pineapple cake instead of pineapple as the menu documented. This diet is often prescribed for residents diagnosed with diabetes mellitus to help control blood sugars. Providing pineapple cake versus pineapple would allow for variances in the number of calories and amount of sugar provided to these residents versus the amount the menu recommended. 3. On 4/16/02, it was noted that the menu cycle had been changed from the fall and winter menus to the spring and summer menus. The food service supervisor was interviewed on 4/16/02 at 11:45 AM. 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	{F 326}		

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{F 326}	Continued From page 15 resident's receiving therapeutic or texture modified diets. She stated that the facility did not have the extended menus for the spring and summer menu cycle. When asked how long the spring and summer menus had been in use, she stated the facility switched menus 2 weeks ago and they were starting on the third week of menus. The extended menu helps guide the dietary staff on what foods residents with diets ordered that are therapeutic or texture modified should receive. Without this extended menu, the staff may not serve the appropriate foods to these residents. 4. On 4/16/02 at 1:37 PM, the facility consultant dietitian was interviewed. When asked if she had tried to get the extended menus for the spring and summer menu cycle that the facility was currently using, she stated that she was unaware that the facility did not have them. She was asked how often she monitored the food preparation tray line. She stated that the tray line was monitored every other week for about an hour. She stated that she was in the facility about 6 hours every week, usually on Tuesdays. A plan of correction was received from the facility on 4/2/02. For non-compliance under this regulation, a correction date of 3/31/02 was given. It included a statement that an inservice was provided by the registered dietitian on 3/26/02 and included information on proper serving sizes, use of correct serving utensils, therapeutic diets and following the menus as written. The consultant dietitian was asked if she had given any staff in-services regarding proper portion sizes and the importance of following the menu as written since 2/26/02. She stated "No". An interview was conducted with the food service supervisor on 4/16/02 at approximately 5:00 PM. She	{F 326}		

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{F 326}	Continued From page 16 stated that an inservice was given by her on 3/22/02. She provided to the surveyors a copy of the inservice documentation which showed that information regarding scoops, portion control and "size cart" was provided, but did not cover therapeutic diets.	{F 326}		
{F 490} SS=L	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: This is a repeat deficiency from the annual recertification survey ending 1/16/02 and a follow up survey ending 3/14/02. Based on the results of a second follow-up conducted 4/16/02 through 4/17/02, from the recertification survey conducted December 31, 2001 through January 16, 2002 and resultant finding of Immediate Jeopardy and Substandard Quality of Care during the current follow-up survey, it was determined that the facility was not being administered in a manner that enabled it to use its resources effectively and efficiently to correct F 326 (harm) for 3 consecutive surveys. Further, new non-compliance was found at F 203 and F 206. Additionally, Immediate Jeopardy and Substandard Quality of Care were identified for the facility failing to have a system for the reporting and investigation of abuse or neglect of residents or misappropriation of resident property (F 225) and failure to have a system for the screening of employees/potential employees (F 226). Finally, Immediate Jeopardy was found for failure to comply with Federal, State, and local laws (F 492)	{F 490}	OK - addendum 5/6/02 drs **F490** Effective **4/22/02**, a new management team (Administrator, DON, Nurse Consultant) was appointed to oversee the operations of the facility and to ensure the facility was using its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This new management team has put systems, processes, policies and procedures in place to address how: 1. Potential employees are to be screened (See POC F226): 2. Misappropriation of resident property (See POC F225); 3. Complying with Federal, State and local laws by verifying professional licenses (See POC F226 and F492); 4. Ensuring residents receive therapeutic diets (See POC F326); 5. Providing appropriate and timely notice to a resident for discharge (See POC F203); 6. Permitting a resident to return after an acute hospital stay (See POC F206); 7. Ensuring that a Quality Assurance program in place to identify and correct potential issues (See POC F521).	

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	465108	A. BUILDING _____ B. WING _____	R 4/17/02

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 490}	Continued From page 17 Findings include: On 4/16/02, a second follow up to the recertification survey was initiated. On 4/18/02, facility administration was noticed of the elements of Immediate Jeopardy and Substandard Quality of Care. The determination of Immediate Jeopardy and Substandard Quality of Care was based on the finding of significant non-compliance in the area of Resident Behavior and Facility Practices/Staff Treatment of Residents [42 Code of Federal Regulations (CFR) 483.13(c)(1)(ii)(A)&(B) Tag F-226. 1. Facility administration failed to have a system in place to screen employees and potential employees. There was a lack of administrative oversight, supervision and monitoring of the facility staff to prevent hiring of unlicensed staff or continued employment of unlicensed staff. (Refer to Tag F-226) 2. Facility administration failed to have a system in place to ensure investigations of alleged misappropriation of resident property. The facility administration did not ensure that an allegation of misappropriation of resident property was reported to the State Agency. (Refer to Tag F-225) 3. Facility administration failed to have a system in place to ensure that the facility was in compliance with Federal, State and local laws. The facility did not have copies of current professional licenses in all of the licensed employees files available for department review. (Refer to Tag F-492) 4. In addition to the finding of Immediate Jeopardy and Sub-Standard Quality of Care, the facility	{F 490}		

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{F 490}	Continued From page 18 administration failed to effectively and efficiently use its 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 second follow up completed on 4/17/02 to the recertification survey completed 1/16/02. a. Facility administration did not ensure that residents received therapeutic diets as ordered by the physician. (Refer to Tag F-326) b. Facility administration did not ensure that proper notice was given to a resident for discharge. (Refer to Tag F-203) c. Facility administration did not ensure that a resident was permitted to return to the facility after an acute hospital stay. (Refer to Tag F-206) d. 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 492 SS=L	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on employee record review and an interview with the facility director of nursing (DON) it was determined that the facility was not in compliance with all applicable State laws. The facility did not ensure	F 492	**F492** The facility conducted a review of its current personnel files. Copies of employee's professional licenses have been obtained and placed in their personnel file. If an employee has not been able to produce a current copy of their professional license, they have either been suspended until they can provide one, or terminated.	

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F 492	Continued From page 19 that licensed personnel were currently licensed. The facility did not have copies on file for all licensed personnel for department review. In accordance with Utah State Licensing regulations (R432-150-10(1)(c), "All personnel must be licensed, certified or registered as required by the Utah Department of Commerce. A copy of the license, certification or registration shall be maintained for (Health) Department review." On 4/19/02, the Bureau of Licensing (BoL), Division of Health Systems Improvement, Utah Department of Health, hand delivered a "Statement of Findings and Plan of Correction" to the facility. The Statement of Findings indicated that BoL found the facility to have violated R432-150-10(1)(c) of the Utah State Licensing regulations at a "Class 1" level. Findings include: During a review of 17 employee records of licensed staff currently working in the facility was done on 4/17/02 which revealed the following: Two LPN's were documented as working on expired licenses. One nurse had a copy of the expired professional license in the file (employee 2) and the other nurse's file (employee 3) had no copy of the professional license. Both licenses expired 1/31/02. Eight of the files had no copy of the professional license in their files (employees 4, 5, 6, 7, 8, 9, 10, 11). Two of the employee files had copies of professional licenses which were not current (employees 12, 13). During an interview with the facility DON on 4/17/02, she stated that the facility did not have a system in	F 492	Effective **5/01/02**, copies of employee's current professional licenses will be obtained upon hire. At least quarterly, a review of professional licenses will be done and a report provided to the Quality Assurance committee. This will be monitored by the Administrator, Director of Nursing or designee.	

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F 492	Continued From page 20 place to ensure that all licensed employees had current professional licenses. She also stated that the facility did not have a system in place to monitor that all currently employed licensed staff had up to date copies of their professional licenses on file in the facility. During the exit conference on 4/18/02, one of the facility owners stated each employee had two files in the facility and that the copy of current licenses were in the files and she would provide the current copies of the licenses on the following day. On 4/19/02, the facility owner provided further documentation from the facility. The facility was unable to provide copies of licenses for 5 current employees (employees 4, 5, 6, 7, 12).	F 492		
{F 521} SS=L	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 review of the quality assurance (QA) minutes, dated 3/27/02 and 4/2/02 and the results of the second follow-up performed by the survey team on 4/16/02 through 4/17/02, it was determined that the facility did not identify issues or implement appropriate plans of action to correct identified quality deficiencies.	{F 521}	**F521** To ensure the facility is identifying potential issues and putting in place action plans to address those issues, the following action has been taken: 1. The Quality Assurance committee will meet at least quarterly and will review at a minimum the following: a. Review of Survey Deficiencies b. Psychotropic Medications c. Falls/Injuries d. Infection Control e. Restraints f. Staff Requirements (licenses, permits, BCI, TB, etc.) g. Environmental/Life Safety h. Other issues as necessary	

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{F 521}	Continued From page 21 Findings include: A review of the facility's quality assessment and assurance committee meeting minutes, dated 3/27/02 and 4/2/02, on 4/16/02 revealed the following: The facility's quality assessment and assurance committee minutes did not identify that the facility failed to investigate and report to the state agency an incident of misappropriation of resident property. (Refer to Tag F-225) The facility's quality assessment and assurance committee minutes did not identify and the facility did not have policies or procedures in place to screen potential licensed employees. (Refer to Tag F-226) The quality assurance and assessment committee failed to monitor the effectiveness of the implemented plan pertaining to therapeutic diets. Non-compliance in the area of therapeutic diets [Tag F-326] was identified during the 1/16/02 re-certification survey. Continued non-compliance was identified during the 3/14/02 follow-up survey and again during the 4/17/02 follow-up survey. (Refer to Tag F-326)	{F 521}	2. A weekly Department Head meeting will also be held to review goals, objectives and to identify potential issues. 3. A "census" or "stand-up" meeting will be conducted daily to communicate information regarding: a. Admissions/Discharges b. Dr. Appointments c. Falls/Injuries d. Activities for the day e. MDS's Due f. Room Changes g. ▲ of Condition/Infection h. Significant Drug changes/IV's i. Resident/Family Complaints The Administrator will be responsible for ensuring that a Quality Assurance program is functioning with the facility. **Implemented on 4/26/02.**	