Utah Department of Health

MAR 2004
402085 HD

PRINTED: 3/4/2004
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ______	2/26/2004

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 226 SS=C	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 review of the facility's policy and procedures, review of the facility personnel files and interviews, it was determined that the facility did not develop a policy and procedure to call the State nurse aide registry prior to allowing a nurse aide to provide direct resident care. In addition, the facility failed to contact the State nurse aide registry for 4 of 4 nurse aides (Employee E1, E2, E3 and E4) hired, and the nurses aides had been providing resident care since their hire dates. Findings include: 1. Anti-Abuse Policy for Residents: The Abuse Policy and Procedures did not address under the "Protocol for Screening New Hires" to call the State nurse aide registry prior to allowing a nurse aide to provide direct resident care. 2. Facility Personnel Files: A. E1 was hired as a nurse aide on 9/22/03. The personnel file of E1 was reviewed on 2/24/04. The personnel file did not contain any	F 226 F226	The information contained herein shall be provided to the QA committee at their next regularly scheduled meeting. We do not agree with the deficiencies cited herein or the scope and severity cited. However, to remain in the Medicare/Medicaid programs we are required to provide a plan of correction. We therefore submit the following. The Abuse Policy and Procedures have been amended to include calling the State nurse aide registry prior to allowing a nurse aide to provide direct resident care. A new policy and procedure for all new hires has been written to assign responsibilities for each step of the employment process and a check off sheet designed which must be certified complete and correct to the administrator before he will authorize active employment of any new hire. A spread sheet has been designed to track all required certifications and licenses held by employees. The Human Resources Assistant will review all new hires and current licenses on the last business day of the month and report to the Administrator for presentation to the QA committee at their next meeting.	4/19/04

3/24/04 POC acceptable with addendum completion date 4/19/04

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3/19/04

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are 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 226	Continued From page 1 documentation to evidence that the facility had sought information from the State nurse aide registry regarding E1 prior to allowing her to serve as a nurse aide. B. E2 was hired as a nurse aide on 9/22/03. The personnel file of E2 was reviewed on 2/24/04. The personnel file did not contain any documentation to evidence that the facility had sought information from the State nurse aide registry regarding E2 prior to allowing him to serve as a nurse aide. C. E3 was hired as a nurse aide on 2/11/04. The personnel file of E3 was reviewed on 2/24/04. The personnel file did not contain any documentation to evidence that the facility had sought information from the State nurse aide registry regarding E3 prior to allowing him to serve as a nurse aide. D. E4 was hired as a nurse aide on 10/16/03. The personnel file of E4 was reviewed on 2/24/04. The personnel file did not contain any documentation to evidence that the facility had sought information from the State nurse aide registry regarding E4 prior to allowing her to serve as a nurse aide. 3. Interviews: On 2/24/04 at 2:40 PM, the Director of Nurses stated that she had not called the State nurse aide registry on any of the hired nurse aides. On 2/24/04 at 2:45 PM, the facility receptionist stated that she calls the nurse aide registry but she had not called on E3 because he was just hired and she did not call on E1, E2 or E4 because they were hired prior to her being	F 226		

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F 226	Continued From page 2 assigned the job duty.	F 226		
F 241 SS=D	483.15(a) QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined the facility did not provide, one sampled and four additional residents, a dignified dining environment; thus, placing residents at risk of diminished self-esteem and self-worth (resident identifiers 16, 27, 30, 41, 63). Findings include: 1. Observation of resident's 27,30, 41 and 63 on 2/23/04, 2/24/04 and 2/25/04 during the breakfast and 2/25/04 during the noon meal are as follows: Resident 27, 41 and 63 was observed being feed by staff during the meals and each resident had a lap buddy on their wheelchair during the entire meal time. Resident 30 was observed to feed himself with assistance and also had a lap buddy on the wheelchair during the entire meal time. 2. On 2/26/04 at 7:40 AM, resident 16 was laying at the end of her bed with her feet touching the ground. Resident 16 had dried food on her chin and her clothing. Resident 16 had a bedside table next to her feet which had a meal tray on it. The meal tray had a glass of milk, a glass of water, a cup of orange juice, a cup of medpass, cup of coffee, cup of yellowish milk, bowl of green	F 241 OK	All residents with lap buddies will have them removed from their wheelchairs and the chairs positioned close to the table with wheels locked or transferred to regular chairs to provide a more dignified and secure eating experience All nursing staff have been in-serviced on the necessity of this procedure. The DON or representative will monitor the procedure weekly for 8 weeks and keep a record of results in a POC logbook, to ensure compliance. Thereafter, monitoring will be done at least monthly, with documentation. Results shall be presented to the QA committee at their next meeting. Resident 16 will have her care plan amended to reflect that she will be given an extra hour to eat, and will be offered help if the meal is not consumed during the normal time The tray will then be removed from the room, even though resident objects, in order to satisfy requirements. A non-time sensitive snack and beverage will be offered, on a tray, to resident when the meal tray is removed in an effort to comfort resident and assuage anxiety, which develops when her food tray is taken from her.	4/19/04

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F 241	Continued From page 3 jello, a slice of wheat bread, puree meat, vegetables and mashed potatoes with gravy on it. The meal tray appeared to be being eaten from and some of the food was dry and crusty. There were drops of food on the floor at the resident's feet and around the bedside table. On 2/26/04 at 7:50 AM, the facility's Assistant Director of Nurses stated that resident 16 will not let the nurse aides pick up the meal trays and that the resident has a care plan to replace the old trays with new trays. The ADON proceeded to go into resident 16's room and pick the meal tray up. On 2/26/04 at 7:55 AM, the facility night nurse stated that resident 16's tray was from dinner the night before and that she tried on four different occasions to pick the tray up and the resident would not let her. When the night nurse was asked if she tried to replace the old tray with a new tray the facility night nurse stated that she did not offer another tray to resident 16.	F 241		
F 279 SS=B	483.20(k) RESIDENT ASSESSMENT The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under s483.25; and Any services that would otherwise be required	F 279		

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F 279	Continued From page 4 under s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that for 9 of 15 sample residents (Residents 9, 11, 12, 16, 22, 34, 39, 46 and 47), the facility did not develop comprehensive care plans for each resident based on their individual needs identified by the facility staff. Findings include: 1. Resident 11 was admitted to the facility on 9/14/03, with diagnoses including dementia, diabetes mellitus type II, congestive heart failure, renal insufficiency, and gastroesophageal reflux disease. An admission MDS (minimum data set) assessment, dated 10/14/03, documented that resident 11 needed extensive assistance with dressing, extensive assistance with toilet use, extensive assistance with personal hygiene, had frequent bladder incontinent episodes, diabetes mellitus and an indwelling catheter. The RAPS (resident assessment protocol summary) for the admission assessment triggered ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, and falls. The facility staff checked the box indicating that they would proceed with care planning. Observations of resident 11 from 2/23/04 to 2/26/04, revealed that he had oxygen on per nasal canula.	F 279	All MDS's will be checked for correlation with care plans and if conflicts or lacks are found the offending document will be rewritten to reflect the most accurate assessment of residents and best meet their needs . A temporary plan of care will be initiated within 4 hours of admission by the admitting charge nurse and care plans by diagnoses will be completed within 72 hours of admission. The care plan will be completed within the 14 day period required as soon as the RAPS are completed. When a charge nurse obtains telephone orders, they will be responsible for updating the care plan, and sign off the all applicable actions required by the telephone order have been, or are being accomplished and shall sign the order. Copies of all orders shall be placed in the DON/ADON mailbox for review for action and accuracy. All licensed nursing staff will be in-serviced on the appropriate procedures. The DON will keep a log of new admissions and will check daily to ensure care plans and MDS's are being completed within the prescribed time periods. The DON shall be responsible to ensure the MDS/Care Plan review is completed in a timely manner. The DON will report to the QA committee at regular meetings on completion of these tasks.	4/19/04

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F 279	Continued From page 5 A review of resident 11's plan of care revealed that an indwelling catheter, ADL's, diabetes mellitus, urinary tract infections, falls and oxygen use had not been incorporated into his plan of care. 2. Resident 34 was re-admitted to the facility 12/2003, with the diagnoses including Alzheimers, urinary tract infections (UTI), and backache. A 30 day MDS assessment dated 1/13/04, documented that resident 34 needed extensive assistance with transfers, does not walk, needs extensive assistance with dressing, needs limited assistance with eating, needs extensive assistance with hygiene, was frequently incontinent of bowel, incontinent of bladder, history of falls, and restraints. A review of resident 34's plan of care revealed that ADL's, incontinence, falls and restraints had not been incorporated into her plan of care. 3. Resident 47 was re-admitted to the facility on 1/4/04, with the diagnoses of non-Hodgkin Lymphoma, reflux, anemia, osteoporosis, renal failure, neuropathy and hypertension. Review of resident 47's care plans on 2/23/04, revealed that the only care plan she had in place was "adjustment to placement." It was documented in resident 47's medical record that she had an indwelling catheter, PICC line, routine lab draws, chronic UTI's, pneumonia, U shaped wedge, antibiotics, ADL needs, pain and restraints. 4. Resident 12 was admitted to the facility on 12/12/03, with diagnosis which included pneumonia, asthma, psoriasis, pulmonary fibrosis and blindness.	F 279		

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Review of resident 12's medical record revealed that she had an indwelling catheter and was on psychotropic medications.

A review of resident 12's plan of care revealed that an indwelling catheter and psychotropic medications had not been incorporated into her plan of care.

5. Resident 16 was re-admitted to the facility on 7/12/03, with diagnosis which included Huntington's chorea, constipation, chronic back pain, chronic sinusitis and depression.

On 2/26/04 at 7:40 AM, resident 16 was laying at the end of her bed with her feet touching the ground. Resident 16 had dried food on her chin and her clothing. Resident 16 had a bedside table next to her feet which had a meal tray on it. The meal tray had a glass of milk, a glass of water, a cup of orange juice, a cup of medpass, cup of coffee, cup of yellowish milk, bowl of green jello, a slice of wheat bread, puree meat, vegetables and mashed potatoes with gravy on it. The meal tray appeared to be being eaten from and some of the food was dry and crusty. There were drops of food on the floor at the resident's feet and around the bedside table.

On 2/26/04 at 7:50 AM, the facility's Assistant Director of Nurses stated that resident 16 will not let the nurse aides pick up the meal trays and that the resident has a care plan to replace the old trays with new trays. The ADON proceeded to go into resident 16's room and pick the meal tray up.

On 2/26/04 at 7:55 AM, the facility night nurse stated that that resident 16's tray was from dinner the night before and that she tried on four

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F 279	Continued From page 7 different occasions to pick the tray up and the resident would not let her. When the night nurse was asked if she tried to replace the old tray with a new tray the facility night nurse stated that she did not offer another tray to resident 16. A review of resident 38's plan of care revealed a care plan which addressed under problem that resident 38 refused to let staff take her tray after meals. Facility staff documented under goals that the resident would eat her meals in a timely fashion, that there would be no left over food in her room, that the resident would be clean every shift and no food on the floor. The facility staff documented that they would review this care plan on 1/4/04. There was no documented evidence that facility staff reviewed or updated this plan of care to meet the resident needs. 6. Resident 22 was originally admitted to the facility on 12/17/03, with diagnosis which included obesity, hypertension, diabetes, sleep apnea, anemia, osteoarthritis, edema, muscle spasms and constipation. Review of resident 22's medical record revealed she had obesity, had an open abdominal wound and a low albumin (protein) level. An admission MDS assessment was completed for resident 22 on 12/24/03. The RAPS for the admission MDS assessment triggered nutritional status and the facility staff checked the box indicating that they would proceed with care planning. A review of resident 22's plan of care on 2/24/04, did not reveal a care plan addressing her nutritional status.	F 279		

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F 279	Continued From page 8 On 2/11/04, a physician's order was written for bladder retraining. The order was written to clamp the indwelling catheter every hour for 24 hours, then every 2 hours for 24 hours, then every 4 hours for 24 hours and then to discontinue. On 2/23/04 and 2/24/04, resident 22 was observed to still have an indwelling catheter in place. There was no physician order in resident 22's medical record to continue with the indwelling catheter after the bladder retraining. A review of resident 22's plan of care revealed that the bladder retraining had not been incorporated into her plan of care. 7. Resident 9 was admitted to the facility on 6/8/02, with diagnoses of Cancer with skin graft to head, osteoarthritis, insomnia, hypertension, dementia with psychotic features and anxiety, and chronic obstructive pulmonary disease. Review of resident 9's medical record was completed on 2/24/04. The following was documented on resident 9's quarterly MDS dated 4/27/03, under Section H. Continence; a., O and b. 1, the resident is continent of bowel and usually continent of bladder. The quarterly MDS dated 1/5/04 documents, Continence ; a., 2 and b., 2, that resident 9 is occasionally incontinent. The current care plan documented that resident 9 was incontinent of bowel and bladder. In an interview with staff member E5, he stated that resident 9 was continent and never really had any problems. During the course of the survey, 2/23/04 to 2/26/04, no episodes of incontinence were observed with.	F 279		

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F 279	Continued From page 9 8. Resident 39 was admitted to the facility on 12/12/03, with diagnoses of chronic Alzheimer's disease, chronic renal insufficiency hyperglycemia and aspiration pneumonia. Review of resident 39's medical record was completed on 2/26/04. The following was documented on resident 39's admission MDS dated 12/24/03, under Section C. 2. Communication; hearing aide present and used. The current care plan did not address resident 39's use of hearing aides. 9. Resident 46 was admitted on 12/26/03, with diagnoses that included asthma, chronic back pain, dementia and chronic obstructive pulmonary disease. Review of resident 46's medical record was completed on 2/26/04. The following was documented on resident 46's admission MDS dated 12/23/03, under Section P. Special Treatments and Procedures, g., oxygen therapy. The current care plan did not address resident 46's use or need for oxygen.	F 279		
F 286 SS=B	483.20(d) Resident Assessment A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review, the facility did not maintain Minimum Data Set (MDS) assessments	F 286		

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F 286	Continued From page 10 completed within the previous 15 months in the resident's active record for 4 of 15 sample residents. Resident identifier: 22, 34, 47 and 59, Findings include: 1. Resident 34 was re-admitted to the facility 12/12/03, with the diagnoses including Alzheimers, urinary tract infections (UTI), and backache. Resident 34 had a discharge tracking form completed on 12/9/03, which documented "return anticipated." There were no MDS assessments in resident 34's active medical record before 12/18/03. 2. Resident 47 was re-admitted to the facility on 1/4/04, with the diagnoses of non-Hodgkin Lymphoma, reflux, anemia, osteoporosis, renal failure, neuropathy and hypertension. Resident 47 had a discharge tracking form completed on 12/19/03, which documented "return anticipated." There were no MDS assessments in resident 47's active medical record. 3. Resident 59 was admitted to the facility on 5/22/03 with the diagnoses including chronic pain, asthma, enlarged heart, pneumonia and hip placement. There were no MDS assessments in resident 59's active medical record 4. Resident 22 was originally admitted to the	F 286	ok All medical charts will be audited to ensure they contain the required MDS's. The DON will do a random audit of 25 chart's to ensure MDS compliance and shall note the names on the charts in the POC log book. Quarterly, the DON, or representative, shall review all charts which have had quarterly reviews for adequate MDS's and shall document the review in the POC log book. Results shall be reported to the QA committee at it's next regular meeting.	4/19/04

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F 286	Continued From page 11 facility on 12/17/03 with diagnoses which included urinary tract infection, hypertension, reflux, osteoarthritis, edema, muscle spasms and anemia. A complete review of resident 22's active medical record was done on 2/24/04. The medical record did not contain any MDS's.	F 286		
F 309 S=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on observation, interviews and medical record review, it was determined that the facility did not provide necessary care and services for 4 of 15 sampled residents. Specifically, resident CL2 did not receive prompt services when she presented with signs of Coumadin therapy complications. Resident 16 did not receive a swallow evaluation as ordered by her physician, Additionally, resident 22 did not receive prompt services when her physician ordered bladder retraining and discontinuation of her indwelling catheter and resident 47 did not receive prompt services when her physician ordered her indwelling catheter to be changed.	F 309		

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F 309	Continued From page 12 Findings include: Coumadin is an oral anticoagulant used to control and prevent clotting disorders. Prescribing the dose that both avoids bleeding complications and achieves therapeutic range clotting times requires monitoring through laboratory tests. The prothrombin time (PT) is a laboratory test used for monitoring blood clotting time in a specific individual. (Reference Guidance: Brunner and Suddarth's textbook of Medical-Surgical Nursing 8th edition 1996 Lippincott pages 802-803). The International Normalized Ratio (INR), is another laboratory test used in conjunction with prothrombin time in determining if therapeutic doses of anticoagulant medication are being administered. (Reference Guidance: Physician's Desk Reference 53 Edition 1999 Medical Economics Company page 932) 1. Resident CL2 was admitted to the facility on 12/22/03 with diagnosis which included femur neck fracture, congestive heart failure, hypokalemia, hypertension and Alzheimers. Resident CL2's medical record was reviewed on 2/26/04. A review of admission orders, dated 12/22/03, revealed the following: Coumadin 2.5 milligrams (mg) every day for 4 weeks and then discontinue; Draw PT/INR on Monday, Wednesday and Friday. Resident CL2's, January 2004, re-certification orders, documented on 12/31/03 the Monday, Wednesday and Friday PT/INR were discontinued.	F 309	All licensed staff have been in-serviced on the new policy and procedures for the handling of Telephone Orders (TO's). All TO originals will be reviewed daily by the DON or representative before being transferred to medical records The DON or rep will check all charts for residents experiencing a change of condition likely to generate TO's, to ensure policy requirements are being met. These checks shall be done daily for 8 weeks, then shall be done 3 times weekly for 8 weeks and weekly thereafter. The DON shall document the charts checked by name and date in the POC log book. All licensed staff have been in-serviced on new policy and procedures for the treatment of lab orders and use of the Lab Log Book. The DON or representative shall check the Lab Log Book daily for compliance for a period of 8 weeks and weekly thereafter. The person checking the Lab Log Book shall initial and date the book each time it is checked. Resident 16 is on a puree diet and will be encouraged by staff members to tuck in chin, sit up straight and take time to swallow completely. The order for a swallow evaluation was discontinued 2/27/04 per physician order Resident 22's bladder training program was completed and catheter removed 2/24/04 per physician's order. The DON or representative will monitor the treatment book daily for 8 weeks and then weekly thereafter, initialing and dating book each time it is checked. When items are needed for resident care, the request will immediately be placed in the central supply box which has been installed	4/19/04

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F 309	Continued From page 13 Based on the admission orders and January 2004 re-certification orders, resident CL2 should have had a PT/INR on 12/24/03, 12/26/03 and 12/29/03. There was no documentation in resident CL2's medical record to evidence that the PT/INR for 12/29/03 had been performed as ordered. On 12/31/03 at 10:00 AM, a facility nurse documented the following in a nursing progress note. "New order for PT/INR. Notify MD (medical doctor) of results - to be drawn 1/02/04." On 12/31/03, the physician wrote an order for a PT/INR on 1/2/04. The physician also documented on the order that he wanted to be notified of the results. There was no documentation in resident CL2's medical record to evidence that the PT/INR was drawn and that the physician was notified of the results. On 1/5/04 on the 7:00 PM to 7:00 AM shift, a facility nurse documented the following on the "24 Hour Nursing Care Record, "Res (resident) was found on the floor about 0200 (2:00 AM). No apparent injury...." On 1/7/04 at 10:00 AM, a facility nurse documented the following on the "24 Hour Nursing Care Record, "Pt (patient) has (zero) edema. Pt has [zero] c/o (complaints of) pain, HA (headache) or dizziness...Pt has [zero] c/o (complaints of) SOB(shortness of breath) or chest pains...." On 1/8/04 at 10:00 AM, a facility nurse documented the following on the "24 Hour	F 309	at each nurse's station. If it is an emergency need, the central supply supervisor shall be called by telephone. If they are not available, the DON, ADON or Administrator shall be called to obtain needed supplies. If the need is not an emergency, the Central Supply Supervisor shall notify nursing of the expected arrival of the item, if not in stock. Nursing shall then notify the Doctor and DON if the item will not arrive in time to meet requirements and await further instructions. All appropriate staff members have been in-serviced on the new procedures. The DON will report to the QA committee at regular meetings on the above policies and procedures and how they are working.	

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F 309	Continued From page 14 Nursing Care Record, "...Pt (patient) has [zero] c/o (complaints of) SOB(shortness of breath), chest pain or dizziness." On 1/9/04 at 10:00 AM, a facility nurse documented the following on the "24 Hour Nursing Care Record, "Pt (patient) has [zero] edema [and] [zero] c/o (complaints of) pain SOB (shortness of breath) or dizziness..." On 1/10/04, the graveyard nurse for 1/9/04 documented the following on the "24 Hour Nursing Care Record, "...Intermittent sleep [with] yelling. Zero urinary output since 0500 (5:00 AM) 1-9-04 to 2230 (10:30 PM) 1-9-04. [resident 22's physician] informed of this by phone...PT__ [unreadable] Sig (? significant) oral bleeding." There was no documentation to evidence that the graveyard nurse had also informed the physician that resident CL2 had oral bleeding. There was no documentation of an injury in resident CL2's medical record that would have explained the bleeding from her mouth. The January 2004 MAR (medication administration record) documented that resident CL2 received her Coumadin 2.5 mg on 1/9/04 at 5:30 PM. On 1/10/04, blood specimens were collected, from resident CL2, for a CBC (complete blood count), BMP (basic metabolic panel) and a PT/INR. Resident 22's WBC (white blood cell) count was 16.4. The WBC count was deemed high per the laboratory utilized by the facility. Resident CL2's PT level was 34.2 seconds and her INR was 8.5 seconds. These PT/INR results were deemed critically high per the laboratory, utilized by the facility.	F 309		

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On 1/10/04, a facility nurse documented the following in a nursing progress note, "[increased] confusion WBC [increased] 16.4 [and] results called to [resident 22's physician and physician's assistant] pt (patient) started on Levaquin 250 mg po (by mouth) [every] day [times] 5 days...Pt has old dried blood coming from oral cavity, unable to accurately assess source of bleeding, but appears to be gums or sores on lips...Call into [resident 22's physician and physician's assistant] [with] above assessment; left message [and] no return call yet..." There was no documentation to evidence that the facility nurse informed resident 22's physician of the critically high PT/INR.

The January 2004 MAR documented that resident CL2 received her Coumadin 2.5 mg on 1/10/04 at 5:30 PM.

Based on PT/INR laboratory test values, facility staff obtained a physician telephone order the next day on 1/11/04 to hold resident CL2's Coumadin until further notice and to administer Vitamin K 10 mg subcutaneous times one now. The physician also ordered to recheck resident CL2's PT/INR on 1/12/04 and 1/14/04.

Resident CL2 died on 1/11/04. Due to her death, facility staff were not able to recheck the PT/INR on 1/12/04 and 1/14/04.

On 1/11/04 at 10:00 AM, a facility nurse documented the following in a nursing progress note, "Notified M.D. (medical doctor) abnormal labs see T.O. (telephone order) for N.O. (nursing order) family notified. Res (resident) condition poor, no po (by mouth) intake unresponsive to verbal stimuli family request hospice..."

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F 309	Continued From page 16 On 2/26/04 at 2:45 PM, the facility nurse who was caring for resident CL2 on 1/11/04, stated that he found the laboratory results dated 1/10/04, with the critical PT/INR sitting on the nurse's desk. He further stated that there was no evidence that the physician had been notified of the critical PT/INR on 1/10/04, so he called the physician and got the order to hold the Coumadin and administer the Vitamin K. The facility nurse further stated that resident CL2 had some bleeding coming from her mouth, she had a high INR and that could have been contributing to the bleeding. On 2/26/04 at 3:15 PM, a representative that worked for the laboratory service. utilized by the facility, was interviewed over the phone. She stated the laboratory had documented that a facility staff member was informed of resident CL2's high critical values of the PT/INR on 1/10/04. She further stated that the lab had collected a PT/INR for resident CL2 on 12/24/03, 12/26/03 and 1/10/04. On 2/26/04 at 3:45 PM, resident CL2's physician's assistant was interviewed. He stated that complications of an elevated PT/INR could include gastrointestinal bleeding as well as intercranial hemorrhaging. When asked if bleeding from the mouth was a complication of Coumadin therapy, he stated it could be. Resident CL2's physician's assistant stated that he did not recall being informed of the PT/INR drawn on 1/10/04 nor could he recall being informed of any oral bleeding. 2. Resident 16 was re-admitted to the facility on 7/12/03 with diagnosis which included Huntington's chorea, constipation, chronic back pain, chronic sinusitis and depression.	F 309		

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F 309	Continued From page 17 A review of resident 16's admission orders, dated 7/12/03, revealed the following: Speech swallow evaluation. On 7/14/03, resident 16 was seen at a hospital due to a fall which resulted in a left rib fracture. The re-admission orders, revealed the following: Monitor eating- would benefit from chin tuck. On 7/15/03, resident 16's physician wrote the following order, "swallowing evaluation recommended secondary to difficulties while eating." There was no documentation in resident 16's medical record of a swallow evaluation being completed. On 2/26/04 at 10:00 AM, a physical therapist at the facility was interviewed. He stated he had not been aware that resident 16 needed a swallow evaluation. On 2/26/04 at 10:15 AM, the DON (director of nurses) stated that she had looked through resident 16's medical record and could not find a speech evaluation. At 12:15 PM, the DON stated that she contacted the speech therapist and the speech therapist did not have any documented evidence that a swallow evaluation had been completed for resident 16. 3 Resident 22 was originally admitted to the facility on 12/17/03 with diagnosis which included obesity, hypertension, diabetes, sleep apnea, anemia, osteoarthritis, edema, muscle spasms and constipation. On 2/11/04 resident 22's physician wrote the following order, "...Start bladder training-	F 309		

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clamp/unclamp catheter [every] hr (hour) [times] 24, then [every] 2 [hours times] 24 [hours] then [every] 4 [hours] - then dc (discontinue)."

Based on the 2/11/04 physician's order, resident 22 should have had her indwelling catheter discontinued on 2/14/04.

Resident 22 was observed by a nurse surveyor on 2/23/04 and 2/24/04, with her indwelling catheter still in place.

On 2/24/04 at 12:55 PM, the RN (registered nurse) caring for resident 22 was interviewed. He stated that he did not know resident 22 was to begin a bladder retraining on 2/11/04. He further stated that he would call resident 22's physician to find out what to do next.

On 2/24/04 at 1:00 PM, resident 22 stated that facility staff members have come at different times and clamped the indwelling catheter and then come back and unclamp it. Resident 22 further stated that she did not know when the indwelling catheter would be discontinued.

On 2/24/04 at 1:30 PM, the DON stated that she worked on 2/20/04 and found the order for resident 22's bladder retraining on 2/11/04. The DON further stated that she could not find any documentation that the bladder retaining was done so she initiated the schedule of clamping and un-clamping the indwelling catheter on 2/20/04 (9 days after the physician wrote the order). When the DON was asked why the indwelling catheter was not discontinued on 2/23/04, the DON replied that she did not know and now the retraining would have to start all over again.

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F 309	Continued From page 19 Resident 47 was re-admitted to the facility on 1/4/04, with the diagnoses of reflux, neuropathy, osteoporosis, renal failure, and hypothyroidism. A physician order for resident 47, dated 1/21/04 documented, "[change] foley today, within 1 week [change] foley to Bard Silver Impregnated, [change] Q (every) month". A nurses note for resident 47, dated 1/21/04 documented. "...[change] foley today. Within 1 week [change] foley to Bard Silver impregnated [change] Q month." A treatment sheet for resident 47, dated 1/04 documented a foley catheter change was completed on 1/21/04. A treatment sheet for resident 47, dated February 2004, documented a foley catheter change was completed on 2/4/04. Based on the physician order dated 1/21/04, resident 47 should have had her indwelling catheter changed to the Bard Silver Impregnated catheter by 1/28/04. There was no documented evidence in resident 47's medical record that the catheter was changed by 1/28/04. On 2/26/04 at 11:00 AM, the ADON (assistant director of nurses) and the central supply manager were interviewed. They stated that the Bard Silver Catheter was ordered on 1/29/04. The central supply manager brought the surveyors the invoice which documented that the catheter was ordered on 1/29/04 (10 days after the physician ordered it) and shipped on 1/29/04 (the same day). The central supply manager also stated that the medical supply company used, reported that the catheter would arrive in 3-4	F 309		

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F 309	Continued From page 20 working days. Making the delivery date of the catheter, either 2/2/04 or 2/3/04. The catheter was changed on 2/4/04. A physician's telephone order for resident 47 dated 2/4/04 documented, "UA/C&S (urinary analysis and culture and sensitivity) to rule out UTI (urinary tract infection)." A nurses note for resident 47, dated 2/4/04, prior to the new catheter being inserted, documented to "obtain a UA/C&S to rule out UTI." A nurses note documented that the lab was received on 2/4/04 at 2:00 PM and was faxed to resident 47's physician. A physician's telephone order for resident 47, dated 2/5/04, documented "Macrobid 100 mg (milligrams) PO (by mouth) BID (twice a day) X (times) 10 days for UTI, Vancomycin 1 gram IV (intravenously) QD (every day) X 3 days for UTI, et (and) Primaxin 500 mg IV Q (every) 8 [hours] X 10 days for UTI." A nurses note for resident 47, dated 2/5/04 at 6:00 PM documented "[physician] ordered Macrobid 100 mg PO BID X 10 days for UTI, Vancomycin 1 gram IV QD X 3 days for UTI, et Primaxin 500 mg IV Q 8 [hours] X 10 days for UTI.	F 309		
F 326 SS=D	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.	F 326		

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F 326	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, interviews and medical record review, it was determined that for 1 of 15 sample residents, the facility did not ensure that the resident received a therapeutic diet when there was a nutritional problem as evidenced by: Resident 22 experienced a significant weight loss, had a low albumin level and an abdominal wound and did not receive a diet as recommended by the facility's registered dietitian. Findings include: 1. Resident 22 was originally admitted to the facility on 12/17/03 and re-admitted to the facility on 2/5/04 with diagnosis which included obesity, hypertension, diabetes, sleep apnea, anemia, osteoarthritis, edema, muscle spasms and constipation. Resident 22 was admitted with an abdominal wound that was infected with MRSA (methicillin resistant staphylococcus aureus) and VRE (vancomycin resistant enterococcus). A lab (laboratory) value taken at the facility and dated 2/12/04 showed an albumin (a protein indicator of malnutrition) level of 3.3 g/dl. An albumin level of 3.0- 3.5 g/dl is considered a mild visceral protein deficit. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 200, page 22). There were no documented weighs for resident 22 in her medical record. Resident 22's medical record did not contain a dietary physician order. A "Change of Diet" slip, dated 2/5/04, in resident 22's medical record,	F 326	The person responsible for weighing residents and recording their weights has received discipline for failure to weigh and record the weight of all residents as required. The Dietary Manager has received discipline for failure to communicate necessary information to the Registered Dietitian. Policy and procedures have been written for a weekly meeting to communicate between the nursing dept, dietary dept, and therapy dept. This meeting is to identify those residents who are nutritionally at risk, and communicate their additional requirements from each department, both to the department and to the Registered Dietitian Consultant. Minutes of the meeting shall be provided to the DON, and Administrator as well as the participants. Results of the meetings shall be provided to the QA committee at their regular meetings.	4/19/04

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F 326	Continued From page 22 documented that resident 22 was on a 1500 calorie diet. On 2/24/04 at 11:00 AM, the RD (registered dietitian) stated that she was not aware of the albumin of 3.3 g/dl on 2/12/04. When the RD was asked about resident 22's weight, the RD stated that on the 12/18/03 assessment she obtained the weight of 384 lbs (pounds) from a hospital stay that resident 22 had in December of 2003. When the RD was asked for a current weight on resident 22, the RD was unable to find one. The RD further stated that the 1500 calorie diet recorded on the "Change of Diet" slip would not meet resident 22's protein needs and that due to the decreased albumin and infected abdominal wound she would not restrict resident 22's caloric intake. On 2/24/04 at 12:30 PM, the RD reported that she obtained resident 22's weight and it was 339 lbs. (This represented a 45 lb (11.7%) weight loss in a 2 month period, which was significant). The RD further stated that due to the low albumin, infected abdominal wound and weight loss, she made recommendations and handed the nurse surveyor four pieces of paper, which documented the following: Kcal needs = 2610 calories per day for maintenance. Protein needs = 131 grams per day for healing and repletion. An SNP (special nutritional program) mechanical soft, NAS (no added salt) and NCS (no concentrated sweets) diet with an 8 oz (ounce) glass of milk three times a day with meals. A night time snack to include a protein snack and drink.	F 326		

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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 ______	2/26/2004

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 326	Continued From page 23 The RD stated that even though the "Change of Diet" slip dated 2/5/04, documented a 1500 calorie diet, that the facility had been providing resident 22 with the SNP, NCS, NAS diet. The RD documented that resident 22 ate 100% of her meals and received approximately 130 grams of protein per day. The RD calculated that resident 22 required 131 grams of protein per day to promote would healing and repletion. On 2/25/04 at 8:05 AM, resident 22 was observed to receive her breakfast tray. A dietary card on resident 22's tray indicated that she was to receive a SNP diet and a glass of milk with her meals. Resident 22's meal consisted of juice, water, coffee, cream of wheat, 1 hard boiled egg, 1 piece of wheat toast and an orange slice. Resident 22 ate everything on her tray except for the cream of wheat. On 2/25/04 at 8:20 AM, the DM (dietary manager) stated that anyone on an NCS - SNP diet would have received super cereal (oatmeal with high protein milk) on their breakfast tray. Resident 22 was not observed to receive milk or the super cereal with her breakfast tray on 2/25/04. On 2/25/04 at 8:40 AM, a facility nursing assistant stated that resident 22 never eats the hot cereal because she does not like it. On 2/25/04 at 12:05 PM, resident 22 was observed to receive her lunch tray. Resident 22's meal consisted of milk, water, juice, green jello, pears, rice, meat with gravy, carrots and a piece of wheat bread with butter. Resident 22 drank 100% of the milk, water and juice. Resident 22 ate 100 of the green jello, 10% of the rice, 10% of	F 326		

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F 326	Continued From page 24 the meat with gravy, 10% of the carrots and none of the pears. On 2/25/04 at 12:15 PM, the DM stated that for lunch residents on a NCS - SNP diet would have received SNP pudding (sugar free pudding, whole milk and sugar free instant breakfast) on their trays. Resident 22 was not observed to receive the SNP pudding with her lunch tray on 2/25/04. During the meal observations on 2/25/04, resident 22 was not observed to receive the SNP diet, she was not observed to receive 8 oz of milk with her breakfast meal and she was not observed to consume a 100% of either of the meals. On 2/25/04 at 12:25 PM, the DM stated that resident 22 had been refusing the SNP diet. The DM further stated that she and the RD discussed resident 22's nutritional status on 2/24/04, but that she did not let the RD know resident 22 was refusing the SNP diet because "it slipped my mind."	F 326		
F 354 SS=C	483.30(b)(1)-(3) NURSING SERVICES Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge	F 354 ok		

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F 354	Continued From page 25 nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on the review of the Staffing Schedule for February of 2004, the census of 64 and an interview with the Director Of Nursing (DON), it was determined that the facility used the DON as a charge nurse to work the floor. Findings include: Review of the nursing schedule for the month of February documented that the DON had been scheduled to work the floor as a charge nurse on 2/14/ 04, 2/15/04, 2/21/04 and 2/22/04. On 2/24/04 at 1:30 PM, the facility DON stated that she worked on the floor as the RN on 2/20/04. On 2/25/04 at 11:10 AM, The DON also said that she had been scheduled to work the floor when she was short staffed.	F 354	The DON has been ordered to cease functioning as a charge nurse and if employed staff is not adequate, to obtain the services of temporary nurses, until adequate staff can be recruited. The facility is currently attempting to recruit additional nurses, even though there is a known shortage of qualified nurses in the area. Results of the recruiting campaign and the amount of agency staff used shall be reported to the QA committee by the DON at regular meetings.	4/19/04
F 360 SS=D	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 interview, medical record review and observations, it was determined that the facility did not ensure resident 22 was provided with a diet that met her special dietary needs. Specifically, resident 22 experienced a significant weight decline, had a laboratory value reflecting	F 360		

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F 360	Continued From page 26 malnutrition and an open abdominal wound, with no documented dietary intervention implemented to ensure she received a diet that would meet her nutritional needs. Findings include: 1. Resident 22 was originally admitted to the facility on 12/17/03 and re-admitted to the facility on 2/5/04 with diagnosis which included obesity, hypertension, diabetes, sleep apnea, anemia, osteoarthritis, edema, muscle spasms and constipation. Resident 22 was admitted and readmitted with an open abdominal wound that was infected with MRSA (methicillin resistant staphylococcus aureus) and VRE (vancomycin resistant enterococcus). An initial nutritional assessment for resident 22 was completed by the RD (registered dietitian) on 12/18/03. The RD's recommendations included an SNP (special nutritional program), NAS (no added salt) and NCS (no concentrated sweets) diet. The RD documented that resident 22 ate 100% of her meals. The RD documented that resident 22's current weight was 384 lbs (pounds) and that resident 22 had an abdominal wound with MRSA and VRE. The RD documented that resident 22's Kcal (calorie) needs were 2760 - 3234 calories per day and that her protein needs were 120 grams per day. There were no other documented dietary assessments or dietary progress notes in resident 22's medical record. There were no documented weighs for resident 22 in her medical record.	F 360	Policy and procedures have been written for a weekly meeting to communicate between the nursing dept, dietary dept. and therapy dept. This meeting is to identify those residents who are nutritionally at risk and communicate their additional requirements from each department, both to the department and the registered dietitian consultant. Both the Dietary manager and the person responsible for weighing residents have been disciplined for failure to do their jobs and failure to request assistance from management. Minutes of the meeting shall be provided to the DON and the Administrator as well as the participants. Results of the meetings shall be provided to the QA committee at their regular meetings.	4/19/04

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F 360	Continued From page 27	F 360		

Resident 22's medical record did not contain a dietary physician order. A "Change of Diet" slip, dated 2/5/04, in resident 22's medical record, documented that resident 22 was on a 1500 calorie diet. The RD calculated on 12/18/03, that resident 22 required 2760 to 3234 calories per day. The diet provided to resident 22 was not meeting the calorie needs the RD had calculated on 12/18/03.

A lab (laboratory) value taken at the facility and dated 2/12/04 showed an albumin (a protein indicator of malnutrition) level of 3.3 g/dl. An albumin level of 3.0- 3.5 g/dl is considered a mild visceral protein deficit. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 200, page 22).

On 2/24/04 at 11:00 AM, the RD stated that she had not re-assessed resident 22's nutritional needs when she was re-admitted to the facility after a hospital stay. The RD further stated that she was not aware of the albumin of 3.3 g/dl on 2/12/04. When the RD was asked about resident 22's weight, the RD stated that on the 12/18/03 assessment she obtained the weight of 384 lbs (pounds) from a hospital stay that resident 22 had in December of 2003. When the RD was asked for a current weight on resident 22, the RD was unable to find one. The RD further stated that the 1500 calorie diet recorded on the "Change of Diet" slip would not meet resident 22's protein needs and that due to the decreased albumin and infected abdominal wound she would not restrict resident 22's caloric intake. The RD also stated that due to the infected abdominal wound she would recommend that resident 22 receive zinc and vitamin C.

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F 360	Continued From page 28 On 2/24/04 at 12:30 PM, the RD reported that she obtained resident 22's weight and it was 339 lbs. (This represented a 45 lb (11.7%) weight loss in a 2 month period, which was significant). The RD further stated that due to the low albumin, infected abdominal wound and weight loss, she made recommendations and handed the nurse surveyor four pieces of paper, which documented the following: Kcal needs = 2610 calories per day for maintenance. Protein needs = 131 grams per day for healing and repletion. An SNP mechanical soft, NAS and NCS diet with an 8 oz (ounce) glass of milk three times a day with meals. A night time snack to include a protein snack and drink. The RD stated that even though the "Change of Diet" slip dated 2/5/04, documented a 1500 calorie diet, that the facility had been providing resident 22 with the SNP, NCS, NAS diet. The RD documented that resident 22 ate 100% of her meals and received approximately 130 grams of protein per day. The RD calculated that resident 22 required 131 grams of protein per day to promote would healing and repletion. On 2/25/04 at 8:05 AM, resident 22 was observed to receive her breakfast tray. A dietary card on resident 22's tray indicated that she was to receive a SNP diet and a glass of milk with her meals. Resident 22's meal consisted of juice, water, coffee, cream of wheat, 1 hard boiled egg, 1 piece of wheat toast and an orange slice. Resident 22 ate everything on her tray except for the cream of wheat.	F 360		

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F 360	Continued From page 29 On 2/25/04 at 8:20 AM, the DM (dietary manager) stated that anyone on an NCS - SNP diet would have received super cereal (oatmeal with high protein milk) on their breakfast tray. Resident 22 was not observed to receive milk or the super cereal with her breakfast tray on 2/25/04. On 2/25/04 at 8:40 AM, a facility nursing assistant stated that resident 22 never eats the hot cereal because she does not like it. On 2/25/04 at 12:05 PM, resident 22 was observed to receive her lunch tray. Resident 22's meal consisted of milk, water, juice, green jello, pears, rice, meat with gravy, carrots and a piece of wheat bread with butter. Resident 22 drank 100% of the milk, water and juice. Resident 22 ate 100 of the green jello, 10% of the rice, 10% of the meat with gravy, 10% of the carrots and none of the pears. On 2/25/04 at 12:15 PM, the DM stated that for lunch residents on a NCS - SNP diet would have received SNP pudding (sugar free pudding, whole milk and sugar free instant breakfast) on their trays. Resident 22 was not observed to receive the SNP pudding with her lunch tray on 2/25/04. During the meal observations on 2/25/04, resident 22 was not observed to receive the SNP diet, she was not observed to receive 8 oz of milk with her breakfast meal and she was not observed to consume a 100% of either of the meals. On 2/25/04 at 12:25 PM, the DM stated that	F 360		

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F 360	Continued From page 30 resident 22 had been refusing the SNP diet. The DM further stated that she and the RD discussed resident 22's nutritional status on 2/24/04, but that she did not let the RD know resident 22 was refusing the SNP diet because "it slipped my mind."	F 360		
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. This REQUIREMENT is not met as evidenced by: Based on observations, confidential resident interviews, a confidential interview with a group of residents and temperature checks of resident trays, it was determined that the facility did not serve food that was palatable and at the proper temperature. Findings Include: On 2/23/04 at 7:00 AM, a confidential interview was done with an alert and oriented resident. When asked about the temperature of the food, the resident stated that the food is not the best and many times the food was cold. On 2/24/04 at 1:30 PM, a confidential group interview was done with alert and oriented residents. When asked about the temperature of the food, six out of nine residents stated that the food was served cool.	F 364 OK	The Dietary Manager will provide a report each day in the morning management meeting of temperatures taken of 10 per cent of the trays served the previous day with an equal number of temperatures taken from each meal and the temperatures of each item on the tray. Temperatures taken during the weekend shall be reported on Monday. The Administrator shall oversee the taking of temperatures for at least three meals per week. Daily temperatures shall be taken for 4 weeks, and from at least 7 meals per week thereafter, with the samples coming from various times of day. The Administrator will randomly sample temperatures of food served. Weekly written reports of temperatures shall be made to the Administrator with the daily log book available for inspection at any time by management. The Dietary Manager shall report on temperature samplings to the QA committee at regularly scheduled meetings.	4/19/04

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F 364	Continued From page 31 On 2/25/04, during the lunch meal, a test tray was obtained. The test tray was taken from the kitchen at 12:15 PM. The temperatures were taken of the food and beverage items on the test tray. The gravy was 105.8 degrees Fahrenheit, the meat was 124.5 degrees Fahrenheit, and the rice was 113.5 degrees Fahrenheit. On 2/26/04, during the lunch meal, a test tray was obtained. The test was taken from the kitchen at 12:20 PM. The temperatures were taken of the food and beverage items on the test tray. The spinach was 106 degrees Fahrenheit, the squash was 101.3 degrees Fahrenheit, the gravy was 106 degrees Fahrenheit, and the meat was 119.3 degrees Fahrenheit.	F 364		
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility did not store, distribute, serve and prepare food under sanitary conditions as evidenced by: multiple foods and beverages which were either expired and not labeled and/or dated in the refrigerators in the kitchen and the pantry and observation of improper sanitizer concentrations in the solutions used by kitchen staff to sanitize and clean the kitchen. Findings include: 1. The following observations were made during	F 371 CK	The Dietary Manager has been instructed to destroy any foods which are out of date, unlabelled, or unfit for use. Kitchen staff have been in-serviced that personal foods are to be kept in the refrigerator in the break room and placing personal items in the kitchen will result in disciplinary action. The Administrator will tour the kitchen, cool areas and storage areas weekly, for 8 weeks and monthly thereafter to observe if sanitary regulations are being met. The Dietary Consultant will be instructed to also observe the area for regulation violations. Kitchen staff has been in-serviced on the appropriate dilution of cleaning solutions. Concentrations shall be checked by the Administrator during his normal surveys. The Plant Operations Manager shall randomly check dilution of cleaning	4/19/04

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F 371	Continued From page 32 the initial kitchen tour on 2/23/04 from 6:20 AM to 7:00 AM. In the walk-in refrigerator: a. There was a pan with 1/2 sandwiches in it, which was not labeled or dated. b. There was one small container of salad, which had (a staff members name) on it. c. There was a container of peanut butter which had an open crack in the rim approximately 3 inches. d. There was a small container with a cream lid that had a white substance in it, which was not labeled or dated. e. There were 2 pans, one small and one large that had meat in them, which were not labeled or dated. f. There was one pan of meat dated 2/22 and had "lunch Monday" written on it, which was not labeled. g. There was half of one gallon of fat free milk with the date 2/7 written on the lid and Feb. 17 printed on the milk container. At 6:47 AM the dietary aide took the milk out of the refrigerator and brought it back at 6:50 AM with some milk gone. h. One 46 oz. container of tomato juice opened, and dated 2/2. i. There was one container of cottage cheese opened and had a printed date of 2/14. j. There was one head of lettuce that was moldy and dated 1/8. k. There was 2 heads of lettuce which were moldy. l. There were 2 green peppers which were moldy. m. There was one container of chicken flavor base which was opened and dated 8/11 and 8/22. n. There was one large white bucket that had a crusty white substance on the outside, just below	F 371	solutions. The two open areas in the ceiling were there due to the maintenance department removing and repairing the ceiling where damage had occurred from roof leaks, which could not be patched until the outside ambient temperature reached at least 40 degrees Fahrenheit. The repairs were completed as expeditiously as possible. The Dietary Manager has received discipline. The Administrator shall report on his surveys of the kitchen area to the QA committee at regular meetings.	

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F 371	Continued From page 33 the rim, which was not labeled or dated. o. There was one container of beef base which was opened and dated 8/11 and 8/22. In the dry storage: a. There was one container of semi-sweet chocolate chips, which was not labeled or dated. b. There was one can of mushrooms, tomato sauce and beets, which were dented. In the walk-in freezer: a. There was one bag of meat that was opened, which was not labeled or dated. b. There were 2 brown bags, which were not labeled or dated. c. There was one bag of cookie dough that was opened, which was not dated. d. There was one large bag of breadsticks that was opened, which was not dated. In the kitchen: a. On 2/23/04, the food service supervisor was asked to check the concentration of the sanitizer solution in both buckets used to store cleaning rags. At 6:30 AM, the bucket by the sink was checked. At 6:32 AM the bucket by one of the work counters was checked. During the check of both buckets, a test strip was submerged into the solution for approximately 20 seconds by the food service supervisor. When the test strips were taken from the solution, they were over 200 ppm (parts per million), which would indicate too much sanitizer solution. There was one large and one small bucket next to the tray line by the silverware and plates. On the ceiling just above the buckets, by the vent, were 2 open areas. When the surveyor asked the kitchen staff why the buckets were there, the staff replied "from water leaking, because the	F 371		

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F 371	Continued From page 34 snow is melting." 2. The following observations were made on 2/24/04. In the walk-in refrigerator: a. There was one small container of salad half eaten, which had (a staff members name) on it. b. There was a container of peanut butter which had an open crack in the rim approximately 3 inches. c. There was a small container with a cream lid that had a white substance in it, which was not labeled or dated. d. One 46 oz. container of tomato juice opened, and dated 2/2. e. There was one container of cottage cheese opened and had a printed date of 2/14. f. There was 2 heads of lettuce which were moldy. g. There were 2 green peppers which were moldy. h. There was one container of chicken flavor base which was opened and dated 8/11 and 8/22. i. There was one large white bucket that had a crusty white substance on the outside, just below the rim, which was not labeled or dated. j. There was one container of beef base which was opened and dated 8/11 and 8/22. In the dry storage: a. There was one container of semi-sweet chocolate chips, which was not labeled or dated. b. There was one can of mushrooms, and tomato sauce, which were dented. In the walk-in freezer: a. There was one bag of meat that was opened, which was not labeled or dated. b. There were 2 brown bags, one opened, which	F 371		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 35 were not labeled or dated. c. There were 3 bags of cookie dough that were opened, which were not dated. d. There was one large bag of breadsticks that was opened, which was not dated.	F 371		
F 426 SS=F	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. This REQUIREMENT is not met as evidenced by: Based on interview, review of resident medical records and observation of medication pass, it was determined that the facility did not provide pharmaceutical services (including the accurate administration of drugs) to meet the needs of its residents. Specifically, one sampled resident did not receive an antibiotic as ordered (Resident 38), two other sampled residents (Residents 11 and 48) with insulin dependent diabetes did not receive the correct amount of insulin based upon the sliding scale as ordered by the physician. Additionally, stock medications had been removed from labeled pharmacy bottles and placed in sterile urine cups. Findings include: 1. Resident 48 was a admitted to the facility on 1/2/04 with the diagnoses of Diabetes Mellitis type II, Hypothyroidism, dementia, hypertension, congested heart failure and insomnia.	F 426	Nurses involved with the improper administration of insulin and/or failure to check blood sugars as ordered received discipline and medication error forms completed. Licensed nurses were in-serviced on the proper use of the sliding scale for insulin administration. The DON will monitor the blood sugar documentation daily for all residents with Drs. Orders for blood sugar checks for 4 weeks, and then weekly thereafter for three months or until the DON determines that random checks are adequate. All antibiotics will be given within four hours of receipt of the Drs. order to do so, unless otherwise specified by the physician. Nursing staff has been informed that no medications may be dispensed from other than the factory labeled containers. All meds in improperly labeled containers were destroyed. Licensed nursing staff has been in-serviced on the above procedures. The DON will report results of monitoring the compliance on these procedures to the QA committee at regular meetings.	4/19/04

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Upon admission to the facility, nurses had a physician's order to provide regular insulin based on the results of resident 48's blood sugars (BS). The sliding scale ordered was as follows:

151 - 200 = 2 U (units)
201 - 300 = 4 U
301 - 350 = 8 U
351 - 400 = 12 U
greater than 400 = 15 U

Nursing staff at the facility were obtaining resident 48's blood sugars (BS) twice a day (at 6:00 AM and 5:00 PM).

On 11/26/03 at 6:00 AM, facility staff recorded a BS of 178. Based on the physician's orders, the resident should have received 2 units of regular insulin, but instead received none.

On 12/18/03 at 5:00 PM, facility staff recorded a BS of 193. Based on the physician's orders, the resident should have received 2 units of regular insulin, but instead received none.

On 12/21/03 at 6:00 AM, facility staff recorded a BS of 151. Based on the physician's orders, the resident should have received 2 units of regular insulin, but instead received none.

On 12/29/03 at 6:00 AM, facility staff recorded a BS of 179. Based on the physician's orders, the resident should have received 2 units of regular insulin, but instead received none.

On 1/1/04 at 6:00 AM, facility staff recorded a BS of 153. Based on the physician's orders, the resident should have received 2 units of regular insulin, but instead received none.

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F 426	Continued From page 37 On 1/2/04 at 6:00 AM, facility staff recorded a BS of 175. Based on the physician's orders, the resident should have received 2 units of regular insulin, but instead received none. On 1/5/04 at 5:00 PM, facility staff recorded a BS of 152. Based on the physician's orders, the resident should have received 2 units of regular insulin, but instead received none. On 1/23/04 at 6:00 AM, facility staff recorded a BS of 194. Based on the physician's orders, the resident should have received 2 units of regular insulin, but instead received none. On 1/28/04 at 6:00 AM, facility staff recorded a BS of 180. Based on the physician's orders, the resident should have received 2 units of regular insulin, but instead received none. There was no documentation to evidence that BS were obtained on 12/6/03 at 6:00 AM, 12/25/03 and 12/26/03 at 5:00 PM, 12/29/03 at 6:00 AM, 1/3/04 and 1/4/04 at 6:00 AM, and 1/10/04 at 6:00 AM. 2. Resident 38 was re-admitted to the facility on 1/24/04 with diagnoses which included osteoporosis, aphasia, coronary artery disease, hypotension and urosepsis. A review of resident 38"s medical record and MAR (medication administration record) was completed on 2/25/04. Resident 38's admitted orders from the hospital dated 1/24/04, revealed a physician's order for Levaquin (an antibiotic) 250 mg (milligrams) for 5 days, Review of the January 2004 MAR revealed that	F 426		

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F 426	Continued From page 38 the Levaquin was not started until 1/28/04, 4 days after the physician's order. On 1/28/04 at 10:30 AM, a facility nurse documented the following in a nurse's progress note, "Pt (patient) started on Levaquin this AM. ordered on discharge from hospital, wife just brought in to facility...." On 2/25/04 at 10:40 AM, the director of nurses (DON) stated that resident 38's wife did not bring the Levaquin to the facility until 4 days after he was re-admitted. When asked if resident 38's medications were filled by the pharmacy service the facility uses, the DON replied that they were. She further stated that she did not obtain a clarifying order from resident 38's physician to begin the Levaquin 4 days after the original order. 3. On 2/23/04 at approximately 7:30 AM, the facility registered nurse (RN) was observed to dispense a white pill from a sterile urine cup which had CA+500 vit D written on the lid in pen. The medication cart the RN was administering medication from was observed to have 7 different sterile urine cups with medications in them. The sterile urine cups were marked as follows: a. DSS/Colace was written on the lid, a dosage was not written on the cup. There were orange gel capsules in the cup. b. EC ASA was written on the lid, a dosage was not written on the cup. There were orange as well as while pills in the cup. c. Iron was written on the lid, a dosage was not written on the cup. There were light green, medium green as well as dark green pills in the cup. d. CA+500VitD was written on the lid. There	F 426		

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F 426	Continued From page 39 were green oblong pills in the cup. e. APAP 500 MG was written on the lid. There were round as well as oblong pills in the cups. f. Vit C was written on the lid, a dosage was not written on the cup. There were round white pills in the cup. g. APAP 325 mg written on the lids. There were round white pills in the cup. When the RN was asked by the nurse surveyor how she knew that the medication written on the lid of the sterile cups was what she was administering the RN stated "I would not know." She further stated that the medication carts were all stocked this way. She further stated that she was not sure who took the medications out of the labeled pharmacy bottles and placed them into the sterile urine cups. On 2/23/04 at 12:50 PM, the second facility medication cart was observed to have 6 different sterile cups with medications in them. The sterile cups were marked as follows: a. APAP 500 mg was written on the lid. There were round as well as oblong white pills in the cup. b. DSS Colace was written on the lid, a dosage was not written on the cup. There were orange gel capsules in the cup. c. Iron was written on the lid, a dosage was not written on the cup. There were light green round pills in the cup. d. Vit C was written on the lid, a dosage was not written on the cup. There were white round pills in the cup. e. Ca+ Vit D was written on the lid, a dosage was not written on the cup. There were green oblong pills in the cup. f. APAP 325 mg was written on the lid. There were round white pills in the cup.	F 426		

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F 426	Continued From page 40 On 2/23/04 at 1:00 PM, the facility's DON was interviewed. She stated that the medications were put into the sterile urine cups for staff convenience while administering medications. The facility DON was then observed to take the sterile urine cups out of the medication carts. On 2/23/03 at 12:50 PM, the third facility medication cart was observed to have 8 different sterile cups with medications in them. The sterile cups were marked as follows: a. ES Tylenol 500 mg was written on the lid. There were white pills in the cup. b. Fe was written on the lid, a dosage was not written on the cup. There were light green round pills in the cup. c. Vitamin C 500 mg was written on the lid. There were white pills in the cup. d. Tylenol 325 mg was written on the lid. There were white pills in the cup. e. Calcium Vit D 500 mg was written on the lid. There were green pills in the cup. f. Colace 100 mg was written on the lid. There were red pills in the cup. g. ASA 325 mg was written on the lid. There were white pills in the cup. h. MVI was written on the lid. There was one red pill and the rest were peach colored pills in the cup. A facility LPN (licensed practical nurse) was interviewed on 2/23/04 at 1:00 PM. He stated that the pills are in the sterile urine specimen cups for "staff convenience." The LPN also stated that it is easier than bending down in the bottom drawer for the larger bottles. While the surveyor was talking to the the LPN, the administrator came up to the LPN and stated,	F 426		

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F 426	Continued From page 41 "you need to empty those bottles immediately." Pointing to the sterile urine specimen cups with the pills in them. 4. Resident 11 was admitted 9/14/03 with the diagnoses of dementia, diabetes mellitus type 2, arthritis, congestive heart failure, hypertension and renal insufficiency. The medical record of resident 11 was reviewed on 2/24/04. During this review, it was noted that a physician's order and nursing care referral form dated October 13, 2003 documented to "check finger stick qac/qhs (every morning and every night) for bs (blood sugars) 0-50 give 1A D50 (1 ampule of dextrose 50) 50-70 orange juice, 70-110 do nothing, 110-150 2 u (units) insulin, 151-200 4 u insulin, 201-250 6 u insulin, 251-399 8 u insulin, 301-350 10 u insulin, >351 12 u insulin & call physician." From November 1 through 26, 2003, a total of 26 days, facility nurses either did not give insulin when needed, did not check BS or did not notify the physician of a high BS, for resident 11 ten times. On 11/1/03, at 8:00 PM, the blood sugar for resident 11 was 188. Facility nurses should have given 2 units of insulin, but instead gave none. On 11/2/03, at 8:00 PM, the blood sugar for resident 11 was 223. Facility nurses should have given 2 units of insulin, but instead gave none. On 11/3/03 at 6:00 AM, the blood sugar for resident 11 was 283. Facility nurses should have given 6 units, but instead gave none. On 11/3/03 at 8:00 PM, the blood sugar for	F 426		

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F 426	Continued From page 42 resident 11 was 336. Facility nurses should have given 8 units, but instead gave none. On 11/4/03 at 8:00 PM, the blood sugar for resident 11 was 336. Facility nurses should have given 8 units, but instead gave none. On 11/9/03 at 8:00 PM, the blood sugar for resident 11 was 175. Facility nurses should have given 2 units, but instead gave none. On 11/12/03 at 8:00 PM, there was no blood sugar taken on resident 11. On 11/15/03 at 8:00 PM, the blood sugar for resident 11 was 261. Facility nurses should have given 6 units of insulin, but instead gave none. On 11/22/03 at 8:00 PM, the blood sugar for resident 11 was 213. Facility nurses should have given 4 units of insulin, but instead gave none. On 11/26/03 at 6:00 AM, there was no blood sugar taken on resident 11. A physician's recert order documented a blood sugar change dated 11/24/03. For BS 150-200 give 2 units reg. (regular) insulin, 201-250 give 4 units insulin, 251-300 give 6 units of insulin, 301-350 give 8 units insulin, 351-400 give 10 units insulin and for BS >351 call MD. From December 14 through 27, 2003, a total of 14 days, facility nurses either did not give insulin when needed, did not check BS or did not notify the physician of a high BS, for resident 11 eight times. On 12/14/03 at 8:00 PM, the blood sugar for resident 11 was 294. Facility nurses should have	F 426		

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F 426	Continued From page 43 given 6 units of insulin, but instead gave none. On 12/15/03 at 8:00 PM, the blood sugar for resident 11 was 271. Facility nurses should have given 6 units of insulin, but instead gave none. On 12/16/03 at 6:00 AM, there was no blood sugar taken on resident 11. On 12/18/03 at 6:00 AM, the blood sugar for resident 11 was 275. Facility nurses should have given 6 units of insulin, but instead gave none. On 12/24/03 at 8:00 PM, the blood sugar for resident 11 was 200. Facility nurses should have given 2 units of insulin, but instead gave none. On 12/25/03 at 8:00 PM, there was no blood sugar taken on resident 11. On 12/27/03 at 8:00 PM, the blood sugar for resident 11 was 367. Facility nurses should have notified the physician of the high blood sugar. There was no documentation in resident 11's medical record of the physician being notified. From January 1 through 31, 2004, a total of 31 days, facility nurses either did not give insulin when needed, did not check BS or did not notify the physician of a high BS, for resident 11 eighteen times. On 1/1/04 at 8:00 PM, there was no blood sugar taken on resident 11. On 1/4/04 at 6:00 AM, there was no blood sugar taken on resident 11. On 1/9/04 at 6:00 AM, the blood sugar for resident 11 was 205. Facility nurses should have	F 426		

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F 426	Continued From page 44 given 4 units of insulin, but instead gave none. On 1/9/04 at 8:00 PM, there was no blood sugar taken on resident 11. On 1/10/04 at 6:00 AM, the blood sugar for resident 11 was 179. Facility nurses should have given 2 units of insulin, but instead gave none. On 1/10/04 at 8:00 PM, the blood sugar for resident 11 was 380. Facility nurses should have notified the physician of the high blood sugar. There was no documentation in resident 11's medical record that the physician was notified. On 1/112/04 at 8:00 PM, the blood sugar for resident 11 was 368. Facility nurses should have notified the physician of the high blood sugar. There was no documentation in resident 11's medical record that the physician was notified. On 1/14/04 at 8:00 PM, there was no blood sugar taken on resident 11. On 1/22/04 at 8:00 PM, there was no blood sugar taken on resident 11. On 1/23/04 at 8:00 PM, there was no blood sugar taken on resident 11. On 1/24/04 at 8:00 PM, the blood sugar for resident 11 was 379. Facility nurses should have notified the physician of the high blood sugar. There was no documentation in resident 11's medical record that the physician was notified. On 1/26/04 at 6:00 AM, there was no blood sugar taken on resident 11. On 1/28/04 at 6:00 AM, the blood sugar for	F 426		

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F 426	Continued From page 45	F 426		

resident 11 was 201. Facility nurses should have given 4 units of insulin, but instead gave none.

On 1/29/04 at 6:00 AM, the blood sugar for resident 11 was 150. Facility nurses should have given 2 units of insulin, but instead gave none.

On 1/30/04 at 3:00 PM, the blood sugar for resident 11 was 252. Facility nurses should have given 6 units of insulin, but instead gave none.

On 1/31/04 at 6:00 AM, the blood sugar for resident 11 was 176. Facility nurses should have given 2 units of insulin, but instead gave none.

From February 3 through 25, 2004, a total of 22 days, facility nurses either did not give insulin when needed, did not check BS or did not notify the physician of a high BS, for resident 11 fourteen times.

On 2/3/04 at 8:00 PM, there was no blood sugar completed for resident 11.

On 2/6/04 at 6:00 AM, the blood sugar for resident 11 was 152. Facility nurses should have given 2 units of insulin, but instead gave none.

On 2/12/04 at 8:00 PM, the blood sugar for resident 11 was 363. Facility nurses should have notified the doctor of the high blood sugar. There was no documentation in resident 11's medical record that the physician was notified.

On 2/13/04 at 6:00 AM, the blood sugar for resident 11 was 186. Facility nurses should have given 2 units of insulin, but instead gave none.

On 2/13/04 at 8:00 PM, there was no blood sugar completed for resident 11.

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F 426	Continued From page 46 On 2/15/04 at 8:00 PM, the blood sugar for resident 11 was 388. Facility nurses should have notified the doctor of the high blood sugar. There was no documentation in resident 11's medical record that the physician was notified. On 2/16/04 at 6:00 AM, the blood sugar for resident 11 was 163. Facility nurses should have given 2 units of insulin, but instead gave none. On 2/16/04 at 8:00 PM, there was no blood sugar taken on resident 11. On 2/18/04 at 8:00 PM, the blood sugar for resident 11 was 384. Facility nurses should have notified the doctor of the high blood sugar. There was no documentation in resident 11's medical record that the physician was notified. On 2/20/04 at 6:00 AM, the blood sugar for resident 11 was 230. Facility nurses should have given 4 units of insulin, but instead gave none. On 2/20/04 at 8:00 PM, there was no blood sugar taken on resident 11. On 2/22/04 at 6:00 AM, the blood sugar for resident 11 was 170. Facility nurses should have given 2 units of insulin, but instead gave none. On 2/23/04 at 6:00 AM, the blood sugar for resident 11 was 162. Facility nurses should have given 2 units of insulin, but instead gave none. On 2/2/04 at 6:00 AM, the blood sugar for resident 11 was 221. Facility nurses should have given 4 units of insulin, but instead gave none. There was no documentation in nurses notes or	F 426		

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F 426	Continued From page 47 anywhere else in resident 11's medical record that any insulin was given on the dates which documented no insulin given. During an interview with the ADON (assistant director of nurses) on 2/25/04, she stated that no insulin was given to resident 11 on the dates where it was blank.	F 426		
F 502 S=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 interview and record review, it was determined that the facility did not obtain laboratory services for 2 of 15 sample residents (Resident CL2 and 16), as ordered by the physician. Findings include: Coumadin is an oral anticoagulant used to control and prevent clotting disorders. Prescribing the dose that both avoids bleeding complications and achieves therapeutic range clotting times requires monitoring through laboratory tests. The prothrombin time (PT) is a laboratory test used for monitoring blood clotting time in a specific individual. (Reference Guidance: Brunner and Suddarth's textbook of Medical-Surgical Nursing 8th edition 1996 Lippincott pages 802-803). The International Normalized Ratio (INR), is	F 502		

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	465108	A. BUILDING ______ B. WING ______	2/26/2004

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 502	Continued From page 48 another laboratory test used in conjunction with prothrombin time in determining if therapeutic doses of anticoagulant medication are being administered. (Reference Guidance: Physician's Desk Reference 53 Edition 1999 Medical Economics Company page 932). 1. Resident CL2 was admitted to the facility on 12/22/03 with diagnosis which included femur neck fracture, congestive heart failure, hypokalemia, hypertension and Alzheimers. Resident CL2's medical record was reviewed on 2/26/04. A review of admission orders, dated 12/22/03, revealed the following: Coumadin 2.5 milligrams (mg) every day for 4 weeks and then discontinue; Draw PT/INR on Monday, Wednesday and Friday. Resident CL2's, January 2004, re-certification orders, documented on 12/31/03 the Monday, Wednesday and Friday PT/INR were discontinued. Based on the admission orders and January 2004 re-certification orders, resident CL2 should have had a PT/INR on 12/24/03, 12/26/03 and 12/29/03. There was no documentation in resident CL2's medical record to evidence that the PT/INR for 12/29/03 had been performed as ordered. On 12/31/03, the physician wrote an order for a PT/INR on 1/2/04. The physician also documented on the order that he wanted to be notified of the results. There was no documentation in resident CL2's medical record to evidence that the PT/INR was drawn and that	F 502	All licensed staff have been in-serviced on the new policy and procedures for the handling of Telephone Orders (TO's). All TO originals will be reviewed daily by the DON or representative before being transferred to medical records. The DON or representative will check all charts for residents experiencing a change of condition likely to generate TO's to ensure procedure requirements are being met. These checks shall be done daily for 8 weeks, then shall be done 3 times weekly for 8 weeks and weekly thereafter. The DON shall document the charts checked by name and date in the POC log book. All licensed staff have been in-serviced on new policy and procedures for the treatment of lab orders and the use of the Lab Log Book. The DON or representative shall check the Lab Log Book daily for compliance for a period of 8 weeks and at least weekly thereafter. The person checking the Lab Log Book shall initial and date the book each time it is checked. Resident 16 had a lab drawn 2/26/04. Albumin results were normal. The DON will report to the QA committee at regular meetings on the above policies and procedures. The Administrator, or representative shall ensure compliance with this plan of correction by monitoring that all required reports are made to the QA committee.	4/19/04

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 502	Continued From page 49 the physician was notified of the results. On 1/10/04, the graveyard nurse for 1/9/04 documented the following on the "24 Hour Nursing Care Record, ":..Intermittent sleep [with] yelling. Zero urinary output since 0500 (5:00 AM) 1-9-04 to 2230 (10:30 PM) 1-9-04. [resident 22's physician] informed of this by phone...PT___ [unreadable] Sig (? significant) oral bleeding." There was no documentation to evidence that the graveyard nurse had also informed the physician that resident CL2 had oral bleeding. On 1/10/04, blood specimens were collected, from resident CL2, for a CBC (complete blood count), BMP (basic metabolic panel) and a PT/INR. Resident 22's WBC (white blood cell) count was 16.4. The WBC count was deemed high per the laboratory utilized by the facility. Resident CL2's PT level was 34.2 seconds and her INR was 8.5 seconds. These PT/INR results were deemed critically high per the laboratory, utilized by the facility. On 1/10/04, a facility nurse documented the following in a nursing progress note, "[increased] confusion WBC [increased] 16.4 [and] results called to (resident 22's physician and physician's assistant) pt (patient) started on Levaquin 250 mg po (by mouth) [every] day [times] 5 days...Pt has old dried blood coming from oral cavity, unable to accurately assess source of bleeding, but appears to be gums or sores on lips...Call into (resident 22's physician and physician's assistant) [with] above assessment; left message [and] no return call yet..." There was no documentation to evidence that the facility nurse informed resident 22's physician of the critically high PT/INR. Based on PT/INR laboratory test values, facility	F 502		

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F 502	Continued From page 50 staff obtained a physician telephone order the next day on 1/11/04 to hold resident CL2's Coumadin until further notice and to administer Vitamin K 10 mg subcutaneous times one now. The physician also ordered to recheck resident CL2's PT/INR on 1/12/04 and 1/14/04. Resident CL2 died on 1/11/04. Due to her death, facility staff were not able to recheck the PT/INR on 1/12/04 and 1/14/04. On 2/26/04 at 2:45 PM, the facility nurse who was caring for resident CL2 on 1/11/04, stated that he found the laboratory results dated 1/10/04, with the critical PT/INR sitting on the nurse's desk. He further stated that there was no evidence that the physician had been notified of the critical PT/INR on 1/10/04, so he called the physician and got the order to hold the Coumadin and administer the Vitamin K. The facility nurse further stated that resident CL2 had some bleeding coming from her mouth, she had a high INR and that could have been contributing to the bleeding. On 2/26/04 at 3:15 PM, a representative that worked for the laboratory service, utilized by the facility, was interviewed over the phone. She stated the laboratory had documented that a facility staff member was informed of resident CL2's high critical values of the PT/INR on 1/10/04. She further stated that the lab had collected a PT/INR for resident CL2 on 12/24/03, 12/26/03 and 1/10/04. On 2/26/04 at 3:45 PM, resident CL2's physician's assistant was interviewed. He stated that complications of an elevated PT/INR could include gastrointestinal bleeding as well as intercranial hemorrhaging. When asked if bleeding from the mouth was a complication of	F 502		

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F 502	Continued From page 51 Coumadin therapy, he stated it could be. Resident CL2's physician's assistant stated that he did not recall being informed of the PT/INR drawn on 1/10/04 nor could he recall being informed of any oral bleeding. 2. Resident 16 was re-admitted to the facility on 7/12/03 with diagnosis which included Huntington's chorea, constipation, chronic back pain, chronic sinusitis and depression. On 1/7/04, the physician ordered an Albumin. There was no documentation in the medical record for resident 16 to evidence that this lab was performed as ordered. On 2/26/04 at 10:10 AM, the facility's assistant director of nurses stated that the Albumin ordered on 1/7/04 had not been completed. She further stated that the Albumin would be drawn today. (2/26/04) stat.	F 502		

Page 1 Changes –

F 279

Page 5, Line 12

Please replace " ..14 day period required as soon as the RAPS are completed" with the following "..within the required seven days after the completion of the comprehensive assessment."

F 326

Please add to our current plan on page 22:

Resident 22 was counseled by the Dietary Manager. Resident 22 agreed to consume her planned diet, in order to promote healing. Resident 22 has been placed on weekly weighings in order to monitor her progress. The RD issued a new diet for Res. 22 and checked on her consumption 3/23/04. Consumption of meals was less than 100 percent, The RD therefore counseled Resident 22 on 3/23/04 and was rewarded with an agreement to also consume two extra diabetic supplements to increase protein intake. The supplements were offered daily, beginning 3/24/04.

The Dietary manager will record daily and submit weekly (Monday mornings) to the Administrator and DON all foods actually placed on Resident 22's trays and the percentage consumed. Ten other trays will be audited and reported on weekly. The DON and/or the Administrator shall randomly monitor the contents of the trays to ensure veracity of the reports. This shall be continued for a period of 4 weeks. Random tray samplings to ensure the correct diet for all residents shall continue for 6 months following. Reports of admissions, readmissions, and discharges shall be reported to the DON daily and shall be checked by the DON and marketing departments and then distributed to all departments to ensure cognizance of the need for plan changes due to change in census. It shall be the responsibility of the nursing dept to bring all such reports to the Nutritionally At Risk meeting weekly. Results and reports shall be presented to the QA committee at regular meetings.

F 0360

Please add to our current plan on page 27:

Resident 22 was reviewed on 3/23/04 by the RD and since her meal consumption was less than 100 per cent, Res 22 was counseled by the RD and agreed to consume two extra diabetic dietary supplements daily to increase protein intake. Resident 22 has been placed on weekly weighings in order to monitor her progress. The supplements were offered daily beginning 3/24/04.

The Dietary Manager will record daily and submit weekly (Monday mornings) to the Administrator and DON all foods actually place on Resident 22"s trays and the percentage consumed. Ten other trays will be audited and report weekly. The DON and/or the Administrator shall randomly monitor the contents of the trays to ensure veracity of the reports. This shall be continued for a period of 4 weeks. Random tray samplings to ensure the correct diet for all residents shall continue for 6 months following. Reports of admissions, re-admissions, and discharges shall be reported to the DON daily and shall be checked by the DON and Marketing department the then distributed to all departments to ensure cognizance of the need for plan changes due to change in census. It shall be the responsibility of the nursing dept. to bring all such reports to the Nutritionally At Risk meeting weekly. Results and reports shall be presented to the QA committee at regular meetings.

F 0426

Please add to our plan on page 36:

The DON will inspect med carts weekly to ensure all stock meds are in factory labeled containers. All licensed staff have been in-serviced on the new policy and procedures for the handling of Telephone Orders (TO's). All original TO's will be reviewed daily by the DON or representative before

Page 2 changes

being transferred to medical records. The DON or rep will check all charts for residents experiencing a change of condition likely to generate TO's to ensure policy requirements are being met. The checks shall be done daily for 8 weeks, then shall be done 3 times weekly for 8 weeks and weekly thereafter. The DON shall document the charts checked by name and date in the POC log book.

The DON shall report results to the QA committee at regular meetings.