STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465112	A. BUILDING _____ B. WING _____	2/26/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CTR OF BOUNTIFUL	460 WEST 2600 SOUTH BOUNTIFUL, UT 84010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on observations, interviews and medical record review it was determined that the facility did not provide the necessary services to maintain the highest practicable mental and physical well-being for 3 of 22 sample residents, one resident who was allowed to sit in her wheelchair without the support of leg/foot rests, allowing her lower legs, feet and ankles to dangle above the floor, one resident who was not assessed or medicated for pain until 27 minutes after her request for pain medicine, and one resident who did not receive prompt compassionate response to her complaint of gastric discomfort. Residents: 8, 42 and 73. Findings include: 1. Resident 73 was a 94 year-old female who was admitted to the facility on 10/16/96 with diagnoses that included dementia and transient ischemic attack. Resident 73's medical record was reviewed on 2/26/03. The quarterly Minimum Data Set (MDS) assessment, dated 1/14/03, documented the resident was totally non-ambulatory (section G1,c and d) but had been able to propel herself in her wheelchair with limited assistance of staff (section G1,e). Resident 73's decision making skills were severely impaired,	F 309 OK HH 4/1/03	F 309 This facility does assure that each resident receives the necessary care and services to attain or maintain their highest practicable physical, mental and psychosocial well-being. SPECIFIC RESIDENTS: Resident # 73 has been fitted with appropriate wheel chair legs, which allow her feet to rest on the foot pedals. This was completed during the annual survey. Resident #8 has been put on a pain assessment monitor to assure pain is addressed and managed effectively. Resident #42's bowel regimen has been reviewed and adjustments made to assure effective management. The specific nurse responsible for the identified issues for residents # 8 and # 42 is no longer an associate in the facility. IDENTIFICATION OF POTENTIAL/SYSTEMATIC CHANGES: This concern has the potential to effect all residents in the facility. In order to assure compliance and prevent reoccurrence of this issue, the facility has put the following measures in place: • All licensed staff have been inserviced on the importance of responding immediately and appropriately to resident concerns.	4/11/03 4/11/03 4/11/03 2/27/03 4/11/03

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

Ronald Kay — Administrator — 3/20/03

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days aft such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1 (section B4) and her ability to communicate was impaired (sections C4 and C5). Resident 73 was observed on 2/25/03 and 2/26/03. Resident 73 sat on a pressure reliving gel-cushion that had been placed in her wheelchair. On 2/25/03, resident 73 was observed for 30 minutes during breakfast to be sitting in her wheelchair without leg/foot rests. Resident 73's feet were dangling approximately six inches above the floor. On 2/25/03, resident 73 was observed for 30 minutes during lunch to be sitting in her wheelchair without leg/foot rests. Resident 73's feet were dangling approximately six inches above the floor. On 2/26/03, resident 73 was observed for 30 minutes during breakfast and for 10 minutes after breakfast to be sitting in her wheelchair without leg/foot rests. Resident 73's feet were dangling approximately six inches above the floor. On 2/26/03 at 10:30 AM, resident 73 was observed for five minutes during an activity to be sitting in her wheelchair without leg/foot rests. Resident 73's feet were dangling approximately six inches above the floor. Resident 73 was not able to reach the floor with her feet to help propel herself, making her totally dependent upon staff for locomotion while she was in her wheelchair. Without leg rests on her wheelchair, the full weight of resident 73's lower legs and feet rested on the area behind her knees that came in contact with the edge of her wheelchair seat and would diminish the circulation to her lower extremities. On 2/26/03, three nurse aides who provided cares for resident 73 were interviewed. One nurse aide stated resident 73 didn't have leg rests. The nurse aides did not know where to find leg rests for resident 73's wheelchair. One nurse aide searched for leg rests in	F 309	• Residents have been educated, via resident council, on the importance of communicating issues with Department Managers to assure areas of concern are addressed immediately. • All staff have been educated on the importance of recognizing resident concerns and acting on those concerns timely, utilizing the facility "Concern and Comment" program. MONITORING: The Director of Nurses and Unit Managers will monitor for compliance through random resident interviews and staff interviews to assure concerns are addressed timely. QUALITY ASSURANCE: Identified ongoing areas of concern will be addressed as needed in the facility monthly QA meeting.	4/11/03 4/11/03

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F 309	Continued From page 2 resident 73's room, but was unable to find any. The nurse who was providing cares for resident 73, on 2/26/03, didn't know where the resident's leg rests were, but stated that there was a room with a lot of leg rests stored in it. 2. Resident 8 was a 77 year-old female who had admitted to the facility on 1/18/03 with diagnoses that included chronic back pain, urinary tract infection, hypertension and anxiety. The medical record for resident 8 was reviewed on 2/26/03. The admission MDS assessment for resident 8, that was signed as completed on 1/31/03, documented the resident had a short term memory impairment, that her long term memory was intact, and that she was "modified independence" for her decision making ability, meaning the resident had "some difficulty in new situations only" (sections B2 and B4). Resident 8 had not communication impairment (sections C4, C5 and C6). On 2/24/03 at 1:16 PM, an observation was made by a surveyor at the nurse's station of a communication between a nurse aide caring for resident 8 and the resident's nurse. The nurse aide reported that resident 8 wanted to know when she was due for a pain pill. The nurse replied, "Probably about now. I'll be with her in a minute." At 1:43 PM, 27 minutes after the resident had asked, resident 8's nurse took medication to her. The medication administration record for resident 8 was reviewed. Resident 8 had orders for prn (to be given as needed) Tylenol and Lortab prn to treat her chronic back pain. Resident 8's nurse did not assess the resident's level of pain before taking Tylenol to her in her room.	F 309		

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F 309	Continued From page 3 At 2:30 PM, resident 8 was interviewed in her room. Resident 8 was asked to identify her pain level on a scale of 1 to 10, where 10 means excruciating. The resident stated that, when she had asked for her pain medication, her pain level was an "8". Resident 8 stated that her pain, at the time of the interview, was at a level of "4". Resident 8 stated that sometimes it takes a long time after she asks for it before she gets her pain medication. Resident 8 said that sometimes, by then, the pain is just too bad. 3. Resident 42 was an 86 year-old female who was admitted to the facility on 12/31/02 with diagnoses that included arteriosclerotic heart disease, hypertension, infection and depression. Resident 42's medical record was reviewed on 2/26/03. The admission MDS assessment for resident 42 documented that the resident was independent for decision making (section B4) and had no problem with communication (sections C4, C5 and C6). Resident 42 was observed in the restorative dining room on 2/25/03 during breakfast. At 7:45 AM, resident 42 was observed to have her eyes closed and was holding her hands over her stomach. When an aide asked if she needed to go back to her room, resident 42 stated that she wanted to finish drinking her milk first. After drinking her milk, resident 42 said, " I'd really better go now." The aide took resident 42 to her room. At 8:24 AM, a nurse aide approached resident 42's nurse about her bowel problem. Resident 42's nurse stated, "She's just going to have to push harder." The nurse aide asked, "Has she had anything recently?" Resident 42's nurse stated, "I gave her a suppository yesterday."	F 309		

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F 309	Continued From page 4	F 309		
F 325 SS=G	483.25(i)(1) QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and staff interview it was determined that the facility did not ensure that a resident maintained acceptable parameters of nutritional status as evidenced by 1 of 22 sampled residents experienced significant weight loss with interventions which were not timely to prevent further weight decline. In addition, this resident had a laboratory value reflecting malnutrition. Calculating weight loss percentages is done by subtracting the current weight from the previous weight, dividing the difference by the previous weight and multiplying by 100. Significant weight losses are as follows: 5% in one month, 7.5% in 3 months and 10% in 6 months. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000). Resident identifier: 8 Findings include: Resident 8, a 77 year- old female, was admitted to the facility on 1/18/03 with diagnoses of chronic back pain, urinary tract infection, hypertension, esophagus reflux, anxiety and insomnia.	F 325 OK 4/1/03 DD	F 325 This facility does assure that residents maintain acceptable parameters of nutritional status. SPECIFIC RESIDENT: Resident #8: Nutritional needs have been addressed and interventions put in place. This resident prefers to remain in bed for meals, and frequently refuses to be repositioned at meals, while in bed. Resident's care plan has been updated to reflect this resident choice. Resident #8 has expressed a desire to continue with weight loss, and is now care planned for weight loss per resident choice. IDENTIFICATION OF POTENTIAL: This citation has the potential to impact all residents in the facility who are experiencing unidentified weight loss. SYSTEMATIC CHANGES: In order to assure compliance and prevent reoccurrence of this issue, the facility has implemented the following: • Resident weights are reviewed within 24 hours of weight taken to assure prompt awareness and action for resident identified to have significant weight loss. • Restorative aides have been educated on the facility policy to recheck resident	4-11-03 per phone c Adam Rem Kapp 4/1/03

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F 325	Continued From page 5 On 2/24/03, resident 8's medical record was reviewed. A review of resident 8's weight revealed the following: January 26, 2003 205.9 lbs (Pounds) February 2, 2003 203.2 lbs February 10, 2003 197.4 lbs February 16, 2003 192.2 lbs February 23, 2003 185.3 lbs Between February 2, 2003 and February 10, 2003 (8 days) resident 8 lost 5.8 lbs (2.8%) which is significant. Between February 2, 2003 and February 16, 2003 (14 days) resident 8 lost 11 lbs (5.4%) which is significant. Between February 10, 2003 and February 16, 2003 (6 days) resident 8 lost 5.2 lbs (2.6%) which is significant. Between January 26, 2003 and February 16, 2003 (21 days) resident 8 lost 13.7 lbs (6.65%) which is significant. Between January 26, 2003 and February 23, 2003 (28 days) resident 8 lost 20.6 lbs (10%) which is significant. A lab (laboratory) value taken at the facility and dated 2/7/03 showed and albumin (protein) level of 3.1 g/dl. The normal reference range, according to the lab used by the facility was 3.3-4.8 g/dl. An albumin level of less than 2.4 g/dl is considered a severe visceral protein deficit, an albumin level of 2.4-2.9 g/dl is considered a moderate visceral protein deficit and an albumin level of 3.0-3.5 g/dl is considered a mild visceral protein deficit. (Reference guidance: Manual or Clinical Dietetics, American Dietetic Association,	F 325	weights immediately per facility protocol. • Direct care staff have been inserviced by the Registered Dietician on procedures to promote increased food intake. • Direct care staff have been educated on proper positioning during meals. MONITORING: The Director of Nurses and Dietary Manager will monitor for compliance through: • Observation of residents during meals for appropriate positioning (focus on room trays) • Random review of charts to confirm identification and follow up on weight loss issues • Review of weights within 24 hours • Weekly Nutrition at Risk meetings QUALITY ASSURANCE: The facility will address ongoing areas of concern as needed in the facility QA meeting.	

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F 325	Continued From page 6 6th edition, 2000, page 22). The albumin of 3.1 g/dl dated 2/7/03 was the most current in resident 8's medical record and the decreased albumin was acknowledged by the registered dietitian (RD) on her admit note dated 2/18/03. An admission minimum data set (MDS) assessment was completed on 1/31/03. The MDS documented under section K., Oral/Nutritional Status, 1. Oral problems, no chewing or swallowing problems and no mouth pain. An initial nutritional assessment for resident 8 was completed by the dietary manager on 1/24/03. The dietary manager's plan of care was to provide resident 8 with a "...reg [regular] diet as tolerated, allow to eat meals in room. Provide set up and assist as needed [every] meal. Monitor weights weekly." The dietary manager also documented the following, "...Usual meal intake [equal or greater than] 75% of all meals..." The plan of care, by the dietary manager, did not document that resident 8 was on a planned weight loss program. A nutritional careplan for resident 8 was completed on 1/30/03. The facility's documented goals for resident 8 were "1...will have no significant weight change (I.E. < 2% X 1 week, < 5% X 1 month, <7.5% X 3 months, < 10% X 6 months...3-...will allow staff to provide setup and/or assist as needed every meal." The facility documented the following approaches, "...2. Encourage intakes > 75%...5. Monitor daily intakes...7. Monitor weights weekly...". On 2/18/03, the facility's RD completed a progress note which documented, "...Pt [patient] is 169% of IBW [ideal body weight], caloric needs to lose wt [weight] = 1590 QD [every day] protein [equal or greater than] 76 g [grams] QD [every day]	F 325		

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F 325	Continued From page 7 ([decreased] albumin)...Current intake appears to meet these needs." The facility's nutritional careplan for resident 8 dated 1/30/03 did not document that resident 8 was on a planned weight loss program. On 2/24/03, the facility's dietary manager completed a progress note which documented, "...KCAL (calorie) needs = 1350-1650 or 61-75%, Pro [protein] needs = 54-66 GMS [grams] or [greater than] 68%...Meal intake = 30% Supplement intake = Has accepted resource 2 X's [2 times] in past 2 days...Has lost 11.2 lbs X 30 days or an equiv [equivalent] of 5.5%...We wrote orders last week for her to receive house supp [supplement] TID [three times a day] between meals and she refused this. She now has orders for resource juice BID [twice a day] and boost BID [twice a day] between meals. We will continue to encourage adequate KCAL and fluid intake [every] meal, offer snacks between meals and encourage acceptance of nutritional supplements. Boost = 240 KCAL and 10 GM (gram) Pro X 2 = 480 KCAL and 20 GM Pro Resource juice = 210 KCAL and 6 GM Pro X 2 = 420 KCAL and 12 Pro 30% meal intake = appro [approximately] 600 Kcal and 15 GM Pro Total = 1500 Kcal and 47 GM Pro..." The progress note did not provide any evidence that the dietary manager was aware of the resident weight of 185.3 lbs which was taken on 2/23/03. At the time of this progress note the resident had actually had a weight loss of 20.6 lbs (10%) in 28 days. On 2/21/03 a physicians's order was written for the following order, "Boost 1 can BID, Resource 1 box BID R/T [related to] poor intake." On 2/24/03 the nursing progress notes were reviewed by a nurse surveyor, there was no mention of resident	F 325		

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F 325	Continued From page 8 8 having a decline in appetite until 2/21/03. On 2/21/03 at 7:00 PM, a facility nurse documented, "Order to give supplement [due to] decline in appetite [and] dietary intake..." This nursing progress note and physician order was written 11 days after resident 8 had a 5.8 lb (2.8%) weight decline in 1 week and 5 days after a 13.7 lb (6.65%) weight decline in 21 days. On 2/25/03 resident 8's breakfast and lunch were observed. For breakfast, resident 8, was served 2 half slices of french toast, 1 sausage link and 180 cc of milk. The resident was observed to be laying flat in bed with her tray at her bed side table uncovered, there was no staff in the resident's room assisting her. The tray was observed to have about 1 bite of french toast missing and 50% of her sausage missing. For lunch resident 8, was served ham and bean soup, salad with dressing, 1 piece of cornbread, diced potatoes, 1 slice of cantaloupe, cake, 180 cc of milk and 180 cc of juice. At 12:25 PM, a facility nurse brought the lunch tray into the resident room. The resident was observed to be laying in bed on her right side with 2 pillows under her head. The nurse set the tray up for the resident and helped the resident take 3 bites of the soup and a sip of the juice. At that time the nurse left the resident and stated to the surveyor that today was the first day she had worked with the resident and for breakfast she only ate the sausage and no liquids. She further stated that the resident was capable of feeding herself but she would keep coming back to assist the resident with the meal. The resident was observed to still be laying in bed on her right side with 2 pillows under her head. At 12:35 PM, the facility nurse was observed to go back into the resident's room. At 12:37 PM, the facility nurse was observed to be leaving the resident's room with the resident's lunch tray. The facility nurse later stated to the surveyor that the resident had eaten some of the cake and she had left the juice for the resident. Resident 8 only had access	F 325		

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F 325	Continued From page 9	F 325		

to her lunch tray for a total of 12 minutes with only 2 staff intervention.

On 2/26/03 a facility certified nursing assistant (CNA) stated that resident 8 "didn't eat her breakfast very well only about 5%."

A review of resident 8's "Diet Sheet" from 1/18/03 - 2/23/03 revealed resident 8 received 109 meals. Thirty of the 109 meals provided no documentation that any of the meal was consumed. Out of the 79 meals that the facility documented on it revealed that resident 8 consumed less than 50% 45 times.

A review of resident 8's "Medication Sheet" from February 21-24, 2003 provided documented evidence that resident 8 received 3 of the 5 boost cans. The facility did not document how much of the boost resident 8 consumed. The medication sheet also provided documented evidence that resident 8 did not receive the the resource juice until 2/24/03 at 10:00 AM, three days after the physician's order written on 2/21/03. The facility staff did not document how much of the resource juice resident 8 consumed.

According to the RD progress note dated 2/18/03, resident 8 needed to consume 76 grams of protein every day due to the low albumin and 1590 calories per day to lose weight. On 2/24/03 the dietary manager documented that resident 8 needed to consume 54-66 grams of protein and 1350-1650 calories per day. She also documented that if resident 8 consumed 100% of the boost, 100% of the resource juice and 30% of her meals she would consume a total of 47 grams of protein and 1500 calories per day. This amount would not meet the RD's recommendation for the 1590 calories to lose weight nor the 76 grams of protein to enhance adequate nutrition to improve the decreased albumin. The dietary manager would not be

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F 325	Continued From page 10 able to accurately calculate if resident 8 was receiving the required calories and protein due to the fact that the facility nursing staff was not consistently documenting resident 8's meal intake as well as her boost and resource intake. It should also be noted that according to the dietary managers calculations resident 8 was not receiving enough calories for a weight loss program or enough to maintain her current body weight. On 2/25/03 at 2:00 PM, the dietary manager stated that she was not aware of the weight taken on 2/23/03 of 185.3 lbs because restorative nursing will do the weights and then medical records will enter them into the computer and she will get a print out on Thursday late in the afternoon and will review them on Friday. She further stated that weekly weights are done on all new residents. She stated that if there is a 5 lb weight difference either positive or negative then restorative nursing will do a re-weigh. The dietary manager stated that the restorative aide would most likely be getting a re-weigh on resident 8 today and would notify her if needed. She stated from there she would notify the RD of the weight concerns on her next visit. She further stated that the "Nutrition at Risk" team had discussed resident 8 on 2/21/03 and the RD would be seeing her today. On 2/25/03 at 2:15 PM, the RD stated that she was made aware today that resident 8 had a significant weight loss, however she was not aware of the weight taken on 2/23/03. She further stated that if a resident was on a planned weight loss program they would have a care plan addressing the planned weight loss. After the RD reviewed resident 8's medical record she stated that resident 8 was not on a planned weight loss program. The RD stated that she receives a list of the high risk residents that the "Nutrition at Risk" team identifies every week and those residents are seen	F 325		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 325	Continued From page 11 when she comes into the facility. On 2/26/03 at 8:35 AM, the restorative aide stated that there is a rule in the facility that if there is a 5 lb weight difference either positive or negative that they will do a re-weigh. She stated that the weights in the the residents medical records would be the weight she kept in her own weight book. Review of the restorative aides weights revealed the same weights that were identified in resident 8's medical record. There was no documentation to provide evidence that a re-weigh had been done on any of resident 8's weights when there was a negative 5 lb or greater difference. The 2/3/03, 2/10/03, 2/17/03 and 2/21/03 "Nutrition at Risk" Reports were reviewed by the nurse surveyor. . Resident 8 was not identified on any of the reports as a concern until 2/21/03. This was 11 days after resident 8 had a 5.8 lb (2.8%) weight decline in 1 week and 5 days after a 13.7 lb (6.65%) weight decline in 21 days. During the 21 days prior to 2/21/03 the "Nutrition at Risk" team had 2 meetings in which they did not trigger resident 8 as a high risk resident for weight loss.	F 325		
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and medical record review, it was determined that for 1 of 21 sampled residents, the facility did not ensure that each resident received a therapeutic diet when there was a nutritional	F 326	OK 4/11/03 SS F 326 This facility does ensure that residents receive a therapeutic diet when there is a nutrition problem.	4/11/03 per phone & Adm Rm kept 4/11/03

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	465112	A. BUILDING _____ B. WING _____	2/26/2003

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F 326	Continued From page 12 problem as evidenced by: one resident did not receive a 2000 mg. (milligram) sodium diet as ordered by the physician. The facility did not follow the therapeutic diet for this resident as prescribed per physician orders. Resident identifier: 101. Findings include: 1. Resident 101 was an 86 year old female with diagnoses including: Hyperpotassemia, congestive heart failure and hypertension. She was also noted to have a history of edema. On 2/25/03 resident 101's medical record was reviewed. A review of the physician progress notes signed by the physician, documented that a 2000 mg. sodium restriction was ordered on 1/24/03. A review of the dietary communication form dated 1/24/03 and signed by a nurse and sent to dietary, documented a NAS diet. An observation of resident 101's meal ticket during the lunch meal on 2/26/03 revealed a NAS (no added salt) diet served to resident 101. In an interview with the dietary manager on 2/26/03 she stated that a NAS diet was not the same diet served on a 2000 mg sodium restricted diet. She stated that no resident in the facility was on a 2000 mg. sodium restriction that she was aware of. She produced a dietary communication form signed by a nurse documenting a NAS as being ordered.	F 326	IDENTIFIED RESIDENT: Resident # 101: Diet has been changed to reflect physicians order. This occurred while the surveyors were in the facility. IDENTIFICATION OF POTENTIAL: All residents in the facility, or admitted to the facility, with specific diet orders have the potential to be impacted. The Dietary Manager has reviewed all diets to assure the order matches the diet provided. SYSTEMATIC CHANGES. In order to assure compliance and prevent reoccurrence of this issue, the following measures have been put in place: • The Director of Nurses and Dietary Manager review orders every morning in the clinical review meeting • The Dietary Manager will review physician order with diet order to assure compliance • All licensed staff have been inserviced by the Registered Dietician on diets available for residents in the facility MONITORING FOR COMPLIANCE: The Dietary Manager will monitor for compliance by reviewing all admission orders and diet order changes to assure diet ordered is diet received. QUALITY ASSURANCE: The facility will address areas of noncompliance as needed in the facility monthly QA meeting	
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions.	F 371 OK 4/1/03 DD		4/1/03

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F 371	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility did not store foods under sanitary conditions as evidenced by numerous out dated, and unlabeled food items found in the facility's kitchen. Findings include: Observations of the facility's kitchen on 2/24/03 at 8:15 AM revealed the following: In the dry storage room: 1. One case of a 24 pack of shelf stable orange juice with "best by September 11 2002"date on the box. 2. One can of diabetic resource with an expiration date of November 2002. In the walk-in refrigerator: 1. Eight plus-2 vanilla shakes thawed with no date. The manufactures recommendations printed on the carton state " use within 10 days". 2. An opened and partially use carton of sour cream with an expiration date of February 19 2003. 3. Two ½ gallons of buttermilk with an expiration date of February 6, 2003 4. Opened and partially use gallon bottles of salsa, sweet and sour and BBQ sauce with no date. 5. A large square container with an unidentifiable white liquid. 6. Opened and partially used liquid eggs with no date. The manufacturer's recommendations printed on the box state that the product should be used within three days after opening. In the walk-in freezer there was one bag of unlabeled meat, which was not identifiable. On the bread rack there was a bag with 8 moldy buns.	F 371	F 371 This facility does store foods under sanitary conditions. All expired/outdated food items identified have been discarded. IDENTIFICATION OF POTENTIAL: This citation has the potential to impact all residents in the facility. SYSTEMATIC CHANGES: To assure ongoing compliance and prevent reoccurrence: • All dietary staff will be inserviced on the "First IN-First OUT" procedure. • Dietary staff will be inserviced on a monthly basis on this process. • The Dietary Manager will check all food storage areas on a weekly basis to assure compliance. • All staff will be inserviced on a monthly basis regarding labeling and dating of all food products. • Staff will be quizzed every 90 days to ensure knowledge of food safety. • Expiration dates and date opened will be clearly marked on all bulk perishable food items. MONITORING: The Dietary Manager will monitor for ongoing compliance through weekly checks of food items. The Executive Director will conduct random monthly audits of food storage areas to assure compliance. QUALITY ASSURANCE: The facility will address ongoing issues as needed in the facility monthly QA meeting.	3/30/03 4/11/03 4/11/03 4/11/03 4/11/03 4/11/03

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F 371	Continued From page 14	F 371		
F 387 SS=E	483.40(c)(1)&(2) PHYSICIAN SERVICES The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that 5of 22 sample residents were not seen by a physician at least every 60 days as required. Resident identifiers: 6, 18, 33, 66 and 86. Findings include: 1. Resident 18 was admitted to the facility on 8/9/01 with diagnoses of pneumonia, dementia with depressive features, stroke, hypertension, urinary tract infection, seizure disorder, cerebrovascular disease, convulsions, osteoporosis, asphyxia and abnormal gait. A review of resident 18's medical record revealed that the resident had been seen by a nurse practitioner on 3/22/02 and 5/28/02 and a physician on 12/3/02. Resident 18 should have been seen by a physician on or around 5/28/02 as well as a physician visit on or around 7/28/02 and 9/28/02. There was no documentation in the medical record to provide evidence that resident 18 had been seen by a physician. In an interview with the medical records person on 2/26/02 at 12:15 PM, she stated that she was only able to locate the same physician visits the survey team had	F 387	F 387 This facility does assure residents are seen by physicians according to regulation. IDENTIFIED RESIDENTS: Residents #6,18,33,66, and 86: Identified issues are not correctable for the specific dates. Concerns are addressed under systematic changes. IDENTIFICATION OF POTENTIAL: All residents in the facility have the potential to be impacted by this citation. SYSTEMATIC CHANGES: In order to assure ongoing compliance and prevent reoccurrence of this issue, the facility has implemented the following measures: • Medical records will conduct monthly audits to assure physician visit compliance. 4/11/03 • All physicians have been sent a letter explaining the facility physician visit process. 4/11/03 • Physicians will be contacted the first day of each monthly to make appointments for the current month routine visits. 4/11/03 • Physicians who are overdue for their visits will be referred to the Executive Director and Medical Director along with a list of residents to be seen. 4/11/03 • If the physician still does not visit the resident by the due date, the Medical Director will be asked to see those residents. 4/11/03	

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F 387	Continued From page 15 found. She further stated that this had been an on going problem. 2. Resident 6 was admitted to the facility on 3/6/02 with diagnoses that included fractured ankle, cerebrovascular accident, hypertension, type 2 diabetes, congestive heart failure and hemiplegia. Resident 6 had physician visits documented for 4/23/02, 5/16/02, 6/25/02, 9/1/02 and 12/6/02. There was no documentation in the medical record to show that the physician had made a visit in November 2002 or February 2003. Resident 6 had documentation of a nurse practitioner visits on 5/22/02. There was no documentation in resident 6's medical record to show that the nurse practitioner had made a visit in November 2002 or February 2003. 3. Resident 33 was admitted to the facility on 8/31/01 with diagnoses that included dementia, osteoporoses, Alzheimer's, weight loss and cerebrovascular accident. Resident 33 had physician visits documented for 3/9/02, 4/15/02, 7/19/02 and 10/18/02. There was no documentation in resident 33's medical record to show that the physician had made a visit after 10/18/02 Resident 33 was seen by the Nurse Practitioner on 3/20/02, 5/7/02, 6/25/02 and 9/27/02. There was no documentation to show that the nurse practitioner had made a visit after 10/18/02. 4. Resident 86 was admitted to the facility on12/1/98 with diagnoses that included dementia, cerebrovascular accident, hypertention, aphasia and Alzheimer's.	F 387	MONITORING: The Director of Health Information will monitor for compliance through monthly audits and random audits through-out the month. QUALITY ASSURANCE: Identified areas of ongoing concern will be addressed as needed in the facility monthly QA meeting.	

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F 387	Continued From page 16 Resident 86 had physician visits documented for 7/7/02, 11/8/02 and 12/6/02. There was no documentation in resident 86's medical record to show that the physician had made a visit after 12/6/02 Resident 86 was seen by the nurse practitioner on 5/7/02 and 9/3/02. There was no documentation to show that the nurse practitioner had made a visit after 12/6/002 5. Resident 66 was admitted to the facility on 4/28/02 with diagnoses of subarachnoid hemorrhage, diabetes, cerebrovascular disease, hypertension and atrial fibrillation. A review of resident 66's medical record on 2/25/03, revealed that resident 66 had been seen by a nurse practitioner on 3/22/02, 5/28/02, and 8/28/02 and by a physician on 12/3/02 and 2/16/03. Resident 66 should also have been seen by a physician on or about 5/28/02, 7/28/02 and 10/28/02.	F 387		
F 388 SS=D	483.40(c)(3)&(4) PHYSICIAN SERVICES Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for 4 of 21 residents, the physician visits did not alternate between the visits of a nurse	F 388		

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F 388	Continued From page 17 practitioner. Resident identifiers: 18, 66, 79, and 99. Findings include: 1. Resident 18 was admitted to the facility on 8/9/01 with diagnoses of pneumonia, dementia with depressive features, stroke, hypertension, urinary tract infection, seizure disorder, cerebrovascular disease, convulsions, osteoporosis, asphyxia and abnormal gait. A review of resident 18's medical record showed that the nurse practitioner had seen the resident on 3/22/02 and 5/28/02. The physician should have seen resident 18 on the 5/28/02 visit. 2. Resident 79 was admitted to the facility on 2/21/01 with diagnoses of bipolar disease, schizophrenia, arthritis, sleep apnea, hypertension, diabetes, neuropathy, peripheral vascular disease, congestive heart failure and chronic sinusitis. A review of resident 79's medical record showed that the nurse practitioner had seen the resident on 3/19/02 and 5/7/02. The physician should have seen resident 79 on the 5/7/02 visit. In an interview with the facility's medical record person on 2/26/02 at 12:15 PM, she stated that she was only able to find the same visits the survey team had found. Medical records was not able to provide any documented evidence that a physician had seen these residents in between the nurse practitioner visits. 3. Resident 66 was admitted to the facility on 4/28/02 with diagnoses of subarachnoid hemorrhage, diabetes, cerebrovascular disease, hypertension and atrial	F 388 OK 4/1/03 DD	F 388 This facility does assure residents receive visits from their physicians. SPECIFIC RESIDENTS: Residents #18,66,79, and 99: The facility is not able to address resident specific concerns, as these visits are in the past and not correctable. Concerns are addressed under systematic changes. IDENTIFICATION OF POTENTIAL: All residents in the facility whose Physician utilizes nurse practitioners have the potential to be impacted by this area of concern. SYSTEMATIC CHANGES: To assure ongoing compliance and prevent reoccurrence with this issue, the facility has put the following measures in place: • Physicians and Nurse Practitioners have been notified by letter that they must alternate routine visits for compliance. • The Director of Health Management will audit records monthly to assure ongoing compliance. • The Executive Director will address areas of non-compliance, should they arise, with the resident's Physician, and follow up with the Medical Director as needed.	4/1/03 per phone 4/1/03 c adm. Ron Kapp DD

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F 388	Continued From page 18 fibrillation. A review of resident 66's medical record on 2/25/03, revealed that resident 66 had been seen by a nurse practitioner on 3/22/02, 5/28/02, and 8/28/02. Resident 66 should have been seen by a physician on the 5/28/02 visit, by 7/28/02 and by 10/28/02. 4. Resident 99 was admitted to the facility on 4/19/97 with diagnoses of closed head injury and colostomy. A review of resident 99's medical record on 2/25/03, revealed that resident 99 had been seen by a nurse practitioner on 3/5/02, 5/14/02, and by a physician on 7/30/02. Resident 99 should have been seen by a physician on the 5/14/02 visit.	F 388	MONITORING: The Director of Health Management will conduct monthly audits to assure ongoing compliance. QUALITY ASSURANCE: The facility will address identified areas of concern as needed in the facility monthly QA meeting.	
F 502 SS=E	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 medical record review and staff interview, it was determined that the facility did not ensure that timely laboratory services were provided as ordered by physicians for 3 of 22 sample residents. The facility did not ensure that adequate monitoring of anticoagulation therapy was done as ordered for 2 sample residents. In addition, the facility did not obtain other laboratory services to meet the needs of 2 sample residents. Coumadin is an oral anticoagulant used to control and prevent blood clotting disorders. Prescribing the dose that both avoids bleeding complications and achieves	F 502		

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F 502	Continued From page 19
	therapeutic range of clotting times requires monitoring through laboratory tests. The protime (PT) is a laboratory test used to monitor blood clotting in a specific individual. (Reference Guide: Brunner and Sarddarth's textbook of Medical-Surgical Nursing 8th Edition 1996 Lippincott pages 802-803.)
	
	Resident identifiers: 66, 79, and 100.
	
	Findings include:
	
	1. Resident 79 was a 74 year old female who was admitted to the facility on 2/21/01 with diagnoses of bipolar disease, schizophrenia, arthritis, sleep apnea, hypertension, diabetes, neuropathy, peripheral vascular disease. congestive heart failure and chronic sinusitis.
	
	A review of resident 79's medical record showed that the resident was admitted on coumadin. A physician's order dated 4/24/01 and a re-certification order dated 12/30/02 revealed resident 79 was to have a PT every month.
	
	Laboratory results for a PT for June and September could not be found in the medical record.
	
	A physician's order dated 4/6/01 and a re-certification order dated 12/30/02 revealed resident 79 was to have a Depakote level every 3 months.
	
	The medical record revealed a Depakote level on April 5, 2002 and September 12, 2002. A Depakote level for July could not be found in the medical record.
	2. Resident 66 was admitted to the facility on 4/28/02 with diagnoses of subarachnoid hemorrhage, diabetes, cerebrovascular disease, hypertension and atrial fibrillation.
	
	A review of resident 66's medical record was done on
		F 502
		ok 4/1/03 AD
			F 502
			
			This facility does obtain laboratory services to meet the needs of its residents in a timely manner.
			
			SPECIFIC RESIDENTS:
			
			Resident # 79: The resident's physician was notified, and Depakote drawn 2/26/03.
			
			Resident # 66: The resident's physician was notified, and no new orders given.
			
			Resident # 100: The resident's physician was notified, and no orders given.
			
			IDENTIFICATION OF POTENTIAL:
			
			This citation has the potential to affect all residents in the facility with orders for labs.
			
			SYSTEMATIC CHANGES:
			In order to assure compliance and prevent reoccurrence of this issue, the facility has implemented the following:
			• Unit Managers will be informed every morning, in the clinical review meeting, of new orders for labs. The Unit Managers will follow up to assure the lab is set up, and the lab slip if filled out.
			• The unit managers will review routine lab orders monthly, and assure those lab orders are processed by:
			  • Filling out the lab slip
			  • Placing order on Medication Administration Record
				3/20/03
				
				3/20/03
				
				3/20/03
				
				4/11/03
				
				4/11/03

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F 502	Continued From page 20 2/25/03. A physician order dated 6/5/02, documented that resident 66 was to have a PT/INR laboratory test done every two weeks. The medical record contained evidence that the PT/INR laboratory tests were done on 7/5/02, 8/2/02, 9/3/02, 10/15/02, 10/29/02, 11/13/02, 1/7/03, 1/21/03, 2/5/03, and 2/20/03. PT/INR laboratory tests should have been done on or around 7/19/02, 8/16/02, 11/27/02, 12/12/02 and 12/26/02. The facility could not provide evidence that the laboratory tests were done as ordered by the physician on those dates. 3. Resident 100 was admitted to the facility on 1/7/00 with diagnoses that included Alzheimer's dementia, gastroesophageal reflux disease, hypertension, congestive heart failure, hypothyroidism and allergies. Resident 100's medical record was reviewed on 2/26/03. A physician's order dated 1/18/00, and a re-certification order dated 12/30/02, revealed resident 100 was to have a TSH (thyroid stimulating hormone) laboratory test done every six months. The medical record contained evidence that a TSH test was done on 1/18/02 and again on 1/20/03. There were no other TSH laboratory tests in resident 100's record. A TSH should have been done, as ordered by the physician, in July 2002. The facility could not provide evidence that another TSH laboratory test had been done for resident 100. In an interview with a facility registered nurse on 2/26/03 at 10:55 AM, he stated that the PT results for	F 502	• Unit Managers will monitor to assure labs are completed by completing random audits on orders for monthly labs. MONITORING The Director of Nurses and Unit Managers will monitor for compliance through random audits monthly. QUALITY ASSURANCE The facility will address ongoing issues as needed in the facility monthly QA meeting.	4/11/03

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F 502	Continued From page 21 June and July were not in resident 79's medical record, he further stated that he could not find a Depakote level for July. He then looked at the laboratory draw book and stated there was no evidence that the laboratory tests for residents 66, 79 and 100 were drawn and that book would show which labs had been drawn for each resident.	F 502		