Utah Department of Health

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AUG 09 2006

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

PRINTED: 07/27/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465112	(X2) MULTIPLE CONSTRUCTION A. BUILDING Bureau of Health Facility Licensing, Certification and Resident Assessment B. WING	(X3) DATE SURVEY COMPLETED 07/13/2006

NAME OF PROVIDER OR SUPPLIER: LIFE CARE CENTER OF BOUNTIFUL

STREET ADDRESS, CITY, STATE, ZIP CODE: 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) COMPLETION DATE
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility did not have an effective maintenance system to ensure that the residents' environment was maintained in good repair, specificaly for screens that did not fit windows, wall paper that was torn and missing in the main dining room, baseboards that needed paint in the main dining room, tile replacement on the threshold between the main dining room and kitchen and a large stain on the tiles in room 122. Findings include: l. Eleven screens had bent frames and did not fit the windows properly. 2. The baseboards in the main dining room were scratched and scuffed and needed to be painted. 3. The threshold between the kitchen and main dining room door had missing linoleum tiles and needed to be replaced. 4. A large black stain covered multiple tiles in the door area of room 122. 5. 2 large (approximately 2 foot by 2 foot) areas of wallpaper were missing on either side of the kitchen door. Wallpaper seams were peeling back and hanging in the same area.	F 253 8/10/06 POC acceptable Completion date 8/27/06 [signature]	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. Please accept this Plan of Correction as our allegation of compliance **F253** **HOUSEKEEPING/MAINTENANCE** **Address how the corrective action will be accomplished for those Residents found to have been affected by the deficient practice.** It was determined that current Residents have the potential for being affected by this deficient practice. Residents benefitted from the corrections set forth: 1. Exterior screens were examined and the eleven badly damaged screens were repaired by 31 Jul 2006 2. The baseboards in the main dining room are being prepped/repaired for painting. Will be completed by August 18, 2006. 3. The threshold between the kitchen and main dining room has been temporarily fixed. A complete replacement and repair will be completed by August 18, 2006.	27 Aug 06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: John A. Stephenson, Exec Director
(X6) DATE: 09 Aug 06

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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 272 SS=E 483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:
Identification and demographic information;
Customary routine;
Cognitive patterns;
Communication;
Vision;
Mood and behavior patterns;
Psychosocial well-being;
Physical functioning and structural problems;
Continence;
Disease diagnosis and health conditions;
Dental and nutritional status;
Skin conditions;
Activity pursuit;
Medications;
Special treatments and procedures;
Discharge potential;
Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and
Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview it was determined that the facility did not make a

F 253 - continued

4. The tiles that have been stained will be replaced by August 18, 2006.
5. The two large areas by the kitchen door were repaired and repapered during the the survey visit; completed July 13, 2006.

Address how the facility will identify other Residents having the potential to be affected by the same deficient practice.
It was determined that current Residents have the potential for being affected by this deficient practice. Residents benefitted from the corrections set forth.

Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.
An Environment checklist has been designed, and will be completed at least weekly by the Maintenance Department and Executive Director/designee. The weekly rounds will include interior and exterior common areas that will assure a sanitary, orderly and comfortable environment for the Residents.

What plan did the facility develop for ensuring that correction is achieved and sustained.
Environment concerns will be discussed in the morning Stand-Up Meeting; each concern will be addressed and follow-up recorded.

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F 272	Continued From page 2 comprehensive assessment of resident's needs. Specifically 12 of 21 sample residents did not have complete comprehensive minimum data set (MDS) assessments. Resident identifier 1, 2, 4, 5, 6, 7, 8, 9, 11, 12, 16, 17. Findings Include: 1. Resident 1 was admitted to the facility on 3/1/06 with diagnoses that included hemiplegia dysphagias, osteoarthritis, hypertension, and insomnia.		**F 253 - continued** **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** The Maintenance Checklist will be added to the QA Meeting agenda and will be discussed therein monthly until threshold reached. The person responsible will be the ED/ Designee and Environmental Services Director. **Completion Date: August 27, 2006**	
	Resident 1's medical record was reviewed on 7/10/06. Section V of the 3/10/06 initial Minimum Data Set (MDS) was incomplete. The Resident Assessment Protocols (RAPs) for 2. Cognitive Loss referred to B2A1, B41, C61 (which all refer to the codes on the MDS), 4. Communication, 5. ADL (activities of daily living) Function/ Rehabilitation potential, and 12. Nutritional status did not include dates for therapy notes and referred to RAP, 17. Psychotropic drug use did not include dates for speech therapy notes and referred to RAPS. 2. Resident 2 was admitted to the facility on 10/16/05 with diagnoses that included diabetes, hypertension, arthritis, dementia, cerebral vascular accident, and depression. Resident 2's medical record was reviewed on 7/10/06. Section V of the 10/24/05 initial Minimum Data Set (MDS) was incomplete. The Resident	F 272	**F272 – COMPREHENSIVE ASSESSMENTS** **Address how the corrective action will be accomplished for those residents found to have been affected.** Residents 1,2,5,9,16,4,7,12,8,6,17 have had the "V" section of the MDS reviewed and documentation is available in the resident medical record. Resident 11 was discharged from the facility on 07/22/06. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** Residents due for comprehensive MDS Assessments are at risk of being affected.	27 Aug 06

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F 272	Continued From page 3 Assessment Protocols (RAPs) for 2. Cognitive Loss see NN (nurse notes) SS (social services) Psychosocial and notes, no dates were documented, 4. Communication did not include dates for therapy notes and referred to C42, C61(which all refer to the codes on the MDS), 8 Mood State, 9. Behavioral Symptoms and 12. Nutritional status, did not include dates as part of the notation referencing the RAP assessment documentation. 3. Resident 5 was admitted to the facility on 3/24/06 with diagnoses that included cerebral vascular accident, hypertension, depression, dysphagia and chronic hearing loss. Resident 5's medical record was reviewed on 7/11/06. Section V of the 6/6/06 initial Minimum Data Set (MDS) was incomplete. The Resident Assessment Protocols (RAPs) for 4. Communication had a reference to admit nsg (nursing) assessment 5/27/06, no documentation about communication skills was found in the assessment dated 5/27/06, 12. Nutritional status, did not include dates as part of the notation referencing the RAP assessment documentation. 4. Resident 9 was admitted on 12/20/05 with diagnoses major depressive disorder, recurrent moderate-severe without psychotic feature in partial remission, post traumatic stress disorder in	F 272	**F 272 - continued** **Address what measures will be put in place or systematic changes made to ensure that deficient practice will not recur.** Residents that have MDS assessments completed with section "V" will be reviewed before final completion to ensure all sections, dates, and documentation location are done as per RAI requirements. Inservice to be provided to Inter-disciplinary team members to review completion of RAP Summary and specifically dates, location of RAP assessment documentation. DON or designee to complete inservice by August 27, 2006. **What plan did the facility develop for ensuring that correction is achieved and sustained?** Random selected MDS and "V" section page will be audited by MDS coordinator or designee monthly before the MDS assessment is placed in the resident's chart. Audits will continue monthly until compliance is maintained. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** Results of audits will be reviewed by the DON and ED with corrective action taken if required. DON/ED will oversee compliance through monthly QI Meetings, with this quality indicator being introduced at the QI meeting to be held August 18, 2006.	

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F 272	Continued From page 4 partial remission. Resident 9's medical record was reviewed on 7/10/06. Section V of the 12/29/05 Annual MDS was not completed. The Resident Assessment Protocols (RAPs) for 8, Mood State and 15, Dental Care did not include dates as part of the notation referencing the RAP assessment documentation. 5. Resident 11 was admitted on 7/15/03 with diagnoses of atrial fibrillation, asthma, adjustment disorder with depression and hypertension. Resident 11's medical record was reviewed on 7/10/06. Section V of the 11/28/05 Annual MDS was not completed. The Resident Assessment Protocols (RAPS) for 2. Cognitive Loss 5, ADL Function, 6, Urinary Incontinance, 11, Fallls, 14, Dehydration, 16, Pressure Ulcers, and 17, Psychotropic Drugs did not include dates as part of the notation referencing the RAP assessment documentation 6. Resident 16 was admitted on 5/2/06 with diagnoses of congestive heart disease, diabetes, osteoarthritis, coronary artery disease, gout, hypothyroidism, total knee replacement times 3. Resident 16's medical record was reviewed on 7/12/06. Section V of the 11/28/05 Annual MDS was not completed. The Resident Assessment Protocols (RAPS) for 5, ADL Function, 12, Nutritional Status and 14, Dehydration did not include dates as part	F 272	**F 272 - continued** **Indicate how often the monitoring will be done and who will be responsible for monitoring the plan of correction.** This monitoring will be done monthly by the Director of Nursing, Executive Director, & MDS Coordinator until the threshold for the quality indicator has been met. This will also be addressed in the QI meeting monthly until the threshold has been met. **Indicate when the plan of correction was integrated into the facility's quality assurance system.** At our next QI meeting on August 18, 2006 this will be integrated into our quality assurance system and will continue to be addressed monthly until the Quality indicator threshold has been met.	

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F 272	Continued From page 5 of the notation referencing the RAP assessment documentation. 7. Resident 4 was admitted in 3/15/02 with diagnoses that included multiple sclerosis (MS), osteoporosis, esophogeal reflux, neurogenic bladder and anxious features related to MS. Resident 4's medical record was reviewed on 07/10/06. Section V of the 11/14/05 annual Minimum Data Set (MDS) was incomplete. The Resident Assessment Protocols (RAPs) for 2. Cognitive Loss, 4. Communication, 8. Mood State and 9. Behavioral Symptoms did not include dates as part of the notation referencing the RAP assessment documentation. As well 4. Communication did not reference assessment data other than "RAP, RAP SUMMARY." 8. Resident 7 was admitted 8/10/90 with diagnoses that included Anemia, colonic polyps, hypertension, peptic ulcer, and macular degeneration. Resident 7's medical record was reviewed on 07/11/06. Section V of the 05/08/06 annual MDS was incomplete. The RAPs for 2. Cognitive Loss, 7.	F 272		

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Psychosocial Well-being, 8. Mood State, 9. Behavioral Symptoms and 12. Nutritional status did not include dates as part of the notation referencing the RAP assessment documentation.

9. Resident 12 was admitted in 7/14/04 with diagnoses that included multiple sclerosis, thromboembolus, and seizure disorder.

Resident 12's medical record was reviewed on 07/12/06.

Section V of the 06/12/06 significant change MDS was incomplete. The RAPs for 2. Cognitive Loss, 8. Mood State and 12. Nutritional Status did not include dates as part of the notation referencing the RAP assessment documentation.

10. Resident 8 was admitted to the facility on 10/20/05 with diagnoses that included hypertension, gastro esophageal reflux disease, depression, insomnia, anemia and morbid obesity.

Resident 8's medical record was reviewed on 7/11/06.

Section V of the 4/28/06 significant change Minimum Data Set (MDS) was not completed. The Resident Assessment Protocols (RAP) for 8. Mood State, and 12. Nutritional Status, were not marked as to the date of the RAP assessment documentation.

11. Resident 6 was admitted to the facility on 12/6/02 with diagnoses that included multiple sclerosis, diabetes, hypercholesterolemia,

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F 272	Continued From page 7 esophagus reflux, dementia, constipation and herpes. Resident 6's medical record was reviewed on 7/11/06. Section V of the 4/06/06 significant change MDS was not completed. The RAP for 4. Communication, 6. Urinary Incontinence, 12. Nutritional Status, and 17. Psychotropic Drug Use were not marked as to the date of the RAP assessment documentation. 12. Resident 17 was admitted to the facility on 10/21/05 with diagnoses that included osteoarthritis, hypertension, sleep apnea, dementia, hearing loss, hypercholesterolemia, congestive heart failure and constipation. Resident 17's medical record was reviewed on 7/11/06. Section V of the 11/01/05 significant change MDS was not completed. The RAP for 2. Cognitive Loss, 8. Mood State, 9. Behavioral Symptoms, 10. Activities, 15. Dental Care 16. Pressure Ulcers, and 17. Psychotropic Drug Use were not marked as to the date of the RAP assessment documentation.	F 272		

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F 279 SS=E	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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 services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that for 5 of 21 sample residents, the facility did not develop comprehensive care plans for each resident based on their individual needs identified by the facility staff. Resident identifiers 1, 7, 10, 17, 19. Findings included: 1. Resident 1 was admitted to the facility on 3/1/06 with diagnoses that included hemiplegia dysphagias, osteoarthritis, hypertension, and insomnia.	F 279	**F 279 COMPREHENSIVE CARE PLANS** **Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice.** **Resident 1** Resident 1 has a care plan in his chart under the care plan section, dated 06/05/06, stating "Alteration in comfort related to pain secondary to osteoarthritis, hemiplegia, PU to heel", with applicable interventions. **Resident 19** Resident 19 is no longer at the facility due to being discharged on 07/06/06, therefore we are unable to update his care plan. **Resident 7** Care plans dated 7 /19/06 are in her chart under the care plan section, stating, "Potential for powerlessness r/t resident is accustomed to making own decisions and setting own goals m/b modified decision making ability in new situations" and "Alteration in behaviors r/t dementia m/b resistance to cares and refuses meds at times." **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** Current residents at the facility have the potential to be affected by the practice.	27 Aug 06

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F 279	Continued From page 9 Resident 1's medical record was reviewed on 7/10/06. Resident 1 had recertification orders, dated July 2006, for Lortab (pain medication) 5/500 1-2 PO (one to two tabs per mouth) every 4 hours PRN (when necessary). The Medication Administration Record (MAR) documented for June and July of 2006 that resident 1 took Lortab almost daily. Resident 1's quarterly Minimum Data Sheet (MDS), dated 6/5/06, documented under section J Health Condition, pain 2. a/2, frequency (pain daily) and b/2, intensity (moderate pain). The current care plan did not address resident 1's pain. Resident 19 was admitted on 6/20/06 with diagnoses that included congestive heart failure, ascites, hepatitis, anemia, sleep apnea, cor pulmonale and pulmonary hypertension. Resident 19's medical rocord was reviewed on 7/12/06. The resident had recertification orders, dated June 2006 for Oxycontin 40 mg. by mouth three times daily at 6 am, 12 noon and 6 pm. The resident received the medication as recorded on the Medication Administration Record (MAR) from June 21-June 28. The resident was also getting Oxycodone HCL 7.5 1-2 tabs PO four times daily, as necessary and Percocet 7/325 1-2	F 279	**F 279 - continued** **Address what measures will be put into place or systemic changes made to ensure that deficient practice will not recur.** MDS Coordinator or designee and medical records staff will perform weekly audits of residents receiving MDS assessments during the week, to assure that each resident's comprehensive care plan has been reviewed and revised where applicable. **What plan did the facility develop for ensuring that correction is achieved and sustained?** MDS Coordinator or designee and medical records staff will perform weekly audits of residents receiving MDS assessments during the week, to assure that each resident's comprehensive care plan has been reviewed and revised where applicable until threshold has been met. **Indicate how often the monitoring will be done and who is responsible for monitoring the POC.** The weekly audits of residents receiving MDS assessments during the week, to assure that each resident's comprehensive care plan has been reviewed and revised where applicable until threshold has been met, will be monitored weekly by the DON, MDS Coordinator, and the ED.	

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F 279	Continued From page 10 every 4 hours as necessary. The resident received those medications as recorded on the MAR from June 28-June 30. Resident 19's significant change MDS, dated 6/27/06, documented under section J Health Condition, pain 2. a/2 frequency (pain daily and b/2, intensity (moderate pain). The current care plan did not address resident 19's pain. 3. Resident 7 was admitted on 8/10/90 with diagnoses that included Anemia, colonic polyps, hypertension, peptic ulcer, and macular degeneration. Resident 7's medical record was reviewed on 07/11/06. Resident 7's annual MDS, dated 5/8/06, section V was triggered for the following RAP (Resident Assessment Protocol) problem areas: 2. Cognitive Loss, 3. Visual Function, 5. ADL (Activities of Daily Living) Function/Rehab potential, 6. Urinary Incontinence and Indwelling Catheter, 7. Psychosocial Well-being, 8. Mood State, 9. Behavioral Symptoms and 12. Nutritional Status. MDS section V documentation indicated that care planning would be conducted for each of the triggered areas. No documentation of care planning could be found for 2. Cognitive Loss or 9. Behavioral	F 279	**F 279 - continued** **Indicate when the plan of correction was integrated into the facility's quality assurance system.** At our next QI meeting on August 18, 2006 this will be integrated into our quality assurance system and will continue to be addressed monthly until the Quality indicator threshold has been met. **Completion date: 27 Aug 2006**	

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Symptoms.

An interview with a staff MDS nurse took place on 07/12/06 at 8:35 AM. The MDS nurse stated that there was no care plan for cognitive loss, as she was unable to find it on the resident's chart. The MDS nurse made no mention of the care plan for behavioral symptoms.

4. Resident 10 was admitted to the facility on 6/1/06 and readmitted on 6/12/06 with diagnoses which included, chronic obstructive pulmonary disease, congestive heart failure, adrenal insufficiency, hypotension, unsteady gait, schizophrenia, hyponatremia, and adult respiratory distress syndrome.

Resident 10's medical record was reviewed on 07/11/06.

Resident 10's physician orders and medication administration record showed that resident 10 was receiving Chlorpromazine hydrochloride 100 mg (milligrams) by mouth, twice a day, for schizophrenia. Chlorpromazine hydrochloride is an antipsychotic drug.

Resident 10's initial MDS was completed on 6/8/06. Resident 10's use of antipsychotic medications was not triggered.

No care plan was developed or found in the medical record for use of resident 10's antipsychotic medication.

5. Resident 17 was admitted on 10/21/05 with

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F 279	Continued From page 12 diagnoses that included osteoarthritis, hypertension, kidney disorder, sleep apnea, and congestive heart failure. Resident 17's medical record was reviewed on 07/11/06. Resident 17's physician orders and MAR, for June and July of 2006, documented that resident 17 was receiving duragesic patch 25MCG/HR (microgram per hour) topically every 72 hours. Resident 17's quarterly MDS was completed on 4/17/06. Resident 17's pain was not triggered. No care plan was developed or found in the medical record for resident 17's pain management.	F 279		
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, it was determined that the facility did not meet professional standards of quality. Specifically for 8 of 21 sample residents documentation of pain medications, reason for administration of the pain medication and the results. Resident identifier 1, 2, 4, 6, 8, 11, 16, 17. Findings include:	F 281	**F281** **COMPREHENSIVE CARE PLANS** **Address how the corrective action will be accomplished for those Residents found to have been affected by the deficient practice.** Due to our corporate and state guidelines, we are unable to go back and correct documentation errors after 48 hours have elapsed. Therefore, the MAR's for residents 1,2,4,6,8,11,16, and 17 are unable to be adjusted to reflect the reason for administration of the pain medication and the results of that medication.	27 Aug 06

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F 281	Continued From page 13 1. Resident 1 was admitted to the facility on 3/1/06 with diagnoses that included hemiplegia dysphagias, osteoarthritis, hypertension, and insomnia. Resident 1's medical record was reviewed on 7/10/06. Resident 1 had recertification orders, dated July 2006, for Lortab (pain medication) 5/500 1-2 PO (one to two tabs per mouth) every 4 hours PRN (as needed). The Medication Administration Record (MAR) documented resident 1 received Lortab 36 times during June 2006, the MAR nurses's medication notes documented only 14 times as to why the medication was given and what the results were. July 1 to July 11, 2006 Lortab was given 9 times with only 1 documentation as to why the medication was given and what the result was. 2. Resident 2 was admitted to the facility on 10/16/05 with diagnoses that included diabetes, hypertension, arthritis, dementia, cerebral vascular accident, and depression. Resident 2's medical record was reviewed on 7/10/06. Resident 2 had recertification orders, dated July 2006, for Lortab (pain medication) 7.5/500 1 PO (one tab per mouth) every 4 hours PRN (as needed). The MAR documented resident 2 received Lortab 8 times during May 2006, the MAR nurses's medication notes documented only 1 time as to	F 281	**F 281 - continued** **Address how the facility will identify other Residents having the potential to be affected by the same deficient practice.** Current Residents have the potential to be affected by this deficient practice. **Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not recur.** Licensed Nurses will be inserviced by SDC, DON or designee on August 15, 2006 to address the proper documentation of pain medications, reason for the administration of the pain medication and the results. In addition, the LPNs and RNs will be instructed in the importance of qshift monitoring of this documentation prior to shift end. **What plan did the facility develop for ensuring that correction is achieved and sustained.** The DON or designee will perform weekly random audits of MARs to assure compliance for two months, then quarterly thereafter until the threshold is met. Any discrepancies will be reported in the daily Department Head meeting.	

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F 281	Continued From page 14 why the medication was given and what the results were. During June 2006, Lortab was given 10 times with only 2 documentation's as to why the medication was given and what the results were. Resident 11 was admitted on 7/15/03 with diagnoses of atrial fibrillation, asthma, adjustment disorder with depression and hypertension. The resident's medical record was reviewed on 7/10/03. The resident's MAR indicated that Lortab 5/500 1 by mouth three times daily as necessary was administered on July 1, 2, 3 4, 8, 9, 10 and 11. Only two out of 14 times described why the medication was given and it's effectiveness Resident 16 was admitted on 5/2/06 with diagnoses of congestive heart failure, diabetes, osteoarthritis, coronary artery disease, gout, hypothyroidism and total knee replacement times 3. The resident's medical record was reviewed on 7/12/06. The resident's MAR indicated that the resident was to receive Oxycodone HCL 5/325 mg, 2 tabs by mouth four times daily, may take 2 doses for breakthrough pain as necessary and was	F 281	**F 281 - continued** **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** Nursing Medical Practices Committee will monitor compliance via quality indicator until threshold is met. The Exec Director, DON and Medical Records Director are responsible for assuring that solutions are sustained. **Date of completion: 27th Aug 2006**	

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F 281	Continued From page 15 administered on July 1-July 11, a total of 15 times. Documentation for reasons given and effectiveness of medication was noted only 3 times. 1. Resident 4 was admitted on 3/15/02 with diagnoses that included multiple sclerosis (MS), osteoporosis, esophogeal reflux, neurogenic bladder and anxious features related to MS. Resident 4's medical record was reviewed on 07/10/06. Resident 4's MAR indicated that the resident was to receive Roxinal 0.25 ml (milliters) every 4 hours PRN (as needed) for pain. The medication was noted on the MAR as being given on 07/02, 03, 04, 05, 08, and 07/09/06. Only the 07/03/06 dose included documentation of the reason the medication was given, and results. Resident 4's MAR also indicated that the resident was to receive Lorazepam 0.5 mg (milligrams) po (by mouth) four times daily PRN (as needed) for anxious features. The medication was noted on the MAR as being given on 07/02, 04, 08, and 07/09/06. No documentation of the reason for giving the medication or results of the medication was found. Resident 8 was admitted on 10/20/05 with diagnoses that included gastric esophageal reflux disease, small bowel obstruction, depression, insomnia, anemia and morbid obesity.	F 281		

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F 281	Continued From page 16 Resident 8's medical record was reviewed on 07/10/06. Resident 8's MAR indicated that the resident was to receive Lortab 5 mg (milligrams) every 4-6 hours PRN (as needed) for pain. The medication was noted on the MAR as being given on 07/01, 02, 03, 04, 05, 08, 09, and 07/10/06. Only the 07/01, 05, and 07/09/06 doses included documentation of the reason the medication was given, and results. Resident 6 was admitted on 12/6/02 with diagnoses that included multiple sclerosis, diabetes, dementia, and herpes. Resident 6's medical record was reviewed on 07/10/06. Resident 6's MAR indicated that the resident was to receive Lortab 750 mg (milligrams) 1-2 4 times daily PRN (as needed) for pain. The medication was noted on the MAR as being given on 07/03, 10, and 07/11/06. The 07/03/06 dose included documentation of the reason the medication was given, and results. Resident 6's MAR also indicated that the resident was to receive Ultracet 37.5 mg (milligrams) 3 times daily PRN (as needed) for pain. The medication was noted on the MAR as being given on 07/05, and 07/11/06. The documentation of the reason the medication was given, and results could not be located on the MAR. Resident 17 was admitted on 10/21/05 with diagnoses that included osteoarthritis,	F 281		

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F 281	Continued From page 17 hypertension, kidney disorder, sleep apnea, and congestive heart failure. Resident 17's medical record was reviewed on 07/10/06. Resident 17's MAR indicated that the resident was to receive Percocet 325 mg (milligrams) 4-6 hours PRN (as needed) for pain. The medication was noted on the MAR as being given on 06/17, 19, 20, 25 and 06/29/06. Only the 06/17, and 6/25/06 dose included documentation of the reason the medication was given, and results. Reference: Lippincott, Seventh Edition, Textbook of Basic Nursing, Caroline Bunker Rosdahl. Chapter 63, Pg. 749, Administration Of Medications. "An important part of medication administration is documentation or charting...Proper documentation communicates to other members of the healthcare team which medications you administered and when. If a medication is PRN or a first-time administration, your documentation will further relay the medication's effect".	F 281		

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F 309 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview it was determined that the facility did not provide the necessary care and services to attain or maintain the highest practicable physical well being for 3 of 21 sample residents. Specifically physician orders were not followed for giving 2 resident immunizations and 1 resident's blood work was not completed. Resident identifiers 5, 6, 17. Findings include: 1. Resident 5 was admitted to the facility on 3/24/06 with diagnoses that included cerebral vascular accident, hypertension, depression, dysphagia and chronic hearing loss. Resident 5's medical record was reviewed on 7/11/06. Resident 5's admission telephone orders documented, "May have TB/PPD (Tuberculin skin test), upon admit and annually thereafter, read and record results in 72 hours. May have pneumovax if not received in last 5 years. There was no documentation in resident 5's	F 309	**F309 – QUALITY OF CARE** **Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice.** **Resident 5** Resident received pneumovax on July 12, 2006 per documentation on MAR. Residents received PPD tuberculin test on July 12, 2006 with results (Negative) being read on July 15, 2006. **Resident 6** Resident 6 had a lipid panel drawn on 07/11/06 with results in the chart on 07/12/06. **Resident 17** Resident 17 was offered a TB/PPD test on 7/12/06 three different times. He refused this each time it was offered, stating, "you just came to bother me." Provided information regarding PPD screening and resident refused. Offered Chest X-ray ordered on 8/8/06 and will be obtained by 8/9/06. Chest x-ray dated 3/2005 in thinned file shows no s/s tuberculosis. TB screen test done my licensed nursed with no evidence of signs of symptoms noted. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** Residents admitted to the facility and current residents have the potential to be affected by this practice.	27 Aug 06

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F 309	Continued From page 19 medical record that a TB/PPD skin test was given or read or that the resident had the pneumovax in the past 5 years. In an interview with the Director of Nursing, on 7/12/06 at 1:30 PM, she said she had talked to the nurses and the resident had not had a PPD skin test and they do not know about the pneumovax, whether the resident had it or not. 2. Resident 6 was admitted to the facility on 12/6/02 with diagnoses that included multiple sclerosis, diabetes, hypercholesterolemia, esophagus reflux, dementia, constipation and herpes. Resident 6's medical record was reviewed on 7/10/06. Resident 6 had a physician's order for Lab test to be drawn in June, the tests requested were, lipid panel and CMP (comprehensive metabolic panel). The lipid panel was not in resident 6's medical record. The Assistant Health Services Director (AHSD) was interviewed on 7/10/06 at 4:10 PM. The ASHD stated that the lipid panel was not drawn and that she would contact the doctor today. 3. Resident 17 was admitted on 10/21/05 with diagnoses that included osteoarthritis,	F 309	**F 309 - continued** **Address what measures will be put into place or systemic changes made to ensure that deficient practice will not recur.** Upon admission to the facility, the admitting licensed nurse will complete a checklist verifying the admit orders have been carried out to completion. The DON or designee will audit new admit charts within 48 hours of admission to the facility to assure physician orders have been followed and carried out. The DON or designee will randomly audit lab orders and results weekly to assure physician's orders have been followed. Provide inservice to licensed nurses regarding TB screening and following physician's orders by August 27, 2006. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** The DON or designee will audit new admit charts within 48 hours of admission to the facility to assure compliance. The DON or designee will audit randomly lab orders and results weekly to assure compliance. The audit results will be addressed monthly with the QI committee.	

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F 309	Continued From page 20 hypertension, kidney disorder, sleep apnea, and congestive heart failure. Resident 17's medical record was reviewed on 7/11/06. Resident 17 had a physician's order dated 11/11/05 to have a TB/PPD (Tuberculin skin test) on admission, annually thereafter. The TB/PPD results were not in resident 17's medical record. The Assistant Health Services Director (AHSD) was interviewed on 7/12/06 at 3:15 PM. The ASHD stated that she could not find documentation that the TB/PPD had been given as ordered.	F 309	**F 309 continued** **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** The DON or designee will audit new admit charts within 48 hours of admission to the facility to assure compliance. The DON or designee will audit randomly lab orders and results weekly to assure compliance. The audit results will be addressed monthly with the QI committee. **Indicate how often the monitoring will be done.** The DON or designee will audit new admit charts within 48 hours of admission to the facility to assure compliance. The DON or designee will audit randomly lab orders and results weekly to assure compliance. **Indicate who will be responsible for the monitoring of the plan of correction and when the plan of correction was integrated into the facility's quality assurance system.** The DON and the ED are responsible for monitoring the plan of correction. The audit results will be addressed monthly with the QI committee at the monthly QI meeting beginning August 18, 2006.	
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that the facility did not maintain			

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F 514	Continued From page 21 accurate medical records for 3 of 21 sample residents. Specifically the medical record was missing a lab result for one resident and orders for 2 resident were transcribed incorrectly. Resident identifiers 2, 8, 11. Findings include: 1. Resident 2 was admitted to the facility on 10/16/05 with diagnoses that included diabetes, hypertension, arthritis, dementia, cerebral vascular accident, and depression. Resident 2's medical record was reviewed on 7/10/06. Resident 2 had recertification orders, dated July 2006, that document Sliding scale insulin as follows; Novalog subcutaneous for B.S. (blood sugar) 0-200 0 units 201-300 4 units 301-400 8 units 351-400 14 units Over 400, call MD On 7/12/06 at 10:00 AM, the surveyor showed the Director of Nursing (DON) the conflict in the sliding scale for B.S. 301-400 and 351-400. The DON stated " the order should have been clarified with the physician". 1. Resident 8 was admitted to the facility on 10/20/05 with diagnoses that included hypertension, gastro esophageal reflux disease, depression, insomnia, anemia and morbid	F 514	**F514 – CLINICAL RECORDS** **Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice.** **Resident 2**—has a clarification order dated 07/12/06 stating, "Sliding Scale Novalog insulin for Blood sugar 0-200 = 0 units 201-300 = 4 units 301-350 = 8 units 351-400 = 14 units over 400 = Call MD" **Resident 8**—has a clarification order dated 07/10/06 stating, "Pepcid 20 mg PO BID, and Prilosec OTC 20 mg PO every morning for dx: GERD, Gastric Ulcers." **Resident 6**—has a clarification order dated 07/12/06 stating, " 2.0 kcal supplement give 120 mL TID between meals, chart mL consumed." **Resident 11**—was discharged from the facility 7/22/06. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** Current residents have the potential of being affected by this practice.	27 Aug 06

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F 514	Continued From page 22 obesity. On 7/10/06 a review of resident 8's medical record was completed. It was documented in resident 8's MAR (medication administration record) that the resident was to be administered Prilosec otc (over the counter) 20 mg (milligrams) P.O. Q AM (per mouth every morning). An order for Prilosec could not be found on the current physicians order dated 7/6/06 for resident 8. On 7/11/06 at 4:15 PM the Assistant Director of Nursing (ADON) was interviewed. The ADON found an order for Prilosec on a physician's order dated 6/26/06. The ADON was asked which order was the current order and she stated the physician's order dated 7/6/06 and that she would contact the doctor to clarify the order for Prilosec. The physician verified the order for Prilosec was to be continued. 2. Resident 6 was admitted to the facility on 12/6/02 with diagnosis that include multiple sclerosis, diabetes, dementia, constipation, and herpes. On 7/10/06 a review of resident 6's medical record was completed. It was documented in resident 8's MAR that the resident was to be administered 2.0 K cal (kilo of calories) supplement 90 ml (milliliters) three times daily between meals.	F 514	**F 514 - continued** **Address what measures will be put into place or systemic changes made to ensure that deficient practice will not recur.** Inservice on August 15, 2006 to licensed nurses educating on read back and verify telephone orders and orders that appear to be contradictory and regarding proper procedures for new month physician order recertifications and MAR double checking, also regarding importance of following physician orders as ordered. DON and Staff Coordinator responsible for this inservice. **What plan did the facility develop for ensuring that correction is achieved and sustained?** Medical records staff and or the DON or designee will perform monthly random audits of recertification of physician orders and MAR's until threshold for the QI has been reached. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.** Medical records staff and or the DON or designee will perform monthly random audits of recertification of physician orders and MAR's until threshold for the QI has been reached. The audit results will be addressed monthly in the QI meeting.	

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F 514	Continued From page 23 It was also documented on the MAR that resident 6 has received 2.0 K cal supplement, at 120 ml, 29 times since 07/01/06. A review of the physicians order dated 07/07/06 reveled the order was written for 20 K cal supplement 90 ml three times daily between meals. On 7/11/06 at 4:15 PM the ADON was interviewed. The ADON stated that the order was for 90 ml and she would call the doctor to clarify the order. Resident 11 was admitted on 7/15/03 with diagnoses of atrial fibrillation, asthma, adjustment disorder with depression and hypertension. A lab for Protime (PT) was ordered by the physician monthly. May's results were not found on resident 11's medical record. An interview with the DON on 7/12/006 at 3 PM was held and she located the lab results on thinned chart in Health Information.	F 514	**F 514 - continued** **Indicate how the monitoring will be done.** The results of the audits of the physician orde recertifications and MAR's done by medical records staff and or the DON or designee will be presented at the monthly QI meeting until the threshold for the QI has been reached. **Indicate who will be responsible for the monitoring of the plan of correction.** The Executive director and the director of nursing will monitor the plan of correction. **Indicate when the plan of correction was integrated into the facility's quality assurance system and when the corrective action will be completed.** The plan of correction will be integrated into our quality assurance system at the QI meeting to be held on August 18, 2006 with the plan's completion date being August 27, 2006. **Completion date: 27 Aug 2006**	