SURVEY 2001

POC acceptable w addition per phone call 6/20/01 [redacted] adm.

SURVEY 2001

F221 PHYSICAL RESTRAINTS WILL NOT BE USED ON ANY RESIDENT WITHOUT PROPER DOCUMENTATION.

1. PHYSICIANS DIAGNOSIS OF MEDICAL SYMPTOMS
2. PHYSICIANS ORDERS
3. RESIDENT OR FAMILY CONSENT
4. NURSING ASSESSMENT AND CARE PLANNING

ONLY THE LEAST RESTRICTIVE RESTRAINT WILL BE USED WHEN A MEDICAL NEED HAS BEEN IDENTIFIED AND THEN ONLY WHEN ALTERNATIVE MEASURES HAVE BEEN TRIED WITHOUT SUCCESS.

RESTRAINTS WILL ONLY BE USED AFTER GOING THROUGH THE ENTIRE PROCESS FOR PROPER USE AND THEN RESTRAINTS WILL ONLY BE USED TO PREVENT INJURY TO THE RESIDENT.

THE DON WILL REVIEW THE CHARTS MONTHLY TO ASSURE RESTRAINTS BEING USED PROPERLY. THE DON WILL THEN REPORT TO THE QA TEAM MONTHLYTO ENSURE THE POLICY IS BEING FOLLOWED.

THE RESTRAINT POLICY WILL BE REVIEWED ANUALLY TO MAKE SUREIT IS UP TO DATE.

AN INSERVICE WAS HELD ON MAY 25, 2001 TO REVIEW AND FAMILIARIZE THE STAFF WITH THE NEW RESTRAINT POLICY.

RESIDENTS 4 AND 19 WERE ASSESSED FOR MEDICAL SYMPTOMS, AND POSSIBLE INTERVENTION TO MEET NEEDS WITH LESSER MEANS. PHYSICIAN ORDERS AS WELL AS FAMILY PERMISSION WAS OBTAINED. NURSING WILL TRACK FOR CONTINUED NEED.

F224 A NEW CALL LIGHT SYSTEM WAS INSTALLED DURING THE SURVEY PROCESS. MAINTENANCE WILL CHECK WEEKLY TO INSURE ALL LIGHTS AND AUDIBLE SIGNALS ARE FUNCTIONING PROPERLY. SHOULD A PROBLEM BE FOUND, THE ADMINISTRATOR WILL BE NOTIFIED AND THE ELECTRONICS COMPANY CALLED IMMEDIATLY FOR REPAIR. DOCUMENTATION WILL BE KEPT AND THE QA TEAM WILL MONITOR SAID DOCUMENTATION QUARTERLY.

F225 ALL INJURIES OF UNKNOWN ORGIN OR ALLEGATIONS OF ABUSE

ADDITIONAL SURVEY INFO

F241 AN INSERVICE REGARDING RESIDENTS RIGHTS AND DIGNITY AND RESPECT ISSUES WAS HELD ON MAY 10, 2001. ALL STAFF WILL TAKE TIME TO LISTEN, ASSIST AND RESPOND TO RESIDENTS. STAFF WILL ADDRESS ANY SPECIAL NEEDS OF RESIDENTS TO RESOLVE ANY INDIVIDUAL PROBLEMS OR CONCERNS. STAFF WILL WILL REFRAIN FROM JOKING WITH RESIDENTS IN AN UNDIGNIFIED MANNER, AND WILL ADDRESS ALL RESIDENTS WITH RESPECT. ANY REPETATIVE COMPLAINTS OR ISSUES VOICED BY RESIDENTS WILL BE RESPONDED TO AND REASSURANCE WILL BE OFFERED. RESIDENT WISHES CONCERNING CARE BY HANDS ON STAFF WILL BE HONORED AND RESPECTED.

INSERVICES WILL BE HELD QUARTERLY FOR THE STAFF TO ASSURE COMPLIANCE. HAND OUTS WILL BE AVAILABLE AND WILL BE GIVEN OUT AT SAID INSERVICES. THE QA TEAM WILL REVIEW & MONITOR QUARTERLY TO AVOID REOCCURANCES.

F248 THE ACTIVITY PROGRAM WILL BE MONITORED BY THE ACTIVITY CONSULTANT AS TOMEET THE NEEDS OF ALL RESIDENTS. NEW STAFF HAS BEEN HIRED TO ASSURE THE NEEDS OF THE RESIDENTS ARE MET. THERE WILL BE OPPORTUNITIES OFFERED TO MEET THE NEEDS OF ALL RESIDENTS REGARDLESS OF THEIR COGNATIVE ABILITIES. THE ACTIVITY MONITORING WILL BE DONE ON A MONTHLY BASIS.

SHOULD A SCHEDUALED ACTIVITY REQUIRE CANCELLATION, A SUBSTITUTION WILL BE MADE AND ALL RESIDENTS WILL BE NOTIFIED OF THE CHANGE. SHOULD AN EMERGENCY OCCUR AN DIVERSIONARY PROGRAM WILL BE OFFERED. THE ACTIVITY STAFF WILL RECORD ANY CHANGES AND REPORT THEM TO THE QA TEAM FOR REVIEW. THE QA TEAM REVIEWED THE ACTIVITY PROGRAM ON JUNE 5, 2001 AND WILL REVIEW THE ACTIVITY PROGRAM QUARTERLY.

F253 ADDITIONAL HOUSEKEEPING STAFF HAS BEEN EMPLOYED BY THE fACILITY IN ORDER TO TO PROVIDE AN ENVIORMENT THAT IS CLEAN AND SANITARY. A CLEANING SCHEDUAL IS NOW IN PLACE. ALL AREAS OF THE FACILITY WILL BE INSPECTED MONTHLY TO INSURE CLEANLINESS.

MAINTENANCE HAS BEEN INCREASED AND WILL CHECK ALL AREAS

OF THE FACILITY MONTHLY. ALL AREAS WILL BE REPAIRED AS NEEDED. (FLOOR TILES, BASE COVE, FAUCETS, AND REPAIRS TO WALLS AND PAINTING OF REPAIRS WILL BE INCLUDED.)

WILL BE REPORTEDTO APS, STATE SURVEY AND THE OMBUDSMAN IMMEDIATLY. ALL INJURIES OR ALLEGATIONS OF ABUSE WILL BE THROUGHLY INVESTIGATED AND THE INVESTIGATION RESULTS WILL BE REPORTED TO THE STATE SURVEY AGENCY WITHIN FIVE WORKING DAYS.

RESIDENTS 4 AND 19 ARE BEING MONITORED CLOSELY FOR ANY INJURIES. ANY SUCH INJURIES WILL BE INVESTIGATED AND

AN INCIDENT REPORT WILL BE MADE OUT BY THE NURSE ON DUTY. ANY INJURY NOT SUBSTANCIATED WILL BE REPORTED TO THE DON AND ADMINISTRATOR AND WILL BE REPORTED TO THE STATE AS OUTLINED ABOVE.

AN INSERVICE WAS HELD ON MAY 25,2001 TO UPDATE THE STAFF ON THE POLICY FOR INJURY AND ABUSE.

A LOG BOOK WILL BE KEPT IN THE ADMINISTRATION OFFICE FOR FOLLOW UP. THE ADMINISTRATOR WILL BE RESPONSIBLE FOR MONITORING AND REPORTING ALL INCIDENTS. THE QA TEAM WILL REVIEW THE LOG QUARTERLY.

ADDITIONAL SURVEY INFO

MAINTENANCE WILL CONTINUE TO UTILIZE THE PREVENTATIVE BOOK FOR WATER CHECKS AND TO INSURE A SAFE ENVIRONMENT. THE WATER BOILER WILL BE ADJUSTED AS NEEDED TO TO INSURE RESIDENT SAFETY. WATER TEMPERATURE CHECKS WILL BE DONE WEEKLY, AND ANY NECESSARY CHANGES DOCUMENTED ON THE LOG BOOK FOR REVIEW.

THE PREVENTATIVE MAINTENANCE LOG WILL BE REVIEWED MONTHLY BY THE QA TEAM.

F272 ALL FACILITY MDS FORMS HAVE BEEN REVIEWED AND CORRECTED. ALL DATA IS NOW CORRECT AND ALL HAVE SIGNATURES IN PLACE, AS WELL AS THE CORRECT DATES. EACH MDS WILL BE REVIEWED PRIOR TO BEING TRANSMITTED TO THE STATE. THE QA TEAM WILL REVIEW THE MD'S QUARTERLY TO ASSURE THEY ARE COMPLETE AND CORRECT FOR TRANSMITTAL. CURRENT MDS'S WERE REVIEWED BY THE QA TEAM ON JUNE 5, 2001.

F281 AN INSERVICE WAS HELD FOR ALL LICENSED NURSES TO REVIEW THE ADMINISTRATION OF DRUGS AND THE MED PASS PROCEDURE. THE FACILITY HAS IN PLACE A NEW POLICY REGARDING ANY MED ERRORS, OR SIGNING INCORRECTLY FOR A MEDICATION. APPROPRIATE VITAL SIGNS WILL BE TAKES PRIOR TO THE ADMINISTERATION OF CERTAIN MEDICATIONS. A COPY OF THE POLICY WILL BE GIVEN TO ALL NEW NURSES UPON HIRE. THE THE DON WILL BE RESPONSIBLE TO SEE ALL NURSES ARE IN COMPLIANCE. THE DON WILL REVIEW FOR MED ERRORS MONTHLY AND REPORT ANY PROBLEMS TO THE QA TEAM ON A MONTHLY BASI

F287 ALL MDS DATA WILL BE TRANSMITTED TO THE STATE AS REQUIRED BY HCFA AND THE STATE OF UTAH. ALL OF THE ATTEMPTS THAT WERE MADE FOR TRANSMITTAL WERE REJECTED BY THE STATE OF UTAH BECAUSE OF SOFT WARE ERRORS. ALL OF THE MDS DATA WAS DELETED AND REENTERED AND TRANSMITTED TO THE STATE. ALL VALIDATION REPORTS HAVE BEEN RECEIVED AND A COMPLETE

FILE WILL BE MAINTAINED IN THE FACILITY AND ARE READILY AVAILABLE FOR REVIEW. ALL MDS DATA WILL BE REVIEWED FOR POSSIBLE ERRORS PRIOR TO TRANSMITTAL. THE DON WILL BE RESPONSIBLE TO SEE THAT THE MDS DATA IS CORRECT. ANY PROBLEMS WILL BE REPORTED TO THE QA TEAM. monthly

F323 THE TEMPERATURE CONTROL ON THE BOILED HAS BEEN DECREASED TO INSURE RESIDENT SAFETY. ADDITIONAL WATER TEMPERATURE CHECKS WILL BE MADE THROUGH OUT THE FACILITY TO INSURE TEMPERATURE CONSISTANCY. THE CHECKS WILL BE DOCUMENTED AND REVIEWED BY THE QA TEAM QUARTERLY. ANY UNUSUAL

per phone call 6/26/01 T administ. [redacted] RN

ADDITIONAL SURVEY INFO

TEMPERATURES WILL BE REPORTED TO THE QA TEAM IMMEDIATELY.

F325 RESIDENT #7 IS NOW RECEIVING DIETARY SUPPLEMENTS WITH EACH MED PASS, AND BETWEEN MEALS. HER DIET IS PUREED AND SHE IS NOW EATING BETTER.

ANY TIME A RESIDENT SHOWS A DECREASE IN APPETITE OR A WEIGHT LOSS, SAID RESIDENT WILL BE CLOSLEY MONITORED TO

ENSURE MAINTENANCE OF ACCEPTABLE NUTRITIONAL STATUS. ANY RESIDENT WITH ANY SIGNIFFICANT CHANGES WILL BE WEIGHED DAILY AND THE DIETARY CONSULTANT WILL REVIEW THE CASE TO ENSURE PROPER NUTRITION.
ANY SUCH PROBLEMS WILL BE REPORTED TO THE DON, AND TO THE QA TEAM. THE QA TEAM WILL MONITOR QUARTERLY FOR COMPLIANCE.

F371 THE DIETARY DEPARTMENT NOW HAS A CLEANING SCHEDUAL WHICH IS BEING FOLLOWED TO PROMOTE SANITARY CONDITIONS. ALL FOODS ARE BEING DATED AND LABELED. ANY LEFT OVER REFRIGERATED ITEM NOT USED WITHIN 3 TO 4 DAYS OF DATE WILL BE DISCARDED. ALL REFRIGERATED OR FROZED FOODS WILL BE SECURED AND DATED AND LABELED AS TO CONTENTS. FOODS WILL BE STORED IN ORIGINAL CONTAINERS OR IN A APPROPRIATE CONTAINER, SECURED AND DATED AND LABELED. NO FOOD ITEMS WILL BE LEFT EXPOSED. UNANNOUNCED AND ROUTINE INSPECTIONS WILL BE CONDUCTED TWICE MONTHLY BY A QA TEAM MEMBER TO INSURE PROCEDURES ARE FOLLOWED.

THE DIETARY SUPERVISOR WILL BE RESPONSIBLE TO SEE THAT THE DIETARY DEPARTMENT MEETS THE REQUIRED STANDARDS.

THE WATER TEMPERATURE IN THE DISH WASHER WILL BE TAKEN DAILY AND RECORDED TO GUARANTEE RECOMMENDED TEMPERATURES.

THE QA TEAM WILL REVIEW THE DIETARY DEPARTMENT ON A QUARTERLY BASIS. THE DIETARY DEPARTMENT WAS REVIEWED ON JUNE 12, 2001 BY THE QA TEAM.

F441 AN INFECTION CONTROL PROGRAM IN NOW IN PLACE. ALL INFECTIONS ARE INVESTIGATED, TRACKED, AND TREATED TO SAFE GUARD PREVENTION OF SPREAD, AND TO IDENTIFY TRENDS AND EFFECTIVENESS OF TREATMENT. THE DON REVIEW THE INFECTION CONTROL PROGRAM MONTHLY. THE QA TEAM WILL REVIEW THE INFECTION CONTROL PROGRAM QUARTERLY.
THE INFECTION CONTROL PROGRAM WAS REVIEWED BY THE QA TEAM ON JUNE 12,2001.

F463 REFER TO TAG # F224. A NEW CALL LIGHT SYSTEM WAS INSTALLED

ADDITIONAL SURVEY INFO

AND FINALIZED ON 04-24-2001. WEEKLY CHECKS ARE BEING DONE BY THE MAINTENANCE DEPARTMENT TO INSURE THE SYSTEM IS WORKING PROPERLY AND THAT THE RESIDENTS ARE NOT IN ANY JEOPARDY. THE QA TEAM WILL REVIEW THE PREVENTATIVE MAINTENANCE QUARTERLY.
THIS WAS REVIEWED ON JUNE 12,2001.

F490 ADMINISTRATION HAS ADDRESSED ALL DEFICIENCIES AS EVIDENCED IN THE PLAN OF CORRECTION. DEPARTMENT HEADS WILL NOW ASSUME RESPONSIBILITY FOR THEIR DEPARTMENTS AND EACH DEPARTMENT WILL BE REVIEWED ON A ROUTINE BASIS TO ASSURE COMPLIANCE WITH STATE REGULATIONS. DOCUMENTATION OF SAID REVIEWS WILL BE KEPT IN THE ADMINISTRATIVE OFFICE.

THE FACILITY ADMINISTRATION WILL BE REVIEWED AT EACH MONTHLY AND QUARTERLY QA MEETING TO ASSURE THE RESIDENTS NEEDS ARE BEING MET AND THE NECESSARY SERVICES ARE PROVIDED TO INSURE THE RESIDENTS ARE FREE FROM NEGLECT AND INJURY. MINUTES WILL BE KEPT OF EACH QA MEETING AND WILL BE KEPT IN THE QA BOOK.

THE QA TEAM REVIEWED THIS ON JUNE 12,2001.

F494 THE DON WILL VERIFY THROUGH THE STATE REGISTRY ALL NEW HIRES FOR THE NURSING DEPARTMENT. ALL NON CERTIFIED EMPLOYEES WILL NOT BE ALLOWED TO WORK PAST FOUR (4) MONTHS UNLESS THEY BECOME CERTIFIED. A LOG BOOK WILL BE KEPT FOR COMPLIANCE VERIFICATION. ANY HANDS ON CARE EMPLOYEE MUST ALSO PASS A BACK GROUND CHECK OR THEY WILL NOT BE KEPT ON STAFF.

EMPLOYEE 1 HAS COMPLETED THE CNA CLASS AND IS WAITING TO TAKE THE STATE TEST.
THE LOG BOOK WILL BE MONITORED ON A MONTHLY BASIS BY THE ADMINISTRATOR TO ASSURE COMPLIANCE.
THE QA TEAM REVIEWED THE LOG BOOK ON JUNE 12, 2001, AND WILL REVIEW QUARTERLY.

F496 THE DON WILL CALL THE REGISTRY ON EACH NEW HIRE IN THE NURSING DEPARTMENT TO ASSURE THEY ARE CERTIFIED. A LOG BOOK WILL BE KEPT FOR VERIFICATION. THE QA TEAM WILL REVIEW THE LOG MONTHLY TO MAKE SURE THE FACILITY IS IN COMPLIANCE. THE LOG WAS REVIEWED JUNE 12,2001.

THE DON HAS REVIEWED EMPLOYEES 1THROUGH 8 AND ONLY TWO REMAIN EMPLOYEED BY THE FACILITY. THE REQUIRED STATE VERIFICATION WILL BE MADE PRIOR TO STARTING WORK AT THE FACILITY.

ADDITIONAL SURVEY INFO

F521 THE QA TEAM WILL MEET MONTHLY TO IDENTIFY, ASSESS, AND RESOLVE ANY PROBLEMS. ALL SURVEY DEFICIENCIES AND ANY NEW FINDINGS WILL BE REVIEWED AS TO AVOID REOCCURANCE. MINUTES OF EACH MEETING SHALL BE KEPT AND WILL BE MADE AVAILABLE TO ALL STATE AGENCIES UPON REQUEST. THE LOG BOOK SHALL BE KEPT IN THE ADMINISTRATION OFFICE.

THE FACILITY ADMINISTRATION WILL BE REVIEWED AT EACH QA MEETING TO ASSURE THE RESIDENTS NEEDS ARE BEING MET AND THE NECESSARY SERVICES ARE PROVIDED, TO INSURE THE RESIDENTS ARE FREE FROM NEGLECT AND INJURY. MINUTES WILL BE KEPT OF EACH MEETING AND WILL BE KEPT IN THE QA BOOK.

ALL OF THE FACILITY DEFICIENCIES WILL BE CORRECTED AND MET BY JUNE 20, 2001

TN

TN to LB 6-14-01

DEPARTMENT OF HEALTH AND HUM SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 5/25/01
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	4/25/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 221 SS=G	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that for 2 of 10 sample residents the facility imposed the use of physical restraints for convenience and not required to treat the resident's medical symptoms. A restraint was used on resident 19 without a physician's diagnosed medical symptom, without a physician's order, without a nursing assessment, consent for use, and per facility staff, to prevent the resident from getting out of her wheelchair and following a family member out of the facility. The facility used a mattress to wedge against resident 4's low bed without a physician's diagnosed medical symptom, physician's order, consent to use, without a nursing assessment of need, and per the facility staff to prevent resident 4 from leaving her low bed. Resident 4 and 19. Finding include: 1. Resident 19: Resident 19 was observe to have a lap buddy restraint on while up in her wheelchair and full siderails up while she was in bed. The facility staff stated that they used the resident to keep resident 19 from following her husband as he was leaving the facility and there was no alternate intervention documented to prevent this behavior documented prior to the use of restraints. The facility had no nursing assessment of medical need, physician diagnosed medical need,	F 221	JUL 13 2001 06/12/01	

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

Lucinda Stone | Admin | 06-08-01

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 after such information 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 221	Continued From page 1	F 221		

or physician order for the use of these restraints. The facility staff did not evaluate resident 19 for any alternate interventions prior to the use of these restraints and there was no signed consent for the use of these restraints found in resident 19's medical record.

a. Resident 19 was admitted to the facility on 10/6/00 with diagnoses that included, fractured left humerus, situational depression, dementia with agitation, arthritis, cerebral vascular accident, and atrial fibrillation.

b. On 4/20/01 at 9:10 AM, resident 19 was observed in the day room with a family member. Resident 19 was alert and sitting in a wheelchair with a lap buddy restraint attached.

c. On 4/24/01 at 4:30 PM, resident 19 was observed lying in bed. The bed was positioned against the wall and both full length siderails were observed to be in th eup position.

d. In an interview on 4/25/01 at 4:00 PM, with the facility administrator, she stated that the facility staff used the lap buddy or soft belt restraint on resident 19 to prevent resident 19 from trying to stand up and get out of her wheelchair to try and follow he husband out of the facility after his visit.

e. Review of an incident report for resident 19, dated 1/9/01, documented that the resident was found "sitting/lying on floor - side rails up on bed. Pt [resident 19] stated she fell." The report documented that resident 19 had been in bed with both side rails up and she had received a bruise on her chin as result of the fall.

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F 221	Continued From page 2 f. On 4/25/01, resident 19's admission comprehensive assessment and quarterly resident assessments were reviewed and revealed the following: The comprehensive admission assessment, dated 10/20/00, section E4. [Mood and Behavior Patterns – Behavior symptoms] documented that resident 19 did not exhibit any wandering, verbally abusive behavior, physically abusive behavior socially inappropriate behavior or resisting care behavior in the last 7 days. Section P.4. [Special Treatments and Procedures – Devices and Restraints], documented that resident 19 had not required the use of any type of bedrails [siderails] or any type of restraint use in the last 7 days. The quarterly assessment, dated 1/9/01, section E4. [Mood and Behavior Patterns – Behavior symptoms, documented that resident 19 exhibited wandering behavior 4 to 6 days in the last 7 days and that the behavior was not easily altered. Section E.4., further documented that resident 19 exhibited verbally and physically abusive behaviors 1 to 3 days in the last 7 days and that these behaviors were easily altered. Section P. 4. [Special Treatments and Procedures – Devices and Restraints], documented that resident 19 required full bedrails and a trunk restraint. This section did not document if these devices or restraints were used less that daily or used daily. The quarterly assessment, partially dated for April 2001, section E4. [Mood and Behavior Patterns – Behavior symptoms, documented that resident 19 exhibited wandering behavior 4 to 6 days in the last 7 days and that the behavior was not easily altered. Section E.4., further documented that resident 19 exhibited verbally and physically abusive behaviors 1	F 221		

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F 221	Continued From page 3 to 3 days in the last 7 days and that these behaviors were easily altered. Section P. 4. [Special Treatments and Procedures – Devices and Restraints], documented that resident 19 required full bedrails and a trunk restraint. This section did not document if these devices or restraints were used less that daily or used daily. g. On 4/25/01, resident 19's comprehensive care plan was reviewed and included the following care plan problems: Care plan problem 4, dated 10/10/00, documented a problem of "Alteration in falls 2 [secondary to] L [left] side weakness, psychotropic drug use and physical restraints. The "resident goals" section documented, "pt will have no falls or injury TNR [through next review]. The approach plan section documented, "1. lap buddy when she through [sic] this off and starts to get [up] use soft belt until calmed [down] again. 2. observe for s/s [signs and symptoms] of agitation. A care plan problem, dated 11/7/00, documented a problem of, "Ineffective individual coping r/t [related to] anxiety m/b [manifested by] restless, wandering, repetitive verbalizations, tearful, crying, mean. " The goal documented, "Resident will calm down within 15 minutes of becoming anxious or tearful per episode TNR." Review of the "approaches" section of this care plan problem revealed that there were no approaches regarding the use of any restraint. h. Review of the nurse's notes from 2/9/01 through 4/22/01 revealed no documentation of any use of siderails or trunk restraint. There was no documentation of any wandering behavior, verbally abusive behavior or physically abusive behavior found	F 221		

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F 221	Continued From page 4 in these nursing notes. i. Review of the physician's order section of resident 19's medical record revealed no documented order for the use of siderails or trunk restraint. There was no documented physician's diagnosis for a medical symptom for the use of siderails or restraints found. j. Review of resident 19's entire medical record revealed no documentation of any assessment for falls, restraint or siderail need. There was no assessment found regarding alternatives to restraint use found. k. Review of resident 19's entire medical record revealed that there was no documentation of a signed consent to use siderails or restraints found. 2. Resident 4: Resident 4 was observed to have a mattress wedged against the open side of her lowbed, preventing resident 4 from getting out of her bed. The facility staff stated that it was used to prevent resident 4 from getting of out her lowbed. The facility had no documentation for an assessment of physician diagnosed medical need or physician's order for the use of the mattress. The facility staff did not evaluate resident 4 for any alternate interventions prior to the use of the mattress and there was no signed consent for the use of the mattress found in resident 4's medical record. a. Resident 4 was admitted to the facility on 7/6/00 with diagnoses that included, dementia with anxious features, history of mastectomy, fractured right hip,	F 221		

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F 221	Continued From page 5 and arthritis. b. Observations of resident 4 revealed the following: On 04/18/01 at 2:55 PM., resident 4 was observed in her room. As the surveyor entered resident 4's room, resident 4 was heard calling out, "Help, help, please help me". Resident 4 was observed to be lying on a low bed, positioned on her right side facing the wall. The low bed was placed against the wall and the opposite side of the bed away from the wall, a mattress was positioned on its side against the low bed. The nightstand at the head of the bed and a wheelchair at the foot of the bed were noted to be wedging the mattress against the low bed. This mattress was noted to extent 12 to 18 inches above the mattress resident 4 was lying on, preventing resident 4 from getting off the low bed. At this time, The surveyor asked resident 4 if she needed anything and resident 4 stated, "Someone to help turn me, help@. On 04/20/01 at 10:12 AM, resident 4 was observed to be positioned on her left side facing the mattress wedged against the open side of resident 4's low bed. Resident 4 had her right arm elevated and grasped the mattress with her hand. The surveyor observed that resident 4's call light was lying on the floor on the outside of the wedged mattress. Resident 4 observed to cry out, "Help me". On 04/24/01 at 1:00 P. M. the surveyor observed resident 4 in her room sleeping in the low bed with mattress wedged against the low bed with the nightstand and wheelchair. The call light was on the floor behind the nightstand. d. On 04/25/01 at 2:15 PM, during an interview with	F 221		

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F 221	Continued From page 6 the registered nurse (RN) on duty, concerning the mattress that was wedged against resident 4's bed, she stated, "Oh, the housekeeper place=s it like that when she comes in the morning to clean the room." When the surveyor informed the nurse that the mattress had been observed on its side against the low bed throughout the day, the RN stated that it helps to keep resident 4 in bed and to prevent resident 4 from falling out of bed and hurting herself. c. On 04/25/01 at 3:30 PM, during an interview with the facility DON and administrator, the administrator stated that this was put into place because the resident had a fear and this made her feel safe. d. On 4/25/01, resident 4's medical record was reviewed and revealed the following documentation. A "Fall/Injury Evaluation" form, dated 7/6/00, documented that resident 4 did not use siderails and required a low bed. The form also documented that resident 4 did not have a previous use of restraints and did not currently require the use of any restraints. The "Physician's Telephone Orders, documented a physician's order, dated 9/22/00, for a low bed to prevent injuries. There was no order found for the use of a mattress wedged against the bed to prevent resident 4 from getting out of bed. Resident 4's care plan, documented a care plan problem, dated March 2001, of "Potential for fall and injuries." The goal for this care plan problem documented that resident 4 would be free from fall or injuries for the next 30 days. The interventions for this care plan problem included that resident 4 was to use a low bed to prevent falls. Further review of resident 4's care plan revealed that	F 221		

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F 221	Continued From page 7 there was no care plan problem, goal or interventions for the need of a mattress against resident 4 bed to prevent resident 4 from getting out of her bed. Review of the nurse's notes from 8/11/00 through 4/23/01 revealed no documentation for the need or use of a mattress wedged against resident 4's bed to prevent resident 4 from getting out of bed. Review of resident 4's medical record revealed no documentation of any assessment of the need for a mattress against the bed to prevent resident 4 from getting out of bed. There was no documentation found of a signed consent to use the mattress against the bed.	F 221		
F 224 SS=K	483.13(c)(1)(i) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (Use F224 for deficiencies concerning mistreatment, neglect or misappropriation of resident property.) This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined that the facility did not provide goods and services necessary to avoid potential harm (neglect) for 25 of 25 residents residing at the facility. The facility did not have a working call light system that would allow the residents to call for assistance while in their rooms or bathrooms.	F 224		

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F 224	Continued From page 8 Findings include: 1. Observations: On 4/18/01, at 1:30 PM, the call light system to all resident rooms and toilet and bathing facilities was tested by the nurse surveyors, for audible or visual signals to the nurses' station to call for assistance from the staff. The results of that test were as follows: Resident rooms 1 through 13, 17 and 18 had no light signals in the hallway above the doors. Resident rooms 1 through 13, 17 and 18 had no audible signals relayed to the nurses' station. Resident bathrooms 1 through 9, 17 and 18 had no light signals in the hallway above the doors. Resident bathrooms 1 through 9, 17 and 18 had no audible signals relayed to the nurses' station. The resident common tub room had no call light system present. The resident common shower room had no light signals in the hallway above the doors and no audible signals relayed to the nurses' station. On 4/20/01, at 7:40 AM, the call light system to the nurses' station from the resident rooms was tested. The results were as follows: There were no lights to signal the nurses' station over the doors of room 1, beds A, B, C. There were no lights to signal the nurses' station over the door of room 2, bed B. There were no lights to signal the nurses' station over the door of room 3, bed A and B. The light to signal the nurses' station over the door of	F 224		

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F 224	Continued From page 9 room 3, bed C, signaled but also caused several other lights to flicker. There was no light to signal the nurses' station over the door of room 4, bed B. There was no light to signal the nurses' station over the door of room 5, bed B. The light to signal the nurses' station over the door of room 5, bed A, signaled but did not remain on. There was no light to signal the nurses' station over the door of room 7, bed A. There was no light to signal the nurses' station over the door of room 8, bed B. There was no call light present in room 9 to signal the nurses' station over the door for bed A. There was no light to signal the nurses' station over the door of room 11, bed B. There were no lights to signal the nurses' station over the door of room 12, bed A and C. There was no light to signal the nurses' station over the door of room 13, bed A. On 4/20/01, at 8:00 AM, the call light system from the resident bathrooms was tested. The results of that test were as follows: The bathroom call light had no light over the door to rooms 1or 2 to signal the nursing staff. (This bathroom was shared with room 2.) The bathroom call light had no light over the door to rooms 3 or 4 to signal the nursing staff. (This bathroom was shared with room 4.) The bathroom call light had no light over the door to rooms 7 or 8 to signal the nursing staff. (This bathroom was shared with room 8.) The bathroom call light had no light over the door to rooms 11 or 12 to signal the nursing staff. (This bathroom was shared with room 12.)	F 224		

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F 224	Continued From page 10 There was no call light in the common tub room. Interviews: On 4/18/01, resident 7 stated, "Call lights haven't been working. I never did have a call light. I told them I wanted one, but it didn't do any good. The call light hasn't worked for about a year." On 4/18/01, at 2:30 PM, an interview was conducted with a resident concerning her use of the call light system. She was asked if she had ever used her call light. The resident stated that she had used her call light once, a long time ago, but that she no longer used it. She stated that if she needed assistance from the staff, she would go to the nurses' station to request assistance. When asked how she would communicate her needs if she were to fall, she stated that she would probably yell. In an interview, on 4/18/01, resident 11 stated, "They [facility] don't have any call lights. I wish they did have. I just call for them. That's not right." "I have two call lights [in bedroom and in bathroom] and they don't work. I just holler until they come. Sometimes they never come." Resident 11 further stated, "I'm sick and tired of them not working. They need to be fixed." In an interview with resident 11 on 4/20/01 at 2:00 PM, resident 11 stated that she had lived at the facility since March of 2000. Resident 11 stated that she had never had a call light since her admission. Resident 11 stated, "It would be nice to have a call light. I yell when I need something."	F 224		

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F 224	Continued From page 11 Review of an incident report for resident 11, dated 1/6/01, it was documented by the RN that, "Call light in bathroom not working." It was further documented that, "Pt [patient/resident] said she pulled hard on call light in BR [bathroom] in an attempt to get help. Slipped to floor in sitting position, getting off toilet," and, "Need call light repaired." In an interview on 4/20/01 at 10:45 AM, resident 10 stated that, "The call lights don't work." Resident 10 stated that if she needed assistance, she would "have to go get staff." Resident 10 stated, "My wheelchair only locks on one side. I tried to get to bed and grabbed the [bed] pad and went down. I got my toe caught in one wheel. I couldn't get up. Oh, they heard me hollering." Resident 10 further stated, "A couple of times [resident 11] has fallen. I've had to get up and go get someone to help." On 4/20/01, in a confidential interview with a cognitive resident, the resident stated, "I have heard people calling out, sometimes 10 or 15 minutes, without anyone coming." The resident stated that he/she could usually go out [of the room] and get help, but, "There are times at night when I can't find anyone." On 4/20/01 at 11:00 AM, other residents were interviewed regarding the call light system. Resident responses were as follows: Resident 1 stated, "It would be nice to have a call light." Resident 3 stated, "I would like a light." Resident 6 stated, "Call light? I just holler all the	F 224		

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time. They don't come."

During an interview with resident 7, resident 7 was asked if she had ever used her call light. Resident 7 stated, "It doesn't work." When asked how she would acquire

assistance if she needed it, she stated, "I yell out." Resident 7 was questioned concerning how long the call light system had not been working and she stated, "Since I've been here." Resident 7 also stated that she had fallen recently and had to yell out and wait for them (staff) to come with assistance to get her up.

Resident 17 stated, "Never used a call light. I can get up alone." He stated that when he needed the staff, "They come after awhile."

Resident 19 stated that she didn't use the call lights. She stated, "I don't believe I could reach it."

Resident 20 stated she doesn't use her call light. She stated that if she needed anything, "I'd get up and walk across the room and get them [staff]."

Resident 23's spouse stated, "The call lights have been out about a year."

Resident 25 stated, "I can go get my own meals. They [staff] don't bother me." When the surveyor asked resident 25 what she would do if she fell, resident 25 stated, "I would have to crawl out. I'd do it too. I'm tough."

In a confidential interview with an employee and two surveyors, the employee stated, "Even a stupid nurse would know that is most important, call lights. That's life or death."

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F 224	Continued From page 13 In a confidential interview with a different employee, the employee stated, "[the call light system] has been out of order about three months. The employee said the call light system "makes the chirp noise" when it is plugged in, so they "unplug it". The staff member stated, "They (residents) just have to call out." In a confidential interview with another employee, the employee estimated the call light system had not been working for about four months. The employee stated, "I have heard residents calling out." The employee further stated, "If I go in and they need something, the call light never works. I have to go find someone to help them." In an interview, on 4/18/01, with employee 4, a direct care staff, the employee stated, "I've taught them to come to the door. When I see them in the doorway, I know they need something." Employee 4 further stated, "In addition, I'm in there every 20 minutes, every room." Employee 4 said he didn't know what was wrong with the call lights, "Maybe water damage." Employee 4 stated, "They did work when I started." He said he couldn't remember when the call lights stopped working. In an interview with the Administrator, on 4/18/01 at 5:30 PM, the Administrator stated the call lights do work and asked, "Are they unplugged?" The Administrator went behind the gate to the nurse's station and plugged in the call light system. She stated, "Sometimes these little people get back in here and unplug this." After plugging in the system, the Administrator and surveyor tested the call lights in room 1. The call	F 224		

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light to bed A did not work when the Administrator pushed the button. She stated, "Sometimes you just need to remove the call light cord out of the wall and shove it back in." The call light worked after she demonstrated unplugging and then plugging the cord back into the wall and holding the button down. The Administrator repeated the procedure to get the next call light for bed C to work. The call light to the bathroom for rooms 1 and 2 did not work after the system was plugged in. .

In an interview with the Administrator, on 4/20/01 at 1:40 AM, she stated the call lights had been out of order, "about two weeks." When asked for repair bills or work orders for the call light system over the past year, the Administrator said there were none. The Administrator stated that it made no sense to get the call light system repaired until the roof has been repaired. She stated the roof had been leaking and was the cause of the problem. She further stated the roof had been scheduled to be replaced the First of May.

In an interview with employee 1, the employee stated the call lights had, "been broken about seven days, no more." In order to determine if the residents need assistance, the employee stated, "I listen for when they (residents) call."

Record review:

On 4/25/01, the facility "Policy and Procedure for Prohibiting Abuse" was reviewed. The section "Facility Policy documented, "It is the policy of this facility to prohibit any abuse of its residents regardless of the source. This facility seeks to promote the well-being of its residents by providing a safe and supportive environment. Every resident has

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F 224	Continued From page 15 the right to be free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. The section "Definition of abuse" documented, "Abuse: the willful infliction on injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.... Neglect: failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness."	F 224		
F 225 SS=E	483.13(c)(1)(ii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established	F 225		

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	procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident record review, review of facility policy and procedure for prohibiting abuse, review of a letter provided by the facility and the State log, it was determined that the facility did not report incidents of injuries of unknown source to the State survey and certification agency. It was also determined that the facility did not thoroughly investigate the injuries of unknown source, prevent potential abuse while the investigation was in process, nor report the result of any investigation to the State survey agency with 5 working days of the incident for 2 of 9 sample residents. Residents: 4, 19. Findings include: 1. Resident 19 was admitted to the facility, on 10/6/00, with diagnoses that included, fractured left humerus, situation depression, dementia with agitation, arthritis, cerebral vascular accident with left hemiparesis, and atrial fibrillation. Review of resident 19's medical record, on 4/25/01,			

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F 225	Continued From page 17 revealed the following: A nurse's note, dated 2/20/01 at 8:00 PM, documented, "When putting [resident] to bed CNA noticed a bunch of bruises on L [left] leg - Thigh has 2 oblong one about 1/2" to 1 inch long or longer - Below knee has 2 large bruises 2 in. [inch] long x [times] 1 inch - [Resident] also has lg [large] bruise 2" x 4" across shin. These are deep purple bruises. [Resident] is however on Coumadin [medication to thin blood and prevent blood from clotting] therapy. Report to noc [night] shift will continue to monitor. The next nursing note, dated 2/23/01, documented the following; "...no falls or injuries noted. Large bruise to L leg cause unknown...". There was no documentation found that the facility investigated these bruises of unknown source. A nurse's note, dated 4/6/01, documented, "L hand above little finger bruised and swollen - ice applied. Will continue to assess." A nurse's note, dated 4/9/01, documented, " L jaw line swollen - small bite in center - spider bite? Cold rag applied. Will continue to assess. L arm c [with] dollar size bruise. Bruises to legs also. Will check with Dr. [doctor] about needed P.T. [Protime, a blood test to determine if a person's blood is too thin and will not clot. Used to monitor how thin a person's blood is, when taking the medication, Coumadin.]...". A nurse's note, dated 4/14/01, documented, "... Bruises noted on R [right] back of leg. Resident denies pain or discomfort." On 4/25/01, the facility incident reports from 1/1/01	F 225		

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F 225	Continued From page 18 through 4/25/01 were reviewed. This review revealed the only incident report found for resident 19 was dated 4/24/01. This report documented an incident of the resident's L hand was swollen and "multiple bruises " were found on resident 19's right thigh and left arm. 2. Resident 4 was admitted to the facility on 7/6/00 with diagnoses that included demential with anxious features, fractured right hip and arthritis. On 04/24/01 resident 4's medical record was reviewed. A nurse's note dated 10/8/00, documented that the nursing staff had found a large lump over resident 4's left eyebrow and that the lump had not been there the day before. A later nurse's note dated 10/8/00 at 7:30 AM, documented that resident 4 did not know how the bruise and lump occurred. Review of the facility incident reports for the months of October 2000 through April 2001 revealed that the facility staff did not fill out an incident report on resident 4's lump and bruise found on 10/8/00. In an interview on 4/24/01 at 2:00 PM, with the facility administrator, the administrator confirmed that the facility had not reported resident 4's injury of unknown origin to the State survey and certification agency. 3. In an interview with the facility administrator on 4/18/01, the administrator stated that she was unaware of any facility policy on prohibiting abuse. On 4/20/01, the facility administrator stated to the survey team that a facility policy and procedure for prohibiting abuse had been found and provided a copy of a policy and procedure to the survey team.	F 225		

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F 225	Continued From page 19 On 4/20/01, the facility administrator also provided, the survey team, a copy of a facility letter which documented the following: "It shall be the policy of [facility name] to report any alledged [sic] incidents of mistreatment, neglect, or abuse. Any such allegations will be thoroughly investigated and will reported with in five days of occurance [sic] to the following agencies. State Licensure, State Survey team, Department of Public Safety (Medicaid Fraud), Adult Protective Services, State Nurse Aid [sic] Registry, Ombudsman A log book will be kept for follow up and verification. Any new applicants will be screened and references checked to prevent hiring any one with a negative history for abuse, mistreatment, neglect or misconduct." There was no documentation found as to the date this letter had been written. In a meeting with the facility administrator, on 4/24/01 at 4:30 PM, the administrator stated that the facility had not been investigating injuries of unknown source. She stated that she had been unaware that the facility needed to investigate and call the State survey and certification agency when a resident had an injury of unknown source. The administrator stated that she had not reported or investigated any injuries of unknown source for residents 4 and 19. On 4/24/01, the facility's "Policy and Procedure for Prohibiting Abuse" was reviewed. The "Investigation and reporting procedures" section of the facility policy documented the following:	F 225		

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F 225	Continued From page 20 "1. Any person who suspects that abuse, neglect or misappropriation of property may have occurred, will immediately report the alleged violation to the facility administration and/or advocacy agencies. 2. The administration will immediately notify Adult Protective Services or local law enforcement authority and the local long-term care ombudsman. Injuries of unknown origin, significant incidents between residents, abuse, and misappropriation of resident's property must be immediately reported (during normal business hours) to the State Survey and Certification Agency at [telephone number]. 3. The administration will initiate the investigation process by interviewing all staff and residents having any knowledge of the allegation immediately. 4. The director of nursing will ensure notification of responsible parties and physician of the alleged incident. 5. The administration will complete the investigation within the next five days and will document all interviews include the date, time, and content of the interview. 6. Following an allegation, the facility will implement increased supervision and monitoring of residents as needed to ensure that all residents are safe from any further abuse. 7. If the complaint alleges abuse by staff, that staff member will be suspended until the investigation has been completed. 8. After investigation is complete, the administration will document a summary of its findings as to whether the alleged abuse was verified and report its findings to the agencies which were notified at the beginning of the investigation. If the nature of the incident required the Survey and Certification was initially notified, the results of the investigation must be faxed to the agency...".	F 225		

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F 225	Continued From page 21 Review of the State agency initial facility reporting logs from 1/1/2000 to 4/25/01 revealed that there was no initial report, or investigation results for any of the injuries of unknown origin for residents 4 or 19 found. The review of the 2000 and 2001 facility abuse reporting logs revealed one initial abuse report, dated 3/23/00, called in by the facility adminitrator and a faxed copy of the facility's investigation report was attached to this initital report.	F 225		
F 241 SS=G	483.15(a) QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined that the facility did not promote care in a manner that maintained or enhanced the resident's dignity for one resident who felt ignored when she called for assistance, one resident who complained of discomfort without staff attempts to provide relief, one resident who was fearful of males who provided her care, and one resident who was refused a meeting she felt she needed to resolve a problem. Residents 6, 7, 8, 10. Findings include: 1. Resident 7 was a 95 year old female admitted to this facility with diagnoses of hypertension,	F 241		

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F 241	Continued From page 22 congestive heart failure, macular degeneration, arthritis, hypothyroidism, and anemia. On 4/25/01, at 8:30 AM, a nurse surveyor observed resident 7 in the hallway in her wheel chair. Resident 7 requested assistance with repositioning related to, "pain in her bottom." A CNA (certified nurse aide) was heard to say that she (resident 7) had a cushion in her wheel chair that was sheepskin. The CNA directed his comment to the RN (registered nurse). The RN returned his comment with the statement, "I know, I know." Resident 7 was not assisted at that time to reposition in her wheel chair. On 4/25/01, at 9:00 AM, a nurse surveyor observed resident 7 in the hallway voicing complaints of, " pain in my rectum." The nurse surveyor approached resident 7 to question her concerning her needs. Resident 7 stated, " I have such pain in my rectum. I'm not sitting on a cushion. It still hurts." Observation of the wheel chair and cushion, revealed that resident 7 was positioned slightly to the right in her wheel chair and a significant amount of the sheepskin was visible to the left of resident 7, in the wheel chair. The RN was informed by the nurse surveyor of resident 7's concerns. The RN stated, " she has a sheepskin cushion. During the conversation with the RN, employee 9 approached resident 7 concerning her complaints. Resident 7 explained to employee 9 that she was having significant pain in her "rectum" and needed a cushion. Employee 9 stated, "I have a pain in my rectum, too, and her name is [resident 7]." Resident 7 stated, "that's not very nice." Employee 9 hugged resident 7 and then assisted her to stand. Observation of the sheepkin in the wheel chair revealed the sheepskin to be rolled	F 241		

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and positioned primarily to the left of the wheel chair. The center of the sheepskin was folded, placing the bottom of the pad directly against resident 7's bottom area. When resident 7 was repositioned in her wheel chair she stated, "that's much better."

2. Resident 10 was an oriented resident with diagnoses of cerebral palsy with low borderline functional intellectual operations.

On 4/20/01 at 10:50 AM, resident 10 stopped in the day room to talk with a surveyor. Employee 9 walked into the room, resident 10 called to her saying, "We've got to talk." Employee 9 replied, "No we don't. We've already had this conversation." Resident 10 stated, "We've got to talk about bad feelings with you and me." Employee 9 said, "There are no bad feelings. We have nothing to talk about."

Resident 10 continued that she wanted to talk with employee 9. Employee 9 said, "We've already had this conversation. You got yelled at. You were told you can't panhandle anymore." The resident said there were bad feelings that needed to be discussed. Employee 9 told resident 10 to just finish her interview. Then employee 9 walked out of the room.

Resident 10 stated to the surveyor, "There are bad feelings, her to me and me to her. We have to talk about it, but she won't talk."

3. Resident 6 was admitted to the facility 12/7/00 with diagnoses of Parkinson's disease, sleeplessness, organic brain disorder and constipation.

On 4/18/01, at 3:20 PM, resident 6 was heard continually crying out from her room. When no staff intervened, a surveyor asked her what was wrong.

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F 241	Continued From page 24 Resident 6 complained of wanting to get up because she was "lonely". Another surveyor asked a nurse if someone could help the resident. Employee 18 entered the room at 3:30 PM and asked resident 6, "Are you sure you want to get up?" When the resident said she did, employee 18 said, "All right, I'll get you up." The surveyors left the room to allow the employee to assist resident 6. A few minutes later, a surveyor, who was in the physical therapy room, overheard employee 18 saying, "I don't want to hear you calling again for another 30 more minutes." The surveyor entered the hallway to learn where the comment came from. The surveyor observed resident 6 on her bed and employee 18 standing beside her. The surveyor then heard employee 18 state, "I'm not going to argue with you [resident 6]." Resident 6 stated, "I'm not arguing with you either." On 4/20/01 resident 6 was heard by surveyors repeatedly calling out for help. Surveyor noted when staff walked past the resident's doorway, resident 6 called out to them by calling them names for ignoring her. In an interview with the facility administrator on 4/18/01, the administrator stated, "She [resident 6] is a frustrating resident." The Administrator stated that a previous employee had "created a monster" by allowing resident 6 to stay "with her [former employee] behind the nurse's station and giving her crackers and things. Now she expects it." In an interview on 4/20/01, resident 6 was asked if she ever tried to use her call light. Resident 6 stated, "Call light? I just holler all the time. They don't care." Resident 6 was asked how she felt when she needed to call out for help. Resident 6 answered,	F 241		

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F 241	Continued From page 25 "Not very good. It would feel better if they would come." Resident 6 stated, "They don't pay attention to me." Resident 6 further stated, "The people here don't come in and visit or help me. They treat me like a stick". Review of the medical record for resident 6 revealed nurses' notes, which documented resident 6, called out frequently for help. A nurse's note, dated 4/8/01 at 2:00 AM, documented, "Resident up in bed screaming for help, wet et (and) soiled." A nurse's note, dated 4/9/01 for the 3:00 PM to 11:00 PM shift, documented, "She has screamed and hollered for 2 hours ('help' help')...". A nurse's note, dated 4/16/01, the afternoon shift nurse documented, "She hollered and screamed about 2 or 3 hrs [hours] total today." 4. Resident 8 was admitted to the facility on 7/8/97 with diagnoses including schizophrenia paranoia, multi infarct dementia with depressive features, osteoarthritis, tardive dyskinesia, cerebral vascular accident, incontinence, and rectal prolapse/bowel resection. During an interview with resident 8 on 4/20/01, while she was sitting at a dining room table after eating breakfast, resident 8 was observed to respond to the questions being asked until a male aide approached the table to clear another resident's plate. The male aide asked resident 8 if she was all right and if he could get her anything. Resident 8 did not answer him, but sat erect and looked forward. The resident stopped answering questions from the surveyor and would only glance at the surveyor briefly when a question was asked.	F 241		

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F 241	Continued From page 26 In a group interview on 4/24/01 at 9:00 AM, resident 8 stated she did not want any male aide to work with her. Resident 8 said, "I get scared," and "I feel better about a girl taking care of me." During an interview with resident 8 on 4/25/01, while resident 8 was sitting in the day room after lunch, resident 8 stated, "I'm frightened."	F 241		
F 248 SS=D	483.15(f)(1) QUALITY OF LIFE The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined that the facility did not provide 4 of 12 activities that had been scheduled for the general population of the facility during survey observations, and did not provide a program of activities designed to meet the interests and the psychosocial, physical and mental well-being of 1 of 10 sample residents. Resident 6. Findings include: 1. Resident 6 was admitted to the facility 12/7/00 with diagnoses including Parkinson's disease, sleeplessness, organic brain disorder and constipation. Observations, interviews with the resident and staff, and record review revealed resident 6 to be cognitive and wanting interactions with other people.	F 248		

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F 248	Continued From page 27 Resident 6 was observed to be sitting or lying in her bedroom on 4/18/01, 4/20/01, 4/21/01, 4/22/01 and 4/23/01. Resident 6 was frequently heard shouting out to passers by for help, insulting staff if they passed by her door without stopping to see what she needed. On 4/20/01, resident 6 was asked why she called out so frequently. The resident stated, "I'm lonely." In an observation, on 4/21/01 at 3:30 PM, all but three residents were in their rooms. There was one CNA and one nurse in the building. Resident 6, who usually requires assist to transfer out of bed and to ambulate, was observed to walk independently from her darkened room to her doorway by using her wheelchair as a walker. The resident smiled and said, "Hi" to the surveyor, the resident and staff standing beside her door. The resident was not allowed to stay up to visit, but was promptly returned to her bed by the aide. ON 4/22/01 from 1:30 PM until 2:15 PM, revealed all residents but resident 6 to be in their rooms. Resident 6 was at the nurse's station repeatedly asking to call a family member. She was reminded that the family member couldn't be reached before 4:00 PM. No therapeutic or other activity was offered to resident 6. No one engaged her in conversation. On 4/23/01, resident 6 had been observed intermittently throughout the day calling for help, and "My hand hurts. Can't anyone do anything about it?" At 4:40 PM resident 6 was interviewed and again told the surveyors she was lonely. Resident 6 stated, "They don't pay attention to me." Resident 6 further stated, "The people here don't come in and visit or	F 248		

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help me. They treat me like a stick." Resident 6 continued, "They won't call my family, they don't have activities that I go to." After making that statement, resident 6 remembered that she had played bingo. When asked if she had attended any activities on 4/23/01, resident 6 stated, "Oh, no, I just sit here and wish I could die."

Resident 6's Therapeutic Recreation Assessment, dated 1/31/01 and updated 4/12/01, documented the resident was blind in her right eye and had a hearing deficit which required increased volume for her to hear.
The Therapeutic Recreation Assessment documented that resident 6 "acts out when frustrated", has a behavioral problem of "crying out for help in a crowd of people". It was also documented, "When [resident 6 is] involved in groups, redirection can be accomplished when inappropriate, yells out for help when TR [recreational therapist] does not focus on her alone," and "Resident feels abandoned according to her. When not able to call family, increased emotions e.g. crying, yelling out."
The assessment further documented that resident 6 was usually awake and in need of activities in the mornings and afternoons. The assessment documented, "Resident [6] seems to do well when 1.1 [interactions are one to one], group activity seems [arrow pointed up] difficult for her to use appropriate behavior. Resident seems to do better when sitting by TR during group. Hearing and sight are a problem - needs to be addressed in care plan."

Review of the comprehensive MDS assessment dated 12/7/00, revealed documentation that resident 6's general activity preferences included crafts/arts, exercise/sports, and talking or conversing (section N4b, d, k).

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F 248	Continued From page 29 On 4/24/01, resident 6 was observed participating in the 2:30 PM activities and was not calling out during the afternoon. Resident 6 had been included in a group playing word games and she worked on a puzzle. On 4/25/01, while she was eating breakfast, resident 6 was observed to be watching the other residents and staff in the dining room. As the meal was ending and residents were being assisted to their rooms, employee 4 commented to the surveyor about resident 6. The employee stated, "See, she's quiet. She love's to sit and watch all the people. All she wants is to be around others and watch what is going on." After breakfast, employee 10 stated, "I watched her [resident 6] put a puzzle together yesterday. She is very, very cognitive." 2. Observation of the facility residents on 4/21/01 at 3:30 PM, revealed all but three residents were in their bedrooms. Resident 6 got up by herself but was promptly taken back to her bed. One male resident was watching television in a common area, one female resident was in her wheelchair at the nurse's station complaining about a wound on her forehead, and one other female resident was with a family member in the front hallway. On 4/22/01 at 2:00 PM, there was a movie scheduled, but no activities were going on. One resident was out of bed but no activity or diversion was offered to her. There was no activity staff and only one CNA and one nurse in the building. The aide stated, "When I work the weekends it's R and R (rest and relaxation) for these people. If they want to stay in bed half the day or all day, that's their right. If they want	F 248		

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F 248	Continued From page 30 breakfast and lunch in their room, they get their way." On 4/23/01, a van ride to the base of Millcreek Canyon, scheduled for 4/23/01 at 2:30 PM, did not take place as scheduled. The activity staff was not available at the facility to be interviewed. On 4/24/01, the activity scheduled for 11:00 AM, Senior Citizen's Band, was crossed off the activity calendar by the activity staff at 9:00 AM because it was also scheduled for the previous day. On 4/25/01, activity that had been scheduled for 9:30 AM was cancelled because activity staff was also the van driver. The activity staff took one resident to a scheduled appointment. The activity calendar in the hallway was marked with the cancellation by the activity staff at 9:05 AM, but residents were not notified.	F 248		
F 253 SS=E	483.15(h)(2) ENVIRONMENT 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 and interview, it was determined that the facility did not provide housekeeping and maintenance services that maintained an environment for the residents that was sanitary, orderly and comfortable as evidenced by: Eleven of fifteen resident room floors and seven of ten bathroom floors were stained or dirty. Two of Ten resident bathrooms had stains of fecal-like material	F 253		

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F 253	Continued From page 31 on the floors. Three of fifteen resident rooms walls were patched, but not painted. Two of ten resident bathrooms sinks had large brown stains in them. Four of Ten bathroom toilets had lines of brown stains. Findings include: 1. Observations on 4/23/01 revealed the following: a. Resident Room 1, the coving at the bathroom door was missing. The linoleum tile on the floor had gray stains present. The door frames to the bathroom had paint scrapes that revealed the metal frame, two feet up from the floor. The resident bathroom, shared with room 2, had brown, gray stains on the linoleum floor. There was fecal-like brown debris on the floor in front of the toilet. b. Resident Room 2, had gray stains present on the linoleum floor tile. c. Resident Room 3, had gray stains on the linoleum floor tile. The sink in the resident bathroom, shared with room 4, had a large brown stain around the drain, measuring approximately 5 inches in diameter. The water was observed to run continuously from the faucet. d. Resident Room 5, had gray, brown stains on the linoleum floor tile. The linoleum floor tile in the in the bathroom, shared with room 6, had gray brown stains present. There was fecal-like debris on the floor in front of the toilet, observation on 4/24/01 at 7:35 AM, revealed that the fecal-like debris remained on the floor in front of the toilet. The inside of the toilet bowl had brown stains present. The hot water handle to the bathroom sink was not working.	F 253		

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F 253	Continued From page 32 e. Resident Room 6, had speckled stains throughout the linoleum floor tiles. f. Resident Room 7, had a patched area on the wall next to the closets that was not painted. There were dark, speckled stains throughout the linoleum tile floor. There was silver "duct" tape securing the linoleum tile in the resident room with the linoleum tile in the bathroom. The toilet in the bathroom, shared with room 8, had brown stains on the inside of the toilet bowl, from the edge of the bowl to below the water line. The bathroom sink had brown stains in the porcelain from under the faucet to the drain. g. Resident Room 9, had dry fecal-like debris on the linoleum tiles next to bed B, observation on 4/24/01, at 7:35 AM, revealed that the fecal-like debris remained next to bed B. There were several sticky, stained areas on the linoleum floor tiles. There was a patched area on the wall behind the beds that was not painted. The linoleum floor tiles in the bathroom, shared with room 10, had gray stains and tears in the tiles. The door frames, at each entry door, had paint scrapes, down to the metal, two feet up from the floor. The recorded temperature of the water from the bathroom sink was 88 degrees Fahrenheit. h. Resident Room 10, had brown gray, stains throughout the linoleum tile floor. i. Resident room 11, had the linoleum separating from the seam at the entry to the room. There were gray stains throughout the linoleum tile floor. There were paint scrapes on the wall behind the headboards of all three beds. The bathroom, shared with room 12, had gray stains on the linoleum floor tiles.	F 253		

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	46A047	A. BUILDING _____ B. WING _____	4/25/01

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F 253	Continued From page 33 j. Resident Room 12, had gray brown stains throughout the linoleum tile floor. The window screen was bent and was attached at the bottom of the window, only. k. Resident Room 13, had gray speckled stains throughout the linoleum tile floor. There were patched areas on the wall next to the closets that were not painted. There was a large circular gray stain at the end of bed B. The toilet bowl, in the resident bathroom, had lines of brown stains on the inside of the toilet bowl, from the edge of the bowl to below the water line. l. The hot water tap in the bathroom sink in resident room 18, was allowed to run for 4 minutes, at which time no hot water returned. 2. Observations on 4/24/01, of the common shower/dressing room revealed that there were gray brown stains throughout the linoleum tile floor. There were lines of brown stains in the inside of the toilet bowl, from the edge of the bowl to down below the water line. There were six holes in the wall above the sink. There were several holes in the tiles of the shower room walls. 3. On 4/24/01, at 8:05 AM, during an interview with the facility housekeeper, she stated that the dark colored stains on the linoleum in the resident rooms were "ground in dirt". She stated that he facility did not have a full time floor man and the equipment was too heavy for her to handle. She further stated that the facility had someone come in and clean the floors.	F 253		

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F 272 SS=E	483.20(b) RESIDENT ASSESSMENT 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;	F 272		

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	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 review of medical records on 4/20/01, the facility did not accurately complete the MDS assessments for 25 of 25 residents. All residents were effected. 1. Resident 1 had an annual MDS dated 03/06/01. Sections AB5 & 7, I1 &2, J5 and M4 were incomplete. The second MDS dated 12/08/00, was missing the face sheet and section K5 was incomplete. For the MDS dated 09/03/00, sections G7, K5 and M2 were incomplete. 2. Resident 2 had a MDS dated March of 2001 with sections AA8, AB10 &11, AC1, AD b (date), A3, F1, F2, F3, G9, I2, P9, R2b that were incomplete. The RAP for this MDS was not dated or signed for care plan. 3. Resident 3 was admitted on 03/31/01 and no MDS was in the chart. 4. Resident 4 had a MDS without a date; sections AA4 & 8, AA 9ab (date) and R2b were incomplete. Sections AA6, AB3, A6, F1, F2, F3 and I2 were incomplete for the significant change MDS dated 08/25/00. 5. Resident 5 had sections AA4 & 8 that were incomplete for the MDS dated 02/09/01. 6. Resident 8 had a MDS dated 03/23/01. Section AA 2, 4 & 8 were incomplete. No RAP was			

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completed. The second MDS that was in the chart did not have a date or reason for assessment. Sections AA 8 & 9 , A 3, O 4 and R2b were incomplete. No RAP was completed. The third MDS, according to the assessment reference date, was on 09/28/00. This was an annual MDS with sections R2a & b incomplete. The forth MDS was a quarterly dated 09/28/00, but the face sheet was missing. This MDS was signed in section R2 by an employee that was hired in December of 2000. Section AA 8 was incomplete for the MDS dated 12/28/00.

7. Resident 9 had sections AB11, ADa and I2 of the MDS dated 03/08/01 were incomplete.

8. Resident 10 had an incomplete MDS discharge tracking form; sections AA4 & 8, AB1 & 2, A6, R3 and 4 were incomplete. The quarterly MDS dated 03/06/01, was missing section AA due to no basic assessment tracking form. The second quarterly MDS dated 12/06/00, did not have the basic assessment tracking form. Sections A6 and B5a of this MDS were also incomplete.

9. Resident 11 had sections AA8 and Q2 that were incomplete for the MDS dated 03/21/01.

10. Resident 12 had an annual MDS dated 02/07/01. Section AB, AC, M1 &2 were incomplete.

11. Resident 13 had a quarterly MDS dated 1/11/01. Section A3, R4, AT2, AT3 & AT 4 were incomplete for the correction request form. Section N3 was incomplete on the MDS.

12. Resident 14 had a MDS dated 04/03/01, on a quarterly assessment form but section AA 8 was incomplete. Sections G1c and d the b column were

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F 272	Continued From page 37 incomplete for the MDS dated 10/03/00. 13. Resident 16 had a MDS dated 4/04/01, but the reason for assessment section AA 8 was not completed. Section AA 4 (race/ethnicity), section H3 11(diseases) and section Q2 (change in care needs) were incomplete. 14. Resident 17 had a quarterly MDS in chart dated 01/18/01, but was missing the basic assessment tracking form section AA. 15. Resident 20 was admitted to the facility 03/02/01 with an incomplete admission MDS. Sections AD, A 3, B1 &2, I1 & 2, J2 &3, O, P4 and R were not complete, signed or dated. No RAP was initiated. 17. Resident 21 had an annual MDS dated 03/07/01with sections AA4, AB6, AB7, AB10, AB11, AC1, ADa &b, E1 i,j,k,l,m and n, G3, G7 and G8 that were incomplete. 18. Resident 22 had sections AA4, AB9, AB10 and ADb that were incomplete for the MDS dated 03/01/01. 19. Resident 24 was admitted 12/02/00 and only had the background (face sheet) information at admission for MDS in chart. Section AB 11, AC 1 ADL patterns and AD was incomplete on the face sheet. 20. Resident 25 was diagnosed with dementia, paranoid features and care planned for alteration in cognition related to mood patterns. But, the annual MDS (minimum data set) dated 03/03/01, under section b (cognitive patterns), reflected that her memory was, "OK". The resident is independent with cognitive skills. Indicators of delirium-periodic	F 272		

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disordered thinking/awareness is marked "behavoir not present". The annual MDS for August of 2000, is not dated or signed in section R, but the AD face sheet signatures are dated 8/31/00. The two MDS's are 7 month's apart, but labeled as annual assessments in section AA 8. The RAP for the August MDS was signed, but not dated in section VB 2 & 4.
Resident 19:
21. Resident 19 was admitted to the facility on 10/6/00. Resident 19's medical record was reviewed on 4/25/01. Review of resident 19's MDS assessments revealed the following areas of the MDSs were found to be incomplete as evidenced by:

Resident 19's admission assessment dated 10/20/00 revealed the following.
Section E5. [Change in Behavior; Symptoms] was blank.
Section VB3. [Resident Assessment Protocol Summary - Signature of Person Completing Care Planning Decision] was blank.
Section VB4. [Resident Assessment Protocol Summary - Date] was blank.

The quarterly assessment dated 1/9/01 revealed the following.
Section P4. a. and c [Special Treatments and Procedures - Devices and Restraints] documented a check mark in both areas. The instructions for this section of the form documented the following; "Use the following codes for the last 7 days. 0. [Zero] not used. 1. Used less that daily. 2. Used daily." There was no documentation of the number of days the restraints were use on resident 19.
Section P7. [Physician Visits] documented a check in this area. The instructions for this section of the form documented, " In the last 14 days (or since admission if less than 14 days in facility) how many days has the

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F 272	Continued From page 39 physician (or authorized assistant or practitioner) examined the resident (Enter 0 if none)." There was no documented number of visits found. A quarterly assessment with a partial date of April 2001 revealed the following. Section A3.a. [Assessment Reference Date - Last Day of MDS observation period] was blank. Section O3. [Injections] was blank. Section O4.d. [Days received the following medication - Hypnotic] was blank. Section O4.e. [Days received the following medication - Diuretic] was blank. Section P4.a. and c. [Special Treatments and Procedures - Devices and Restraints] documented check marks in both areas. There was no documented number of days the restraints were used on resident 19. Section R2.b.[Date RN Assessment Coordinator signed as complete] documented the month and year of this assessment, but the date of the month that the assessment was signed as complete was blank. 22. Resdient 6's first assessment, dated 12/21/00, revealed the following: Section AA8a and b, Reasons for Assessment, had a check mark instead of the required explanatory code. Section AD, Face Sheet Signatures, had no date of completion or signatures. Section A6, Medical Record Number, was blank. Section A8a, Reasons for Assessment, was coded "18". Coded responses must be a number between "0" and "10". Section O2, New Medications, was blank. Section O3, Injections, was blank. Section 04a-d, Days Received the Following Medication - Antipsychotic, Antianxiety,	F 272		

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F 272	Continued From page 40 Antidepressant, Hypnotic, were all blank. A positive entry is required. Section P3k, Nursing Rehabilitation/Restorative Care, was blank. The second assessment, dated 3/21/01, revealed the following: Section AA8a, Reasons for Assessment, was blank. Section B5a-d, Indicators of Delirium-Periodic Disordered Thinking/Awareness, was blank. Section I2, Infections, was blank. Section J4, Accidents, was blank. Section K2a, Height, was blank. Section O4 a,b,d,e, Days Received the Following Medication - Antipsychotic, Antianxiety, Hypnotic, Diuretic, was blank. Resident 8's quarterly assessment dated 3/23/01 revealed the following: Section AA2, Gender, was blank. Section AA4, Race/Ethnicity, was blank. Section AA8a, Reasons for Assessment, was blank. E2, Mood Persistence, was documented as "0", No Mood Indicators, although Section E1p, Mood Indicators, was documented as "1", Loss of Interest - Reduced Social Interaction. Section R2a, Signature of Person Coordinating the Assessment, was blank. The other quarterly assessment dated March, 2001, revealed the following: Section AA8a, Reasons for Assessment, was blank. Section 9a, the Attestation, had one signature but no sections designated and no date of completion. Section A3, Assessment Reference Date, documented the month as "03" and the year as "2001" but the day	F 272		

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F 272	Continued From page 41 was blank. The entire assessment is dependent on the Assessment Reference Date which designates the specific time period in which the assessment was made, including medications counted, behaviors and level of care monitored and documented, pain symptoms assessed, and physicians visits counted. Section E2, Mood Persistence, was blank. Section K1, Oral Problems, was blank. Section O1, Number of Medications, was blank. Section O4a-e, Days Received the Following Medication - Antipsychotic, Antianxiety, Antidepressant, Hypnotic, Diuretic, was blank. Section R2b, Date RN Assessment Coordinator signed as complete, was blank, although the RN Assessment Coordinator had signed section R2a. The two MDSs for resident 8 had conflicting answers in the following areas: Section AA7, Medicaid Number. Sections A1, Room Number. Section E1p, Reduced Social Interaction. Section G7, Task Segmentation. Section I1, Diseases - Phychiatric/Mood. Section I2, Wound Infection. Section I3, Other Current Diagnoses. Section J2a and b, Pain Symptoms. Section J5, Stability of Conditions. Section M4, Other Skin Problems. Section M5, Skin Treatments. Section O2, Number of Injections. Section P8, Physician Orders. Resident 23 was admitted to the facility 12/19/96. Resident 23's medical record was reviewed 4/20/01. Review of resident 23's MDS assessments revealed the following areas to be incomplete or inaccurate as evidenced by:	F 272		

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F 272	Continued From page 43 Section AA9, Signatures of Persons who Completed a Protion of the Accompanying Assessment, was blank. Section G1d, a and b, Locomotion on Unit - Self-Performance and Support, was blank. 24. Resident 15's MDS assessment dated 3/16/01, should have been a comprehensive initial assessment, including the RAPS (resident assessment protocol). Section AA8 had no identification as to the reason for this assessment on the copy in resident 15's chart. Section E (o,p) were completed. Section K4 (c) was completed, section K5 was completed, and section N (1,2,3,4,5) were completed. There was a signature present on the MDS, in section AD, on the face sheet, in "signature of person completing face sheet." There was no date. There was an additional signature present on Section R (others signatures) but no date was present. The entire eight pages of the MDS were incomplete, excluding these sections. There were no RAPS present in resident 15's chart. The facility used the MDS 2.0 1998 form that did not include the section AA9 for attestation of coompletion and accuracy. 25. Resident 7's MDS assessment dated 4/19/01, was the annual comprehensive assessment, including the RAPS. Section AA8 had no identification as to the reason for this assessment on the copy in resident 7's chart. The form used in resident 7's chart was a quarterly form. There was one signature in section AA9, the attestation of completion and accuracy. There was no date present for this signature.	F 272		
F 281 SS=E	483.20(k)(3)(i) RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 272	Continued From page 42 23. Resident 23's annual MDS assessment, dated February, 2001, revealed the following: Section AB6, Lifetime Occupation, was blank. Section AB7, Education, was blank. Section AB9, Mental Health History, was blank. Section ADa, Signature (and date) of RN Assessment Coordinator was blank, but the RN had signed the attestation at section ADb. The signature was dated 2/25/01. Section A3, Assessment Reference Date, was blank. Section G1h,A, Eating Self-Performance, was blank. Section G1i, A and B, Toilet Use Self-Performance and Support, was blank. Section I1, Diseases, was marked "None of the Above", and Section I3, Other Current or More Detailed Diagnoses, was blank. Resident 23 had multiple diagnoses which should have been listed. Section M2b, Type of Ulcer, was blank. Section M3, History of Resolved Ulcers, was blank. Section O3, Injections, was blank. Section P9, Abnormal Lab Values, was blank. Section R2a and b, Signature of Person Coordinating the Assessment, was signed and dated 2/25/01. The Resident Assessment Protocols (RAPS) which are part of the comprehensive MDS assessment, were signed and dated, at Section VB, 1 and 2, as being completed on 2/23/either MDS and RAPS are the mandated Resident Assessment Instrument (RAI) and must be complete and accurate. The Care Planning Decision should be made after the MDS is completed, using the information obtained from the RAI. The RN who signed the MDS as complete on 2/25/01, also signed section Vb, 3 and 4 on 2/23/01, documenting the Care Plan Decision was made prior to completing the MDS. The quarterly MDS assessment for resident 23, dated 11/24/00, revealed the following:	F 272		

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	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility did not provide services that met professional standards of quality in the area of medication administration for 3 of 25 residents at the facility. The facility nurses did not verify if medications scheduled to be given, but already documented as being given prior to administering the scheduled medication and properly assessing a resident's pulse prior to giving heart medication. Residents: 13, 13 and 18. Findings include: Observation of the facility nurse during the morning medication pass on 4/24/01, the nurse was observed to administer Provera 2.5mg by mouth (PO) and Ferrous Sulfate 325mg PO to resident 13. The nurse was also observe to administer Prednisone 10mg PO to resident 18. Review of the medication administration records (MAR), for these residents revealed documentation that these medications had already been initialed as given. The nurse was observed to draw a line through the initials and write her own initials next to the lines. The nurse stated to the nurse surveyor, "Oh, this happens, the previous nurse accidently initialed the wrong box, I have done this too." Surveyor questioned the registered nurse after the medication pass on what the facility's policy and procedure was for what to do when a medication had already been marked given for your medication pass. The nurse stated, "During shift change report the nurse will state if she gave any medications that were not scheduled for her shift, for example if someone is			

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F 281	Continued From page 45 leaving LOA (leave of absence) and you can look at the 24 hour report at the desk to see if they documented giving any other medications other than scheduled. I know the night nurse did not give those drugs, she initialed for my shift" During an interview with the director of nursing on 4/24/01 at 2:40 PM, the director of nursing stated that the facility's policy was that the nurse administering the medications should contact the previous nurse to verify if the medications had been given prior to administering the medications. Review of the facility policy and procedure manuals revealed no documentation of what to do if a medication is already marked given prior to administering medication. Potter & Perry's Basic Nursing Theory and Practice, second edition in 1991: "The safe and accurate administration of medications is one of the nurse's most important responsibilities. The nurse is responsible for..... administering the drug correctly. The nurse's judgement is critical for proper drug administration" p. 541. 2. During observation of the medication pass on 4/25/01 at 7:50 AM, a nurse was observed to prepare resident 12's medicatons, including Lanoxin 0.125 milligrams (mg). The nurse took resident 12's radial pulse for 15 seconds, immediately before administering the medications. In an interview with the medication nurse, on 4/25/01 at 8:00 AM, the nurse stated that resident 12's pulse, "skips a lot. It is very unusual and varies a lot. You can take one in the morning and one hour later it is totally different".	F 281		

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F 281	Continued From page 46 According to Nursing 98 Drug Handbook, Lanoxin is given for congestive heart failure and atrial fibrillation. Potential adverse reactions to the medication include toxicity. Toxic effect on the heart may be life-threatening and require immediate attention. Nursing considerations when giving Lanoxin include. "Use with extremem caution in elderly patients" and "Before giving, take apical-radial pulse for a full minute. Record and report to the doctor significant changes (sudden increase or decrese in pulse rate, pulse deficit, irregular beats and, particularly, regularization of a previously irregular rhythm)." The instructions include, "Alert: Excessive slowing of the pulse reate (60 beats/minute or less) may be a sign of digitalis toxicity. Withold drug and notify the doctor."	F 281		
F 287 SS=E	483.20(f)(1-4) Resident Assessment Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: Admission assessment; Annual assessment updates; Significant change in status assessments; Quarterly review assessments; A subset of items upon a resident's transfer, reentry, discharge, and death; Background (face-sheet) information, if there is no admission assessment;	F 287		

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	Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by HCFA and the State. A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month, including the following: Admission assessment; Annual assessment; Significant change in status assessment; Significant correction of prior full assessment; Significant correction of prior quarterly assessment; Quarterly review; A subset of items upon a resident's transfer, reentry, discharge, and death; Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. The facility must transmit data in the format specified by HCFA or, for a State which has an alternate RAI approved by HCFA, in the format specified by the State and approved by HCFA. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident record review,			

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F 287	Continued From page 48 review of the Health Care Financing Administration (HCFA) Quality Indicators - Resident Listing and the HCFA State Report Roster Report, it was determined that the facility did not transmit, at least Monthly, MDS data to the State for all assessments conducted during the previous month for 20 of 25 facility residents. Residents: 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, and 24. Findings include: Review of the HCFA Quality Indicators - Data Submission Summary report revealed that the facility had not submitted any acceptable MDS assessment for the months of November 2000, December 2000, January 2001, February 2001 or April 2001. The report revealed that the facility had submitted 5 acceptable reports in the month of March 2001. In an interview with the facility administrator, on 4/25/01 at 4:00 PM, she stated that the facility had been having problems transmitting the MDS assessments due to a computer software problem. Review of the HCFA Quality Indicator report - Resident Listing form and the HCFA State Report - Roster Report revealed that there was no documentation that the facility had transmitted any of the assessments on residents 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, and 24.	F 287		
F 323 SS=E	483.25(h)(1) QUALITY OF CARE The facility must ensure that the resident environment remains as free of accident hazards as is possible.	F 323		

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	This REQUIREMENT is not met as evidenced by: Based on observation, the facility did not ensure that the resident remained free of accident hazards in the area of hot water temperatures. The hot water temperatures in three of ten resident bathrooms were found to be at temperatures that had the potential to cause burns to the residents. Findings include: On 4/24/01, the temperatures were checked in the sinks in the resident bathrooms and the common sink in the dressing room. The following temperatures were noted: 1. The bathroom sink, shared by residents in rooms 1 and 2, had a hot water temperature of 124 degrees Fahrenheit. 2. The bathroom sink, shared by residents in rooms 3 and 4, had a hot water temperature of 130 degrees Fahrenheit. 3. The bathroom sink, shared by residents in rooms 7 and 8, had a hot water temperature of 128 degrees Fahrenheit. 4. The bathroom sink, in room 13, had a hot water temperature of 124 degrees Fahrenheit. 5. The sink in the common dressing room, available to all residents, had a hot water temperature of 130 degrees Fahrenheit. 6. The Intermountain Burn Center graph documented that a water temperature of 124 degrees Fahrenheit for 3 minutes and a water temperature of			

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F 323	Continued From page 50 127 degrees Fahrenheit for 1 minute would cause a person to receive a severe burn.	F 323		
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 observation, interview and medical record review, the facility did not ensure that a resident maintained acceptable parameters of nutritional status as evidenced by: One of ten sampled residents lost 7.5% of her total body weight in 30 days. Resident identifier 7 Findings include: Resident 7 was a 95 year old female admitted to this facility with diagnoses of hypertension, congestive heart failure, macular degeneration, hypthyroidism, and anemia. Review of resident 7's medical record revealed that a dietary assessment was done on 10/7/99, with a recommendation of a regular diet. Resident 7's usual weight was identified as 84 pounds. Her ideal body weight was identified as 94-112 pounds. Resident 7's weight in March of 2001, was 83.7 pounds. In April of 2001, resident 7's weight was 77 pounds. On 11/20/00, a diet order was written for a regular diet. Resident 7 remained on a regular diet until 4/24/01.	F 325		

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F 325	Continued From page 51	F 325		

Review of resident 7's dietary notes done regularly, every three months, from 1/24/00 until 1/17/01, documents that resident 7's weight was stable. On 4/24/01, a dietary note documented that resident 7 had lost 6.7 pounds since March, which was excessive and that her appetite had steadily declined over the past two weeks. The dietary note documented that NuBasic 2.0 (dietary supplement) of 120cc would be ordered for three times a day with her medications and a pureed diet.

The recertification orders for resident 7, dated 3/27/01, were signed by the physician on 3/28/01, to continue with a regular diet.

Review of resident 7's care plan problem (5), dated 2/12/00, revealed that resident 7 had alteration in nutrition related to degenerative changes, altered taste sensation and poor vision. The care plan problem stated that resident 7 was at risk for need of assistance in feeding and for decrease in appetite. The goals, identified by the facility, stated to stabilize present weight or increase weight. It also stated that the resident would eat 75-100% of meals. There were seven approaches to this care plan problem. The approaches, identified by the facility, stated that resident 7 would be weighed as ordered and as necessary. The facility would monitor and document food acceptance and would identify factors that put the resident at nutritional risk. It also stated that staff would have the responsibilities for maintaining nutritional status, set up meal trays and have them ready to eat.

Review of resident 7's nursing care sheet, documented by the nurse aides, revealed that resident 7's oral intake for meals in the month of January, 2001, was

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F 325	Continued From page 52 50-100% of all meals. The nursing care sheet revealed that her oral intake for meals for the month of February, 2001, was 50-100% of all meals. The nursing care sheet also revealed that her oral intake for meals in the month of March, 2001, decreased to 25-75% with occasional refusals to eat. In addition, the nursing care sheet revealed that her oral intake for meals in the month of April, 2001, continued to remain low at 25-75% with occasional refusals to eat. Review of resident 7's medication administration record, documented by facility nurses, for the months of January, February, and March, revealed that she had not received a nutritional supplement during those months. On 4/24/01, Nubasics 2.0, 160cc (cubic centimeters) three times a day, was added to resident 7's medication administration record. Review of resident 7's nurses' notes for the month of March, 2001, revealed that on 3/11/01, the nurse documented "appetite fair, c/o (complains of) food and refuses to eat at HS (hour of sleep)." On 3/17/01, the nurse documented, "ate 50% of meal." On 3/25/01, the nurse documented, "ate 50% of breakfast." There was no other documentation in the nurses' notes of resident 7's oral intake. On 4/24/01, review of the facility weight documentation, revealed that on 3/1/01, resident 7 weighed 83.7 pounds. On 4/1/01, she weighed 77 pounds. This represents a 6.5 pound weight loss or 7.5% of her body weight, in one month. On 4/24/01, during an interview with the RN (registered nurse) providing care for resident 7, she was questioned concerning resident 7's weight loss. The RN stated that she was not surprised that resident 7 had lost weight, since resident 7's appetite had	F 325		

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F 325	Continued From page 53 decreased in the past couple of months. On 4/24/01, the nurse aide providing care for resident 7, was questioned concerning resident 7's weight loss. He stated that resident 7 had decreased in her oral intake. On 4/24/01, the registered dietician for the facility was questioned concerning resident 7's weight loss. She stated that she was not aware of resident 7 's weight loss until 4/24/01. She stated that resident 7's weight loss was excessive.	F 325		
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not store food under sanitary conditions as evidenced by: Five of five refrigerators had soiled doors and shelves. Packages of dry foods were opened with no closures. Containers of food were outdated or unlabeled or undated. The kitchen area had dirt, grease and food particles present. The dish machine did not maintain temperatures for sanitation of dishes. Findings include: On 4/23/01, at 3:00 PM, during the initial observation of the kitchen, there were areas identified which were not sanitary and contained to prevent rodents or pests. These observations are as follows:	F 371		

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F 371	Continued From page 54 In refrigerator number two, there was a pitcher of applesauce labeled 4/19/01. The stove had grease and food particles down the front. The front covering on the gas piping at the bottom of the stove was missing. In the areas under the gas piping was a collection of grease and food particles. There was a sign over a sink in the dish area that stated, "Don't use this sink, clogged," The faucet in this sink had a continuous drip. On 4/24/01, at 1:30 PM, the applesauce noted on 4/23/01, in refrigerator number two, remained in the refrigerator. This same refrigerator had a sign that stated, "Temperature varying, do not use." Food products must remain at a constant temperature to prevent bacterial growth. There were sticky food particles on the bottom shelf and the shelves in the door. The door handle had sticky, grease smudges on it. On 4/25/01, at 3:00 PM, the applesauce remained in refrigerator number two. Refrigerator number three had two packages of cheese that were not labeled or dated. There was a large piece of roast, in a zip lock bag, that was not labeled or dated. A bag of sliced roast beef was in a zip lock bag and labeled 4/1/01. There was a plastic bag, with a knot tied in the top, that had sliced ham in it. The bag was not labeled or dated. Standard practice is to discard meats or dairy products, once opened, after three to four days. These meats were stored in a plastic tub on the top shelf. There was a crack in the left area of the tub, that curved to the bottom area. On the second shelf, under the container of meat, was a large box of margarine patties, exposed to any drips from the meat that might occur. In freezer number one, there was a zip lock bag with broccoli chips in it. This bag was not dated and labeled. There was a blue garbage bag, with a knot tied in the top, containing peas and carrots. This bag	F 371		

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F 371	Continued From page 55 was not dated and labeled. There were areas on the door and the handle that were sticky with food particles. In freezer number two, there was a plastic bag, with a knot tied in the top, that contained chicken squares. This bag was not dated and labeled. There was a red meat, in a plastic bag, tied with a knot at the top. This bag was not dated and labeled. A cardboard box was present on the second shelf. Inside the box was an opened plastic filler with link sausages. The top of the box was completely open, with no covering on the link sausages. The container was not dated and labeled. There were areas on the door and the handle that were sticky with food particles. In refrigerator number four was a bowl of tuna salad that was dated 4/17/01. The handle and the door had sticky smears present. In refrigerator number five was a zip lock bag with an unidentifiable meat. This bag was not dated and labeled. There was a bag of salad greens opened. This bag was not dated and labeled. The handle and the door had sticky smears present. There were large bags of cereal opened but not dated. There was a bag of fortune cookies that were not tied or labeled or dated. There was a container of pasta open and untied. It had no labeled or dated. The facility dish machine was checked for temperatures on 4/24/01, on two different occasions. The manufacturer's recommendation for the dish machine was 150 degrees Fahrenheit. The first cycle for the dish machine reached 148 degrees Fahrenheit. The second cycle for the dish machine reached 144 degrees Fahrenheit. An interview was conducted with a dishwasher staff on 4/24/01, concerning the temperatures of the dish machine. She was questioned concerning the routine	F 371		

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F 371	Continued From page 56 of the facility for maintaining the appropriate temperatures for sanitation of dishes. She stated that the staff tested the temperatures every once in a while but do not document the tests. During an interview with the administrator, on 4/24/01, she stated that the facility did not have a regular cleaning schedule for the kitchen area.	F 371		
F 441	483.65(a)(1)-(3) INFECTION CONTROL The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of the facility infection control log, it was determined that the facility did not maintain infection control program that maintained a record and corrective actions related to infections. Findings include: In an interview with the facility DON, on 4/24/01 at 3:30 PM, she stated that she had not worked on any infection control program since she had been hired in December 2000. In an interview with the facility DON on 4/25/01 at 1:30 PM, she stated that during the QA meeting, the committee goes over any residents on antibiotics and tries to determine why they are on the antibiotics.	F 441		

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F 441	Continued From page 57 Review of the facility Infection Control Manual, on 4/24/01, revealed a policy for "Bloodborne Pathogens Exposure Control Plan, dated January 1998 and updated on January 1999 and January 2000. There was no other documentation of any facility infection control program procedure found. The Infection Control manual contained tracking of resident infections and individual resident infection reports for the months of January 2000, February 2000, and March 2000. In April 2000,May 2000 June 2000, and July 2000, the manual contained individual "Resident Infection Report". There was no documentation of any tracking of infections in the facility for those months. The manual did not indicate whether the infection was community acquired or nosocomial. No documentation could be found to indicate that the infections had been monitored for effectiveness of treatment. There was not further documentation of any tracking of resident infections or individual resident infection reports found in the manual since July 2000. In an interview with the facility administrator on 4/25/01 at 4:00 PM, she stated that the nurse that had been doing the infection control tracking was not presently working at the facility and that the facility did not have a formal infection control program in place at the current time. No evidence could be found or produced by the facility, that there was any method of identification, tracking trends of infection, effectiveness of treatment, or prevalence of infection in the facility, which might have provided the necessary information	F 441		

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F 441	Continued From page 58 to decrease the rate or severity of any infections among facility residents.	F 441		
F 463 SS=K	483.70(f) PHYSICAL ENVIRONMENT The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on Observation and interview it was determined that the facility was not equipped with a functioning communication system from resident rooms, toilet and bathing facility to the nurses' station. This affected all residents at the facility. Findings include: 1. Observations: a. On 4/18/01, at 1:30 PM, the call light system to all resident rooms and toilet and bathing facilities was tested by the nurse surveyors, for audible or visual signals to the nurses' station to call for assistance from the staff. The results of that test were as follows: Resident rooms 1 through 13, 17 and 18 had no light signals in the hallway above the doors. Resident rooms 1 through 13, 17 and 18 had no audible signals relayed to the nurses' station. Resident bathrooms 1 through 9, 17 and 18 had no light signals in the hallway above the doors. Resident bathrooms 1 through 9, 17 and 18 had no audible signals relayed to the nurses' station.	F 463		

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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 463	Continued From page 59 The resident common tub room had no call light system present. The resident common shower room had no light signals in the hallway above the doors and no audible signals relayed to the nurses' station. b. On 4/20/01, at 7:40 AM, the call light system to the nurses' station from the resident rooms was tested. The results were as follows: There were no lights to signal the nurses' station over the doors of room 1, beds A, B, C. There were no lights to signal the nurses' station over the door of room 2, bed B. There were no lights to signal the nurses' station over the door of room 3, bed A and B. The light to signal the nurses' station over the door of room 3, bed C, signaled but also caused several other lights to flicker. There was no light to signal the nurses' station over the door of room 4, bed B. There was no light to signal the nurses' station over the door of room 5, bed B. The light to signal the nurses' station over the door of room 5, bed A, signaled but did not remain on. There was no light to signal the nurses' station over the door of room 7, bed A. There was no light to signal the nurses' station over the door of room 8, bed B. There was no call light present in room 9 to signal the nurses' station over the door for bed A. There was no light to signal the nurses' station over the door of room 11, bed B. There were no lights to signal the nurses' station over the door of room 12, bed A and C. There was no light to signal the nurses' station over the door of room 13, bed A.	F 463		

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	46A047	A. BUILDING _____ B. WING _____	4/25/01

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F 463	Continued From page 60 c. On 4/20/01, at 8:00 AM, the call light system from the resident bathrooms was tested. The results of that test were as follows: The bathroom call light had no light over the door to rooms 1 or 2 to signal the nursing staff. (This bathroom was shared with room 2.) The bathroom call light had no light over the door to rooms 3 or 4 to signal the nursing staff. (This bathroom was shared with room 4.) The bathroom call light had no light over the door to rooms 7 or 8 to signal the nursing staff. (This bathroom was shared with room 8.) The bathroom call light had no light over the door to rooms 11 or 12 to signal the nursing staff. (This bathroom was shared with room 12.) There was no call light in the common tub room. 2. Interviews: a. On 4/20/01, at 11:00 AM, a confidential interview was conducted with a resident. During this interview the resident was asked if she had ever used her call light. The resident stated, "it doesn't work." When asked how she would acquire assistance if she needed it, she stated, "I yell out." The resident was questioned concerning how long the call light system had not been working and she stated, "Since I've been here." She also stated that she had fallen recently and had to yell out and wait for them (staff) to come with assistance to get her up. b. In an interview on 4/18/01 at 5:30 PM, with the facility administrator, she stated, "Oh yes, they work, last years survey was aware of this. There is a problem with the wiring and it's no use in replacing	F 463		

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F 463	Continued From page 61	F 463		

the call light system until the roof is replaced." The administrator walked behind the nurses station and plugged the call light system in, while stating "Oh, sometimes these little people get back there and unplug this." The administrator stated, "Sometimes you just need to remove the call light cord out of the wall and shove it back in." The surveyor asked the administrator if the residents know and are able to pull the cord out of the wall, re-insert it, and then push on call light button? The administrator did not respond.

c. On 4/20/01 at 7:50 AM, a facility nurse approached surveyor and stated, "...[Administrator] was upset because the nurses were unplugging the call light system."

d. In an interview, on 4/18/01, with employee 4, a direct care staff, the employee stated, "I've taught them to come to the door. When I see them in the doorway, I know they need something." Employee 4 further stated, "In addition, I'm in there every 20 minutes, every room."

Employee 4 said he didn't know what was wrong with the call lights, "Maybe water damage." Employee 4 stated, "They did work when I started." He said he couldn't remember when the call lights stopped working.

e. In an interview with employee 1, the employee stated the call lights had, "been broken about seven days, no more." In order to determine if the residents need assistance, the employee stated, "I listen for when they (residents) call."

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F 490 SS=K	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on an abbreviated survey with subsequent extended recertification survey, conducted April 18, 2001 through April 25, 2001, and the resultant finding of Immediate Jeopardy to resident health and safety, the identified system failures in the facility in regard to neglect of the facility to provide goods and services to avoid physical harm or mental anguish when the facility had no functioning call light system and the facility did not make repairs the facility call light system. Additionally, during the extended survey, the facility was found to be non-compliant in the areas of use of physical restraints, reporting of potential abuse of residents, lack of dignity to residents, lack of personalized activities for residents, lack of safe hot water temperatures, lack of accurate MDS assessments of residents, lack of timely transmission of MDS assessments, lack of intervention for significant weight loss of a resident, lack of nurse aide verification, lack of an infection control program, and lack of an effective quality assurance program. This had the potential to affect all residents in the facility. Findings include: On 4/18/01, an abbreviated survey was initiated. Based on the preliminary findings of the abbreviated survey, a recertification survey began on 4/23/01. On 4/20/01, facility administration was noticed of the	F 490		

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F 490	Continued From page 63 elements of Immediate Jeopardy to resident health and safety and Sub-Standard Quality of Care. The determination of Immediate Jeopardy was based on the findings of significant non-compliance in the areas of Resident Behavior and Facility Practices, Staff treatment of residents (neglect) [42 Code of Federal Regulations (CFR) 483.13(c), Tag F-224], and Physical Environment, Resident call system [42 CFR 483.70 (f), Tag F463]. Failure of the facility to address problems identified in these areas were present to such an extent that residents were residing in an environment in which the potential for significant resident harm was likely to occur. 1. Facility administration failed to have systems in place that would ensure that neglect of the residents did not occur when the facility failed to have an operational call light system for the residents to use to seek assistance and ensure that their needs were met. There was a lack of administrative oversight, supervision and monitoring of the staff to ensure that the facility staff was meeting the resident's needs when the facility call light was non-functional. The facility administration failed to put an alternate call system in place to ensure that the facility residents could contact the facility staff to seek assistance in meeting their needs. (Refer to Tag F-224) 2. Facility administration failed to have systems in place that would ensure that the facility had a functional call system that the residents had a means to directly contact the staff at the nurse's station from the resident rooms, toilet areas and bathing areas. The facility was cited for this deficiency in April 2000 at the annual recertification survey. The facility	F 490		

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F 490	Continued From page 64 administration failed to ensure that the corrective actions taken following the April 2000 recertification survey were effective and maintained the facility call light system in a functional status. (Refer to Tag F-463) 3. In addition to the areas of Immediate Jeopardy stated above, the facility administration failed to effectively and efficiently use it resources to ensure that the each resident attained or maintained their highest practicable, physical, mental, and psychosocial well-being in the following areas of deficient practice cited during the extended survey completed on 4/25/01. a. Facility administration failed to ensure that the rights of the residents to be free from physical restraints, imposed for the purpose of convenience and not required to treat a medical symptom, were ensured. (Refer to Tag F-221) b. Facility administration failed to ensure that all allegations of mistreatment, neglect, abuse, including injuries of unknown origin were reported immediately to the administrator, that all allegations were thoroughly investigated, that further potential abuse was prevented while the investigation was in progress, and that all allegations were reported to officials in accordance with state law. (Refer to Tag F-225) c. Facility administration failed to ensure that the facility staff promoted care for the residents in a manner and in an environment that maintained or enhanced the resident's dignity and respect. (Refer to Tag F-241)	F 490		

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F 490	Continued From page 65 d. Facility administration failed to ensure that the facility activities staff provided an on-going program of activities that was designed to meet the interests and the physical, mental, and psychosocial well-being of each resident, in accordance with that resident's comprehensive assessment. (Refer to Tag F-248) e. Facility administration failed to ensure that the facility housekeeping and maintenance staff provided services necessary to maintain comfortable water temperatures and an interior environment that was clean, sanitary and comfortable. (Refer to Tag F-253) f. Facility administration failed to ensure that a comprehensive assessment of a resident's needs, using the RAI (resident assessment instrument) specified by the state, was accurately completed on each resident. (Refer to Tag F-272) g. Facility administration failed to ensure that all resident assessments were electronically transmitted monthly. (Refer to Tag F-287) h. Facility administration failed to ensure that the facility staff provided medications, to facility residents, in a manner that met professions standards of clinical practice. (Refer to Tag F-281) i. Facility administration failed to ensure that the facility maintained an environment that was free of water temperatures that could scald or harm residents. (Refer to Tag F-323)	F 490		

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F 490	Continued From page 66 j. Facility administration failed to ensure that residents maintained acceptable parameters of body weight and prevented unplanned weight loss. (Refer to Tag F-325) k. Facility administration failed to ensure that facility dietary staff stored, and prepared food under sanitary conditions. (Refer to Tag F-371) l. Facility administration failed to ensure that the facility had an infection control program in place. (Refer to Tag F-441) m. Facility administration failed to ensure that the facility did not employee nurse aides for more than four months that had not completed a state approved training and competency program. (Refer to Tag F-494) n. Facility administration failed to ensure that the facility received registry verification that a nurse aide has met competency evaluation requirements prior to allowing the nurse aide to work at the facility. (Refer to Tag F-496) o. Facility administration failed to ensure that the facility quality assurance committee identified issues in which quality assessment and assurance activity was required to develop and implement appropriate plans of action to correct identified quality deficiencies. (Refer to Tag F-521)	F 490		

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F 494 SS=D	483.75(e)(2)-(3) ADMINISTRATION A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of ss483.151-483.154 of this part; that individual has been deemed or determined competent as provided in s483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. This REQUIREMENT is not met as evidenced by: Based on review of facility employee files and a telephone interview with the CNA Registry staff, it was determined that 1 nursing assistant, currently employed by the facility, had worked at the facility longer than 4 months with completing a training and competency evaluation program, therefore not meeting the accepted State requirements. Employee 1. Findings include: Facility employee files were reviewed on 2/25/01. The review revealed that employee 1 did not have documentation in her file that she had completed a training and competency program or received certification as a nurse aide. Employee 1's file documented that employee 1 had been hired by the facility on 8/1100 and had been	F 494		

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F 494	Continued From page 68 working as a nursing assistant for 8 months. In a telephone interview, on 4/26/01, with the staff at the CNA Registry, it was confirmed that employee 1 had not completed a training and competency evaluation program and had not received her nurse aide certification.	F 494		
F 496 SS=F	483.75(e)(5)-(7) ADMINISTRATION Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on staff interview, employee file review, review of a list of new employee hires, Review of the facility staffing schedules for April 2001, and a telephone interview with CNA registry staff, it was determined	F 496		

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F 496	Continued From page 69 that the facility allowed eight individuals to serve as nursing assistants before verification from the CNA Registry was obtained. Employees: 1, 2, 3, 4, 5, 6, 7, 8. Findings include: 1. On 4/23/01, a list of new employee hires was reviewed. On 4/25/01, five employee files and the facility staffing schedules were reviewed. These reviews revealed the following: a. Employee 1 was hired by the facility on 8/11/00. There was no documentation found that the facility had called the CNA Registry for verification prior to employee 1 beginning work as a nursing assistant at the facility. b. Employee 2 was hired by the facility on 8/18/00. There was no documentation found that the facility had called the CNA Registry for verification prior to employee 2 beginning work as a nursing assistant at the facility. c. Employee 3 was hired by the facility on 8/30/99. There was no documentation found that the facility had called the CNA Registry for verification prior to employee 3 beginning work as a nursing assistant at the facility. d. Employee 4 was hired by the facility on 11/20/00. There was no documentation found that the facility had called the CNA Registry for verification prior to employee 4 beginning work as a nursing assistant at the facility. e. Employee 5 was hired by the facility on 4/2/01.	F 496		

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F 496	Continued From page 70 There was no documentation found that the facility had called the CNA Registry for verification prior to employee 4 beginning work as a nursing assistant at the facility. f. Employee 6 was hired by the facility on 3/12/01. The nurse aide staff schedule documented that employee 6 was currently working as a nursing assistant at the facility. g. Employee 7 was hired by the facility on 3/21/01. In an interview with the facility administrator on 4/18/01 at 3:45 PM, the administrator stated that employee 7 had worked as a nursing assistant at the facility, but had terminated her employment at the facility on 4/1/01. h. Employee 8 was hired by the facility on 2/9/01. In an interview with the facility administrator on 4/18/01 at 3:45 PM, the administrator stated that employee 8 had worked as a nursing assistant at the facility, but had terminated her employment at the facility on 4/1/01. 2. In an interview with the facility administrator, on 4/25/01, the administrator stated that the facility had not been verifying with the CNA Registry prior to allowing a nursing assistant to begin work at the facility. 3. In telephone interviews with the staff at the CNA Registry on 4/23/01 and 4/26/01, the staff at the CNA registry stated that they had no documentation that the facility had called for verification on the eight employees.	F 496		

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F 521 SS=E	483.75(o)(2)&(3) ADMINISTRATION The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. This REQUIREMENT is not met as evidenced by: Based on interviews with the facility administrator and director of nursing, and review of QA (Quality Assurance) log provided by the facility, it was determined that the facility did not effectively identify, assess, develop and implement appropriate plans of action to correct quality deficiencies in the areas of non-functional call light system, abuse reporting, significant weight loss, dignity, MDS accuracy and transmission, physical restraints, infection control, accident hazards and nurse aide verification. Findings include: 1. On 4/24/01 at 2:45 PM, in an interview with the facility administrator, she stated that the facility's QA committee consisted of the administrator, the director of nursing (DON), a charge nurse on duty the day of the meeting, the dietary supervisor the activities director, the social service worker and the medical director when available. She stated that the committee met at least quarterly and that it usually met monthly. The administrator stated that the last meeting was in February 2001.	F 521		

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F 521	Continued From page 72 The administrator stated that in the past the QA committee had discussed skin care, incontinence care and hydration and hot water temperatures. The administrator did not state that the facility had identified, assessed or implemented any plans of correction regarding the problems with the facility's call light system, hot water temperatures that were above 120 degrees, abuse reporting, MDS accuracy and transmission, physical restraints, infection control, and significant weight loss. On 4/24/01, the administrator was asked to provide the minutes of the QA committee meetings to the surveyors. The administrator stated that she could not find these meetings notes and that the binder In which the notes were kept in was missing also. On 4/25/01 at 1:00 PM, the administrator was again asked if the QA meeting minutes had been located. The administrator stated that she was still unable to locate the QA meeting minutes. 2. On 4/25/01 at 12:50 PM, two nurse surveyors interviewed the DON about the facility's QA committee. The DON stated that she had only worked for this facility since December 2000, and that prior to her working at this facility she had not been involved in any QA committees or meetings. The surveyors inquired as to who the QA committee members were. The DON stated, "The administrator, myself, a nurse who is on duty and a nursing assistant who is on duty the day of the meeting." The DON stated that the last QA meeting was in February 2001, and that the committee discussed how the facility was meeting the needs of the residents. The DON stated, " I look and see if anyone is on an antibiotic and try to find out why the resident is on the antibiotic, these	F 521		

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PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 521	Continued From page 73 are things we discuss in QA meetings." The DON did not have the QA meeting minutes, but said that the administrator would have them. 3. On 4/25/01, the facility QA policy and procedure manual was reviewed. The review revealed that the manual contained, "Sample Policies, Procedures, and 45 Audit Tools". The review revealed that there was no documentation regarding a actual facility policy and procedure for the facility QA process found. 4. The facility's QA committee failed to identify and subsequently establish corrective action plans to ensure that residents of the facility were provided with a functional call light system that would enable the residents to obtain needed assistance from the facility staff in a timely manner. (Refer to Tag F-463) 5. The facility's QA committee failed to identify and subsequently establish corrective action plans to ensure that resident's assessed needs were being met and that necessary goods and services were provided. The administration failed to operationalize and put in place systemic processes to ensure that residents resided in an environment free from neglect. (Refer to Tag F-224)	F 521		

6/14/01

POC is not acceptable hand carried information needed to administrator on 6/15/01 LB.

Pine Ridge Care Center
Information Needed for an Acceptable
Plan of Correction
June 14, 2001

F-221
1. Need to address what was done for the residents identified in the deficiency, residents 4 and 19.
2. In the #3, is the statement saying – Resident or Family Consent?
3. In the paragraph, "Restraints will only be used..." Should it state that restraints will only be used when a medical need has been identified?
4. How will the DON monitor restraint issues?
5. How often will the DON monitor restraint issues?
6. When will the DON take this monitoring to the QA committee and how often will it be reviewed by the QA committee?
7. Was an inservice given regarding the new restraint policy and if so when was the inservice?

F-224
1. What will the facility do if a problem occurs with the call light system, ie will it be reported to administration, will administration act promptly to resolve the problems identified?
2. When will the monitoring checks be reviewed by the QA committee and how often will the monitoring be reviewed by the committee?

F-225
1. Need to address what was done for the residents identified in the deficiency, residents 4 and 19.
2. The POC needs to state that all allegations of abuse and any injuries of unknown origin will be immediately reported to APS, State survey and ombudsman. The POC also need to state that all allegations of abuse and injuries of unknown origin will be investigated and the results reported to the State survey agency within 5 working days.
3. Was the staff inserviced on the abuse policy and if so when?
4. Who will be responsible to keep the log book and for monitoring that all incidents are reported correctly.
5. Has the log book been reviewed by the QA committee and if so when?
6. How often will this log book be reviewed by the QA committee.

F-241
1. What is "routinely" in regarding to the inservices?
2. Who is responsible for monitoring compliance?
3. How often is the monitoring to be done?
4. Has the monitoring been reviewed by the QA committee and is so when?
5. How often will this monitoring be reviewed by the QA committee?

F-248
1. How is the activity staff going to be monitored for compliance?
2. Who will be doing this monitoring and how often will the monitoring be done?
3. Has the monitoring been reviewed by the QA committee and if so when?
4. How often will the monitoring be reviewed by the QA committee?

F-253
1. How often will the housekeeping be inspected?
2. How often will the fixtures and equipment be monitored?

F-253 Continued
3. What is "inspected as needed" and how will be doing the inspections?
4. How often are the water checks done?
5. How will these system changes be monitored and by whom?
6. How often will monitoring be reported to the QA committee?

F-272
1. How often are the MDS's routinely reviewed?
2. Has this review been taken to the QA committee and if so when?
3. How often will these reviews be taken to the QA committee?

F-281
1. How often is the DON to monitor the nurses for compliance?
2. Has the monitoring been taken to the QA committee and is so when?
3. How often will the monitoring be taken to the QA committee?

F-287
1. How often is the monitoring of transmissions of the MDS's to be done and by whom?
2. Has the monitoring been taken to the QA committee and if so when?
3. How often will the monitoring be reviewed by the QA committee?

F-323
1. How often will the monitoring checks be done and by whom?

F-325
1. What type of monitoring will be done, ie. weights, assessments, dietary consults etc.?
2. Will this monitoring be reported to the DON.
3. How often will the monitoring be done and by whom?
4. Has this monitoring been taken to the QA committee and if so when?
5. How often will the monitoring be reviewed by the QA committee?

F-371
1. What would be the minimum number of unannounced inspections, ie. weekly twice a month?
2. How often is the dishwasher temperatures to be monitored and by whom?
3. How often is the Kitchen to be monitored for cleanliness?
4. Has the monitoring been taken to the QA committee?
5. How often will the monitoring be reviewed by the QA committee?

F-441
1. How often will the DON monitor to see if the infection control program is followed?
2. Has the monitoring been taken to the QA committee?

F-463
1. How often will the monitoring be done and by whom?
2. Has the monitoring been taken to the QA committee?
3. How often will the QA committee review the monitoring?

F-490
The statement in the QA tag regarding the monitoring of administration should be moved to this tag.
1. How often will monitoring be done?

F-490 continued
2. Has the monitoring been taken to the QA committee?
3. How often will the QA committee review the monitoring?

F-494
1. Need to address what was done to correct the problems with employee 1.
2. How often will the monitoring of the log book be done and by whom?
3. Has the monitoring been taken to the QA committee?
4. How often will the monitoring be reviewed by the QA committee?

F-496
1. What was done to correct the problems with employees 1 through 8?
2. The verification of NA's and CNA's needs to be done prior to their starting work at the facility.
3. How often will the log book be monitored and by whom?
4. Has the monitoring be taken to the QA committee for review and if so when?
5. How often will the QA committee review the monitoring?

F-521
OK

SURVEY 2001

F221 PHYSICAL RESTRAINTS WILL NOT BE USED ON ANY RESIDENT WITHOUT PROPER DOCUMENTATION.

1. PHYSICIANS DIAGNOSIS OF MEDICAL SYMPTOMS
2. PHYSICIANS ORDERS
3. RESIDENT OF FALILY CONSENT
4. NURSING ASSESSMENT AND CARE PLANNING

ONLY THE LEAST RESTRICTIVE RESTRAINT WILL BE USED, AND ONLY WHEN ALTERNATIVE MEASURES HAVE BEEN TRIED WITH OUT SUCCESS.

RESTRAINTS WILL ONLY BE USED AFTER GOING THROUGH THE ENTIRE PROCESS FOR PROPER USE AND THEN RESTRAINTS WILL ONLY BE USED TO PREVENT INJURY TO THE RESIDENT.

THE DON WILL REVIEW ALL RESTRAINTS BEING USED AND WILL REPORT TO THE QA TEAM TO ENSURE THE POLICY IS BEING FOLLOWED.

F224 A NEW CALL LIGHT SYSTEM WAS INSTALLED DURING THE SURVEY PROCESS. MAINTENANCE WILL CHECK WEEKLY TO INSURE ALL LIGHTS AND AUDIBLE SIGNALS ARE FUNCTIONING PROPERLY. DOCUMENTATION WILL BE KEPT AND THE QA TEAM WILL MONITOR SAID DOCUMENTATION QUARTERLY.

F225 ALL INJURIES OF UNKNOWN ORGIN WILL BE THROUGHLY INVESTIGATED. IF UNSUBSTANTIATED, INJURY WILL BE REPORTED TO THE FOLLOWING AGENCIES WITHIN FIVE WORKING DAYS OF OCCURANCE

ADULT PROTECTIVE SERVICES
STATE SURVEY AND CERTIFICATION AGENCY
OMSBUDSMAN

STATE LICENSURE
STATE AIDE REGISTRY

A LOG BOOK WILL BE KEPT FOR FOLLOW UP. THE QA TEAM WILL REVIEW THE LOG BOOK AT EACH QA MEETING.

F241 AN INSERVICE REGARDING RESIDENTS RIGHTS AND DIGNITY AND RESPECT ISSUES WAS HELD ON MAY 10, 2001. ALL STAFF WILL TAKE TIME TO LISTEN, ASSIST AND RESPOND TO RESIDENTS. STAFF WILL ADDRESS ANY SPECIAL NEEDS OF RESIDENTS TO RESOLVE ANY INDIVIDUAL PROBLEMS OR CONCERNS. STAFF WILL WILL REFRAIN FROM JOKING WITH RESIDENTS IN AN UNDIGNIFIED MANNER, AND WILL ADDRESS ALL RESIDENTS WITH RESPECT. ANY REPETATIVE COMPLAINTS OR ISSUES VOICED BY RESIDENTS WILL BE RESPONDED TO AND REASSURANCE WILL BE OFFERED. RESIDENT WISHES CONCERNING CARE BY HANDS ON STAFF WILL BE HONORED AND RESPECTED.

INSERVICES WILL BE HELD ROUTINELY FOR THE STAFF TO ASSURE COMPLIANCE. HAND OUTS WILL BE AVAILABLE AND WILL BE GIVEN OUT AT SAID INSERVICES. THE QA TEAM WILL REVIEW & MONITOR TO AVOID REOCCURANCES.

F248 THE ACTIVITY PROGRAM WILL BE MONITORED MORE CLOSLY AS TO MEET THE NEEDS OF ALL RESIDENTS. NEW STAFF HAS BEEN HIRED TO ASSURE THE NEEDS OF THE RESIDENTS ARE MET. THERE WILL OPPORTUNITIES OFFERED TO MEET THE NEEDS OF ALL RESIDENTS REGARDLESS OF THEIR COGNATIVE ABILITIES.

SHOULD A SCHEDUALED ACTIVITY REQUIRE CANCELLATION, A SUBSTITUTION WILL BE MADE AND ALL RESIDENTS WILL BE NOTIFIED OF THE CHANGE. SHOULD AN EMERGENCY OCCUR AN DIVERSIONARY PROGRAM WILL BE OFFERED. THE ACTIVITY STAFF WILL RECORD ANY CHANGES AND REPORT THEM TO THE QA TEAM FOR REVIEW.

F253 ADDITIONAL HOUSEKEEPING STAFF HAS BEEN EMPLOYED BY THE fACILITY IN ORDER TO TO PROVIDE AN ENVIORMENT THAT IS CLEAN AND SANITARY. A CLEANING SCHEDUAL IS NOW IN PACE. ALL AREAS OF THE FACILITY WILL BE ROUTINELY INSPECTED TO INSURE CLEANLINESS.
MAINTENANCE HAS BEEN INCREASED AND WILL ROUTINELY CHECK ALL AREAS OF THE FACILITY TO INSURE PROPER WORKING FIXTURES AND EQUIPTMENT. ALL AREAS WILL BE REPAIRED AND INSPECTED AS NEEDED. (FLOOR TILES, BASE COVE, FAUCETS, AND REPAIRS TO WALLS AND PAINTING OF REPAIRS WILL BE INCLUDED.)
MAINTENANCE WILL CONTINUE TO UTILIZE THE PREVENTATIVE BOOK FOR WATER CHECKS AND TO INSURE A SAFE ENVIRONMENT. THE WATER BOILED WILL BE ADJUSTED AS NEEDED TO TO INSURE RESIDENT SAFETY.

F272 ALL FACILITY MDS FORMS HAVE BEEN REVIEWED AND CORRECTED.

ALL DATA IS NOW CORRECT AND ALL HAVE SIGNATURES IN PLACE, AS WELL AS THE CORRECT DATE. THE QA TEAM WILL REVIEW THE MD'S ON A ROUTINE BASIS TO ASSURE THEY ARE COMPLETE AND CORRECT FOR TRANSMITTAL

F281 AN INSERVICE WAS HELD FOR ALL LICENSED NURSES TO REVIEW THE ADMINISTRATION OF DRUGS AND THE MED PASS PROCEDURE. THE FACILITY HAS IN PLACE A NEW POLICY REGARDING ANY MED ERRORS, OR SIGNING INCORRECTLY FOR A MEDICATION. APPROPRIATE VITAL SIGNS WILL BE TAKES PRIOR TO THE ADMINISTERATION OF CERTAIN MEDICATIONS. A COPY OF THE POLICY WILL BE GIVEN TO ALL NEW NURSES UPON HIRE. THE THE DON WILL BE RESPONSIBLE TO SEE ALL NURSES ARE IN IN COMPLIANCE. THE DON WILL REPORT ANY PROBLEMS TO THE QA TEAM.

F287 ALL MDS DATA WILL BE TRANSMITTED TO THE STATE AS RE-

F287 ALL MDS DATA REQUIRED BY HCFA AND THE STATE OF UTAH. ATTEMPTS WERE MADE FOR TRANSMITTAL BUT WERE REJECTED BY THE STATE OF UTAH BECAUSE OF SOFT WARE ERRORS. ALL OF THE MDS DATA WAS DELETED AND REENTERED AND TRANSMITTED TO THE STATE. ALL VALIDATION REPORTS HAVE BEEN RECEIVED AND A COMPLETE

FILE WILL BE MAINTAINED IN THE FACILITY AND ARE READILY AVAILABLE FOR REVIEW. ALL MDS DATA WILL BE REVIEWED FOR POSSIBLE ERRORS PRIOR TO TRANSMITTAL. THE DON WILL BE RESPONSIBLE TO SEE THAT THE MDS DATA IS CORRECT. ANY PROBLEMS WILL BE REPORTED TO THE QA TEAM.

F323 THE TEMPERATURE CONTROL ON THE BOILED HAS BEEN DECREASED TO INSURE RESIDENT SAFETY. ADDITIONAL WATER TEMPERATURE CHECKS WILL BE MADE THROUGH OUT THE FACILITY TO INSURE TEMPERATURE CONSISTANCY. THE CHECKS WILL BE DOCUMENTED AND REVIEWED BY THE QA TEAM QUARTERLY. ANY UNUSUAL TEMPERATURES WILL BE REPORTED TO THE QA TEAM IMMEDIATELY.

F325 RESIDENT #7 IS NOW RECEIVING DIETARY SUPPLEMENTS WITH EACH MED PASS, AND BETWEEN MEALS. HER DIET IS PUREED AND SHE IS NOW EATING BETTER.

ANY RESIDENT SHOWING A DECREASE IN APPETITE OR A WEIGHT LOSS WILL BE CLOSLEY MONITORED TO ENSURE MAINTENANCE OF ACCEPTABLE NUTRITIONAL STATUS. ANY RESIDENT WITH ANY SIGNIFFICANT CHANGES WILL BE MONITORED BY THE DON AND REPORTED TO THE QA TEAM.

F371 THE DIETARY DEPARTMENT NOW HAS A CLEANING SCHEDUAL WHICH IS BEING FOLLOWED TO PROMOTE SANITARY CONDITIONS. ALL FOODS ARE BEING DATED AND LABELED. ANY LEFT OVER

REFRIGERATED ITEM NOT USED WITHIN 3 TO 4 DAYS OF DATE WILL BE DISCARDED. ALL REFRIGERATED OR FROZED FOODS WILL BE SECURED AND DATED AND LABELED AS TO CONTENTS. FOODS WILL BE STORED IN ORIGINAL CONTAINERS OR IN A APPROPRIATE CONTAINER, SECURED AND DATED AND LABELED. NO FOOD ITEMS WILL BE LEFT EXPOSED. UNANNOUNCED AND ROUTINE INSPECTIONS WILL BE CONDUCTED BY A QA TEAM MEMBER TO INSURE PROCEDURES ARE FOLLOWED. THE DIETARY SUPERVISOR WILL BE RESPONSIBLE TO SEE THAT THE DIETARY DEPARTMENT MEETS THE REQUIRED STANDARDS.

THE WATER TEMPERATURE IN THE DISH WASHER WILL BE MONITORED AND RECORDED TO GUARANTEE RECOMMENDED TEMPERATURES.

F441 AN INFECTION CONTROL PROGRAM IN NOW IN PLACE. ALL INFECTIONS ARE INVESTIGATED, TRACKED, AND TREATED TO SAFE GUARD PREVENTION OF SPREAD, AND TI IDENTIFY TRENDS AND EFFECTIVENESS OF TREATMENT. THE DON WILL SEE THAT THE INFECTION CONTROL PROGRAM IS FOLLOWED. THE QA TEAM WILL REVIEW THE INFECTION CONTROL PROGRAM QUARTERLY.

F463 REFER TO TAG # F224. A NEW CALL LIGHT SYSTEM WAS INSTALLED AND FINALIZED ON 04-24-2001. WEEKLY CHECKS ARE BEING DONE TO INSURE THE SYSTEM IS WORKING PROPERLY AND THAT THE RESIDENTS ARE NOT IN JEOPARDY.

F490 ADMINISTRATION HAS ADDRESSED ALL DEFICIENCIES AS EVIDENCED IN THE PLAN OF CORRECTION. DEPARTMENT HEADS WILL NOW ASSUME RESPONSIBILITY FOR THEIR DEPARTMENTS AND EACH DEPARTMENT WILL BE REVIEWED ON A ROUTINE BASIS TO ASSURE COMPLIANCE WITH STATE REGULATIONS. DOCUMENTATION OF SAID REVIEWS WILL BE KEPT IN THE ADMINISTRATIVE OFFICE.

F494 THE DON WILL VERIFY THROUGH THE STATE REGISTRY ALL NEW HIRES FOR THE NURSING DEPARTMENT. ALL NON CERTIFIED EMPLOYEES WILL NOT BE ALLOWED TO WORK PAST FOUR (4) MONTHS UNLESS THEY BECOME CERTIFIED. A LOG BOOK WILL BE KEPT FOR COMPLIANCE VERIFICATION. ANY HANDS ON CARE EMPLOYEE MUST ALSO PASS A BACK GROUND CHECK OR THEY WILL NOT BE KEPT ON STAFF.

F496 THE DON WILL CALL THE REGISTRY ON EACH NEW HIRE IN THE NURSING DEPARTMENT TO ASSURE THEY ARE CERTIFIED. A LOG BOOK WILL BE KEPT FOR VERIFICATION. THE QA TEAM WILL REVIEW THE LOG TO MAKE SURE THE FACILITY IS IN COMPLIANCE.

F521 THE QA TEAM WILL MEET MONTHLY TO IDENTIFY, ASSESS, AND RESOLVE ANY PROBLEMS. ALL SURVEY DEFICIENCIES AND ANY NEW FINDINGS WILL BE REVIEWED AS TO AVOID REOCCURANCE.

MINUTES OF EACH MEETING SHALL BE KEPT AND WILL BE MADE AVAILABLE TO ALL STATE AGENCIES UPON REQUEST. THE LOG BOOK SHALL BE KEPT IN THE ADMINISTRATION OFFICE.

THE FACILITY ADMINISTRATION WILL BE REVIEWED AT EACH QA MEETING TO ASSURE THE RESIDENTS NEEDS ARE BEING MET AND THE NECESSARY SERVICES ARE PROVIDED, TO INSURE THE RESIDENTS ARE FREE FROM NEGLECT AND INJURY. MINUTES WILL BE KEPT OF EACH MEETING AND WILL BE KEPT IN THE QA BOOK.

ALL OF THE FACILITY DEFICIENCIES WILL BE CORRECTED AND MET BY JUNE 20, 2001