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TN to RR 7-22-02

DEPARTMENT OF HEALTH AND HUMA ERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 7/1/20
FORM APPROVE
2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465117	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED 6/19/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE OF SOUTH OGDEN	**5540 SOUTH 1050 EAST OGDEN, UT 84405**

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F 225 SS=D	483.13(c)(1)(ii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to 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 interviews and record review, it was determined for three allegations of abuse, the facility did not report incidents and investigations of alleged	F 225	Accepted 8/1/02 with amendment [initials] The statements made on this plan of correction are not an admission of guilt and do not constitute an agreement with the alleged deficiencies herein. Utah Dept. of Health 7099 3220 0001 9947 3353 JUL 22 2002 07/19/02 H7 Bur. of Medicare/Medicaid Prog. Certification and Res. Assessment	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 7-16-02

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

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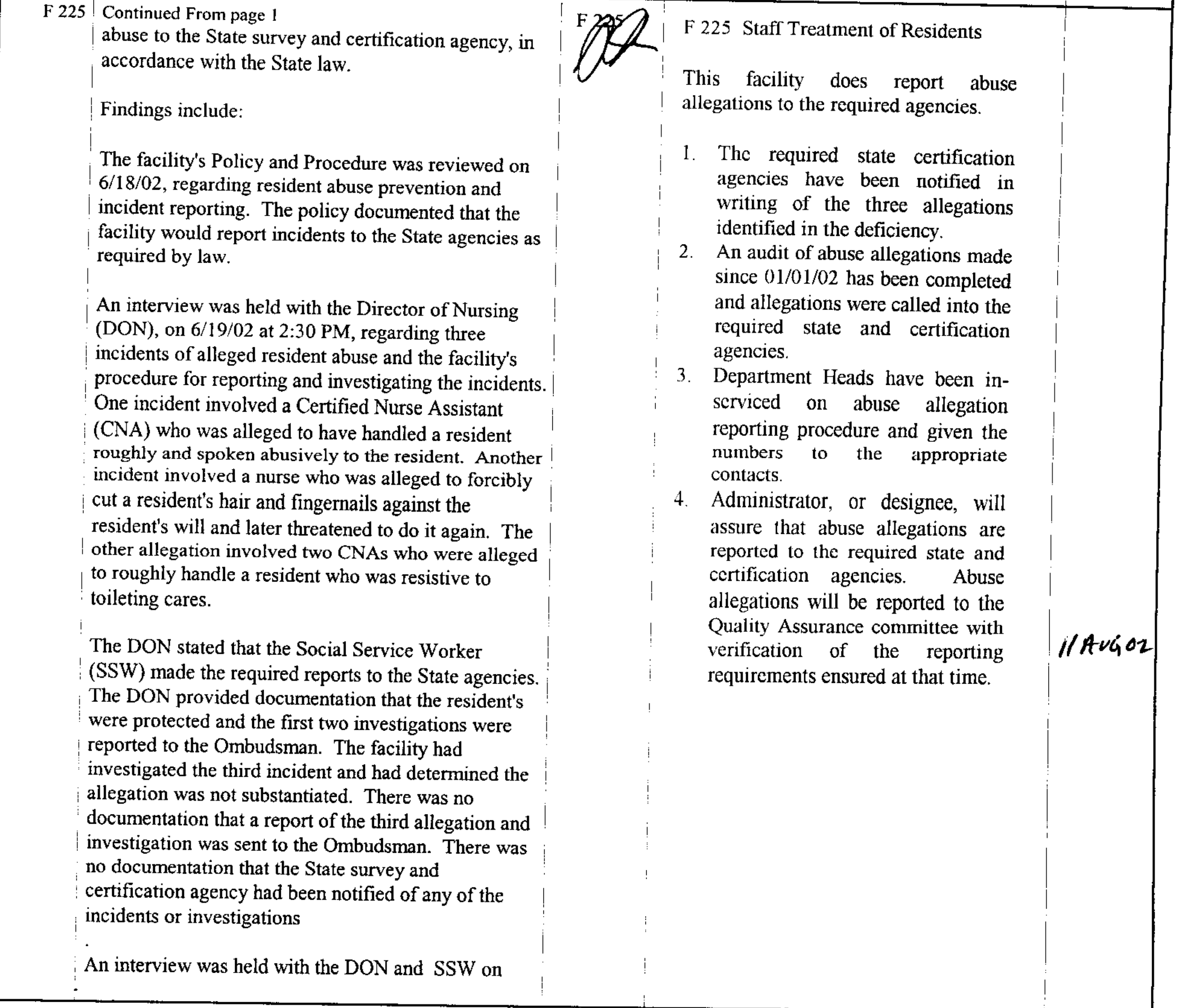

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F 225	Continued From page 1 abuse to the State survey and certification agency, in accordance with the State law. Findings include: The facility's Policy and Procedure was reviewed on 6/18/02, regarding resident abuse prevention and incident reporting. The policy documented that the facility would report incidents to the State agencies as required by law. An interview was held with the Director of Nursing (DON), on 6/19/02 at 2:30 PM, regarding three incidents of alleged resident abuse and the facility's procedure for reporting and investigating the incidents. One incident involved a Certified Nurse Assistant (CNA) who was alleged to have handled a resident roughly and spoken abusively to the resident. Another incident involved a nurse who was alleged to forcibly cut a resident's hair and fingernails against the resident's will and later threatened to do it again. The other allegation involved two CNAs who were alleged to roughly handle a resident who was resistive to toileting cares. The DON stated that the Social Service Worker (SSW) made the required reports to the State agencies. The DON provided documentation that the resident's were protected and the first two investigations were reported to the Ombudsman. The facility had investigated the third incident and had determined the allegation was not substantiated. There was no documentation that a report of the third allegation and investigation was sent to the Ombudsman. There was no documentation that the State survey and certification agency had been notified of any of the incidents or investigations . An interview was held with the DON and SSW on	F 225	F 225 Staff Treatment of Residents This facility does report abuse allegations to the required agencies. 1. The required state certification agencies have been notified in writing of the three allegations identified in the deficiency. 2. An audit of abuse allegations made since 01/01/02 has been completed and allegations were called into the required state and certification agencies. 3. Department Heads have been in-serviced on abuse allegation reporting procedure and given the numbers to the appropriate contacts. 4. Administrator, or designee, will assure that abuse allegations are reported to the required state and certification agencies. Abuse allegations will be reported to the Quality Assurance committee with verification of the reporting requirements ensured at that time.	11 AUG 02

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F 225	Continued From page 2 6/19/02 at 3:30 PM. The SSW gave examples of incidents of possible resident to resident abuse that had been reported to the Adult Protective Services (APS). The SSW stated that the Ombudsman was always notified and provided documentation that investigation reports had been faxed to the Ombudsman. The SSW stated that the last time a report was made, the Ombudsman told her to notify the State agency. The SSW stated that two different telephone numbers were provided by the Ombudsman to call in the reports, but that neither telephone number was correct. The SSW and a corporate Nurse Manager stated that this facility did not report allegations of abuse to the State survey and certification agency in Utah.	F 225	F 274 Resident Assessment This facility will continue to identify residents with a significant change and take the appropriate care towards their specific care needs.	
F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT Within 14 days after the facility determines, or should have determined, that there has been a significant change in the residents physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the residents status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the residents health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility did not make a comprehensive assessment, using the Resident Assessment Instrument (RAI) as specified, within two weeks of determining a resident had experienced a significant change of condition for 1 of 20 sample residents and 1 supplemental resident.	F 274	1. A significant change MDS has been completed and care plans updated to reflect current care needs on resident's 16 and 21. 2. Residents that have triggered for a significant change, per the significant change log obtained by the MDS nurse, have received a completed significant change MDS. 3. The significant change log will be reviewed by the MDS nurse on a weekly basis. Any change of condition identified in the building will be reviewed at stand-up meeting by the Interdisciplinary Team where the need for a significant change MDS will be determined. Staff have been re-educated to significant chance criteria.	

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F 274	Continued From page 3 Residents: 16 and 21 Findings include: 1. Resident 16 was a 79 year-old female who was admitted to the facility on 10/26/01 with diagnoses that included non-insulin dependent diabetes mellitus, dementia, lethargy, hypertension, hypothyroidism, arthritis, and recent history of edema. Resident 16's medical record was reviewed on 6/18/02. Facility staff had completed an admission Minimum Data Set (MDS) assessment for resident 16, dated 10/31/01, and a quarterly MDS assessment dated 1/30/02. The quarterly MDS documented a significant improvement in seven areas of resident 16's level of care. The facility did not complete a significant change RAI after identifying the significant change. Documented areas of improvement for resident 16, from 10/31/01 to 1/30/02, included: Physical Functioning - Section G1, c - ability to walk in room and walk in corridor improved from "activity did not occur" to ambulation with limited assistance of one person, g - ability to dress self from extensive assistance to limited assistance of one person, i - ability to toilet self from extensive assistance to limited assistance of one person, G2 - ability to bath/shower self from extensive assistance to limited assistance of one person; Continence - Section H1, a - from totally incontinent of bowel to never incontinent of bowel, b - from totally incontinent of urine to never incontinent of urine. Resident 16 had a significant weight change of 17 percent, which was documented in Section K2,b - Nutritional Status, an increase from 103 pounds to 120 pounds. 2. Resident 21 was a 79 year-old female who was	F 274	4. The MDS nurse assures that residents identified with a significant change in status receive a significant change MDS where appropriate. The nurse manager for documentation, or designee, will review and evaluate the need for significant change(s). The change of condition log will be reviewed in Quality Assurance meeting.	11AUG02

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F 274	Continued From page 4 admitted to the facility on 3/3/00 with diagnoses that included congestive heart failure, osteoporosis, Alzheimer's dementia, Crohn's disease, chronic obstructive pulmonary disease, hypothyroidism and pneumonia. Resident 21's medical record was reviewed on 6/19/02. Facility staff had completed a quarterly MDS assessment for resident 21, dated 12/12/01, and completed a Medicare re-admission MDS assessment, dated 01/14/02. The readmission MDS documented a significant change of decline in six areas of resident 21's level of care. An annual MDS assessment, dated 3/13/02, documented the resident remained at the lower level of functioning previously identified, and her weight continued to decline. The facility did not complete a significant change RAI after identifying the significant change. Documented areas of decline for resident 21, from 12/12/01 to 1/14/02, included: Physical Functioning - Section G1, b - ability to move and reposition self in bed declined from limited assistance to maximum assistance of one person, c - ability to transfer self between surfaces declined from limited assistance to maximum assistance of one person, i - ability to toilet self declined from limited assistance to maximum assistance of one person; Continence - Section H1, a - from occasionally incontinent of bowel to incontinent all or almost all of the time, b - from occasionally incontinent of urine to incontinent all or almost all of the time. Resident 21 had experienced a significant weight loss of 5 percent in one month, which was documented in Section K2,b - Nutritional Status, a decrease from 168 pounds to 159 pounds.	F 274		

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~~F 287~~	~~Continued From page~~ 5	~~F 287~~		
F 287 SS=B	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; 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;	F 287	F 287 Resident Assessment It is the practice of this center to accurately discharge residents from the MDS system in the appropriate time frame and manner. 1. Four of the five residents identified in the deficiency have been appropriately discharged from the MDS system as required. The remaining resident identified cannot be discharged from our system as required. Our MDS nurse has contacted the appropriate state MDS technical support person and is awaiting his assistance with this discharge. 2. Discharged residents have been appropriately discharged as required. 3. The OBRA Assessments Incomplete form will be printed monthly by the MDS nurse. 4. The MDS nurse will assure that all required transmission to the state has been completed. The OBRA Assessments Incomplete form will be reviewed at Quality Assurance meeting.	11AUG02

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F 287	Continued From page 6 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: F287 Based on interview, review of the facility's current resident roster, and the "Center for Medicare and Medicaid Services (CMS) State-End of Month Roster Report" for May 2002, it was determined that the facility did not encode or transmit Minimum Data Set (MDS) discharge tracking forms to the state database for 5 of 95 facility residents listed on the CMS State-End of Month Roster Report. Resident identifiers: 3, 26, 72, 84, and 94. Findings include: 1. The facility's current resident roster and the CMS State-End of Month Roster Report (a report that documents the MDS assessments and tracking forms encoded and transmitted by the facility), dated May 2002, were reviewed. This review revealed that 5 of 95 residents listed on the CMS State Roster Report were not listed on the facility's current resident roster.	F 287		

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F 287	Continued From page 7 2. On 6/18/02, the MDS Coordinator printed the validation reports and confirmed that some of the records had not been transmitted to the state MDS system.	F 287		
F 314 SS=G	483.25(c) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews it was determined that the facility did not prevent 1 of 12 sample residents from developing a pressure ulcer that was clinically avoidable. Resident identifier: 4. Findings include: Resident 4's medical record was reviewed on 6/17/02 and revealed the following: Resident 4 was admitted to the facility on 6/10/02 with diagnoses that included open reduction internal fixation of right hip fracture and Alzheimer's. In an interview with the charge nurse, on 6/17/02 at 7:45 AM, she stated that she thought the heel ulcer was facility acquired and as soon as she observed the left heel ulcer she applied a pressure relieving boot (mouse house) to the left foot and a pressure relieving	F 314	F 314 Quality of Care This facility strives to assess, upon admission, for pressure ulcers and will continue to prevent in-house acquired pressure areas. 1. Resident #4's heel has resolved. 2. An audit of skin conditions in the building has been completed. Appropriate treatment measures are in place with care plans updated accordingly. Head-to-toe skin assessments are completed upon admission and skin risk factors re-evaluated quarterly. Skin breakdown preventative modalities are in place and care planned. 3. Nursing staff have been re-educated to the Quality of Life skin program ulcer prevention elements. 4. Director of Nursing, or designee, will track and trend pressure ulcers and report findings to Quality Assurance Committee. D.O.N. or designee will assure compliance to skin program and prevention of in-house acquired pressure ulcers.	11 AUG 02

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F 314	Continued From page 8 mattress to his bed. She also stated that she had documented the ulcer as a stage II but that staging really could not be determined due to eschar (a dried covering of dead tissue) covering the ulcer, and that she referred resident 4 to the wound care team. She also stated that she only works weekends and the first time she observed resident 4 was on 6/15/02. Review of resident 4's nursing note, dated 6/16/02 at 5:15 PM, documented "Late entry regarding Stage II pressure ulcer L [left] heel 6 cm [centimeters] x 6 cm x 2 cm [with] serosanguinous [a mixture of serum and blood] exudate. Eschar surrounding/covering. Cleansed [with] ns [normal saline]. IntraSite applied et. [and] covered [with] primapore. Mouse house for elevation of foot from bed. Family and physician notified." The late entry nursing note was signed by the charge nurse. A physicians order, dated 6/15/02, stated "Stage II pressure ulcer to L heel. Cleanse [with] NS. Apply IntraSite. Cover [with] Primapore." Review of resident 4's Admission Nursing Assessment form, dated 6/11/02, documented that resident 4's right hip incision was dry and clean with staples intact, no other skin problems were identified. Under the ADL (activities of daily living) section of the assessment, it was documented that resident 4 needed limited assistance with bathing, dressing and transferring and that he was at no risk for skin break down. A resident with Alzheimer's and who is recovering from hip surgery is at risk for pressure ulcers, especially of the heels. Reference: U.S. Department of Health and Human Services AHCPR Publication No. 92-0048 May 1992 titled Preventing Pressure Ulcers states..."Persons who are in a coma or who are	F 314		

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F 314	Continued From page 9 paralyzed or who have a hip fracture are at special risk...When mental awareness is lowered (such as Alzheimer's), a person cannot act to prevent pressure ulcers..." In an interview with the facilities corporate nurse manager, on 6/19/02 at 2:00 PM, she stated that resident 4 had slipped through the system and felt that the heel ulcer was probably present on admission to the facility from the hospital, due to the length of time needed to form an eschar covering, and that the heel ulcer was not identified on the initial nursing assessment. There was no MDS (minimum data set) assessment in resident 4's medical record since he was still within the regulatory timeframe of 14 days from admission to the facility. A care plan for resident 4, dated 6/15/02, documented "Potential for skin breakdown R/T [related to] poor mobility, et R hip fx. [fracture], alt. [altered] nutrition. 6/15/02-unstaged ulcer to L heel"	F 314		
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 staff interviews and clinical record review, it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by 1 of 20 sampled	F 325	F 325 Quality of Care The center will continue to offer/provide the nutritional value needed to our residents. 1. Resident #16's weight has stabilized (now 109.3 lbs. on 7/8/02). House Supplements were started 6/26/02 three times per day and refused by the resident who asked that the supplements be stopped on 7/3/02. Labs drawn	

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F 325

Continued From page 10
residents who experienced significant, unplanned weight loss without interventions implemented to prevent further weight decline. Resident: 16.

Findings include:

1. Resident 16, a 79 year-old female, who was admitted to the facility on 10/26/01, had diagnoses including non-insulin dependent diabetes mellitus, dementia, lethargy, hypertension, hypothyroidism, arthritis, and recent history of pitting edema.

A review of resident 16's weekly weight tracking record revealed weight fluctuations from 103 lbs (pounds) to 133.6 lbs due to edema and diuretic therapy, making it difficult to assess her actual body weight. Resident 16 received her last dose of diuretic medication on 4/5/02, but her weight continued to decline. The facility did not review her weight loss until 5/30/02, and did not implement corrective measures until 6/10/02. Resident 16 lost 14 percent of her body weight between 4/5/02 and 6/10/02.

Resident 16's weight tracking record documented her weight to be:

Date	Weight
April 5, 2002	125.1 lbs
April 21, 2002	119.5 lbs
April 31, 2002	123.2 lbs
May 6, 2002	119.9 lbs
May 18, 2002	115.2 lbs
May 27, 2002	115.5 lbs
June 1, 2002	112.0 lbs
June 9, 2002	108.0 lbs
June 19, 2002	107.0 lbs

Calculating weight loss percentages is done by subtracting the current weight from the previous weight, dividing the difference by the previous weight

F 325

7/5/02: Vitamin B12 (high) and TSH (dropped from mid-normal in Dec 01 to 0.19 - low). Lab results faxed to MD 7/5/02. Received order to discontinue Duragesic patch and clarification of current Prednisone orders. Follow up lab work is ordered for August.

2. Interdisciplinary Team members are actively participating in meal monitoring to identify behaviors of staff or residents which may lead to weight loss and aatempt to stop potential weight loss before it occurs. Weight loss is identified by close monitoring of monthly and weekly weights. Causal factors are determined by the Interdisciplinary Team through weekly Quality of Life meetings. Interventions are implemented and monitored during meal service and results reviewed and documented in weekly Quality of Life meetings. House scales have been evaluated for accuracy and calibrated where needed. A CNA weight team has been trained and deployed to standardize weighing process. Meal intake documentation program is in place and staff educated to needed accuracy.
3. Staff have been re-educated to Nutrition Quality of Life programs emphasizing weight-gain programs, early detection and weight-loss prevention.
4. D.O.N. or designee will monitor program compliance and report

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MANOR CARE OF SOUTH OGDEN	**5540 SOUTH 1050 EAST OGDEN, UT 84405**

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F 325	Continued From page 11 and multiplying by 100. Significant weight losses are defined as follows: 5% in one month, 7.5% in 3 months and 10% in 6 months. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000). Weight loss of any higher percentage than documented above is severe weight loss. A review of the medical record for resident 16, documented the resident had a recent history of edema. Resident 16 had been treated with diuretic medication. Review of the Medication Administration Record (MAR) for resident 16, dated February 2002, documented the resident had been admitted with an order to receive Lasix 80 mg every morning. On 2/2/02, the diuretic was decreased to every other morning. After the 2/16/02 dose, resident 16's diuretic was further reduced to twice a week and then changed to prn (as needed). Resident 16 received her last dose of the diuretic on 4/5/02, but her weight continued to decline. Review of the weight tracking sheet for resident 16 documented that on 4/5/02, resident 16 weighed 125.1 lbs. On 5/18/02, she weighed 115.2 lbs. The resident had lost 8% of her body weight over the six weeks, from 4/5/02 to 5/18/02. By 6/1/02, two months after the diuretic had been discontinued, resident 16's weight was 112.2 lbs, a loss of 10% of her body weight. On 6/9/02, resident 16 weighed 108 lbs. A serum lab (laboratory) value, drawn 4/9/02 from resident 16, was reviewed. The lab result revealed a serum albumin (protein) level of 2.6. The normal range, according to the lab used by the facility, was 3.2-5.6 g/dl (grams per deciliter). An albumin level of 2.4 g/dl to 2.9 g/dl is considered a moderate visceral protein deficit. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000, page 22). Resident 16's total serum	F 325	monthly to QUALITY ASSURANCE. D.O.N. or designee will assure on-going compliance to Nutrition programs as written through provided program validation tools no less than quarterly.	11AUG02

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protein level was 5.4. Normal levels were documented as 6.0 to 8.5 g/dl. Resident 16's hematocrit (HCT) was 27.00. The normal range, according to the lab used by the facility, was 37.00 to 47.00.

A review of the Registered Dietician's (RD) Nutrition Risk Assessment for resident 16, dated 3/18/02, documented resident 16's score to be 13 points, where 8 or more points indicated a high nutrition risk. The Assessment documented resident 16's desirable weight as being 130 lbs, plus or minus 10 lbs. It documented resident 16's weight was 126.7 lbs r/t [related to] an increased appetite and 3-plus, pitting edema. Resident 16 was on a regular diet and did not want to have a diabetic diet. The RD recommended to add "NAS" [no added salt] to her diet to help manage the resident's edema. The RD recommended to continue resident 16's same plan of care.

Review of resident 16's plan of care, dated 3/7/02 and 3/27/02, documented a goal that resident 16 would "stabilize weight at 120-130 [pounds] for next 90 days and that her labs would be in normal range on next review". Approaches to follow to reach the goal were:
1. Diet as ordered and tolerated.
2. Assist to main dining room for all meals.
3. Encourage fluids with meals.
4. Offer snack at bedtime.
5. Encourage to stay in dining room when she appears anxious.

In an Interdisciplinary Team (IDT) care conference, on 3/6/02, the IDT documented the resident's weight was "increasing gradually following" a fall she had. The IDT notes for resident 16, dated 3/27/02, documented, "Primary issues around anxiety et [and] pain control. Therapy assisting et not aggressive due to this. Considerable decline after fall." Resident 16's weight was not addressed in the documentation.

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It was documented in the Interdisciplinary Progress Notes, dated 5/30/02, that resident 16 was reviewed and considered for weight loss. The team decided to wait one more week before putting her in their Quality of Life program (for team focus to help improve a resident's condition) because her weight was stable from the previous week (up 0.3 lbs).

In the Weight Loss Assessment, dated 6/6/02, the Certified Dietary Manager (CDM) documented resident 16's current weight as 112.2 lbs and her previous weight as 119.9 lbs for a 6.4 % weight loss in one month.. The CDM documented, "At this time weight is questionable. We will wait another week and assure weight report is correct. DON has noticed [resident] eating 90-100% of meals. If weight loss is true we will begin enhanced meals."

On 6/10/02, the RD reviewed resident 16's weight change. The RD's notes, dated 6/10/02, documented resident 16 lost 18.2 lbs in 90 days and 11.9 lbs in 30 days which was a "significant weight loss X [times] 30 : 90 days." The RD documented resident 16's HCT was 34.8 at that time. The RD suggested "enhanced foods with meals tid [three times daily] and assess for need of additional nutritional supplements. Continue with plan of care."

In an interview on 6/19/02, a CNA who provided cares for resident 16 stated that the resident "feeds herself and eats really well, about 80%" of her meals.

In an interview on 6/19/02 at 10:30 AM, the DON explained the facility's policy and procedure for weight loss. The DON used a flow chart to indicate what steps needed to be taken for resident 16. He stated that when the resident had a weight change, the nurse, physician, dietetic professional and family member

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F 325	Continued From page 14 should have been notified and the dietetic professional should have prepared a weight loss assessment and initiate an acute care plan. Following the flow chart, the DON stated, resident 16's weight loss was "avoidable" and that it was an "unintended loss". The DON stated that the IDT had not pursued resident 16's weight loss because they reasoned it was probably a side effect from her fractured ribs. In an interview with the corporate Nurse Manager, on 6/19/02 at 10:45 AM, the Nurse Manager stated the problem was identified late. She stated, "They knew of the loss but considered it related to diuretics and didn't shift gears to this loss."	F 325		
F 371 SS=D	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, the facility did not store and distribute food under sanitary conditions as evidenced by undated, uncovered food found in the refrigerator, cardboard boxes of food being stored on the floor and non-food service personnel without hair nets walked through the kitchen during the breakfast tray line preparation. Findings include: On 6/17/02 at 6:30 AM there were 4 partially used cases of mighty shakes that had been taken out of the freezer, placed in the refrigerator and were not dated. The label on the cartons stated that the product was to be used within 14 days after it had been thawed. There were opened containers of sour cream and ranch	F 371	F 371 Dietary Services This facility does adhere to the required food infection control practices. 1. Issues identified in this deficiency have been addressed and corrected. The staff identified in the deficiency have been retrained as to the related state requirement(s). 2. Current items have been checked (audited) to assure proper labeling and storage is taking place. 3. Dietary staff have been in-serviced on proper labeling, dating, and food storage/safety. Hair nets are now available outside of each kitchen entrance. An audit will be completed by the Food Service Manager, or designee, twice per week to assure food is being stored and labeled properly.	

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F 371	Continued From page 15 dressing in the refrigerator that had not been dated. In the freezer there was an opened bag of french toast that had not been dated. In the refrigerator, there was one pitcher of apple juice, one of orange juice, one of tomato juice and one of fruit punch which were not covered. There was a cardboard box of icecream located on the floor of the freezer and a cardboard box of bananas located in the south west corner of the main kitchen. On 6/18/02, during the breakfast preparation of the tray-line, a maintenance man, certified nursing assistant and administrator walked through the kitchen without proper hair restraints. Staff who have been working with residents or other areas and then come into the food preparation area increase the chance for food borne illness and cross contamination.	F 371	4. The weekly audits will be reviewed at the monthly Quality Assurance meeting. The Food Servcice Manager will assure adherence to these requirements.	11AU602
F 463 SS=D	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, the facility did not provide a call light communication system from two resident accessable toilet facilities to the nursing station. Two restrooms by the main dining room, in the main hallway, did not have a call system. Findings include:	F 463	F 463 Physical Environment This facility is equipped to receive resident calls through communication systems from resident rooms and toileting and bathing facilities. 1. Call light communication systems linking the two identified, resident accessible toilet facilities to nurses stations are in place. 2. The added call light system now functions as required to alert staff to resident needs when activated	

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F 463	Continued From page 16 On 6/17/02, observation revealed, two restrooms by the main dining room, in the main hallway, did not have a call system. Two facility CNAs were interviewed on 6/18/02. The CNAs stated that the residents occasionally use these restrooms. She added that she will sometimes assist a resident into the restroom, but then wait outside for him/her to finish.	F 463	from the resident-accessible public restrooms in the main hallway. 3. Staff was inserviced to the new equipment installed in the public restrooms and to respond to resident calls from those locations with the same promptness as is expected for any call light response. 4. Call light response and equipment function are randomly audited by Administrator or designee. Results trended, deficiencies, if any, addressed, and results reported to Quality Assurance quarterly.	11AUG02
F 496 SS=D	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 interviews with the staff developer and review of personnel records, it was determined the facility did not receive registry verification before allowing an individual to serve as a nurse aide for 2 of	F 496	F 496 Administration This facility will continue to call the State Registry for new employees as required. 1. The required call to the State Registry has occurred on both employees identified in this deficiency. 2. An audit has been completed to assure that a call to the State Registry, where necessary, has occurred on all current employees. 3. The State Registry will be called prior to employment on all ~~CNA~~ Nurse Assistants in the future, ~~particularly~~ including those enrolled in facility-sponsored CNA classes. Our system for verification with the State Registry has been reviewed and is sound.	

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F 496	Continued From page 17 5 nurse aides in the sample. Employees: 1 and 2. Findings include: Personnel records were reviewed for 5 nurse aides who had been hired by the facility within the past four months. The records documented: Employee 1 was hired on 3/11/02 as a nurse aide. Employee 2 was hired on 5/10/02 as a nurse aide. There was no documentation that the State Registry had been contacted for information regarding possible history of abuse findings for either of the nurse aides. In an interview with the Director of Human Resources (HR), the HR stated she had not been aware that new nurse aides, who said they had not been certified previously, needed to be have their status verified with the Registry.	F 496	4. The Human Resource Director assures that required reporting/ calls are conducted upon employee hire. The list verifying State Registry calls is reviewed and presented to the Quality Assurance committee quarterly. Amended per telephone call with DON on 7-31-02	11AUG02