DEPARTMENT OF HEALTH AND HUMAN SERVICES CRUTTOOO 22 PRINTED: 10/4/2004 CENTERS FOR MEDICARE & MEDIC D SERVICES **EORM APPROVED** ŌMB NO. <u>0938-039</u>1 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED B. WING 465117 NAME OF PROVIDER OR SUPPLIER 8/11/2004 STREET ADDRESS, CITY, STATE, ZIP CODE MANOR CARE OF SOUTH OGDEN 5540 SOUTH 1050 EAST **OGDEN, UT 84405** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5)CROSS-REFERENCED TO THE APPROPRIATE TAG COMPLETION DATE DEFICIENCY) 483.10(b)(4) NOTICE OF RIGHTS AND F 155 S=G SERVICES 9/20/04 F-155: Quality of Life The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as A) Resident CL 1 was specified in paragraph (8) of this section. discharged home per family request. This REQUIREMENT is not met as evidenced B) by: The facility has Based record review and interview, the facility did reviewed the advanced not ensure a resident had the right to choose directives of all health care consistent with his interests and residents currently medical treatment plan. receiving IV Therapy to Resident identifier: CL 1 ensure consistency. 2) The Licensed Nursing Staff will receive staff Findings included: education to review a CL 1 was admitted to the facility on 6/28/04, with resident's advanced the diagnoses that included lumbago, directive before diverticulum of esophagus, advanced senile commencing heroic dementia and neoplasm. measures. 2) Licensed Nursing Staff 1. On 8/2/04, a review of resident CL 1's medical will receive staff record was completed. education in regards to Notification prior to A review of resident CL 1's medical treatment commencing a new plan,dated 6/29/04, revealed that resident CL 1 Certification and Residen form of had a DNR (Do Not Resuscitate) status, was not treatment. to receive tube feedings, IV(intervenous) fluids, or antibiotics. The 'Change in Status Report" (24-hour On 6/29/04 the facility social worker documented Report Sheet) includes that she had spoken to resident CL 1's family in a section for the regards to resident CL 1's advanced Licensed Nurse to directives, and DNR status. The social worker also complete when the documented that no heroic measures, no IV fluids family has been and antibiotics were to be given. She documented notified of a change that the facility was to, "Provide comfort care." to a medication or treatment. A record review of resident CL 1's Physician ABORATORY DIRECTOR'S PAPROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE ny deliciency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

COMPLAINT

her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

DRM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5EIG11

Facility ID. UT0050

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/4/2004 CENTERS FOR MEDICARE & MEDIC. ... SERVICES FORM APPROVED OMB NO: 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465117 NAME OF PROVIDER OR SUPPLIER 8/11/2004 STREET ADDRESS, CITY, STATE, ZIP CODE MANOR CARE OF SOUTH OGDEN 5540 SOUTH 1050 EAST **OGDEN, UT 84405** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE (X5)COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 155 Continued From page 1 F 155 Progress Notes dated 06/30/04 revealed that the physician had ordered blood work to be drawn. The Licensed Nursing On 7/2/04 the results of the blood work were Staff will report received by the facility and faxed to the physician completion of the by a facility LPN. The same laboratory results for resident/family resident CL 1 were returned to the facility via fax notification when by the doctor with instructions; "1) Dehydrated reviewing physician [arrow] place IV (intravenous catheter) and give order changes to 1/2 NS (normal saline) @ 100cc/hr (hour) X medications or (times) 3 liters then D/C (discontinue)....." treatments on the "24 Hour Report Sheet" in On 07/5/04 at 2:45 PM, on a facility IDT progress the daily Stand-Up note, a nurse had written, "Daughters here asking Meeting. about IV. Object to IV contrary to Adv (advance) 3) The Director of Directive. Called [resident CL 1's] Dr... & ok to Nursing and/or designee will review D/C IV." the Family Notification 2. On 8/2/04 at 1:45 PM, an interview with a section on the "24 facility nurse, who had taken care of resident CL Hour Report Sheet 1, was conducted. He stated that he routinely has been completed does not look at advanced directives before on a regular basis. starting an IV and that he assumed the doctor 4) The Social Services would have worked out the, "specifics" and been, Director will conduct "cognizant" of the resident's requests. a quarterly in-service. for the Nursing Staff 3. On 08/17/04, at 12:20 PM resident CL 1's POA on resident rights. (power of attorney) was contacted. The POA D) The Director of Nursing stated that on 2/22/00 she was given power of will identify any trends of attorney for resident CL 1. non-compliance and report the findings to the QA The POA stated that on 6/29/04, one day after Committee on a monthly resident CL 1 was admitted to the facility, she had basis. conferenced with facility staff and discussed with E) This Plan of Correction them that resident CL 1 did not want IV fluids, (POC) will be completed tube feedings, or antibiotics administered. She by 9/20/04. did, however, agree that resident CL 1 would not

measures.

have objected to the use of oxygen for comfort

The POA stated that on Saturday July 3, 2004,

STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE S	ETED
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F 155	Continued From pa		F 155			
	that if there were an 1, the facility was to surrogates. The PO	lity that on Monday July 5, ng town for a few days and y problems with resident CL notify specifically named A stated that she gave the				
	placed on the front p medical chart. She t 2004, she left town a	with the surrogates names pers and saw the post-it note page of resident CL 1's hen stated that on July 5, at 6:30 AM and did not arrive 004. The POA further stated				
	at no time did the fac fluid therapy for resid The POA stated that	if resident CL 1 had been				·
	been very upset by i	/ therapy and "he would have ts infusion.			· · · · · · · · · · · · · · · · · · ·	, we
ſ	equest, on 7/8/04 an	facility, at the family's ad died two days later.				
h h	OA, was interviewed ad never contacted !	5 PM, Surrogate 1 for the d. He stated that the facility him for any reason and did hysician's order to place an				
re	eceive a call from the L 1. She went with re	PM, Surrogate 2 for the She stated she did not e facility concerning resident esident CL 1's wife to visit day morning, July 5, 2004 at				
ui ac tre	ocordain if an IV was ocordance with reside eatment plan. At app	e IV infusing. She was appropriate and in ent CL 1's medical roximately 1:00 PM she				
iv	omed Surroyate 3, 10	or the POA, of the infusing				ř.

DEPARTMENT OF HEALTH AND HUMN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 10/4/2004 FORM APPROVED OMB NO: 0938-0391

STATEM	ENT OF DEFICIENCIES					OWB N	<u>O. 0938-039</u>
AND PLA	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	IULTIPLI	E CONSTRUCTION	(X3) DATE	SURVEY
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NAME O	F PROVIDER OR SUPPLIER			577.5		8/	11/2004
MANO	P CARE OF COURT AS			STREE	T ADDRESS, CITY, STATE, ZIP CODE	Ξ	
MANO	R CARE OF SOUTH OG	DEN			SOUTH 1050 EAST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	<u> </u>	- JGL	DEN, UT 84405		
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F 15	5 Continued From pag	ge 3	F1	55			<u> </u>
							ŀ
	receive a telephone concerning resident received a call from 7/5/04, stating reside infusing. Surrogate Surrogate 2 and dischad IV fluids infusing surrogates, the phys	O PM, Surrogate 3 for the d. She stated she did not call from the facility CL 1. Surrogate 3 stated she Surrogate 2 on Monday ent CL 1 had IV fluids 3 went to the facility with covered that resident CL 1. At the request of the ician was contacted by the ds were discontinued.					
33=0	A facility must immed consult with the resid known, notify the resid known, notify the resid accident involving the injury and has the pot intervention; a signific physical, mental, or production of the clinical complications significantly (i.e., a ne existing form of treatment); or a decisithe resident from the fix483.12(a). The facility must also pand, if known, the resident from the fix483.12(a).	ment due to adverse commence a new form of on to transfer or discharge acility as specified in promptly notify the resident dent's legal representative	F 15	57	F-157: Notification of Right Services 1-6: A) Resident CL 1 was discharged home per family request. B) Licensed Nursing Stareceive staff education regards to Notification prior to commencing form of treatment. C) 1) The 'Change in Seport' (24-hour Report Sheet) income a section for the Licensed Nurse to complete when the family has been notified of a chanton a medication of treatment.	aff will on in on a new status	9/20/04

UEPA	AHIMENT OF HEALTI	HAND HUNN SERVICES		~	PRINTED: 10/4/200
_CEN	TERS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE
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NAME O	F PROVIDER OR SUPPLIER	465117			8/11/2004
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F 15	7 Continued From pa	ge 4	F 1	57	M*
	specified in s483.1 resident rights underegulations as specithis section. The facility must redithe address and philegal representative. This REQUIREMENT by: Based on medical rewas determined that family of a resident finew form of treatment (power of attorney) with facility received an offluids. Resident idented Resident CL 1 was a 6/28/04, with the diagrumbago, diverticulur dementia and neoplasion of the facility and faxe facility LPN. The same	5(e)(2); or a change in r Federal or State law or ified in paragraph (b)(1) of ord and periodically update one number of the resident's or interested family member. T is not met as evidenced ecord review and interview, it the facility did not notify the or the commencement of a not. Specifically, the POA was not notified when the order for IV (intravenous) tifier: CL 1 dmitted to the facility on phoses that included not esophagus senile	F 19	2) The Licensed Nursing Staff will report completion of the resident/family notification when reviewing physician order changes to medications or treatments on the "24 Hour Report Sheet" in the daily Stand-Up Meeting. 3) The Director of Nursing and/or designee will revie the Family Notification section on the "24 Hour Report Sheet been completed on regular basis. 4) The Social Service Director will condi a quarterly in-servi for the Nursing Sta on resident rights. D) The Director of Nursin	has a a s uct ice. uff
	Dehydrated [arrow up catheter) and give 1/2 (times) 3 liters then D/On 7/5/04 at 6:02 AM (Interdisciplinary team	4 with instructions; "1) place IV (intravenous NS @ 100cc/hr (hour) X C (discontinue)"		will identify any trends non-compliance and re the findings to the QA Committee on a month basis.	port

		AND HUMAN SERVICES & MEDIC SERVICES					FORM	D: 10/4/200 1 APPROVE), 0938-039
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		465117	B. WIN	G		_	8/1	C 1/2004
NAME OF F	PROVIDER OR SUPPLIER	, 		STREET ADDR	ESS, CITY, STATE,	ZIP CODE	<u> </u>	772004
MANOR	CARE OF SOUTH OG	DEN	_	5540 SOUT OGDEN, U	H 1050 EAST JT 84405			
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F 157	Continued From pa	ge 5	F 1	57				
	saline at) 100cc (cu accidentally on ano	order for 1/2 NS @ (normal bic centimeters)/(hour) I found ther fax machine. Hence, . 1's name] didn't get started 6:00 AM)"		E	(POC) will b by 9/20/04.			
·	note a nurse had wi asking about IV. Of	PM, on a facility IDT progress ritten, "Daughters (sic) here bject to IV contrary to Adv . Called (resident CL 1) Dr						
	she notified the faci 2004, she was leavi that if there were an 1, the facility was to surrogates. The PO	that on Saturday July 3, 2004, lity that on Monday July 5, ng town for a few days and ly problems with resident CL notify specifically named A stated that she gave the			: : :			
	and telephone numl placed on the front p medical chart. She to 2004, she left town back until July 8th, 2	with the surrogates names pers and saw the post-it note page of resident CL 1's then stated that on July 5, at 6:30 AM and did not arrive 2004. The POA further stated cility contact her to discuss IV dent CL 1.						
	POA, was interviewed had never contacted	15 PM, Surrogate 1 for the ed. He stated that the facility I him for any reason and did order to place an IV.						
	4. On 08/5/04, at 2:3	35 PM, Surrogate 2 for the						

POA was interviewed. She stated she did not receive a call from the facility concerning resident CL 1. She went with resident CL 1's wife to visit resident CL 1 on Monday morning, July 5, 2004 at 10:00 AM and saw the IV infusing. She was uncertain if an IV was appropriate and in accordance with resident CL 1's medical

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/4/2004 FORM APPROVED CENTERS FOR MEDICARE & MEDICALD SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 465117 8/11/2004 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5540 SOUTH 1050 EAST MANOR CARE OF SOUTH OGDEN **OGDEN, UT 84405** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 157 Continued From page 6 F 157 treatment plan. At approximately 1:00 PM, she notified the Surrogate 3. 5. On 08/5/04 at 3:00 PM, Surrogate 3 for the POA was interviewed. She stated she did not receive a telephone call from the facility concerning resident CL 1. Surrogate 3 stated she received a call from Surrogate 2 on Monday 7/5/04, stating resident CL 1 had an IV infusing. F-241: Quality of Life Surrogate 3 went to the facility with Surrogate 2 and discovered that resident CL 1 had IV fluids infusing. At the request of the surrogates, the physician was contacted by the facility and the IV A) No resident identifier #. fluids were discontinued. B) 1) The Licensed Nurses 6. On 08/12/04, at 3:47 PM, an interview with will receive staff resident CL 1's physician was conducted via the education related to telephone. The physician stated he does not being present in the usually order IV fluids and usually speaks with the assistive dining room nurse before ordering IV fluids. for resident safety. 2) The Licensed Nursing Staff have received Basic Life Support F 241 483.15(a) QUALITY OF LIFE F 241 9/20/04 Training which includes SS=E the Heimlich maneuver. The facility must promote care for residents in a C) manner and in an environment that maintains or 1) The C.N.A Staff will enhances each resident's dignity and respect in receive staff education full recognition of his or her individuality. on dining room safety. 2) The facility will

This REQUIREMENT is not met as evidenced

Based on observations of meal service, it was

service in a manner and in an environment that

would enhance each residents' dining experience

determined the facility did not provide meal

in the assistive dining room. Residents who

arrived in dining areas, either independently or with staff assistance, were not served their meals

in a timely fashion. Additionally, residents were

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۲.

implement a

with meals.

Management Dining

residents are receiving

the necessary assistance

Room Observation

Program to ensure

DEPARTMENT OF HEALTH AND HUM I SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 10/4/2004 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			MULTIP ILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		465117	B. WI	NG		8/1	11/2004
	PROVIDER OR SUPPLIER CARE OF SOUTH OG			55	EET ADDRESS, CITY, STATE, ZIP CODE 40 SOUTH 1050 EAST GDEN, UT 84405		
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	their meals. Resident identifiers 1,3,11,14,16,17,18, residents were not Findings included: 1. On 07/27/04, at 2 facility CNA 1 was 6 CNA 1 stated that t	19,22,23,24,26,27,28. Four identified. 2:55 PM an interview with conducted. he facility's criteria for			3) The Managers will observe the assisti dining room to enthe following: appropriate nursing staff is proresidents receive to necessary assistant with meals, reside are positioned	esent, he ice	
	-anyone on thic - had swallowing -needed encoung -or cannot feed. She further stated to the dining room of the work of the assistive dining the assistive dining the stated the assist one nurse and two	ragement to eat; themselves. here should always be a nurse or a resident that may choke. hany residents were usually in room, she stated that right ir limit, which was eighteen. stive dining room should have CNA's at all times.			properly, meals ar and are served in a timely fashion, residents receive the correct therapediets, and resident groomed appropriprior to exiting the dining area. 4) Any issues identified during the Dining Room Observation Program will be reported to the	eutic is are ately e ñed	
	dining room was consistent residents with dining room by a Classistant), beginning were seated at a tain dependent reside arrived at 6:34 PM. by 6:46, which was minutes after being minutes after the 5: the assistive dining observed in the assistive dining observed	observation of the assistive inducted. were helped to the assistive NA (certified nursing g at 5:50 PM and all residents ble by 6:07 PM. Two nts arrived later. Meal trays All resident trays were served thirty-one to forty-nine seated and twenty nine 55 PM posted meal time for room. Three CNA's were sistive dining room. In the magainst the north wall, on a			Administrator for immediate follow 5) A monthly scheduling room monimal will be completed the Dietary Mana and the Administ will monitor for compliance. D) The Administrator will report any identified is to the QA Committee	-up. ule of itors by ger rator	

DEPAR	RTMENT OF HEALTH	AND HUN SERVICES				PRINT	ED: 10/4/2004
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F 241	Continued From page	ge 8	F2	241			<u> </u>
	built in cabinet, then picture full of water carafes, one filled whot chocolate. The have been served the residents and only of There were five square four residents at each minute time period, to have been served were assisted with the requested a drink and CNA's assisted only tables. Table 1: At 6:10 PM, one CN seated at table 1 if such chocolate. The resident about the condition of the condition. The resident waited 34 minutes for served the hot chocol twice.	e was a tray with one water and ice, cups and two ith coffee and one filled with water was not observed to be entire dinner period to any one cup of coffee was served. The are tables to accommodate the table. During the forty-four residents were not observed any water. Four residents heir food. One resident and was not given one. Two one resident at different. A asked one of four residents he would like coffee or hot dent responded she would was given a cup of coffee. At esident at table 1 asked for a link said she would ask the resident was on thickened A in the room responded the second resident was on 6:20 PM, the second for a drink. The second decheck with the kitchen. At resident leaned over to the sed drinking her coffee and cup. I've got to have responded to the second at requesting a hot chocolate ther meal tray and was not late she had requested.			monthly basis for further recommendations. E) This plan of correction to completed by 9/20/04. 2. A) The C.N.A Staff will receive staff education on providing appropriate ADL assistance to residents # 3 and #19. B) The C.N.A Staff will receive staff education on providing appropriate ADL assistance to residents. C) 1) The facility will implement a Management Dining Room Observation Program to ensure residents are receiving the necessary assistance with meals. 2) The Managers will observe the assistive dining room to ensure the following: appropriate nursing staff is present, residents receive the necessary assistance	be	
	Resident 17, who nee with dining per the res	eded extensive assistance sident's admission MDS			necessary assistance		

DEPAR	TMENT OF HEALTH	AND HUM SERVICES			,	PRINT	ED: 10/4/2004
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F 241	Continued From pa	ge 9	F2	241	,	·	
	(Minimum Data Set 5:56 PM. At 6:36 P to assist with feedin spoke in a loud voice who was across the takes this long to eathat lately resident 1 The CNA was not of assist the other three. Table 3: One resident arrived resident was served next to the resident CNA was not observed the three residents. Table 4: A resident arrived at resident made the state of the resident was seforty-four minutes after oom. Resident 3 arrived at waiting twenty minutes.	dated 7/19/04, arrived at M a CNA sat with the resident g. At 6:55 PM, the CNA e and asked a second CNA, room, if this resident always t. The other CNA responded 7 was taking longer to assist. Deserved to encourage or e residents at table 2. I at 6:05 PM. At 6:39 PM, the a dinner tray and a CNA sat to assist with feeding. The red to encourage or assist the sat table 3. 5:55 PM. At 6:33 PM the atement, "Sure are slow". rved a dinner tray at 6:39 PM, er coming to the dining	F2	241	with meals, resident are positioned propositioned propositioned propositioned arrive and are served in a timely fashion, residents receive the correct therapeutic diets, and residents are groomed appropriate prior to exiting the dining area. 4) Any issues identified during the Dining Room Observation Program with the English of the Administrator for follow up. 5) A monthly schedule of dining room monitors with the Dietary Manager and the Administrator will be responsible to monitor for compliance. 7) The Administrator will report any identified issues to the	erly, d ely ll -	
	behind the resident's to take resident 3 ou. The CNA spoke in a who was across the identures had been foinform or speak to rebeing taken out. Resident 19, who need in the dining per the resider arrived in the dining reM, after waiting eight	wheelchair and proceeded of the assistive dining room. loud voice to a second CNA, room, that the resident's ergotten. The CNA did not sident 3 as to why he was eded limited assistance with at's quarterly 5/19/04 MDS, room at 6:07 PM. At 6:25 ateen minutes for her meal, too long, and that she was		E 3	QA Committee on a monthly basis for further recommendations. This plan of correction to be completed by 9/20/04.	1	

dizzy. The CNA responded to resident 19 that

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUM SERVICES			-	FOR	ED: 10/4/200 M APPROVE	D
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE COI	NSTRUCTION	(X3) DATE	PLETED	<u>11</u>
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MANOR CARE OF SOUTH OG			5540 SOL	DRESS, CITY, STATE, UTH 1050 EAST , UT 84405		11/2004	
PREFIX (EACH DEFICIENCY)	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE A ROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	,
6:26 PM, the reside lie down. The CNA late because it was would lie the resider resident stated, "I got resident was served assisted by a CNA. again stated, "I gotta resident 19 to drink immediately drank? her cup on the table PM, the CNA took rewheelchair without a not encourage her fushe would like to eat A fourth resident arriserved dinner at 6:35 minutes after being served dinner at 6:35 minutes arrived in 12:22 PM to 1:30 PM Lunch trays arrived in 12:22 PM. There was the help of the Activiti residents. Fourteen is second CNA came to eighteen minutes late came to assist at 12:2 minutes after trays we came to the dining route of the dining route.	sident down after dinner. At not stated again she needed to responded that dinner was Monday and after dinner she at down. At 6:32 PM, the lotta go". At 6:35 PM, the her meal, and was not At 6:39 PM, the resident a go". The CNA asked her milk. Resident 19 at of her cup of milk and set a stating "No more". At 6:40 esident 19 out in her ssisting her with dining, did orther or ask the resident if her dinner in her room. In the dinner in her room at the resident's er to reheat the resident the residen	F2		resident for preference 3) Resident # referred to Occupation	pood ss. \$22 has been all be screened riate evices. If will flucation on opriate e to y will a ent om on ensure re he with gers will e assistive m to following: e nursing sent, eceive the assistance t, residents ned heals are served		

DEPA CENT	RTMENT OF HEALTH ERS FOR MEDICARE	AND HUM SERVICES & MEDICAID SERVICES					FOR	D: 10/4/20 APPROVE	ED
STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	AULTIPL	E CONSTR	RUCTION	(X3) DATE COMP). 0938-039 SURVEY LETED	<u> 31</u>
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			TAG		CHOSS	REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE	
F 241	Continued From pag	ge 11	F 2	241				<u> </u>	\dashv
						residents receive			İ
	Table 1:					the correct		1	ı
	One resident arrived	at 12:18 PM, and was				therapeutic diets, and		1	- 1
	served her lunch tra	y at 12:48 PM. At 1:10 PM the				residents are]	
•	resident, who had no	ot eaten or drank anything				groomed		1	- [
	stated she wanted to	leave the dining room. In				appropriately prior to	i	· .	-
	response, a CNA en	couraged the resident to eat.				exiting the dining		1	- 1
	The resident stated:	she didn't know what to eat.				area.			
	The CNA walked up	to and sat with the resident				 Any issues identified 			- 1
`.	twenty-two minutes :	after being served. The CNA				during the Dining			-
1.	did not offer to rehea	at the resident's meal.		į		Room Observation		İ	ı
		at the resident's meal,						H	- [
•	Table 3:					Program will			ı
						be reported to the			
	AL 12:43 PM, one Up	NA asked resident 23 if she				Administrator for			1
	wanted butter on her	bread. The resident said		ļ		immediate follow-up			
	she did not care. Wi	hile the CNA buttered		i		A monthly schedule (of		
4	resident 23's bread,	she stated to another CNA,		ŀ		dining room monitors	5		1
	who was on the othe	r side of the room, "I don't				will be completed by		-	1
	think she'll even notic	ce".		İ		the Dietary Manager		***	j
				i		and the Administrato	r	-	ı
•	Resident 22, who nee	eded limited assistance with				will be responsible to			1
	dining per the resider	nt's quarterly 7/14/04 MDS,				monitor for complian		-	1
	arrived at 12:15 PM.	and was served her lunch		İ	י וכו	The Administrator will	CC.		1
	tray at 12:45 PM twe	nty three minutes after trays				report any identified issue	-		1
	arrived Resident 22	had a lap buddy on her		- 1					1
	wheelchair which wor	uld not allow the wheelchair		Ì		to the QA Committee on a	1		
	to be pushed close to	the table. Resident 22 had				monthly basis for further	Í		1
	contracted hands and	dingers and because 22 had		ļ		recommendations.	_		
	not extend to a full	fingers and her arms would				This plan of correction to	be		ı
	Hornessee of the Harris	nge of motion. After several				completed by 9/20/04.			ļ
i	unsuccessful attempt	s to reach her glass,		4	4.		1		ĺ
	resident 22 gave up a	nd pulled her plate onto her		-	A)			= 1	1
. 1	lap buddy. As she atte	empted to place food in her		Ì]	1) The Licensed Nurses	j		
	mouth with a fork, the	food spilled onto her				will receive staff	-		
	clothing protector and	lab buddy. At 12:52 PM		ļ		education related to			
İ	seven minutes after b	eing served, a CNA sat		1		being present in			
	down to assist her. A	t 12:55 PM, the CNA				the assistive dining	1		ĺ
`	placed resident 22's p	late back on the table and				room for resident		l	
.	left the resident. At 1:	12 PM, resident 22 pulled				safety.	ļ		l
	the plate back on to th	e lap buddy but could not				satery.	1	en:	i
]	reach her fork so she	ate with her fingers At					1	-	

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	THE REPORT OF TH			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	1/2004	_
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F 24	1 Continued From pag	10 12	 	_	DEFIDICION)			-
	The state of the s		F2	241	·			٦
	1:18 PM, the CNA re	eturned to resident 22 and			The C.N.A Staff will	1		ļ
ė	moved her plate bac	ck to the table. The CNA		}	receive staff educati	on		- [
•	gave resident 22 a b	bowl with a spoon and walkad		- 1	on dining room safe	tv.		-1
	away. The resident	made several unsuccessful			3) The C.N.A Staff wil		1	
	attempts to bring the	SDOOD to her mouth. The	1	ĺ	receive staff educati		1	1
	UNA returned, took t	the spoon and howl away	1		on providing		,	-
	indin resident 22 and	I gave the resident a drink			appropriate ADL		,	-
	through a straw. Wh	en the resident was finished		}	assistance to resider	ıta	140	ı
	swallowing, the CNA	placed the glass on the table			B) The C.N.A Staff will	its.	٠	
	and walked away At	1:20 PM, the resident	'	İ				1
	attempted to reach h	er plate and glass but could			receive staff education of	n .		1
	not Resident 22 star	tod picking the factorial			providing appropriate	Ì		L
	Spilled onto har lan h	ted picking the food that had		- 1	ADL assistance to			1
	food droplets and the	uddy and began eating the			residents.	}		
	roturned to the	king her fingers. The CNA			C)	ſ		ſ
	returned to the reside	ent and without asking if	i	1	 The facility will 	İ		1
	resident 22 was done	started washing the			implement a			
	resident's hands. At	1:24 PM, the resident was	ļ		Management Dining			1
	taken out of the dining	0 (00m. The resident had			Room Observation	' .		1
	i consumed a little less	than one-half of her total			Program to ensure	ł	**	ı
	meal. The nutritional:	Supplement served with her			residents are	i		1
	lunch meal remained	out of her reach and was		}				1
	not offered to her.	THE TOUGHT AND WAS		- 1	receiving the	-		ĺ
	1	i		- [necessary assistance]	.]	ĺ
	Table 5:			- 1	with meals.	J		
					2) The Managers will			
	Besident 27 arrived at	12:15 DM A 10.05 DI		1	observe the assistive	1		ı
	she made the some-	12:15 PM. At 12:35 PM,			dining room to			
	nassing the travel **	nt, "I wish they would keep			ensure the following	:	. 1	
	served har times. At	12:39 PM, resident 27 was			appropriate nursing		·	
	other three works	eleven minutes after the			staff is present,		.	
. [other three residents a	at table 4 had been served.			residents receive the		ļ	
					necessary assistance	1	· .	
	Hesident 16 was serve	ed at 12:30 PM. At 12:49			with meals, residents		ľ	
1	PM, nineteen minutes	after being served the		1	are positioned	'	ŀ	
}	activity director sat dol	ND to assist resident to			properly, meals	ł	į.	
J	The activity director did	not offer to reheat the						
İ	resident's lunch.	The same to rome at the			arrive and are served		ļ	
1	•				in a timely fashion,		Ī	
	4. On 08/02/04, an obs	servation of the assistive			residents receive		ľ	
}	dining room was condi	icted for the lunch meal.			the correct		ŀ	
	The lunch trave arrived	from the kitch-		}		[ŀ	
	anon mays arrived	from the kitchen at 12:15				1	l	

DEPAI CENTI	RTMENT OF HEALTH ERS FOR MEDICARE	AND HUN SERVICES & MEDICAL SERVICES				PRINTE FORM	ED: 10/4/2004 MAPPROVED
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NAME OF	PROVIDER OR SUPPLIER			T		8/1	1/2004
MANOF	CARE OF SOUTH OG	DEN		5540 \$	ADDRESS, CITY, STATE, ZIP CODE SOUTH 1050 EAST EN, UT 84405		
(X4) ID PREFIX TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL GC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	II O RE	(X5) COMPLETION - DATE
	PM. Table 1: Resident 16, who ne per the resident's quas served her lunc PM, sixteen minutes resident 16 with two the resident. Resides self propelling herse room. She was not a Table 3: Resident 22 was ser PM. At 12:54 PM, the stated to another CN everything and was of the resident any additional Resident 23, who need with dining per the resident 12:50 PM, twenty-one was encouraged to easked the CNA, "When CNA then sat down to the resident 11 started of choking at 12:43 PM, she was "okay". At 12 therapist, who was as walked up to the resident 12 the resident 24, who need the resident 24.	eded supervision with dining larterly MDS dated 7/7/2004, h tray at 12:34 PM. At 12:50 later, a CNA assisted or three bites of food and left ent 16 ate ¼ of her tray before if out of the assistive dining encouraged to eat more. Wed her lunch tray at 12:35 e CNA assisting resident 22 A that resident 22 had eaten lone. The CNA did not offer tional food or drink. Reded extensive assistance sident's quarterly 6/23/04 r lunch tray at 12:31 PM. At eminutes later, resident 23 at her potatoes. Resident 23 at am I doing here?" The passist resident 23. Thoking at 12:34 PM. Still a CNA asked resident at table 3, ent and stayed with her for	F	241	therapeutic diets, and residents are groomed appropriately prior to exiting the dining area. 4) Any issues identified during the Dining Room Observation Program will be reported to the Administrator for immediate follow-up. 5) A monthly schedule of dining room monitors will be completed by the Dietary Manager and the Administrator will be responsible to monitor for compliant D) The Administrator will report any identified issues to the QA Committee on a monthly basis for further recommendations. E) This plan of correction to be completed by 9/20/04.	of ce.	

OEPAI CENTI	RTMENT OF HEALTH	HAND HUM SERVICES - & MEDICAIU SERVICES				PRINT	ED: 10/4/2004 MAPPROVED
		T WEDICAID SERVICES				OMB N	<u>0. 0938-0391</u>
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NAME OF	PROVIDER OR SUPPLIER		<u></u>	1	TOUT ADDRESS	8/	11/2004
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(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		<u>. </u>	· ····································		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 241	Continued From page	ge 14	F:	241	1		
	hall. At 12:56 PM. r	esident 24 started to leave			']
	the dining room. A	CNA asked him why he hadn't					
	eaten. Resident 24	responded he did not like the					
	Tiunon. The UNA said	I she would go to the kitchen					
	and get him someth	ing else. Resident 24]
	propelled his wheeld	hair back to the table and			,] [
	waited. The CNA di	d not return with an alternate					· [
	Resident 24 was not	the assistive dining room.					1 1
	assistive dining roon	spoken to as he left the					1
	assisting toom	"					
	with dining per the re 6/30/04, was served At 12:55 PM, he star	eded extensive assistance esident's quarterly MDS dated his lunch tray at 12:25 PM. ted banging his fists on his					
	wheelchair table. At	12:58 PM, a CNA					
	approached the resid	lent and asked him if he was					
-	hands. The CNA	s squishing his food in his					
	nanus. The CNA gar	ve the resident two bites of		j			
	CNA's arm and soit of	esident 26 grabbed the					
ĺ	the resident to ston h	out the food. The CNA asked ecause he was hurting her		ł			1
	and she walked away	Resident 26 had eaten all					1
	of his peas, spit out the	ne bites of pureed chicken;					1
;]	urank % glass of milk	: and 95% of his juice				Ì	
- 1	Resident 26's arms w	ere contracted and did not		-		ĺ	
1	nave a full range of m	otion. Resident 26's milk		.		- 1	ļ
1	and juice had been m	oved from out of his reach.		J		ĺ	
-	Resident 26 ala not hi	ave a clothing protector on.					
j	Resident 26 was droe	, hands, arms, and table.		ĺ			j
	1:15 PM resident 26'	ling from his mouth. At stray was cleared away					1
·].	from the table. Resid	ent 26 was not assisted					1
. 1	urther, nor encourage	ed to eat anything else and					ļ
, [1	not assisted with his d	rinks that he could not				1	
· 1	each. One CNA aske	ed another CNA to clean				1	[
. [1	esident 26 up before	taking him to his room				ĺ	j .
1	ine CNA waited a few	Seconds and wheeled					İ
់ ្រំ	esident 26 and anoth	er resident out of the					1
6	assistive aining room.	Resident 26 was taken to					

DEPARTMENT OF HEALTH AND HUM SERVICES PRINTED: 10/4/2004 CENTERS FOR MEDICARE & MEDICAL SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465117 8/11/2004 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MANOR CARE OF SOUTH OGDEN 5540 SOUTH 1050 EAST **OGDEN, UT 84405** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID Œ PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 241 Continued From page 15 F 241 his room. He was left unattended for a few minutes when one CNA returned to clean his hands. When she started wiping his hands, resident 26 grabbed both her wrists. The second CNA came into resident 26's room. She assisted in releasing resident 26's hands and said to the resident they would come back when the resident was in a better mood. Neither CNA attempted to find out why the resident was grabbing their arms to see if the resident needed something. Neither CNA attempted to ask resident 26 if he was still hungry, thirsty or needed something else. F 312 | 483.25(a)(3) QUALITY OF CARE F 312 9/20/04 SS=E A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and record reviews and interview, the facility did not ensure that all residents in the assistive dining room received the assistance necessary from the facility staff to maintain good nutrition. Resident identifiers: 3, 14, 22, 26. F-312: Quality of Care Findings included: 1-4 1. On 07/27/04, an observation of the lunch meal 1) Resident #14 is currently in the assistive dining room was conducted from receiving plastic utensils 12:22 PM to 1:30 PM. with all meals.

Resident 14 arrived at the assistive dining room in

a wheelchair accompanied by a staff member at 12:30 PM and was served her lunch tray at 12:39

2) The facility requested to

have resident #14

DEPARTMENT OF HEALTH AND HUN SERVICES PRINTED: 10/4/2004 FORM APPROVED CENTERS FOR MEDICARE & MEDICAL SERVICES OMB NO: 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465117 8/11/2004 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5540 SOUTH 1050 EAST MANOR CARE OF SOUTH OGDEN **OGDEN, UT 84405** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 312 Continued From page 16 F 312 PM at table 4. CNA 4 was assisting resident 3, evaluated by Geri-Psych. who needed extensive assistance with eating per but the family refused. the resident's admission MDS (Minimum Data The C.N.A Staff has been Set) dated 6/28/04, when Resident 14 looked at instructed to remove CNA 4, and stated to no one in particular, "Get resident #14 from the her out of here. She's a liar." After resident 14 assistive dining room if made several negative comments to CNA 4, she begins to demonstrate resident 14 raised her fork with the prong sides inappropriate behaviors. down, and in an upward and downward motion B) The C.N.A Staff will receive attempted several times to stab CNA 4's arm. staff education on the She was unsuccessful because CNA 4 moved appropriate reporting process out of the way. This occurred a second time so for resident behaviors. CNA 4 moved her chair to the right side of the C) resident 3. Resident 3 had arrived at 12:10 PM, 1) The C.N.A Staff will and was served at 12:40 PM. At 12:38 PM, report observed resident resident 3 was saying, "Please". CNA 4 was behaviors to the Charge distracted and not assisting resident 3 fully. Nurse for that individual Resident 3 had drank only one fourth of both his resident. milk and juice and did not finish his meal. 2) The Charge Nurse will Resident 3 received assistance for eleven document reported minutes from CNA 4. Resident 14 continued with behaviors in the her negative comments to CNA 4. At 12:51 PM, Medication CNA 4 stood up to take resident 3 out of the Administration Records. dining room and resident 14 threw her fork at 3) The Psychotropic CNA 4, striking her in the face, near her eye. Committee reviews CNA 4 called out and ran out of the room crying. documented resident A few minutes later CNA 4 returned to resident 3. behaviors quarterly or As CNA 4 turned resident 3 to leave the table. more often if needed. resident 14 threw her spoon at CNA 4, striking the 4) The Director of Nursing back of the CNA 4's leg. CNA 4 did not ask will monitor to ensure resident 3 if he was finished, or offer any further compliance. assistance. D) The Psychotropic Committee will report results to the QA During this time, resident 26, who required Committee on a monthly extensive assistance with eating per the basis.

resident's quarterly MDS dated 6/30/04, had not

eaten anything and was not receiving assistance.

The activity director got another metal spoon and sat down with the resident 14 to assist her. At 12:56 PM, CNA 4 approached table 4 in an

E) This Plan of Correction to be

completed by 9/20/04.

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

PRINTED: 10/4/2004 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF	DEFICIENCIES
AND PLAN OF		

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

465117

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

A. BUILDING B. WING

С 8/11/2004

NAME OF PROVIDER OR SUPPLIER

MANOR CARE OF SOUTH OGDEN

STREET ADDRESS, CITY, STATE, ZIP CODE 5540 SOUTH 1050 EAST

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F 312 Continued From page 17		F 312		
attempt to assist resident 26 became agitated and tried to wheelchair at CNA 4. CNA 4 not approach resident with reside reported. She stated that reside this every day" and it was gerorying at the time. At 1:04 Pl taken out of the assistive dinic CNA 4 began assisting reside after being served. At 1:13 Forying again and left the room few minutes later to continue 26, however she started cryin resident 26 at 1:15 PM. Resiout of the dining room at 1:30 had eaten approximately one was not assisted further. 2. On 07/27/04 at 1:30 PM, a CNA 4 was conducted. She sfor some reason, does not like making negative comments at towards her everyday. The Ci 14 resides on hall 100 and the CNA does not report to the 10 4, who works on the 200 hall a assistive dining room, stated sincidents to the nurse on the 2	Resident 14 blunge out of her 4 stopped and could NA 4 stated to CNA ent 14 needed to be sident 14 "acts like titing to her, she was M, Resident 14 was ing room. At 1:07, ent 26, thirty minutes PM, the CNA started in. CNA 4 returned a to assist resident ing again and left dent 26 was taken ing PM. Resident 26 half of his meal and in interview with stated resident 14, is her and has been ind having behaviors NA stated resident in on hall nurse. CNA and assists in the ishe reports these indo hall.	REFIX	S-6 A) 1) Resident #22 has been referred to Occupational Therapy to be screened for appropriate assistive devices. 2) The C.N.A Staff will receive staff education on the appropriate reporting process for resident behaviors. B) The C.N.A Staff will receive staff education on providing appropriate ADL assistance to residents. C) 1) The facility will implement a Management Dining Room Observation Program to ensure residents are receiving the necessary assistance with meals. 2) The Managers will observe the assistive dining room to	COMPLETIC
3. On 08/02/04, an interview was conducted. She stated re throws forks and has behavior resident 14 does not like CNA had hit CNA 4 "in the eye" with	sident 14 usually s. CNA 3 stated 4 and resident 14		ensure the following: appropriate nursing staff is present, residents receive the necessary assistance	
4. An interview with the facility and the dietitian was held on 8/Neither the facility dietary manadietitian were aware that reside	dietary manager /2/04 at 2:00 PM.		with meals, residents are positioned properly, meals	
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NAME OF	PROVIDER OR SUPPLIER	, , , , , , , , , , , , , , , , , , ,		STREET ADDRESS		8/1	1/2004
MANOR	CARE OF SOUTH OG	DEN		5540 SOUTH	ESS, CITY, STATE, ZIP CODE H 1050 EAST T 84405		lee
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EA	PROVIDER'S PLAN OF CORRECT CH CORRECTIVE ACTION SHOU S-REFERENCED TO THE APPRI DEFICIENCY)	ULDBE	(X5) COMPLETION DATE
F 312	Continued From pa	ge 18	F3	12			
	behaviors that imparent other residents. 5. On 07/27/04, and in the assistive dining 12:22 PM to 1:30 PM. Resident 22, who need to be pushed close to the contracted hands and the extending protector and seven minutes after 1 down to assist her. A placed resident 22's left the resident 22's left t	oted the staff's ability to assist	F3	D)	arrive and are served in a timely fashion, residents receive the correct therapeutic diets, and residents are groomed appropriately prior to exiting the dining area. 4) Any issues identified during the Dining Ro Observation Program be reported to the Administrator for immediate follow-up 5) A monthly schedule dining room monitor will be completed by Dietary Manager and Administrator monitor for compliance. The Administrator will reany identified issues to the QA Committee on a month basis for further recommendations. This plan of correction to completed by 9/20/04.	d o d oom n will of rs the d the or eport te thly	中では、1900年には、1900年には、1900年には、1900年には、1900年には、1900年には、1900年には、1900年には、1900年には、1900年には、1900年には、1900年には、1900年には、19
	101. Hesident 22 starti	ed picking the food that had ddy and began eating the					

DEPA	RTMENT OF HEALTH	AND HUM SERVICES			~	PRINTE	D: 10/4/2004
		& MEDICAID SERVICES				OMB NO	APPROVED 0. 0938-0391
AND PLA	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BL	ILDIN		(X3) DATE :	SURVEY . ETED
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NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STR	EET ADDRESS SITV STATE	8/1	1/2004
MANO	R CARE OF SOUTH OG	DEN		55	EET ADDRESS, CITY, STATE, ZIP CODE 540 SOUTH 1050 EAST GDEN, UT 84405		
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F 312	Continued From page	ge 19	F	312			
	food droplets and lice returned to the resident 22 was done resident's hands. At taken out of the dinitions on sumed a little less meal. The nutritional	cking her fingers. The CNA lent and without asking if e started washing the tall 1:24 PM, resident 22 was ng room. The resident had is than one-half of her total supplement served with her dout of her reach and was	F ,	312			
	dining room was con	bservation of the assistive ducted for the lunch meal. ed from the kitchen at 12:15					
	with dining per the re 6/30/04, was served At 12:55 PM, he start wheelchair table. At approached the resid done and why he was hands. The CNA gave pureed chicken. Res arm and spit out the fresident to stop becaushe walked away. Rehis peas, spit out the drank ¾ glass of milk: Resident 26's arms whave a full range of mand juice had been mand juic	eded extensive assistance sident's quarterly MDS dated his lunch tray at 12:25 PM. ed banging his fists on his 12:58 PM, a CNA ent and asked him if he was a squishing his food in his re the resident two bites of ident 26 grabbed the CNA's cod. The CNA asked the use he was hurting her and esident 26 had eaten all of bites of pureed chicken; and 95% of his juice. Here contracted and did not obtain. Resident 26's milk coved from within his reach, hands, arms, and table. In tray was cleared away ent 26 was not assisted d to eat anything else and rinks that he could not ed another CNA to clean					

		HAND HUMAN SERVICES			FORM): 8/19/2004 APPROVED 0938-0391
IENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN		(X3) DATE SI COMPLE	URVEY ETED C
		465117	B. WING _		8/11	/2004
	CARE OF SOUTH O	GDEN	5	REET ADDRESS, CITY, STATE, ZIP CODE 1540 South 1050 EAST DGDEN, UT 84405		
D IX	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IQULD BE	(X5) COMPLETION DATE
	drank ¾ glass of n Resident 26's arm have a full range of and juice had been Resident 26 did not Food was on his s Resident 26 was of 1:15 PM, resident from the table. Refurther, nor encoun not assisted with his reach. One CNA are resident 26 up bef. The CNA waited are resident 26 and are assistive dining rothis room. He was minutes when one hands. When she resident 26 grabber CNA came into retain releasing resider resident they would was in a better mother find out why the retained on the resident they would be see if the resider CNA attempted to	he bites of pureed chicken; hilk; and 95% of his juice. Is were contracted and did not of motion. Resident 26's milk in moved from within his reach. In the action of the color of motion in the color on the color of the color o	F 312			
326 3S=D	483.25(i)(2) QUAL Based on a reside assessment, the f	LITY OF CARE ent's comprehensive acility must ensure that a a therapeutic diet when there is	F 326	1) The inst	llated mug of as immediatel I from Reside	ly

This REQUIREMENT is not met as evidenced

		AND HUMAN RVICES				FORM	D: 8/19/2004 APPROVED . 0938-0391
-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465117	(X2) MUL A. BUILD B. WING	-	OCTION	1	
	ROVIDER OR SUPPLIER	DEN		TREET ADDRESS 5540 SOUTH 16 OGDEN, UT			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTIVE ACTION SHOTH CORRECTIVE ACTION SHOTH REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 326	record review, it was ampled residents, precautions, the fact resident received the was a swallowing president:11. Findings included: Resident 11 was act 10/28/00 with diagn gastroesophageal recerebrovascular act depression, diabete pulmonary disease. 1. On 7/27/04 at 2:2 water was observed resident 11 was in the Nursing Assistant) mug was thickened the mug and stated thickened and furth on regular thin liquids for as lothe facility. 2. A review of resident completed on 7/27/04 A physician's order resident 11 was to the W(with)/THICKENE	on, interview, and medical s determined that for 1 of 6 who were on aspiration sility did not ensure that each sickened liquids when there roblem noted. Imitted to the facility on oses that included eflux disease, esophagitis, cident, hypertension, is, asthma and chronic et at resident 11's bedside and the bed. CNA 5 (Certified was asked if the water in the CNA 5 removed the lid from that the water was not er stated that resident 11 was ids and had been on regular ng as the CNA had worked at ent 11's medical records was od. dated 6/3/04 documented that be on a "PUREE D LIQUIDS" diet.	F 320	B)	 The C.N.A's will receive an in-serv to the association symbols for thick liquids. The Resident Snar Cards includes a section to identify residents who receive thickened liquids. The Resident Snar Cards will be post behind closet door in the resident room as a quick reference the C.N.A's. The Licensed Nurrowill be responsible change the Resident Snapshot Card to reflect current physician's orders. The Unit Manager will randomly audit Resident Snapshot Cards for accuracy The Unit Managers rep 	ice as of the ened pshot ed es ms ce for ses et to int	
}		show difficulty swallowing, given (with) thickened liquid."			the results of their audit	t to	

PRINTED: 8/19/2004 DEPARTMENT OF HEALTH AND HUMAN RVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING C B. WING 465117 8/11/2004 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5540 SOUTH 1050 EAST MANOR CARE OF SOUTH OGDEN **OGDEN, UT 84405** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 326 Continued From page 22 F 326 3. On 7/27/04 at 2:45 PM, the DM (dietary the QA Committee on a manager) was interviewed. The DM stated that monthly basis for a period resident 11 was currently on a thickened liquid of 90 days. diet. The DM stated that resident 11 had resisted E) This Plan of Correction to being on a thickened liquid diet in the past, but be completed by 9/20/04. recently had agreed to it. F 332 483.25(m)(1) QUALITY OF CARE F 332 SS=D The facility must ensure that it is free of F-332: Quality of Care medication error rates of five percent or greater. 1-2 (2 A) This REQUIREMENT is not met as evidenced The Flonase was ordered and administered to resident #10 Based on observation and record review the the following day. 2) The Multi-Vitamin and facility did not ensure that it was free of medication error rates of 5% or greater. Of 40 Depakote were ordered medications observed there were 3 errors. This and administered to resident was a 7.5% medication error rate. #12 the following day. Residents: 10 and 12. B) The Licensed Nursing Staff will receive staff education discussing Findings included: proper medication administration. C) 1. Resident 10 was an 86 year old female 1) The Pharmacy Order Sheets admitted to the facility on 10/28/02 with diagnoses have been updated to include which included dementia, COPD (Chronic a section for the Nurse's Obstructive Pulmonary Disease), hypertension to communicate their needs and congestive heart failure. to the Pharmacist. 2) The Director of Nursing On 7/26/04 at 8:00 PM, during a medication pass and/or

cart.

for resident 10, it was observed that the nurse did not administer Flonase. The facility nurse stated that there was none available in her medication

recertification orders revealed that Flonase 0.05% spray was to be administered twice daily for nasal

A record review of resident 10's physician

DEPARTMENT OF HEALTH AND HUMAN RVICES PRINTED: 8/19/2004 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 465117 8/11/2004 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5540 SOUTH 1050 EAST MANOR CARE OF SOUTH OGDEN **OGDEN, UT 84405** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 332 Continued From page 23 F 332 designees will congestion and was originally ordered on 2/11/03. observe a medication pass on a monthly basis 2. Resident 12 was an 89 year old female for compliance. admitted to the facility on 10/7/03 with diagnoses 3) The Nursing Staff will communicate if a which included dehydration, renal insufficiency. hypertension and insulin dependent diabetes. medication is unavailable via the Daily Stand-Up On 7/27/04 at 12:00 PM, during a medication Meeting and appropriate pass for resident 12, it was observed that the action will be taken to nurse did not administer a multivitamin. The ensure medications are facility nurse stated that there was none available provided for in a timely in stock, but it had been ordered. fashion. D) On 8/2/04, a record review of resident 12's July 1) The Director of 2004 MAR (Medication Administration Record), Nursing will monitor revealed that the multivitamin had originally been to ensure ordered on 10/7/03. compliance. 2) The Director of A record review of resident 12's Physician's Nursing will report Telephone Orders was done and revealed that the results of the there was an order dated 7/8/04 for Depakote Medication Pass 250 milligrams to be taken twice daily. During the Observation and any medication pass, it was observed that the medication errors to Depakote was not administered. the OA Committee E) This Plan of Correction to be completed by 9/20/04. F 426 483.60(a) PHARMACY SERVICES F 426 F-426: Pharmacy Services SS=D 1-2; A facility must provide pharmaceutical services A) (including procedures that assure the accurate 1) The Detrol LA order acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet for resident #1 was discontinued the needs of each resident. 2) Resident #12 is This REQUIREMENT is not met as evidenced currently receiving the prescribed Depakote and by: has demonstrated no ill

Based on record review the facility did not assure

the accurate dispensing and administration of all drugs and biologicals to meet the needs of the

effects related to the event.

DEPAR	TMENT OF HEALTH	AND HUMANATRVICES				PRINTE	D: 8/19/2004
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	residents. Resident: 1,12. Findings included: 1. Resident 1 was an 4/15/02 with diagnost cerebrovascular accosteoporosis, schizospasms, hypothyroid A review of resident completed on 8/2/04. A physician's telephorevealed that resider order to discontinue prescribed for patien bladder.) A review of resident administration record physician's orders for resident 1 did not have betrol is also prescribed prescribed for patien bladder.) On 8/2/04 LPN 1 was asked about the 7/16 discontinue Ditropan. esident 1 was not cushe would contact the	dmitted to the facility on sees that included ident, hydrocephalus, affective disorder, bladder lism and depression. 1's medical chart was one order dated 7/16/04 at 1's physician wrote an Ditropan. (Ditropan is ts with an overactive urinary 1's MAR (medication ly for July 2004 and the July 2004 revealed that we a current order for an order for Detrol LA. (ped for patients with an	F	426	B) The Licensed Nursing Staff will receive a staff education related to proper Telephone Order transcription. C) 1) The Unit Managers and/or designee will review telephone orders to ensure appropriate transcription of medication orders into the Medication Administration Records (MARS). 2) The Unit Managers and/or designee will aud the (MARS) on a weekly basis to ensure proper transcription of orders. 3) The Nursing Staff will communicate if a medication is unavailable via the Daily Stand-Up Meeting. D) 1) The Director of Nursing to monitor to ensure compliance. 2) The Unit Managers will report the results of the MAR audits to the QA Committee. E) This plan of correction to be	n o	
C	1/3/04 revealed that the	in and received the order to			completed by 9/20/04.		

TATEME	VT OF DEFICIENCIES	E & MEDICAID _RVICES			OMB NO	APPROV 0. 0938-03
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	PROVIDER OR SUPPLIER CARE OF SOUTH OF		5!	REET ADDRESS, CITY, STATE, ZIP CO		1/2004
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F 426	Continued From pa	age 25	F 426			
	which included deh	an 89 year old female lity on 10/7/03 with diagnoses ydration, renal insufficiency, n dependent diabetes and				
	done. It revealed the Depakote 250 millig A review of resident (Medication Administration nurse had documents)	d review of resident 12's le Orders dated 7/8/04 was at there was an order for grams to be given twice daily. 12's July 2004 MAR stration Record) revealed that mented that the Depakote //04. This was 20 days after written.				
r t	i elephone Orders d evealed that there v he Depakote. The d	esident 12's Physician ated 7/29/04 was done. It was a clarification order for loctor clarified that the d with the Depakote was for				
th b	nterdisciplinary Prog lone. It revealed that nat resident 12 had a ehaviors and explait een observed grabb ocial worker wrote the	review of resident 12's press Notes for 7/28/04 was to the social worker had noted a significant change in her ned that resident 12 had bing and hitting staff. The nat staff were to continue to calm and consistent routine				