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

COMPLAINT NUMBER ut00002333

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 155 SS=G	483.10(b)(4) NOTICE OF RIGHTS AND SERVICES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. This REQUIREMENT is not met as evidenced by: Based record review and interview, the facility did not ensure a resident had the right to choose health care consistent with his interests and medical treatment plan. Resident identifier: CL 1 Findings included: CL 1 was admitted to the facility on 6/28/04, with the diagnoses that included lumbago, diverticulum of esophagus, advanced senile dementia and neoplasm. 1. On 8/2/04, a review of resident CL 1's medical record was completed. A review of resident CL 1's medical treatment plan,dated 6/29/04, revealed that resident CL 1 had a DNR (Do Not Resuscitate) status, was not to receive tube feedings, IV(intervenous) fluids, or antibiotics. On 6/29/04 the facility social worker documented that she had spoken to resident CL 1's family in regards to resident CL 1's advanced directives,and DNR status. The social worker also documented that no heroic measures, no IV fluids and antibiotics were to be given. She documented that the facility was to, "Provide comfort care." A record review of resident CL 1's Physician	F 155	F-155: Quality of Life 1. A) Resident CL 1 was discharged home per family request. B) 1) The facility has reviewed the advanced directives of all residents currently receiving IV Therapy to ensure consistency. 2) The Licensed Nursing Staff will receive staff education to review a resident's advanced directive before commencing heroic measures. 2) Licensed Nursing Staff will receive staff education in regards to Notification prior to commencing a new form of treatment. C) 1) The 'Change in Status Report" (24-hour Report Sheet) includes a section for the Licensed Nurse to complete when the family has been notified of a change to a medication or treatment.	9/20/04

1/4/05 POC for revised 2567 acceptable [illegible] ok

Utah Department of Health
JAN 04 2004
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 12/29/04

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 155	Continued From page 1 Progress Notes dated 06/30/04 revealed that the physician had ordered blood work to be drawn. On 7/2/04 the results of the blood work were received by the facility and faxed to the physician by a facility LPN. The same laboratory results for resident CL 1 were returned to the facility via fax by the doctor with instructions; "1) Dehydrated [arrow] place IV (intravenous catheter) and give 1/2 NS (normal saline) @ 100cc/hr (hour) X (times) 3 liters then D/C (discontinue)....." On 07/5/04 at 2:45 PM, on a facility IDT progress note, a nurse had written, "Daughters here asking about IV. Object to IV contrary to Adv (advance) Directive. Called [resident CL 1's] Dr... & ok to D/C IV." 2. On 8/2/04 at 1:45 PM, an interview with a facility nurse, who had taken care of resident CL 1, was conducted. He stated that he routinely does not look at advanced directives before starting an IV and that he assumed the doctor would have worked out the, "specifics" and been, "cognizant" of the resident's requests. 3. On 08/17/04, at 12:20 PM resident CL 1's POA (power of attorney) was contacted. The POA stated that on 2/22/00 she was given power of attorney for resident CL 1. The POA stated that on 6/29/04, one day after resident CL 1 was admitted to the facility, she had conferenced with facility staff and discussed with them that resident CL 1 did not want IV fluids, tube feedings, or antibiotics administered. She did, however, agree that resident CL 1 would not have objected to the use of oxygen for comfort measures. The POA stated that on Saturday July 3, 2004,	F 155	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 review the Family Notification section on the "24 Hour Report Sheet has been completed on a regular basis. 4) The Social Services Director will conduct a quarterly in-service. for the Nursing Staff on resident rights. D) The Director of Nursing will identify any trends of non-compliance and report the findings to the QA Committee on a monthly basis. E) This Plan of Correction (POC) will be completed by 9/20/04.	

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F 155	Continued From page 2 she notified the facility that on Monday July 5, 2004, she was leaving town for a few days and that if there were any problems with resident CL 1, the facility was to notify specifically named surrogates. The POA stated that she gave the facility a post-it note with the surrogates names and telephone numbers and saw the post-it note placed on the front page of resident CL 1's medical chart. She then stated that on July 5, 2004, she left town at 6:30 AM and did not arrive back until July 8th, 2004. The POA further stated at no time did the facility contact her to discuss IV fluid therapy for resident CL 1. The POA stated that if resident CL 1 had been able to speak for himself, he would have "definitely" refused IV therapy and "he would have been very upset" by its infusion. The POA stated that resident CL 1 was discharged from the facility, at the family's request, on 7/8/04 and died two days later. 4. On 08/5/04, at 2:15 PM, Surrogate 1 for the POA, was interviewed. He stated that the facility had never contacted him for any reason and did not notify him of the physician's order to place an IV. 5. On 08/5/04, at 2:35 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 treatment plan. At approximately 1:00 PM, she notified Surrogate 3, for the POA, of the infusing IV.	F 155		

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F 155	Continued From page 3 6. 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 IV fluids infusing. 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 fluids were discontinued.	F 155		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as	F 157	F-157: Notification of Rights and Services 1-6: A) Resident CL 1 was discharged home per family request. B) Licensed Nursing Staff will receive staff education in regards to Notification prior to commencing a new form of treatment. C) 1) The 'Change in Status Report" (24-hour Report Sheet) includes a section for the Licensed Nurse to complete when the family has been notified of a change to a medication or treatment.	9/20/04

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F 157	Continued From page 4 specified in s483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that the facility did not notify the family of a resident for the commencement of a new form of treatment. Specifically, the POA (power of attorney) was not notified when the facility received an order for IV (intravenous) fluids. Resident identifier: CL 1 Resident CL 1 was admitted to the facility on 6/28/04, with the diagnoses that included lumbago, diverticulum of esophagus, senile dementia and neoplasm. 1. On 07/26/04, a review of resident CL 1 medical record was completed. The medical record documented that, on 6/30/04, resident CL 1's physician ordered blood work to be drawn. On 7/2/04 the results of the blood work were received by the facility and faxed to the physician by a facility LPN. The same laboratory results for resident CL 1 were returned to the facility via fax by the doctor on 7/2/04 with instructions; "1) Dehydrated [arrow up] place IV (intravenous catheter) and give 1/2 NS @ 100cc/hr (hour) X (times) 3 liters then D/C (discontinue)....." On 7/5/04 at 6:02 AM a facility IDT (Interdisciplinary team) progress note for resident CL 1, revealed that a RN (registered nurse) had	F 157	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 review the Family Notification section on the "24 Hour Report Sheet has been completed on a regular basis. 4) The Social Services Director will conduct a quarterly in-service. for the Nursing Staff on resident rights. D) The Director of Nursing will identify any trends of non-compliance and report the findings to the QA Committee on a monthly basis.	

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F 157	Continued From page 5 written, "Dr....your order for 1/2 NS @ (normal saline at) 100cc (cubic centimeters)/(hour) I found accidentally on another fax machine. Hence, those orders for [CL 1's name] didn't get started until this AM 0600 (6:00 AM)..." On 07/5/04 at 2:45 PM, on a facility IDT progress note a nurse had written, "Daughters (sic) here asking about IV. Object to IV contrary to Adv (advance) Directive. Called (resident CL 1) Dr... & ok to D/C IV." 2. The POA stated that on Saturday July 3, 2004, she notified the facility that on Monday July 5, 2004, she was leaving town for a few days and that if there were any problems with resident CL 1, the facility was to notify specifically named surrogates. The POA stated that she gave the facility a post-it note with the surrogates names and telephone numbers and saw the post-it note placed on the front page of resident CL 1's medical chart. She then stated that on July 5, 2004, she left town at 6:30 AM and did not arrive back until July 8th, 2004. The POA further stated at no time did the facility contact her to discuss IV fluid therapy for resident CL 1. 3. On 08/5/04, at 2:15 PM, Surrogate 1 for the POA, was interviewed. He stated that the facility had never contacted him for any reason and did not notify him of the order to place an IV. 4. On 08/5/04, at 2:35 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	F 157	E) This Plan of Correction (POC) will be completed by 9/20/04.	

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F 157	Continued From page 6 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. 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 fluids were discontinued. 6. On 08/12/04, at 3:47 PM, an interview with resident CL 1's physician was conducted via the telephone. The physician stated he does not usually order IV fluids and usually speaks with the nurse before ordering IV fluids.	F 157	F-241: Quality of Life 1. A) No resident identifier #. B) 1) The Licensed Nurses will receive staff education related to being present in the assistive dining room for resident safety. 2) The Licensed Nursing Staff have received Basic Life Support Training which includes the Heimlich maneuver. C) 1) The C.N.A Staff will receive staff education on dining room safety. 2) The facility will implement a Management Dining Room Observation Program to ensure residents are receiving the necessary assistance with meals.	
F 241 SS=E	483.15(a) QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations of meal service, it was determined the facility did not provide meal service in a manner and in an environment that would enhance each residents' dining experience 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	F 241		9/20/04

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F 241	Continued From page 7 observed not to be assisted or encouraged with their meals. Resident identifiers: 1,3,11,14,16,17,18,19,22,23,24,26,27,28. Four residents were not identified. Findings included: 1. On 07/27/04, at 2:55 PM an interview with facility CNA 1 was conducted. CNA 1 stated that the facility's criteria for residents to be in the assistive dining room are: -anyone on thickened liquids; - had swallowing problems; -needed encouragement to eat; -or cannot feed themselves. She further stated there should always be a nurse in the dining room for a resident that may choke. When asked how many residents were usually in the assistive dining room, she stated that right now they are at their limit, which was eighteen. She stated the assistive dining room should have one nurse and two CNA's at all times. 2. On 07/26/04, an observation of the assistive dining room was conducted. Sixteen residents were helped to the assistive dining room by a CNA (certified nursing assistant), beginning at 5:50 PM and all residents were seated at a table by 6:07 PM. Two independent residents arrived later. Meal trays arrived at 6:34 PM. All resident trays were served by 6:46, which was thirty-one to forty-nine minutes after being seated and twenty nine minutes after the 5:55 PM posted meal time for the assistive dining room. Three CNA's were observed in the assistive dining room. In the assistive dining room against the north wall, on a	F 241	3) The Managers will observe the assistive dining room to ensure the following: appropriate nursing staff is present, residents receive the necessary assistance with meals, residents are positioned properly, meals 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 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 monitor for compliance. D) The Administrator will report any identified issues to the QA Committee on a	

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F 241	Continued From page 8 built in cabinet, there was a tray with one water picture full of water and ice, cups and two carafes, one filled with coffee and one filled with hot chocolate. The water was not observed to have been served the entire dinner period to any residents and only one cup of coffee was served. There were five square tables to accommodate four residents at each table. During the forty-four minute time period, residents were not observed to have been served any water. Four residents were assisted with their food. One resident requested a drink and was not given one. Two CNA's assisted only one resident at different tables. Table 1: At 6:10 PM, one CNA asked one of four residents seated at table 1 if she would like coffee or hot chocolate. The resident responded she would like coffee and she was given a cup of coffee. At 6:12 PM, a second resident at table 1 asked for a hot chocolate. The CNA said she would ask the kitchen if the second resident was on thickened liquids. A second CNA in the room responded that she thought that the second resident was on thickened liquids. At 6:20 PM, the second resident again asked for a drink. The second CNA stated she would check with the kitchen. At 6:29 PM, the second resident leaned over to the first resident, who was drinking her coffee and asked, "What's in the cup. I've got to have some." Neither CNA responded to the second resident. The resident requesting a hot chocolate waited 34 minutes for her meal tray and was not served the hot chocolate she had requested twice. Table 2: Resident 17, who needed extensive assistance with dining per the resident's admission MDS	F 241	monthly basis for further recommendations. E) This plan of correction to be 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	

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F 241	Continued From page 9 (Minimum Data Set) dated 7/19/04, arrived at 5:56 PM. At 6:36 PM a CNA sat with the resident to assist with feeding. At 6:55 PM, the CNA spoke in a loud voice and asked a second CNA, who was across the room, if this resident always takes this long to eat. The other CNA responded that lately resident 17 was taking longer to assist. The CNA was not observed to encourage or assist the other three residents at table 2. Table 3: One resident arrived at 6:05 PM. At 6:39 PM, the resident was served a dinner tray and a CNA sat next to the resident to assist with feeding. The CNA was not observed to encourage or assist the other three residents at table 3. Table 4: A resident arrived at 5:55 PM. At 6:33 PM the resident made the statement, "Sure are slow". The resident was served a dinner tray at 6:39 PM, forty-four minutes after coming to the dining room. Resident 3 arrived at 5:59 PM. At 6:19 PM, after waiting twenty minutes, a CNA walked up from behind the resident's wheelchair and proceeded to take resident 3 out of the assistive dining room. The CNA spoke in a loud voice to a second CNA, who was across the room, that the resident's dentures had been forgotten. The CNA did not inform or speak to resident 3 as to why he was being taken out. Resident 19, who needed limited assistance with dining per the resident's quarterly 5/19/04 MDS, arrived in the dining room at 6:07 PM. At 6:25 PM, after waiting eighteen minutes for her meal, stated "it" was taking too long, and that she was dizzy. The CNA responded to resident 19 that	F 241	with meals, residents are positioned properly, meals 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 Room Observation Program will be reported to the Administrator for 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 compliance. 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. 3. A) 1) No resident identifier #. 2) The C.N.A Staff will receive staff education on complying with	

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F 241	Continued From page 10 she would lie the resident down after dinner. At 6:26 PM, the resident stated again she needed to lie down. The CNA responded that dinner was late because it was Monday and after dinner she would lie the resident down. At 6:32 PM, the resident stated, "I gotta go". At 6:35 PM, the resident was served her meal, and was not assisted by a CNA. At 6:39 PM, the resident again stated, "I gotta go". The CNA asked resident 19 to drink her milk. Resident 19 immediately drank ½ of her cup of milk and set her cup on the table, stating "No more". At 6:40 PM, the CNA took resident 19 out in her wheelchair without assisting her with dining, did not encourage her further or ask the resident if she would like to eat her dinner in her room. A fourth resident arrived at 6:00 PM and was served dinner at 6:39 PM. At 6:55 PM, sixteen minutes after being served a CNA sat next to the resident to assist with feeding. The CNA did not offer to reheat the resident's food. 3. On 07/27/04, an observation of the lunch meal in the assistive dining room was conducted from 12:22 PM to 1:30 PM. Lunch trays arrived in the assistive dining room at 12:22 PM. There was one CNA to pass trays with the help of the Activity Director for seventeen residents. Fourteen minutes later, at 12:36 PM, a second CNA came to assist in passing trays, eighteen minutes later, a third and fourth CNA came to assist at 12:40 PM, and nineteen minutes after trays were delivered, a fifth CNA came to the dining room to assist serving tray, at 12:41 PM. All trays were passed by 12:48 PM, twenty-six minutes after meal trays arrived from the kitchen.	F 241	resident food preferences. 3) Resident #22 has been referred to Occupational Therapy to be screened for appropriate assistive devices. 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 with meals, residents are positioned properly, meals arrive and are served in a timely fashion,	

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F 241	Continued From page 11 Table 1: One resident arrived at 12:18 PM, and was served her lunch tray at 12:48 PM. At 1:10 PM the resident, who had not eaten or drank anything, stated she wanted to leave the dining room. In response, a CNA encouraged the resident to eat. The resident stated she didn't know what to eat. The CNA walked up to and sat with the resident twenty-two minutes after being served. The CNA did not offer to reheat the resident's meal. Table 3: At 12:43 PM, one CNA asked resident 23 if she wanted butter on her bread. The resident said she did not care. While the CNA buttered resident 23's bread, she stated to another CNA, who was on the other side of the room, "I don't think she'll even notice". Resident 22, who needed limited assistance with dining per the resident's quarterly 7/14/04 MDS, arrived at 12:15 PM, and was served her lunch tray at 12:45 PM, twenty three minutes after trays arrived. Resident 22 had a lap buddy on her wheelchair which would not allow the wheelchair to be pushed close to the table. Resident 22 had contracted hands and fingers and her arms would not extend to a full range of motion. After several unsuccessful attempts to reach her glass, resident 22 gave up and pulled her plate onto her lap buddy. As she attempted to place food in her mouth with a fork, the food spilled onto her clothing protector and lab buddy. At 12:52 PM, seven minutes after being served, a CNA sat down to assist her. At 12:55 PM, the CNA placed resident 22's plate back on the table and left the resident. At 1:12 PM, resident 22 pulled the plate back on to the lap buddy but could not reach her fork so she ate with her fingers. At	F 241	residents receive the correct 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 compliance. 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. 4. A) 1) The Licensed Nurses will receive staff education related to being present in the assistive dining room for resident safety.	

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F 241	Continued From page 12 1:18 PM, the CNA returned to resident 22 and moved her plate back to the table. The CNA gave resident 22 a bowl with a spoon and walked away. The resident made several unsuccessful attempts to bring the spoon to her mouth. The CNA returned, took the spoon and bowl away from resident 22 and gave the resident a drink through a straw. When the resident was finished swallowing, the CNA placed the glass on the table and walked away. At 1:20 PM, the resident attempted to reach her plate and glass but could not. Resident 22 started picking the food that had spilled onto her lap buddy and began eating the food droplets and licking her fingers. The CNA returned to the resident and without asking if resident 22 was done started washing the resident's hands. At 1:24 PM, the resident was taken out of the dining room. The resident had consumed a little less than one-half of her total meal. The nutritional supplement served with her lunch meal remained out of her reach and was not offered to her. Table 5: Resident 27 arrived at 12:15 PM. At 12:35 PM, she made the comment, "I wish they would keep passing the trays". At 12:39 PM, resident 27 was served her lunch tray eleven minutes after the other three residents at table 4 had been served. Resident 16 was served at 12:30 PM. At 12:49 PM, nineteen minutes after being served, the activity director sat down to assist resident 16. The activity director did not offer to reheat the resident's lunch. 4. On 08/02/04, an observation of the assistive dining room was conducted for the lunch meal. The lunch trays arrived from the kitchen at 12:15	F 241	2) The C.N.A Staff will receive staff education on dining room safety. 3) The C.N.A Staff will receive staff education on providing appropriate ADL assistance to residents. 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 with meals, residents are positioned properly, meals arrive and are served in a timely fashion, residents receive the correct	

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F 241	Continued From page 13 PM. Table 1: Resident 16,who needed supervision with dining per the resident's quarterly MDS dated 7/7/2004, was served her lunch tray at 12:34 PM. At 12:50 PM, sixteen minutes later, a CNA assisted resident 16 with two or three bites of food and left the resident. Resident 16 ate ¼ of her tray before self propelling herself out of the assistive dining room. She was not encouraged to eat more. Table 3: Resident 22 was served her lunch tray at 12:35 PM. At 12:54 PM, the CNA assisting resident 22 stated to another CNA that resident 22 had eaten everything and was done. The CNA did not offer the resident any additional food or drink. Resident 23, who needed extensive assistance with dining per the resident's quarterly 6/23/04 MDS, was served her lunch tray at 12:31 PM. At 12:50 PM, twenty-one minutes later, resident 23 was encouraged to eat her potatoes. Resident 23 asked the CNA , "What am I doing here?" The CNA then sat down to assist resident 23. Table 4: Resident 11 started choking at 12:34 PM. Still choking at 12:43 PM, a CNA asked resident 11 if she was "okay". At 12:47 PM, the speech therapist, who was assisting a resident at table 3, walked up to the resident and stayed with her for a few minutes until the choking subsided. Resident 24, who needed extensive assistance with dining per the resident's admission MDS dated 7/23/04, was served his lunch tray at 12:27 PM. A CNA assisted resident 24 at 12:39 PM for two minutes then left to assist another CNA in the	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 compliance. 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.	

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F 241	Continued From page 14 hall. At 12:56 PM, resident 24 started to leave the dining room. A CNA asked him why he hadn't eaten. Resident 24 responded he did not like the lunch. The CNA said she would go to the kitchen and get him something else. Resident 24 propelled his wheelchair back to the table and waited. The CNA did not return with an alternate and the resident left the assistive dining room. Resident 24 was not spoken to as he left the assistive dining room. Resident 26, who needed extensive assistance with dining per the resident's quarterly MDS dated 6/30/04, was served his lunch tray at 12:25 PM. At 12:55 PM, he started banging his fists on his wheelchair table. At 12:58 PM, a CNA approached the resident and asked him if he was done and why he was squishing his food in his hands. The CNA gave the resident two bites of pureed chicken and resident 26 grabbed the CNA's arm and spit out the food. The CNA asked the resident to stop because he was hurting her and she walked away. Resident 26 had eaten all of his peas, spit out the bites of pureed chicken; drank ¾ glass of milk; and 95% of his juice. Resident 26's arms were contracted and did not have a full range of motion. Resident 26's milk and juice had been moved from out of his reach. Resident 26 did not have a clothing protector on. Food was on his shirt, hands, arms, and table. Resident 26 was drooling from his mouth. At 1:15 PM, resident 26's tray was cleared away from the table. Resident 26 was not assisted further, nor encouraged to eat anything else and not assisted with his drinks that he could not reach. One CNA asked another CNA to clean resident 26 up before taking him to his room. The CNA waited a few seconds and wheeled resident 26 and another resident out of the assistive dining room. Resident 26 was taken to	F 241		

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F 241	Continued From page 15 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 241		
F 312 SS=E	483.25(a)(3) QUALITY OF CARE 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. Findings included: 1. On 07/27/04, an observation of the lunch meal in the assistive dining room was conducted from 12:22 PM to 1:30 PM. 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	F 312	F-312: Quality of Care 1-4 Ok A) 1) Resident #14 is currently receiving plastic utensils with all meals. 2) The facility requested to have resident #14	9/20/04

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F 312	Continued From page 16 PM at table 4. CNA 4 was assisting resident 3, who needed extensive assistance with eating per the resident's admission MDS (Minimum Data Set) dated 6/28/04, when Resident 14 looked at CNA 4, and stated to no one in particular, "Get her out of here. She's a liar." After resident 14 made several negative comments to CNA 4, resident 14 raised her fork with the prong sides down, and in an upward and downward motion attempted several times to stab CNA 4's arm. She was unsuccessful because CNA 4 moved out of the way. This occurred a second time so CNA 4 moved her chair to the right side of the resident 3. Resident 3 had arrived at 12:10 PM, and was served at 12:40 PM. At 12:38 PM, resident 3 was saying, "Please". CNA 4 was distracted and not assisting resident 3 fully. Resident 3 had drank only one fourth of both his milk and juice and did not finish his meal. Resident 3 received assistance for eleven minutes from CNA 4. Resident 14 continued with her negative comments to CNA 4. At 12:51 PM, CNA 4 stood up to take resident 3 out of the dining room and resident 14 threw her fork at CNA 4, striking her in the face, near her eye. CNA 4 called out and ran out of the room crying. A few minutes later CNA 4 returned to resident 3. As CNA 4 turned resident 3 to leave the table, resident 14 threw her spoon at CNA 4, striking the back of the CNA 4's leg. CNA 4 did not ask resident 3 if he was finished, or offer any further assistance. During this time, resident 26, who required extensive assistance with eating per the 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	F 312	evaluated by Geri-Psych, but the family refused. 3) The C.N.A Staff has been instructed to remove resident #14 from the assistive dining room if she begins to demonstrate inappropriate behaviors. B) The C.N.A Staff will receive staff education on the appropriate reporting process for resident behaviors. C) 1) The C.N.A Staff will report observed resident behaviors to the Charge Nurse for that individual resident. 2) The Charge Nurse will document reported behaviors in the Medication Administration Records. 3) The Psychotropic Committee reviews documented resident behaviors quarterly or more often if needed. 4) The Director of Nursing will monitor to ensure compliance. D) The Psychotropic Committee will report results to the QA Committee on a monthly basis. E) This Plan of Correction to be completed by 9/20/04.	

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F 312	Continued From page 17 attempt to assist resident 26. Resident 14 became agitated and tried to lunge out of her wheelchair at CNA 4. CNA 4 stopped and could not approach resident 26. CNA 4 stated to CNA 2 that the incident with resident 14 needed to be reported. She stated that resident 14 "acts like this every day" and it was getting to her, she was crying at the time. At 1:04 PM, Resident 14 was taken out of the assistive dining room. At 1:07, CNA 4 began assisting resident 26, thirty minutes after being served. At 1:13 PM, the CNA started crying again and left the room. CNA 4 returned a few minutes later to continue to assist resident 26, however she started crying again and left resident 26 at 1:15 PM. Resident 26 was taken out of the dining room at 1:30 PM. Resident 26 had eaten approximately one-half of his meal and was not assisted further. 2. On 07/27/04 at 1:30 PM, an interview with CNA 4 was conducted. She stated resident 14, for some reason, does not like her and has been making negative comments and having behaviors towards her everyday. The CNA stated resident 14 resides on hall 100 and the CNA does not report to the 100 hall nurse. CNA 4, who works on the 200 hall and assists in the assistive dining room, stated she reports these incidents to the nurse on the 200 hall. 3. On 08/02/04, an interview with a facility CNA 3 was conducted. She stated resident 14 usually throws forks and has behaviors. CNA 3 stated resident 14 does not like CNA 4 and resident 14 had hit CNA 4 "in the eye" with a fork last week. 4. An interview with the facility dietary manager and the dietitian was held on 8/2/04 at 2:00 PM. Neither the facility dietary manager nor the dietitian were aware that resident 14 was having	F 312	5-6 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 ensure the following: appropriate nursing staff is present, residents receive the necessary assistance with meals, residents are positioned properly, meals	

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F 312	Continued From page 18 behaviors that impacted the staff's ability to assist other residents. 5. On 07/27/04, an observation of the lunch meal in the assistive dining room was conducted from 12:22 PM to 1:30 PM. Resident 22, who needed limited assistance with dining per the resident's quarterly 7/14/04 MDS, arrived at 12:15 PM, and was served her lunch tray at 12:45 PM, twenty- three minutes after trays arrived. Resident 22 had a lap buddy on her wheelchair which would not allow the wheelchair to be pushed close to the table. Resident 22 had contracted hands and fingers and her arms would not extend to a full range of motion. After several unsuccessful attempts to reach her glass, resident 22 gave up and pulled her plate onto her lap buddy. As she attempted to place food in her mouth with a fork, the food spilled onto her clothing protector and lab buddy. At 12:52 PM, seven minutes after being served, a CNA sat down to assist her. At 12:55 PM, the CNA placed resident 22's plate back on the table and left the resident. At 1:12 PM, resident 22 pulled the plate back on to the lap buddy but could not reach her fork so she ate with her fingers. At 1:18 PM, the CNA returned to resident 22 and moved her plate back to the table. The CNA gave resident 22 a bowl with a spoon and walked away. The resident made several unsuccessful attempts to bring the spoon to her mouth. The CNA returned, took the spoon and bowl away from resident 22 and gave the resident a drink through a straw. When the resident was finished swallowing, the CNA placed the glass on the table and walked away. At 1:20 PM, the resident attempted to reach her plate and glass but could not. Resident 22 started picking the food that had spilled onto her lap buddy and began eating the	F 312	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 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 monitor for compliance. 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.	

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F 312	Continued From page 19	F 312		

food droplets and licking her fingers. The CNA returned to the resident and without asking if resident 22 was done started washing the resident's hands. At 1:24 PM, resident 22 was taken out of the dining room. The resident had consumed a little less than one-half of her total meal. The nutritional supplement served with her lunch meal remained out of her reach and was not offered to her.

6. On 08/02/04, an observation of the assistive dining room was conducted for the lunch meal. The lunch trays arrived from the kitchen at 12:15 PM.

Resident 26, who needed extensive assistance with dining per the resident's quarterly MDS dated 6/30/04, was served his lunch tray at 12:25 PM. At 12:55 PM, he started banging his fists on his wheelchair table. At 12:58 PM, a CNA approached the resident and asked him if he was done and why he was squishing his food in his hands. The CNA gave the resident two bites of pureed chicken. Resident 26 grabbed the CNA's arm and spit out the food. The CNA asked the resident to stop because he was hurting her and she walked away. Resident 26 had eaten all of his peas, spit out the bites of pureed chicken; drank ¾ glass of milk; and 95% of his juice. Resident 26's arms were contracted and did not have a full range of motion. Resident 26's milk and juice had been moved from within his reach. Resident 26 did not have a clothing protector on. Food was on his shirt, hands, arms, and table. Resident 26 was drooling from his mouth. At 1:15 PM, resident 26's tray was cleared away from the table. Resident 26 was not assisted further, nor encouraged to eat anything else and not assisted with his drinks that he could not reach. One CNA asked another CNA to clean

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12	Continued From page 20 his peas, spit out the bites of pureed chicken; drank ¾ glass of milk; and 95% of his juice. Resident 26's arms were contracted and did not have a full range of motion. Resident 26's milk and juice had been moved from within his reach. Resident 26 did not have a clothing protector on. Food was on his shirt, hands, arms, and table. Resident 26 was drooling from his mouth. At 1:15 PM, resident 26's tray was cleared away from the table. Resident 26 was not assisted further, nor encouraged to eat anything else and not assisted with his drinks that he could not reach. One CNA asked another CNA to clean resident 26 up before taking him to his room. The CNA waited a few seconds and wheeled resident 26 and another resident out of the assistive dining room. Resident 26 was taken to 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		
326 SS=D	483.25(i)(2) QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced	F 326	F-326: Quality of Care 1. OK A) 1) The insulated mug of water was immediately removed from Resident's #11 bedside.	

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

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F 326	Continued From page 21 by: Based on observation, interview, and medical record review, it was determined that for 1 of 6 sampled residents, who were on aspiration precautions, the facility did not ensure that each resident received thickened liquids when there was a swallowing problem noted. Resident:11. Findings included: Resident 11 was admitted to the facility on 10/28/00 with diagnoses that included gastroesophageal reflux disease, esophagitis, cerebrovascular accident, hypertension, depression, diabetes, asthma and chronic pulmonary disease. 1. On 7/27/04 at 2:20 PM, an insulated mug of water was observed at resident 11's bedside and resident 11 was in the bed. CNA 5 (Certified Nursing Assistant) was asked if the water in the mug was thickened. CNA 5 removed the lid from the mug and stated that the water was not thickened and further stated that resident 11 was on regular thin liquids and had been on regular thin liquids for as long as the CNA had worked at the facility. 2. A review of resident 11's medical records was completed on 7/27/04. A physician's order dated 6/3/04 documented that resident 11 was to be on a "PUREE W(with)/THICKENED LIQUIDS" diet. A nursing note dated 6/27/04 documented that resident 11, "Does show difficulty swallowing, meds were crushed given (with) thickened liquid."	F 326	2) All residents have been reviewed and proper hydrations needs have been identified. B) Signs with symbols were immediately posted outside those resident room's who receive thickened liquids. C) 1) The C.N.A's will receive an in-service as to the association of the symbols for thickened liquids. 2) The Resident Snapshot Cards includes a section to identify residents who receive thickened liquids. 3) The Resident Snapshot Cards will be posted behind closet doors in the resident rooms as a quick reference for the C.N.A's. 4) The Licensed Nurses will be responsible to change the Resident Snapshot Card to reflect current physician's orders. 5) The Unit Managers will randomly audit the Resident Snapshot Cards for accuracy. D) The Unit Managers report the results of their audit to	

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F 326	Continued From page 22 3. On 7/27/04 at 2:45 PM, the DM (dietary manager) was interviewed. The DM stated that resident 11 was currently on a thickened liquid diet. The DM stated that resident 11 had resisted being on a thickened liquid diet in the past, but recently had agreed to it.	F 326	the QA Committee on a monthly basis for a period of 90 days. E) This Plan of Correction to be completed by 9/20/04.	
F 332 SS=D	483.25(m)(1) QUALITY OF CARE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility did not ensure that it was free of medication error rates of 5% or greater. Of 40 medications observed there were 3 errors. This was a 7.5% medication error rate. Residents: 10 and 12. Findings included: 1. Resident 10 was an 86 year old female admitted to the facility on 10/28/02 with diagnoses which included dementia, COPD (Chronic Obstructive Pulmonary Disease), hypertension and congestive heart failure. On 7/26/04 at 8:00 PM, during a medication pass 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 cart. A record review of resident 10's physician recertification orders revealed that Flonase 0.05% spray was to be administered twice daily for nasal	F 332	F-332: Quality of Care 1-2 A) 1) The Flonase was ordered and administered to resident #10 the following day. 2) The Multi-Vitamin and Depakote were ordered and administered to resident #12 the following day. B) The Licensed Nursing Staff will receive staff education discussing proper medication administration. C) 1) The Pharmacy Order Sheets have been updated to include a section for the Nurse's to communicate their needs to the Pharmacist. 2) The Director of Nursing and/or	

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F 332	Continued From page 23 congestion and was originally ordered on 2/11/03. 2. Resident 12 was an 89 year old female admitted to the facility on 10/7/03 with diagnoses which included dehydration, renal insufficiency, hypertension and insulin dependent diabetes. On 7/27/04 at 12:00 PM, during a medication pass for resident 12, it was observed that the nurse did not administer a multivitamin. The facility nurse stated that there was none available in stock, but it had been ordered. On 8/2/04, a record review of resident 12's July 2004 MAR (Medication Administration Record), revealed that the multivitamin had originally been ordered on 10/7/03. A record review of resident 12's Physician's Telephone Orders was done and revealed that there was an order dated 7/8/04 for Depakote 250 milligrams to be taken twice daily. During the medication pass, it was observed that the Depakote was not administered.	F 332	designees will observe a medication pass on a monthly basis for compliance. 3) The Nursing Staff will communicate if a medication is unavailable via the Daily Stand-Up Meeting and appropriate action will be taken to ensure medications are provided for in a timely fashion. D) 1) The Director of Nursing will monitor to ensure compliance. 2) The Director of Nursing will report the results of the Medication Pass Observation and any medication errors to the QA Committee. E) This Plan of Correction to be completed by 9/20/04.	
F 426 SS=D	483.60(a) PHARMACY SERVICES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: 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	F 426	F-426: Pharmacy Services 1-2: A) 1) The Detrol LA order for resident #1 was discontinued. 2) Resident #12 is currently receiving the prescribed Depakote and has demonstrated no ill effects related to the event.	

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F 426	Continued From page 24 residents. Resident: 1,12. Findings included: 1. Resident 1 was admitted to the facility on 4/15/02 with diagnoses that included cerebrovascular accident, hydrocephalus, osteoporosis, schizoaffective disorder, bladder spasms, hypothyroidism and depression. A review of resident 1's medical chart was completed on 8/2/04. A physician's telephone order dated 7/16/04 revealed that resident 1's physician wrote an order to discontinue Ditropan. (Ditropan is prescribed for patients with an overactive urinary bladder.) A review of resident 1's MAR (medication administration record) for July 2004 and the physician's orders for July 2004 revealed that resident 1 did not have a current order for Ditropan but did have an order for Detrol LA. (Detrol is also prescribed for patients with an overactive urinary bladder.) On 8/2/04 LPN 1 was interviewed. LPN 1 was asked about the 7/16/04 physician's order to discontinue Ditropan. LPN 1 stated that since resident 1 was not currently prescribed Ditropan, she would contact the physician and clarify if the Detrol LA is the medication that should have been discontinued. A review of the physician's telephone order dated 8/3/04 revealed that the facility nurse had contacted the physician and received the order to discontinue the Detrol LA.	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 audit 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 completed by 9/20/04.	

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F 426	Continued From page 25 2. Resident 12 was an 89 year old female admitted to the facility on 10/7/03 with diagnoses which included dehydration, renal insufficiency, hypertension, insulin dependent diabetes and mood disorder. On 8/2/04, a record review of resident 12's Physician Telephone Orders dated 7/8/04 was done. It revealed that there was an order for Depakote 250 milligrams to be given twice daily. A review of resident 12's July 2004 MAR (Medication Administration Record) revealed that the nurse had documented that the Depakote was started on 7/29/04. This was 20 days after the order had been written. A record review of resident 12's Physician Telephone Orders dated 7/29/04 was done. It revealed that there was a clarification order for the Depakote. The doctor clarified that the diagnoses associated with the Depakote was for mood disorder. On 8/2/04, a record review of resident 12's Interdisciplinary Progress Notes for 7/28/04 was done. It revealed that the social worker had noted that resident 12 had a significant change in her behaviors and explained that resident 12 had been observed grabbing and hitting staff. The social worker wrote that staff were to continue to redirect and provide calm and consistent routine care.	F 426		