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

PRINTED: 08/10/2006
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 ______	08/02/2006

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

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F 241 SS=E	483.15(a) DIGNITY 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 individual and group interviews conducted at the facility on 8/1/06 and 8/2/06, it was determined that the facility did not promote care for residents in a manner and environment that maintained or enhanced each resident's dignity and respect, for 10 of 13 residents interviewed in group. Findings included: 1. Timely response to call lights During resident group interview held on 8/1/06, thirteen residents attending the meeting were asked if they had any concerns regarding enough staff to take care of everyone. Several residents related that nursing staff are unable to answer call lights in a timely manner. One resident stated she had timed response to a call light that took over 90 minutes to be answered. Two other residents related instances of waiting over 30 minutes and longer than 45 minutes by the residents timing of the interval. Residents stated that the problem was worse on evening and weekend shifts and that they have observed staff members regularly scheduled on those shifts were unable to respond to all the resident requests for assistance. One resident stated, and other residents agreed that, in many instances, staff would come into the room when a call light was put on and turn the call light off, promising to	F 241	F 241 Call lights This facility does and will continue to promote care for residents in a manner that maintains and enhances each resident's dignity. Staff has been reeducated regarding the expectations of appropriate response to patient call lights. Specifically to not turning off the call light before the residents needs have been met. The Administer or designee will review with the Resident Council the call light response improvement on a monthly basis. Random audits will be conducted on a daily basis until process stabilized. Results will be reviewed in QAA monthly. Frequency of ongoing audits will be directed through the QAA process. Responsible Party. Administrator or designee.	

8/31/06 POC acceptable completion date 9/22/06 Baumhart RN

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

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 241	Continued From page 1 return after they finished providing cares to other residents. The residents related similar instances and stated that staff seldom got back to respond to their requests for them before 30 minutes. Residents stated that it was embarassing and shameful to "sit in your soiled brief" and wait for staff to assist with toileting. By show of hands, 10 of the thirteen residents attending the meeting had concerns with timely staff response to call lights. A confidential staff interview was held on 8/2/06. The staff member interviewed was a nurse aide. The surveyor asked the staff member if he/she was aware of incidents in which resident call lights were not answered promptly. The staff member responded that, at times, staff were busy and unable to answer call lights timely and that call lights have been signalling for extended periods of time. This staff member stated that he/she personally had turned resident call lights off, telling the resident that he/she would return soon, but that it had taken in excess of 30 minutes to get back to the resident. He/She explained this happened because he/she had been busy assisting other residents. 2. Staff use of personal cell phones during resident cares Three residents in the group interview related that some of the facility nursing assistant staff carry their own cell phones with them and answer them while they are attending to personal cares of the residents. These residents and other residents present at the meeting stated that this had been brought up to the facility in resident council	F 241	Cell Phones. Staff has been reeducated to facility standard indicating cell phones are only to be used during scheduled break or lunch time in non resident care areas. Compliance for this standard will be monitored through resident council on a monthly basis until situation is resolved. Visual checks will be conducted by department managers during daily rounds. Issues identified by department managers will be addressed as they arise. Resident council report will be brought to QAA on at least a quarterly basis. Responsible party: Administrator or designee.	9-22-06

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F 241	Continued From page 2 meetings and the facility had "talked to nursing staff" but that the staff behavior was still occurring. Seven of the 13 residents stated that nursing staff use of personal cell phones during resident cares was a concern for them. 3. Activities cancelled Residents at the group interview were asked about activities. Several residents stated that they would like to have more scenic rides in the facility van but that they were told the facility did not have enough help to conduct van rides. Five residents stated that the outside shopping trip had been cancelled because the facility could not "find enough volunteers to help all the residents" who were in wheelchairs. Five of thirteen residents expressed that cancellation of shopping trips was disappointing and discouraging to them since they looked forward to being able to get out of the facility and go to the mall. The facility Activities Director was interviewed related to van trip activities. The Activities Director stated that the shopping trip was cancelled because the facility did not have enough staff and volunteer help to safely assist residents ambulating in wheelchairs for the activity. She further stated that "enough help is a problem."	F 241	Activities. This facility does and will continue to provide outside activities on a regular basis. The facility will review the strategy of matching appropriate available numbers of staff and volunteers to the activity. Satisfaction of residents for the activities provided. Prior to the cancellation of an outside activity the Administrator or designee will be notified to assist with identifying an alternative to cancellation if possible. Incidents of activity cancellation will be tracked and trended and reported to QAA on at least a quarterly basis. Responsible Party: Administrator or designee.	9-22-06

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F 283 SS=D	483.20(l)(1)&(2) DISCHARGE SUMMARY When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on 1 of 3 closed record reviews, it was determined that facility did not provide appropriate discharge planning and communication of necessary information upon discharge from the facility. The discharge documentation did not include resident, family or caregiver access to services, coordination of care, or continuing treatment. Findings included: Resident CL-3 was admitted to the facility on 06/20/06 with diagnosis which included: Cardiac dysrhythmia, congestive heart failure, pacemaker, and hypertension. On 08/02/06 at 12:30 PM, a review of CL-3's medical record indicated that no documentation had been completed on the physician's discharge record and summary, the interdisciplinary discharge summary, post discharge plan, or the social work assessment and history. On 08/02/06 at 2:00 PM during an interview with the medical record coordinator, she stated that the procedure for discharge planning included the	F 283	F 283 Discharge Summary This facility does and will continue to provide a discharge summary that includes a recapitulation of the residents stay and a final summary of the resident's status at the time of discharge. The recapitulation record for closed record #3 has been completed. Residents discharging from the facility have discharge requirements completed. The process as it exists has been reviewed. The process is in place and to ensure the process is consistently completed medical records will audit the chart on the day of discharge. The licensed nursing staff, the social worker and the medical record manager have been reeducated to the discharge process.	9-22-06

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F 283	Continued From page 4 nurse filling out the post discharge plan, the medical records department to complete the upper part of the discharge summary and the physician to complete the bottom part (mailed to physician), and the interdisciplinary team to complete the sections of the discharge summary. She stated, "If they are not there, then it hasn't been done."	F 283	Results of the discharge audit will be summarized, evaluated for trends, issues corrected if any and reported to QAA on at least a quarterly basis. Responsible party: Medical Records Manager.	9-22-06
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and review of medical records, it was determined that for 1 of 21 sample residents, the facility did not provide the necessary care and services to attain or maintain the highest practicable physical well-being in accordance with the comprehensive assessment and plan of care. Findings included: Resident 20 was admitted to the facility on 18/02/05 with diagnoses which included, dementia, multiple cerebral vascular accidents with right side hemiparesis, hypertension, severe osteoporosis and urinary tract infection.	F 309	F 309 Quality of Care This facility does and will continue to provide the necessary care and services to attain or maintain the highest practicable physical wellbeing in accordance with the comprehensive plan of care. Resident 20 is no longer at the facility. A resident who has "popping" heard during transfer will be: assessed for injury, placed on alert charting, radiological evaluation obtained when indicated, the interdisciplinary team will be notified through the 24 hour reporting mechanism, and pain, if any, will be assessed and responded to, to meet resident comfort goal.	9-22-06

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F 309	Continued From page 5 Resident 20's medical record was reviewed on 8/02/06. It revealed the following documentation in the nurses notes; 7/24/06, at 5:00 AM, "Rt (right) side arm{the front fatty part} got pinched under her and looks like it is causing a bruise. Repositioned. Elbow red and non blanchable right when aides came to get nurse. Will continue to monitor." 7/24/06, at 7:00 to 11:00 AM, "Spoke with hospice and discussed plan of care. V.S. (vital signs) T (temperature) 97.8, P (pulse) 156, R (respirations) 32, B/P (blood pressure) 140/70. Tylenol 650mg (milligrams) given for fever and pain with some effects. Hospice nurse called back with new aide. (Up) in w/c (wheelchair). Bruising is apparent to (upper) right arm. She is complaining of discomfort. Will continue to monitor. New order noted." 7/42/06, at 10:00 PM, "Resident has been very lethargic. Resident had poor appetite. Resident. c/o (complained of) pain, Tylenol given. Resident is now resting in room without any c/o pain or discomfort at this time. ...will continue to monitor." 7/25/06 at 9:00 AM, "...resident (up) in w/c, has had (no) coughing at this time. She did state that her R (right) arm is bothering her. Bruise apparent to (upper) R (right) arm. Family notified...Roxanol .5cc (cubic centimeters) given x (times) 2 for c/o pain of upper right arm with good effects at this time." 7/26/06 at 3:00 PM, "Right arm is swollen and very Comfort Hospice Care called to get x-ray.	F 309	Licensed staff has been reeducated to: the alert charting process, the 24 hour reporting process, timely documentation of assessment and pain evaluation. Monthly random audit of alert charting to assure documentation of pain assessment and resident response will occur. Results will be summarized and trends, if any, will be identified and responded to immediately then reported to QAA at least quarterly. Responsible party: ADNS. Or designee	9-22-06

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F 309	Continued From page 6 Schryver Medical called they will be in tonight. Schryver here and obtained x-ray. Resident denies any pain at this time. (Up) in wheelchair throughout most of shift. Will continue to monitor." 7/26/06 at 10:00 PM, "Schryver Medical called at 10:00 PM about x-ray called (right) shoulder and (right) elbow (no) fx (fracture) and (right) humeral neck (fracture). Comfort Care Hospice called." 7/27/06 at 10:00 AM, "Resident's son notified about humoral fracture..." 7/27/06 at 9:00 PM, "Resident complain of (right) arm pain at 2:10 PM an MS (Morphine Sulfate) SL (sublingual) .5 (with) effect. ...Sat (oxygen saturation) 96 RA (room air). MS .5 SL given at this time (9:00 PM)" On 7/28/06 at 12:00 PM, "Late Addendum", dated 7/21/06 at 8:00 PM "...At approx. (approximately) 8 PM, this nurse was called into resident's room. CNA (certified nurses assistant) approached this nurse and stated while she was transferring resident she heard a "popping" sound. CNA was not sure where sound came from. This nurse preceded to do a physical assessment of both shoulders and arms. Resident had good flexion to both arms, but due to hemiparesis of right side, she has poor extension. All of back and spine was assessed with 0 (no) distress. Resident did not complain of any pain or discomfort and visibly every thing was normal and symmetrical." A review of resident 20's hospice nursing notes was done. They revealed the following;	F 309		

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F 309	Continued From page 7 7/22/06, "...Resident does not feel well at all and has a temp; (temperature)" 7/24/06, " ...She is in a lot of pain today." A review of the resident 20's physician progress notes revealed notes from resident's hospice physician dated 7/28/06. "...Fracture (right) humeral neck probably (about) 7/21/06 per nurses notes. Bruising noted 7/25 and x-ray on 7/26 confirms. ...Osteoporosis probably contributed to humeral neck fracture without obvious trauma possibly in transferring." Resident 20's medication administration record contained a pain scale that resident was to be assessed for signs and symptoms of pain, each shift. On 7/24/06 nursing staff noted that resident had a 2, on a scale of 1 to 10, on the day shift. Evening shift was left blank and night shift had a 0. On 7/25/06, nursing staff noted the resident had a 3 on the day shift. Evening and night shift was left blank. On 7/26/06, nursing staff noted the resident had a 3 on the day shift. Evening and night shift was left blank. On 7/27/06, nursing staff left day shift blank, while evening shift had noted a 5. Night shift was also left blank. On 7/28/06 nursing staff noted the resident had a 3 bon the day shift. Evening shift had a 2, and	F 309		

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F 309	Continued From page 8 night shift was left blank. Resident 20"s narcotic record was obtained which showed resident 20 had received Roxanol as follows; .5 cc on 7/25/06 at 8:00 AM. .5 cc on 7/25/06 at 11:00 AM. .5 cc on 7/27/06 at 9:00 AM. .5 cc on 7/27/06 at 2:05 PM. .5 cc on 7/27/06 at 9:00 PM. .5 cc on 7/28/06 at 8:00 AM. .5 cc on 7/28/06 at 9:00 AM. .5 cc on 7/28/06 at 9:00 PM. .5 cc on 7/28/06 at 11:00 PM. Based on record review, nursing staff heard an audible "popping" sound when providing cares for resident 20 on 7/21/06. No documentation about the incident was recorded until 7/28/06 in a "late addendum", in which an initial assessment was done. It was 7/24/06 before any further or repeat assessment was done. Resident 20 complained of pain numerous times. An order for Roxanol was obtained on 7/24/06 for resident 20's pain, but wasn't administered until 7/25/06, and no further assessment of resident's pain was done until 7/26/06 when physician was called and an x-ray was ordered which revealed the fracture.	F 309		

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F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING 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 observations, reviews of record and interviews, it was determined that the facility did not provide necessary assistance to maintain good nutrition for two residents who required assistance with feeding. Resident identifiers 2 and 19 (supplemental). Findings included: During the annual recertification survey conducted at the facility on 8/1/06, observations were made of the morning meal on the special needs unit. Residents 2 and 19 were observed sitting at a table in the middle dining room. Both residents were served their meals by a facility nursing assistant who removed plated food from serving trays, applied clothing protectors for the residents and removed plate and cup covers from the food. The facility nursing assistant then left the table to assist other residents. Resident 19 was observed to begin dipping her fingers into her bowl of hot cereal and sucking the cereal from her fingers. She was observed to eat all of the cereal from the bowl in this manner. The surveyor inquired about resident 19's need for assistance of the two assistants who were helping other residents in the dining room. One of the assistants stated that resident 19 "will slap	F 312	F 312 Activities of Daily Living. This facility does and will continue to provide necessary assistance to maintain good nutrition for residents who require assistance with feeding. Resident #2 and #19's need for assistance with dining has been evaluated and appropriate assistance is being provided. Dining strategies for residents requiring assistance have been reviewed and revised, and dining area placement altered where indicated to support individual resident need. Staff has been reeducated to recognize and respond to resident dining assistance needs. Random dining room audits will be completed weekly until process is stabilized and the at least quarterly, with trend reports, if any to QAA. Responsible party ADNS or designee.	9-22-06

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F 312	Continued From page 10	F 312		

your hands out of the way if you try to touch her food" and demonstrated this by turning resident 19's plate of food. Resident 19 responded by slapping at the assistant's hands. Resident 19 was observed to continue dipping her fingers in the food on her plate and sucking it from her fingers. The facility staff member picked up resident 19's spoon from the table top, scooped pureed scrambled eggs into the spoon and placed it in resident 19's right hand. Resident 19 was then observed to use the spoon and continue feeding herself with the spoon, consuming the pureed eggs and hash browns from her plate and what appeared to be the house supplement of chocolate pudding from a bowl near her plate.

A review of resident 19's facility record indicated that she was admitted to the facility on 9/25/2000 with diagnoses which included Alzheimer's Disease. Resident 19's medical record title "Nutrition Review" showed a notation under "Ability to feed self" of "Total Assist overall" dated for 5/30/04, 8/26/05 and 11/7/04. Entry under "Ability to feed self" dated 5/1/06 showed "self with tray set up and cueing". Entry dated 7/25/06 shows "resists assistance". The medical record shows no mention of strategies to encourage resident 19 to use eating utensils or directions for staff to assist her with eating.

Resident 2 was observed to feel over the table top for his plates and bowls of food. He was observed to pick up the bowl of cereal which was not prepared with sugar or milk and drink the cereal from it. Resident 2's facial grimaces indicated that the cereal was warm or hot but he continued to drink it and then pause to rub his tongue against his upper lip. When he had

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F 312	Continued From page 11 finished all the cereal, he placed the empty bowl down on top of his plate of pureed eggs and hash browns. Resident 2 then felt the table top for more food and began to pull his plate of food toward him. He was observed to pull the plate of food off the edge of the table onto his clothing protector. The plate of food was tipped at an angle but the food did not run off onto resident 2's clothing protector. When the surveyor stood up and approached resident 2, a facility staff assistant stepped over to resident 2 and assisted him by sitting his plate back onto the table in front of him and placing his cereal bowl on the table. The facility staff assistant began to prepare resident 2's plate with seasonings and encourage him to eat the food with his spoon. Resident 2 required total assistance to spoon the food into his mouth. Resident 2 was observed to eat with good appetite. Resident 2's medical record showed that he was admitted to the facility on 1/24/06 with diagnoses which included Alzheimer's Disease, insomnia and prostate hypertrophy. The facility's registered dietician completed a Dietary Weight Loss Evaluation for resident 2 on 3/5/06 which showed resident 2's with a "weight loss trend". Under "ADL's, the Dietary Weight Loss Evaluation showed that "Inability to feed self was checked and requested orders for clinical interventions of "enhanced food diet" and a clinical plan to "provide assistance with meals". The medical record included a "Nutrition Review" dated 4/24/2006 which noted "needs full assist with feeding, but doesn't always accept it". A facility staff member was interviewed on 8/1/06. The facility staff member stated that residents on	F 312		

PRINTED: 08/10/2006
FORM APPROVED
OMB NO. 0938-0391

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

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	465117	A. BUILDING _____ B. WING _____	08/02/2006

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F 312	Continued From page 12 the special needs unit need a lot of help to eat and sometimes staff couldn't "get around fast enough" to help everyone. A facility nurse was interviewed on 8/1/06 regarding feeding assistance on the special needs unit. When the surveyor asked if there was enough staff to assist the residents on the special needs unit, she responded "What is enough help? We do the best we can." She stated that a facility nursing assistance who was scheduled to work on the special needs unit on 8/1/06 during the morning meal had not reported for work.	F 312		
F 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: F322 Based on observations, interviews and record review, it was determined that for 2 of 2 residents with gastrostomy tubes, the facility did not provide coordinated interventions to ensure the residents received appropriate treatment with regard to gastrostomy tube flushes and free water. Resident identifiers 7 and 17.	F 322	F 322 Nasal Gastric Tube. The facility provides coordinated interventions to ensure residents with gastrostomy tubes receive appropriate treatment. Resident's #7 & 17 hydration orders have been clarified and each resident is receiving fluids as ordered. An order format has been created to facilitate clarity of hydration orders associated with gastrostomy tubes. Order for hydration associated with tube feeding will be reviewed when written to assure formate and clarity. Orders will be reviewed on a monthly to assure no changes have occurred and that format remains consistant.	9/22/06

PRINTED: 08/10/2006
FORM APPROVED
OMB NO. 0938-0391

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

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F 322	Continued From page 13 Findings include: 1. Resident 7 was readmitted to the facility on 11/8/02, with diagnoses including esophageal reflex, traumatic head injury, aspiration pneumonia, aphasia, hemiplegia/hemiparesis, and depression. A review of Resident 7 's medical record was completed on [8/2/06]. Upon admission to the facility, Resident 7 had a gastrostomy tube for enteral feedings and medication administration. On 07/31/06 at 4:00 PM, the surveyor observed a facility registered nurse (RN) administering Resident 7's enteral feeding. The RN informed the surveyor that she had already checked Resident 7 ' s G-tube for correct placement. The RN drew up 60cc (cubic centimeters) of water using a 60cc piston syringe. She opened the G-tube clamp, connected the 60 cc syringe, and allowed the 60cc of water to flow, by gravity, into the G-tube. The RN then proceeded to administer the enteral tube feeding; pouring the formula into a 60 cc syringe, allowing the formula to infuse by gravity. Following the formula administration, the RN flushed the G-tube with 60cc of water. An interview was held with this RN, following resident 7 ' s enteral feeding administration. The RN stated . . ." I usually use somewhere between 50cc to 60cc before feedings and when giving medications." On 6/7/06, a physician order included instructions to, " flush tube every 6 hours with 500 ml's	F 322	Licensed staff and dietician educated to revised format of gastrostomy tube hydration orders. Orders for hydration involving a gastrostomy tube are reviewed for format and clarity and corrections made if needed. Audit results reported to QAA should issues arise. ADNS or designee will monitor for continue compliance.	

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

PRINTED: 08/10/2006
FORM APPROVED
OMB NO. 0938-0391

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F 322	Continued From page 14 (milliliter) of water." Note: One cubic centimeter equals one milliliter. A review of resident 7's Enteral Flow Records for July and August 2006, was completed on 8/2//06. The order on the Enteral Flow Record, under "Verification" documented that staff were to administer 375 ml of water to resident 7 every six hours, for total of 2000 ml free water. Note: This is a total of 1500 ml, not 2000 ml. The "Verification" on the Enteral Flow Record did not indicate if the water was in addition to, or inclusive of the water flushes before and after medications and enteral feedings. Below the " Verification " on the resident's Enteral Flow Record was the following order which stated: (no date when the order was written) a. Elevate HOB (Head of bed) 45 degrees b. Product: Nutren 1.5 Fiber c. Strength: Full d. Cal/24/hours: 1875 grams of protein e. Flow Rate: 250cc bolus cc/hr x 5 qd f. Flush tube with water g. Flush amount: 50 cc before and after feeding h. Flush freq: every 6 hours i. Total mili- liters for 24 hours 1250ml On 08/01/06 at 10:10 AM, a facility licensed practical nurse (LPN) was interviewed regarding her understanding of the amount of water that was used before and after the bolus feeding of resident 7. She stated..."let ' s look at the treatment sheet..." The LPN was unable to explain what the treatment sheet meant by 250cc bolus five times a day or the amount of water that should be used to flush the tube. She made the comment that she, "usually uses about 20 to 30cc of water before giving medications or bolus	F 322		

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

PRINTED: 08/10/2006
FORM APPROVED
OMB NO. 0938-0391

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F 322	Continued From page 15	F 322		

feeding . . . depending on what medications are being given." The LPN was unable to explain what the 2000ml of free water meant. She also stated, "The initials of the staff on the enteral flow record indicated that the nurse had checked for residual or placement and did not document the amount of water used to flush the tube or deliver medications."

On 08/01/06 at 10:50 AM, the dietitian was interviewed. She indicated that if staff gave 375 ml of free water every six hours, the resident would receive 1500 ml. The dietitian continued to say, "If you take 50cc of water before and after the tube feeding (every 6 hours) it would be equal to 400 ml that total 1900 ml. She stated, "I am not sure on the amount of water the nursing staff is using before giving medications or when administering the tube feedings..."

2. Resident 17 was admitted to the facility with diagnoses including closed head injury, dysphasia, hemeplegia, and anxiety. Resident 17 was a resident with a gastrostomy tube used for enteral feedings and medication administration.

On 08/02/06 at 9:45 AM, the surveyor observed a facility licensed practical nurse (LPN), discontinuing resident 17's enteral feeding of Replete with fiber. The LPN entered resident 17's room, informed the resident of the procedure, placed on non sterile gloves, turned off the pump, and disconnected the feeding tube from the resident's gastrostomy tube. She gathered the empty bag and placed it into the garbage can. She then left the resident's room. After exiting the room the surveyor asked the LPN if she should flush resident 17's gastrostomy tube with

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

PRINTED: 08/10/2006
FORM APPROVED
OMB NO. 0938-0391

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F 322	Continued From page 16	F 322		

water after she discontinued the feeding. She stated, "I do not know". She then went to the Medication Administration Record (MAR) to observe an order. She stated she was unable to determine if she needed to flush the gastrostomy tube and stated, "I will have to check with the ADON (assistant director of nursing)."

On 08/02/06 at 10:45 AM, during an interview with the ADON regarding her understanding of the amount of water that was to be used before and after the feeding of resident 17. She stated..."let ' s look at the treatment sheet". The ADON observed the order to read 300cc but stated ..."it is not specific as to what should be flushed through the tube before or after the feeding... we need to clarify the order with the physician." The ADON stated that they do not have a policy for flushing gastrostomy tubes, but ..."refer to specific physician orders."

On 08/02/06, resident 17 ' s medical record was reviewed. Resident 17 ' s July 2006 Enteral Flow Record documented that staff were to flush the gastrostomy tube with 300 cc of water. The Enteral Flow Record did not indicate the amount of water that should be used to flush the tube before and after administering enteral feedings and medications.

On 08/02/06, a dietary progress note documented, "feeding and 300cc water flush every 6 hours . . . feeding as ordered with flush meets estimated needs."

Fundamentals of Nursing, Concepts, Process, and Practice, seventh edition, Prentice Hall, 2004; Procedure for irrigating a Gastrointestinal Tube,

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

PRINTED: 08/10/2006
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
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F 322	Continued From page 17 pp. 923...states the following: ... draw up the ordered volume of irrigating solution in the syringe; 30 ml of solution per instillation is usual, but up to 60 ml may be given per instillation if ordered. Fundamentals of Nursing, Concepts, Process, and Practice, seventh edition, Prentice Hall, 2004; Procedure for Administering Gastrostomy Feeding, pp. 1214 states the following:...just before all the formula has run through and the syringe is empty, add 30 ml of water. Water flushes the tube and preserves its patency.	F 322		
F 328	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined that for 1 of 21 sampled residents, the facility did not ensure that a resident received proper respiratory care and treatment. Resident identifier: 4.	F 328	328 Special needs. The facility does and will continue to ensure that residents receive proper respiratory care and treatment. Resident #4 is no longer at the facility. The facility has identified residents who require continuous oxygen and have ensured licensed staff and CNA'S are aware of the residents needs. Residents requiring the monitoring of Oxygen Saturation have been identified. The monitoring and documentation of oxygen saturation is occurring as ordered.	9-22-06

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

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OMB NO. 0938-0391

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F 328	Continued From page 18 Findings included: Resident 4 was admitted to the facility on 03/15/05, and re-admitted 12/23/05, with diagnoses that included: closed fractures of the hip, closed fractures of the C1-C4, dizziness/giddiness, falls, essential hypertention, kidney disorder, pneumonia, diabetes, and UTI. On 8/2/06, a review of Resident 4's medical record revealed that upon Resident 4's readmission to the facility, on 12/23/05, he had a Physician's order for : "O2 (Oxygen) continously @1-2 liters and check SATS (oxygen saturation) BID (twice daily)". A physicians telephone order, dated 7/6/06, included: "O2 (oxygen) per NC (Nasal Canula) @ 2 liters continously for shortness of breath. [Check] sats (saturations) BID keep > 90%." Between 12/23/05 and 7/6/06, there was no documentation or order that resident 4's oxygen therapy was to be discontinued. On 08/01/06 at 7:35 AM, observations of Resident 4 were made in the Ben Lomond Dining Room. At that time, Resident 4 was already seated in a wheel chair, at a table, in the dining room. He was not wearing the oxygen via a nasal canula. His oxygen canister was not in the dining room. At 7:45 AM, LPN 1 (a facility staff licensed practical nurse) administered Resident 4's morning medications. Resident 4's meal intake was poor, consuming approximately 30 %.. At 8:15 AM, Resident 4 was observed having difficulty breathing. At that time, CNA 2 removed Resident 4 from the Dining Room and assisted him to the hallway where LPN 1 was standing. LPN 1 placed a pulse oximeter on Resident 4's finger to assess the resident's oxygen saturation	F 328	The newly admitted resident with orders for continuous oxygen or oxygen saturation monitoring are identified and the orders implemented as written. Facility staff has been reeducated to the identification process for persons on continuous oxygen. The licensed staff reeducated to the oxygen saturation monitoring and documentation process. Random monthly audits of the Treatment Record documentation to ensure oxygen saturation is recorded as ordered. The facility maintains a list of persons on continuous oxygen. The information will be shared with appropriate departments. The audit results will be reviewed if issues arise at QAA. Responsible party ADNS. Or designee.	9-22-06

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

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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 _____	08/02/2006

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F 328	Continued From page 19 level. Resident 4's oxygen saturation level was 86%. LPN 1 was observed instructing CNA 2 to take Resident 4 back to his room immediately and put him back on his oxygen.. At 8:25 AM, LPN 1 was observed in Resident 4's room checking his oxygen saturation level. At that time, Resident 4's oxygen saturation was 99%. An interview was held on 08/2/06 at 9:15 AM, with LPN 1. LPN 1 stated she had recently been on extended leave from the facility, returning to work on 8/1/06. She stated she was not very familiar with Resident 4's care needs. LPN 1 stated she had been assigned to provide nursing cares to Resident 4 during the day shift on 8/1/06 and 8/2/06. The surveyor asked LPN 1 if she recalled an incident on 8/1/06, in which Resident 4's oxygen saturation level was decreased. LPN 1 advised that a nurse aide brought Resident 4 to her and that the nurse aide stated the resident was not breathing well. LPN 1 stated she checked Resident 4's oxygen saturation level and determined the level was low at 86%. LPN 1 stated she instructed the nurse aide to take Resident 4 back to his room and to place him on his oxygen. as his oxygen saturation level was too low. LPN 1 stated she returned to Resident 4 approximately five minutes later to reassess his oxygen saturation level. She stated Resident 4 was at 99%. The surveyor asked LPN 1 if she had documented this incident in Resident 4's medical record, to which she replied she had not. An interview was held on 8/2/06 at 9:35 AM, with CNA 2 . CNA 2 stated that she had worked at the facility for three months and that she was familiar with Resident 4's care needs. CNA 2 stated that she had been assigned to provide	F 328		

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

PRINTED: 08/10/2006
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 _____	08/02/2006

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F 328	Continued From page 20 cares to Resident 4 on several occasions, including the day shift of 8/1/06 and 8/2/06. She stated that the day shift was 6:00 AM to 2:00 PM. CNA 2 stated that she was aware that Resident 4 had orders to use oxygen, stating this was a fairly recent order, but that she did not know he had to wear the oxygen all the time. CNA 2 stated she brought Resident 4 to the dining room for breakfast on 8/1/06 at approximately 7:30 AM. She stated she did not bring Resident 4's oxygen with him to the dining room. CNA 2 stated she did not consult with Resident 4's nurse prior to bringing the resident to the dining room without the oxygen. A review of the Quartly MDS (Minimum Data Set) assessment, dated 06/15/06, was completed. Under Section P1, Special Treatments/Procedures, facility staff did not document that Resident 4 was receiving oxygen therapy. *Note: Physician orders from 12/23/05 included Resident 4's use of oxygen therapy. A review of the comprehensive care plan for Resident 4 was completed on 8/2/06. Facility staff had not developed a care plan to address Resident 4' s use of oxygen therapy. A review of the nursing notes for Resident 4 was completed on 8/2/06. There was no nursing note entry, dated 8/1/06, to describe the incident in which Resident 4's oxygen saturation level dropped to 86% while he was on room air. A review of Resident 4's Treatment Administration Records (TAR), for the months of July 2006 and August 2006 was completed on 8/2/06. The TAR included a space for staff to	F 328		

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

PRINTED: 08/10/2006
FORM APPROVED
OMB NO. 0938-0391

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F 328	Continued From page 21 document Resident 4's oxygen saturation level in the AM and in the PM. On 8/1/06, in the AM space, Resident 4's oxygen saturation level was documented to be 99%. The fact that Resident 4's oxygen saturation level was decreased at 86% was not reflected in documentation on the TAR. Per documentation on Resident 4's July 2006 TAR, the resident's oxygen saturation level was not checked 13 times as directed by the 7/6/06 Physician telephone order to check oxygen saturation levels twice a day.	F 328	507 Laboratory services This facility does and will continue to provide lab testing as ordered and results are placed in the medical record.	9-22-06
F 507 SS=B	483.75(j)(2)(iv) LABORATORY SERVICES The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility did not have clinical record laboratory reports for 2 of 21 sample residents. Residents 5 and 11. Findings included: 1. Resident 11 was admitted to the facility on 7/5/02 with diagnoses including: cardiac dysrhythmias, hypertension, cerebral vascular accident, hemiparesis, depression, aphasia, and atrial fibrillation. Resident 11's medical record was reviewed on 7/31/06. The physician had ordered a laboratory	F 507	The labs ordered for resident #5 and 11 have been obtained reported and are on file in the residents chart. The lab tracking process has been reviewed, revised and reimplementation. Licensed staff has been reeducated to the laboratory tracking process. The laboratory tracking log will be reviewed weekly until the process is stable and then randomly at least quarterly and the results reported to QAA. Responsible party ADNS or designee.	

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MANOR CARE OF SOUTH OGDEN	5540 SOUTH 1050 EAST OGDEN, UT 84405

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F 507	Continued From page 22 Chem 7 to be drawn every 3 months. A Chem 7 was done on 3/9/06. Another Chem 7 was due on 6/9/06. There were no other Chem 7 laboratory reports for resident 11. On 8/1/06 the Director of Nursing (DON) was asked for the laboratory report that could not be found in the resident's chart. On 8/2/06, the DON said that the Chem 7 had not been done for June 2006 for resident 11. 2. Resident 13 was readmitted to the facility on 6/27/06 with diagnoses with included congestive heart failure, pelvic fracture and Alzheimer's Disease. Resident 13's medical record was reviewed on 8/1/06 and showed a physician order dated 6/29/06 for laboratory TSH and T4 Thyroid function tests. No evidence was found in resident 13's record to indicate these tests had been done. On 8/1/06, the facility's Director of Nursing was asked to furnish copies of the laboratory reports for the ordered tests. The facility did not furnish the requested evidence and the Director of Nursing stated that the tests had not been done.	F 507		