STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A051	A. BUILDING _____ B. WING _____	9/12/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK HEALTH CENTER	3520 SOUTH HIGHLAND DRIVE SALT LAKE CITY, UT 84106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 242 SS=E	483.15(b) QUALITY OF LIFE The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on mealtime observations, individual interviews and an confidential interview with a group of 6 alert and oriented residents, it was determined that 1 resident on the survey sample and one supplemental resident plus 4 out of 6 residents in the group, complained of being hungry at times, did not get second helpings of food when they asked for it, and/or did not get necessary assistance with meals. Residents 4 and 54 and a confidential group of residents. Findings include: 1. Resident 54 was a 43-year-old female who was admitted to the facility 1/16/02 with diagnoses which included hereditary cerebellar ataxia and seizure disorder. The medical record for resident 54 was reviewed on 9/11/02. The MDS assessment, dated 7/24/02, documented resident 54 required extensive assistance of staff for eating (Section G1, h). Resident 54 was identified as having impaired communication (Section C). On 9/12/02, resident 54 was observed sitting at the breakfast table with a plate of cut up pancakes in front of her. After a staff member cut her pancakes, no staff was observed to assist resident 54 to eat her pancakes. Staff was observed to remove the pancakes without	F 242	Acceptable BB The dining room procedure has been re-organized to include the following: Staff assigned to the dining room are to ask residents if they are still hungry and to offer choices if the resident feels he/she wants more food. Seconds will be given at the time the resident asks and plates will not be cleared until the resident has been asked if they are finished. Aides will offer assistance to each resident at the time that the residents' plate is served. Department heads have been assigned to observe and assist in the dining room for meals. The director of nursing has been assigned the duty of training all new aides as to the proper dining room procedure. All staff have been inserviced as to the correct dining room procedure. The above will be monitored for compliance by the director of nursing. Continued compliance assurance will be integrated in Quality Assurance meetings and will be reviewed quarterly. 5 08 09 WB Utah Dept. of Health OCT 15 2002 Bur. of Medicare/Medicaid Prog. Certification and Res. Assessment	11-11-02

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

12-13-02

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F 242	Continued From page 1 asking resident 54 if she was finished. In an interview with resident 54, on 9/12/02, the resident stated "I love pancakes. They took them away this morning; no one asked." and she stated "I didn't get any [pancakes]." Resident 54 stated that it has happened before at breakfast. The resident further stated, "They do it all the time at night." When asked if she ever left a meal hungry, resident 54 stated, "Yes, sometimes I get hungry at night, but I'm okay." 2. Resident 4 was a 71-year-old male who was admitted to the facility on 8/1/02 with diagnoses of Alzheimer's dementia, hypertension and hypernatremia. The medical record for resident 4 was reviewed on 9/12/02. Resident 4 was identified on his Minimum Data Set (MDS) assessment as having had a Customary Routine of "eating between meals" (Section AC 1, i and j). Resident 4 was identified as communicating with clear speech (Section C5), and able to be understood (Section C4), as having the ability to "sometimes" understand others (C6), as being independent with activities of daily living except that he required supervision for eating and minimal staff assist for personal hygiene (Section G1). Observations were made of resident 4 on 9/11/02. Following breakfast, on 9/11/02 at 9:15 AM, resident 4 was observed for 25 minutes. The resident returned to the dining room during the second breakfast serving and sat alone at a table. He appeared to be watching some residents as they were eating and other residents who were going in and out the door to the porch. After about 15 minutes, the surveyor asked the resident if he had eaten and then if he was hungry. Resident 4 replied that he had eaten, but that he was	F 242		

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F 242	Continued From page 2 still hungry. He said he had not told anyone that he was hungry. After about three more minutes of observing the resident watching other residents eat, the surveyor mentioned to a certified nurse aide (CNA) that resident 4 said he was hungry. The CNA asked resident 4 if he was hungry and the resident said he was. The CNA asked, "What do you want?". Resident 4 stated that he wanted a piece of coconut cream pie. The CNA said that there wasn't any pie and that pie wasn't served in the morning. The CNA left without offering anything else to resident 4. 3. During a group interview held on 9/11/02 at 3:45 PM it was stated by 4 out of 6 residents that they frequently left meals hungry. The residents stated that they were not allowed to ask for or get seconds until the second group of residents had eaten and the facility was sure there enough food for everyone.	F 242		
F 248 SS=E	483.15(f)(1) QUALITY OF LIFE The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff and residents, and on record review, it was determined that for 2 of 14 residents on the sample, the facility did not assist the residents to participate in activities of their choice that were of their identified interests and that were provided to other residents within the facility and for 1 additional resident whose chosen activity was interrupted twice for other activities in spite of her verbalized objection. Residents: 4, 29 and 54.	F 248 Acceptable BD	A new activity director has been hired. Comprehensive assessments, activity assessments and care plans have been reviewed with particular emphasize on identified interests and on residents that are prevented from exiting the building due to the wanderguard device. Resident interviews have been conducted as to resident preference for activities by new activity director. Activity plans have been modified where necessary to include one on one outside activities for residents that are unable to go out on their own and to better incorporate identified interests. Residents 4, 29 and 54 have been offered and participated in outside activities in addition to activities of their preference. Resident 54 will be invited to activities by activity director on a one-one basis. Care plans and activity plans have been revised to reflect their needs.	11-11-02

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F 248	Continued From page 3 Findings include: 1. Resident 4 was a 71-year-old male who was admitted to the facility on 8/1/02 with diagnoses of Alzheimer's dementia, hypertension and hypernatremia. The medical record for resident 4 was reviewed on 9/12/02. Resident 4 was identified on his Minimum Data Set (MDS) assessment as having had a "Customary Routine" of "going out 1+ days a week" and having "daily contact with relatives/close friends" and that he did not spend most of his time alone or watching television (Section AC 1, c, e and s) Resident 4 was identified as communicating with clear speech (Section C5), and able to be understood (Section C4), as having the ability to "sometimes" understand others (C6), as being independent with his ambulation and other activities of daily living (ADL) except he required supervision for eating and minimal staff assist for personal hygiene (Section G1). The MDS assessment documented that resident 4 was awake all or most of the time, morning through evening, (Section N1) and that the activities he preferred included going outdoors, conversing, music and watching television (Section N4). Review of resident 4's care plan documented a concern that the resident had an "alteration in activities and social pattern" with a goal that "resident will make and remember decisions regarding what he wants daily by NR [next review]"and "resident will know when and where activities are held daily by NR". An approach was documented to help the resident reach the goal by "1 X 1 [one to one] personal invite to activities such as . . . movies . . . to increase socialization . . . and attention span."	F 248	(continued) The above will be monitored for compliance by the activity director and the recreation consultant. Continued compliance assurance will be integrated in Quality Assurance meetings and will be reviewed quarterly.	

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Observations were made of resident 4 on 9/10/02, 9/11/02 and 9/12/02. Following breakfast, on 9/11/02 at 9:15 AM, resident 4 was observed for 25 minutes. The resident sat alone at a table in the dining room. He appeared to be watching as some residents were eating and others as they were going in and out the door to the porch. Periodically resident 4 walked to the door and gently pushed, in an attempt to open it. Because he was wearing a wander guard device, the door locked whenever resident 4 approached it.

During the three days of observation, the facility staff were observed to take other residents outside to smoke after breakfast was over and about every hour throughout the day. Some of the residents who were accompanied outside were wearing wander guard devices. Resident 4 was not observed to be taken outside the facility during the survey.

In an interview with resident 4, on 9/12/02 at 8:50 AM, the resident was asked what he did during most days. He replied that he was looking forward to being able to go out to a movie that day. At 1:10 PM, resident 4 was observed in the hallway near the entrance to the facility, with several residents who were getting into the facility van. At 1:30 PM, the resident was observed standing in the hallway, after the facility van had driven away with several other residents in it. A surveyor approached the resident and asked how he was doing. The resident just replied, "I thought I was going to get to go to a movie, but there wasn't room in the van." There were no other organized activities while the activity staff was away at the movie.

In an interview by a second surveyor, on 9/12/02 at 3:30 PM, resident 4 stated, "Today I was excluded from the trip to the movies. I object to not being included in activities that I like." When asked if there

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were other activities he enjoyed, resident 4 said he liked basketball, but "they never play it."

Resident 4 was flown to Utah, on the day of his admit, from the State of his residence, where his friends and family continued to reside. The resident does not routinely get visits from friends or family and does not go out to visit them. He was not observed to socialize with other residents although he was receptive to conversation with the surveyors. Resident 4 was not allowed go outside alone because he was new to the facility and a possible flight risk. Resident 4 is dependent upon the facility staff to accompany him outside and to make available to him a variety of leisure activities that he enjoys.

2. Resident 54 was a 43-year-old female who was admitted to the facility 1/16/02 with diagnoses which included hereditary cerebellar ataxia and seizure disorder.

The medical record for resident 54 was reviewed on 9/11/02. The MDS assessment, dated 1-24-02, documented that resident 54 was awake all or most of the time, morning through evening, (Section N1) and that the activities she preferred included going outdoors, conversing, music, games, exercise, religious activities and watching television (Section N4). The MDS assessment, dated 7/24/02, documented resident 54 spent "little - less than 1/3" of her time involved in activities

During observations on 9/10/02, 9/11/02 and 9/12/02, resident 54 was observed to be out of her room for meals in the dining room each day. There was no interaction observed between resident 54 and the other residents at her table on any of the three days. Resident 54 was observed eating a popsicle at a dining room table on 9/11/02 at 2:30 PM and was visited by a

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family member earlier in the day. Other observations of resident 54, on 9/11/02 at 11:00 AM and at 1:00 PM, revealed the resident to be in her room watching television. On 9/11/02 at 4:00 PM, resident 54 was sitting in her wheelchair in her room, but the television was not on. Each time resident 54 was observed in her room, the curtain was drawn between her and her roommates.

On 9/12/02 at 2:00 PM, resident 54 was interviewed. Resident 54 was sitting in her wheelchair; she was facing her television which was not on; the curtain was drawn between resident 54 and her roommates' beds. One of her 70+-year-old roommates was in bed asleep. Resident 54 was asked about how she usually spends her day. Resident 54 said "I make do". When queried further, resident 54 stated that she spent most of her time in her room and that sometimes she enjoyed watching television. Resident 54 stated that she had no interaction with her roommates. When asked what she liked to do, resident 54 stated, "I love to go outdoors. They don't ask me. They think I'm stupid. I'm not stupid." Then she said, "It's been gorgeous and I would love to go outside. They just don't ask me." When asked if she let the staff know that she wanted to go outside, the resident stated, "They think I'm stupid. It's okay, I make do."

In an interview with a family member of resident 54, the morning of 9/11/02, the family member stated that the facility took good care of the resident. When asked about resident 54's life style now, the family member stated, "She comes out to the activities now, but not all the time." Resident 54's family member stated, "I would like to see her get to go out on trips more often. I understand they only have one van and limited staff, but it would be good if she could go out."

3. Resident 29 and 10 other residents were observed,

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F 248	Continued From page 7 on 9/11/02 at 10:05 AM, to be watching a video movie that the activity director had just started. At 10:50 AM, two volunteers were setting up for a religious meeting in the area of the television. They asked this surveyor if they could turn the television off, but were referred to ask the residents. Resident 29 stated, "No, I want to see what happens." The activity director said, "They can watch it later. It is just a video." The activity director turned the television off. After lunch was over, about 1:30 PM, the activity director started the video movie from the beginning. As it was just starting, resident 29 brought a drink into the television room and sat down to watch. Resident 29 stated, "I want to see this one." At about 2:15 PM, the activity director again turned off the movie and served popsicles to the residents who had been redirected to the dining room tables. At 3:15 PM, the activity director put the same movie in the video player and turned it on from the beginning a third time.	F 248		
F 253 SS=B	483.15(h)(2) ENVIRONMENT The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations of the facility on 9/10/02, 9/11/02,and 9/12/02 the facility did not provide maintenance services necessary to maintain a sanitary and comfortable interior - specifically resident care equipment, as evidenced by 5 out of 14 sampled residents and 5 additional residents + wheelchairs, gerichairs and/or lap buddies in various states of disrepair. Residents: 6, 9, 14, 18, 24, 28, 31, 52 and	F 253	All lap buddies that were in disrepair have been replaced with new lap buddies. A back stock will be kept on hand for prompt replacement when needed. All arm rests have been replaced. All staff have been inserviced to notify central supply and/or maintenance when lap buddies or armrests need replaced. A weekly check will be performed by the central supply person to determine if any items are in disrepair. Documentation will be done on a weekly check form. Lap buddies that need replaced will be done	11-11-02

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F 253	Continued From page 8 54. Findings included: Resident 18's gerichair had a large piece of pink torn vinyl hanging off the foot rest. Resident 6's lap buddy had numerous places where the vinyl was torn. Resident 9 had a high backed chair with a turquoise quilted covering over the chair back. The covering was torn over an area of 5 1/2 inches by 3 1/2 inches just above the resident's head. The distal ends of the resident's green arm rests were torn. The right arm rest was torn 1 inch by 3/4 inch. The left arm rest was torn 1/2 inch by 1/2 inch with a second hole in the plastic of 1/2 inch diameter. Resident 31's lap buddy had 6 inch tears on the left front, top and bottom seams. The right front bottom seam was torn about 5 inches and the top right had tears from 1 inch to 3 inches with small intact areas between the tears. Resident 14's wheelchair had a 7 inch by 3 inch tear in the hard plastic of the left arm rest. The plastic had rough edges that could scratch or tear the skin on his left arm. Resident 24's wheelchair had a 2 1/2 inch tear in the left arm pad and there was no arm rest over the side bar on her right side. Resident 28's right arm rest was torn the length of the pad and it was a reddish color. The left arm rest on resident 28's chair was a blue color and was torn at the back. Resident 54's wheelchair was missing an arm rest that	F 253	(continued) so by the central supply person. The weekly check form will be forwarded to the plant manager when repairs are needed. Compliance to be monitored by the central supply person and the assistant administrator. Continued compliance assurance will be integrated in Quality Assurance meetings and will be reviewed quarterly.	

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F 253	Continued From page 9 should have been attached to the bar on her right side. The left arm rest on resident 54's wheelchair was positioned about two inches higher than the bar on her left. Resident 52's wheelchair was missing an arm rest that should have been attached to the bar on her right side.	F 253		
F 278 SS=E	483.20(g) - (h) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly-- Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on clinical record review, it was determined the	F 278	Acceptable BB The MDS coordinator and the registered nurse will meet weekly to review all MDS assessments that are due and completed for IDT that week. They will check all sections for accuracy and completeness, as compared to the chart, to reflect the residents' status before the registered nurse or other health professionals sign the MDS. All MDS will then be signed off by the correct health professionals and finally, the registered nurse will sign and certify that the assessment is completed. Resident 4-assessment has been corrected to accurately reflect his height. Resident 52-was not admitted with a diagnoses of diabetes, but was assessed for diabetes in June of 2002. Assessment has been corrected to accurately reflect the diagnoses of diabetes, amputation of a limb and the open lesions/foot problems. Resident 18-assessment has been corrected to accurately reflect the continence self control and the indwelling catheter. Resident 32-MDS of 7/24/02 has been corrected to accurately that the assessment is an annual rather than an admission assessment.	11-11-02

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F 278	Continued From page 10 facility did not assure that each resident had accurate and complete Minimum Data Set (MDS) assessments as evidenced by 4 of 14 sample residents were not accurately portrayed on their MDS assessments. Residents: 4, 18, 32, 52, and CR1. Findings include: 1. Resident 4 was admitted to the facility on 8/1/02. Resident 4 was independently mobile and was 74 inches tall. Resident 4 was identified on his initial MDS assessment as being 60 inches tall (Section K2,a). The MDS was signed by the DON as being completed and accurate, and by the dietary manager as having completed section K accurately. 2. Resident 52 was admitted to the facility on 7/24/00 with multiple diagnoses that included diabetes mellitus. Resident 52's left arm had been amputated and the resident had developed open wounds on both of her heels secondary to her diabetes. The clinical record for resident 52 was reviewed on 9/11/02. The annual comprehensive MDS assessment on resident 52's active record, dated 7/24/02, was hand written and was signed by the Director of Nursing (DON) as being complete and accurate. The MDS assessment did not identify that the resident had diabetes (Section I1,a), did not identify that the resident had a missing limb (Section I1,n), and did not identify that the resident had open lesions on her feet (Section M6,c) or any problems with her feet (M6,a). 3. Resident 18 was admitted to the facility on 10/17/2001 with diagnoses that included quadriplegic, chronic urinary tract infections, methicillin resistant staphylococcus aureus, depression, suicidal behavior, hypertension, gastroesophageal reflux disease and seizure disorder.	F 278	(continued) Resident CR1-All assessments, including discharge and reentry forms have been completed. Compliance to be monitored by the director of nursing, mds coordinator and the health information manager. Continued compliance assurance will be integrated in Quality Assurance meetings and will be reviewed quarterly.	

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The clinical record for resident 18 was reviewed on 9/12/02. The MDS Quarterly Assessment Form, dated 7/31/02, was signed by the DON as being accurate and complete. The Continence Self-Control Categories-appliances and programs (section H3) was left blank. Section H3-d (indwelling catheter) should have been checked. The assessment did not identify that resident 18 had an indwelling supra-pubic catheter.

4. Review of the medical record for resident 32, who was admitted to the facility on 5/17/95, documented a handwritten, assessment dated 7/24/02 and signed by the DON as being complete and accurate. The MDS assessment documented that it was the Admission Assessment for resident 32.

5. Resident CR1 was admitted to the facility on 3/26/02, temporarily discharged on 4/29/02, readmitted on 5/16/02 and discharged with no return anticipated on 8/2/02.

The clinical record for resident CR1 was reviewed on 9/12/02. There were two comprehensive MDS assessments in resident CR1's closed record. Neither of the two comprehensive MDS assessments in the file had been completed. In addition, resident CR1 should have had one Discharge Tracking MDS form for each of his discharges and one Re-Entry tracking MDS form documenting his return to the facility. There were no Discharge or Re-Entry tracking forms in the closed record.

Errors or omissions were as follows:
. The MDS assessment, dated 4/8/02, was documented as an annual assessment when it was the residents initial assessment for his first admission to the facility (Section AA8).
. The behavior documentation (Section E5) was left

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F 278	Continued From page 12 blank. Resident CR1's MDS assessment for bowel and bladder continence (Section H1 a and b and Section H4) were left blank. . The resident's diagnosis data did not include an identifying code for one of his diagnoses (Section I3). . Resident CR1's Oral/Nutrition Status was incomplete. The areas for identifying any oral problems (Section K1, a-d), identifying the resident's weight (Section K2, b), and for identifying any nutritional problems (Section K4, a-d) were left blank. . Resident CR1's Activity Pursuit Patterns were left blank for identifying the average time she was involved in activities (Section N2) . The Resident Assessment Protocols (RAPs - second part of the required Resident Assessment Instrument) had not been identified accurately (Section VA a). Four areas that should have been triggered from the MDS assessment data were not identified and not addressed: RAP problem area 1 - Delirium, 8 - Mood State, 11 - Falls, and 16 - Pressure Ulcers. Because the areas had not been identified as having been triggered, the problem areas were not addressed or documented as being care planned (Section VA b). The Resident Assessment Instrument (RAI) consisting of both the MDS assessment and RAP data, were signed as being complete and accurate by the DON on 4/8/02. The RAI for resident CR1, dated 5/29/02, was signed as being complete and accurate by the DON on 5/29/02, but four areas of the RAP Summary were not identified as having been triggered or as needing a care planning decision and were left blank (Section VA a and b): 1 - Delirium, 8 - Mood State, 14 - Dehydration/Fluid Maintenance, and 15 - Dental Care. On 9/12/02, the DON stated there were additional copies of the RAI on her desk. On 9/17/02, the	F 278		

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F 278	Continued From page 13 surveyor received a faxed copy of completed and corrected, encoded copies of the 4/8/02 and 5/29/02 MDSs. There were no copies of the MDS tracking forms for resident CR1's discharges or his re-admit.	F 278		
F 281 SS=G	483.20(k)(3)(i) RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews and clinical record review it was determined that the facility did not ensure that 1 of 14 sampled resident's weight was being monitored per professionally accepted clinical standards. Resident identifiers: 18 Findings include: Resident 18 was admitted to the facility on 10/17/2001 with diagnoses that included quadriplegic, chronic urinary tract infections, methicillin resistant staphylococcus aureus, depression, suicidal behavior, hypertension, gastroesophageal reflux disease and seizure disorder. A review of resident 18's medical record was done on 9/12/02. A review of the 7/ 31/02 MDS (minimum data set) documented resident 18's weight at" 035" (K2) with the hand written notation on the right margin of the MDS form of "abd. girth." The DON (director of nursing) was interviewed on 9/12/02 at 10:00 AM by the surveyor and was asked,"What does abd. girth stand for?" The DON replied,"Abdominal girth." The DON stated that they were unable to weigh resident 18 because he shakes too much, and his joints were stiff. The DON stated,	F 281	Acceptable PSB The facility has discontinued using the practice of measuring abdominal girth as a means of indicating weight loss. To meet professionally accepted clinical standards, a stand/on, roll on scale has been purchased and is being used to accurately monitor weight for residents. Resident 18-An accurate weight was obtained from the hospital. Interventions were put in place during survey, ie house supplement tid, 2Kal tid, resident preferences were reviewed and offered. Compliance to be monitored by the director of nursing and the registered dietitian. Continued compliance assurance will be integrated in Quality Assurance meetings and will be reviewed quarterly.	11-11-02

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F 281	Continued From page 14 "that is all I could come up with." The DON was asked by the surveyor if the dietitian was aware the facility was using an abdominal girth as a nutritional assessment for residents. The DON replied that she didn't know if the dietitian was aware. On 9/12/02 at 10:45 AM resident 18 was observed by the surveyor to be weighed by a CNA (certified nursing assistant). Resident 18 was seated on a weight chair, the only scale available in the facility at that time, and assisted to position his legs. His weight was observed to be 123 lbs. A review of resident 18's medical record revealed the following recorded weights: 1/2002 - 168 lbs (pounds) per monthly weight roster 2/ 2002 - 166 lbs. per monthly weight roster 2/9/02 - 168 lbs. per physician's progress notes 3/2002 - no weight documented per monthly weight roster 3/2/02 - 166 lbs per nursing monthly summary 4/2002 - no weight documented per monthly weight roster 4/10/02 - 166 lbs. per physician's progress notes Starting in May of 2002 an abdominal girth was documented instead of weight. Resident 18's abdominal girth was 36 inches. An abdominal girth was also documented for the months of June (resident 18's abdominal girth was 35), July (resident 18's abdominal girth was 35), and August (resident 18's abdominal girth was 35) of 2002 . As documented by the physician on 4/10/02 and as observed by the surveyor on 9/12/02, resident 18 lost 43 lbs. which was 25% of his total body weight in less that 6 months.	F 281		

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F 281	Continued From page 15 A fax was received from the facility, after the survey was completed, on 9/16/02. The fax documented that on 9/14/02, resident 18 was weighed by a local hospital . Resident 18's weight was reported as 64.5 kg or 141.9 lbs. If the hospital weight, as reported on 9/16/02, was the more accurate weight than the facility weight on 9/12/02, resident 18 would have lost 25 lbs or 15% of his total body weight which is significant. In a separate interview with the assistant administer, following the survey, the assistant administrator stated that resident 18 had been weighed again at the facility. She stated that, after repositioning resident 18 farther back into the weight chair, the scaled showed his weight about 20 lbs greater than when he sat near the front of the chair. There were no interventions by the registered dietitian or the dietary manager to prevent resident 18's weight loss. There was no documentation that the weight loss had been identified by the facility, nursing or dietary staff. The "Dietary Progress Notes", signed by the dietary manager and co-signed by the registered dietitian on 6/19/02, documented resident 18's weight as 035 and the summary documented,"Unable to measure body weight. Food intake reveals resident meeting nutritional needs. Diet:Order - General." The "Dietary Progress Notes" signed by the dietary manager and co-signed by the registered dietitian on 7/31/02, documented that resident 18's weight as 035;" Diet Order - General High Calorie; no change in waist girth. Unable to measure body weight." The use of abdominal girth (measuring the circumference of the waist) is not an acceptable measure for a nutritional assessment or estimation of weight. Measurements of the waist can change after	F 281		

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F 281	Continued From page 16 eating, with bloating, excess gas, fluid retention, with many other disease processes and even with the time of day. The use of anthropometric (the science of measuring the human body for subcutaneous fat estimation) measures can be utilized to evaluate body composition but do not include measuring the waist or abdominal girth. (Reference guidance:Nutritional Assessment and Support, 4th edition, 1991, page 9.)	F 281		
F 287 SS=C	483.20(f)(1-4) Resident Assessment Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: Admission assessment; Annual assessment updates; Significant change in status assessments; Quarterly review assessments; A subset of items upon a resident's transfer, reentry, discharge, and death; Background (face-sheet) information, if there is no admission assessment; Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by HCFA and the State. A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to	F 287	Accepted PB MDS coordinator has been inserviced as to the importance of encoding and transmitting assessments in accordance with regulation. MDS coordinator has attended training given by state health department resident assessment section and duties have been restructured to allow for timeliness of encoding and transmitting. Assessments will be transmitted at least twice a month. At month end, state reports accessed off the CMS system will be reviewed to check for missing assessments and resident roster to verify that all assessments correspond to census and MDS schedule. All assessments noted in tag have been encoded and transmitted and current assessments are meeting regulation. Compliance to be monitored by the MDS coordinator and the administrator. Continued compliance assurance will be integrated in Quality Assurance meetings and reviewed quarterly.	11-11-02

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the State for all assessments conducted during the previous month, including the following:

Admission assessment;

Annual assessment;

Significant change in status assessment;

Significant correction of prior full assessment;

Significant correction of prior quarterly assessment;

Quarterly review;

A subset of items upon a resident's transfer, reentry, discharge, and death;

Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

The facility must transmit data in the format specified by HCFA or, for a State which has an alternate RAI approved by HCFA, in the format specified by the State and approved by HCFA.

This REQUIREMENT is not met as evidenced by:

Based on an interview with the Assistant Administrator, review of the Center for Medicare and Medicaid Services (CMS) End-of-month Roster Report for August 2002, and review of medical records, it was determined the facility did not encode a Minimum Data Set (MDS) assessment within 7 days after the assessment was completed and did not transmit an encoded MDS assessments and/or subset data within 1 month after each assessment should have been completed. MDS assessments or tracking forms had not been transmitted within 1 month of their due

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dates for 6 residents who had discharged within the past 12 months and for 39 residents reviewed who had been at the facility longer than 6 weeks and who continued to reside at the facility during the survey. Residents: CR1, CR2, CR3, CR4, CR5 CR6 and residents 2, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 16, 17, 18, 19, 21, 22, 23, 25, 27, 28, 29, 32, 33, 35, 38, 40, 41, 42, 44, 45, 46, 47, 48, 49, 50, 52, 53, and 54.

Findings include:

Resident CR1 was admitted to the facility on 3/26/02, temporarily discharged on 4/29/02, readmitted on 5/16/02 and discharged with no return anticipated on 8/2/02.
The clinical record for resident CR1 was reviewed on 9/12/02. Resident CR1 should have had one MDS Discharge Tracking form for each of his discharges and one MDS Re-Entry tracking form documenting his return to the facility. There were no Discharge or Re-Entry tracking forms in the closed record, and none had been transmitted to the CMS.

Resident CR2's most recent MDS assessment was dated 3/20/02 and was transmitted 6/15/02. Resident CR2 was not on the facility's current resident census roster and did not have a discharge tracking form.

Resident CR3's most recent MDS assessment was dated 4/5/02 and was transmitted 6/18/02. Resident CR3 was not on the facility's current resident census roster and did not have a transmitted discharge tracking form.

Resident CR4's most recent MDS assessment was dated 5/2/02 and was transmitted 6/27/02. Resident CR4 expired on 6/27/02 and did not have a transmitted discharge tracking form.

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F 287	Continued From page 19 Resident CR5's most recent MDS assessment was dated 3/27/02 and was transmitted 6/15/02. Resident CR5 was not on the facility's current resident census roster and did not have a transmitted discharge tracking form. Resident CR6's most recent MDS assessment was dated 12/26/01 and was transmitted 2/13/02. Resident CR6 was not on the facility's current resident census roster and did not have a transmitted discharge tracking form. On 9/10/02, the facility's CMS End of Month Roster report for August 2002, was reviewed. The report documented a list of 69 of the facility's current and former residents. Thirty-five of the facility's current residents were on the list because their most recently transmitted MDS assessments were dated between 3/6/02 and 4/29/02, more than 4 months prior to the survey. An MDS assessment is required to be completed at least every 3 months. Review of the facility's Data Submission Summary, on 9/10/02, documented the facility had not transmitted MDS assessments since June 2002. In an interview on 9/11/02, the Assistant Administrator stated that she new the transmissions were behind.	F 287		
F 325 SS=G	483.25(i)(1) QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.	F 325	The facility has discontinued using the practice of measuring abdominal girth as a means of indicating weight loss. To assure that weight loss is identified, and to ascertain that residents are maintaining acceptable parameters of nutritional standards, a stand/on, roll on scale has been purchased and is being used to accurately monitor weight for residents.	11-11-02

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F 325	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interview, it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by 1 of 14 sampled residents experienced significant weight loss without facility intervention. Resident identifier: 18 Calculating weight loss percentages is done by subtracting the current weight from the previous weight, dividing the difference by the previous weight and multiplying by 100. Significant weight losses are as follows: 5% in one month, 7.5% in 3 months, and 10% in 6 months. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000) Findings include: Resident 18 was admitted to the facility on 10/17/2001 with diagnoses that included quadriplegic, chronic urinary tract infections, methicillin resistant staphylococcus aureus, depression, suicidal behavior, hypertension, gastroesophageal reflux disease and seizure disorder. A review of resident 18's medical record was done on 9/12/02. A review of the 7/ 31/02 MDS (minimum data set) documented resident 18's weight at" 035" (K2) with the hand written notation on the right margin of the MDS form of "abd. girth." The DON (director of nursing) was interviewed on 9/12/02 at 10:00 AM ,by the surveyor and was asked,"What does abd. girth stand for?" The DON replied,"Abdominal girth." The DON stated that they were unable to weigh resident 18 because he shakes too much,and his joints were stiff. The DON stated," that is all I could come up with." The DON was asked	F 325	(continued) The nutrition team composed of the director of nursing, dietician and dietary manager will review every resident's weight, intake and health status on a monthly basis to ascertain that residents are maintaining acceptable parameters of nutritional status. Resident 18-An accurate weight was obtained from the hospital. Interventions were put in place during survey, ie house supplement tid, 2Kal tid, resident preferences were reviewed and offered. Compliance to be monitored by the director of nursing and the registered dietitian. Continued compliance assurance will be integrated in Quality Assurance meetings and will be reviewed quarterly.	

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F 325	Continued From page 21 by the surveyor if the dietitian was aware that the facility was using an abdominal girth as a nutritional assessment for resident 18. The DON replied that she didn't know if the dietitian was aware. The DON was asked to weigh resident 18. On 9/12/02 at 10:45 AM, resident 18 was observed by the surveyor to be weighed by a CNA, (certified nursing assistant). Resident 18 was seated on a weight chair, the only scale available in the facility at that time, and was assisted to position his legs. His weight was observed to be 123 lbs.. A review of resident 18's medical record revealed the following recorded weights: 1/2002 - 168 lbs (pounds) per monthly weight roster 2/ 2002 - 166 lbs. per monthly weight roster 2/9/02 - 168 lbs. per physician's progress notes 3/2002 - no weight documented per monthly weight roster 3/2/02 - 166 lbs per nursing monthly summary 4/2002 - no weight documented per monthly weight roster 4/10/02 - 166 lbs. per physician's progress notes Starting in May of 2002 an abdominal girth was documented instead of weight. Resident 18's abdominal girth was 36 inches. An abdominal girth was also documented for the months of June (resident 18's abdominal girth was 35), July (resident 18's abdominal girth was 35), and August (resident 18's abdominal girth was 35) of 2002 . As documented by the physician on 4/10/02, and as observed by the surveyor on 9/12/02, resident 18 lost 43 lbs. which was 25% of his total body weight in less that 6 months.	F 325		

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F 325	Continued From page 22	F 325		

A fax was received from the facility, after the survey was completed, on 9/16/02. The fax documented that on 9/14/02, resident 18 was weighed by a local hospital . Resident 18's weight was reported as 64.5 kg or 141.9 lbs. If the hospital weight, as reported on 9/16/02, was the more accurate weight than the facility weight on 9/12/02, the resident would have lost 25 lbs or 15% of his total body weight which is significant.

There were no interventions by the registered dietitian or the dietary manager to prevent resident 18's weight loss. There was no documentation that the weight loss had been identified by the facility, nursing or dietary staff.

The "Dietary Progress Notes", signed by the dietary manager and co-signed by the registered dietitian on 6/19/02, documented resident 18's weight as 035 and the summary documented, "Unable to measure body weight. Food intake reveals resident meeting nutritional needs. Diet:Order - General." The "Dietary Progress Notes" signed by the dietary manager and co-signed by the registered dietitian on 7/31/02, documented that resident 18's weight as 035;" Diet Order - General High Calorie; no change in waist girth. Unable to measure body weight."

The use of abdominal girth (measuring the circumference of the waist) is not an acceptable measure for a nutritional assessment or estimation of weight. Measurements of the waist can change after eating, with bloating, excess gas, fluid retention, with many other disease processes and even with the time of day. The use of anthropometric (the science of measuring the human body for subcutaneous fat estimation) measures can be utilized to evaluate body composition but do not include measuring the waist or abdominal girth. (Reference guidance:Nutritional

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F 325	Continued From page 23 Assessment and Support, 4th edition, 1991, page 9.)	F 325		
F 361 SS=E	483.35(a)(1)-(2) DIETARY SERVICES The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs. This REQUIREMENT is not met as evidenced by: Based on staff interview and observations it was determined that the facility did not utilize their part-time consultant dietitian in a manner which provided adequate supervision to the dietary manager or nursing staff regarding: 1. accurately monitoring and assessing residents at risk for weight loss and 2. monitoring the sanitation of the dining room. Findings include: 1. Based on clinical record review it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by 1 of 14 sampled residents experienced significant weight loss with no dietary interventions implemented to prevent further weight decline. Further, the dietitian did not provide services and supports, through assessment, monitoring and	F 361	Acceptable BB The part-time consultant dietitian has been advised to provide the consultant hours needed to accomplish adequate supervision to the dietary manager or nursing staff. The facility has reorganized the dining room procedure to ensure proper sanitation in the dining room. The consultant dietitian has been asked to randomly observe and perform quality assurance checks on the dining room performance. Compliance to be monitored by the director of nursing and the registered dietician. Continued compliance assurance will be integrated in Quality Assurance meetings and will be reviewed quarterly.	11-11-02

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F 361	Continued From page 24	F 361		

recommendations, to meet each resident's nutritional needs.

The facility failed to provide dietetic supports and services which maintained the body weights for each resident as evidenced by:

a.b. Observations of facility staff were made on 9/11/02, between 8:00 AM and 9:20 AM. The observations were made in the dining room and revealed the following:

Two dietary aides were observed to clear the plate of several residents and scrape the remaining food off into a large tub. They were then observed to assist another resident with eating. This was repeated four times by one aide and three times by the other aide. The two aides were not observed to wash their hands or to use sanitizer in between the residents they assisted. These same aides were observed to remove a paper towel and dip it into a tub of water and squeeze it out over the tub of water. They used the paper towel to wipe the face, mouth and hands of the resident. This procedure was repeated by one aide four times and three times by the other aide without washing or sanitizing their hands when direct contact with a resident was made.
Resident 18 was admitted to the facility on 10/17/2001 with diagnoses that included quadriplegic, chronic urinary tract infections, methicillin resistant staphylococcus aureus, depression, suicidal behavior, hypertension, gastroesophageal reflux disease and seizure disorder.

A review of resident 18's medical record was done on 9/12/02. A review of the 7/ 31/02 MDS (minimum data set) documented resident 18's weight at" 035" (K2) with the hand written notation on the right margin of the MDS form of "abd. girth."

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F 361	Continued From page 25 The DON (director of nursing) was interviewed on 9/12/02 at 10:00 AM by the surveyor and asked,"What does abd. girth stand for?" The DON replied,"Abdominal girth." Then the DON further explained that they were unable to weigh the resident because he shakes too much,and his joints are stiff. The DON stated that is all I could come up with." The DON was asked by the surveyor if the dietitian knew that they were using an abdominal girth as a nutritional assessment. The DON replied that she didn't know if the dietitian was aware. The DON was asked to weigh resident 18. On 9/12/02 at 10:45 AM resident 18 was observed by the surveyor to be weighed by a CNA. He was seated on a weight chair, the only scale available in the facility at that time, and needed help positioning his legs. His weight was observed to be 123 lbs.. A review of resident 18's medical record revealed the following weights were recorded: 1/2002 - 168 lbs (pounds) per monthly weight roster 2/ 2002 - 166 lbs. per monthly weight roster 2/9/02 - 168 lbs. per physician's progress notes 3/2002 - no weight documented per monthly weight roster 3/2/02 - 166 lbs per nursing monthly summary 4/2002 - no weight documented per monthly weight roster 4/10/02 - 166 lbs. per physician's progress notes Starting in May of 2002 an abdominal girth was documented instead of weight. Resident 18's abdominal girth was 36 inches. An abdominal girth was also documented for the months of June (resident 18's abdominal girth was 35), July (resident 18's abdominal girth was 35), and August (resident 18's	F 361		

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F 361	Continued From page 26 abdominal girth was 35) of 2002 . As documented by the physician on 4/10/02 and as observed by the surveyor on 9/12/02 resident 18 lost 43 lbs. which was 25% of his total body weight over the 5 month period. A fax was received from the facility, after the survey was completed, on 9/16/02. The fax documented that on 9/14/02 resident 18 was weighed by a local hospital . Resident 18's weight was reported as 64.5 kg or 141.9 lbs.. In the exit conference the assistant administrator asked the surveyor if she felt that resident 18's weight was accurate. The surveyor replied, "Are you telling me that the scale is inaccurate?" The assistant administrator replied "no". If the hospital weight, as reported on 9/16/02 is the more accurate weight than the facility weight on 9/12/02, the resident would have lost 25 lbs or 15% of his total body weight which is significant. There were no interventions by the registered dietitian or the dietary manager to prevent resident 18's weight loss. There was no documentation that the weight loss had been identified by the facility, nursing or dietary staff. The "Dietary Progress Notes", signed by the dietary manager and co-signed by the registered dietitian on 6/19/02, documented resident 18's weight as 035 and the summary stated that "Unable to measure body weight. Food intake reveals resident meeting nutritional needs. Diet:Order - General." The "Dietary Progress Notes" signed by the dietary manager and co-signed by the registered dietitian on 7/31/02, documented that resident 18's weight as 035;" Diet Order - General High Calorie; no change in waist girth. Unable to measure body weight."	F 361		

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F 361	Continued From page 27 The use of abdominal girth (measuring the circumference of the waist) is not an acceptable measure for a nutritional assessment or estimation of weight. Measurements of the waist can change after eating, with bloating, excess gas, fluid retention, with many other disease processes and even with the time of day. The use of anthropometric (the science of measuring the human body for subcutaneous fat estimation) measures can be utilized to evaluate body composition but do not include measuring the waist or abdominal girth. (Reference guidance:Nutritional Assessment and Support, 4th edition, 1991)	F 361		
F 368 SS=E	483.35(f)(1)-(3) DIETARY SERVICES Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on posted meal times, it was determined that the facility did not insure that there was no more than 14 hours between a substantial evening meal and breakfast the following day.	F 368	The dinner mealtime was changed during survey to 5:30 pm. This will meet the regulation of no more than 14 hours between the substantial evening meal and the breakfast meal the following day. For mealtimes to be changed in the future, the dietary manager must present the proposed plan to the administrator for review to ensure that the change would meet with regulations. The dietary manager has been inserviced on the above. Compliance to be monitored by the dietary manager and the administrator. Continued compliance assurance will be integrated in Quality Assurance meetings and will be reviewed quarterly.	11-11-02

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F 368	Continued From page 28 On 3/27/01, the posted mealtime schedule was reviewed. The mealtimes were scheduled as follows: Breakfast: 7:30 AM 8:30 AM Lunch: 11:30 AM 12:30 PM Dinner: 4:30 PM 5:30 PM The amount of time between the first dinner meal and the first breakfast meal was 15 hours. The resident council meeting minutes were reviewed. The resident council minutes did not document that the resident group had discussed or agreed to a greater than 14 hour time span between the evening meal and the following breakfast meal.	F 368		
F 431 SS=D	483.60(d) PHARMACY SERVICES Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. This REQUIREMENT is not met as evidenced by: Based on observation of the 2 of 2 medication carts located in the only nurses station, it was determined that both carts contained expired medications. The following conditions were noted: 1. The label on the vial of Haldol for resident 55 indicated its shelf-life expired on 7/02.	F 431	Medications that are prescribed for occasional or prolonged use will be checked by the nurse for expiration before administering the medication. All expired medications will be discarded by that nurse. When the night nurse performs the weekly cleaning of med carts, he/she will check for any expired meds and pull them to be discarded. The director of nursing will do weekly checks of med carts to ensure that expired medications have been discarded. Compliance to be monitored by the director of nursing and the consultant pharmicist. Continued compliance assurance will be integrated in Quality Assurance meetings and reviewed quarterly.	11-11-02

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F 431	Continued From page 29 2. Two tubes of Bephamide indicated their shelf-life expired on 4/02 and 9/02 respectively. 3. A vial of Novalin for resident 1 did not contain the date when medication was first drawn from the vessel. The label indicated the prescription expired on 7/17/01. 4. A bottle of AKWA Tears for resident 15 indicated its shelf life expired on 9/02. 5. The label on the bottle of Halopendol for resident 13 stated, "Discard after 7/04/02." The Nursing 99 Drug Handbook, Springhouse Corporation, Springhouse, Pennsylvania copyright 1999, page 12 states, "When using a drug prescribed for occasional or prolonged use, check the container for an expiration date. Discard any drugs that are outdated or no longer needed."	F 431		
F 444 SS=E	483.65(b)(3) INFECTION CONTROL The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Resident 8 was observed to stand from the table after eating. One certified nurse aide (CNA) was observed to remove resident 8's clothing protector. The CNA was observed to wipe resident 8's face and then his nose and then his hands with the cloth. The CNA did not was her hands after assisting the resident before assisting another resident. Based on observations, it was determined that dietary	F 444	All staff have been inserviced as to proper sanitation procedure in the dining room. The procedure has been reorganized to assign specific staff to scrape and clear plates. The assigned staff will not assist residents with eating, nor will they clean faces, etc. Staff that have direct contact with residents will wash or sanitize their hands between each resident. Clothing protectors will not be used to clean residents. Paper towels and water will be utilized with proper sanitation of hands prior to usage.	11-11-02

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F 444	Continued From page 30 aide staff failed to wash their hands or to use sanitizer as indicated when direct contact with residents occurred. The observations occurred during meal times as staff were assisting residents with their meals. Findings include: Observations of facility staff were made on 9/11/02, between 8:00 AM and 9:20 AM. The observations were made in the dining room and revealed the following: Two dietary aides were observed to clear the plates of several residents and scrape the remaining food off into a large tub. They were then observed to assist another resident with eating. This was repeated four times by one aide and three times by the other aide. The two aides were not observed to wash their hands or to use sanitizer in between the residents they assisted. These same aides were observed to remove a paper towel and dip it into a tub of water and squeeze it out over the tub of water. They used the paper towel to wipe the face, mouth and hands of a resident. This procedure was repeated by one aide four times and three times by the other aide without washing or sanitizing their hands when direct contact with a resident was made.	F 444	(continued) Department heads have been assigned to observe and assist in the dining room for meals. The director of nursing has been assigned the duty of training all new aides as to the proper dining room procedure. All staff have been inserviced as to the correct dining room procedure. The above will be monitored for compliance by the director of nursing. Continued compliance assurance will be integrated in Quality Assurance meetings and will be reviewed quarterly.	
F 514 SS=D	483.75(l)(1) ADMINISTRATION The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was	F 514	Accepted BD Heights will be taken and documented by nursing personnel upon admit. Heights will then be double checked for accuracy by the dietary manager and documented in the resident's clinical record on the dietary assessment. Health information will perform audits of assessments to ensure completeness of assessment and accuracy	11-11-02

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F 514	Continued From page 31 determined the facility did not maintain accurate clinical records with accepted professional standards and practices that were complete and accurately documented for one resident whose nutritional assessment was based on a height measurement that was 14 inches shorter than the resident's actual height. Resident 4. Findings include: 1. Resident 4 was admitted to the facility on 8/1/02 with diagnoses that included Alzheimer's dementia, hyponatremia and hypertension. Resident 4 was observed to be independently mobile, tall and slender. Resident 4 was 74 inches tall. Resident 4's medical record was reviewed on 9/12/02. The nutritional assessment for resident 4, dated 8/2/02, was signed by the dietary manager and by the registered dietician. The assessment documented resident 4's height to be 60 inches (in). Resident 4's nutritional needs were determined based on his documented height, as if he were 5 feet tall rather than 6 feet 2 inches tall. Resident 4's weight was documented on the nutritional assessment as being 176 pounds (lbs). The ideal body weight for resident 4 was documented as 125 - 153 lbs. A general guideline for determining baseline daily kcaloric (kcal) needs is to multiply the resident's Basal Energy Expenditure (BEE - a calculation determined by factoring the resident's height, weight and age) by the resident's activity factor. Based on a height of 60 in, resident 4's BEE was documented in the nutritional assessment as being 1450 kg. Resident 4's caloric needs were documented by the dietary manager and registered dietician, to be 1450 x 1.3 = 1885 kcal/day.	F 514	(continued) Health information personnel will also audit for cohesiveness between assessments and mds information. BM information is provided by the C.N.A. to the nurses, who in turn document the BM tracking on the MAR. The MAR is then reviewed every other day by the director of nursing or assistant director of nursing to ensure that the BM protocol is followed when indicated. Resident 4-correct height has been obtained and the baseline daily Kcaloric needs have been recalculated The dietary assessment has been corrected to reflect the changes and all blanks have been filled in to reflect the health status of resident 4. The above will be monitored for compliance by the director of nursing. Continued compliance assurance will be integrated in Quality Assurance meetings and will be reviewed quarterly.	

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F 514	Continued From page 32 A general guideline for determining baseline daily fluids needs is to multiply the resident's body weight in kilograms (kg) times 30 cubic centimeters (cc) (2.2 lbs = 1 kg). The fluid requirement for resident 4 was documented in the nutritional assessment as 1500 - 200 cc per day. The fluid requirements for a man who is 176 lbs would be 2400 cc daily. In addition, the nutritional assessment for resident 4 documented the resident had a chewing problem, but the area to "Describe problem" was left blank. The resident was documented as needing an altered texture diet. The line for "If yes, explain why", was left blank. The nursing admission assessment, dated 8/1/02, documented that resident 4 had his own teeth. The resident's Minimum Data Set (MDS) assessment, dated 8/14/02, documented the resident had no chewing problems and no oral problems. 2. Resident 53 was admitted to the facility on 4/25/00 with diagnoses which included constipation, gastric distress and gastric esophogeal reflux disease. Review of the medical record for resident 29 documented physician's orders for a bowel and bladder program of: If no bowel movement (BM) for 3 days, give 8 ounces of prune juice at 8:00 AM. If no BM by 5:00 PM that day, give 30 cc (cubic centimeters) Milk of Magnesia. If no BM by next morning, give dulcolax suppository at 6:00 AM. Review of the BM tracking for resident 29 documented by the nurse, on the Medication Administration Record (MAR) and the daily tracking records of the CNAs for resident 29's BM frequency and of the resident's flow sheets documented by the CNAs did not accurately assess the residents episodes of constipation (no BM for 3 days per the facility's	F 514		

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F 514	Continued From page 33 protocol) that needed to be treated. The MAR for June 2002 documented resident 29 went 3 days, from 6/8/02 to 6/10/02, 4 days, 6/16/02 to 6/19/02 and 5 days, from 6/24/02 to 6/28/02 without a BM and without interventions. The CNA flow sheet for resident 29 for June 2002 documented the resident went 4 days, from 6/1/02 to 6/4/02 and 6 days, from 6/9/02 to 6/14/02, without having a BM. Review of the July records and the August records documented similar discrepancies. In an interview with the DON, she stated she was aware of the discrepancies in charting. The DON stated she had implemented the separate CNA daily BM charting about 8 months ago to help resolve the problem. When current charting was compared for 9/11/02 and 9/12/02, the three reports did not match. The DON stated that she was aware the CNAs' daily BM charting and the CNAs' flow sheets were not matching. She stated she had hoped the daily BM charting would be the more accurate of the two, but that it was not yet working.	F 514		