TN to SG 12-9-02 Received by NPR 12-17-02
acceptable POC c̄ addendum
12/11/02 Shauna Slindl RN

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

PRINTED: 11/18/
FORM APPROVE
2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING ______ B. WING ______	11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

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F 157 SS=D 483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES

F 157 OK 12/11/02 SS c̄ addendum

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on record review, it was determined that the facility did not notify a residents physician when the resident developed a pressure sore. (Resident 19)

Findings include:

A review of resident 19's medical record was done on 11/5/02 and revealed the following:

This Plan of Correction (POC) constitutes my written allegation of compliance for the deficiencies cited. However, submission of this POC is not an admission that a deficiency exists or that one was cited correctly. This POC is submitted to meet requirements established by state and federal law.

F157
1. This POC is in reflection to resident 19. Resident 19's chart was reviewed by the Medical Director and the dietician for any interventions and follow-up. The following POC will apply to all residents in the facility and all future residents.
2. An inservice was held on November 13th with the licensed personnel concerning skin assessment procedures and changes. It was re-iterated that they are to obtain doctors orders before treatment commences and frequent assessments are to be made, with follow-up to MD. Director of Nursing completed an audit of all the residents' skin integrity.
3. Random skin checks will be completed bi-monthly by the DON for a quarter and then randomly once per quarter for the next quarter and as needed. Weekly IDT meetings will also address this issue with the weight review.
4. Quality Assurance (QA) quarterly meeting will review random checks to assure continued compliance.
Completion Date: 01-05-03

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	NHA	12/6/02

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

Utah Dept. DEC - 6 2002 Bur. of Medicare/Medicaid Prog. Certification and Res. Assessment

#507804

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F 157	Continued From page 1 Resident 19 was ad,admitted top the facility on 4/30/02 with diagnoses of Alzheimer's , hypothyroidism, fibromyalgia, coronary artery disease and gastroesophageal reflux disease. A significant change in status assessment dated 8/6/02, completed by facility staff, documented that resident 19 had a stage 2 pressure ulcer. A "Skin Integrity Care Plan" completed by facility staff, dated 5/4/02, documented under problem 6, that resident 19 was at risk for skin breakdown and that resident 19 had a rash. One of the approaches to the problem was to notify the MD (Physician) if further decline in skin integrity and turgor occurred. A nurses' note dated 8/2/02 at 4:00 AM, for resident 19 documented,"CNA [certified nursing assistant] noted red spot on residents L [left] hip. It appears to be a stage II DQ [decubitus]. Tegaderm applied to spot approx [approximately] 1.5 cm [centimeters]. Will continue to monitor." Review of nurses notes for resident 19, dated from 8/2/02 through 8/18/02 revealed documentation that facility nurses were doing dressing changes on resident 19's "DQ". A "Weekly Skin Assessment Form", dated 8/13/02, completed by facility staff for resident 19 documented that resident 19 had a stage II decub on the left hip and Tegaderm was applied to the site every 3 days and whenever necessary. No documentation could be found in resident 19's medical record that the physician had been notified of the skin breakdown, or that the physician had ordered the treatment for resident 19's skin breakdown.	F 157		

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F 157	Continued From page 2	F 157		
F 225 SS=E	483.13(c)(1)(ii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 225 OK c 12/11/02 SD c addendum	F225 1. This POC is in reflection to residents 3, 12, 19, 22, 27, 29, 31, 39, 42, 43. The following POC will apply to all residents in the facility and all future residents. 2. An inservice was held on November 6th concerning abuse, investigations and complete reporting procedures i.e. those who require the information reported to (APS, Department of Health, Ombudsman). 3. Based on review, any further investigation procedures will be implemented and the worksheet will be attached to the report. 4. Administrator, DON, and IDT members review all incident reports at morning meeting for potential abuse or injuries of unknown origin. Completion Date: 01-05-03	

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F 225	Continued From page 3	F 225		

Based on resident record review, review of facility incident reports, review of facility investigative reports, and interviews with facility administrative staff, it was determined that the facility did not investigate or report injuries of unknown origin, and did not report alleged staff to resident abuse to the State Agency. (Residents 3, 12, 19, 22, 27, 29, 31, 39, 42, and 43.)

Findings include:

1. Review of the facility incident reports on 11/8/02 revealed the following injuries of unknown origin that the facility had not investigated or reported:

a. An "Incident/Accident Report" dated 6/3/02, completed by facility staff, documented that resident 3 was noted to have a skin tear on her right arm and a bruise under her left eye.

b. An "Incident/Accident Report" dated 7/10/02, completed by facility staff, documented that resident 42 was noted to have a large bruise on left shin and a smaller bruise on the back of her left leg.

c. An undated "Incident/Accident Report" completed by facility staff, documented that resident 43 was noted to have a bruise on her left eye and nose.

d. An "Incident/Accident Report" dated 8/11/02, completed by facility staff, documented that resident 31 was noted to have a bruise on her left eye.

e. An "Incident/Accident Report" dated 8/15/02, completed by facility staff, documented that resident 42 was noted to have a skin tear and bruise on her left elbow.

f. An "Incident/Accident Report" dated 8/27/02,

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F 225	Continued From page 4 completed by facility staff, documented that resident 42 was noted to have a bruise the covered the whole top of her left foot. g. An "Incident/Accident Report" dated 8/27/02, completed by facility staff, documented that resident 39 was noted to have a skin tear and 2 bruises on her left arm. h. An "Incident/Accident Report" dated 9/7/02, completed by facility staff, documented that resident 12 was noted to have a large bruise on the left leg from the buttocks to below the knee on the back of the leg of unknown origin. 2. Previous to conducting a survey, the survey team reviews information in the office. One of the areas reviewed is the reports from Adult Protective Services, (APS) submitted to the State Agency on a weekly basis. During the review of those reports for the facility, it was found that the facility had reported allegations of staff to resident verbal abuse for residents 22, 27, and 29 to APS but had not reported the alligations to the State Agency. A review of the facility investigation for the above APS report on 11/6/02, revealed that the facility had investigated the alligations and terminated the employee accused of the verbal abuse, but had not reported the incidents to the State Agency. 3. A review of resident 19's medical record on 11/8/02, revealed a nurses note dated 10/28/02 at 7:00 AM, that documented, "This nurse heard aide yelling in residents room to 'come on get your shirt on'. The resident started yelling 'get away from me, get away from me'....Aide said, come on get these teeth in your mouth..."	F 225		

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F 225	Continued From page 5 An interview was held with the facility social worker on 11/6/2. The social worker stated that the incident had been investigated by the facility administrator, the facility director of nursing and determined that there had been no abuse. The social worker also stated that the alleged abuse had been reported to APS, but that she was not aware that the incident had to be reported to the State Agency.	F 225		
F 278 SS=B	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:	F 278 OK 12/11/02	F278 1. This POC is in reflection to residents 2, 31 and 19. The following POC will apply to all residents in the facility and all future residents. 2. An inservice was held on accurate skin assessments, completion of documentation, and follow up with MD. The DON completed skin checks on each resident in the building and the results of each audit were placed in the resident's chart. Based on the audits, the MDS was adjusted as needed. 3. Random MDS's will be reviewed bimonthly by the DON for a quarter and then once per quarter for the next quarter and then as needed. 4. As issues arise, these will be addressed at the IDT meeting each week and adjustments made to MDS accordingly. Completion Date 01-05-03	

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F 278	Continued From page 6 3. Resident 31 was admitted to the facility 4/28/98 with diagnoses of Alzheimer's dementia with anxious features, peptic ulcer disease, anemia, hypertension and status post cerebrovascular accident with depressive features. A review of resident 31's medical record was done on 11/6/02. A comprehensive MDS assessment, dated 10/15/02, was documented as a significant correction of a prior assessment in Section AA8 - a, Reason for Assessment. The assessment should have been documented as a significant change in status assessment. A comprehensive MDS assessment dated 7/23/02 and the comprehensive MDS assessment dated 10/15/02 each documented, under Section M1 and M2, Skin Condition, Ulcers, and Type of Ulcer, that resident 31 had one Stage II pressure ulcer. A skin condition assessment, witnessed by the nurse surveyor on 11/7/02, revealed that resident did not have a pressure ulcer. Interviews were conducted, on 11/7/02, with a nurse and a nurse aide who provided cares for resident 31. Both of the nursing staff stated that resident 31 did not have and had not had any pressure ulcers. Based on review of Minimum Data Set (MDS) assessments for 3 of 15 sample residents, it was determined that the facility did not ensure that the MDS assessments completed by facility staff, accurately reflected resident's status. (Residents 2, 19, and 31). Findings include:	F 278		

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F 278	Continued From page 7 1. Resident 2 was admitted to the facility on 1/8/99 with diagnoses of Alzheimer's with anxious and depressive features, hypertension and hypothyroidism. Resident 2's medical record was reviewed on 11/5/02. Resident 2 had a physician order dated 3/27/01 for a lap buddy while up in the wheelchair. Resident 2 was observed on 11/5/02 at 8:00 AM and 12:30 PM to be up in the wheelchair with a lap buddy in place. A quarterly MDS assessment dated 9/3/02, completed by facility staff did not document under Section P:Special Treatments and Procedures, 4. Devices and Restraints, e., chair prevents rising, that resident 2 used a lap buddy daily. 2. Resident 19 was admitted to the facility on 4/30/02 with diagnoses of Alzheimer's, coronary artery disease, hypothyroidism, fibromyalgia, and gastroesophageal reflux disease. Resident 19's medical record was review on 11/5/02. Resident 19 had a physician order dated 4/30/02 for a lap buddy while up in the wheelchair. Resident 19 was observed on 11/5/02 at 8:10 AM and 12:20 PM to be up in a wheelchair with a lap buddy in place. A significant change in status MDS assessment dated 8/6/02, completed by facility staff did not documented under Section P: Special Treatments and Procedures, 4. Devices and Restraints, e.. chair prevents rising, that resident 19 used a lap buddy daily.	F 278		

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F 286 SS=B	483.20(d) Resident Assessment A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility did not maintain 15 months of Minimum Data Set (MDS) assessments in 3 of 15 sample resident's active medical record. (Residents 9, 27, and 30.) Findings include: 1. Resident 9 was originally admitted to the facility on 4/11/95, and readmitted to the facility on 10/14/02 after a short hospital stay. Review of resident 9's medical record on 11/7/02, revealed that resident 9's active medical record contained an admission MDS assessment dated 10/18/02, and a Medicare 14 day MDS assessment. Resident 9's active medical record did not contain 15 months of MDS assessments as required. 2. Resident 27 was originally admitted to the facility on 2/28/02, and readmitted to the facility on 10/17/02 after a short hospital stay. Review of resident 27's medical record on 11/6/02, revealed that resident 27's active medical record contained an admission MDS assessment dated 10/21/02, and a Medicare 14 day MDS assessment dated 10/30/02. Resident 27's active medical record did not contain 15 months of MDS assessments as required. 3. Resident 30 was originally admitted to the facility on 1/25/02, and readmitted to the facility on 6/23/02 after a short hospital stay.	F 286 OK 12/11/02 [handwritten initials]	F286 1. This POC is in reflection to residents 9, 27, and 30. The following POC will apply to all residents of the facility and all future residents. 2. The Heath Information Manager (HIM) pulled the MDS from the closed charts and placed in the current chart. 3. The HIM was made aware of the regulations concerning appropriate information needed in the chart. 4. The DON or designee will complete random checks of the charts to assure charts are maintained per regulations. Completion Date: 01-05-03	

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F 286	Continued From page 9 Review of resident 30's medical record on 11/7/02, revealed that resident 30's active medical record contained a Re-entry tracking form dated 6/23/02, a significant change MDS dated 7/30/02 and a significant change to the prior full MDS assessment dated 10/22/02. Resident 30's active medical record did not contain all the MDS assessments completed on resident 30 since admission on 1/25/02.	F 286		
F 314 SS=G	483.25(c) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and medical record review, it was determined the facility did not provide the necessary interventions to prevent new ulcers from developing for 1 of 15 sample residents who had a history of pressure ulcers.(Resident 16) Findings include: Resident 16 was admitted to the facility on 2/7/01 with diagnoses of Alzheimer's dementia with delusions, depression, paraplegia of the lower extremities, indwelling catheter, glaucoma, history of spinal cord injury, and history of alcohol abuse.	F 314 OK 12/11/02 c̄ addendum	F314 1. This POC is in reflection to resident 16. The following POC will apply to all residents of the facility and all future residents. 2. An inservice was held on November 13th on what is necessary to correctly complete weekly skin checks, this also included any information that the doctor needs to be made aware of. The DON has completed the skin assessments on all the residents for a baseline on November 30th. 3. An appropriate pressure-relieving bed has been obtained for resident 16. His wheel chair had a pressure-relieving pad at the time of the survey. Resident 16 has unavoidable pressure sores as a result of his diagnosis. Based on the Doctor's review there are standing orders for wounds. The facility has a qualified dietician on staff and she has reviewed resident 16's chart and made recommendations, MD notified of these recommendations. FSM and DON to monitor. 4. Any new skin changes will be assessed by the DON for the first quarter and then randomly per month for the next quarter and as needed to ensure complete documentation. The IDT/weight meetings dietary is made aware any new wounds for nutritional interventions. Completion Date: 01-05-03	

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F 314	Continued From page 10	F 314		

Review of the medical record, on 11/7/02, documented resident 16 had been admitted with a stage I pressure ulcer on his left buttock and a stage II pressure ulcer on his right buttock. Subsequent documentation revealed the pressure ulcer had been healed, but the resident remained at high risk for skin impairments.

Review of the 2/8/02 Malnutrition / Dehydration - Pressure Sore Risk Assessment, for resident 16, documented the resident had current skin condition of "Stage I-II DQs [decubitus/pressure ulcers] present." The risk assessment documented, "Total Score of 8 or higher = HIGH SKIN RISK". Resident 16 was given a total score of "20" by the Registered Nurse (RN) who completed the assessment. On the 5/7/02 and the 7/30/02 risk assessments, the RN documented that resident 16 had "Skin turgor good Integrity intact" with a total score of "14". On the 10/22/02 risk assessment, the RN documented resident 16 had "Skin turgor good Integrity intact" with a total score of "13".

Review of the physician's progress notes dated 4/6/02 and 6/12/02 documented that resident 16's skin was without breakdown or DQ's.

A nurse's note in resident 16's active record, dated 8/12/02 at 2:00 PM, documented, "Breakdown noticed on coccyx." A second note documented the resident's family had been notified and a note was left for the physician. Subsequent nurses' notes, dated 8/12/02, 8/13/02 8/17/02, and 8/19/02 documented the resident was encouraged to turn and reposition, the tissue was still intact, and nurses were providing treatments to the site. On 8/22/02, a nurse's note documented, "Coccyx excoriated, no open areas." The last nurse's note that referred to resident 16's skin condition, dated 8/26/02 documented, "Breakdown improving."

Further review of resident 16's medical record

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F 314 Continued From page 11 F 314

revealed there had been no physician's order for treatments for resident 16's pressure ulcer. Review of the physician's progress notes dated 8/17/02 and 10/22/02 documented that resident 16's skin was without breakdown or DQ's.

On 11/17/02, a nurse surveyor and the resident's nurse observed resident 16's skin to have an open, draining pressure ulcer, approximately 1 inch wide by 1 inch high, on the left side of his coccyx. Resident 16's right buttock, next to the coccyx was red and non-blanching over an area about 3 inches wide and 3 inches high. The ulcer had been partially covered by a DuoDerm dressing that had slipped and bunched up at one corner.

Resident 16's bed had no pressure relieving device.

Review of the nutritional assessments section of resident 16's medical record documented no qualified dietitian had reviewed the nutritional needs or made recommendations for healing resident 16's skin breakdown and no new dietary interventions had been implemented.

Review of the initial nutritional assessment for resident 16, signed by the former Food Service Supervisor (FSS) and dated 2/20/02, documented the resident had 2 pressure ulcers "upon arrival". It was documented that the resident's weight was 125 lbs (pounds) when he was admitted, that his weight at the time of assessment, 2 weeks later, was 120 lbs, and that he ate 50 to 60 % (percent) of his meals. There was one typed notation that resident 16 had been "reviewed at weight skin meeting on 20 February 2002," and it was recommended that the resident should be weighed weekly, receive 73 gm (grams) of protein daily, 60 cc (cubic centimeters) of a supplement four times per day, and receive a multivitamin with zinc. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING ____ B. WING ____	11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 314	Continued From page 12 progress note was initialed by the former FSS on 2/21/02. The physician's orders recertification, dated November 2002, documented resident 16 was to receive "regular diet as tolerated, small portions" as of 2/7/02. There had been one change on 4/3/02 when it was ordered that resident 16 was to receive 60 cc of house supplement three times daily. There had been no new dietary interventions to promote healing of the wound identified on 8/12/02. In an interview with the FSS on 11/6/02, the FSS stated that it had not been communicated to him that resident 16 had a skin breakdown.	F 314		
F 329 SS=E	483.25(l)(1) QUALITY OF CARE Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on reviews of residents medication administration records, it was determined that the facility nursing staff were not monitoring residents' conditions prior to administering medications which required assessment. Specifically, nursing staff were not consistently documenting assessment of blood sugar levels on of residents, with physician orders for blood sugar monitoring. (Residents 9, 15 and 30.)	F 329 OK 12/11/02 [initials]	F329 1. This POC is in reflection to residents 9, 15, and 30. The following POC will apply to all residents of the facility and all future residents. 2. An inservice was held on November 13th concerning proper documentation with emphasis placed on blood sugars and coordinating them with the sliding scale insulins. 3. For residents 9,15, 30 an **HgA1c** was obtained to ensure that blood sugars were within normal range. DON or designee performed audits twice a week for one month to monitor blood sugar efficacy and documentation and once per quarter thereafter. 4. The nurses on the NOC shift will audit the MAR to ensure that the blood sugars have been transposed from the blood sugar sheet to the MAR on a daily basis. DON will check every week and randomly thereafter to assure consistency. Completion Date: 01-05-03	

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	465086	A. BUILDING ___ B. WING ___	11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

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F 329	Continued From page 13 Findings include: 1. Resident 9 was originally admitted to the facility on 4/11/95 and readmitted to the facility on 10/14/02 after a short hospital stay. Resident 9 was admitted with the diagnoses of pneumonia, dehydration, Alzheimer's, atrial fibrillation and diabetes. Resident 9's medical record was reviewed on 11/7/02. Resident 9 had a physician order dated 10/14/02 to monitor resident 9's blood sugar (BS) twice daily at 6:00 AM and 8:00 PM. Review of the October 2002, medication administration record (MAR) for resident 9 revealed that the BS to be done at 6:00 AM was not documented as being done on 10/15/02, 10/20/02, and 10/24/02. The BS to be done at 8:00 PM was not documented as being done on 10/15/02, 10/18/02, 10/23/02 and 10/31/02. Review of the November 2002, MAR for resident 9 revealed that the BS to be done at 6:00 AM was not documented as being done on 11/1/02, 11/3/02, 11/4/02, 11/5/02 and 11/6/02. The BS to be done at 8:00 PM was not documented as being done on 11/1/02, 11/3/02, 11/4/02, 11/5/02 and 11/6/02. 2. Resident 15 was admitted to the facility on 3/10/1995 with diagnoses of bipolar disorder, insulin dependent diabetes mellitus, constipation, peptic ulcer disease, osteoarthritis, hypertension and asthma. A review of resident 15's medical record was done on 11/5/02. The recertification of physician 's orders dated November 2002, documented that resident 15 was to	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING B. WING	11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

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F 329	Continued From page 14 have BS twice a day since 4/3/02. Review of resident 15's October 2002 MAR revealed that BS to be done at 8:00 AM was not documented as being done on 10/5/02,10/7/02,10/8/02, 10/12/02, 10/13/02, 10/26/02, and 10/27/02. The BS to be done at 9:00 PM was not documented as being done on 10/3/02,10/9/02,10/11/02, 10/12/02, 10/15/02, 10/16/02, 10/18/02, 10/20/02, 10/23/02, 10/24/02, 10/26/02,10/27/02, 10/29/02, and 10/31/02. 3. Resident 30 was originally admitted to the facility on 1/25/02 and readmitted to the facility on 6/23/02 after a short hospital stay. Resident 30 was admitted with the diagnoses of cerebral vascular accident, hypertension hypothyroid and diabetes. Resident 30's medical record was reviewed on 11/7/02. Resident 30 had a physician order dated 6/23/02 to monitor resident 30's BS four times daily at 8:00 AM, 12:00 PM, 5:00 PM and 9:00 PM. Review of the August 2002, MAR for resident 30 revealed that the BS to be done at 12:00 PM was not documented as being done on 8/14/02, 8/24/02, 8/25/02 and 8/30/02. Review of the September 2002, MAR for resident 30 revealed that the BS to be done at 12:00 PM was not documented as being done on 9/22/02. The BS to be done at 5:00 PM was not documented as being done on 9/3/02. The BS to be done at 9:00 PM was not documented as being done on 9/3/02. Review of the October 2002, MAR for resident 30 revealed that the BS to be done at 8:00 AM was not documented as being done on 10/9/02 and 10/10/02.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING B. WING	11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

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F 329	Continued From page 15 The BS to be done at 12:00 PM was not documented as being done on 10/7/02, 10/9/02, 10/10/02, 10/13/02 and 10/30/02. The BS to be done at 5:00 PM was not documented as being done on 10/15/02, 10/18/02 10/23/02 and 10/31/02. The BS to be done at 9:00 PM was not documented as being done on 10/15/02, 10/18/02, 10/23/02, 10/29/02 and 10/31/02.	F 329		
F 361 SS=G	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 interviews with the Food Service Supervisor (FSS) and the facility Administrator, and on medical record review, it was determined the facility did not employ a qualified dietitian full-time, part-time, or on a consultant basis, from February 2002 through October 2002, as evidenced by 4 of 15 sample residents did not receive dietician's interventions to identify dietary needs and to care plan and implement personal dietary programs. (Residents 15, 16, 20, 30, and CL 1). Findings include:	F 361 ok 12/11/02 [initials]	F361 1. This POC is in reflection to resident 15, 16, 20, and 30. The following POC will apply to all residents of the facility and all future residents. 2. A qualified dietician was hired in October and completed an assessment of each residents nutritional needs. Residents 15, 16, 20, 30 have been reviewed by the dietician and nutritional interventions have been implemented. The dietician has seen Resident 15 and new nutritional interventions have been implemented. See F314 for resident 16's POC. Resident 30 has been a diabetic for many years and has made own calculations of carbohydrates. Resident's Physician has indicated that he would like the resident to continue her independent carbohydrate counting with nurse supervision. Medical Director reviewed lab results and stated that for diabetic residents a 6.6 is not considered high and that a 7.2 is an acceptable level. For resident 20, dietician has assessed for nutritional needs and interventions have been implemented to assist wound healing. The MDS on this resident has been revised to reflect current nutritional and skin	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING ____ B. WING ____	11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

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F 361 Continued From page 16

1. Resident 30 was originally admitted to the facility on 1/25/02 and readmitted to the facility on 6/23/02 after a short hospital stay. Resident 30 was admitted with the diagnoses of cerebral vascular accident, hypertension hypothyroid and diabetes.

Resident 30's medical record was reviewed on 11/7/02.

Resident 30 had a physician order dated 6/23/02 to monitor blood sugars four times daily at 8:00 AM, 12:00 PM, 5:00 PM, and 9:00 PM.

Resident 30 had a physicians order dated 6/23/02, for sliding scale insulin to be administered by calculating carbohydrate content of meals at 8:00 AM, 11:30 AM, and 5:30 PM.. The order stated that for every 12 grams of carbohydrate, 1 unit of Humalog regular insulin was to be administered to resident 30. The order also stated resident will calculate prn (whenever necessary). Resident 30 also had a physician order dated 7/3/02, for Lantus insulin 4 units at 8:00 AM and 3 units at 9:00 PM.

A medication pass was observed on 11/6/02 between 7:30 AM and 8:30 AM. Resident 30 asked the facility nurse passing medications, what was being served for breakfast. The facility nurse told resident 30 that the breakfast was wheat hearts, poached egg, juice, toast and jelly, and milk. Resident 30 then told the nurse that she should get 4 units of regular insulin along with the 4 units of Lantus insulin. The facility nurse administered the insulin to resident 30.

The facility nurse was asked how she knew that resident 30 was accurately determining the amount of regular insulin she should receive. The nurse stated, "(Resident 30) just knows but there is a book in the medication cart we can refer to if we need to."

F 361

integrity. CL1 is no longer in the building therefore the plan of correction does not affect him. An inservice was held on November 13th with the licensed personnel concerning carbohydrate counting and sliding scale insulins. Dietician has educated FSM as to the proper exchanges and carbohydrate counting for each meal and menus will reflect total carbohydrates per meal, which will enable the nurses to gauge the proper insulin amount. Doctor's orders and appropriate follow up for enacting the orders was discussed at this inservice.
3. Any resident with a difference in weight of < or > 5 pounds will be addressed for interventions at the weekly IDT/weight meeting. A registered dietician has been hired to ensure residents nutritional requirements are being met. A qualified dietician has been hired.
4. Nurses on the NOC shift will check charts on a nightly basis to make sure orders have been forwarded to the appropriate departments. DON will randomly check charts biweekly for a month and then randomly for the next quarter and then as needed for a quarter.
Completion Date: 01-05-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING ____ B. WING ____	11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	**5865 SOUTH WASATCH DRIVE OGDEN, UT 84403**

(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 361	Continued From page 17	F 361		

A review of the diet orders that the dietary department was using on 11/6/02, revealed that resident 30 was to receive a regular with carbohydrate counting, small portions, mechanical soft, no added salt, no concentrated sweets diet. The diet list provided by the food service supervisor had not been updated since 7/10/02.

A review of the November 2002 physician recertification orders for resident 30 documented that resident 30 was to be on an American Diabetic Diet 1600 calorie carbohydrate counting diet.

A review of resident 30's "Nutritional Assessment", completed by the food service supervisor on 7/16/02, did not document that resident 30 required any special needs with her nutrition. There was no documentation in resident 30's medical record that a registered dietitian had assessed resident 30's special nutritional needs. There was no documentation in resident 30's medical record that carbohydrate counting had ever been done to determine the correct sliding scale dose of insulin for resident 30.

A review of resident 30's blood sugar monitoring from 6/23/02 through 10/30/02, revealed that resident 30's blood sugars were very erratic and ranged from as low as 29 to as high as 439.

On 9/27/02 resident 30 was seen by her physician. The physician ordered a laboratory test, a glycohemoglobin (a test to determine blood glucose level) to be done and to have the dietician call him. The facility did not have a dietitian at the time so the physician was not contacted by a dietitian. The laboratory test was not done until 10/14/02. The result was 6.6. The laboratory used by the facility indicated that the value was high.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING ____ B. WING ____	11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	**5865 SOUTH WASATCH DRIVE OGDEN, UT 84403**

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F 361	Continued From page 18	F 361		

Brunner and Suddarth's Textbook of Medical Surgical Nursing. Suzanne C. Smeltzer and Brenda G. Bare, Ninth Edition, Lippincott, published in 2000, Chapter 37,Assessment and Management of Patients with Diabetes Mellitus, pages 980 and 981 documents, " For patients who require insulin to help control blood glucose levels, maintaining as much consistency as possible in the amount of calories and carbohydrates eaten at different meal times is important for control of blood glucose. In addition, consistency in the approximate time intervals between meals, with the addition of snacks if necessary, helps in the prevention of hypoglycemic reactions and in overall blood glucose control...."

"Carbohydrate counting is a new nutritional tool used for blood glucose management because carbohydrates are the main nutrients in food that influence blood glucose levels...."

"When developing a diabetic meal plan using carbohydrate counting, all food sources should be considered. Once digested, 100% of carbohydrates are converted to blood glucose. However, approximately 50% of protein foods (meat, fish, and poultry) are also converted to glucose."

"One method of carbohydrate counting includes counting grams of carbohydrates. This is typically used for those with Type I diabetes who need to be more accurate while on an insulin regimen..."

2. Resident 16 was admitted to the facility on 2/7/01 with diagnoses of Alzheimer's dementia with delusions, depression, paraplegia, indwelling catheter, glaucoma, spinal injury, and history of alcohol abuse.

Resident 16's medical record was reviewed on 11/7/02.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING ______ B. WING ______	11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 361	Continued From page 19	F 361		

A nurse's note, dated 8/12/02, documented resident 16 had a new "breakdown noticed on coccyx". On 8/22/02, a nurse's note documented, "Coccyx excoriated, no open areas."

Review of the nutritional assessments section of resident 16's medical record documented no qualified dietitian had reviewed the nutritional needs or made recommendations for healing resident 16's skin breakdown and no new dietary interventions had been implemented.

On 11/17/02, a nurse surveyor and the resident's nurse observed resident 16's skin to have an open, draining pressure ulcer.

3. Resident 15 was admitted to the facility on 3/10/1995 with diagnoses of bipolar disorder, insulin dependent diabetes mellitus, constipation, peptic ulcer disease, osteoarthritis, hypertension and asthma.

Resident 15 was interviewed on 11/7/02 at 8:30 AM. Resident 15 stated she had problems with swallowing her food at times.

A review of resident 15's Malnutrition/ Dehydration care plan documented as a goal to have no unexpected or unplanned weight loss every month and as an approach to monitor significant unplanned weight loss.

The facility's "Malnutrition / Dehydration/ Pressure sore Risk Assessment" last reviewed by staff on 1/2/02 documented that resident 15 was not at risk for malnutrition, dehydration, or pressure sore.

On 11/6/02, a review was conducted of resident 15's facility weight history for 2002 and revealed the following:
January 165 lbs (pounds

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING ______ B. WING ______	11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 361	Continued From page 20 February 163 lbs March 170 lbs April 167 lbs May 171 lbs June 170 lbs July 156 lbs August 167 lbs September 170.25 lbs October 167.25 lbs Between the months of June and July 2002, resident 15 lost 14 lbs or 8.23% of her total weight which is deemed "significant" by federal survey standards. A review of the facility's "Nursing Monthly History " dated July 2002 documented that resident 15 had a gradual loss of 14 pounds. The monthly history documents the staff reviewed resident 15's care plan for month. Under care plan 3, Malnutrition/ Dehydration, staff documented that the goal was not met. The reason for why the goal was not met was not documented. A review of the nurses notes dated 5/29/02 documented "Resident was seen by house physician (with) c/o [complaints] of 'food being hard to swallow, feel like there is a lump in throat' New order to refer resident to prior ENT [ear nose and throat physician] for eval [evaluation]." A review of the nurses note dated 6/3/02 documented appointment went well and no further treatment planned at this time. A laboratory value was done on 1/7/02 and documented a serum albumin level of 2.5. According to the lab used by the facility, a normal albumin range was 3.4-5.0 gm/dl (grams per deciliter). Using the Manual of clinical Dietetics as a guideline, resident	F 361		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING ___ B. WING ___	11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	**5865 SOUTH WASATCH DRIVE OGDEN, UT 84403**

(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 361	Continued From page 21 15's albumin level fell at the bottom range of moderate protein deficit . The recertification of physician's orders dated November 2002, documented that on 3/9/98 resident 15 was to receive non-concentrated sweet diet, small portions with no deviations and no orange juice with her diet. A review of the dietary notes revealed a nutritional assessment was done 7/17/01 by the dietary manager not signed by a registered dietitian. Resident 15's estimated protein needs were not calculated. The assessment notes that resident 15's ideal body weight (IDW) was calculated as 118-132 pounds. Resident 15's quarterly nutritional reassessment note dated 3/26/02 under laboratories does not document resident low albumin level done January 2002. The quarterly nutritional reassessment notes dated 6/18/02 and 9/10/02 did not document resident 15's 8% weight loss in month of June and July 2002. None of the quarterly assessments had a registered dietitians signature. A review of the IDT note dated 3/26/02 documented that resident 15's albumin was low at 2.5 and her normal hemoglobin A1 c (Hga1c) was high at 8.3. According to Brunner Suddarth's Textbook of Medical-Surgical Nursing (Lippincott Williams and Wilkins 9th edition, 2000, page 986). "Hga1c is a blood test that reflects average blood glucose levels over appropriately 2 to 3 months. .. normally range for Hga1c was 4% (percent) to 6%." There was no plan that was documented and the dietary staff signature was not documented as part of the IDT. A review of the IDT note dated 9/10/02 did not address resident 15 's weight loss that occurred between June and July 2002.	F 361		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING ________ B. WING ________	11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	**5865 SOUTH WASATCH DRIVE OGDEN, UT 84403**

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F 361	Continued From page 22	F 361		

4. Resident 20 was re-admitted to the facility on 10/10/01 with diagnoses of diabetes, a closed fracture of fibula and tibia, personality disorder, asthma, hyperglyceridemia, obesity, and degenerative joint disease.

Resident 20's medical record was reviewed on 11/5/02.

The facility's "Resident Assessment-Data Collection Form" dated 10/10/01 documented that resident 20 had numerous open wounds.

Facility staff completed a MDS on 12/26/01 that documented that resident 20 had nine stage 2 sores and two stage 3 sores and one stage 4 sore. The facility staff documented that none of the sores were caused by pressure and four of the sores were a stasis sores. The staff also assessed resident 20 as requiring ulcer care with application of dressing and ointments and other preventable skin care. The staff did not assess that resident 20 needed any nutritional interventions.

Facility staff completed a MDS on 9/10/02 that documented that resident 20 had a stage 2 pressure sore and a pressure sore that was a stage 3. The staff assessed resident 20 as requiring ulcer care and application and ointments. The staff did not assess that resident 20 needed any nutritional interventions.

The facility's "Malnutrition/ Dehydration – Pressure Sore Risk Assessment", dated 9/3/02 and 10/10/02 documented that resident 20 was a high skin risk and high nutrition risk.

The facility staff had plans of care for resident 20's altered nutrition and for being at nutritional risk. The nutritional risk care plan documented that resident was at risk for skin breakdown associated with scratching.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING ______ B. WING ______	11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	**5865 SOUTH WASATCH DRIVE OGDEN, UT 84403**

(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 361	Continued From page 23	F 361		

The facility's "Weekly Skin assessment form" dated 11/4/02 documented that resident 20 had pressure sores. The body diagram on the weekly skin assessment documented improving ulcerations on resident 20's left buttock, multiple large ulcerations to resident 20's right groin areas, and 3 by 3 centimeters ulceration to resident 20's right leg.

The recertification of physician's orders dated November 2002 documented that resident 20 was receiving several different treatments for resident 20's skin since 3/26/02. The recertification of physician order documented resident 20 on a diabetic diet with no concentrated sweets and 2% milk since 10/10/01.

The facility's "Nutritional Assessment" was dated 9/3/02 and was not signed by a registered dietitian. The diagnoses section did not document resident 20's pressure sores. Resident 20's usual weight, ideal body weight , and estimated nutrient needs were not documented. Resident 20's nutritional problems or plan was not documented. The section of this assessment that documents resident 20's skin condition documented that his skin was intact.

The first quarter of the facility's "Quarterly Nutritional Assessment " was undated and not signed by a registered dietitian. The second and third quarter of the assessments were dated but not signed by a registered dietitian. The section of this assessment for all three quarters documented that resident 20's skin integrity was intact.

A registered nurse was interviewed on 11/5/02 at approximately 2:00 PM. She stated that resident 20 had pressure sores. The pressure sore on resident 20 buttock was caused by his resident 20's refusal to lye down and to use a different wheelchair. She stated that resident 20's skin in his groin area was broken down

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	465086		11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

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F 361	Continued From page 24	F 361		

from resident 20 scratching and resident 20's ulcer on his leg was caused by resident 20's refusal to take off his leg brace for a period of time.

A nurse was interviewed on 11/7/02 at 2:00 PM. She stated that for residents with pressure sores and or weight loss she notifies the physician and the resident 's family. She obtains an order from the physician and carries out the orders.

5. Resident CL1 was admitted to the facility on 8/26/02 with diagnoses of intestinal obstruction, pulmonary embolism, myocardial infarction, generalized weakness, anemia, pneumonia, renal failure, depression, anxiety, thrombocytopaenia, dementia, malnutrition, syncope, hyperglycemia, chronic artery disease and acidosis.

Resident CL1's medical record was reviewed on 11/7/02.

Facility staff completed an initial Minimum Data Set (MDS) on 9/8/02 that documented that resident CL1 had a stage 2 pressure sore. The facility staff assessed resident 1 as needing applications of dressing and ointments. The facility staff did not assess resident CL1 as needing nutritional interventions to manage skin problems.

The facility's "Resident Assessment –Data Collection Form" dated 8/26/02 documented that resident CL1 had one stage 2 pressure sore.

A review of resident CL1's laboratory results from the hospital was done. Resident CL1's albumin level was 2.20 on 8/15/02.

According to the Manual of Clinical Dietetics

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465086	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/7/02
NAME OF PROVIDER OR SUPPLIER: SOUTH OGDEN REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 5865 SOUTH WASATCH DRIVE OGDEN, UT 84403		

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F 361	Continued From page 25	F 361		

(American Dietetic Association, 6th edition, 2000, page 22), albumin levels are as follows:

Severe visceral protein deficit = less than 2.4 g/dl
Moderate visceral protein deficit = 2.4 g/dl- 2.9 g/dl
Mild visceral protein deficit = 3.0 g/dl-3.5 g/dl

Using this as a guideline, resident CL1's albumin level fell below the severe visceral protein deficit.

Geriatric Nutrition, A Comprehensive Review, second edition, By Morley, Glick and Rubenstein pg. 57, 335-338 states that, albumin is significant in regards to pressure sores, in that if an albumin level is low, visceral protein stores are low, and a high protein level is essential in the healing process.

The facility's "Malnutrition/ Dehydration-Pressure Sore Risk Assessment" dated 8/26/02 documented the following "...If the total score is 8 or greater the resident should be consider a high risk for pressure sore development. If the total score is 10 or higher the resident should also be considered to be a high risk for malnutrition/dehydration problems. A preventive protocol should be initiated immediately and documented in the care plan. A nutrition/ hydration program must be considered for all skin problems. " The facility staff assessed resident CL1 a score of 14. The albumin level for resident CL1 was not documented on the Malnutrition/ Dehydration assessment form.

The facility's "Nutritional Assessment" was undated and not signed by a registered dietitian. The diagnoses section was the only section of the assessment had any documentation for resident CL1. The diagnoses section did not include resident CL1's diagnoses of malnutrition and hyperglycemia. The nutritional assessment for resident CL1 did not document the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	465086		11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 361	Continued From page 26	F 361		

pertinent medications that might have dietary implications to be considered. The sections on "Clinical Data, Physical Assessment, Diet History and Eating Environment, Skin Condition and Factors Effecting Skin and Mental Status and Meal Behavior, Laboratory Values and Estimated Nutrient Needs, Nutritional Problems and Plan had no information documented. These sections would have provided concrete steps to form a plan to improve the nutritional status of CL1 and to assist in healing of his skin. They could have ensured appropriate and timely nutritional interventions.

The facility staff had plans of care for resident CL1's pressure sore, malnutrition/ dehydration, and altered nutrition. The pressure sore care plan documented, as one of the goals, to have resident CL1's current area of skin concern to be healed by October 1, 2002 without further decline in overall integrity. The Malnutrition/Dehydration care plan documented an approach was to provide nourishments/supplements as ordered by MD or deemed necessary by nursing and/or dietary staff.

The nurse's note dated 8/27/02 documented that the family requested resident CL1 to have a supplement.

The recertification of physician's orders dated October 2002 documented that on 8/28/02 resident CL1 was to receive enriched mechanical soft diet and hi pro and nova source four times a day.

The Interdisciplinary team (IDT) note dated 9/3/02 documented "Since admission, he has fallen, no doctor visits. No med (medication) changes, no labs (laboratory tests). Present weight is 119 pounds. His "healthy weight is 135 pounds...." The dietary staff signature was not documented as part of IDT.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING ______ B. WING ______	11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 361	Continued From page 27 The discharge summary dated 10/4/02 documented resident CL1 still had a stage 2 pressure sore. 6. The FSS was interviewed on 11/6/02 at 10:30 AM. The FSS stated he had started working as the manager in July 2002. The FSS stated there had not been Registered Dietician (RD) for him to consult with from the time he started until the facility hired one in October 2002. The FSS stated that it was his responsibility to monitor the residents' weights. He stated he was supposed to review the data after the nurse aides weighed the residents. The FSS said he met weekly with the interdisciplinary team (IDT) for weight meetings in conjunction with the IDT meetings. The FSS said it was his responsibility to report any weight fluctuations of 5% or greater to the Director of Nursing (DON). The FSS stated that the DON would decide what nutritional interventions were to be implemented. The FSS stated that he would follow the DON's orders for diet changes. The FSS stated that he had never been made aware of any residents who had wounds, pressure ulcers or any special dietary needs that might require nutritional intervention. 7. The facility administrater had been employed in the facility for less than a month. An interview was held with the facility administrator on 11/7/02 at 3:00 PM. She stated that she could not find any consultant reports from a registered dietitian since February 2002. She further stated that the facility had just recently contracted with a registered dietitian who was just beginning to review the residents. The assistant administrator was present during the interview and stated that there had not been a consultant dietitian for	F 361		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING ______ B. WING ______	11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	**5865 SOUTH WASATCH DRIVE OGDEN, UT 84403**

(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 361	Continued From page 28 the facility since February 2002. The facility had not had any intervention from a registered dietitian for residents requiring intervention for 7 months	F 361		
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations of the kitchen, it was determined the facility did not prepare and distribute food under sanitary conditions. Findings include: Initial observation: On 11/5/02 at 7:15 AM, after breakfast had been prepared and was being held on the steam table, the kitchen was observed. A moist cleaning cloth, scouring pad, and scrubbing brush were in a dry bucket in the dirty area of the dish cleaning counter. There was no sanitizing solution in the bucket. Two rectangular plastic containers were resting across the lip of an uncovered garbage container. The stove had a build-up of dried on food debris over a flat metal surface to the left of the burners, in the corners and edges of the metal surface, and on the burners. Another stove had two flat metal griddles with a crevice between them. There was a build-up of dried on food debris in the crevice between the two griddles, around the edges of the griddles and down the side of the stove. Observation was made of a shiny, black and gold substance which had formed droplets along a metal strip under the vents which were over both stoves. The wall, behind the stove with the grills, was	F 371 ok 12/11/02 [handwritten initials]	F371 1. No specific resident was mentioned for this tag. The following POC will refer to all residents of the facility and all future residents. 2. An inservice was given on November 13th on the following: proper food storage, cleaning procedures, sanitation requirements, hairnets and temperature regulations. All staff has been inservice on the necessary use of hairnets while in the kitchen. 3. Hairnets were provided at the entrance of the kitchen. The black line policies have been re-iterated to the staff and they have been instructed to have dietary staff assist them with all food items beyond the black line. The dishwasher was serviced and test strips were made available to accurately monitor chemical levels in the dishwasher. 4. The FSM will monitor the cleaning and temperature checklist weekly to assure accurate documentation and continued compliance. Educational inservices will be given quarterly or as needed based on the dietician's monthly inspections and FSM daily rounds. Completion Date: 01-05-03	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING ______ B. WING ______	11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	**5865 SOUTH WASATCH DRIVE OGDEN, UT 84403**

(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 371	Continued From page 29	F 371		

white with gray and black soiled areas.

The floor of the pantry had torn papers and dry food spills on it. The area where the floor met the wall was rough textured and had a dark build up of soil around the perimeter of the room. A cardboard box containing 6 bottles of bleach, was resting over the edge of an open bin of powdered thickener. Torn trash papers were observed in the bin. Plastic scoops with the handles down were in bins of mashed potato flakes and powdered sugar. Two stacks of paper bowls were leaning on end with the open side directly against a painted conduit pipe on the wall. The pipe had a visible black dusty build up on the upper surface. A rectangular metal sheet, approximately 24 inches by 16 inches, was covered with 3 - 4 inches of a linty or loose insulation type of substance. The tray was leaning upright against storage shelves and an open box of potatoes.

Flakes of a dry white substance were scattered over the base of the mixer. A metal shelf between the end of the tray line counter and the food preparation area was across from the back door. Metal hot plates, miniature serving cups in a large bowl, and deep rectangular and round pans were all stored upright on the shelf, approximately 7 inches above the floor. They were not covered and could become contaminated by dirt or dust from staff sweeping, walking by or opening the back door.

The same observations were made at 8:50 AM, at 12:20 PM and at 3:15 PM with two exceptions: the dry bucket containing moist cleaning supplies was no longer in the dish washing area and a sheet of foil paper had been spread over the flat metal surface left of the burners on one stove.

On 11/6/02 at 7:10 AM, observation of the kitchen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465086	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 371	Continued From page 30	F 371		

revealed the center of the pantry floor had been swept and the box of bleach had been removed from on top of the bin of thickener. Other observations of the pantry and the stoves were the same. At 9:30 AM, the food service manager (FSM) was advised regarding the previous observations. The FSM stated that the the staff had not been able to get the stoves cleaner and that the dusty tray in the pantry had ben left by a maintenance person. On 11/7/02, the dusty tray was still leaning against the box of potatoes in the pantry, and small portion of the dried foods had been wiped off the side of the stove.

Sanitation:
Observations were made of the warewashing machine on 11/5/02 at 12:35 PM. The machine was connected by hoses to three containers of liquid. One container was marked, "All temperature warewasher detergent," another was marked, "Low temperature drying aid for dishwashers." and the other container had no label or identifying marks.

The person operating the machine and another dietary employee were asked if the machine sanitized with chemical or hot water, but neither employee was certain. The employees were not aware of a any record for the temperatures or sanitizer levels that would indicate the facility was tracking to be certain the machine was functioning properly.

The temperature gauge on the warewashing machine read 110 degrees Fahrenheit when the machine was not running. During a wash cycle, at 12:35 PM, the temperature gauge was observed to reach 118 degrees Fahrenheit. The gauge reached 132 degrees Fahrenheit during the rinse cycle. Three automatic dials that delivered additives to the wash and rinse cycles were observed to rotate, but one hose remained dry and was not observed to add anything to the water.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING B. WING	11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	**5865 SOUTH WASATCH DRIVE OGDEN, UT 84403**

(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 371	Continued From page 31 None of the dietary personnel were able to locate a chemical test strip to measure the level of sanitizer in the machine. During a second cycle, the wash temperature measured 124 degrees Fahrenheit and the rinse temperature measured 132 degrees Fahrenheit. The acting kitchen manager for the day, who was the former FSM, was interviewed on 11/5/02 at 1:00 PM. The manager stated that the warewashing machine sanitized with bleach, but he was not able to locate any chemical test strips.. He stated the temperatures needed to be tested and logged three times daily, once for each meal time. He was unable to locate the current temperature log. The manager stated that the water had previously been too hot and that the temperature had been lowered a week ago. The manager was advised that the surveyor had not seen anything coming out of one of the tubes connected to the warewashing machine. He stated that, "Sometimes it gets plugged." At 1:07 PM, the manager and surveyor observed a third cycle of the warewasher. The temperature reached 116 degrees Fahrenheit during the wash. The rinse temperature was not observed, but the additive tubes were watched closely. The manager stated, "No nothing's getting through. It's completely dry." He identified the malfunctioning tube to be the one that added sanitizer to the rinse water. The dishes that had been run through the dishwasher without sanitizer were not rewashed. On 11/6/02, at 4:10 PM, the food service manager and the maintenance person were asked to provide manufacturers specifications for operation of the warewashing machine. None were provided by the time the surveyors exited at 4:30 PM on 11/7/02. The 1993 Food Code recommends the low	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING ____ B. WING ____	11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 371	Continued From page 32 temperature warewashers should be 120 degrees Fahrenheit with 25 parts per million of Hypochlorite (household bleach) on dish surfaces. For hot water, the wash should reach 140 degrees Fahrenheit and the rinse should reach 180 degrees Fahrenheit unless manufactures specifications state otherwise. Observations of the walk-in refrigerator: On 11/5/02 at 7:15 AM, a box of loose mushrooms was observed in the walk-in refrigerator. The mushrooms box was stacked over a box one-half full of bacon. Part of the bacon was not covered by any wrapper. The box was dated 9/19/02. Another unopened box of bacon, dated 10/22/02, was under the open box. Seven bowls of mixed fruit were stored but not labeled or covered. An open, uncovered bowl of pineapple chunks was on a tray above the mixed fruit. There were two 5-gallon plastic cannister on a shelf. Neither were labeled and each were approximately one-third full of colored liquid - one with green liquid and one with red liquid. On a shelf above the cannisters, there was a box of ten cantaloupe melons. A covered container of chic peas was dated 10/19/02. On another shelf was a quart container of liquid egg, opened and partially used but not dated. There was a nearly empty five-pound container of cottage cheese and a five-pound container of sour cream with drips down the side. Neither were dated to indicate when they had been opened. Above containers with left over meats, gravies, and soup base, were boxes of fresh tomatoes, cucumbers and green peppers. Fresh vegetables are considered contaminated and should not be stored above ready to eat foods. Hair coverings: Observation of the kitchen, on 11/5/02 at 7:15 AM, revealed two dietary staff members the kitchen, both were wearing hair coverings and aprons. There was a black line drawn on the floor of the kitchen that	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING ____ B. WING ____	11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	**5865 SOUTH WASATCH DRIVE OGDEN, UT 84403**

(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 371	Continued From page 33 extended along the width of the kitchen, from the door to the dining room and past the beverage dispensers and a food preparation table. The tray line counter extended approximately half the length of the kitchen along the pathway leading from the outside delivery door through to the dining room door. Hot foods were on the steam table at one end of the tray line, next to the black line. Breakfast trays had been set along the tray line counter and were being set-up with the breakfast meal. At 7:20 AM. two female facility staff members walked through the kitchen and along the tray line. The staff members entered from the outside, through the delivery door, and exited through the dining room door. At 7:30 AM, another female staff member entered the kitchen from the dining room and walked past the steam table to fill a beverage cup. At 7:32 AM, a male staff member entered the kitchen from the outside door and walked past the tray line to exit through the dining room door. None of the staff members wore aprons or hair coverings or washed their hands. At 7:35 AM, a dietary staff member entered through the outside door and walked down the tray line to the beverage dispenser area, then around to a food preparation table to prepare a cup of coffee, then into the office. At 12:22 PM, a non-dietary staff member was observed to be in the kitchen without a hair covering. At 3:15 PM, two staff members entered the kitchen from the dining room to fill a beverage pitcher. A third staff member came in, while the pitcher was filling, to talk with one of the others. None were observed to wash their hands or to wear hair coverings.	F 371		
F 463 SS=D	483.70(f) PHYSICAL ENVIRONMENT The nurses' station must be equipped to receive	F 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465086	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 463 Continued From page 34
resident calls through a communication system from resident rooms; and toilet and bathing facilities.

This REQUIREMENT is not met as evidenced by:
Based on observations and interviews the facility was not equipped to receive resident calls through a communication sytem from one bathing facility and one resident room. The facility whirlpool located in the physical therapy room was not equipped with a call light and resident room 209 does not have an operational call light.

Findings include:

The whirlpool in the physical therapy room was observed on 11/7/02 at approximately 2:00 PM. This whirlpool was not observed to have a call light.

The nursing switch board was observed to not have a light that marked a call light for the whirlpool in the physical therapy room.

Two aides were interviewed on 11/7/02 at 2:00 PM. They stated that there was always a staff person in with the resident when a resident was in the whirlpool.

Resident 20 was observed to be using the whirlpool in the physical therapy gym on 11/6/02 at 9:00 AM.

Room 209 room was observed on 11/5/02 at 12:10 PM. In room 209 bed B, the call light cord was pulled and no light above door was observed .

Two aides were interviewed on 11/7/02 at 2:00 PM. They stated that call light in room 209 does not light up at the door or at the nurses station. They also stated that resident 28 resides in room 209 but resident 29 was independent with her cares.

F 463

ok addendum 12/11/02

F463

1. No specific resident was mentioned for this tag. The following POC will apply to all residents of the facility and all future residents.
2. The whirlpool will be monitored on all future residents' use.
3. The existing whirlpool room should be "grandfathered" therefore; when the whirlpool is in use we will be using a baby monitor to ensure residents ability to communicate with staff even though resident will not be left unattended as per policy. Call light over 209 along with the nurses' switchboard has been repaired.
4. Maintenance Supervisor will monitor through the maintenance log and quarterly rounds. Rounds and maintenance log will be reviewed in quarterly QA meetings for continued compliance.
Completion Date: 01-05-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465086	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 11/7/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH OGDEN REHAB CENTER	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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

South Ogden Rehab Center
Addendum to annual survey on 11/7/02

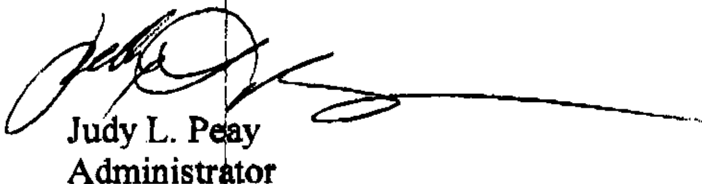
F157
The Director of Nursing will monitor that the doctor has been notified regarding change in skin conditions and have obtained orders for treatment. This will be completed on a bimonthly basis by the DON for a quarter and then randomly once per quarter for the next quarter and as needed.

F225
The Administrator will monitor weekly the APS and internal investigations to assure compliance.

F314
The Director of Nursing and Administrator will randomly monitor the skin checks for completion and accuracy. This will be completed bimonthly for the first quarter then as need for the next quarter.

F463
The whirlpool room will not be used until a call light is installed.

The QAAC have reviewed the annual survey of November 11, 2002 on December 4, 2002 and will review again at the next QAAC meeting in March 03.



Judy L. Peay
Administrator