TN to LB 2-17-04

DEPARTMENT OF HEALTH AND HUM/ ;ERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 2/6/2004
FORM APPROVED
2567-L

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 C 1/26/2004
NAME OF PROVIDER OR SUPPLIER: SOUTH OGDEN REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 5865 SOUTH WASATCH DRIVE OGDEN, UT 84403		

COMPLAINT NUMBER. UT00001690

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F 157 SS=D	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as 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 and interview, it was determined that the facility failed to immediately notify the family of one resident, when a medication error had occurred. (resident 1) Findings included:	F 157 2/26/04 POC acceptable completion date 3/26/04 [illegible] RN	The facility will notify all families, physicians, D.O.N. and Administrator when medication errors occur. Although this deficiency is an isolated incident, the D.O.N. will inservice nursing staff on proper procedure for detecting and reporting such incidents. Detection of such errors can be enhanced by using a four way check (i.e. verifying residents name, the label, Telephone order, physician order.) Any incidents will be written accordingly and reviewed daily (5 x weekly) by the D.O.N. and Administrator. All such incidents are logged and reviewed at monthly Q.A. for further follow-up and to look for any trends if necessary. The D.O.N. and Administrator will monitor for compliance.	3/26/04

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 2/16/04

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction 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 after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Utah Department of Health
FEB 17 2004
#402059 H
Bureau of Medicare/Medicaid Program Certification and Resident Assessment

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F 157	Continued From page 1 Resident 1 was a 99 year old female who was admitted to the facility on 4/15/03 with diagnoses of coronary artery disease, dementia, hypertension and insomnia. A review of the pharmacy's medication incident reporting form dated 1/22/04 documented that a medication error had occurred with resident 1. The facility's pharmacy mistakenly processed an order of Zyprexa 10 mg (milligrams) for resident 1 that should have been labeled for resident 2. The facility's consulting pharmacist was interviewed on 1/29/04 at 8:00 AM. The pharmacist stated that the facility contacted him on approximately 12/15/03. The order for Zyprexa was filled on 12/2/04 and a 30 day supply was sent to the facility on 12/5/03. The medication Zyprexa should have been labeled for resident 2 but had been labeled with resident 1's name. The pharmacist stated, "the error occurred on our end, the input technician who filled the order and labeled the medication, labeled the medication card with the wrong resident name." The pharmacist documented the following on the incident reporting form, "This incident was discussed in quarterly QA (quality assurance) meeting on 12/17/03 with QA personnel, including [Facility physician]. [Facility physician] stated that he thought no intervention was needed and the patient was fine after the medication was stopped." The facility's Director of Nursing (DON) was interviewed on 1/24/04 at 2:40 PM. She stated that a medication error occurred because the facility pharmacy mislabeled resident 2's, Zyprexa, 10 mg pills, with resident 1's name. Resident 1 did not have a physician's order for Zyprexa and had received Zyprexa 10 mg in error, that was resident 2's medication. The DON was asked if she knew how many doses resident 1 had received in error, and the	F 157		

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F 157	Continued From page 2 DON stated that she wasn't sure. The DON further stated the error could have been prevented if the night shift nurses had been checking the physicians orders against the medication administration record. The DON stated that it was brought to her attention on 12/15/03 when employee 2, a licensed practical nurse had found the error. The surveyor asked the DON if she thought the Zyprexa medication error had negatively effected resident 1. The DON stated, "No, not to any great extent. She kept falling, and falling, and falling." The surveyor asked if the facility had a Fall Prevention program in place, to which the DON stated, "It's a work in process - but yes." Employee 1, a licensed practical nurse, was interviewed on 1/22/04 at 10:30 AM. Employee 1 stated that she remembered administering Zyprexa to resident 1, but she was not aware that a medication error had occurred. Employee 2, a licensed practical nurse was interviewed on 1/22/04 at 1:20 PM . Employee 2 stated that she was administering medications to resident 1, and noticed there was a new medication card for Zyprexa, and realized that this resident was not on the medication Zyprexa. Employee 2 then went to the resident's medical chart to double check the order, and realized that an error had occurred. Employee 2 stated that she couldn't remember how many pills had been administered to resident 1, in error. On 1/22/04, a review of the admission and discharge summary of resident 1 was completed. It was revealed that resident 1's son was listed as the responsible party and resident 1's grandson and granddaughter were marked as the emergency contacts.	F 157		

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F 157	Continued From page 3 On 1/22/04, resident 1's son and grandson were contacted and on 2/3/04, resident 1's granddaughter was interviewed. During their interviews, each interested family member stated that they were not notified of the drug error by the facility. A record review of the facility policies and procedures for medication errors was reviewed 2/3/04. It revealed that when a medication error occurred the "pertinent individuals must be notified i.e. family, physician, Director of Nursing, and the Administrator."	F 157		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on interviews and record review it was determined that the facility did not provide the necessary services to attain or maintain the highest practicable physical, mental and psychosocial well-being of a resident. (resident 1) Specifically, between 12/5/03 and 12/15/03, resident 1 received in error, Zyprexa 10 mg. Following 12/5/03, resident 1's incidents of falls increased. Resident identifiers: 1 Findings include:	F 309	The fall risk assessment form is done quarterly and as needed. This plan can work in concert with the four way check (i.e. verifying residents name, the label, Telephone order, Physicians order.) thereby reducing the chance of medication errors. It is the facilities policy to then include results from the risk assessment on quarterly care plans. Care plans will be ~~upde~~ updated quarterly and as needed by the following means: Medical Records will review weekly 10% resident records to ensure that a fall risk assessment is completed →	

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F 309	Continued From page 4 A review of the pharmacy's medication incident reporting form dated 1/22/04, documented that a medication error had occurred with resident 1. The facility's pharmacy mistakenly processed an order of Zyprexa 10 mg (milligrams) every evening for resident 1, that should have been labeled for resident 2. Zyprexa is an antipsychotic medication with potential side effects of dizziness, orthostatic hypotension, and joint pain. Recommendations for Zyprexa are to start therapy at the low end of the dosage range in the elderly population. ". . .Initially, give 5 mg to patients who are debilitated, predisposed to hypotension, pharmacologically sensitive to the drug, or those who may metabolize [Zyprexa] more slowly, such as nonsmoking women age 65 and older." Zyprexa has unknown onset and duration. (Reference Guidance: Nursing Drug Handbook 23rd edition 2003 Springhouse page 483-484) The facility's consultant pharmacist was interviewed on 1/29/04 at 8:00 AM. The pharmacist stated that the facility contacted him on approximately 12/15/03. The order for Zyprexa 10 mg every evening was filled on 12/2/04 and a 30 day supply was sent to the facility on 12/5/03. The medication Zyprexa should have been labeled for resident 2 but had been labeled with resident 1's name. The pharmacist stated, "the error occurred on our end, the input technician who filled the order and labeled the medication, labeled the medication card with the wrong resident name." The pharmacist documented the following on the incident reporting form, "This incident was discussed in quarterly QA (quality assurance) meeting on 12/17/03 with QA personnel, including [Facility physician]. [Facility physician] stated that he thought no intervention was needed and the patient was fine after the medication was stopped."	F 309	and the information obtained is reflected upon the careplan. If no careplan exists, the D.O.N. will then be notified to correct the situation. Resident 1's care plan and fall risk has been re-evaluated and corrected according to policy. This system will be monitored by medical records and the D.O.N. Reporting on success/failure will be done during monthly Q.A. meeting. 3/26/04	

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F 309	Continued From page 5 1. Resident 1 was a 99 year old female who was admitted to the facility on 4/15/03 with diagnoses of coronary artery disease, dementia, hypertension and insomnia. A review of resident 1's medical record was completed on 1/22/04 and revealed the following: Facility staff completed a quarterly MDS (minimum data set) assessment of resident 1 on 10/16/03 and again on 1/5/04. Facility staff assessed resident 1 as having moderately impaired cognitive skills on 10/16/03 and 1/5/04. In comparison, facility staff assessed resident 1's abilities declined between the two assessments. Facility staff assessed resident 1's decline as follows: a. Resident 1 went from requiring limited assistance with set up help only to requiring limited assistance with one person physical assistance for bed mobility, transfer, toilet use and personal hygiene. b. Resident 1 went from requiring supervision with set up help only to requiring limited assistance with one person physical assistance for walking in her room. c. Resident 1 went from having an unsteady balance with the ability to rebalance herself without physical assistance to requiring physical support while standing. Facility nurses completed a Fall Risk Assessment on admission. A fall risk assessment was also completed on 7/22/03, 10/15/03 and a again on 1/5/03. Per instructions on the facility Fall Risk Assessment, "if the total score is 10 or greater, the resident should be considered a high risk for potential falls. If the resident scores a 10 or higher for total score, a preventive protocol should be initiated immediately and documented in the care plan." Facility staff assessed resident 1's fall risk as follows:	F 309		

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F 309	Continued From page 6 a. On admission - "7", a low risk for falls. b. On 7/22/03 and 10/15/03- "9", a low risk for falls. c. On 1/5/04. "21", a high risk for falls. A review of resident 1's comprehensive care plan was completed on 1/22/04. Resident 1's care plan did not address her fall risk. From her admission to the facility through 1/26/04, resident 1 experienced the following falls per staff documentation: a. 5/2/03- Per documentation in the facility's Incident Report Log. b. 9/3/03- Per documentation in the facility's Incident Report Log. c. 10/2/03- Per documentation in the facility's Incident Report Log. d. 10/8/03- Per documentation in the facility's Incident Report Log. e. 12/7/03 at 10:30 PM, Per documentation in resident 1's nursing notes, "...Resident yelling for help. Found sitting on her bathroom floor..." "...She ambulated with walker to bed while being monitored for steadiness. She almost fell backwards on way back to bed..." "...Resident very combative, delusional, and paranoid..." "...Ativan 2 mg given..." f. 12/7/03- Resident 1 fell two times on this date per documentation in the facility's Incident Report Log. g. 12/9/03 at 10:30 PM - Per documentation in resident 1's nursing notes, "... CNA (certified nurse aide) reports fall to the floor . . . Pt [patient] [with] knees bent [and] arms up [at] forehead - noted bleeding. Pt. [with] 1 cc. [cubic centimeters] 2 1/2 - 3 cm [centimeters] to forehead bleeding. . . . Rolled to back with pressure applied to forehead. Pt. alert [and] confused, has been confused [with] hx [history] over last 3 days of multiple falls... order received to send	F 309		

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F 309	Continued From page 7 pt. to ER [emergency room] . . ." h. 12/10/03 at 8:30 PM- Per documentation in resident 1's nursing notes, "...resident found on floor. Appears to have fallen forward while sitting on edge of bed..." "...personal alarm will now be used..." i. 12/10/03 at 12:00 AM-Per documentation in resident 1's nursing notes, "...Bed alarm went off. Resident found sitting on her bedroom floor next to her chair. O (no) injury found, put onto floor. Resident returned to bed, staff unable to locate part of bed alarm..." j. 12/11/03 at 6:45 AM- Per documentation in resident 1's nursing notes, "...Resident found on floor face down. Has skin tear, (approximately 3" X 5") on lateral side of right elbow..." k. 12/12/03 at 11:00 PM TO 7:00 AM- Per documentation in resident 1's nursing notes, "...Will not stay in bed..." "...cannot comprehend to stay in bed or in chair..." "... Her legs are weak and she sits or slides to the floor..." l. 12/12/03 at 5:45 AM- Per documentation in the facility's "Incident/Accident Report", "CNA found resident face down in front of easy chair with head toward closets. Approximately a 3 cm X 5 cm skin tear on the lateral side of right elbow. m. 12/13/03 at 1:00 PM -Per documentation in resident 1's nursing notes, "...Patient found on floor next to recliner chair, had been on her low bed. Sm [small] skin tear rt [right] forearm approximately 2 cm..." n. 12/15/03 at 8:00 PM- Per documentation in the facility's Incident Report Log, resident 1 "slid backwards and her head went through the wall." o. 12/15/03 at 8:00 PM- Per documentation in resident 1's nursing notes, "...Licensed nursing staff summoned into resident's bathroom per resident hollering for help, et [and] noted resident sitting on floor, next to wall..."	F 309		

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F 309	Continued From page 8 p. 12/17/03 at 4:00 AM- Per documentation in resident 1's nursing notes, "...Resident found sitting on her bedroom floor by her low bed..." "...Re-opened old skin tear on [upper] forearm. Steri-stripped wound and covered with tegaderm..." q. 12/20/03 at 1:00 AM- Per documentation in resident 1's nursing notes, "...Resident found on floor had skin tear on left forearm and an old looking abrasion on right knee..." "...Resident made to understand through written notes that she is not to get out of bed by self and use call light..." r. 12/22/03 at 1:10 AM- Per documentation in resident 1's nursing notes, "...Resident on floor crawling on knees next to her roommates bed. O (no) injury. Alert. Behavior typical for this resident. Resident has been in low bed. Resident moved near nursing station for close monitoring..." s. 12/24/03 at 4:15 AM- Per documentation of nursing notes "...She was found yelling for help. Found on bedroom floor next to recliner lying on her L [left] side. No new injuries noted..." t. 1/15/04 at 04:00 AM - Per documentation in resident 1's nursing notes, "...fof [found on floor] on her knees by her bedside. Abrasion on R (right) knee. Cleansed + (and) antibiotic oint (ointment) c (with) bandaid applied..." u. 1/18/04 at 9:00 PM - Per documentation in resident 1's nursing notes, "...At 17:30 (5:30 P.M.) Res (resident) fof (found on floor) by cna (certified nurse aide) Res (resident) LOC (level of consciousness), ROM (range of motion), injury and bleeding (checked). There were no injuries et (and) no changes. A physician order, dated 12/10/03, documented that resident 1 had a personal alarm initiated for her safety. Also on 12/10/03, resident 1's nursing notes included an entry that the resident was placed on a low bed with a mattress on the floor.	F 309		

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F 309	Continued From page 9 A physician order, dated 12/16/03, documented that resident 1 had a low bed with a mattress on the floor initiated. A review of resident 1's medication administration records was completed on 1/22/04. The following medications were administered to resident 1, which may have increased her risk for falls, sedation and decreased level of consciousness, when given with Zyprexa: a. 12/7/03 - Ativan 2 mg at 11:30 PM, after resident had fallen. b. 12/8/03 - Restoril 30 mg at HS (hour of sleep). c. 12/10/03 -Ativan 1 mg at 1:00 AM . d. 12/12/03 - Ativan 0.5 mg at 1:00 AM, and Restoril 30 mg at 9:00 PM. e. 12/13/03 - Ativan 0.5 mg (2) at 9:00 PM and Restoril 30 mg at 9:00 PM. In addition, per documentation on resident 1's medication administration record, resident 1 was receiving Risperdal 1 mg, every evening since 4/15/03. Interviews: The facility's Director of Nursing (DON) was interviewed on 1/24/04 at 2:40 PM. She stated that a medication error occurred because the facility pharmacy mislabeled resident 2's, Zyprexa, 10 mg pills, with resident 1's name. Resident 1 did not have a physician's order for Zyprexa and had received Zyprexa 10 mg in error, that was resident 2's medication. The DON was asked if she knew how many doses resident 1 had received in error, and the DON stated that she wasn't sure. The DON further stated the error could have been prevented if the night shift nurses had been checking the physicians orders	F 309		

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F 309	Continued From page 10	F 309		

against the medication administration record. The DON stated that it was brought to her attention on 12/15/03 when employee 2, a licensed practical nurse had found the error. The surveyor asked the DON if she thought the Zyprexa medication error had negatively effected resident 1. The DON stated, "No, not to any great extent. She kept falling, and falling, and falling." The surveyor asked if the facility had a Fall Prevention program in place, to which the DON stated, "It's a work in process - but yes."

Employee 1, a facility licensed practical nurse, was interviewed on 1/22/04 at 10:30 AM. Employee 1 stated that she remembered administering Zyprexa to resident 1, but she was not aware that a medication error had occurred.

Employee 2, a facility licensed practical nurse was interviewed on 1/22/04 at 1:20 PM . Employee 2 stated on one day she was administering medications to resident 1, and noticed there was a new medication card for Zyprexa. She stated she realized that this resident was not on the medication Zyprexa. Employee 2 then went to the resident's medical chart to double check the order, and realized that an error had occurred. Employee 2 stated that she couldn't remember how many pills had been administered to resident 1, in error.

On 1/21/04, the facility's Social Service Worker (SSW) was interviewed regarding resident 1. The SSW stated that resident 1 had experienced a change in condition, beginning in December, 2003. The SSW stated resident 1's ability to ambulate with a walker declined, and that she was more confused and lethargic. The surveyor asked the SSW why she felt resident 1 had declined. The SSW stated she had heard from the licensed nursing staff that resident 1

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F 309	Continued From page 11 had received another resident's medication in error. She stated the medication given in error was Zyprexa. The SSW stated the medication error had occurred in the beginning of December, 2003. Resident 1's physician was interviewed on 1/22/04 at 1:00 PM. He stated that Zyprexa, as an antipsychotic medication, may increase a resident's risk for falling. A facility nurse was interviewed on 1/26/04 at 2:30 PM. The facility nurse stated that if a resident was assessed at risk for falls, the fall prevention protocols would be included in the resident's care plan. Two facility nurse aides were interviewed on 1/22/04 at 9:30 AM. These two nurse aides stated that resident 1 had fallen into the wall in the recent past. This incident was documented on a facility's incident report on 12/15/03. Facility staff documented resident 1 experienced no injuries, as a result of the fall. However, facility staff documented the fall caused a hole in the wall. The nurse aides stated the hole in the wall was large enough that it required being patched. An interview was held with another facility nurse aide on 1/22/04 at 9:00 AM. She stated that resident 1 had been alert and ambulatory, using her walker, going to and from the dining room. The nurse aide stated that in the first part of December 2003, resident 1 began falling all the time and became confused. She stated that one time resident 1 fell in the bathroom, and made a hole in the wall, and that resident 1 had hurt her hip. The nurse aide stated that the change in resident 1 had been sudden. On 1/22/04, at 2:30 PM, the facility Administrator was interviewed regarding resident 1's Zyprexa medication error and falls. The Administrator stated that resident	F 309		

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F 309	Continued From page 12 1 had received resident 2's Zyprexa medication for "multiple days, 6 or 7 doses.." The surveyor asked the Administrator if he had thought resident 1 had been negatively effected because of the medication error. The Administrator stated, "No, she was drugged." The surveyor asked the Administrator if he thought that resident 1 had been falling because she was "drugged", to which the Administrator stated, "I don't know."	F 309		
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 staff interviews and the pharmacy medication incident reporting form it was determined that the facility used a medication that was not labeled in accordance with current accepted professional principles. Specifically, resident 1 received Zyprexa due to an error in medication labeling. The Zyprexa label included resident 1's name in place of resident 2's name. (Resident identifiers 1,2) Findings include: A review of the pharmacy's medication incident reporting form dated 1/22/04 documented that a medication error had occurred with resident 1. The facility's pharmacy mistakenly processed an order of Zyprexa 10 mg (milligrams) every evening for resident 1 that should have been labeled for resident 2.	F 431	The medication error for resident 1 was an isolated incident which can be corrected by using current policy and procedure which require the following: - obtain a M.D. Order - Transmit order to Pharmacy - Upon receipt of medication from Pharmacy, verify correct patient, drug, dose, time and method. Quality assurance will be sustained by using a 4 way check daily as all new orders are received, all monthly refill orders will be checked against Physician Order and Pharmacy print outs of Residents.	

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F 431	Continued From page 13 The facility's consultant pharmacist was interviewed on 1/29/04 at 8:00 AM. The pharmacist stated that the facility contacted him on approximately 12/15/03. The order for Zyprexa was filled on 12/2/04 and a 30 day supply was sent to the facility on 12/5/03. The medication Zyprexa should have been labeled for resident 2 but had been labeled with resident 1's name. The pharmacist stated, "the error occurred on our end, the input technician who filled the order and labeled the medication, labeled the medication card with the wrong resident name." The pharmacist documented the following on the incident reporting form, "This incident was discussed in quarterly QA (quality assurance) meeting on 12/17/03 with QA personnel, including [facility physician]. [Facility physician] stated that he thought no intervention was needed and the patient was fine after the medication was stopped." The facility's Director of Nursing (DON) was interviewed on 1/24/04 at 2:40 PM. She stated that a medication error occurred because the facility pharmacy mislabeled resident 2's, Zyprexa, 10 mg pills, with resident 1's name. Resident 1 did not have a physician's order for Zyprexa and had received Zyprexa 10 mg in error, that was resident 2's medication. The DON was asked if she knew how many doses resident 1 had received in error, and the DON stated that she wasn't sure. The DON further stated the error could have been prevented if the night shift nurses had been checking the physicians orders against the medication administration record. The DON stated that it was brought to her attention on 12/15/03 when employee 2, a licensed practical nurse had found the error. The surveyor asked the DON if she thought the Zyprexa medication error had negatively effected resident 1. The DON stated, "No, not to any great extent. She kept falling, and falling, and falling." The surveyor asked if the facility had a	F 431	The 4 way check will consist of verifying the residents name, label, telephone order, and physician order. Inservices will be performed by the D.O.N. to reinforce procedures to licensed staff. Nurses will do checks upon receipt of medication. The D.O.N or assigned nurse will monitor and spot check staff no less than weekly. Progress reports are done in monthly Q.A. 3/26/04	

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F 431	Continued From page 14 Fall Prevention program in place, to which the DON stated, "It's a work in process - but yes." The facility's Administrator was interviewed on 1/22/04 at 2:30 PM. The Administrator stated that resident 1 had received resident 2's Zyprexa medication for "multiple days, 6 or 7 doses.." Employee 1, a licensed practical nurse, was interviewed on 1/22/04 at 10:30 AM. Employee 1 stated that she remembered administering Zyprexa to resident 1, but she was not aware that a medication error had occurred. Employee 2, a licensed practical nurse, was interviewed on 1/22/04 at 1:40 PM. Employee 2 stated that she was administering medications to resident 1, and noticed there was a medication card for Zyprexa, and realized that this resident was not on the medication Zyprexa. Employee 2 then went to the resident's medical chart to double check the order, and realized that an error had occurred. Employee 2 stated that she couldn't remember how many pills had been administered to resident 1, in error.	F 431		
F 490 SS=E	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interviews with facility staff and review of facility records, it was determined that the facility was	F 490	The Administrator knew of only one instance that employee 1 acted outside the scope of her varience. That was on January 16, 2004 when the Administrator come to work, only to find employee 1 the only nurse in →	

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F 490	Continued From page 15 not administered in a manner that utilized licensed nursing staff so that each resident may attain or maintain their highest practicable well-being. Specifically, the facility Administrator did not adhere to the licensing restrictions of one licensed practical nurse, and allowed falsification of information in residents records. (Employee 1) An abbreviated survey was conducted on 1/21/04 through 1/26/04. Noncompliance was found in two areas: 1. Compliance with Federal, State, and local laws and professional standards, Code of Federal Regulation (CFR) 483.75, Tag F-492. 2. Clinical Records (CFR) 483.5, Tag F-514 Findings include: A review of employee 1's file was completed on 1/22/04, which revealed the following: In employee 1's file was a document from The Division of Occupational and Professional Licensing of the Department of Commerce of the State of Utah (DOPL). The document was a Stipulation and Order, Case number DOPL 2003-185, imposing sanctions and restrictions on employee 1's ability to practice as a licensed practical nurse. Specific sanctions and restrictions imposed on September 8, 2003, included but were not limited to the following: a. (2j) "Respondent shall restrict her practice to duties and surroundings which do not allow her access to, or require her to account for controlled substances." b. (2n) "Respondent shall practice only under the	F 490	the facility due to a call off by another nurse. Agency was called and for approximately 2-3 hours, employee 1 worked unsupervised by a R.N. or the D.O.N. Since this time, employee 1 and the D.O.N. have been released from employment. for improper supervision as well as the improper signing (initialing) of the narcotics record. The facility now has as its policy that no licensed staff will be hired with any kind of restriction or variance on their license. The medication administration record and Narcotics record will be audited weekly and checked for proper initialing. medical Records →	

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F 490	Continued From page 16 on-site supervision of a registered nurse in good standing with the Division. The supervising nurse or physician shall be primarily one (1) person who may periodically delegate to other qualified personnel." A second document in employee 1's file, dated September 29, 2003, from the State of Utah, Utah Department of Health, Bureau of Licensing, revealed that the facility had requested a variance to R432-35 (background screening). The Bureau of Licensing granted this variance. The document outlines the specific conditions of the variance that was approved with the following restrictions: a. (2j) "When [employee 1] is working as a LPN [Licensed Practical Nurse], she will be under the direct supervision of a RN [Registered Nurse]. That RN will do the narcotic count at the beginning and the end of each shift. [Employee 1] will have a key to the routine medication cart, but the RN will have the key to any and all narcotics or other controlled substances in her possession at all times." b. (2n) "[Employee 1] will be supervised at all times by a RN in good standing with the Board. This RN will be the primary nurse [employee 1] will be working with." The Administrator was interviewed on 1/22/04, at 2:20 PM. The Administrator stated that he was aware that employee 1 had restrictions on her license and that employee 1 was to be supervised by a registered nurse. The designated registered nurse was to be the Director of Nursing. The Administrator stated he was aware that employee 1 had been working as a floor nurse alone, unsupervised. The Director of Nursing (DON) was interviewed on	F 490	will do the audits. The D.O.N. is responsible to follow-up and monitor. a report will be reviewed monthly at Q.A., with any anomilies checked immediately by the D.O.N. and administrator 3/26/04	

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F 490	Continued From page 17	F 490		

1/21/04, at 2:45 PM. The surveyor asked the DON if she was aware that employee 1 had a restricted nursing license, to which the DON responded she was aware. The surveyor asked the DON if she was aware of the specific restrictions to employee 1's nursing license. The DON stated that employee 1's was not to have access to narcotics. The DON stated that she had allowed employee 1 to administer narcotics, carry the narcotic keys, and count the controlled substances with out supervision.

Employee 1 was interviewed on 1/22/04 at 10:30 AM. Employee 1 stated she did have a restricted license. She stated the restrictions were that she was to be supervised by a registered nurse and that she could not administer narcotics. Employee 1 stated that the Administrator was aware that she was working unsupervised by a registered nurse and had administered narcotics to facility residents.

Two facility nursing staff were interviewed on 1/21/04 at 2:30 PM. The two nurses stated that employee 1 did carry the narcotic keys and was counting the narcotics.

Five facility aides were interviewed on 1/22/04. The five nursing aides stated that employee 1 had been working without being supervised by an RN.

A review of the facility's nursing schedules, time cards, and agency invoices from 11/1/03 through 1/15/04, was completed on 1/26/04.

Employee 1 had worked with another LPN on 11/22/03, 11/28/03, 12/4/03, 12/6/03, and 1/2/04. There had not been a registered nurse working on those dates to supervise employee 1.

Employee 1 had worked alone and unsupervised in the

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F 490	Continued From page 18 building on 11/27/03, 12/25/03, 12/26/03, 1/11/04, and 1/14/04. (Refer to F 492) 2. A review of the facility's Controlled Drug Administration Records, between 1/9/04 and 1/22/04 was completed on 1/22/04. Employee 1 was interviewed on 1/22/04 at 10:30 AM. Employee 1 stated the DON had her initial the DON's initials on the Controlled Drug Administration Records, on individual resident's medication administration records and individual residents' narcotic records. Employee 1 was asked to identify how may times she had signed the DON's initials on the Controlled Drug Administration Records. Employee 1 identified eight times in January, 2004, that she had signed the DON's initials. A review of the narcotic records for individual residents, for October 1, 2003 through January 22, 2004 was completed on 1/22/04. Employee 1 was asked to identify how may times she had signed the DON's initials on the individual residents narcotic records. Employee 1 identified 100 out 114 times she initialed the DON 's initials on the narcotic records. The facility's DON was interviewed on 1/21/04 at 2:45 PM. The DON acknowledged that she had employee 1 initial the Controlled Drug Administration Records and the individual residents' narcotic records with initials that were not hers.	F 490		

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F 490	Continued From page 19 (Refer to F 514)	F 490		
F 492 SS=E	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on employee record review and staff interviews it was determined that the facility failed to comply with all applicable State laws. The facility did not ensure that a licensed practical nurse (LPN) that had a restriction on her license was adhering to the restrictions placed on her license. (Employee 1) Findings include: A review of employee 1's personnel file was completed on 1/22/04, which revealed the following: In employee 1's file was a document from The Division of Occupational and Professional Licensing of the Department of Commerce of the State of Utah (DOPL). The document was a Stipulation and Order, Case number DOPL 2003-185, imposing sanctions and restrictions on employee 1's ability to practice as a licensed practical nurse. Specific sanctions and restrictions imposed on September 8, 2003; included but were not limited to the following; a. (2j) "Respondent shall restrict her practice to duties and surroundings which do not allow her access to, or require her to account for controlled substances."	F 492	The facility will ensure no future problems with restricted licenses by adhering to a new facility policy that does not allow the hiring of any nurse with a varience or other restrictions upon their license. Before any new hires are done, the facility will check licenses as it already does and will continue to do background checks. If a current nurse is placed on license restriction, it will be the policy of this facility to terminate the employment of that nurse to sustain compliance with this regulation. →	

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F 492	Continued From page 20 b. (2n) "Respondent shall practice only under the on-site supervision of a registered nurse in good standing with the Division. The supervising nurse or physician shall be primarily one (1) person who may periodically delegate to other qualified personnel." A second document in employee 1's file, dated September 29, 2003, from the State of Utah, Utah Department of Health, Bureau of Licensing, revealed that the facility had requested a variance to R432-35 (background screening). The Bureau of Licensing granted this variance. The document outlines the specific conditions of the variance that was approved with the following restrictions: a. (2j) "When [employee 1] is working as a LPN [Licensed Practical Nurse], she will be under the direct supervision of a RN [Registered Nurse]. That RN will do the narcotic count at the beginning and the end of each shift. [Employee 1] will have a key to the routine medication cart, but the RN will have the key to any and all narcotics or other controlled substances in her possession at all times." b. (2n) "[Employee 1] will be supervised at all times by a RN in good standing with the Board. This RN will be the primary nurse [employee 1] will be working with." 2. Interviews with facility staff revealed the following: Employee 1 was interviewed on 1/22/04 at 10:30 AM. Employee 1 confirmed and acknowledged that she had a restricted license. Employee 1 was asked to explain her understanding of	F 492	Monitoring of this process is to be done by the D.O.N, administrator and the Office manager. Reports will be given in quarterly Q.A. 3/26/04	

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F 492	Continued From page 21	F 492		

the restriction on her license, in relation to administering medications. Employee 1 stated that she was required to be working under the supervision of a RN. Employee 1 stated that the restriction allowed her to administer non-narcotic medications to residents under the supervision of an RN. Employee 1 stated that she was not allowed to have access to or administer narcotics.

Employee 1 was asked if she had been administering narcotic medications to residents at the facility and she stated, "Yes."

Employee 1 was asked if she had been requested to administer narcotics in the facility, and who had made that request. Employee 1 stated, "Yes." she had been asked to administer narcotics, by the DON (Director of Nursing), and the ADON (Assistant Director of Nursing).

Employee 1 was asked if she had ever refused to administer narcotics. Employee 1 stated that she told the DON that she was "uncomfortable doing it."

Employee 1 was asked if she had ever signed or put the DON's initials on facility narcotic sign out sheets, individual resident sign out sheets, or on individual resident MAR's (medication administration records). Employee 1 stated, "Yes", she had signed these documents with the DON's initials. Employee 1 stated that the DON had instructed her to sign the records with her initials (the DON's initials). Employee 1 stated that the DON had stated that she would handle any problems from doing it.

Employee 1 was asked if she ever had possession of the facility's narcotic keys. Employee 1 stated, "Yes."

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F 492	Continued From page 22 Employee 1 was asked if she had ever worked alone, (as the only licensed nurse in the building) and did she ever administer narcotics during those times. Employee 1 stated, "Yes, but not very often." Employee 1 stated that the last time she was working alone in the building was Friday, January 16, 2004. Employee 1 stated that she was working alone in the building until an agency nurse came in to help. Employee 1 was asked if she had ever worked alone in the building when the DON was on vacation. Employee 1 stated, "Yes." Employee 1 was asked if the Administrator was aware that she had been working alone, unsupervised by a RN, and administering narcotics. Employee 1 stated, "Yes, he told me to do what was needed to take care of the residents." Employee 1 was asked when the facility's Administrator was first made aware of the restriction on her license. Employee 1 stated that she thought it was in September or October of 2003. The DON was interviewed on 1/21/04 at 2:45 PM. The DON was asked if employee 1 had ever had possession of the facility narcotic keys. The DON stated, "I can't lie, she has." The DON was asked if employee 1 had been allowed to administer narcotics to the residents. The DON stated that she (employee 1) had administered narcotics to the residents. The DON was asked if employee 1 had been allowed to sign her (DON's) initials on the resident MAR's (medication administration record) and the facility narcotic counting sheet. The DON stated, "Yes." The	F 492		

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F 492	Continued From page 23 DON then clarified that the signatures, could have been signed by either one of them, (employee 1 or DON). The DON then stated that both of them, had been initialing and signing resident MAR's, and narcotic count sheets, with the DON's initials and signatures. The DON was asked how she specifically supervised employee 1. The DON stated that she made sure employee 1's residents were taken care of. The DON stated that she made sure that the residents were given their medications, and that the medications were given on time. The DON was asked if she supervised employee 1 all the time. The DON stated, "No, I am not there to supervise her the whole time." The DON stated that if she was in a meeting, she would have [employee 1] administer narcotic medications to the residents. The DON was asked what her understanding of employee 1's license restriction. The DON stated, "It was my understanding that [employee 1] shouldn't be giving the narcotics." The DON was asked when she was made aware of the restriction on employee 1's nursing license. The DON stated that employee 1 had told them (DON and Administrator) about the restriction, but she wasn't sure of the exact date, but thought it was in September or October of 2003. The DON was asked if she had ever asked employee 1 to administer narcotics to residents. The DON stated that she had asked employee 1 to administer narcotics to residents. The DON was asked what employee 1's reply was	F 492		

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	465086	A. BUILDING _____ B. WING _____	C 1/26/2004

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 492	Continued From page 24 when [employee 1] was asked to administer narcotics. The DON stated that employee 1 said that she was "uncomfortable doing it." The DON was asked why employee 1 was allowed to administer narcotics. The DON said, "I did it for the residents." The DON was asked if there had been any negative outcome to any of the residents as a result of employee 1 administering narcotics. The DON said, "No." The DON was asked if employee 1 had ever worked alone at the facility. The DON stated that employee 1 had worked alone, without supervision in the facility. The date was January 16, 2004. The DON stated that employee 1 had only worked alone for 4 hours on that shift. The facility's Administrator was interviewed on 1/22/04, at 2:20 PM. The Administrator was asked when he was made aware of employee 1's license restriction. The Administrator stated that employee 1 had told him of her license restriction in September, 2003. The Administrator was asked if he knew who had asked employee 1 to administer narcotics to the residents. The Administrator stated that he didn't know. The Administrator stated that he suspected employee 1 was administering narcotics to the residents during the week the DON was on vacation on a day when employee 1 was the only nurse in the building. He stated that he was not aware that employee 1 had been administering narcotics to residents at other times. The Administrator was asked why this practice had	F 492		

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F 492	Continued From page 25 been allowed. The Administrator stated that employee 1 had been the only nurse at the facility that day. The Administrator stated that he had tried to call 3 different nurses to come in and work, and none of the nurses could come in to work. The Administrator stated that this had been allowed because employee 1 was the only nurse available to work that day. He stated, "I let this happen, and it was my responsibility." Two facility nurses were interviewed on 1/21/04, at 2:30 PM. The two nurses acknowledged and confirmed that employee 1, had been administering narcotic medications to residents at the facility. One of the nurses stated, "Yes, [employee 1] carries the narcotic keys." She stated that employee 1 had been a nurse on the floor, but was now doing paperwork. The nurse stated, when employee 1 was a nurse on the floor, her responsibilities were to pass medications, patient safety, charting, counting narcotics, and signing off physicians orders. "Employee 1 was passing medications up until yesterday, I think." The other nurse stated, "Yeah, [employee 1] has had the narcotic keys whenever she's on the floor. She also counts the narcotics." On 1/22/04, five facility nurse aides were interviewed about their knowledge of employee 1 working alone, as the only nurse in the building. On 1/22/04, nurse aide 1 stated that employee 1 worked alone in the building when the DON was on vacation.	F 492		

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F 492	Continued From page 26 On 1/22/04, nurse aide 2 stated that employee 1 was the only nurse working a couple of times. The nurse aide could not remember exact dates. On 1/22/04, nurse aide 3 stated employee 1 had worked alone. On 1/22/04, nurse aide 4 stated, employee 1 had worked alone in the building, and "No" the DON did not supervise her. On 1/22/04, nurse aide 5 stated that employee 1 administered medications to the residents, and "No" the DON did not supervise her. 3. A review of the facility's Controlled Drug Administration Records, (narcotic counting sheets) between 1/9/04 and 1/22/04, was completed on 1/22/04. Employee 1 was asked to identify how may times she signed the DON's initials on the Controlled Drug Administration Records. Employee 1 identified eight times for the month of January, 2004. 4. A review of the narcotic records for individual residents, for October 1, 2003, through January 22, 2004, was completed on 1/22/04. Employee 1 was asked to identify how may times she had signed the DON's initials on the narcotic records. Employee 1 identified 100 out 114 times. 5. A review of the facility's nursing schedules, time cards, and agency nurse time sheet invoices from November 1, 2003, through January 15, 2004 was completed.	F 492		

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F 492	Continued From page 27 Employee 1 had worked with another LPN on 11/22/03, 11/28/03, 12/4/03, 12/6/03, and 1/2/04. There had not been a registered nurse working on those dates to supervise employee 1. Employee 1 had worked alone and unsupervised in the building on 11/27/03, 12/25/03, 12/26/03, 1/11/04, and 1/14/04. Employee 1 documented on her January, time card, pay period ending 1/15/04, the following, "worked 4 hours by myself, 4 hours double time." Employee 1 documented on her December's time card, pay period ending 12/15/03, the following, "I worked alone on Thanksgiving 3-11 and was informed that I was to get double time, and was only paid for regular 8 hours. I need the 8 hours extra please." Employee 1 documented on her December's time card, pay period ending 12/16/03 (sic),the following, "worked alone double time."	F 492		
F 514 SS=E	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 interviews and record review, it was determined that the facility failed to ensure that resident clinical records were maintained in accordance with accepted professional standards and	F 514	(1) The facility administration terminated the employment of both employee 1 and the D.O.N. for allowing the cited practices. To ensure no future incidents of this nature, the facility will systematically audit the medication administration →	

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F 514	Continued From page 28 practices. 1. The facility allowed a licensed practical nurse to document medications she had administered that were not given by another nurse in the facility. 2. The facility did not ensure that when a medication error was made, that the incident was documented in the resident's clinical record. Findings include: 1. A review of the facility's Controlled Drug Administration Records, between 1/9/04 and 1/22/04 was completed on 1/22/04. Employee 1 was interviewed on 1/22/04 at 10:30 AM. Employee 1 stated the the DON had her initial the DON's initials on the Controlled Drug Administration Records, on individual residents' medication administration records and individual residents' narcotic records. Employee 1 was asked to identify how may times she had signed the DON's initials on the Controlled Drug Administration Records. Employee 1 identified eight times in January, 2004, that she had signed the DON's initials. A review of the narcotic records for individual residents, for October 1, 2003 through January 22, 2004, was completed on 1/22/04. Employee 1 was asked to identify how may times she had signed the DON's initials on the individual resident narcotic records. Employee 1 identified 100 out 114 times she initialed the DON 's initials on the narcotic records.	F 514	Record and Narcotic sheets weekly, checking ~~against~~ against nurse initials. Medical Records will audit and will report on at the monthly Q A . The D.O.N will monitor. (2) An inservice will be given to all licensed staff to ensure proper documentation for medication errors into resident records Errors will be reported on the "medication Error" incident report (EXHIBIT A), and reviewed upon receipt from nursing by the D.O.N. and administrator. All medication error incidents will be acted upon immediately by the D.O.N. and the licensed staff reporting to ensure the safety of the resident. All →	

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F 514	Continued From page 29 The facility's DON was interviewed on 1/21/04 at 2:45 PM. The DON acknowledged that she had employee 1 initial the Controlled Drug Administration Records and the individual residents narcotic records with initials that were not hers. 2. By interview of facility staff, it was determined that a medication error was made in December, 2003, involving resident 1. A review of resident 1's entire medical record was completed on 1/22/04. Resident 1's medical record did not contain documentation about the incident on the nursing notes or medication administration record. Employee 2, an LPN (Licensed Practical Nurse) was interviewed on 1/22/04 at 1:20 PM. Employee 2 stated that she was administering medications to resident 1, and noticed there was a new medication card for Zyprexa, and realized that this resident was not on the medication Zyprexa. Employee 2 then went to the resident 1's medical chart to double check the order, and realized that an error had occurred. Employee 2 stated that she couldn't remember how many pills had been administered to resident 1, in error. Employee 1, an LPN was interviewed on 1/22/04 at 10:30 AM. Employee 1 stated that she remembered administering Zyprexa to resident 1, but she was not aware that a medication error had occurred.	F 514	Medication errors will then be logged in the incident report log book and reported on in monthly and Quarterly Q.A. D.O.N. to monitor. This 3/26/04 method will be used to ensure no further incidents will occure with resident 1.	

MEDICATION ERROR REPORT

CONFIDENTIAL

Date of Report:_____

EXHIBIT A

Resident:_____ Room:_____ Physician:_____

Date & Time Error Discovered:_____ Date & Time Error Occurred:_____

Medication Given:_____ Dosage:_____ Route of Admin._____

Physician Order & Date:_____

_____

Description of Error:_____

_____

_____

Physician Notified:_____ Date:_____ Time:_____

Orders Received at Time of Notification:_____

_____

Correction of Error:_____

Family Notified:_____ Date:_____ Time:_____

Staff Member Filing Report:_____

Staff Member Making Error:_____

Supervisor Review (apparent cause of error):_____

_____

Consultation with staff member making error, including measures taken to prevent reoccurrence:

_____

_____

Staff Member Signature_____ Supervisor Signature_____

Administration Review:

Nursing Service Director:_____ Date:_____

Administrator:_____ Date:_____

Medical Director:_____ Date:_____