DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465069	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 1/13/00

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT OGDEN NURSING & REHABILITATION	375 EAST 5350 SOUTH OGDEN, UT 84405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Memo INITIAL COMMENTS An abbreviated complaint survey was completed at the facility on 10/27/99. The allegations were substantiated and two deficiencies were written. Tag F-309 was written at a scope and severity level of 'E' and tag F-314 was written at a scope and severity level of 'G' which constituted actual harm to one resident. On 11/18/99, the facility submitted a CAC alleging full compliance on 12/27/99. The follow-up to the complaint survey of 10/27/99 was performed simultaneously with the annual recertification survey 1/3/00 through 1/13/00. On 1/13/00, it was determined that the facility had failed to correct tag F-314 that was cited during the 10/27/99 complaint survey and had not followed their plan of correction. Specific information on deficient practices and how the plan of correction was not followed are located within the repeat citing of tag F-314. The repeat deficiency was cited at a scope and severity level of 'G' which constituted actual harm to the residents identified.	F 000	POC accepted 3-9-00 by ETD Last completion date 3-24-00	
F 157 SS=G	483.10(b)(11) Requirement 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	F 157 ETD	Z 271 147 967 MAR - 6 03-03-2000 HT	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Admin | (X6) DATE 3-2-00

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.

HCFA-2567L

ATG021299

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F 157	Continued From page 1 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 W483.12(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 W483.15(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 observation, interview and review of a medical record, it was determined that for 1 of the 15 sample focus, the facility did not immediately inform or consult with the resident's physician when there was a significant change in the resident's physical status with a need to alter treatment significantly. Resident identifier: 43. Findings include: Resident 43 was a 45 year old male who was admitted to the facility on 5/23/97 with the diagnoses of multiple sclerosis, unspecified protein-calorie malnutrition, chronic obstructive pulmonary disease, paralytic syndrome, and cauda equise syndrome with neurogenic bladder. Resident 43 was found to have a stage 2 pressure sore	F 157	F157 1) Resident 43's physician will be notified of the resident's stage 2 pressure sore to the coccyx. The nurse will obtain an order to treat the stage 2 pressure sore to the coccyx. 2) On February 10, 2000 the Director of Nursing will conduct an inservice for our Nurses. This inservice will include proper assessment of residents, following physician orders, and notifying the physician within one hour of any significant changes in the residents condition. This notification will be noted in the nurses notes, and on the 24 hour report. 3) The Attending Nurse, or member of the Nurse Management team will notify the physician of any significant change to the resident within one hour. If known, will also attempt to notify the residents legal representative within 12 hours. This information will be noted in the nursing notes, as well as the 24 hour report. The Assistant Director of	3-24-00

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F 157	Continued From page 3 different days the pressure sore was observed (1/4/00 at 2:15PM, 1/5/00 at approximately 10:10 AM, 1/12/00 at 2:00 PM and 1-13/00 at approximately 3:30 PM), the pressure sore to the coccyx of resident 43 had a dressing on it only one day (1/5/00). The pressure sore was not observed to have protective cream on it during any of the four days of observation. On 1/3/00, a facility nurse had documented on the weekly skin monitoring sheets that resident 43 had a stage 1 red pressure area to his coccyx which measured 1/4 cm. On 1/4/00, the registered nurse surveyor and a facility registered nurse performed a skin check of resident 43. Resident 43 was found to have a stage 2 pressure sore on his coccyx which measured approximately .25 cm by .25 cm. The 300 hall nurse, who had documented the presence of the red pressure area the day before, was asked if she was aware that the pressure sore had progressed and was now open at a stage 2. The 300 hall nurse replied that she was not aware that the wound was a stage 2 and stated that she would "take care of it." On 1/5/00, the registered nurse surveyor checked the chart of resident 43. The nurse's notes, dated 1/4/00, documented "Pt. (patient) has DQ (decubitus ulcer/pressure sore) 1/4 X (by) 1/4 in circumference - Dr. (resident's physician) Notified - See Orders - Duoderm applied - tx (treatment) to chg (change) q (every) 3rd day until resolved." Upon review of the medical record of resident 43 on 1/5/00, the surveyor observed that there were no orders from the physician regarding the pressure sore. However, within the 300 hall treatment book on a	F 157	Nursing will review this report daily to ensure that this is being done properly. She will sign and date the bottom of the report to indicate that follow through is being completed. The Director of Nursing will review the 24 hour reports on a weekly basis to ensure compliance. 4) Medical Records will also be given a copy of the 24 hour report. Weekly, She will audit each chart which has been identified as having a significant change to see that the physician orders have been signed and returned. This will be done until a 95% success has been achieved. At this time, this audit will be reduced to once a month. 5) The Director of Nursing and Administrator will be responsible to ensure compliance.	

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F 157	Continued From page 2 to his coccyx on 1/4/00. The facility was not aware of the stage 2 pressure sore to the coccyx of resident 43 until it was identified by the registered nurse surveyor on 1/4/00. Facility staff did not notify resident 43's physician of the stage 2 pressure sore to the coccyx of resident 43 until 1/13/00, nine days after they became aware of it. Facility staff did not obtain an order to treat the stage 2 pressure sore to the coccyx of resident 43 until 1/13/00, nine days after they became aware of it. The physician was not made aware of resident 43's pressure sore until 1/12/00 when the registered nurse surveyor called him to discuss the resident. During a telephone interview with the physician of resident 43 (also the facility's medical director) on 1/12/00 at 2:00 PM, the physician was asked if he was aware that resident 43 had a stage 2 pressure ulcer on his coccyx. The physician stated that he was "not aware", that he "had not been told" of the pressure sore to the coccyx of resident 43. When the physician was asked if her had ordered anything to treat the pressure sore, the physician stated, "no". The physician was informed that a nurse's note in the chart of resident 43 stated that he had been notified on 1/4/00 and orders for duoderm had been received. The physician stated that possibly the nurse had notified his office. The RN surveyor asked if his office would have given orders to treat the pressure sore. The physician stated, "no". From the first observation of the pressure sore by the RN surveyor on 1/4/00 to the last observation performed prior to exit on 1/13/00, the stage 2 pressure sore had increased in size from .25 cm (centimeter) by .25 cm to 1 cm by .5 cm. Of the four	F 157		

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F 157	Continued From page 4 page designated solely for resident 43, the following was written "1-4-00 Duoderm chg (change) q (every) 3rd day and PRN (as necessary) until resolved." The area identified for this treatment was the coccyx. During the mini exit on 1/5/00, the Director of Nurses (DON) and the Administrator were notified that a physician's order for the treatment of the stage 2 pressure sore to the coccyx of resident 43 could not be found in the resident's chart. On 1/12/00, another skin check was performed on resident 43 with a facility nurse. It was observed that the stage 2 pressure sore had increased in size, from the .25 cm by .25 cm on 1/4/00, to 1 cm by .25 cm. The stage 2 pressure sore was not covered by a dressing nor did it have any protection cream on it. On 1/13/00, another skin check of resident 43's coccyx was performed with a facility aide. It was observed that the stage 2 pressure sore had increased, from 1 cm by .25 cm on 1/12/00, to 1cm by .5 and appeared to be branching off in two additional areas. The pressure sore was again observed without a dressing or protective cream. During interview with the 300 hall nurse on 1/12/00 at approximately 3:00 PM, she was asked if she had resident 43 scheduled for a dressing that day. The nurse replied that she did not because there were no orders to treat the pressure sore. The nurse stated that she was going to contact the resident's physician and get orders for the pressure sore. Review of the medical record of resident 43 on 1/13/00 revealed that there continued to be no orders to treat the stage 2 pressure sore to his coccyx. The DON was made aware that there continued to be no	F 157		

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F 157	Continued From page 5 orders to treat the pressure sore on resident 43. The DON confirmed that she, too, could not find orders to treat the current stage 2 pressure sore. The pressure sore had increased in size from .25 cm by .25 cm on 1/4/00 to 1 cm by .5 cm on 1/13/00 without the facility notifying the resident's physician.	F 157	F-241	
F 241 SS=E	483.15(a) Requirement QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This Requirement is not met as evidenced by: Based on a confidential group interview, confidential resident interviews, a confidential family interview, an interview with the Ombudsman, and observations, it was determined that call lights were not answered in a timely fashion. Findings include: 1. In a confidential group meeting held 01/04/00, at 10:45 AM, 10 of 11 residents reported that call lights were not answered in a timely manner. Residents stated: "They come when they want to," "Sometimes wait about an hour," "If I do need assistance, it's anywhere from 45 minutes to an hour," " Ten or 15 minutes because we have no help," and, "I have to wait about 1/2 hour. I think they don't have enough help." 2. In a confidential resident interview held 01/04/00, at 9:40 AM, the resident stated, "I can't reach my call	F 241	1) On February 10, 2000 an in-service will be given to the Nurses and Certified Nursing Assistants by the Director of Nursing. Proper placement of the call lights, and answering them with a first contact should be done within a period of time not exceeding 5 minutes. 2) The Director of Staff Development will monitor the positioning and answering of the call lights by conducting a random survey which will be done no less than twice a week. This audit tool will detail room numbers, dates, and times. She will also sign the bottom of this form. A percentage of compliance will also be detailed at the bottom of each survey. This will be done for a period of one month. At the end of that period of time, if the success rate of 95% is reached, this survey will be conducted no less than once a month. Results of this monitoring will be reported to the QA committee, as well as Resident's Council.	3-24-00

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F 241	Continued From page 6 light. I have waited up to 4 hours. I call and it usually takes about an hour." In another confidential resident interview held 01/04/00, at 1:45 PM, the resident stated, "It takes an hour to an hour and one half to answer call lights. Sometimes they have someone else to take care of." 3. During a confidential family interview on 01/5/00, the family member stated that he had "quit using the call light" to get help for his loved one. The family member stated that "sometimes it can take up to 3 or 4 hours to get help, and by that time, she's been lying in that soiled diaper for hours. They just don't have enough help." The family member stated that lately he had been going to the nurses station to get help for his loved one. 4. On 1/4/00 at 11:00 AM, during a confidential interview with a resident's family, the family member reported, "There is never enough staff, but I guess that's the same everywhere". The family member reported observing an episode where the resident's roommate called for assistance to the bathroom. The roommate waited 30 minutes before the call light was answered. The family member stated, "It's a real emergency (when a resident needs assist to toilet)". The family member said, "They (residents) have to wear diapers, so they (the staff) say it's okay, but people don't want to do that (use the briefs instead of the toilet)." 5. In an interview with the Ombudsman held on 01/12/00, held at 9:00 AM, the surveyor was given a note from a personal planner page for November 2, 1999. The note stated, "Spoke with her about cares.	F 241	3) In addition, a family survey will be conducted by the receptionist each month. She will survey no less than 9 family members a month. Information from the survey will deal with how we are responding to call lights. 4) A Resident Survey will also be conducted by Social Services. She will survey no less than 9 Residents each month. Again, questions from the survey will deal with response time to call lights. Written results from both of these surveys will be presented at the QA meeting. 5) The Director of Staff Development, and Administrator will be responsible to ensure compliance.	

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F 241	Continued From page 7 Her issue was insufficient staff to toilet her. Said when she rings bell there is usually 15 - 20 minute wait. Sometimes has accidents, Sunday and Monday of this week. Says she wears disposable briefs to help if she doesn't get to the toilet in time. Said staff is always busy. Just need more help." 6. On 1/5/00 at 8:35 AM, a surveyor observed the call light to room 302 for 6 minutes before it was answered. While the call light was on, 3 aides and 2 other staff members were observed in the hallway. Two aides were observed, at different times, to walk past room 302 without acknowledging the call light. 7. On 01/11/00 the call light for room 302 was activated from 11:37 AM to 11:45 AM. This was a time span of eight minutes. 8. Resident 37 stated, " Often after meals I don't feel good and need to lie down. All the aides are often in the dining room. Sometimes I feel they are ignoring me. I have to wait 20 minutes to an hour." 9. Resident 37 had her call light between the sheets of her bed that had been made up for the day. This resident has restricted range of motion and could not reach the call light. 10. In the resident council minutes of July 1999, it states, "Lights are slow to be answered." In the minutes for April, it states, "Call lights in reach more often."	F 241		
F 252 SS=E	483.15(h)(1) Requirement ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to	F 252 		

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F 252	Continued From page 8 use his or her personal belongings to the extent possible. This Requirement is not met as evidenced by: Based on observations made 01/05/00, from 9:15 AM through 3:00 PM, it was determined that the facility had not provided residents with a safe and clean environment in 14 of 40 resident bathrooms. Rooms 100, 101, 103, 105, 203, 209, 211, 302, 307, 308, 310, 312, 313, 316. Other rooms were dirty or in need of repair. (Rooms 102, 107, 202, 206, 210, 212, 317, 400, 503, 506, and 507). Findings include: 1. Fourteen of 40 bathrooms had a common problem. The seams at the threshold to the bathroom were torn or unglued. They stuck up into the air and presented a potential hazard for a resident to stumble on them. 2. Other rooms were dirty or in need of repair. Room 102 had debris in the corner of the room and a buildup of dirt at the metal strip that covered the threshold seam. Room 107 had two pieces of urinal deodorant bar melting on the floor behind the toilet. Room 202 had plaster smears about one foot square above the rubber glove holder. It needed sanding and paint. Room 206, at the toilet base, there was a brown stain vertical from the top of the toilet base to the bottom. Room 210 had two tissues behind the toilet on the floor. Room 212 was missing a bolt cover on the base of the toilet presenting a hazard. Room 317 had a rubber glove on the floor and dirt particles on the tub floor. Room 400 had a water spill on the floor under the sink and holes in the East wall. Room 503 had plaster off the wall dividing the toilet and shower. Room 506 had a chest of drawers with handles	F 252	F-252 1) The Maintenance Supervisor will repair torn or unglued seams at the threshold to the bathrooms in the residents rooms 100, 101, 103, 105, 203, 209, 211, 302, 307, 308, 310, 312, 313, and 316. In room 202, he will repair the plaster above the rubber glove holder. In room 212, he will replace the missing bolt cover on the base of the toilet. In room 503, he will replace the plaster on the wall dividing the toilet and the shower. In room 506, he will repair a chest of drawers which has it's handles missing, and hook the drapes. In room 507, he will repair the missing floor cover at the threshold to the bathroom. 2) The Housekeeping Supervisor will clean resident rooms 102, 107, 206, 210, 317, and 400. 3) On February 10, 2000 the Housekeeping Supervisor will conduct an inservice for the housekeepers. She will educate them in the proper way to clean a residents room. She will present the housekeepers with a cleaning room checklist.	3-24-0

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F 252	Continued From page 9 missing. The drapes were unhooked, and a recliner had dirty arms with mats of dried food, spots and debris on it. There was a rust color buildup in the corner of the room. Room 507 had the floor cover missing at the threshold to the bathroom.	F 252	4) The Housekeeping Supervisor, and/or Maintenance Supervisor will monitor, by way of written audit tool. This audit will check for cleanliness, as well as items which need to be repaired. Items which need to be repaired will be corrected by Maintenance. This audit will detail dates, and times, as well as signed by the person conducting the survey. Rooms found to be unsatisfactorily cleaned, will be cleaned by the Housekeeping supervisor. This audit will be completed weekly for a period of one month, consisting of one wing per week. At that time, the audit will be done no less than once a month. Results of this audit will be reported at the QA meeting. 5) The Housekeeping Supervisor and the Administrator will be responsible to ensure compliance.	
F 254 SS=E	483.15(h)(3) Requirement ENVIRONMENT The facility must provide a clean bed and bath linens that are in good condition. This Requirement is not met as evidenced by: Based on observation, a confidential group interview, and a family interview, it was determined the facility did not provide clean bed linens that were in good condition. Findings include: 1. On 01/04/00 at 10:45 AM, a confidential group meeting was held. In this meeting, it was reported by 6 of 11 residents that bed linens do not get changed on the days of their bath schedule. Facility policy is to change linens on the days residents bathe and as needed. 2. On 01/3/00 at 1:15 PM, a family member stated that the resident's bed linens don't get changed. The family member lifted a quilted pad that she had placed on the bed to cover a 5 inch diameter brown stain near the center of the bedspread. A 3 inch diameter brown stain was observed to be near the foot of the bedspread. On 01/5/99, at 8:23 AM, the same markings were observed to be on the bedspread and pad on the resident's bed. On 01/6/00 at 9:00 AM, the same bedspread and pad were observed to be on the resident's bed.	F 254		

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F 254	Continued From page 10 3. On 01/5/00 at 8:50 AM, resident 50's bedspread was observed to be stained. The bedding was pulled back to reveal dark brown crumbs on the bottom sheet and a brown smear on the quilted pad in the bed. 4. On 01/05/00 at 11:50 AM, both residents 44 and 45 were observed to have large stains on their bed spreads. 5. The bed linens of resident 53 were observed 01 4 00 and 01 5 00. The sheets had 15 or more dried brownish colored streaks on them during both days.	F 254	F- 254 1) On February 10, 2000, the Director of Nursing will conduct an inservice for the Certified Nursing Assistants. She will educate the C.N.A.'s to change residents bedding on their bath days, or if it is dirty. 2) The Assistant Director of Nursing will conduct a weekly written audit, to determine the cleanliness of the Resident's linen. This audit will be random, and include no less than 12 rooms. This audit will be dated, as well as indicate the time which it was completed. The ADON will also sign the bottom of the audit tool. Findings of this survey will be reported at the bottom of the form by way of %. When the goal of 95% has been reached, this audit will be completed no less than one time per month. Results of this audit will be shared each month with the QA committee.	3-24-00
F 312 SS=E	483.25(a)(3) Requirement QUALITY OF CARE A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This Requirement is not met as evidenced by: Based on observation, a confidential group interview, review of the aides flow sheets for the month of December 1999, and review of the aides flow sheets for 6 of 18 sample residents, it was determined that the facility failed to carry out the bath schedules for residents and failed to provide necessary services for eating and "cares every shift". Residents: 4, 10, 29, 43, 53, 66 and 71. Findings include: 1. In a confidential group meeting held 01/04/00, at 10:45 AM, 6 of 11 residents reported that they didn't receive a bath when it was scheduled. 2. A review of 27 aide flow sheets, at random, for	F 312		

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	465069	A. BUILDING ____ B. WING ____	1/13/00

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F 312	Continued From page 11 the month of December 1999, where the bath schedule and the recording of baths appear, bath schedules were missed as follows: a. Missed 3 to 5 times = 3 residents b. Missed 6 to 8 times = 6 residents c. Missed 9 or more times = 9 residents Only 3 of 27 were bathed on schedule. 3. Review of the aides flow sheets for 4 sample residents, where the bath schedule and the recording of baths appear, bath schedules were missed as follows: a. Resident 4, with a Stage II skin breakdown on her coccyx during this time, was to have a whirlpool bath (CT) on Thursdays. Resident 4 missed one bath in each of September, October, and November 1999. Missing of one bath meant this resident went without a bath for two weeks. b. Resident 10, with a Stage II skin breakdown on his coccyx during this time, was to have a "CT every day until healed before treatment". Resident 10: missed 5 of 12 from January 1-12, 2000; missed at least 16 in December, 1999; missed 3 in November, 1999; missed 9 in October, 1999; missed 7 in September, 1999; missed 12 in August, 1999; and missed at least 11 in July, 1999. Baths were missed 1 to 6 days in a row. c. Resident 29 was scheduled to bathe on Monday, Wednesday, and Friday. Resident 29: missed 6 times in December, 1999, and went 7 to 8 days between bathing; missed one in November, 1999; and missed four in October, 1999.	F 312	3) The Housekeeping Supervisor will audit the condition of the residents bedding weekly, by way of a written audit tool. This tool will detail the date, and time of the audit, and signed by the Housekeeping Supervisor. If the bedding is in poor condition, she will immediately replace it. Bedding that is in poor condition will be discarded by the laundry staff, and new bedding will be ordered by the Housekeeping Supervisor to replace it. An inservice by the Housekeeping Supervisor will be held on February 10, 2000 for all of the laundry staff to educate them on this process. Totals of compliance will be calculated at the bottom of this audit tool. When a success rate of 95% has been achieved this audit will then be completed no less than once a month. The results of this audit will be shared with the QA committee. 4) The Housekeeping Supervisor, and Administrator will be responsible to ensure compliance.	

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F 312	Continued From page 12 d. Resident 71, due to skin grafts on her legs was to have a bed bath on Monday, Wednesday, and Friday. Resident 71 missed three baths in November, 1999, and one bath was a day late. She missed a bed bath six days in a row from 11/23 through 11/28/99. 4. Review of the aides flow sheets revealed two pages where the aides documented information. Page one identified specific care areas and page two may identify more specific care areas, depending upon the individual resident, as well as a section entitled, "Cares q shift." On 1/25/00, during an interview with an aide, she stated that "cares q shift" included the specific mentioned cares identified on page 1 and all the other cares a resident needed but were not specifically identified on page one. The aide further stated that this section must always be completed even if there was documentation on page one since it included the cares not specifically mentioned. She stated that "cares q shift" included items such as oral care, pericare, nail care, shaving for both men and women, combing of hair, assisting with makeup, washing out eyes in the morning, etc. On 1/25/00, during an interview with the nursing staff in charge of the aides, this staff person stated that each specific care was to be initialled (on page one) and that the "care q shift" (on page two) was to also be initialled. The section "Care q Shift" was specifically for the initials of the aide responsible for providing the care to that resident since there was not space available by each of the specific care areas on the flow sheet for the aide's initials. She stated, "If the initials are not there, assume the cares are not done. If not signed (documented), not done." Review of the aides flow sheets and the section entitled, "Cares q (every) shift", and the recording of cares being done for 4 of 18 sample residents, revealed the following:	F 312	F-312 1) On February 10, 2000 an in-service will be given by the Director of Nursing to the Certified Nursing Assistants. Following Resident bath schedules, proper charting in the C.N.A. flow sheets, and turning and repositioning our Residents will be discussed. 2) On February 25th, 2000 an inservice will be conducted by the D.S.D. and Administrator to discuss peri care, oral care, nail care, shaving, hair care, and assistance with meals. 3) For Residents 4, 10, 29, 43, 53, 66, and 71, as well as all other residents, the Director of Staff Development will be responsible for monitoring the Certified Nursing Assistant flow sheets weekly to ensure that the baths, as well as personal care as detailed above, have been completed. To indicate monitoring, the D.S.D. will sign, as well as note time and date, those flow	3-24-00

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F 312	Continued From page 13 a. Resident 4: missed 29 of 90 "cares q shift" in November, 1999; missed 28 of 93 in October, 1999, and missed 33 of 90 in September, 1999. b. Resident 10: missed 9 of 36 between 01/01-12/00; missed at least 33 of 93 in December, 1999, with 1-3 days in a row and 1 day without cares by any shift; missed 33 of 90 in November, 1999, with up to 5 days in a row and 4 days without cares by any shift; missed 32 of 90 in October, 1999, with up to 5 days in a row and 1 day without cares by any shift; missed 40 of 90 in September, 1999, with up to 7 days in a row and 3 days without cares by any shift; missed 31 of 93 in August, 1999, with up to 4 days in a row and 1 day without cares by any shift; and missed 36 of 93 in July, 1999, with up to 3 days in a row and 3 days without cares by any shift. c. Resident 29: missed 12 of 93 in December, 1999, with 1-3 days in a row; and missed 15 of 93 in October, 1999, with 1-3 days in a row. d. Resident 71: missed 50 of 90 in November, 1999, with from 1 to 7, 8, and 9 days in a row, and 6 days without cares by any shift. The missing of baths and other cares detracts from residents' abilities to reach or maintain their highest practicable level of functioning. 5. Resident 66 was a 99 year old female with diagnoses of dementia and arthritis. The Food Service Supervisor's annual weight tracking record documented resident 66's last weight to be 85.5 pounds on 1/6/2000.	F 312	sheets as detailed above. This audit will continue until a 95% success can be determined by the QA committee, at which time will be reduced to a once a month audit. 4) The Director of Staff Development will monitor, by way of written audit tool, to see that the personal cares as detailed above are being completed. This audit will be completed weekly, and will include a random sample of at least 20 residents. When a success of 95% has been reached, this audit will be reduced to once a month. When substandard results are noticed, the Director of Staff Development will immediately review proper care techniques with the responsible Certified Nursing Assistant. Results of this audit will be shared with the Q.A. Committee. 5) The Administrator and Director of Nursing will be responsible to ensure compliance.	

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The resident was identified on her Minimum Data Set (MDS) dated 10/33/99, as needing total assistance for eating. The MDS also identified resident 66 as having limited range of motion to her arms and hands bilaterally, full loss of voluntary movement to her arms, and partial loss of voluntary movement to her hands.

Resident 66's plan of care dated 10/21/99, problem #2, addressed "chewing and swallowing difficulties with need for mechanically altered foods". The care plan goal was that resident 66 "will have no choking episodes". Care plan interventions for problem #2 were identified as:
1. Pureed diet
2. Monitor chewing and swallowing abilities
3. Monitor dietary intake q (every) meal
4. Monitor weight q (every) month
5. IBW (ideal body weight) 115, usual 100, admit 2/96 = 89, 4/97 = 90, 3/98 = 88, 2/99 = 92
6. Snacks 10-2-HS (Bedtime)
7. HN (nutritional supplement) qid (four times daily)

Problem #3 of the same care plan identified resident as totally dependent on staff for eating. The goal was for the resident's weight not to decrease below 80 pounds.

Resident 66 was observed, on 01/5/00 from 8:05 AM through 8:47 AM. At 8:05 AM the resident was observed sleeping in her bed with full side rails up on both sides. A regular textured breakfast tray was near her bed on her overbed table. At 8:13 AM, a nurse aide was observed to bring a second tray of beverages and pureed food into the room. No attempt was made to waken or to feed the resident at that time. During the time period between 8:05 AM and 8:47 AM, the aide was observed to remain in resident 66's room for

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2 minutes prior to removing the full breakfast tray at 8:47 AM.

An interview was conducted on 01/5/00 with the 2 pool nurse aides (temporary contracted staff) responsible for the hall on which resident 66 resided. Both nurse aides stated that they had not worked with the residents before. They stated the only orientation they received before working with the residents on the hall was, "Who gets up themselves, who needs assist to get up, and who needs 2-person assist, and thats about it".

A confidential interview was conducted on 01/5/00 with a nurse aide. She stated the "pool aides usually work the 300 hall because that is where they are usually short".

On 1/5/00 at 10:17 AM, nutritional supplements were delivered to the hall on which resident 66 resides. At 11:07, resident 66's carton of Resource nutritional supplement was observed to be at her bedside, unopened. At 1:00 PM, the same carton of Resource was observed to be unopened and at her bedside.

6. Resident 43 was a 45 year old male who was admitted to the facility on 5/23/97 with the diagnoses of multiple sclerosis, unspecified protein-calorie malnutrition, chronic obstructive pulmonary disease, paralytic syndrome, and cauda equise syndrome with neurogenic bladder.

The MDS (minimum data set) for resident 43, a mandatory comprehensive assessment of the resident completed by qualified facility staff, dated 9/22/99 and 12/17/99, documented that resident 43:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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- needed extensive assistance with bed mobility (how the resident moves to and from lying position, turns side to side, and positions body while in bed)

- was totally dependent upon staff for transferring (how the resident moves between surfaces - to/from: bed, chair, wheelchair, standing position)

- was totally dependent upon staff for toilet use, bathing, dressing and personal hygiene

- was not verbally or physically abusive, was not socially inappropriate and did not resist care

During interview with a nurse on 1/12/00, she stated that resident 43 had never refused to turn or reposition when she had offered to assist him.

During an interview with a facility aide on 1/12/00, the aide stated that he/she had worked at the facility over 8 months. The aide stated that there was "definitely a problem with lack of staff" and that there were "many times we haven't been able to do baths, change briefs (incontinence pads) or provide turning and repositioning due to lack of staff." When asked specifically about resident 43, the aide stated that there "were times when he wasn't changed or repositioned like he should have been - sometimes for four hours or more." The aide continued to state that resident 43 had "never refused to be repositioned or turned", "never refused to be moved from his chair to his bed" and was "usually the one who requests to be put in bed or repositioned."

During another interview with a facility aide on 1/13/00, the aide stated that he/she had worked at the facility over 6 months. The aide stated that "there

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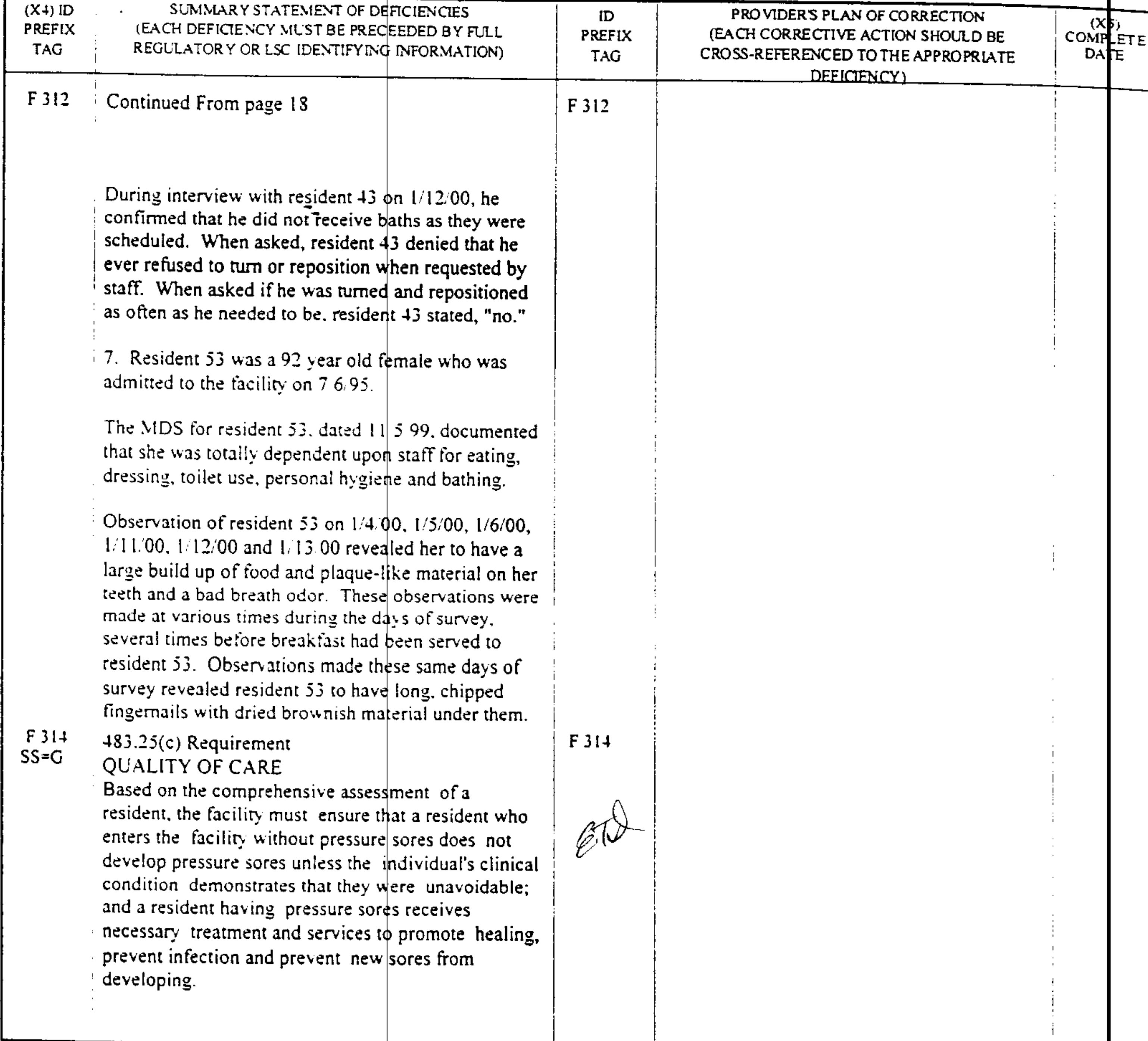
have been many times we've been short staffed." When the aide was asked how this affected the care provided in the facility, the aide stated, "not being able to get to turning and repositioning or incontinence care and hardly ever getting to oral care." When asked specifically about resident 43, the aide stated that there were times they "didn't turn him or change him because there wasn't enough help." The aide stated that resident 43 "doesn't refuse to turn or reposition."

Observation of the inner mouth of resident 43 on 1/4/00, 1/5/00, 1/6/00, 1/11/00, 1/12/00 and 1/13/00 revealed him to have very red gums with a large build up of yellow and brown plaque-like material on his teeth and a bad breath odor.

Review of the October 1999 Flow Sheet record for resident 43 revealed that he received a total of 4 baths that month. Baths on the Flow Sheet were scheduled to occur every Tuesday, Thursday and Saturday. Resident 43 should have received a total of 13 baths in October 1999, not 4.

Review of the November Flow Sheet record for resident 43 revealed that he received a total of 5 baths that month. Baths on the Flow Sheet were scheduled to occur every Tuesday, Thursday and Saturday. Resident 43 should have received a total of 13 baths in November 1999, not 5.

Review of the December 1999 Flow Sheet record for resident 43 revealed that he received a total of 6 baths that month. Baths on the Flow Sheet were scheduled to occur every Tuesday, Thursday and Saturday. Resident 43 should have received a total of 13 baths in December 1999, not 6.



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F 312	Continued From page 18 During interview with resident 43 on 1/12/00, he confirmed that he did not receive baths as they were scheduled. When asked, resident 43 denied that he ever refused to turn or reposition when requested by staff. When asked if he was turned and repositioned as often as he needed to be, resident 43 stated, "no." 7. Resident 53 was a 92 year old female who was admitted to the facility on 7/6/95. The MDS for resident 53, dated 11/5/99, documented that she was totally dependent upon staff for eating, dressing, toilet use, personal hygiene and bathing. Observation of resident 53 on 1/4/00, 1/5/00, 1/6/00, 1/11/00, 1/12/00 and 1/13/00 revealed her to have a large build up of food and plaque-like material on her teeth and a bad breath odor. These observations were made at various times during the days of survey, several times before breakfast had been served to resident 53. Observations made these same days of survey revealed resident 53 to have long, chipped fingernails with dried brownish material under them.	F 312		
F 314 SS=G	483.25(c) Requirement 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.	F 314		

FORM APPROVED

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This Requirement is not met as evidenced by:
This is a repeat deficiency from the 10/27/99 abbreviated complaint survey.

Based on observation, interviews, review of resident medical records, and review of the facility's plan of correction for the 10/27/99 survey, it was determined that the facility did not follow their plan of correction. It was also determined that for 2 of 18 sample focus residents, the facility did not ensure that a resident without pressure sores did not develop pressure sores and did not ensure that a resident having pressure sores receives necessary treatment and services to promote healing. Resident identifiers: 43 and 26.

Findings include:

1. Resident 43 was a 45 year old male who was admitted to the facility on 5/23/97 with the diagnoses of multiple sclerosis, unspecified protein-calorie malnutrition, chronic obstructive pulmonary disease, paralytic syndrome, and cauda equise syndrome with neurogenic bladder.

Resident 43 was found to have a stage 2 pressure sore to his coccyx on 1/4/00. The facility was not aware of the stage 2 pressure sore to the coccyx of resident 43 until it was identified by the registered nurse surveyor on 1/4/00.

Facility staff did not notify resident 43's physician of the stage 2 pressure sore to the coccyx of resident 43 until 1/13/00, nine days after they became aware of it. Facility staff did not obtain an order to treat the stage 2 pressure sore to the coccyx of resident 43 until 1/13/00, nine days after they became aware of it. The physician was not made aware of resident 43's pressure sore until 1/12/00 when the registered nurse

Provider's Plan of Correction — F-314

1) On February 10,2000 and inservice will be given to the Nurses and the Certified Nursing Assistants by the Director of Nursing. She will discuss DQ staging and wound care.

2) For Residents 26 and 43, a complete skin integrity check will be preformed weekly by the Care Plan Coordinator. This will be by way of a written tool, signed and dated. This weekly/monthly monitoring will be in addition to the weekly skin checks preformed by the nurses. Information will be reported to the nurse caring for these residents, as well as the wound care team which meets no less than once a month. Physician notification and orders will be given to treat these DQs, and if ordered, pressure reliving devices will be used. Turning and positioning sheets will be filled out for residents 26 and 43 by the Certified Nursing Assistants.

Mt. Ogden Nursing & Rehab
Wound & Skin Assessments
Policy & Procedures For Assessing Wounds & Skin

Basic Responsibility: Licensed Nurse
Procedure Performed By: R.N., L.P.N.

Purpose:

1. To promote skin integrity.
2. To prevent wounds and skin breakdown.
3. To promote healing of existing wounds.
4. To seek treatment as soon as possible.

Procedure:

1. Braden Risk Assessment: To be completed on all new admissions within 24 hours, then monthly if compromised in skin integrity. Then placed on skin flow sheet to be checked no less than once a week. The Assistant Director of Nursing will be responsible to see that these are complete.
2. Wound and High Risk Residents: When the resident scores 14 or less on the Braden Scale, or if they have a pressure ulcer or other wound, the Nurse will fill out the Wound Team Evaluation Request form and turn it into the Director of Nursing. The Director of Nursing will notify the Dietary Manager so that the nutritional needs can be adjusted if necessary.
3. Wound Care Team: Consisting of the Director of Nursing, Assistant Director of Nursing, Care Plan Coordinator, Dietary Manager, Dietary Consultant. This team will perform an evaluation of the wound, and recommend a course of treatment within 48 hours of their meeting.
4. The D.O.N., and Dietary Manager will receive copies of these recommendations.
5. Contacting the Physician: The nurse caring for the resident will contact the resident's physician regarding the wound team's recommendations if changes are necessary. If there has been significant change, a family member shall also be called. New orders, if any, shall be followed. No treatment changes will be made without consulting with the Wound Care Team, unless specific orders are given by the attending physician.
6. Treatment and Dressing Changes: Will be performed by the attending Nurse.
7. Weekly Skin Assessments: Will be performed by the nurse no less than every 3 months, and placed in their chart.
8. Physical Therapy will assess and evaluate the need for pressure relieving devices, as well as disbursement. They will also initiate the telephone order implication, and follow through.
9. When the wound is not healing properly, or if any other significant changes occur, the Wound Care Team will reevaluate the wound, notify the physician for possible new orders.

10. Refer to "Smith and Nephew - Pharmaceutical Wound Care Protocol" for staging & interventions of D.Q.'s.
11. The Nurse should complete the documentation as outlined on the skin care and pressure record, as defined by Smith and Nephew.
12. Skin breakdown referrals from the nursing staff will be evaluated during the following Wound Care meeting. However, should the nurse feel that a quicker response is necessary, an immediate call can be made to the physician.
13. The Wound Care team will make recommendations, via the nurse, to the Physician regarding pressure relieving devices if appropriate.

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F 314	Continued From page 20 surveyor called him to discuss the resident. During the telephone interview with the physician on 1/12/00, the physician denied knowing of a pressure sore to the coccyx of resident 43. The physician also denied giving the order for "duoderm" which was found on the January 2000 treatment record for resident 43. Facility staff were not consistently providing treatment and services to promote healing of the pressure sore. From the first observation of the pressure sore by the RN surveyor on 1/4/00 to the last observation performed prior to exit on 1/13/00, the stage 2 pressure sore had increased in size from .25 cm (centimeter) by .25 cm to 1 cm by .5 cm. Of the four different days the pressure sore was observed (1/4/00, 1/5/00, 1/12/00 and 1/13/00), the pressure sore to the coccyx of resident 43 had a dressing on it only one day (1/5/00). The pressure sore was not observed to have protective cream on it during any of the four days of observation. The MDS (minimum data set) for resident 43, a mandatory comprehensive assessment of the resident completed by qualified facility staff, dated 9/22/99 and 12/17/99, documented that resident 43: - needed extensive assistance with bed mobility (how the resident moves to and from lying position, turns side to side, and positions body while in bed) - was totally dependent upon staff for transferring (how the resident moves between surfaces - to/from: bed, chair, wheelchair, standing position)	F 314	3) The Wound and Skin Committee will make recommendation for the above residents, as well as other residents, and follow up information will be given to the attending nurse for follow up with the physician. When the Wound Care Tem has determined that the skin integrity has been restored with these two residents, their audit will be changed to once a month. 4) Our facility will follow the "Wound and Skin Assessments " policy and procedures for assessing wounds and skin. (See enclosed.) 5) The Care Plan Coordinator and the Administrator will be responsible to ensure compliance.	

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F 314	Continued From page 21 - was totally dependent for toilet use and personal hygiene - had no ulcers (either pressure or stasis) - was not verbally or physically abusive, was not socially inappropriate and did not resist care On 1/3/00, a facility nurse had documented on the weekly skin monitoring sheets that resident 43 had a stage 1 red pressure area to his coccyx which measured 1/4 cm. On 1/4/00, the registered nurse surveyor and a facility registered nurse performed a skin check of resident 43. Resident 43 was found to have a stage 2 pressure sore on his coccyx which measured approximately .25 cm by .25 cm. The 300 hall nurse, who had documented the presence of the red pressure area the day before, was asked if she was aware that the pressure sore had progressed and was now open at a stage 2. The 300 hall nurse replied that she was not aware that the wound was a stage 2 and stated that she would "take care of it." On 1/5/00, the registered nurse surveyor checked the chart of resident 43. The nurse's notes, dated 1/4/00, documented "Pt. (patient) has DQ (decubitus ulcer/pressure sore) 1/4 X (by) 1/4 in circumference - Dr. (resident's physician) Notified - See Orders - Duoderm applied - tx (treatment) to chg (change) q (every) 3rd day until resolved." Upon review of the medical record of resident 43, the surveyor observed that there were no orders from the physician regarding the pressure sore. However, within the 300 hall treatment book on a page	F 314		

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designated solely for resident 43, the following was written "1-4-00 Duoderm chg (change) q (every) 3rd day and PRN (as necessary) until resolved." The area identified for this treatment was the coccyx. Observation of resident 43's coccyx area on 1/5/00, revealed that it was covered by a duoderm dressing but that the dressing was rolling back upon itself causing an additional area of pressure to the resident's skin.

During the mini exit on 1/5/00, the Director of Nurses (DON) and the Administrator were notified that a physician's order for the treatment of the stage 2 pressure sore to the coccyx of resident 43 could not be found in the resident's chart.

On 1/12/00, another skin check was performed on resident 43 with a facility nurse. It was observed that the stage 2 pressure sore had increased in size, from the .25 cm by .25 cm on 1/4/00, to 1 cm by.25 cm. The stage 2 pressure sore was not covered by a dressing nor did it have any protection cream on it. The resident had some fecal material within his gluteal fold near the open pressure area. The lack of a dressing on the pressure sore of resident 43 was confirmed with the facility nurse.

On 1/12/00, the January 2000 treatment record for resident 43 was reviewed. The dressing changes to the coccyx of resident 43 had been scheduled by nursing staff to be performed on 1/4/00, 1/7/00, and 1/10/00. The scheduled changes on 1/4/00 and 1/7/00 had been signed as having been performed. The scheduled change for 1/10/00 had not been signed as having been performed. Resident 43, who was alert and oriented, was interviewed regarding the pressure sore to his coccyx and was asked when he

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last had a dressing on it. Resident 43 replied, "There hasn't been a dressing on it for days and days." When asked if staff had applied any protective cream to his coccyx, resident 43 replied, "maybe once".

During a telephone interview with the physician of resident 43 (also the facility's medical director) on 1/12/00 at 2:00 PM, the physician was asked if he was aware that resident 43 had a stage 2 pressure ulcer on his coccyx. The physician stated that he was "not aware", that he "had not been told" of the pressure sore to the coccyx of resident 43. When the physician was asked if her had ordered anything to treat the pressure sore, the physician stated, "no". The physician was informed that a nurse's note in the chart of resident 43 stated that he had been notified on 1/4/00 and orders for duoderm had been received. The physician stated that possibly the nurse had notified his office. The RN surveyor asked if his office would have given orders to treat the pressure sore. The physician stated, "no".

During interview with the 300 hall nurse on 1/12/00 at approximately 3:00 PM, she was asked if she had resident 43 scheduled for a dressing that day. The nurse replied that she did not because there were no orders to treat the pressure sore. The nurse stated that she was going to contact the resident's physician and get orders for the pressure sore.

On 1/13/00, another skin check of resident 43's coccyx was performed with a facility aide. It was observed that the stage 2 pressure sore had increased, from 1 cm by .25 cm on 1/12/00, to 1cm by .5 and appeared to be branching off in two additional areas. The pressure sore was again observed without a dressing or protective cream. Review of the medical

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record of resident 43 on 1/13/00 revealed that there continued to be no orders to treat the stage 2 pressure sore to his coccyx. The DON was made aware that there continued to be no orders to treat the pressure sore on resident 43. The DON confirmed that she, too, could not find orders to treat the current stage 2 pressure sore.

During interview with the 300 hall nurse on 1/13/00 at approximately 2:00 PM, she stated that she had called the physician of resident 43, had obtained orders to treat the stage 2 pressure sore to his coccyx and was proceeding to do the treatment.

Lack of services to prevent pressure sores and promote healing of the existing pressure sore:

During interview with a nurse on 1/12/00, she stated that resident 43 had never refused to turn or reposition when she had offered to assist him.

During an interview with a facility aide on 1/12/00, the aide stated that he/she had worked at the facility over 8 months. The aide stated that there was "definitely a problem with lack of staff" and that there were "many times we haven't been able to do baths, change briefs (incontinence pads) or provide turning and repositioning due to lack of staff." When asked specifically about resident 43, the aide stated that there "were times when he wasn't changed or repositioned like he should have been - sometimes for four hours or more." The aide continued to state that resident 43 had "never refused to be repositioned or turned", "never refused to be moved from his chair to his bed" and was "usually the one who requests to be put in bed or repositioned."

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During another interview with a facility aide on 1/13/00, the aide stated that he/she had worked at the facility over 6 months. The aide stated that "there have been many times we've been short staffed." When the aide was asked how this affected the care provided in the facility, the aide stated, "not being able to get to turning and repositioning or incontinence care and hardly ever getting to oral care." When asked specifically about resident 43, the aide stated that there were times they "didn't turn him or change him because there wasn't enough help." The aide stated that resident 43 "doesn't refuse to turn or reposition."

Review of the December 1999 Flow Sheet record for resident 43 revealed that he received a total of 6 baths that month. Baths on the Flow Sheet were scheduled to occur every Tuesday, Thursday and Saturday. Resident 43 should have received a total of 13 baths in December 1999, not 6.

During interview with resident 43 on 1/12/00, he confirmed that he did not receive baths as they were scheduled. When asked, resident 43 denied that he ever refused to turn or reposition when requested by staff. When asked if he was turned and repositioned as often as he needed to be, resident 43 stated, "no."

The care plan for resident 43 was reviewed several times during the survey process, with the last review on 1/13/00. The care plan for resident 43 included the problem of "Potential for Alteration in Skin Integrity" which had not been updated to reflect the actual skin breakdown from 11/7/99 to 11/24/99 or the actual skin breakdown observed 1/4/00. Several of the interventions for this care plan included:

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F 314	Continued From page 26 - Notify MD with questions and concerns. - Treatment per orders. - Keep skin clean and dry. - Turn and reposition every 2 hours and as necessary. The facility did not provide treatment and services to prevent development or promote healing of the stage 2 pressure sore on the coccyx of resident 43. The facility did not follow the care plan for "Potential for Alteration in Skin Integrity". The facility did not notify the MD with questions and concern regarding the stage 2 pressure sore to the coccyx of resident 43 for 9 days after they became aware of it. The physician only became aware of the stage 2 pressure sore on 1/12/00 because the RN surveyor called him to inquire about resident 43. The facility did not obtain orders to treat the stage 2 pressure sore to the coccyx of resident 43 until 1/13/00, 9 days after they became aware of the pressure sore. Based on observation of resident 43 on 1/4/00 and 1/5/00 soiled with feces, interview with two nurse aides, interview with resident 43 and review of the 12/99 flow sheet record for resident 43, the facility did not keep the resident clean and dry as written in the care plan. Based on interviews with resident 43 and 3 facility staff, the facility did not provide turning and repositioning every 2 hours and as necessary as written in the care plan. 2. Resident 26 was a 93 year old female who was readmitted to the facility on 5/6/99 with the diagnoses of cerebrovascular disease, hypertension, Parkinson's disease, coronary artery disease, hypothyroidism, and sick sinus syndrome with a pacemaker. The MDS (minimum data set) assessment dated 11/11/99 documented that resident 26 had developed	F 314		

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a Stage II pressure ulcer. The treatment record dated November, 1999, documented the Stage II pressure ulcer on her coccyx as being healed on 11/15/99. The Braden Scale, dated 11/24/99, identified resident 66 as being at moderate risk for pressure ulcers.

Resident 26 was identified on 01/02/00 as acquiring a Stage II pressure ulcer on her coccyx. A review of the 24-hour nursing report, physician's orders, treatment sheets, and nurses' progress notes evidenced the following:

01/02/00 - resident 26 was identified as having a "split" Stage II pressure ulcer as reported by the day shift nurse on the written 24 hour report which was provided to the Director of Nurses (DON). The day shift nurse wrote that she was going to have a nurse call the physician on 01/03/00. Nurses' progress notes for 01/02/00 indicated that the resident's "skin (was) warm and dry". There was no notation about a pressure ulcer or changes in treatment.

01/03/00 - Nurses progress notes dated 01/3/00 at 6:50 PM documented the following: "CNA (certified nurse aide) states open area on coccyx. Noc (night) shift nurse to assess. AM nurse of (off) duty and resident up in chair. Noc shift nurse will assess".

01/03/00 - A physician's telephone order was obtained 01/03/00 at 8:00 PM for "Duoderm to Stage II skin breakdown on coccyx - change q (every) 3 days and prn (as needed) until healed - monitor daily". There were 25 hours between the time the 1/2/00 day nurse identified the pressure ulcer on the 24-hour report until the night nurse notified the physician and obtained a treatment order on 1/3/00.

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01/05/00 - Nurses' progress note dated 01/05/00 at 11:00 PM documented 2 new skin problems of .25 cm reddened circular areas on resident 26's right outer heel and on her mid left heel. The nurse noted the resident's heels were elevated off the bed and lotion was applied. She also documented the resident's hands were examined with no redness nor open areas found.

01/06/00 - Observation of resident 26 at 10:30 AM by facility nurse and 2 nurse surveyors revealed a 1 cm x .3 cm Stage II pressure ulcer in the gluteal fold at her coccyx. On her right heel there was a 4 cm diameter red Stage I pressure ulcer with a 2 cm x 1.5 cm white inner circle with a darkened center. On her left heel was 3.5 cm x 4 cm reddened area with a .5 cm x .3 cm. grayish area at the center. A .25 cm open linear lesion within a .5 cm reddened area was observed on the second knuckle of her left ring finger. Observation on 01/06/00 revealed that there was no pressure relieving device on her bed.

01/06/00 - At 7:00 PM on 01/06/00, a nurse noted a telephone order to "1) turn q 2 hours while in bed, 2) heel protectors on at all times - suspended heel - theraboot to be ordered, 3) gel mattress, 4) hand splints per RTA (restorative therapy aide)".

Failure to Follow the Plan of Correction:

The facility alleged substantial compliance with the long term care regulations on 12/27/99.

The follow-up to the abbreviated complaint survey of 10/27/99 and the annual recertification survey were completed simultaneously from 1/3/00 through 1/13/00.

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F 314	Continued From page 29 The facility did not follow their plan of correction for the 10/27/99 survey based on the following: Paragraph 1 of the plan of correction stated, "Upon admission...nursing will also complete a 'Braden Scale - For Predicting Pressure Sore Risk' form. That will determine if the resident is a high, moderate, or low risk for pressure sores. The Care Plan Coordinator will gather the information to determine if it needs to be addressed on the plan of care." During interview with the Director of Nurses (DON) on 1/11/00 at 3:16 PM, she stated that as per facility policy, "upon admission" means within 24 hours. Three residents were admitted to the facility after the facility claimed compliance on 12 27 99. Resident 11 was admitted on 12 31 99. A Braden Scale assessment was completed on 12/31/99. Resident 91 was admitted on 1 4 00 and passed away on 1/8/00. Resident 91 was admitted with multiple pressure sores, some at stage 4. A Braden Scale skin assessment was not completed for resident 91 before she died. This was confirmed with the DON and the care plan coordinator on 1 11 00. Resident 7 was admitted to the facility on 1/4/00. As of 1/11/00, the facility had not yet completed a Braden Scale skin assessment as mentioned in the plan of correction. On 1 12 00, the care plan coordinator reported to the surveyor that the Braden Scale skin assessment for resident 7 had now been	F 314		

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completed by her.

The Care Plan Coordinator did not gather the (Braden Scale) information to determine if needs would be addressed on the plan of care because nursing did not complete the Braden Scale skin assessments for 2 of the 3 admissions.

Paragragh 2 of the plan of correction stated,

"The 'Braden Scale - For Predicting Pressure Sore Risk' form will be filled out by nursing on residents quarterly and if there is a significant change in condition. The Care Plan Coordinator will assess from that form if any changes need to be made to the residents plan of care."

The 15 current medical records of the focus sample were reviewed for quarterly Braden Scale skin assessments. Two of the 15 records (residents 40 and 53) did not have the quarterly Braden Scale skin assessments completed as per the plan of correction.

Resident 40 had been admitted to the facility on 8/3/99. A Braden Scale skin assessment form was found in the medical record of resident 40. The Braden Scale skin assessment had not been completed by nursing staff, was not dated, and was blank on both sides of the form. A Braden Scale skin assessment was not performed upon admission. There were no other Braden Scale skin assessments for resident 40. A quarterly assessment for resident 40 should have been performed on 11/3/99. As of 1/5/00, resident 40 had a stage 2 pressure sore.

Resident 53 was admitted to the facility on 7/6/95. As of 1/5/00, during observation of resident 53, she had 3

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pressure sores which were facility acquired. The last Braden Scale skin assessment completed for resident 53 was dated 8/28/99. A quarterly Braden Scale skin assessment should have been completed, per the plan of correction, on 11/28/99.

Paragraph 3 of the plan of correction stated,

"A skin care and pressure ulcer assessment will be done by nursing on each resident weekly. That assessment will include: A) if there is any noticeable alterations in skin integrity , or B) for pressure sores and would the assessment would include size, site, drainage, color, odor, granulation, and if the wound was healing or not. The Director of Nursing would review the assessments weekly and note any changes in the skin integrity of the residents. Significant changes would be passed on to the Care Plan Coordinator and the Inter Disciplinary Team and appropriate changes made in the plan of care."

The 15 current medical records of the focus sample and all treatment books were reviewed for weekly skin care and pressure ulcer assessments. Two of the 15 residents (residents 26 and 39) did not receive weekly skin care and pressure ulcer assessments as per the plan of correction.

On the weekly skin care and assessment sheet for resident 26, it was documented that she had a stage 2 pressure sore which resolved on 11/7/99. Skin checks were performed on resident 26, by nursing staff, on 11/14/99, 11/17/99, 12/8/99, 12/12/99 and 12/15/99. No skin checks were documented as being performed between 12/15/99 and 1/3/00, a total of 18 days. When a skin care and pressure ulcer assessment was performed on 1/3/00, nursing staff documented that

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resident 26 had a stage 2 pressure sore on her coccyx.

Resident 39, who had a recent history of a pressure sore to his buttocks, last received a skin care and pressure ulcer assessment on 12/27/99. The next weekly assessment should have been performed on 1/3/00, but was not.

Paragraph 4 of the plan of correction stated,

"On November 24, 1999 an inservice will be given to Nursing Staff. This will be given by the Care Plan Coordinator and the Staff Coordinator. The topic will include necessary care and services related to pressure sores to improve quality of care. The Care Plan Coordinator will educate staff about pressure sores on the care plan and the interventions that are included on a problem on a resident care plan. This would include, but not be limited to: Medication as ordered. Turn and reposition every 2 hours. Changing of incontinence pad of briefs when soiled. Monitor for signs and symptoms of skin breakdown. Encourage rest period out of wheelchair during waking hours. Notify M.D. Duoderm. Pressure relieving devices. The inservice would explain the importance of nursing staff following the interventions on the care plan to improve skin integrity."

When the DON was interviewed on 1/4/00 regarding the inservice on pressure sores mentioned in the plan of correction, she presented four pressure sore inservices that had been given dated 10/28/99, 12/9/99, 12/10/99 and 12/23/99. A list of nurses who had worked in the facility during November and December 1999 was obtained from the facility personnel department. After reviewing all of the

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participants from the four pressure sore inservices and then reviewing the list of nurses from personnel, it was determined that 1 of the 5 registered nurses and 6 of the 11 licensed practical nurses had not attended any of the four inservices. (Nurses 3, 6, 9, 10, 12, 15 and 16) When interviewed on 1/6/00 at 9:47 AM, nurse 16 stated that she had been hired "near the second week in November (1999)" and had "not attended any inservices as of yet."

Paragraph 5 of the plan of correction stated,

"The Staff Coordinator will continue to monitor, educate, and train staff weekly on proper skills to improve skin integrity and quality of care. Results of this monitoring will be brought up at monthly Quality Assurance meetings."

The Staff Coordinator was interviewed 1/13/00 at 3:00 PM. She stated that she had taken over the position of Staff Coordinator "about 12/12/99". When asked to show documentation on how she had been monitoring, educating and training staff weekly on proper skills to improve skin integrity and quality of care, she stated that she was "not aware this was my responsibility." When asked if, upon accepting the position of staff coordinator, she had been told of her role required in the plan of correction, she stated, "no."

Paragraph 6 of the plan of correction stated,

"...The Staff Coordinator will monitor Resident 1 weekly to make sure procedures dealing with skin integrity such as turning and positioning and changing of incontinence pads or briefs when soiled are being done."

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	During further interview with the Staff Coordinator on 1/13/00 at 3:08 PM, she was asked to provide documentation to show that she had been monitoring resident 1 as required by the plan of correction. The Staff Coordinator stated, "I was not aware that this had been made my responsibility."		F-325	3-24-00
F 325 SS=D	483.25(i)(1) Requirement QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This Requirement is not met as evidenced by: Based on observation, interview and review of medical records, it was determined that for 1 of the 18 focus sample, the facility did not ensure the resident maintained acceptable parameters of nutritional status, such as body weight. Resident identifier: 53. Findings include: 1. Resident 53 was a 92 year old female who was admitted to the facility on 7/6/95 with the diagnoses of blindness, organic brain syndrome and disorders of fluid, electrolyte and acid base balance with volume depletion. As of survey 1/3/00 through 1/13/00, resident 53 had 3 pressure sores. Resident 53 lost 14.56% of her body weight in 5 months going from 103 pounds on 8/18/99 to 88 pounds on 1/3/00. During two mealtime observations, staff were not observed to provide sufficient	F 325	1) On February 10, 2000 an in-service will be given to the Nurses and Certified Nursing Assistants by the Director of Nursing. Weight loss, prompting, and offering substitute meals when Residents refuse to eat will be discussed. Specific instruction regarding resident 53 will be given to the CNA's by the Administrator. Details include: Inviting her to eat in the dining room for her meals. If refused, to properly position her for her meal, either rolling her bed up to a sitting position, or assisting her into her chair. Prepare her meal, explaining what is being offered. Assist her in eating if accepted. If refused, offer a alternative meal. If after several prompts she refuses, come back in several minutes and offer anything that she desires to eat. If she refuses, honor her rights by not forcing her to eat.	

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assistance and time necessary to ensure that resident 53 maintain acceptable parameters of nutrition.

The "Weight Loss Report" located in the medical record of resident 53 documented the following:

- 8/18/99 103 pounds
- 9/6/99 94 pounds
- 10/23/99 94 pounds
- 11/6/99 93 pounds
- 11/15/99 92 pounds
- 12/3/99 91 pounds
- 12/16/99 90.5 pounds
- 12/23/99 89 pounds
- 1/3/2000 88 pounds

The diet order for resident 53 was for puree, texture as tolerated with health shakes six times a day. During interview with the food service supervisor on 1/12/00, she stated that the health shakes were 4 ounces each providing 190 calories (a total of 1140 calories for all 6 health shakes) and 7 grams of protein.

A dietary note, dated 11/2/99, documented "Resident continues with a m/s (mechanical soft) diet and tolerates it well at this time, generally greater than or equal to 75% at meals. Will take house nourishment X 6 qd (everyday) = 100%. Needs to receive them consistently between meals..." During an additional interview with the food service supervisor on 1/12/00, she confirmed that resident 53 will drink 100% of her supplement when offered.

The MDS (minimum data set) for resident 53, a mandatory comprehensive assessment of the resident completed by facility staff, dated 8/27/99, documents

F 325

2) For Resident 53, a written log will be kept by the attending CNA, regarding dates and times that reminding prompts were given to eat. The plan which is detailed above will be followed by the CNA's. This information will be given to the weight loss committee each time they meet for evaluation on what has been successful. Those successful prompts noted will be passed along to the CNA's by the Director of Staff Development. Weights for resident 53 will be done weekly. The Dietary Manager will monitor her weight weekly to check progress.

3) The Weight-Loss committee will audit the CNA flow sheets once a month. Those residents who are refusing to eat frequently, or have weight loss in excess of 5% or greater in the last 30 days, or 10% in the last 180 days will be reviewed, and specific direction will be given to the nursing staff for follow-up. These sheets will be signed my a member of the committee and dated when reviewed.

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that resident 53's cognitive skills for daily decision making were severely impaired, her vision was severely impaired, and she needed extensive assistance with eating.

The MDS for resident 53, dated 11/5/99, documented that resident 53 had become totally dependent upon staff to eat and drink.

Based on the following, the facility did not intervene as aggressively as possible for this resident who was losing a significant amount of weight:

a. It was observed on 1/4/00 during breakfast that resident 53 was one of the last two residents on the 300 hall to be served her tray and fed. Resident 53's breakfast had been sitting in the hall cart over 30 minutes before it was taken to her room. The aide assisting the resident was an aide in training and told the surveyor she had only worked in the facility a few days. Resident 53 was observed in her bed with the head of the bed elevated approximately 30 degrees. Resident 53 was slightly turned to her right side which was facing away from the direction the aide was standing. The aide did not heat the resident's food prior to feeding resident 53 and did not elevate the head of the bed or help adjust the resident to a better position to make the dining experience easier and more pleasant for the resident. The aide spent a total of 7 minutes feeding resident 53. Resident 53 ate less than 10%.

b. It was observed on 1/5/00, during breakfast, that resident 53 was the last resident on the 300 hall to be served her tray and fed. Resident 53's breakfast had been sitting in the hall cart over 40 minutes when it was taken to her room. While her tray was still on the

Provider's Plan of Correction:

4) Each resident will be weighed no less than once a month, unless otherwise noted by the weight loss committee. Those residents determined by the weight loss committee as being high risk, 5% or greater weight loss in the past 30 days, 10% or greater weight loss in the past 180 days, skin breakdown, frequently refusing to eat, decrease in food intake, will be weighed no less than 2 times a month. Recommendations for those residents will be given at that time. The Dietary Manager will be responsible to ensure that those recommendations from the weight loss committee are implemented.

5) Our staff will follow the facility's weight loss policy and procedure.

6) The Dietary Manager and Administrator will be responsible to ensure compliance.

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hall cart, the surveyor observed all the items on resident 53's breakfast tray.

At 8:20 AM, an aide entered the room of resident 53 with her breakfast tray. Resident 53 was sleeping in bed, with the head of her bed at approximately 20 degrees, and her body turned slightly to the right (facing the wall).

At 8:23 and 30 seconds, the aide exited the room of resident 53 with the breakfast tray, placed the tray back on the hall cart and went on with other duties. It was observed that resident 53 was in bed with her eyes closed and in the exact position she was in prior to the aide entering the room. The surveyor went to the hall cart and observed resident 53's breakfast tray. The tray was still 100% full, resident 53 had not received anything off the tray.

At 8:26 AM, the surveyor entered the room and talked with resident 53. The resident responded with "Good morning". When asked if she was hungry, resident 53 said, "Oh, yes." When asked if she could eat something, resident 53 said, "I think so. What's for breakfast?"

c. When the DON was notified that the aide had spent 3 and 1/2 minutes with resident 53 and that the resident had not received any portion of her breakfast, the DON requested a replacement tray from the kitchen. The replacement tray did not include the house supplement of which the resident will drink 100% when offered.

d. Resident 53 had a pressure sore which developed 8/25/99 and other pressure sores which were observed during the 10/27/99 complaint survey. Resident 53

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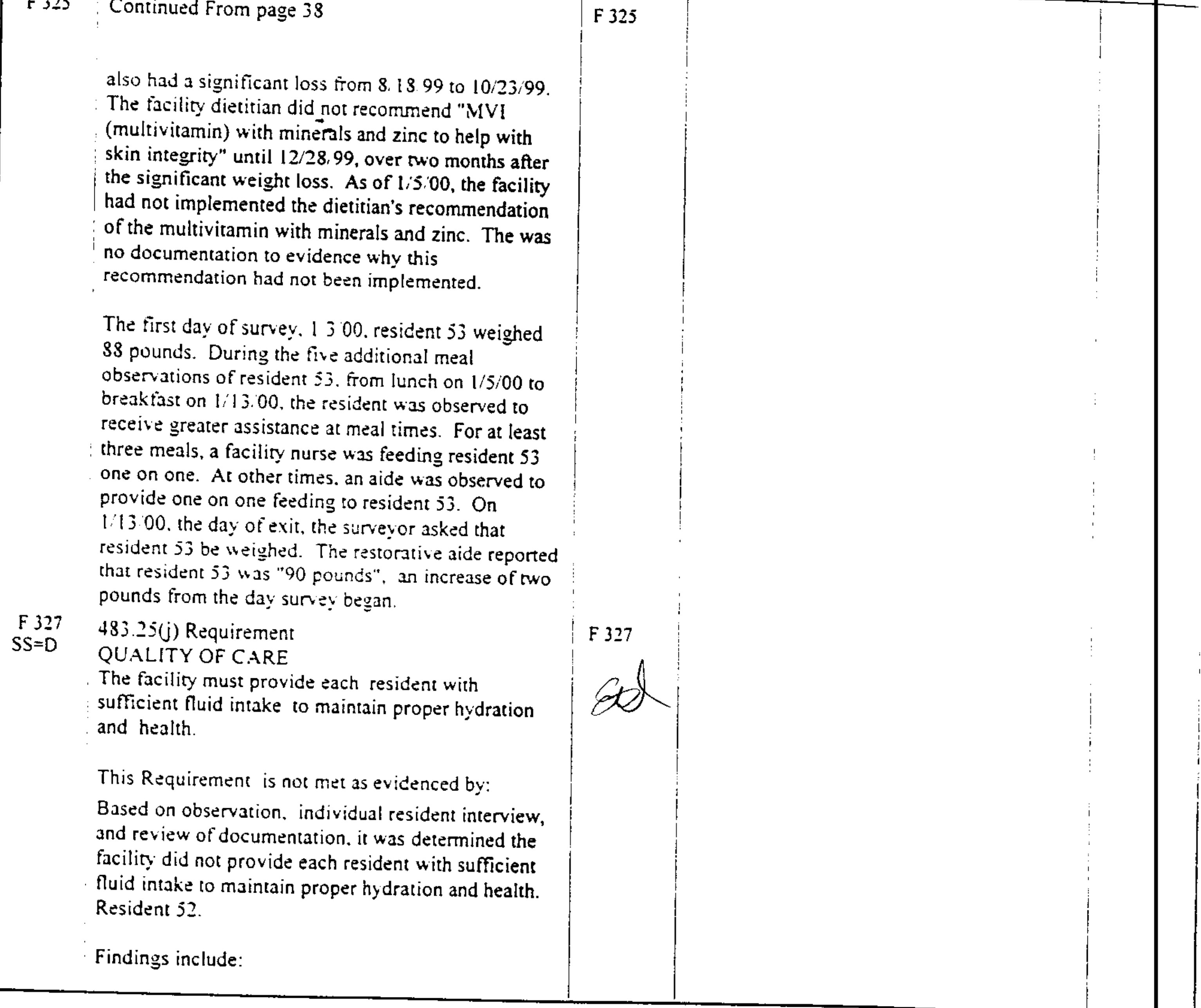

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F 325	Continued From page 38 also had a significant loss from 8/18/99 to 10/23/99. The facility dietitian did not recommend "MVI (multivitamin) with minerals and zinc to help with skin integrity" until 12/28/99, over two months after the significant weight loss. As of 1/5/00, the facility had not implemented the dietitian's recommendation of the multivitamin with minerals and zinc. The was no documentation to evidence why this recommendation had not been implemented. The first day of survey, 1/3/00, resident 53 weighed 88 pounds. During the five additional meal observations of resident 53, from lunch on 1/5/00 to breakfast on 1/13/00, the resident was observed to receive greater assistance at meal times. For at least three meals, a facility nurse was feeding resident 53 one on one. At other times, an aide was observed to provide one on one feeding to resident 53. On 1/13/00, the day of exit, the surveyor asked that resident 53 be weighed. The restorative aide reported that resident 53 was "90 pounds", an increase of two pounds from the day survey began.	F 325		
F 327 SS=D	483.25(j) Requirement QUALITY OF CARE The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This Requirement is not met as evidenced by: Based on observation, individual resident interview, and review of documentation, it was determined the facility did not provide each resident with sufficient fluid intake to maintain proper hydration and health. Resident 52. Findings include:	F 327		

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1. Resident 52 was observed approximately 20 times over the days of 01/04/00, 01/05/00, and 01/06/00. During these observations, resident 52's call light was located at the head of the bed and outside of the handrail, out of reach of the resident. Her water pitcher was on the bedside table which was approximately three feet from the resident, and out of reach of the resident. Observation of the resident revealed that she wore oxygen, her lips were dry and flaky, and her tongue was caked with a thick, gummy saliva. When resident 52 spoke, her tongue would stick to the roof of her mouth.

2. During the morning of 01/06/00, resident 52 was interviewed. When asked how she got water, resident 52 responded, "They give it to me". When asked if she was given water often enough to meet her needs, she said, "No". The surveyor then asked resident 52 if she was thirsty now, and the resident said, "Yes". The surveyor asked how resident 52 contacted the facility staff. Resident 52 said, "My bell (call light)". Observation at this time revealed resident 52's call light was out of reach of the resident.

3. Review of the Weekly Evaluation sheets for resident 52 where intake and output are recorded, revealed the documentation for intake was not complete for 10/99, 11/99, 12/99, and 1/00. Review of the intake recorded revealed:
01/03-09/00: 6 of 7 days with an intake amount. Total cc's (cubic centimeters) for these days were 120, 600 (2 days), 720, 1360, and 1600.
12/99 5 of 11 days identified for recording intake amount had amounts listed. Total cc's for these days were 600, 1150, 60, 2145, and 580.
11/99 13 of 16 days identified for recording intake

Provider's plan of correction:

1) On February 10, 2000 an inservice will be given to the Nurses and Certified Nursing Assistants by the Director of Nursing. Hydration, offering frequent verbal ques to drink, keeping water fresh and available, as well as keeping call lights within reach will be discussed.

2) For resident 52, the Certified Nursing Assistants will keep a written log of dates and results which liquid was offered to her each day. Her call light, and her bed tray containing her water, will be within her reach when she is in her bed. The Care Plan Coordinator will monitor her fluid intake weekly to see that it is within the guidelines given by the Dietary Manager, using the fluid requirement formula.

Complete date: 3-24-00

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F 327	Continued From page 40 amount had amounts listed. Total cc's for these days were 1320, 1070, 1260, 600, 1140, 1320, 1320, 1100, 1200, 1440, 1200, 780, and 1820. 10/99 24 of 29 days had documentation. Total intake amounts ranged from 340cc to 1320cc. Fifteen were less than 1000cc intake per day. The Consultant Dietitian, Winter 1998, Volume 22, pg. 6, Dr. Trish Welch, reads "When working with the elderly, recommendations concerning fluid needs to replace insensible losses, maintain renal function and good skin turgor, range from 1500cc to 2500cc/day." (cc = cubic centimeters) If one used the general guideline for formulating baseline daily fluid needs, which is to multiply the resident's weight in kilograms (kg) by 30cc, the minimum fluid requirements for resident 52, based on her weight during survey of 122 pounds (55.5 kg), would be 1664cc per day. For 45 of the 48 days of documentation reviewed for October, November, and December 1999, and January, 2000, resident 52 received less than 1664cc, which is the minimum recommendation of fluid intake for a person weighing 122 pounds.	F 327	3) Upon admission to the facility, the Dietary Manager will assess the fluid requirements needed for that resident. The formula used will be (weight divided by 2.2 times 30.) This will also be done for all of the residents within the facility, and the results placed on the closet doors of the Residents rooms. Those Residents who have been determined by the Dietary Manager as "High Risk" will have a picture of a glass of liquid hung upon their wall. This will que the Certified Nursing Assistants to offer liquid frequently when they are in the Residents room. 4) The Care Plan Coordinator and Administrator will be responsible to ensure compliance.	
F 353 SS=E	483.30(a)(1)&(2) Requirement NURSING SERVICES The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient	F 353		

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F 353	Continued From page 41 numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses; and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This Requirement is not met as evidenced by: Based on interviews with a resident group, individual residents, family members, the Ombudsman, and staff, it was determined that the facility did not have sufficient staff to provide the needed services for residents as required. Findings include: 1. Complaints of short staffing. a. In a confidential group interview held 01/04/00, at 10:45 AM, 8 of 11 alert and oriented residents reported that the facility was often short staffed. One resident stated, "Didn't get bathed Saturday because only two people (staff) on the hall." Another resident stated, "I get bathed when there's enough people to bathe me." Another resident stated, "Fifteen to 20 minutes (answering call lights), because we have no help." Another resident stated, "They're supposed to have two people watch me in the bathroom and they said they had other things to do." Yet another resident stated, "When they call trays are ready for the 300 hall, I have timed it and it's an hour before I get my tray."	F 353	F-353 1) This plan of correction is detailed in the insert titled, "F353 Nursing Services Staffing". 2) When a staff member is used from another section of our company, or a pool nurse, they will be given a written orientation form to review with the nurse who is responsible for the hall that they have been assigned to. This Orientation form will be signed by the staff member, and given to the Director of Nursing. 3) Each Week, the Administrator, and Nurse Management Team will review the staffing for the week. Full staff is determined by obtaining a 95% compliancy of the company's Nursing budget guideline of 2.8 p.p.d.. Until this is obtained, recruiting efforts will continue as detailed in the plan mentioned in "Nursing Services Staffing". 4) The Administrator will meet with the residents in Resident Council monthly. This information, as well as Resident and Family Member survey results mentioned in F-241 will also assist in determining if the facility is properly staffed. 5) The Administrator and Director of Staff Development will be responsible to ensure compliance.	3-24-00

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F 353	Continued From page 42 b. In a confidential resident interview, a resident stated, "On the 1st there was only one person (staff) on the hall. The aide will say you're not my patient and go away". c. On 01/03/00 at 1:15 PM, in a confidential interview, a family member who visited every other day, reported the facility was "shorthanded all the time". The family member reported an incident when the resident they visit was "dirty and filthy and hadn't had his/her bath" when brought to the dining room for a special dinner. The family member said the facility staff explained the bath wasn't given because, "We're short on help". d. In a confidential interview on 01/4/00 at 11:00 AM, a family member reported, "There is never enough staff". He/she said, "Some people have to wait a long time to get help". The family member reported observing a resident who had to wait 30 minutes to get help to the bathroom. e. On 01/03/00 at 10:30 AM, in a confidential interview, a family member stated that the resident they visit, "Went several days without a bath. They told me that they were short of help last Tuesday and Saturday". f. On 01/05/00, a staff member said, "The 300 hall is a heavy care wing and they're (the residents) always on their call lights. Pool aides (temporary help hired through a contract agency) are always assigned there because that's where its always short staffed". The staff member said the hall had previously been staffed with 4 or 5 aides and is now staffed with 2 or 3 aides. g. On 01/13/00, during a confidential interview, a	F 353		

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staff member said the "Medicare hall" had "usually" been running with 3 aides, but they "have had 2 for the past couple months".

h. On 01/04/00, during a confidential resident interview, the resident stated there was a shortage of nurse aides during the holidays, occasionally at night, but mostly during the breakfast time.

i. On 01/11/00, during a confidential resident interview, the resident stated that she had no set schedule for being turned and that the staff turn her "Just when they are not busy".

j. On 01/11/00, during another confidential resident interview, the resident stated that she was turned, "When they're not busy".

k. On 01/12/00, during a confidential staff interview, the facility staff stated that it was very hard to meet the needs of the residents on the 300 hall when there are only three aides working on the hall. The facility staff further stated that there are three aides consistently working on the 300 hall and that during the Christmas and New Year's holiday season, there were two aides working on the 300 hall. Areas where needs were not always met included turning of the residents and delivery of snacks.

l. During survey and during a confidential staff interview, the facility staff stated that during the holiday season there were two aides for 41 residents on three halls and that all the cares were not done for these residents. When asked what resident cares do not get met when there was an insufficient number of aides (during the day shift), the facility staff stated: 1 of 4 whirlpool baths (CT) is not done; residents are

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not turned and repositioned; residents are gotten up late; residents are not shaved; occasionally oral cares are not given; resident showers are missed; and residents who are not helped to lay down become incontinent by the time the aides have time to help them lay down. The facility staff also stated that if residents who are usually assisted with eating in the dining room aren't gotten up in time to go to the dining room, the aides must feed them in their rooms. Some of these residents then have cold food because they are fed one at a time. Those who wait end up having cold food.

m. During an interview with a facility aide on 1/12/00, the aide stated that he/she had worked at the facility over 8 months. The aide stated that there was "definitely a problem with lack of staff" and that there were "many times we haven't been able to do baths, change briefs (incontinence pads) or provide turning and repositioning due to lack of staff."

n. During another interview with a facility aide on 1/13/00, the aide stated that he/she had worked at the facility over 6 months. The aide stated that "there have been many times we've been short staffed." When the aide was asked how this affected the care provided in the facility, the aide stated, "not being able to get to turning and repositioning or incontinence care and hardly ever getting to oral care."

o. During a confidential family interview on 1/5/00, the family member stated that he/she had "quit using the call light" to get help for his/her loved one. The family member stated that "sometimes it can take up to 3 or 4 hours to get help, and by that time, she's been lying in that soiled diaper for hours. They just don't

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have enough help." The family member stated that lately he/she had been going to the nurses station to get help for his/her loved one.

2. Call lights.

a. In a confidential group meeting held 01/04/00, at 10:40 AM, 10 of 11 residents reported that call lights were not answered timely.
b. One family interview stated call lights were not answered timely. In another confidential family interview, it was stated, "I have seen them just ignore it (call light) because they don't have time."
c. Surveyor observations during survey verify call lights were not answered timely.
d. On 01/04/00, during one confidential resident interview, the resident stated that it takes up to 10 to 15 minutes for staff to answer call lights. When the resident needed to use the bathroom, the resident was not always able to wait for the staff to come, resulting in incontinence.

3. Bath schedules.

a. In a confidential group interview held 01/04/00, at 10:40 AM, 6 of 11 residents complained of not getting baths that were scheduled for them.
b. A random review of 27 flow sheets documented that only 3 of 27 residents reviewed got their baths as scheduled.
c. Review of the flow sheets for 4 of 18 sample residents, revealed that they did not get their baths as scheduled.

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F 353	Continued From page 46 4. Oral care. a. Observation of the inner mouth of resident 43 on 1/4/00, 1/5/00, 1/6/00, 1/11/00, 1/12/00 and 1/13/00 revealed him to have very red gums with a large build up of yellow and brown plaque-like material on his teeth and a bad breath odor. b. Observation of resident 53 on 1/4/00, 1/5/00, 1/6/00, 1/11/00, 1/12/00 and 1/13/00 revealed her to have a large build up of food and plaque-like material on her teeth and a bad breath odor. These observations were made at various times during the days of survey, several times before breakfast had been served to resident 53. 5. Clean bed linens. a. Six of 11 residents in a confidential group meeting of residents held 01/04/00 at 10:45 AM, reported that their bed linens were not changed when they were scheduled to be after they bathed. b. On 01/03/00 at 1:15 PM, a family member complained that the resident's bedding didn't get changed. She lifted a quilted pad she had put on top of the resident's bedspread and pointed to a 5 inch diameter brown stain. A similar 3 inch stain was on the bedspread near the foot of the bed. The same bedspread and pad were observed by the surveyor to be on the bed 01/05/00 at 8:55 AM, and again at 01/06/00 at 9:00 AM. c. Four residents were observed to have dirty or heavily stained linen on their beds.	F 353		

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6. Cold food.

a. In a confidential group meeting held on 01/04/00, at 10:40 AM, 4 of 11 residents stated that their food was cold when they got it.
b. On 01/04/00 at 9:30 AM, during a confidential individual interview, the resident stated that breakfast was cold and that the facility staff did not offer to warm up the food.
c. On 01/05/00, during serving of the breakfast meal to residents eating in their rooms on the 300 hall, food temperatures were tested on a resident's tray. The temperature of the egg was 93 degrees and the resident stated that it was cold.
d. On 01/05/00, during serving of the lunch meal, a sample tray was sent to the 300 hall. Serving time of the room trays took approximately 40 minutes from when the food cart left the kitchen and to when all the residents received their trays. The food temperatures on the sample tray, taken when the last resident received their tray, indicated that the hot food was lukewarm and the cold food was warm. The mixed vegetable were 105 degrees, lukewarm, and tasted and looked overcooked. The meatballs were 110 degrees and lukewarm. The milk was 60 degrees and warm. Refer to F-364.

7. "Cares q (every) shift".

Review of the aides flow sheets revealed two pages where the aides documented information. Page one identified specific care areas and page two may identify more specific care areas, depending upon the individual resident, as well as a section entitled, "Cares q shift." On 1/25/00, during an interview with

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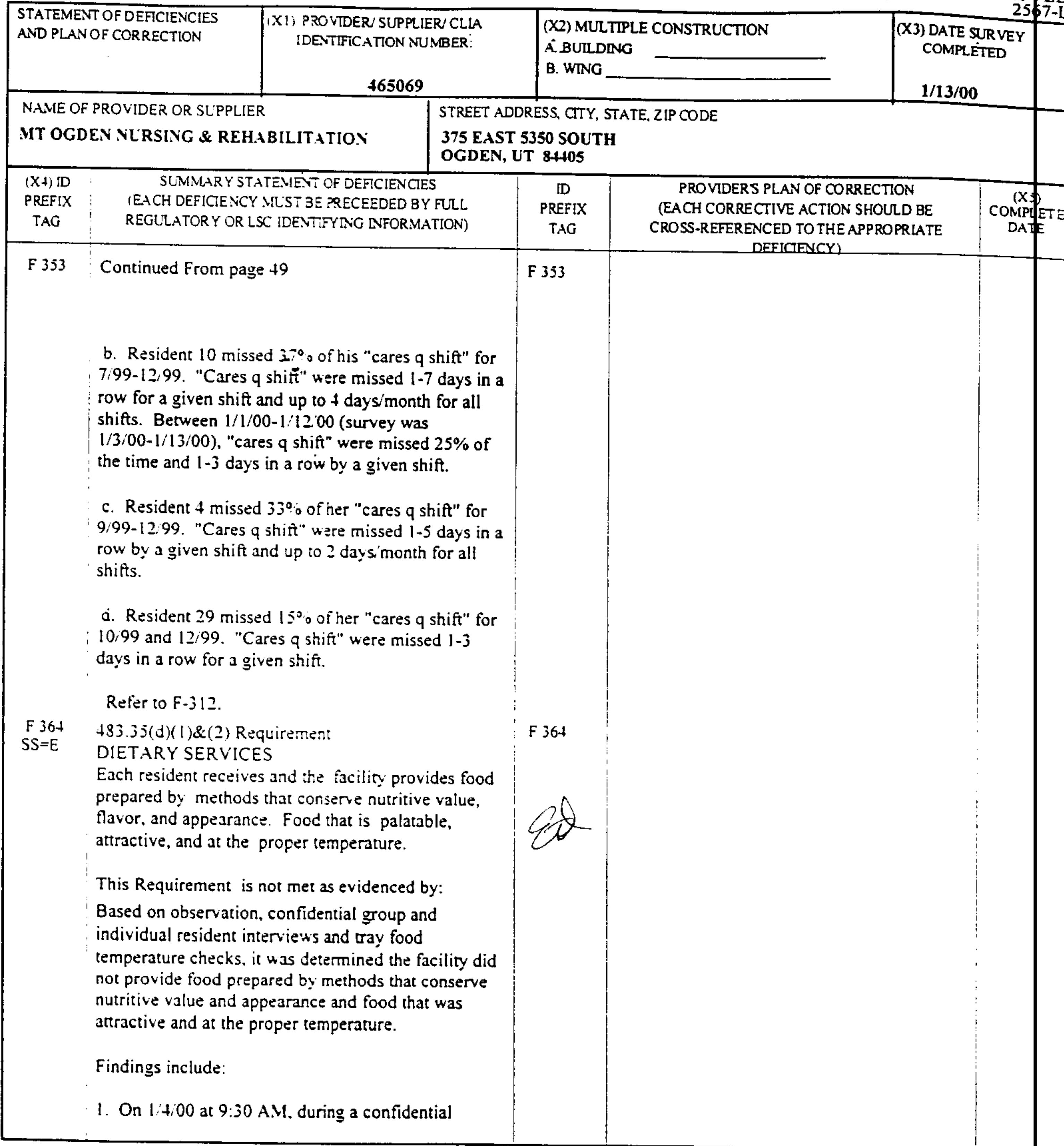
an aide, she stated that "cares q shift" included the specific mentioned cares identified on page 1 and all the other cares a resident needed but were not specifically identified on page one. The aide further stated that this section must always be completed even if there was documentation on page one since it included the cares not specifically mentioned. She stated that "cares q shift" included items such as oral care, pericare, nail care, shaving for both men and women, combing of hair, assisting with makeup, washing out eyes in the morning, etc. On 1/25/00, during an interview with the nursing staff in charge of the aides, this staff person stated that each specific care was to be initialled (on page one) and that the "cares q shift" (on page two) was to also be initialled. The section, "Care q Shift," was specifically for the initials of the aide responsible for providing the care to that resident since there was not space available by each of the specific care areas on the flow sheet for the aide's initials. She stated, "If the initials are not there, assume the cares are not done. If not signed (documented), not done."

Review of the flow sheets, "Cares q shift" section, for 4 of 18 sample residents, revealed that cares were missed from 15% to 56% of the time during a month, from 1 to 9 days in a row, and up to 6 days for all three shifts in a given day.

a. For 11/99, resident 71 (admitted 11/1/99) missed "cares q shift" 56% of the time-60% on 6-2 shift, 73% on 2-10 shift, and 40% on 10-6 shift. "Cares q shift" were missed 1-9 days in a row with all shifts missing 6 days in the month. Review of the flow sheet revealed the 6-2 shift gave "cares q shift" 5 of 18 days between 11/1-11/18/99 and the 2-10 shift 3 of 21 days between 11/1-11/21/99.



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F 353	Continued From page 49 b. Resident 10 missed 37% of his "cares q shift" for 7/99-12/99. "Cares q shift" were missed 1-7 days in a row for a given shift and up to 4 days/month for all shifts. Between 1/1/00-1/12/00 (survey was 1/3/00-1/13/00), "cares q shift" were missed 25% of the time and 1-3 days in a row by a given shift. c. Resident 4 missed 33% of her "cares q shift" for 9/99-12/99. "Cares q shift" were missed 1-5 days in a row by a given shift and up to 2 days/month for all shifts. d. Resident 29 missed 15% of her "cares q shift" for 10/99 and 12/99. "Cares q shift" were missed 1-3 days in a row for a given shift. Refer to F-312.	F 353		
F 364 SS=E	483.35(d)(1)&(2) Requirement DIETARY SERVICES Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance. Food that is palatable, attractive, and at the proper temperature. This Requirement is not met as evidenced by: Based on observation, confidential group and individual resident interviews and tray food temperature checks, it was determined the facility did not provide food prepared by methods that conserve nutritive value and appearance and food that was attractive and at the proper temperature. Findings include: 1. On 1/4/00 at 9:30 AM, during a confidential	F 364		

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F 364	Continued From page 50 individual interview, the resident stated that breakfast was cold and that the facility staff did not offer to warm up the food. 2. On 1/4/00 at 10:45 AM, during the confidential group meeting, 4 of 11 residents stated that their food was cold when they got it. They stated that residents who ate in their rooms received cold food and thought it was due to how the food was delivered. 3. On 1/5/00 during serving of the breakfast meal, a resident on the 300 hall who was eating in their room, gave permission for testing the temperature of their breakfast food. The resident had just taken the lid off of the main plate. The temperature of the scrambled eggs was 93 degrees Fahrenheit. As the resident sampled the food, the resident stated the hot food was cold. The resident also stated that the orange juice did not taste very good. 4. On 1/5/00, a test tray was ordered during the lunch meal to go on the 300 hall food cart. The loading of the resident trays on to this food cart was completed in the kitchen at 12:13 PM. The food cart was pushed out into the main dining room awaiting a facility staff to deliver it to the 300 hall. At 12:17 PM, an announcement was made over the loud speaker system that this cart was ready for delivery. At 12:20 PM, a facility staff took the food cart to the 300 hall. At 12:22 PM, a volunteer asked for the tray for a specific resident. This was the first tray taken off the food cart. Two facility staff continued delivery of the food trays. At 12:52 PM, facility staff took the next to the last resident tray off the cart. This resident awaited assistance from facility staff before being able to eat. One tray remained on the food cart at 12:56 PM when temperatures were taken of the food on the test	F 364	F-364 1) The Dietary Department will change to the "Batch Cooking" method of preparing meals. This is done twice during each meal. This will accommodate both staff members as well as residents meals to conserve nutritional value, flavor, and appearance. 2) The Dietary Manager will order insulated domes and bottoms for the meals that are going out to the Residents rooms. 3) The Dietary Staff will place the beverages into the freezer prior to meals going to the Residents rooms. 4) A microwave will be added to the Nurses station for the purpose of reheating a Resident's meal.	3-24-00

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F 364	Continued From page 51 tray and the food was sampled. The mixed vegetable were 105 degrees, lukewarm, and tasted and looked overcooked. The meatballs were 110 degrees and lukewarm. The milk was 60 degrees and warm. It took the facility staff 40 minutes after the trays were completed in the kitchen to serve the trays to the 300 hall residents eating in their rooms. During an interview with the cook at 11:40 AM, she stated that the mixed vegetables had been frozen vegetables and that all the vegetables for facility staff and residents were prepared at the same time. She further stated that the lunch foods had been put in the steam table by 10:15 AM for serving to facility staff at 10:30 AM. Observation of the mixed vegetables revealed them to look overcooked. Resident tray line was scheduled to start at 11:45 AM for the lunch meal, 1 hour and 30 minutes after the food was placed in the steam table. 5. On 1/3/00 at 1:00 PM, a lunch tray was observed on a table near the foot of resident 50's bed. The resident was not in the room. At 1:50 PM, resident 50 had returned to the room. A nurse aide was observed to serve him the lunch tray which had been sitting out. Roast turkey, gravy, stuffing, carrots, bread and butter, and beverages were observed to be on the tray. Resident 50 ate a bite of dressing and stated that it was "too dry". The resident did not consume the rest of the meal. Resident 50 allowed the surveyor to test the temperatures of food items on the tray. The turkey was 82 degrees, dressing 82 degrees, and carrots were 78 degrees.	F 364	5) On February 25th, 2000, the Administrator will conduct an inservice with the Certified Nursing Assistants. From the time that the tray cart is delivered to the hall, all trays are expected to be passed to the Residents within a 20 minute period of time. If the tray has not been passed within that period of time, or should the Resident complain of cold food, the CNA is to warm up the plate of food for 2 minutes in the microwave. This will be taught at the inservice. 6) The Dietary Manager, or Dietary Supervisor, will monitor all meals, hot and cold, with a written log. This log will be kept daily, until a 95% compliance is obtained. At this time, a test will be conducted once a week. These findings will be shared at the Quality Assurance meeting monthly.	
F 368 SS=E	483.35(f)(1)-(3) Requirement DIETARY SERVICES Each resident receives and the facility provides at	F 368		

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F 368	Continued From page 52 least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in (4) below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This Requirement is not met as evidenced by: Based on observation, confidential group interview, staff interview, and documentation, it was determined the facility had greater than 14 hours between a substantial evening meal and breakfast the following day without the resident group agreeing to a greater than 14 hour span and that snacks were not offered at bedtime daily to all residents. Findings include: 1. On 1/4/00 at 11:10 AM during interview with the food service supervisor, she stated that the mealtimes were: 7:10 AM for breakfast, 11:45 AM for lunch, and 4:45 PM for dinner. This is a 14 hour and 25 minute time span between a substantial evening meal and breakfast the following day. Review of the resident council minutes for the past year revealed no documentation identifying that the resident council had given approval for a time span greater than 14 hours between the evening meal and breakfast the following day.	F 368	7) The Dietary Manager will conduct an inservice with her staff on February 10th, and 25th to discuss the above information. 8) The Dietary Manager, and Administrator will be responsible to ensure compliance. F 368 1) Meal time for the residents will be as follows: Breakfast 7:15 am Lunch 12:00 pm Dinner 5:15 pm This will satisfy the 14 hour time requirement between dinner and breakfast. 2) The Dietary Manager will monitor when the meals are started. This will be done no less than weekly, by way of written tool, signed and dated by her. This will be done until a compliance of 95% success is reached. At that time the monitoring will be once a month.	3-24-00

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F 368	Continued From page 53 On 1/5/00 during an interview with the administrator, he stated that there were no resident council meeting minutes giving approval for the greater than 14 hour time span between the evening meal and breakfast the following day. 2. On 1/4/00 during the confidential group meeting, 4 of 11 residents stated that they were not offered a snack before bedtime daily.	F 368	3) On February 25th, and inservice was given to the Certified Nursing Assistants by the Administrator. Offering a bedtime snack was discussed. All residents will be offered a bedtime snack. This will be monitored through a Resident satisfaction survey which is to be conducted by Social Service. Findings will be shared each month at the Quality Assurance meeting. The Director of Staff Development will also be monitoring the Certified Nurse Aide flow sheets to ensure compliance. 4) The Dietary Manager and Administrator will be responsible to ensure compliance.	
F 371 SS=E	483.35(h)(2) Requirement DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This Requirement is not met as evidenced by: Based on observation, interview, and temperature checks, it was determined the facility did not store, prepare, distribute, and serve food under sanitary conditions. Findings include: 1. On 1/4/00 at 2:15 PM, the dish washing machine temperatures were checked. The rinse water temperatures ranged from 95 to 105 degrees on three different washing cycles and the wash water temperatures ranged from 75 to 95 degrees. The placard on the side of the dish washing machine identified the minimum temperature for both the rinse and the wash cycle was 120 degrees for washing and sanitizing the dishes. 2. On 1/5/00 at 11:40 AM, food temperatures were taken for the lunch meal. The cold food temperatures were taken by the surveyor with the facility's food	F 371		

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F 371	Continued From page 54 thermometer. The milk (already poured in glasses and sitting on a tray on the counter) was 53 degrees, the grape juice was 57 degrees, the orange juice was 56 degrees, and the high protein nourishment was 56 degrees Fahrenheit. Good sanitary practice identifies that cold foods are to be maintained at 41 degrees or below when served from tray line. 3. On 1/5/00 the "breakfast club" meal included fried eggs. Observation in the main dining room during the breakfast meal, revealed that eggs were being fried in an electric fry pan by facility staff. There were approximately 12 eggs in the fry pan at one time. Four of the eggs observed were cooked to the extent that the egg whites were white. Approximately eight newly cracked eggs had been added to the fry pan. The whites of these eggs were clear. These newly cracked eggs were touching and among the four mostly cooked eggs. Residents were served the mostly cooked eggs before the newly cracked eggs were cooked. Observation of the residents' main plates in the main dining room, revealed that the fried eggs on many of the plates had left a liquid yolk residue. Observation of the fried eggs in the special needs unit, revealed that the fried eggs were piled two to three inches high on a dinner plate. Residents were then served eggs taken from this dinner plate. Liquid yolk residue was observed on the dinner plate with the fried eggs and on the individual resident main plates. Review of the currently used 5 week cycle menu, revealed "soft cooked eggs" were on the menu one to two times per week for all 5 weeks. Fried eggs were	F 371	F-371 1) The Maintenance Supervisor will install a booster to the dish washing machine. This will increase the minimum temperature for both the rinse and the wash cycle to 120 degrees for washing and sanitizing the dishes. 2) The meal beverages will be chilled in the freezer prior to serving. This will maintain cold foods at 41 degrees or below, when served from the tray line. 3) Soft cooked eggs and fried eggs will be replaced with pasteurized eggs. 4) The Dietary Manager, or Dietary Assistant will monitor daily, with a written tool, the dishwashing temps, as well as the cold beverage temps. This will be done for all meals.	3-24-00

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F 371	Continued From page 55 on the menu one to two times per week for 3 of the 5 weeks as well as being offered two times a month at the "breakfast club" meal. Nursing home residents are considered a highly susceptible population. Good food sanitation practices identify that immediately broken raw shell eggs shall be cooked to heat all parts of the food to 145 degrees or above for 15 seconds. Pasteurized eggs are to be substituted for shell eggs in the preparation of foods where four or more eggs are pooled to be cooked separately. References: Food Code, U.S. Public Health Service, 1999, and the state Food Service Sanitation Rule, Effective Date: October 15, 1996.	F 371	5) An inservice will be conducted by the Dietary Manager on February 10th, and 25th for the dietary staff to instruct them of these changes. 6) Findings from the above audit will be provided to the QA committee each month. 7) The Dietary Manager, and Administrator will be responsible to ensure compliance.	
F 441 SS=E	483.65(a)(1)-(3) Requirement INFECTION CONTROL The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This Requirement is not met as evidenced by: Based on observation, it was determined the facility did not establish and maintain in infection control program which controls and prevents infections in the facility for 3 of 18 sampled residents and 3 others. Residents 01, 11, 26, 43, 51, and 91. Findings include: 1. Resident 51 was observed lying on his bed at 1:15	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465069	A. BUILDING ______ B. WING ______	1/13/00

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT OGDEN NURSING & REHABILITATION	375 EAST 5350 SOUTH OGDEN, UT 84405

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F 441	Continued From page 56 PM on 01/3/00. Resident 51 had a foley catheter which drained into a leg bag. The resident was observed to be lying flat with his legs elevated above his torso. His position allowed collected urine to flow backwards from the leg bag towards his bladder. On 01/13/00 at 2:00 PM, resident 51 was observed to have a down drain bag hanging from under his wheelchair. While two aides were getting ready to transfer resident 51 from wheelchair to bed, one aide was observed to hold the catheter bag elevated higher than the resident's waist. A down drain bag should always be positioned lower than the resident's bladder to prevent urine from flowing back into the bladder. 2. Resident 91 was admitted 01/4/00 with a foley catheter to down drain bag. On 01/5/00 at 2:40 PM, her catheter bag was observed to be resting on the floor at her bedside. The tubing was clamped to her sheet, but the bag was not attached to the bed frame. A nurse was observed to pick up the down drain bag to check for urine output, then set it flat on the floor under her bed. The increased the risk of contamination and the spread of infection. 3. On 01/4/00 at 11:45 AM, resident 1 was observed propelling himself in the hallway with the catheter bag and one foot of tubing dragging along the floor under his wheelchair. 4. On 01/5/00 at 2:25 PM, a nurse was observed to change the dressing over a new supra pubic catheter site for resident 11. The nurse cut a 4X4 gauze bandage to go around the catheter tube and placed the dressing over the wound. A cut gauze dressing has loose fibers which can cause infection in a wound.	F 441	F-441 1) On February 10, 2000 an inservice will be given to the Nurses and Certified Nursing Assistants by the Director of Nursing. Foley care, including proper positioning, related infection control issues, as well as dressing changes and the disposal of contaminated items will be discussed. 2) For Residents 1, 11, 26, 43, 51, and 91 infection control related concerns such as Foley care, and positioning will be monitored. This will be done not less than once a week, and will be detailed on a written audit tool, consisting of date, time and signature. The audit will include catheter care done properly, proper tubing placement and elevation, checking for contaminates in room during dressing changes. This audit will continue until a success rate of 95% is obtained, at which time the audit will be reduced to no less than once a month. 3) Results from this audit will be shared each month at the QA meeting.	3-24-00

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465069	A. BUILDING ______ B. WING ______	1/13/00

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 57 Resident 11's catheter down drain bag was observed to be resting on the floor at the resident's bedside. The plastic down drain bag was laying on the floor and on top of a section of catheter tubing which was also laying on the floor. 5. On 01/13/00 at 8:30 AM, a soiled disposable brief was observed to be laying on the overbed table of resident 26. A hair comb was on the table, protruding out from under the brief. 6. On 1/4/00, a facility staff nurse was observed to provide incontinence care to resident 43 who was soiled with feces. The staff nurse used washcloths and hand towels to clean away the feces and was then observed to place the soiled linens directly onto the floor next to the resident's bed. The staff nurse was not observed to call for housekeeping to clean the area of floor that had been contaminated by the soiled linens.	F 441	4) The Assistant Director of Nursing will be responsible for follow-up matters discussed by the Quality Assurance team members. 5) The Assistant Director of Nursing and the Administrator will be responsible to ensure compliance. F 520	3-24-00
F 520 SS=E	483.75(o)(1) Requirement ADMINISTRATION A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. This Requirement is not met as evidenced by: Based on interview and record review, it was determined the facility did not maintain a quality assessment and assurance committee which included a physician designated by the facilty. Findings include: 1. On 01/13/00 at 9:30 AM, an interview was	F 520	1) Our Quality Assurance committee will be comprised of no less than the following: Medical Director Administrator Director of Nursing Asst. Director of Nursing Staff Developer Care Plan Coordinator Dietary Manager Maintenance Supervisor Housekeeping Supervisor 2) The Director of Nursing and the Administrator will be responsible, making sure that all members attend, assuring compliance.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 1/13/00

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F 520	Continued From page 58 conducted with the Director of Nurses (DON). The DON reported that the physician had not attended the quality assessment and assurance (QA&A) committee meetings. 2. Minutes of the monthly QA&A meetings from July,1999 through December, 1999, were reviewed. There was no documentation of who attended the meetings from July to November, 1999. Names of those attending were included on the minutes for December, 1999, but no physician was listed. 3. On 01/12/00 at 3:40 PM, in an interview with the facility medical director, the physician stated he doesn't attend QA&A meetings with the facility. He stated that he was unable to remember the last time he attended a QA&A meeting but may have attended "Maybe two" over the past year.	F 520		

ATG
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER: 465069	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 1/13/00

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 59	F 520		

Mt. Ogden Nursing and Rehab
Satisfaction Survey

Dear Resident, or Family Member:

In order to better assist us in providing for the needs of our residents, could you please take a few moments, and fill out the following questions regarding the care received at our facility.

Please answer the questions using the following:
1-poor, 2-fair, 3-good, 4-excellent
or N-if not utilized

Nursing

_____ Friendliness of our nursing staff.
_____ Does the nursing staff understand the specific needs of the resident?
_____ When a concern regarding care is given to the staff, are they helpful in resolving it?
_____ Is their a 'prompt' response in answering the call lights?
_____ Do you feel that necessary information is passed from shift to shift?
_____ Overall rating for Nursing care provided.

Tell us about your favorite Nursing staff member______________________________________

____

Comments to improve our nursing care____

____

Dietary

_____ Are dietary staff members helpful and courteous?
_____ How would you rate the taste of our meals?
_____ Is their variety in the meals which are offered?
_____ Are the meals served at a desirable temperature?
_____ Are meal substitutions being offered when regular menu items are not acceptable?
_____ Are snacks offered between meals, and at night?
_____ Do you enjoy our special events such as Restaurant night, and Breakfast club?
_____ Overall rating of our Dietary department.

What do you enjoy most about our Dietary dept?______________________________________

____

Comments to improve our Dietary dept____

____

Activities

_____ Are the activities offered interesting, and a good variety?
_____ Are the materials adequate for the activities?
_____ Is there adequate supervision during the activities?
_____ Are the dates, times, and places of the activities easily accessible?
_____ Overall rating of our Activity dept?

What do you enjoy most about the Activities?____

____

Comments to improve our Activity dept____

____

Social Service & Administration

_____ Are your complaints or concerns addressed within an appropriate time frame?

_____ Are complaint or concerns resolved or explained?

_____ Are the Family Action Council meetings helpful, and of benefit?

_____ Are the emotional needs of the resident being met?

_____ Is information regarding Medicare, Medicaid or Billing helpful?

_____ Are residents and their family members being invited to our Interdisciplinary Team Meeting (I.D.T.), where resident's care information is reviewed?

_____ Overall rating of this dept?

Tell us about someone who has been helpful in this dept?______________________________

____

Comments to improve this dept____

____

___ Overall rating of our facility?

Thank you for participating in our survey. Our continued desire is to provide excellent quality health care for all of our residents.

Respectfully,

Ray Wilde
Administrator

F353 Nursing Services
Staffing

On January 1st, through February 4th 2000, meetings attended by Utah Senior Service's President, Vice President, as well as Mt. Ogden's Administrator, Acting Director of Nursing, Assistant Director of Nursing, and other various department heads were conducted. Among other issues, short staffing resolutions were discussed. Our plan of action consists of the following, which divides the solution into two areas.

Urgent Staffing Resolution.

On February 2nd, the President and Vice President contacted various branches of the parent company Utah Senior Services to set in place the recruiting of RN's, LPN's, and CNA's to fill immediate positions at Mt. Ogden Nursing, thus filling open shifts which the facility is experiencing. This process included overtime approval, bonuses, travel expense, as well as some hotel expenses which are to be paid by the company.

Each Monday, a "Staff Needed" hot sheet will be faxed to these locations by the Acting Director of Nursing, which details any shifts which need to be filled. The Director's at those locations will then respond back to the Acting DON with those employees who can fill the shifts. This process will continue until Mt. Ogden Nursing is considered to be "Fully Staffed" in their nursing dept.

Direction has also been given by the President that the facility is NOT to use pool nurses, unless the situation is unavoidable. With the overwhelming response that we have been getting from the other branches of the company, it is very unlikely that we will be using the pool.

Long-Term Staffing Resolution.

The long term solution to our short staffing will come by successfully resolving the following areas:

1. Advertising and Recruiting Efforts
2. Current Management Changes
3. Employee Compensation
4. Staff Morale
5. New Employee Orientation and Training
6. Misc

Advertising and Recruiting

The Acting Director of Nursing, and the Assistant Director of Nursing will continue to place "Help Wanted" adds in the local newspaper. Additional recruiting contacts will be made to the following:

1. Job Corps
2. D.A.T.C.
3. Weber State University Dept of Nursing

Other Solutions include:

1. Offering a "Sign-On" bonus to new employees who successfully complete 6 months of employment.
2. Offering a "Finders" bonus to any current staff member who attracts a new nursing employee who again, completes 6 months of employment.
3. The Acting Director of Nursing will contact various nursing employees who have resigned in hopes to attract them back to employment as result of management changes, and other issues that have been resolved.
4. Considering higher salaries for CNA's.

Current Management Changes

On February 7th, the President will be making a change with our Director of Nursing. As a result of this change, other Nursing Management positions will be changed as well.

Effective Immediately, Ray Wilde who is the Vice President of Utah Senior Services inc., will be acting as Assistant Administrator spending a great deal of time within the facility, working towards the resolution of these survey concerns. Dan Heiner, President of Utah Senior Services inc., will also be assisting greatly, with frequent days spent in the facility in a consulting role, offering assistance in this difficult piece of our survey deficiencies.

Our current Administrator Mike Wilde will be resigning from his position on March 1. At this time, Ray Wilde, license # 88-123008-1501, will be acting as Administrator until the position can be permanently filled.

Employee Compensation.

On February 8th, the Director of Nursing, Administrator, and Vice President will review all current nursing staff's salaries. Adjustments will be made if necessary if they are found to be inadequate with the current market.

The Director of Nursing and Assistant Director of Nursing have also conducted a survey of the nursing facilities in the area to determine the industry salary standard. There will be discussion on the 8th of February to determine if the our current starting salary needs to be adjusted, based upon those findings.

Staff Morale.

During the week of January 31st, Dan Heiner and Ray Wilde conducted interviews with current nursing staff members to assess the morale of the facility, as well as identifying areas of concern.

Based upon those findings, as well as current management input, the following plan will be followed.

1. Change of Nurse Management, which has already been addressed.
2. Staff working short, addressed as detailed above in recruiting staff.
3. New Staff working with new residents after their orientation without understanding specifics of these residents. This will be addressed in New Employee Training and Orientation.
4. Employees not feeling appreciated for a job well done. Dan Heiner has given management direction to "Catch Staff Doing Right!" Constant rewards of praise, as well as occasional gifts such as movie tickets, soft drinks, treats, etc will be given to those staff members who are doing great things for the residents.

New Employee Orientation and Training.

We will continue to orient new CNA's with 'hands-on' instruction for the same amount of time which they presently are receiving, which is up to 37.5 hours. However, the following changes will be made in this process.

1. The program "Train the Trainer" will be implemented. This program consists of approximately 6 seasoned CNA's, which have been approved by management to serve as trainers. As these CNA's train new staff, consistency should result, thus enhancing our staff's performance.

2. Once trained, that new staff member will stay on the same hall where they were orientated for a minimum of two weeks, baring immediate needs elsewhere throughout the facility. This will create a feeling of comfort and reduce some of the frustration that new staff are experiencing.

3. "Welcome to Our Family". The Director of Nursing will meet with the nursing staff on February 10th, instructing them to welcome all of our new staff members into our "Mt. Ogden" employee family. Care should be given to see that all of the new staff are welcome, and feel happy to be a part of the facility.

4. The Director of Nursing or the Assistant Director of Nursing will meet with each new nursing employee within 2 weeks of their employment to personally see if they are feeling a part of the team.

Misc.

Any additional assistance from agencies such as Job Corps, Weber State University, and D.A.T.C. will be solicited.