Correction Date For All Changed to 02/20/02 Per Telephone with Administrator 01/14/01
POC acceptable [signature]

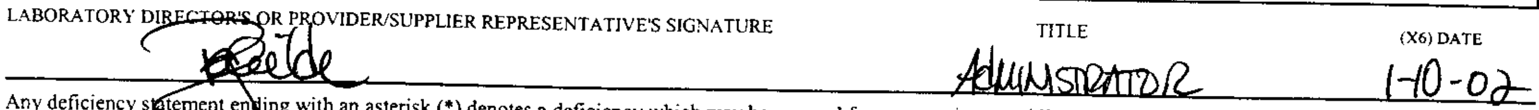
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 12/27/
FORM APPROVE
2567

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 ______	12/20/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT OGDEN NURSING & REHAB	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 252 SS=E	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, a confidential group interview, and one staff member interview, the facility did not provide a safe, clean, comfortable and homelike environment, for residents as evidenced by: Water temperatures checked by the nurse surveyor in resident rooms and bathrooms accessible to residents for use, ranged from 77 degrees Farenheit to 120 degrees Farenheit. Water temperatures below 100 degrees are too cool for comfortable bathing. Temperatures were checked on two different days at two different times of the day. Findings include: The water was allowed to run from two to three minutes on 12/19/01, at 12:20 PM, in resident sinks. The water temperatures revealed the following information: Room 303 water temperature was 110 degrees Farenheit Room 302 water temperature was 105 degrees Farenheit Room 308 water temperature was 112 degrees Farenheit Room 204 water temperature was 118 degrees Farenheit Room 211 water temperature was 118 degrees Farenheit Room 103 water temperature was 112 degrees Farenheit	F 252	F 252 The Maintenance Manager has made contact with an outside water heater company to install water heaters at various locations throughout the facility. This will allow hot water to be available at these listed locations. The maintenance manager will continue to check the water temperatures, and will ultimately be responsible for compliance. These findings will be shared monthly at our Quality Assurance meeting. Utah Dept. of Health JAN 1 1 2002 Bur. of Medicare/Medicaid Prog. Certification and Res. Assessment pm 1/10/02	Mar 1 2002 TB 02/20/02



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 1-10-02

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 aft such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 252	Continued From Page 1 Room 106 water temperature was 120 degrees Farenheit The occupational therapy room bathroom sink was 119 degrees Farenheit The women's bathroom outside the physical therapy room was 58 degrees Farenheit The men's bathroom outside the physical therapy room was 118 degrees Farenheit On 12/19/01, at 12:40 PM, the water temperatures just outside the locked special needs unit and bathrooms inside the unit revealed the following information: Room 402 water temperature was 78 degrees Farenheit Room 507 water temperature was 77 degrees Farenheit Room 506 water temperature was 78 degrees Farenheit Room 510 water temperature was 88 degrees Farenheit The water was allowed to run from two to three minutes on 12/20/01, at 7:00 AM, in resident sinks. The water temperatures revealed the following information: Room 303 water temperature was 110 degrees Farenheit Room 302 water temperature was 104 degrees Farenheit Room 308 water temperature was 104 degrees Farenheit Room 204 water temperature was 118 degrees Farenheit Room 103 water temperature was 106 degrees Farenheit Room 106 water temperature was 112 degrees Farenheit Room 402 water temperature was 98 degrees Farenheit Room 510 water temperature was 120 degrees Farenheit Room 506 water temperature was 94 degrees Farenheit	F 252		

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F 252	Continued From Page 2 The occupational therapy room bathroom sink water temperature was 104 degrees Farenheit The women's bathroom outside the physical therapy room was 56 degrees Farenheit The men's bathroom outside the physical therapy room was 115 degrees Farenheit On 12/20/01 an interview was conducted with the maintenance manager of this facility. During the interview he was questioned concerning the water temperature fluctuation in the building. He stated that the water temperature did fluctuate in different parts of the building at different times of the day. He also stated that he had attempted to maintain water temperatures but had not been successful. On 12/18/01, during a confidential group interview, 2 of 9 residents complained that during their bath times the water was cold and not at a comfortable temperature.	F 252	F 279	
F 279 SS=E	483.20(k) RESIDENT ASSESSMENT The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under s483.25; and Any services that would otherwise be required under s483.25 but are not provided due to the resident's	F 279	On 12-19-2001, the Care Plan Coordinator made the following corrections to the care plans: Resident 37 - problem addressing an indwelling catheter. Resident 1 - problem addressing activities of daily living. Resident 80 - problem addressing potential for dehydration. Resident 13 - problem addressing recurrent fecal impactions.	Mar 1, 2002 35 02/20/02

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F 279	Continued From Page 3 exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and interview, the facility did not develop a comprehensive care plan with measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs and did not describe the services that were furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 4 of 18 sampled residents. Residents 37 did not have a care plan problem initiated by the interdisciplinary team that addressed an indwelling catheter. Resident 1 did not have a care plan problem that addressed activities of daily living. Resident 80 did not have a care plan problem initiated by the interdisciplinary team that addressed potential for dehydration. Resident 13 did not have a care plan problem dealing with recurrent fecal impactions. Resident identifiers 1, 37, 80, 13. Findings include: 1. Resident 37 was a 79 year old female admitted to this facility on 9/28/01 with diagnoses including renal failure, non-insulin dependent diabetes mellitus and congestive heart failure. Resident 37 had a physician's order, dated 9/28/01, for a Foley catheter. Observations on 1218/01, 12/19/01, 12/20/01 and 12/21/01 revealed that resident 37 did have a Foley catheter in place. Review of resident 37's medical record revealed that the resident had no care plan problem with goals and approaches to address the Foley catheter.	F 279	On 1-10-2001 an inservice was held by the Director of Nurses for all licensed staff to discuss the following details regarding care plans: All telephone orders, physician visits which result in orders, clinic visits producing orders, change of conditions, recerts, and psychotropic drug review orders will be copied and given to the care plan coordinator. This will assure that items will not be missed on the care plans. A sampling of Care plans will be audited by the Director of Nursing each week. This information will be reviewed by the Quality Assurance Committee each month. The Director of Nursing will be ultimately responsible to ensure compliance.	Mar 1 2002 02/20/02

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F 279	Continued From Page 4 2. Resident 1 was an 81 year old female admitted to this facility on 7/9/01 with diagnoses including Alzheimer's disease, hypertension and chronic obstructive pulmonary disease. On 12/18/01, a review of resident 1's medical record was done. The Medicare MDS' (minimum data sets) completed for this resident and dated 7/13/01, 7/22/01, 8/8/01, 9/7/01 and 10/7/01 all documented the following: resident 1 required limited to extensive one person physical assistance with activities of daily living including transferring between surfaces, locomotion both on and off the unit, dressing, eating, personal hygiene and bathing. A review of resident 1's medical record revealed that the resident had no care plan problem with goals and approaches to address her need for assistance with activities of daily living. 3. Resident 80 was a ninety six year old female admitted to the facility with the diagnoses of dehydration, hypertension ands transient ischemic attacks (small strokes). Review of resident 80's intake flow sheet, documented by the nurse aids, indicated that she was not receiving hydration to meet her fluid requirements for December 1 through December 19, 2001. Further review of resident 80's care plan, updated on 11/21/01 by the facility interdisciplinary team, did not have a care plan problem addressing the potential for dehydration or list interventions to prevent dehydration. 4. Resident 13 was an 88 year old female with diagnoses of hypertension, Parkinson's Disease, dementia with anxious features, gout, arthritis and hypoxia.	F 279		

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F 279	Continued From Page 5 On 12/19/01, a record review of resident 13's Nurses Progress Notes was done. On 10/4/01 and 10/11/01, the nurses noted that they had manually removed large fecal impactions. A review of resident 13's care plan revealed that there were no problems listed dealing with goals and approaches to address fecal impactions. An interview was done on 12/19/01 with the director of nurses, she stated that fecal impactions had not been care planned for resident 13. Later that day, she presented this surveyor with an amended care plan addressing fecal impactions.	F 279		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on medical record review, the facility did not provide the necessary care and services to attain or maintain the highest practicable physical well-being , in accordance with the comprehensive assessment and plan of care, for one of eighteen sampled residents. Resident CR1 did not receive an antibiotic for five days after it was ordered by the physician for the treatment of pneumonia. It was started one day prior to her death. Findings include:	F 309	F 309 On 1-10-2002 an inservice was held by the Director of Nursing for all licensed staff. Proper policy and procedure for ordering and administering medications, specific to antibiotics was discussed. This policy will be followed. (See Policy) The Director of Nursing will audit all new antibiotic orders to ensure compliance. These findings will be shared each month in our Quality Assurance Committee meeting. The Director of Nursing will be ultimately responsible to ensure compliance.	Mar 1, 2002 02/20/02 [illegible]

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F 309	Continued From Page 6 1. Resident CR1 was a ninety six year old female admitted to this facility with diagnoses of diverticulitis, atherosclerotic heart disease, gastric reflux, colitis, ischemic heart disease, and an aortic aneurysm. 2. Review of resident CR1's medical treatment plan, written and signed on March 26, 1994, revealed the following hand written statement: "If resident has a "normal" illness such as colds, bronchitis or pneumonia, we want her to receive adequate treatment so she will be made comfortable." There was a portion of the medical treatment plan that identified that resident CR1 desired treatment with antibiotics either orally or intramuscularly. 3. Further review of resident CR1's medical record, revealed a nursing note, dated 10/04/01, at 2:30 PM, identifying a harsh, wet, productive cough. The nursing note stated that the physician had been notified and orders were received for a chest x-ray and a complete blood count. The nursing note stated that resident CR1 had been transported to an acute hospital for tests. On 10/05/01, another nursing note, timed at 3:00 PM, stated that resident CR1's son had been notified of the resident's change in condition. There was no further nursing note until 10/09/01, timed at 7:00 PM, which stated that the physician had been notified that an antibiotic was not started on 10/5/01, as ordered. The nursing note stated that a new order was written to start the antibiotic, Levaquin 500mg (milligrams) one by mouth every day for seven days. The nursing note continued, "F/U (follow up) order from 10/5/01."	F 309		

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F 309	Continued From Page 7 Review of resident CR1's physician's telephone orders, revealed a physician's order written on 10/5/01, for Levaquin 500mg one by mouth every day for seven days. The order was signed by the nurse and the physician. Continued review of resident CR1's physician's telephone orders, revealed a physician's order written on 10/9/01, to start Levaquin 500mg one by mouth every day for seven days. "F/U order 10/5/01." Review of resident CR1's medication administration record revealed a hand written order for the medication Levaquin 500mg one by mouth every day x (times) seven days. The first day that resident CR1 received this medication was documented, by the nurse, as 10/9/01. There was no other documentation that resident CR1 received Levaquin 500mg before 10/9/01. Continued review of resident CR1's nursing notes revealed a nursing note, dated 10/10/01, at 8:30 PM, which stated that resident CR1 had been brought back from the dining room unresponsive. The nursing note stated that the resident's vital signs were checked and her oxygen saturation on room air was 88 per cent (normal is above 90). The nursing note stated that oxygen was placed on resident CR1at 2 liters per minute through a nasal cannula and the physician was notified. On 10/10/01, at 9:30 PM, a nursing note stated that resident CR1's vitals were taken and that she was beginning to respond. On 10/10/01, at 11:00 AM, a nursing note stated that a productive cough was noted. On 10/10/01, at 3:00 PM, another nursing note stated that the physician had visited and no new orders were received. It also stated that resident CR1's color was "gd" (good), no output was noted, and a wet cough was noted. On 10/10/01, timed "7P-7A," the final nursing note	F 309		

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F 309	Continued From Page 8 was noted. The nursing note stated that at 7:30 PM, resident CR1's vital signs ceased. The nursing noted stated that the physician had been notified and had given orders to release the body to the mortuary. Review of resident CR1's discharge summary/post discharge plan of care, initiated by the facility, and signed by the physician, revealed that the nursing summary of stay stated that resident CR1's final discharge was a "quick and unexpected death." The final diagnosis on the discharge summary form was, "pneumonia."	F 309		
F 327 SS=D	483.25(j) 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 medical record review and observation, the facility did not provide each resident with sufficient fluid intake to maintain proper hydration and health as evidenced by: One of eighteen sampled residents did not receive the calculated fluid requirements to maintain appropriate hydration. Resident identifier Findings include: Resident was a ninety six year old female admitted to this facility in February of 1994 with diagnoses of dehydration, hypertension, and trans-ischemic attacks (small strokes). Resident fluid requirements were calculated by multiplying her body weight of 148 in kilograms by 2.2. These requirements were 2018cc (cubic centimeters) each twenty four hour period.	F 327	F 327 On 1-10-2002 an inservice was held by the Director of Staff Development for all Certified Nursing Assistants. Proper policy and procedure was discussed. Upon admission, the Director of Nursing will evaluate all new residents for dehydration risk. Those identified will have a picture of a glass of water placed over their bed. When a Certified Nursing Assistant enters the room to offer care for the resident, they will routinely offer something to drink. These residents will also require that the Certified Nursing Assistant document on the flow sheet, their fluid intake for the shift. The Director Of Staff Development will review these flow sheets weekly to ensure compliance. These resident's flow sheets will be reviewed by the Quality Assurance Team monthly. The Director of Staff Development will ultimately be responsible to ensure compliance.	02/20/02 Mar 1, 2002

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F 327	Continued From Page 9	F 327		

Review of resident intake flow sheet record, initiated by the facility and documented by the certified nurse aids, revealed that from December 1 until December 19, 2001, resident did not receive the calculated fluid requirements according to her body weight. The fluid documented by the nurse aids included her mealtime intake, her house supplement intake, and extra water given to her from her water pitcher. The following information was documented on the resident flow sheet;

1. December 1- 1050cc
2. December 2- 1320cc
3. December 3- 280cc
4. December 4- 1390cc
5. December 5- 1320cc
6. December 6- 480cc
7. December 7- 950cc
8. December 8- 1240cc
9. December 9- 480cc
10. December 10- 810cc
11. December 11- 1110cc
12. December 12- 396cc
13. December 13- 1280cc
14. December 14- 960cc
15. December 15- 290cc
16. December 16- 720cc
17. December 17- 1580cc
18. December 18- 940cc
19. December 19- 1180cc

Resident did not received the fluid requirement amounts for nineteen of the nineteen days documented.

Observation of resident in her room on 12/20/01, at 8:00 AM, revealed the resident sitting in her wheelchair, facing the door, next to her bed. The water pitcher was noted to be on a table beside the television, across the room from her. The lid was

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F 327	Continued From Page 10 removed by the nurse surveyor to reveal five cubes of ice present in a full pitcher. At 9:15 AM, resident was again observed in her room. The water pitcher was present on the over-the-bed table beside her. The lid was removed by the nurse surveyor to reveal there was no ice present and the level of the water in the pitcher remained the same. At 11:00 AM, resident was observed in her wheelchair in her room in the same position as previously observed. The water pitcher remained on her over-the-bed table. The lid was removed by the nurse surveyor to reveal there was no ice present and the level of the water in the pitcher remained the same as observed previously. At 1:15 PM, resident was observed in her bed. The water pitcher was noted to be on the over-the-bed table next to her bed. The lid was removed by the nurse surveyor to reveal there was no ice present and the level of the water in the pitcher remained the same as observed previously. At 1:45 PM, resident was observed in her bed. The water pitcher was noted to be in the same position on the over-the-bed table next to her bed. The lid was removed by the nurse surveyor to reveal there was no ice present and the level of the water in the pitcher remained the same as observed previously.	F 327		
F 329 SS=D	483.25(l)(1) QUALITY OF CARE Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or	F 329		

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F 329	Continued From Page 11 discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility did not ensure that resident 13's drug regimen was free from an unnecessary drug (Zestril for the treatment of high blood pressure), which was given when the blood pressure recorded was below the parameter ordered by the physician. This occurred in one of eighteen sampled residents. Findings include: Resident 13 was an 88 year old female admitted to the facility on 9/12/2000 with the diagnoses of hypertension, Parkinson's, dementia with anxious features, gout, arthritis and hypoxia. On 12/20/01, a record review of the Medication Administration Record was done. It was documented that Zestril 10 MG (milligrams) was to be given twice daily and to be held if the BP (blood pressure) was below 130/80. On 12/20/01, an interview was done with the director of nurses. She stated that the documented 9:00 AM and PM blood pressures were actually taken before medication administration at 8:00 AM and PM. She also added that the 1:00 PM blood pressure was taken to determine if the medication was effective. The following was documented on the Medication Administration Record. It was dated 11/01/01: On 11/2/01, the evening BP was documented as 127/66 and the dose was signed as given by the nurse. On 11/17/01, the morning BP was documented as	F 329	F 329 An inservice was held on 1-10-2002 by the Director of Nursing for all licensed staff regarding the following information: Before Zesril is given, the attending nurse will take that residents blood pressure. If their blood pressure is greater than 130/80, that medication will be held until the next scheduled dose. This will be audited by the Director of Nursing weekly to ensure compliance. This information will be reviewed by the Quality Assurance committee monthly. The Director of Nursing will be ultimately responsible to see that this stays in compliance.	Mar 1 2002 02/20/02

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2567

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 ______	12/20/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT OGDEN NURSING & REHAB	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 329	Continued From Page 12 120/70 and the dose was signed as given by the nurse. On 11/18/01, the morning BP was documented as 130/68, and the dose was signed as given by the nurse. On 11/20/01, the morning BP was documented as 110/90, and the dose was signed as given by the nurse. On 11/24/01, the evening BP was documented as 126/84, and the dose was signed as given by the nurse. Resident 13 received Zestril 10 mg. five times when the recorded blood pressure was below 130/80.	F 329	F 371	Mar 1, 2002
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility did not store, prepare and distribute food under sanitary conditions as evidenced by kitchen staff having no documentation that the sanitizer concentration on the facility's low temperature dish-washing machine was being routinely checked and monitored. Findings include: Observations on 12/19/01 at 1:44 PM revealed a dietary aide washing dishes in the dish room. At 1:51 PM, this surveyor asked the dietary aide to check the sanitizer solution in the dish machine. The aide stated that she could but she wasn't sure she knew how. When asked how long she'd worked in the facility she stated 7 years and had done dishes throughout her employment. She stated the sanitizer was not checked routinely.	F 371	On 1-10-2002 an inservice was held by the Dietary Manager for all dietary employees. The proper way to check the sanitization system was discussed, as well as how to document the findings. The dishwashing employee will check the sanitizing system not less than once a day. Negative results will immediately be reported to the Dietary Manager. The Dietary Manager will audit these reports twice a month, and will share the results with the Quality Assurance Committee. The Dietary Manager will be ultimately responsible to ensure compliance.	02/20/02

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F 371	Continued From Page 13 Observations of the "Dishwasher Temperatures" sheet posted in the dish room revealed that dietary staff members were recording dish machine temperatures three times per day during the breakfast, lunch and dinner wash cycles. There was no documented evidence on this sheet that the sanitizer concentration was being checked daily. On 12/19/01 at 2:03 PM an interview with the dietary supervisor was done. She stated the dish machine sanitizer was checked from time to time. She stated that the facility did have a contract with a dish machine service company and they checked the sanitizer but she was unable to recall the date of their last visit. She was asked to provide any documented evidence of dish machine sanitizer checks. On 12/19/01 at 3:16 PM, the dietary supervisor provided a dish machine service company report to this surveyor dated 10/12/01. She stated that the service company representative had not visited the facility in November and she didn't think he'd come during the month of December. No other documented evidence of routine dish machine sanitizer checks was provided to this surveyor.	F 371		