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

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 _____	C 08/01/2005

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) COMPLETION DATE
F 000	INITIAL COMMENTS Immediate jeopardy to resident health and safety was identified during an abbreviated survey conducted from 7/21/05-7/28/05. Deficiencies cited under immediate jeopardy to resident health and safety were F-157 and F-309. On 8/2/05, a follow-up survey was conducted to determine if the facility had removed the immediate jeopardy to resident health and safety. It was determined that immediate jeopardy had been removed as of 8/01/2005, but the facility was not in substantial compliance and substandard quality of care remained.	F 000	Amended per IDR completed on 10/31/05 original POC accepted on 8/17/05 by L. Bussenbark	
F 157 SS=J	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative	F 157	Utah Department of Health 11-9-05 NOV 1 4 2005 Bureau of Health Facility Licensing, Certification and Resident Assessment	8/1/05

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

Administrator 11-7-05

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are 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 157	Continued From page 3 On 7/18/05 at 6:40 PM, LPN 1 documented in a nursing note, "Patient has no VS. Son notified of condition. Mortuary called for transport. Doctor was left message on machine. Body was released to mortuary." No documentation could be found in Resident 1's medical record to indicate that LPN 1 or any other facility staff had contact with the primary care physician from 1:30 PM to 6:40 PM on 7/18/05, when a message was left on the physician's voice mail regarding Resident 1's death. LPN 1 was interviewed on 7/26/05 and 7/27/05 at 2:20 PM and 2:00 PM respectively. LPN 1 was the nurse assigned to the unit in which Resident 1 resided in the facility. LPN 1's work hours were from 7:00 AM to 7:00 PM on 7/18/05. During both interviews, LPN 1 stated at 10:00 AM, she noticed that Resident 1 was, "Not acting herself", so LPN 1 called the resident's son and the son requested that LPN 1 call Resident 1's attending physician. LPN 1 further stated that she called the attending physician at 1:15 PM and left a message on the voice mail about the change in Resident 1's condition. At both interviews, the surveyor asked LPN1 what information she had provided on the voice mail. LPN 1 responded, "I told them that (Resident 1) was not acting herself." LPN 1 was questioned further, during both interviews, to determine if she had given any additional information. LPN 1 responded that she provided no additional information either on the voice mail or to the physician's office staff, when they returned her call at 1:30 PM.	F 157		

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F 157	Continued From page 4 During both interviews with LPN 1, the surveyor asked LPN 1 if she had provided any additional information to Resident 1's attending physician, either by voice mail or to the physician's office manager. Both times LPN 1 stated that she had not. Following this response at the second interview, the surveyor asked LPN 1 specifically if she had informed Resident 1's attending physician of the resident's vital signs. At that time, LPN 1 stated that she did provide the physician's office with Resident 1's vital signs that had been taken after lunch. Note: Per nursing note entry on 7/18/05 at 1:15 PM, Resident 1's vital signs were documented to be 78/54, 120, 58. Documentation of the medication administration record indicated that Resident 1's 11:00 AM insulin dose was held on 7/18/05. During an interview on 7/26/05, LPN 1 stated that she held the insulin, "because her (Resident 1's) blood sugar was low. I don't remember the number, but it was low so I did not give the insulin." No documentation was available in Resident 1's medical record to reflect what Resident 1's blood sugar was prior to LPN1 holding the insulin or that Resident 1's attending physician had been notified of the low blood sugar and need to hold the scheduled dose of insulin. Interviews with LPN 1 and the physician's office manager confirmed that the low blood sugar was not reported to the physician. During an interview on 7/27/05, LPN 1 stated that Resident 1 ate 30-40 % of lunch on 7/18/05. LPN 1 further stated that Resident 1 did not consume any food at dinner on 7/18/05. She stated resident 1, "kept spitting it out."	F 157		

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F 157	Continued From page 5 On 7/26/05 and again on 7/26/05, LPN 1 confirmed that Resident 1, "did not look so good" during dinner. LPN 1 stated she called the son and he responded by telling LPN 1, "I'll be right there." On 7/26/05 and again on 726/05, LPN 1 reported that on 7/18/05 at 6:20 PM, Resident 1 was Cheyne - Stoking (breathing pattern consisting of periods of apnea lasting 10-60 seconds followed by gradually increasing depth and frequency of respirations). LPN 1 reported that this breathing lasted 10-15 minutes. LPN 1 stated that she checked on Resident 1, during the 10-15 minutes of Cheyne - Stoking, every 4-5 minutes until Resident 1 was found with no vital signs at 6:40 PM. On 7/27/05 at 11:50 AM, a telephone interview was held with resident 1's attending physician's office manager (POM). Resident 1's attending physician's office manager (POM) stated in her interview that, "I was told that (Resident 1) was not acting herself". The surveyor asked the POM what instructions were provided to the facility relating to Resident 1 not acting herself. The POM stated that she called the facility and spoke with a female (name unknown) and that since the physician was standing near her, she placed the phone on hold to receive instructions from the physician. The POM stated that she then relayed the physician's instructions to the female on the phone. The POM stated the physician's instructions were to, "Monitor the patient and call if there were any changes." The POM stated that she was not informed that Resident 1's blood pressure was 78/54 and that the resident was not responding.	F 157		

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F 157	Continued From page 6 The POM stated that had she been given that information, she would have instructed the facility to send Resident 1 to the emergency room immediately. On 7/26/05 at 5:30 PM, a telephone interview was held with Resident 1's attending phyisician. The physician stated that had his office been informed that Resident 1's blood pressure was 78/54, his wife who runs the office would, "have informed me immediately". He stated that he would have instructed the facility to initiate some intervention for the low blood pressure. The physician further stated that he was "suprised" when he received the death certificate for Resident 1 and remembered thinking, "I wonder what happened."	F 157		
F 309 SS=J	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. This REQUIREMENT is not met as evidenced by: Based on interview and medical record review it was determined that for 1 of 13 sample residents the facility did not provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive	F 309	F 309 Resident 1 has been discharged from our facility. Refer to Plan of correction for F 157.	8/1/05

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F 309	Continued From page 7 assessment and plan of care. Specifically, Resident 1 had a change in condition that was not reported to the physician in a manner in which he could make an appropriate decision regarding treatment or transfer to the hospital, nor did the staff monitor the resident and document changes from 1:30 PM to 6:40 PM when Resident 1 was found without vital signs. Findings included: Resident 1 was admitted to the facility on 6/2/05 with diagnoses including, cardiac pace maker insertion, atrial fibrillation, acute myocardial infarction, history of bacterial endocarditis, urosepsis, renal failure, insulin dependent diabetes mellitus, anemia, hypertension, and a history of colon cancer. Record review was conducted on 7/21/05 and 7/26/05. The Physician Order of Life Sustaining Treatment (POLST), for Resident 1, was initiated on 6/2/05, and included; "Do Not Resuscitate with Limited Additional Interventions, including; oxygen, suction, treatment of airway obstruction, bag-mask/demand valve, monitor cardiac rhythm, medication, intravenous fluids, transfer to hospital if indicated, but no endotracheal intubation or long -term life support measures." Per instructions on the POLST, Resident 1 could receive antibiotics or artificially administered fluids and nutrition if family was notified and approved. On 7/18/05, vital signs for Resident 1 were documented to be: blood pressure 110/52; temperature 96.4; pulse 76; and respirations 20.	F 309		

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F 309	Continued From page 8 On 7/18/05 at 10:00 AM, LPN 1 (Licensed Practical Nurse) documented in a nursing note that resident was "Alert this am. Speaks very little. Responds to verbal stimuli very little. No s/s (signs or symptoms) of pain or discomfort. Dependent with all ADL's (activities of daily living). Needs help with eating. Will continue to monitor." On 7/18/05 at 1:15 PM, LPN 1 documented in a nursing note, "Doctor called, left message on voice mail about change in patients condition. Son called and notified. Will continue to keep both parties notified. Awaiting call back from doctor. VS (vital signs) 78/54, 120, 58. Patient not responding to verbal stimuli. O2 (oxygen) saturation 92% at 2L (liters) per NC (nasal cannula). Will continue to monitor." On 7/18/05 at 1:30 PM, LPN 1 documented in a nursing note, "Doctor called back update given. Doctor wants to watch her (Resident 1) plus update him if anything new happens. Son notified informed him that he will be notified if there are any changes. Will continue to monitor." On 7/18/05 at 6:40 PM, LPN 1 documented in a nursing note, "Patient has no VS. Son notified of condition. Mortuary called for transport. Doctor was left message on machine. Body was released to mortuary." Five professional level nursing staff, who were on duty the day Resident 1 died, were interviewed as follows: 1.) DON (Director of Nursing) on 7/27/05 at 1:40 PM 2.) ADON (Assistant Director of Nursing), LPN 2	F 309		

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F 309	Continued From page 9	F 309		

on 7/27/05 at 2:25 PM
3.) LPN 1 (Licensed Practical Nurse) on 7/26/05 and 7/27/05 at 2:20 PM and 2:00 PM respectively
4.) RN1 (Registered Nurse) on 7/27/05 at 2:40 PM
5.) CNA 1 (Certified Nursing Assistant) on 7/27/05 at 2:15 PM

Resident 1's attending physician was interviewed on 7/26/05 at 5:30 PM, and his office manager was interviewed on 7/27/05 at 11:50 AM.

LPN 1 was the nurse assinged to the unit in which Resident 1 resided in the facility. LPN 1's work hours were 7:00 AM to 7:00 PM on 7/18/05.

During both interviews with LPN 1, she stated that Resident 1 had eaten 100% of her breakfast on 7/18/05 and was lucid enough in the morning to talk with the nurse and say "Hi". At 10:00 AM, LPN 1 stated that Resident 1 was "not acting herself" so LPN 1 called the son and the son requested that LPN 1 call the resident's attending physician. LPN1 further stated that she called the attending physician at 1:15 PM and left a message on the voice mail about the change in Resident 1's condition. At both interviews, the surveyor asked LPN1 what information she had provided on the voice mail. LPN 1 responded, " I told them that (Resident 1) was not acting herself." LPN 1 was further questioned during both interviews to determine if she had given any additional information. LPN 1 responded that she provided no additional information either on the voice mail or to the physician's office staff, when they returned the call at 1:30 PM.

During the interview with LPN 1 on 7/27/05, LPN 1 stated that prior to placing the call to resident

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F 309	Continued From page 10	F 309		

1's attending physician, she informed the ADON that Resident 1 was not acting herself and asked the ADON to look at Resident 1.

The ADON, also a licensed practical nurse, stated in her interview that she was asked by LPN 1 to go and look at Resident 1. The ADON stated that she accompanied LPN 1 to see Resident 1. The surveyor asked the ADON if she, or LPN 1, gathered any assessment data when she went to Resident 1. The ADON responded, " No, we just looked at her."

According to LPN 1, during her interview on 7/27/05, Resident 1 ate 30-40% of lunch on 7/18/05. LPN 1 reported that Resident 1 was not talking at lunch so LPN 1 requested that a CNA obtain a set of vital signs. Note: Per nursing note entry on 7/18/05 at 1:15 PM, Resident 1's vital signs were documented to be 78/54, 120, 58.

During both interviews with LPN 1, the surveyor asked LPN 1 if she had provided any additional information to Resident 1's attending physician, either by voice mail or to the physician's office manager. Both times LPN 1 stated that she had not. Following this response at the second interview, the surveyor asked LPN 1 specifically if she had informed Resident 1's attending physician of the resident's vital signs. At that time, LPN 1 stated that she did provide the physician's office with Resident 1's vital signs that had been taken after lunch.

Resident 1's attending physician's office manager (POM) stated in her interview that, "I was told that (Resident 1) was not acting herself". The surveyor asked the POM what instructions were provided to the facility relating to Resident 1 not

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F 309	Continued From page 11	F 309		

acting herself. The POM stated that she called the facility and spoke with a female (name unknown) and that since the physician was standing near her, she placed the phone on hold to receive instructions from the physician. The POM stated that she then relayed the physician's instructions to the female on the phone. The POM stated the physician's instructions were to, "Monitor the patient and call if there were any changes." The POM stated that she was not informed that Resident 1's blood pressure was 78/54 and that the resident was not responding. The POM stated that had she been given that information, she would have instructed the facility to send Resident 1 to the emergency room immediately.

Documentation of the medication administration record indicated that Resident 1's 11:00 AM insulin dose was held on 7/18/05. LPN 1 stated on 7/26/05 that she had held the insulin, "because her (Resident 1's)blood sugar was low. I don't remember the number, but it was low so I didn't give the insulin." No documentation was available in Resident 1's medical record to reflect what Resident 1's blood sugar was prior to LPN 1 holding the insulin or that Resident 1's attending physician had been notified of the low blood sugar and need to hold the scheduled dose of insulin.

Interviews with both LPN 1 and the POM confirmed that Resident 1's low blood sugar was not reported to the physician.

On 7/27/05, CNA 1 stated that on 7/18/05, she had received report from the off-going shift at 2:00 PM and began care of Resident 1 for her shift (2-10 PM). CNA 1 stated that at 2:30 PM, she went in to deliver personal cares to Resident

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F 309	Continued From page 12	F 309		

1 and noticed she, "had rapid breathing." CNA 1 stated that she reported this to LPN 1 and that LPN 1 replied, "Yeah. I know. She is dying." When questioned as to whether or not CNA 1 was asked to do any vital signs for Resident 1 on her shift, CNA 1 replied, "No".

On 7/26/05, LPN 1 stated that Resident 1 did not eat any dinner, that she, "kept spitting it out" and that Resident 1 "did not look so good". LPN 1 stated she called the resident's son and he responded by telling LPN 1, "I'll be right there." LPN 1 reported in both interviews that at 6:20 PM on 7/18/05, Resident 1 was Cheyne-Stoking (breathing pattern consisting of periods of apnea lasting 10-60 seconds followed by gradually increasing depth and frequency of respirations). LPN 1 reported that this breathing lasted 10-15 minutes. LPN 1 stated in both inteviews that she checked on Resident 1, during the 10-15 minutes of Cheyne-Stoking, every 4-5 minutes until Resident 1 was found with no vital signs at 6:40 PM.

No documentation could be found in the medical record to indicate that LPN 1 or any other facility staff had contact with the primary care physician from 1:30 PM to 6:40 PM on 7/18/05 when a message was left on the physician's voice mail regarding Resident 1's death.

On 7/27/05, RN 1 stated that she did not assess Resident 1 but was aware that Resident 1 was having difficulties because LPN 1 was worried the son of Resident 1 would not, "Make it in before she passed away."

On 7/27/05 The DON stated that she was aware that Resident 1 was, "not acting herself", but she

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F 309	Continued From page 13 did not go down and assess the resident. The DON further stated that she was suprised to hear that Resident 1 had died when she arrived at the facility the next morning. On 7/26/05 at 5:30 PM, a telephone interview was conducted with resident 1's attending physician. The physician stated that had his office been informed that Resident 1's blood pressure was 78/54, his wife who runs the office would, "have informed me immediately". He stated that he would have instructed the facility to initiate some intervention for the low blood pressure. The physician further stated that he was "suprised" when he received the death certificate for Resident 1 and remembered thinking, "I wonder what happened."	F 309		
F 325 SS=G	483.25(i)(1) NUTRITION 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 medical record review it was determined that for 1 of 13 sampled residents the facility did not maintain acceptable parameters of nutritional status, such as body weight and protein levels. Specifically, Resident 2 received a gastronomy tube -feed diet of Glucerna that consisted of 500 kilocalories, 34 grams of protein, and 975 milliliters of fluid a day for 22 days. This diet resulted in a 16 pound weight loss in one	F 325		8/10/05

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F 325	Continued From page 14 month. Findings included: Resident 2 was admitted to the facility on 6/19/02 with diagnosis including, insulin dependent diabetes mellitus, hypertension, degenerative disc disease, peripheral vascular disease, protienuria, seizures, history of hysterectomy, status post cholecystectomy, history of depression and anxiety, obesity, dementia, congestive heart failure, and gastroesophageal reflux disease. Record review was completed on 7/21/05. The Physician Order for Life Sustaining Treatment (POLST) was initiated on 11/15/04. This form included "Do Not Resuscitate with Limited Additional Interventions which includes; oxygen, suction, treatment of airway obstruction, bag-mask/demand valve, monitor cardiac rhythm, medication, intravenous fluids. Transfer to hospital if indicated, but no endotracheal intubation or long - term life support measures". Resident 2 could also receive per the POLST form" Long-term feeding tube/ intravenous fluids". Resident 2 had a gastronomy tube placed on 9/30/04. After placement of the tube, Resident 2 remained on a 1500 calorie ADA (American Dietetic Association) diet of Glucerna at 80 milliliters an hour for 22 hours a day from October 2004 until March 17, 2005. According to the Ross 2000 Enteral Nutrition Guide, this diet provided 1760 kilocalories with 73.5 grams of protein, and 1,501 milliliters of water, from the glucerna, per day. Additionally, Resident 2 received 600 milliliters of water a day for a grand total of 2,101 milliliters of fluid per day.	F 325	F 325 Resident #2 has been discharged from the facility. The Weight and Wound committee will meet twice a month. This will consist of the Director of Nursing, Assistant Director of Nursing, Care Plan Coordinator, Treatment Nurse, Dietary manager, and Dietician. The committee will identify any resident who is a risk for potential weight loss. Once identified, a "Weight Loss Risk Resident Worksheet" (See attached), will be filled out by the committee. The doctor will be notified by the attending nurse if orders are needed. These residents will be weighed at least twice a month by the Restorative Therapy Assistants.	

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

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	465069	A. BUILDING _____ B. WING _____	C 08/01/2005

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F 325	Continued From page 15 Record review revealed that Resident 2 maintained a stable weight range of 150-154 pounds from October 2004 until March 2005. During this five month period Resident 2 remained on the original gastronomy tube diet of Glucerna at 80 milliters per hour for 22 hours a day. Medical record review revealed that on 3/10/05 Resident 2 was sent to the emergency room for coffee ground emesis. Resident 2 was admitted to the hospital on 3/10/05 with a diagnosis of gastrointestinal bleed. On 3/11/05 Resident 2 underwent a Esophagogastroduodenoscopy with gastric biopsy. During the procedure Resident 2 was found to have Esophagitis, Gastritis, Duodenitis, and an occlusion of the pylorus from the balloon of the gastronomy tube migrating down into the pylorus. During the procedure the physician deflated the gastronomy tube balloon and withdrew the tube back further into the stomach so the balloon would be up against the gastric wall. Resident 2 was admitted back into the facility on 3/12/05. Upon return Resident 2's gastronomy tube feeding of Glucerna was started at 40 milliters an hour for 22 hours a day. According to the Ross 2000 Enteral Nutrition Guide, this diet would have provided 880 kilocalories with 36.7 grams of protein, and 750 milliters of water, from the glucerna, per day. Additionally, Resident 2 received 600 milliters of water a day for a grand total of 1,350 milliters per day. According to the medical record review this diet remained in place from 3/12/05 through 3/17/05. The RD (Registered Dietician) documented on	F 325	The "eyeglass" picture, (which is our facility's way to confidentially alert nursing to areas such as fall risk, skin risk, fluid restriction, thickened liquids, dehydration risk, and weight loss risk), with an "*" will be posted in the resident's room. This will alert the Nursing staff that this is a resident who is a risk for weight loss. The staff will then offer more attention to assist the resident to eat more during their meals, as well as snacks. The Director of Nursing will also place a note in these Resident's flow sheets to alert the Certified Nursing Assistants to properly chart all food that was given to the resident, or all efforts that were offered to aid the resident in eating. Intake, as well as weight status will be assessed by the Weight and Wound committee twice a month.	

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F 325	Continued From page 16 3/15/05 on a dietary progress note that Resident 2 remained on a G-Tube (gastronomy tube) feeding of Glucerna at 40 milliters per hour for 22 hours a day. The RD also noted that she would try to get the tube feeding rate increased to 80 milliters per hour for 22 hours a day for adequate nutrition. On 3/17/05 a facility nurse documented on a nursing progress note that Resident 2 had a small amount of coffee ground emesis. The tube feed was put on hold and the nurse received an order for Resident 2 to receive bolus feeds of 15 milliters of Glucerna every 30 minutes until emesis subsides. On 3/17/05 a facility nurse received a physician's order to restart the tube feedings at 20 milliters per hour. Review of the nursing notes revealed that Resident 2 had no further episodes of emesis until 3/21/05. On 3/21/05 a facility nurse documented in the nurse progress notes that Resident 2 had emesis times two that shift which was greenish in color. The tube feeding was not stopped. The tube feeding continued with Glucerna at 20 milliters per hour for 22 hours a day. The RD documented on 3/22/05 on a dietary progress note that Resident 2 was receiving Glucerna at 20 milliters per hour for 22 hours a day. The RD also noted how much nutrition this diet would provide to Resident 2. This diet provided 440 kilocalories with 19 grams of protein and 375 milliters of water. RD further noted that weight loss was anticipated with the decrease in the tube feeding rate.	F 325	If necessary, the social worker will notify the resident, (family) of the need for a feeding tube for the resident. If refused, a continued effort will be attempted, and documented by the attending nursing staff. All residents who have a feeding tube will have their feeding rates, calories, as well as free H2O amounts addressed by weekly notes from our Registered Dietician. This report will go to the Director of Nursing weekly for follow up. The Director of Nursing will ensure that all residents who are on a feeding tube, receive adequate nutrition, according to the guidelines which have been established. Should they not receive enough calories due to refusal, the physician will be notified, and the direction of the doctor will be followed. On 8-10-2005, and in-service will be held by the Director of Nursing for all members of the nursing staff to discuss this process.	

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F 325	Continued From page 17 Review of RD notes from 3/15/05 through 3/29/05 revealed that no current weight for Resident 2 was provided to RD for her weekly assessment of Resident 2. Review of the nurse progress notes on 7/21/05 from 3/22/05 through 4/7/05 revealed that Resident 2 experienced no further episodes of nausea or vomiting. For 17 days Resident 2 had no emesis and it was documented that the tube feeding was being tolerated well. The facility had no documentation to indicate they contacted the physician to have tube feeding rate re-evaluated and possibly increased. On 3/29/05 the RD documented on a dietary progress note that Resident 2 remained on the tube feed of Glucerna at 20 milliters per hour for 22 hours a day and that this diet was not adequate to meet the nutritional needs of Resident 2. An Addendum to the 3/29/05 RD note documented that the Director of Nursing needed to talk with the physician about advancement of tube feeding rate or a change in position of tube feeding placement. No documentation could be found in Resident 2's medical record to indicate that the physician was notified regarding the RD's recommendations on 3/29/05. On 4/5/05 the RD documented on a dietary progress note that Resident 2 continues with same rate of tube feeding. Resident's weight as of 4/1/05 was 136 pounds. On 3/1/05 Resident 2's weight was documented as 152 pounds. A 16 pound weight difference was documented in a one month time frame.	F 325	Every month, the Director of Nursing will share the findings of the Weight and Wound committee with our Quality Assurance team during our meeting. The Director of Nursing will be ultimately responsible to ensure compliance.	

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F 325	Continued From page 18 RD documented on 4/5/05 that weight loss may continue with inadequate tube feeding. A facility nurse received a telphone order dated 4/6/05 which documented, "Deflate G-tube cuff and pull back 1 inch due to emesis. Schedule upper GI through G-tube." On 4/7/05 a facility nurse documented on a physician's order to increase the tube feeding rate by 10 milliters an hour until 80 milliters was reached as tolerated. This was to start on 4/8/05. Documentation showed that the facility did start the tube feed advancement on 4/8/05 and according to nursing note documentation Resident 2 reached the goal rate of 80 milliters an hour by 8:00 PM on 4/8/05. Medical record review revealed that Resident 2 experienced further episodes of emesis on 4/9/05 and 4/10/05. On 4/10/05 Resident 2 was transferred to the hospital per the daughter's request. Resident 2 was admitted to the hospital on 4/10/05	F 325		