STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 465069	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE 3/22/2006
NAME OF PROVIDER OR SUPPLIER **MT OGDEN NURSING & REHAB**	STREET ADDRESS, CITY, STATE, ZIP CODE **375 EAST 5350 SOUTH OGDEN, UT**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 225	483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interviews, medical record review, and review of facility documentation, it was determined that the facility did not ensure that all alleged violations of mistreatment were immediately (within 24 hours) reported to the State survey and certification agency. Specifically, one alleged violation of abuse was not reported to the state agency until the investigation was faxed 5 days later.

Findings include:

On 2/22/06 the facility administrator was notified by the DON (Director of Nursing) that a family member had complained that she overheard a facility nurse being "verbally abusive" to her mother while she was listening over the phone. The family member then phoned the facility to report the abuse. An investigation was initiated by the facility on 2/22/06.

The facility did not substantiate the alleged allegation of abuse. On 2/27/06 the facility faxed the final investigation to the state survey agency. It should be noted that the facility did not notify the state agency of the alleged abuse until 5 days later.

On 3/22/06, at approximately 3:00 PM the facility administrator stated that upon hearing of the situation he did not feel that abuse had occurred, and therefore the state agency did not need to be notified. He further stated that the only reason an investigation was initiated was because the family had requested that it be

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 225	Continued From Page 1 looked into.

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F 157 SS=G	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 or interested family member when there is a change in room or roommate assignment as specified in §483.15(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 medical record review and interview it was determined that for one of ten sampled residents the facility did not immediately notify the resident's physician and the resident's	F 157	F 157 On 3-22-06, a clarification order was obtained from the physician regarding the use of oxygen for resident #2. On 11-3-05 a new P.O.L.S.T. was completed, replacing one that was a bit confusing regarding specific treatment desires. Regardless on the resident's P.O.L.S.T. status indicated in Section B of the form, whenever a staff nurse notices that a resident's condition changes, they will notify their physician in a timely manner. Details regarding the current health status will be shared with the doctor, as well as the the resident's direction on their P.O.L.S.T. form. Immediately after notifying the physician regarding the change, the nurse will contact the resident's responsible representative with the same update.	05/10/06

4/12/06 POC acceptable compliance date 5/10/06 Rwambuke RN

Utah Department of Health
PM 4/6/06
APR 07 2006
Cert # 7005 3110 0001 3274 6344
Bureau of Health Facility Licensing, Certification and Resident Assessment

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

HA — ADMINISTRATOR — 4/6/06

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 1 responsible party when there was: a.) A significant change in the resident's physical, mental, or psychosocial status requiring physician interventions; and, b.) A need to alter treatment significantly. Specifically, the physician and responsible party were not notified for resident 2 when she had a change in condition requiring medical interventions until approximately 4 hours after the change in condition was first noted by a facility nurse. Findings included: 1. Resident 2 was admitted to the facility on 12/30/01 with diagnoses which included hypertension, seizure disorder, convulsions and embolism. On 3/21/06 and 3/22/06 resident 2's medical record was reviewed. Review of resident 2's face sheet revealed that the responsible party for resident 2 was her son. A quarterly minimum data set (MDS) assessment was completed on 8/10/05. Facility staff documented under section P: Special Treatments and Procedures., that resident 2 had oxygen therapy. On 2/11/02, resident 2 completed a medical treatment plan, which was signed by resident 2 and resident 2's attending physician. The medical treatment plan directed that resident 2 did not want oxygen therapy.	F 157	The nurse will follow the doctor's orders regarding the treatment of the resident. The nurse will notify the "On Call" nurse manager with details of the resident's change. The nurse will fill out a "Assessment – Change in Condition" worksheet. (See Worksheet) with the details of the resident's condition. Information will be updated on this sheet should the doctor direct the nurse to continue to monitor the resident. The nurse will make a copy of the change on condition worksheet and place it in the Director of Nursing's box. On 4-25-06, the Director Of Nursing will have an in-service for all of the nurses. The above information will be taught.	

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F 157	Continued From page 2 On 10/12/05 (dated 9/12/05 by error) on the 7:00 PM to 7:00 AM shift, facility nurse 1 documented the following in a "Nurses Progress Note": "In to give HS (hour of sleep) pills, pt (patient) asleep- would not arouse to verbal stimuli, did sternal rub, pt awoke to say "ouch" and opened eyes for seconds. Audible crackles heard. LS (left side) wet crackles throughout. RA (room air) sats (oxygen saturations) 74% O2 (oxygen) placed [at] 4L (4 liters) sats [up] 91%. Pt lips [and] fingers cyanotic, improving [with] oxygen. Close monitoring. Held oxycontin, did arouse enough to swallow other HS pills [without] aspiration problems. Will cont (continue) to closely monitor [and] report [changes]." A review of the medication administration record revealed documented evidence that facility nurse 1 held resident 2's oxycontin at 9:40 PM. On 10/13/05 at 12:30 AM, facility nurse 1 documented the following on a "Assessment for a patient with change in condition" worksheet, "O2 sats (oxygen saturations) 74% RA (room air)...Patients current level of cognition: unresponsive, responds [with] moans [and] "ouch" to painful stimuli Neurological findings: responds only to painful stimuli Skin: cool, pale, cyanotic lips [and] fingertips Heart: distant, Brady Lungs: crackles thrueout [sic], wheezes left side wet. Loose cough...Other pertinent information: O2 (oxygen) immediately placed per cannula [at] 4L (four liters) sats (oxygen saturations) [up] 91%, then stayed around 88-89%..." On 10/13/06, facility nurse 1 also started a "Change in Condition Worksheet" which documented the following,	F 157	The Director of Nursing will share the change of condition worksheets monthly at our Quality Assurance meeting, and will ultimately be responsible to ensure compliance.	

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F 157	Continued From page 3 12:30 AM, "...findings cyanotic lips, sats remain about the same, Neuro remains the same, LS (left side) same...O2 sats 89% 4L..." 1:30 AM, "...findings Neuro remains same, LS same...O2 sats 88% 4L..." 2:20 AM, "...findings Paramedics here [and] transported pt (patient) to ED (emergency department..." The facility nurse documented on the "Change of Condition Worksheet" that she contacted resident 2's physician at 1:45 AM. This was 4 hours and 5 minutes after resident 2 was found by facility nurse 1 to be unresponsive except to painful stimuli and with an oxygen saturation of 74%. The facility nurse documented on the "Change of Condition Worksheet" that she contacted resident 2's responsible party at 1:50 AM. This was 4 hours and 10 minutes after resident 2 was found by facility nurse 1 to be unresponsive except to painful stimuli and with an oxygen saturation of 74%. On 3/22/06 at 8:45 AM, facility nurse 1 was interviewed by telephone contact. She stated she recalled the incident involving resident 2 on 10/12/05 during the graveyard shift. She stated she found resident 2 at about 10:00 PM with decreased oxygen saturations and unresponsive. On 3/22/06 at 9:40 AM, resident 2's responsible party was interviewed by telephone contact. He stated that in October of 2005 his mother was admitted to the hospital. He further stated that in the "middle of the night" around 2:00 AM in October of 2005 he was contacted by the facility to let him know they thought his mother needed to go to the emergency room.	F 157		

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F 157	Continued From page 4 Resident 2 was admitted to an acute care hospital on 10/13/05. The discharge summary from the acute care hospital, dated 10/15/05, documented the following, "...Discharge diagnoses pneumonia...hypoxia..."	F 157		
F 279 SS=B	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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 services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that for 4 of 15 sample residents (Residents 1, 6 and 8) the facility did not develop a comprehensive care plan for the resident based	F 279	F 279 Details regarding Resident #1's skin breakdown were incorporated on their care plan by the Care Plan Coordinator. Details regarding Resident #6 and #8's incontinence, and psychotropic medications were detailed by the Care Plan Coordinator on their care plans. The treatment nurse will provide the Care Plan Coordinator with details of all residents with skin conditions which are of concern. The Care Plan Coordinator will address this on the resident's care plan.	05/10/06

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F 279	Continued From page 5 on their individual needs identified by the facility staff. Findings include: 1. Resident 1 was admitted to the facility on 12/26/03, with diagnoses which included pneumonia, hypertension, anxiety, depression and cellulitis. On 3/21/06, resident 1's medical record was reviewed. On 3/2/06, a facility nurse documented in a nurse's note that resident 1 had a stage II pressure ulcer on her left buttocks which measured 4.0 by 3.5 centimeters. A review of resident 1's plan of care revealed that the actual breakdown on resident 1's buttocks had not been incorporated into her plan of care. 2. Resident 6 was admitted to the facility on 8/2/05, with diagnoses which included pneumonia, renal failure, dehydration and anxiety. On 3/21/06, resident 6's medical record was reviewed. On 8/15/05, an admission MDS (minimum data set) assessment was performed by the facility for resident 6. After completing the assessment, the following RAP's (resident assessment protocol) were triggered: Vision, ADL (activites of daily living), Incontinence, Falls, Nutrition, Dehydration, Pressure ulcers, and Psychotropic medications. The facility documented that all of the triggered areas would be care planned. A review of resident 6's medical record on	F 279	Every two weeks, the facility conducts a "weight and wound" committee meeting. The Care Plan Coordinator will ensure that all residents, who have been identified as having skin problems, are included in the discussion of the meeting. The Care Plan Coordinator will review each of the resident's care plans to ensure that the skin breakdown is included on the care plan. The Care Plan Coordinator will make a Care Plan for each resident who is taking Psychotropic medications. This will detail the potential adverse reactions from the medications. The Social Service Worker will also document these medications on the resident's "Behavior / Mood" Care Plan. The Care Plan Coordinator will audit each of these care plans during our monthly Psychotropic meeting, and will be responsible to ensure compliance.	

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F 279	Continued From page 6 3/21/06 revealed care plans for each of the triggered RAP's except Incontinence, and Psychotropic medications. The facility Administrator and DON (Director of Nursing) were made aware of the care plans which could not be found. No Incontinence or Psychotropic care plans were provided to the surveyor. 2. Resident 8 was admitted to the facility on 10/24/05, with diagnoses which included MS (Multiple Sclerosis), and chronic UTI (Urinary Tract Infection). On 3/21/06, resident 8's medical record was reviewed. On 11/8/05, an admission MDS assessment was performed by the facility for resident 8. After completing the assessment, the following RAP's were triggered: Cognition, ADL, Incontinence, Psychosocial, Falls, Nutrition, Pressure ulcers, and Psychotropic medications. The facility documented that all of the triggered areas would be care planned. A review of resident 8's medical record on 3/21/06 revealed care plans for each of the triggered RAP's except Incontinence, and Psychotropic medications. The facility Administrator and DON were made aware of the care plans which could not be found. No Incontinence or Psychotropic care plans were provided to the surveyor.	F 279	All findings will be shared by the Care Plan Coordinator during our monthly Quality Assurance meeting.	
F 309 SS=G	483.25 QUALITY OF CARE	F 309		

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F 309	Continued From page 7 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 medical record review and interview it was determined that the facility did not provide the necessary care and services to attain or maintain the highest practicable physical well being for 1 of 4 sample residents (resident 2). Specifically, resident 2 did not receive promptly on-going assessment and services when she presented with a change in condition in her mental status. Findings Included: 1. A review of the facility's policies and procedures, relating change in patient condition, was completed on 3/22/06. The policies directed the following: "1. Fill out change in condition worksheet. 2. Call patients M.D. (medical doctor) use information obtained from worksheet/assessment to give the M.D. a clear picture of patients current condition...4. Notify patients responsible party regarding patients change in condition and inform them of the direction given by M.D. 5. Notify nurse management of patients change in condition. 6. Continue to monitor patient at 1 hour intervals. check v/s (vital signs) 7. Document findings on change in condition worksheet and nurses notes..."	F 309	F 309 Refer to plan of correction for F 157.	05/10/06

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F 309	Continued From page 8 2. Resident 2 was admitted to the facility on 12/30/01 with diagnoses which included hypertension, seizure disorder, convulsions and embolism. On 3/21/06 and 3/22/06 resident 2's medical record was reviewed. A quarterly minimum data set (MDS) assessment was completed on 8/10/05. The MDS documented under section B., that resident 2 had short and long term memory problems. Facility staff documented that resident 2 had no problems with memory recall or ability. Facility staff documented that resident 2's cognitive skill for daily decision making were severely impaired. Under indicators of delirium/periodic disordered thinking/awareness, facility staff documented that resident 2 had problems with periods of lethargy and her mental function varied over the course of the day, but the behaviors were not of a recent onset. Facility staff documented under section P: Special Treatments and Procedures., that resident 2 had oxygen therapy. On 2/11/02, resident 2 completed a medical treatment plan, which was signed by resident 2 and resident 2's attending physician. The medical treatment plan directed that resident 2 did not want oxygen therapy. On 10/12/05 (dated 9/12/05 by error) on the 7:00 PM to 7:00 AM shift, facility nurse 1 documented the following in a "Nurses Progress Note": "In to give HS (hour of sleep) pills, pt (patient) asleep- would not arouse to verbal stimuli, did sternal rub, pt awoke to say "ouch" and opened eyes for seconds. Audible crackles heard. LS (left side) wet crackles throughout. RA (room air)	F 309		

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F 309	Continued From page 9 sats (oxygen saturations) 74% O2 (oxygen) placed [at] 4L (4 liters) sats [up] 91%. Pt lips [and] fingers cyanotic, improving [with] oxygen. Close monitoring. Held oxycontin, did arouse enough to swallow other HS pills [without] aspiration problems. Will cont (continue) to closely monitor [and] report [changes]." A review of the medication administration record revealed documented evidence that facility nurse 1 held resident 2's oxycontin at 9:40 PM. On 10/13/05 at 12:30 AM, facility nurse 1 documented the following on a "Assessment for a patient with change in condition" worksheet, "O2 sats (oxygen saturations) 74% RA (room air)...Patients current level of cognition: unresponsive, responds [with] moans [and] "ouch" to painful stimuli Neurological findings: responds only to painful stimuli Skin: cool, pale, cyanotic lips [and] fingertips Heart: distant, Brady Lungs: crackles thrueout [sic], wheezes left side wet. Loose cough...Other pertinent information: O2 (oxygen) immediately placed per cannula [at] 4L (four liters) sats (oxygen saturations) [up] 91%, then stayed around 88-89%..." On 10/13/06, facility nurse 1 also started a "Change in Condition Worksheet" which documented the following, 12:30 AM, "...findings cyanotic lips, sats remain about the same, Neuro remains the same, LS (left side) same...O2 sats 89% 4L..." 1:30 AM, "...findings Neuro remains same, LS same...O2 sats 88% 4L..." 2:20 AM, "...findings Paramedics here [and] transported pt (patient) to ED (emergency department)..."	F 309		

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F 309	Continued From page 10 The facility's policy and procedure stated that when a resident has a change in condition, hourly monitoring and vital signs must be performed. Based on the documentation it was determined that resident 2 was found unresponsive except to painful stimuli and with an oxygen saturation of 74% at 9:40 PM. Facility nurse 1 completed an assessment and obtained vital signs at 9:40 PM. There was no documentation in the medical record to provide evidence that facility staff continued ongoing assessment of resident 2's vital signs, oxygen saturation or level of consciousness again until 12:30 AM, 2 hours and 50 minutes later. The facility nurse documented on the "Change of Condition Worksheet" that she contacted resident 2's physician at 1:45 AM. This was 4 hours and 5 minutes after resident 2 was found by facility nurse 1 to be unresponsive except to painful stimuli and with an oxygen saturation of 74%. The facility nurse documented on the "Change of Condition Worksheet" that she contacted resident 2's responsible party at 1:50 AM. This was 4 hours and 10 minutes after resident 2 was found by facility nurse 1 to be unresponsive except to painful stimuli and with an oxygen saturation of 74%. Resident 2 was admitted to an acute care hospital on 10/13/05. The discharge summary from the acute care hospital, dated 10/15/05, documented the following, "...Discharge diagnoses pneumonia...hypoxia..." On 3/22/06 at 8:45 AM, facility nurse 1 was interviewed by telephone contact. She stated she recalled the incident involving resident 2 on	F 309		

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F 309	Continued From page 11 10/12/05 during the graveyard shift. She stated she found resident 2 at about 10:00 PM with decreased oxygen saturations and unresponsive. On 3/22/06 at 9:00 AM, the director of nurses was interviewed. She stated when a resident has a change in condition the nursing staff is to call the nurse management, which is on call 24 hours a day. The director of nurses further stated that she receives a copy of the "Change in Condition Worksheet". The DON reviewed the book which contained the "Change of Condition Worksheets" and then stated "I was not made aware of the incident with [resident 2]" The director of nurses further stated she "would expect my nurses to call especially when a resident is not arousable."	F 309		
F 371 SS=E	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on interview and observation of the kitchen it was determined that the facility did not store, prepare, distribute and serve food under sanitary conditions. Findings include: The following observations were made on 3/20/06 from 1:35 PM until 2:00 PM. 1. Refrigerator:	F 371	F 371 A new oatmeal bin has been purchased by the Dietary Manager, and the old one discarded. All snacks will be "Date Stamped" by the dietary staff when made, with the current days date. The dietary staff will cover all drinks which are placed in the cooler, with plastic, or pan liners. They will label them detailing their content, as well as date stamp them.	05/10/06

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F 371	Continued From page 12 a. Seventeen glasses of pink milk, which were not covered, labeled or dated. b. Twelve glasses of yellowish milk, which were not covered, labeled or dated. c. One hundred twelve glasses of juice, which were not covered, labeled or dated. d. Ninety-four glasses of milk, which were not covered, labeled or dated. e. Four glasses of 2% milk, which were not dated. f. Six glasses of boost, which were not dated. g. Five glasses of ProMod skim, which were not dated. h. One glass of ensure, which was not dated. i. Four glass of fluid which was labeled "R" but was not dated. j. Thirty glasses of thick clear fluid, which were not covered, labeled or dated. k. Two glasses or thickened ProMod, which were not dated. l. Four glasses of mocha, which were not dated. m. A pitcher of chocolate syrup, which was dated 3/9/06. n. Four glasses brown fluid, which was not covered, labeled or dated.	F 371	Frozen foods will be wrapped in white butcher paper by the butcher, or dietary staff upon delivery. They will then label and date each wrapped item. Frequent checks will be preformed by the Dietary Manager, and any outdated, non labeled, or non covered items will be discarded. On 4-25-06, the Dietary Manager will meet with all of the dietary staff to train them on the changes. These findings will be shared by the Dietary Manager monthly at the facility's Quality Assurance meeting. She will also be responsible to ensure compliance.	

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F 371	Continued From page 13 o. One glass of V-8, which was not dated. p. One glass of breeze, which was not dated. q. One glass of coffee ensure, which was not dated. r. One glass of regular NH, which was not dated. s. Eight half sandwiches, which were not labeled or dated. t. Two small bowls of diet jello, which were not dated. u. One small bowl of pineapples, which were not dated. v. One container of pineapples, which were dated 3/13/06. w. One whole sandwich, which was not labeled or dated. x. Thirty-one glasses of fluid, which were not labeled or dated. 2. Freezer: a. One package of dark brownish-red meat, which was not labeled. b. One package of ground meat, which was not labeled. c. Three packages of light meat, which was not labeled. 3. Kitchen:	F 371		

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F 371	Continued From page 14 a. An oatmeal bin had the lid broken off.	F 371		
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that 4 of 15 sample residents (Resident 1, 2, 3 and 4) were not seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days as required. Findings include: 1. Resident 1 was admitted to the facility on 12/26/03, with diagnoses which included pneumonia, hypertension, anxiety, depression and cellulitis. A review of resident 1's medical record revealed that the resident had been seen by a physician 7/17/05 and 10/4/05. Resident 1 should have been seen by a physician on or around 9/17/05.	F 387	F 387 The Medical Records Dept Head will prepare a list for the Medical Director each week regarding those residents who need to be seen for their required visits. The residents on the list will include those who are within 5 days of their scheduled due date. Should the Doctor not see the resident, a Nurse Practitioner or another Physician will be called in to see the resident. For residents who are seen by outside Physicians, the Medical Records Dept Head will provide our van driver with a list at the first of each month. This list will contain the following information: *Residents who need to be seen during the month. *The specific date which the resident needs to be seen by.	05/10/06

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F 387	Continued From page 15 There was no documentation in the medical record to provide evidence that resident 1 had been seen by a physician on or around 9/17/05. 2. Resident 2 was admitted to the facility on 12/30/01 with diagnoses which included hypertension, seizure disorder, convulsions and embolism. A review of resident 2's medical record revealed that the resident had been seen by a physician on 10/21/05 and 1/6/06. Resident 2 should have been seen by a physician on or around 12/21/05 and 3/6/06. There was no documentation in the medical record to provide evidence that resident 2 had been seen by a physician on or around 12/21/05 and 3/6/06. 3. Resident 4 was admitted to the facility on 3/16/02 with diagnoses which included esophageal stricture, hypertension, diabetes mellitus and dementia with aggressive and depressive features. A review of resident 4's medical record revealed that the resident had been seen by a physician on 1/13/05, 3/28/05, 6/13/05, 8/29/05 and 11/14/05. Resident 4 should have been seen by a physician on or around 3/13/05, 5/28/05, 8/13/05, 10/29/05, 1/14/06 and 3/14/06. There was no documentation in the medical record to provide evidence that resident 4 had been seen by a physician on or around 3/13/05,	F 387	*The Physician that is to see the resident. The Van Driver will then schedule the appointment prior to the due date, and provide a copy of the appointments made to the Medical Records Dept Head. Should that Physician not be able to see the resident timely, our Medical Director will be called by Medical Records to see them. Details of the month's Physician visits will be shared by the Medical Records Dept Head each month at the facility's Quality Assurance meeting. She will also be responsible to ensure compliance.	

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F 387	Continued From page 16 5/28/05, 8/13/05, 10/29/05, 1/14/06 and 3/14/06. On 3/21/06, during the exit conference the director of nurses was asked to see if she could locate the missing physician visits. On 3/22/06 at 8:30 AM, the director of nurses stated she was not able to find any of the missing physician visits. 4. Resident 3 was admitted to the facility on 1/25/05, with diagnoses that included duodenal ulcer, gastric reflux disease, cerebral vascular accident, dementia with depression and anxious features, chronic anemia, and hypertension. Resident 3's clinical record was reviewed on 3/20/06, revealed that the resident had been seen by a physician 9/21/05, 83 days later on 12/14/05 and then 77 days later on 3/1/06. Resident 3 should have been seen by a physician on or around 11/21/05 and 2/21/06. There was no documentation on resident 3's medical record to provide evidence that resident 3 was seen by the physician on or around these dates.	F 387		
F 431 SS=B	483.60(d) LABELING OF DRUGS AND BIOLOGICALS Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the	F 431	F 431 The Director of Nursing destroyed all insulin bottles that were not dated on 3-30-06. These were replaced on that same date as well.	05/10/06

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F 431	Continued From page 17 facility was using medications that were not labeled in accordance with currently accepted professional principles. Specifically, based on observation, it was determined that the facility was using medications that were not dated when they were opened. Findings include: An observation of the facilities medication refrigerator was performed on 3/21/06 and 3/22/06. On 3/21/06, the following medications were found to be stored in the refrigerator open, but without a date. 1. Three vials of Lantus Insulin 2. One vial of Novalog Insulin 3. One vial of Novolin R Insulin The 26th Edition of Nursing 2006 Drug Handbook pages 794, and 797 states the following: 1. For Lantus Insulin : "...Discard opened vials after 28 days whether refrigerated or not....". 2. For Novalog Insulin: "...open vials and cartridges of Novalog are stable at room temperature for 28 days...". On 3/22/06, the DON (Director of Nursing) was interviewed about the labeling of Insulin. She stated that the consultant pharmacist had provided the facility with "General Insulin Storage Guidelines" stating that Insulin could be refrigerated for 90 days with the exception of Lantus Insulin which must be discarded 28 days after opening. The guidelines also state "Insulin that is currently in use may be kept (always date and initial the vial when opened)...". Also observed in the medication refrigerator were: 11 Promethegan 12.5 mg (milligram)	F 431	All insulin bottles will be dated by the nurse when they are opened. This medication will be destroyed within the guidelines provided by our pharmacy. The floor nurse will replace any insulin bottle that is outdated. An in-service will be conducted by the Director of Nursing for all nurses to discuss the above policy. Each week the Director of Nursing will perform an audit regarding dated, and outdated insulin bottles. Bottles will be destroyed if necessary. Findings will be shared by the Director of Nursing monthly at the facility's Quality Assurance meeting, and will ultimately be responsible to ensure compliance.	

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F 431	Continued From page 18 suppositories which expired in 12/04, and Lorazepam 1 mg/0.1 ml (milliliters) syringes which expired on 2/2/06.	F 431	F 432	
F 432 SS=B	483.60(e) STORAGE OF DRUGS AND BIOLOGICALS In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation of temperatures in the facility's only medication refrigerator on three occasions, it was determined that the facility is not storing biologicals under proper temperature controls. Specifically, the medication refrigerator temperature was above 50 degrees. Findings include: While accompanied by a facility nurse on 3/21/06, the temperature of the medication refrigerator was checked at 3:25 PM. The temperature was	F 432	The Maintenance Director will replace the refrigerator which stores the medication. The temperature in the refrigerator will be maintained at 36-46 degrees. The 200 hall nurse will be responsible to check the temperature of the refrigerator daily, and note their findings on the chart located on the refrigerator. Adjustments to the temperature will be made as needed. The Director of Nursing will conduct and in-service on 4-25-06 for all nurses to discuss the changes. The Director of Nursing will conduct a weekly audit, and will be responsible to ensure compliance. She will also share her findings monthly at our Quality Assurance meeting.	05/10/06

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F 432	Continued From page 19 50 degrees Farenheit (F). The temperature was also checked at 8:25 AM, and 11:29 AM on 3/22/06. The temperature was 52, and then 51 degrees F. The refrigerator contained multiple medications; including Novalog, Novolin R, Lantus, and Procrit. Reference: Health Facility Licensure Rules R432-150-24 (5)(e)(ii), ""Refrigerated medications shall be maintained within 36 and 46 degrees F.""	F 432		
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility did not maintain clinical records on each resident that were complete. Specifically 7 of 15 sample residents, did not have physician re-certification orders, dialysis notes, urology consult, or MDS's that were complete. Resident identifiers, 3, 5, 6, 7, 8, 9, 14.	F 514	F 514 Re-Certs, dialysis notes, urology consults, and M.D.S.'s that were missing for residents 3,5,6,7,8,9, and 14 were filed in the resident's medical charts. Resident 14 did have care plans, as well as the necessary M.D.S.'s in their medical chart. This was a discharged chart. At the end of each month, the Medical Records Dept Head will generate a new "Physician Re-Certification" sheet for each resident.	05/10/06

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F 514	Continued From page 20 Findings include: 1. Resident 3 was admitted to the facility on 1/25/05, with diagnoses that included duodenal ulcer, gastric reflux disease, cerebral vascular accident, dementia with depression and anxious features, chronic anemia, and hypertension. Resident 3's clinical record was reviewed on 3/20/06. Resident 3 had re-certification orders for February 2006, there were no re-certification orders for March 2006. 2. Resident 5 was admitted to the facility on 1/20/06, with diagnoses that included left leg wound, cellulitis, renal failure, hypothyroidism, hypertension, anemia, anxiety, and dysthymia disorder. Resident 5 had re-certification orders for February 2006, there were no re-certification orders for March 2006. 3. Resident 7 was admitted to the facility on 10/31/05 and readmitted on 1/1/06, with diagnoses that included insulin dependant diabetes mellitus, cerebral vascular accident, hypokalemia, congestive heart failure, ileus, hypothyroidism, and anemia. Resident 7 had re-certification orders for February 2006, there were no re-certification orders for March 2006.	F 514	The Assistant Director of Nursing will then audit each sheet against the "Medication Administration Record". Any changes will be made if necessary. She will then sign each "Re-Cert". These "Re-Certs" will then be mailed out to the appropriate Physician for signature by Medical Records. When the "Re-Cert" is received from the Physician, Medical Records will stamp it with the date received. They will then give the "Re-Cert" to the Assistant Director of Nursing for review, and signature. If the Physician has made any adjustments, she will note the change in the residents medical chart. A copy of the change will be given to Medical Records to update the computer. The Assistant Director of Nursing will then give the "Re-Certs" to the appropriate nurse for filing.	

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F 514	Continued From page 21 4. Resident 6 was admitted to the facility on 8/2/05, with diagnoses that included renal failure, dehydration, and anxiety Resident 6's clinical record was reviewed on 3/21/06. Resident 6 had re-certification orders for February 2006, there were no re-certification orders for March 2006. Review of resident 6's record revealed that he had a urology consult ordered on 8/10/05; however, no consultation report was found in resident 6's clinical record. 5. Resident 8 was admitted to the facility on 10/24/05, with diagnoses that included Multiple Sclerosis, and chronic Urinary Tract Infections. Resident 8's clinical record was reviewed on 3/21/06. Resident 8 had re-certification orders for February 2006, there were no re-certification orders for March 2006. 6. Resident 9 was admitted to the facility on 1/14/06, with diagnoses that included Renal failure, Diabetes Mellitus, and malnutrition. Resident 9's clinical record was reviewed on 3/21/06. Resident 9 had re-certification orders for February 2006, there were no re-certification orders for March 2006.	F 514	"Re-Certs" not received back from the Physician within 14 days will be considered untimely, which will result in Medical Records placing a phone call to the Physician to locate the form. The Director of Nursing will contact the Dialysis Center to request that a copy of Physician notes for our residents be routinely sent to our facility. These will be kept in the resident's medical record. The Director of Nursing will conduct an in-service on 4-25-06 for all nurses, and medical records staff to discuss the change in procedure. Each month, the van driver will turn in the Physician appointment schedule to Medical Records. A monthly audit will be conducted by Medical Records to ensure that all Physician progress notes have been filed in the medical chart. Medical Records will share their findings monthly at our Quality Assurance, and will be responsible to ensure compliance.	

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F 514	Continued From page 22 Review of resident 9's physician progress notes revealed that the physician documents his progress notes in the dialysis progress notes; however, no dialysis progress notes were found in resident 9's medical record. In an interview with the Director of Nursing (DON), on 3/22/06 at 10:30 AM, she said the re-certification orders were in the night nurses file box for halls 100, 200 and 400. 7. Resident 14 was admitted to the facility on 6/24/05, with diagnoses which included Anxiety, Depression, CAD (Coronary Artery Disease), anemia, and HTN (Hypertension). On 3/22/06, resident 14's medical record was reviewed. There were no MDS's (minimum data set), or care plans found in resident 14's medical record.	F 514		