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

PRINTED: 05/17/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465125	A. BUILDING ______ B. WING ______	05/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MURRAY CARE CENTER	835 EAST VINE STREET MURRAY, UT 84107

(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 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and review of medical records, it was determined that for 1 of 15 sampled residents, the facility did not conduct a comprehensive assessment of the resident within 14 days after the facility determined, or should have determined, that there had been a significant change in the resident's physical status. Resident identifier: 9. Findings included: Resident 9 was an 83 year old female who had recently returned from the hospital (3/30/06) after undergoing surgical repair of her left ankle which was broken during a fall at the facility. The medical record of resident 9 was reviewed on 5/1/06, 5/2/06 and 5/3/06.	F 274 5/25/06 POC acceptable c addendum completion date 6/8/06	F274 A Significant Change MDS was completedon resident 9. A new assessment (see attached) will be completed on all residents who leave the facility overnight for medical care or who go to the hospital for any invasive procedures to determine any significant changes in condition. If there are 3 or more areas of change noted a significant change MDS will be completed and the care plan updated to reflect the changes. The Medical Records Director will add this person to the IDT list to be reviewed in the meeting held within the next 7 days. Nurses will be in-serviced on the new policy on May 25, 2006 by the D.O.N. D.O.N. will monitor - monthly and report findings in a QA meeting on June 1, 2006. Murray Care Center will be in compliance with this issue by June 8, 2006.	5/25/06 added c summary VB 5-25-06 755874

Utah Department of Health
MAY 24 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melinda Spel 5/24/2006
TITLE: Administrator
(X6) DATE

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 274	Continued From page 1 An MDS (minimum data set) is a mandatory comprehensive assessment of a resident completed at least quarterly and with any significant changes in the resident's status. The last MDS completed by staff for resident 9 was on 2/16/06, a month and ten days prior to her fall and fracture. As of the 2/16/06 MDS, resident 9 could transfer, dress and eat independently, and needed minimal assistance with ambulation and hygiene. Also at the time of this assessment, resident 9 had no pressure sores and weighed 159 pounds. During observation on 5/2/06 and 5/3/06, resident 9 was observed with a cast/immobilizing device on her left foot and wheeling herself about in a wheelchair. Resident 9 was observed to need assistance with dressing and transferring. Resident 9 was observed with an open, undressed pressure sore on her right heel. A weight obtained on 5/2/06, at the request of the surveyor, revealed a weight of 146.2, which was a weight loss of 12.8 pounds or 8.0% in one month, which was significant. Resident 9 experienced a significant change in her physical status which was not identified or addressed through a new MDS.	F 274	5/25/06 in a telephone call to Adm. + DON - How often DON will monitor for tag F274 F279 F314, F325, + F426 was added to each tag & permission of Adm & DON Busenbark RD	

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F 279 SS=D	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 upon record review and interview with staff members, it was determined that the facility did not use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. Specifically, it was found that care plans did not address all resident needs in 2 of 15 sampled residents. Resident identifiers: 9 and 8. Findings include: 1. Resident 9 was an 83 year old female who had recently returned from the hospital (3/30/06) after	F 279	F 279 Care Plans for residents #8 & #9 were updated to reflect all triggered areas. A review of all Care Plans will be done to ensure all triggered areas on M.D.S. have had a R.A.P. completed and those required Care Planning have been addressed on the Care Plan. In the area of the M.D.S. where it is checked to indicate a problem area to be care planned, the Care Plan # will be written. This will be done by the R.N. who does the Care Plan determination and documents completion of the care plan on the M.D.S. and the Medical Records Director will audit to be sure that the notation has been added. Nurses will be in-serviced on the new policy on May 25, 2006 by the D.O.N. 5/25/06 audit i promise VB weekly 6-8-06 Continued on next page	

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F 279	Continued From page 3 undergoing surgical repair of her left ankle which was broken during a fall at the facility. The medical record of resident 9 was reviewed on 5/1/06, 5/2/06 and 5/3/06.. Based on review of the nurse's notes, it was determined that a pressure sore began on 4/4/06 and was noted as follows: On 4/4/06 at 7:00 AM, resident 9 had "an open area R (right) heel St 3 (stage 3) probably d/t shoe rubbing. Notified MD." Resident 9 was observed in the dining area by two nurse surveyors on 5/2/06 from 7:02 AM to 7:22 AM. She was observed sitting in her wheelchair at a table. Resident 9 had a cast/immobilizing device on her left foot and no sock or shoe on her right foot. On the back of her right foot, resident 9 had a wound area which appeared to be approximately 4 cm by 4 cm of a darker reddish area and within that area there was an approximately 2 cm by 2 cm open wound area. Resident 9 was observed to have this open wound area sitting directly on the dining room floor and was observed to rub it back and forth across the floor beneath her table. The medical record did not contain a care plan which addressed the open wound to the resident's right heel. The last time the skin care plan had been updated was 2/14/06 and did not address any open wounds. 2. During a record review of resident 8's medical record, the Minimum Data Set (MDS) dated 3-26-06, reflected the following items to be	F 279	slashes added to summary monthly D.O.N. will monitor and report findings in a QA meeting on June 1, 2006. Murray Care Center will be in compliance with this issue by June 8, 2006.	

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F 279	Continued From page 4 triggered as a Resident Assessment Protocol Problem Area (RAP Triggers): -Delirium -Cognitive Loss -Visual Function -Communication -ADL Functional Rehabilitation Potential -Psychosocial Well Being -Mood State -Behavioral Symptoms -Falls -Nutritional Status -Dehydration/Fluid Maintenance -Oral/Dental Care -Psychotropic Drug Use During a record review of resident 8's medical record and concurrent interview with MDS Nurse (RN #1), she could not show that the following RAP Triggers had been addressed in the care plan: -Delirium -Dehydration -Oral Care	F 279		

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F 314 SS=G	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of resident medical records, it was determined that for 1 of 15 sampled residents (resident 9), the facility did not ensure that the resident received necessary treatment and services to promote healing or prevent infection. Findings included: Resident 9 was an 83 year old female who had recently returned from the hospital (3/30/06) after undergoing surgical repair of her left ankle which was broken during a fall at the facility. The medical record of resident 9 was reviewed on 5/1/06, 5/2/06 and 5/3/06. During the initial tour of the facility on 5/1/06, the LPN stated that resident 9 had had some breakdown on her right heel, but that it was now healed. Resident 9 was observed in the dining area by two nurse surveyors on 5/2/06 from 7:02 AM to	F 314	F 314 Care Plan for resident #9 has been updated to reflect wound and treatment. A new check-off sheet (see attached) has been developed for all residents who develop a wound. A protocol has been initiated which includes: 1. Notifying M.D. & family of wound 2. Obtaining orders for treatment, labs, and nutritional supplements 3. Wound and treatments to be added to Care Plan, Kardex, and Treatment Sheet 4. Add to dietary list for supplements 5. Restorative C.N.A. notified to add to weekly weight list 6. Review of resident in weekly skin committee meeting and weight review meeting. Continued on next page	

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F 314	Continued From page 6 7:22 AM. She was observed sitting in her wheelchair at a table. Resident 9 had a cast/immobilizing device on her left foot and no sock or shoe on her right foot. On the back of her right foot, resident 9 had a wound area which appeared to be approximately 4 cm by 4 cm of a darker reddish area and within that area there was an approximately 2 cm by 2 cm open wound area. Resident 9 was observed to have this open wound area sitting directly on the dining room floor and was observed to rub it back and forth across the floor beneath her table. The medical record did not contain a physician's order to address the open wound to the right heel. The medical record did not contain physician or nurse's notes that addressed the open wound to the right heel. The medical record did not contain a care plan which addressed the open wound to the resident's right heel. The last time the skin care plan had been updated was 2/14/06 and did not address any open wounds. The May 2006 treatment sheet was viewed and did not contain documentation that the wound to the right heel of resident 9 was being addressed. The May 2006 treatment sheet did have an order that resident 9 should wear a podus boot on her right foot at all times. (This was observed to not be in place on 5/2/06 from 7:02 AM to 7:36 AM.) The medical record also contained a skin risk assessment form, dated 5/1/06, which scored resident 9 at a "15". The assessment documented that if a resident scored 15+, they	F 314	Nursing staff will be in-serviced on new protocol and proper documentation on May 25, 2006 by D.O.N. and Medical Records Director will audit Care Plans and Physician Orders. New physician order forms will be initiated which have a check off at the bottom to indicate that M.D. was notified and new order care planned for compliance. Wound nurse will review all charts and Care Plans during skin committee meeting weekly. The check list will be kept with the wound tracking sheet in the D.O.N. office. D.O.N. will monitor weekly and report findings in a QA meeting on June 1, 2006. Murray Care Center will be in compliance with this issue by June 8, 2006. 5/26/06 added per phone conversation with IB 6-8-06	

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F 314	Continued From page 7 should be considered at high risk for skin breakdown. On 5/2/06 at 7:36 AM, the right heel of resident 9 was observed by both the director of nurse's (DON) and the registered nurse surveyor. During this observation, resident 9 was heard to say that the staff had forgotten to put her boot on that morning. The right heel of resident 9 was confirmed to have the dimensions as described above. The DON was asked what the facility policy was if a resident scored high risk on the skin assessment form. The DON stated that the resident would receive supplement if they were losing weight, they would have an albumin performed, and they would make sure the resident was being turned and repositioned. On 5/2/06 at 8:01 AM, the LPN in charge of the care for resident 9 was interviewed. The LPN was asked if the treatment to the right heel of resident 9 had been started again. The LPN stated, "No. Our treatment nurse likes to leave it open to air." Based on review of the nurse's notes, it was determined that this pressure sore began on 4/4/06 and was noted as follows: On 4/4/06 at 7:00 AM, resident 9 had "an open area R (right) heel St 3 (stage 3) probably d/t shoe rubbing. Notified MD." The medical record for resident 9 documented that staff obtained a physician's order to treat this pressure sore on 4/4/06. The April 2006 treatment sheet for resident 9	F 314		

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F 314	Continued From page 8 documented that the treatment to the open area on the right heel of resident 9 was changed daily through 4/20/06. After that, there was a notation on the treatment sheet that the treatment was discontinued. At the time of the review of physician's orders on 5/2/06 at 7:15 AM, the medical record for resident 9 did not contain a physician's order to discontinue this treatment. The Resident Monthly Summary for April 2006, dated by the nurse on 4/20/06, documented that resident 9 had a pressure ulcer on her right heel. The area under this which asks about "treatment and response" for the pressure sore was left blank. A weekly skin monitoring sheet, kept in a separate book by the treatment nurse, documented on 4/21/06 that resident 9 had a stage 3 pressure sore which measured 3 cm by 4 cm. The notes on this weekly assessment documented "wound dry open to air". There was no documentation in the medical record of resident 9 to evidence that staff monitored this pressure sore wound after 4/21/06. There was no documentation that staff were aware of continued or recurrent breakdown until it was brought to their attention on 5/2/06 at 7:36 AM when the surveyor did a skin check with the DON. The DON was not aware of the breakdown. The nurse in charge of resident 9 was not aware of the breakdown. The medical records for resident 9 contained no evidence of physician orders, treatments or nurse's notes which would demonstrate knowledge and follow-up for this pressure sore.	F 314		

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F 314	Continued From page 9	F 314		

The treatment nurse was interviewed on 5/2/06 at 1:05 PM. The treatment nurse stated that she was aware of the breakdown on the right heel of resident 9 and had obtained physician's orders the day before (5/1/06). When the surveyor stated that she could not locate a physician's order for a new treatment, the treatment nurse stated, "I told the nurse to do it." The treatment nurse then paused and stated, "Or I may have forgotten to tell her."

The stage 3 pressure sore on the right heel of resident 9 was first identified by facility staff on April 4, 2006. At this time, resident 9 was on a regular no concentrated sweets diet.

During the month of April 2006 the meal intake average for resident 9 was as follows:

- breakfast 48%
- lunch 39%
- dinner 18%

During an interview with the dietitian consultant on 5/2/06, she stated that she became aware of the pressure sore during the weight and skin meeting which took place on 4/13/06.

The dietitian did not address the pressure sore with additional or different interventions, considering the resident's intake was poor, until this was brought to her attention by the registered nurse surveyor on 5/2/06.

Facility staff did not follow their own policy, as described by the DON, and obtain an albumin level to establish the nutritional status of resident 9 and what changes in her diet she may need to

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F 314	Continued From page 10 assist in the healing process of a stage 3 pressure sore.	F 314		
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 observation, interview and review of resident medical records, it was determined that for 1 of 15 sampled residents (resident 9), the facility did not ensure the resident maintained acceptable parameters of nutritional status. Specifically, resident 9 lost 8.0 % of her body weight in one month. This was not an expected weight loss and was not addressed by facility staff. Findings included: Resident 9 was an 83 year old female who had recently returned from the hospital (3/30/06) after undergoing surgical repair of her left ankle which was broken during a fall at the facility. The medical record of resident 9 was reviewed on 5/1/06, 5/2/06 and 5/3/06. During February, March and April 2006, resident 9 was receiving a regular no concentrated sweets	F 325	F325 Resident #9 was added to the weekly weight list and reviewed in Weight meeting. Labs were ordered and found to show that the residents' nutritional levels are WNL and weight was within IBW parameters. Order for supplements to be given with medications was obtained. The resident was moved to a table in the dining room, where she could receive additional help while eating. Consultant Dietician has reviewed her labs, diet orders, protein needs and weights. Visit with residents' family for suggestions for residents' favorite foods. Continued on next page	

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F 325	Continued From page 11 diet. The weight records kept by the facility documented the following monthly weights for resident 9: January 2006 - 159.5 February 2006 - 159.0 March 2006 - 159.4 April 2006 - 159.0 On May 2, 2006, the facility's consultant dietitian visited the facility and wrote a progress note for resident 9 which contained the following: (# is a symbol for pounds) "wt 159 # (4-1-06), variable 155 - 159 # X (times) 180 days" "meal intake 25 - 75% - adeq. (adequate) to prevent wt loss." After reading this progress note, the surveyor asked facility staff to obtain a current weight for resident 9. The weight obtained by facility staff on 5/2/06 was 146.2 pounds. This was a weight loss of 12.8 pounds or 8.0% in one month, which is considered significant. The meal intake sheet for April 2006 was reviewed on 5/2/06. During the month of April 2006 the meal intake average for resident 9 was as follows: - breakfast 48% - lunch 39% - dinner 18%	F 325	The new protocol for residents with wounds and for residents who leave the facility for medical care will also monitor for changes in weight. Nursing staff in-serviced on proper documentation of meal percentage of intake and to notify Dietician and charge nurse of change in eating amounts, behaviors, and independence, on May 25, 2006 by D.O.N. 5/25/06 added per mmm VB D.O.N. will monitor weekly and report findings in a QA meeting on June 1, 2006. Murray Care Center will be in compliance with this issue by June 8, 2006.	6-8-06

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F 325	Continued From page 12 The month prior to her fall and surgery, March 1 through the 25th, 2006, the meal intake average for resident 9 was higher, as shown: - breakfast 66% - lunch 55% - dinner 55% Resident 9 was observed during three meals. During breakfast on 5/2/06, resident 9 was observed to eat half of a slice of french toast and half a small sausage patty. She did not eat any of her hot cereal. She drank approximately 2 ounces of milk and none of her juice. During breakfast on 5/3/06, resident 9 was served scrambled eggs, biscuits and gravy, hot cereal, milk and juice. Resident 9 was observed to eat 4 bites of her food, and left approximately 95% of her meal on her tray. During lunch on 5/3/06, resident 9 was served pork roast, gravy, a vegetable, milk and juice. Resident 9 was observed to eat 4 bites of her lunch and leave the remainder. The pork roast was not cut up and the resident was observed to have significant difficulty getting some pork in her mouth. At one point, she had a large bite in her mouth with a large portion hanging from her mouth as she attempted to cut the meat with her teeth. Resident 9 was not observed to receive assistance during these meal times. She was not offered encouragement. The consultant dietitian was interviewed by phone	F 325		

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

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	465125	A. BUILDING _____ B. WING _____	05/03/2006

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F 325	Continued From page 13 at approximately 4:30 PM on 5/2/06. The consultant dietitian was unaware of the resident's 12.8 pound weight loss. The facility had four weight and skin review meetings in April 2006. None of these meetings addressed any weight loss or eating habit changes in resident 9. Resident 9 recently returned from the hospital on 3/30/06 after receiving surgical repair of her ankle. Her 4/1/06 weight was 159 pounds. After the significant episodes of a fracture and surgery, facility staff did not increase monitoring of the nutritional health of resident 9. Subsequently, resident 9 lost 12.8 pounds in one month of which staff was not aware.	F 325		
F 371 SS=E	483.35(i)(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 upon observation and interview, it was determined that food is not properly stored under sanitary conditions. Specifically, food stored in the walk-in refrigerator was not properly covered, labeled, or dated. Findings include:	F 371	F 371 The Dietary manager in-serviced the Dietary staff about the proper way to store, prepare, distribute, and serve food under sanitary conditions on May 4, 2006. The Dietary manager will continue to monitor and report to findings in QA meeting on June 1, 2006. Dietary Manager will monitor sanitary conditions weekly. Murray Care Center will be in compliance by June 8, 2006.	6-8-06

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F 371	Continued From page 14 Based upon an inspection of the walk-in refrigerator, freezer and kitchen on May 1, 2006 at 1:00 P.M., the following items were found: Walk-in Refrigerator: -Two cans of Glytrol (250 ml each) expired 5-23-2005. -2 1/2 Quart plastic container of tomato paste dated 4-25-06. -4 Quart plastic container of green chilies dated 4-21-06. -Container of ham slices with ripped foil top. -5 pound container of sour cream, opened and undated. -5 pound container of cottage cheese, opened and undated. -Ham wrapped in plastic wrap undated and unlabeled. -One plastic container full of unidentified meat dated 4-22-06. -One plastic container full of unidentified meat dated 4-18-06. -Three trays stacked on each other containing pre-poured glasses of liquid appearing to be milk, uncovered and unlabeled. -4 Quart container marked "Carmel", dated 4-17-06, covered with ripped plastic wrap. -20 Quart container containing unlabeled, undated brown substance. -Large bowl of salad, unlabeled, undated, covered with ripped plastic wrap. -1 Gallon opened Prune juice, undated. -1 Gallon Golden Italian dressing, opened, undated. -1 Gallon lemon juice, undated, lid missing. -2 1/2 Quart fruit punch dated 4-13-06. -2 2/2 Quart pink liquid dated 2-22-06. -3 Gallons milk "sell by April 30"	F 371		

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F 371	Continued From page 15 -50# opened undated "veg A/P Shortening". Based upon an inspection of the walk-in refrigerator, freezer and kitchen on May 2, 2006 at 6:45 A.M., the following items were found: -Orange Juice, pre poured into 35 glasses, uncovered, unlabeled. -Apple Juice, pre poured into 35 glasses, uncovered, unlabeled. Freezer: -Temperature 8 degrees F. -One plastic bag of Tortillas marked "3-11-06 open and on floor of freezer. Kitchen, General: -Mixer (univex SRMF20) found to be encrusted with food. -pile of rock salt under water heaters. Dry Storage: -Flour 25# opened bag, undated. -Powdered sugar 25# bag, opened, undated. -Brown Sugar 25# bag, opened, undated. -Split peas 25# bag, opened, undated. -Flake premium coconut 25# bag, opened, undated. -Brown Rice 25# bag, opened, undated. Based upon Interview with the dietary manager on May 1, 2006 at 4:43 P.M., she stated that the uncovered, pre poured glasses of milk had been pour "around lunchtime" and left uncovered in the walk-in refrigerator.	F 371		

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F 426 SS=G	483.60(a) PHARMACY SERVICES - PROCEDURES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for 1 of 16 sampled residents, the facility did not provide pharmaceutical services to meet the needs of resident 16. Specifically resident 16 (a medicaid resident) did not receive pain medication as prescribed by the physician for 22.5 hours, and was instructed by facility staff on 5/1/06 that he would need to use his own money to buy the pain medication if he wanted some prior to 5/5/06. Findings included: Resident 16 was a 40-year-old male admitted to the facility 10/28/05 with diagnosis of endocarditis, arthritis, renal diease, hematuria, depressive disorder, personality disorder, anemia, obesity, gastroesophageal reflux. On 5/3/06 at 10:30 AM, during a facility resident group interview, resident 16 stated that he was concerned about having to pay for his medications out of his personal funds. A personal interview was scheduled later in the day with resident 16. On 5/3/06 at 1:00 PM resident 16 was interviewed. Resident 16 stated that on 4/27/06	F 426	F 426 Residents on medications that are limited in number provided by Medicare, Medicaid, or Private Insurance will be informed of the number of medications provided under their coverage. When medications are within two days of being used up: 1. The M.D. will be notified of limitations and determine if medication is to be continued or if an alternative medication is to be given. 2. If medication is to be continued, pharmacy will be called and approval for medication to be sent, at facility expense, until medication can again be covered by the usual pay source. Continued on next page	

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F 426	Continued From page 17 his physician had prescribed a temporary increase in his Lortab dose to address an acute episode of gout, which he stated was painful. The resident stated that due to the temporary increase in the medication his previous prescription had run out, and he had asked the facility to fill the new prescription to address his pain. The resident stated that the facility had told him that the medication could not be filled by the pharmacy until the beginning of the month on 5/05/06. The resident stated that the facility told him that if he needed the medication he would need to use his own money to have the prescription filled. Resident 16 stated that due to the daily increase in the pain medication he was taking for the gout, he ran out of his pain medication on the evening of 5/01/06. On 5/03/06 a review of resident 16's medical record was completed. A new prescription (physician's order) dated 4/27/06 stated that the resident may have an increase in his 7.5 mg Lortab from 1-2 tablets three times daily, to 1-2 tablets four times daily. On 5/03/06 a review of the narcotic record was completed. The narcotic record documented that the last 7.5 mg Lortab given to resident 16 was at 11:30 PM on 5/01/06. On 5/03/06 at 2:00 PM resident 16 was interviewed. Resident 16 stated that on 5/02/06 by 12:00 PM that his pain on a scale of 1-10 was at a 10 (with 10 being the worst). The resident stated that the pain would reach its peak each time his heart would pump blood. He stated that the pain continued until approximately 9:00 PM on 5/02/06 when he received his next administration	F 426	3. If unable to obtain before last dose is given, medication will be taken from the pharmacy emergency drug box, and charged to the facility. 4. M.D. will be notified of any missed doses. Nurses will be in-serviced by D.O.N. on May 25, 2006 of this protocol. Pharmacy will provide a list of medications that are limited in number that can be sent in a 30 day time frame. The list will be kept in the front of each M.A.R. for reference by the medication nurse. 5/25/06 added & permission monthly VB D.O.N. will monitor and report findings in a QA meeting on June 1, 2006. Murray Care Center will be in compliance with this issue by June 8, 2006. 6-8-06	

DEPARTMENT OF HEALTH AND HU ERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 426	Continued From page 18 of pain medication. Resident 16 went 22.5 hours without receiving his pain medication, Lortab. In the nurses noted dated 5/03/06 it was documented that the facility had tried to fill resident 16's medications, but were instructed by the pharmacy that resident 16's medicaid coverage would not pay for a refill until 5/05/06. The nurse's note stated that the patient was notified by the facility nurse that he would have to wait until 5/05/06 when his medication was refilled, but could use Tylenol until that time. The nurse's note documented that resident 16 stated that the wait until 5/05/06 was too long. The nurse's notes documented that the resident was told by the facility nurse that if the resident paid out of his own pocket he would receive the medications by the evening of 5/02/06. The resident agreed, and the prescription was filled and billed to the resident. During the exit interview on 5/3/06, the staff were questioned as to why the facility did not absorb the cost of the Lortab as they should have. The director of nurses stated that it was her fault that had happened. She stated that she thought the medicaid benefits of resident 16 would soon stop and that she did not want to incur any further expenses for the facility.	F 426		

CHECK LIST FOR IDENTIFIED WOUNDS

When wound is found follow the following protocol and notify wound nurse or DON office.

____ Call M.D. and family and notify of wound.

____ Get order to initiate treatment on wound.

a. Abx. Ointment and cover with non-stick dressing
b. Foot wounds are to be wrapped with Kerlex type dressing for protection.
c. Skin tears – pull torn skin back into place and apply steri-strips. Abx ointment with a non-stick dressing and cover with kerlex type dressing.

____ Add wound to the Care Plan and Kardex

____ Make note in residents chart.

____ Add treatment to treatment sheet.

_____ Notify Dietary dept. to provide supplements with meals.

_____ Restorative C.N.A. add resident to weekly wt. list

Turn this sheet into the D.O.N.'s office to be given to treatment nurse.

Nurses signature_____

RESIDENTS NAME_____Date_____

ASSESSMENT FOR CHANGE IN CONDITION

If **three** or more areas show changes a new R.A.P., in each of those areas, will be completed, if the changes are significant and long term, a new M.D.S. will be initiated as a Significant change, and care plan updated to reflect the changes.

TRIGGER	IMPROVEMENT / DECLINE / NO CHANGE (explain how the resident has changed)
Delirium	
Cognitive loss	
Visual Function	
Communication	
ADL performance / rehab potentiaL	
Psychosocial Well being	
Mood state	
Behavioral symptoms	
Falls	
Nutritional status	
Dehydration / fluid maintenance	
Oral / Dental care	
Psychotropic drugs	

From the assessment completed is a significant change M.D.S. indicated. YES__ NO__
If your answer is yes turn this form into Med. Rec. to be put on M.D.S. list.

Nurses signature_____ Date_____

RESIDENT NAME_____