STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465141	A. BUILDING _____ B. WING _____	07/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OGDEN REGIONAL MEDICAL CENTER TCU	5475 SOUTH 500 EAST OGDEN, UT 84405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 157 SS=D	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 interview and medical record review it was determined that the facility did not immediately consult with the resident's physician of a significant change in the resident's clinical	F 157		8/17/07

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465141	A. BUILDING _____ B. WING _____	07/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OGDEN REGIONAL MEDICAL CENTER TCU	5475 SOUTH 500 EAST OGDEN, UT 84405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 157	Continued From page 1	F 157		

condition. Specifically the facility did not notify the physician in 1 out of 4 residents when there was a change in the residents bowel program.

Resident 4 was admitted to the facility on 6/21/07 with diagnoses that included stroke, left foot surgery, dysphasia, hypertension, constipation, and neuropathy.

Review of the electronic medical record was done with the assistance of the DON and RN 1. A listing of the dates that resident 4 had a stool was printed. It revealed that resident 4 had a stool on 6/26/07 then did not have another until 6/30/07. A 4 day span.

The electronic medical record also revealed that resident 4 had a stool on 7/11/07, then did not have another until 7/16/07. A 5 day span.

On 7/17/07 at 8:45 AM and at 12:50 PM an interview was conducted with resident 4 and her husband. Her husband stated and resident 4 agreed that the weekend nurse kept track of resident 4's BM's. Resident 4 was always irregular with her BM's. Resident 4 was very uncomfortable on Sunday (7/15/07) with a pain level of 5. "The weekend nurse cleaned her out." Her husband stated that stool was removed with the nurses fingers.

On 7/17/07 at 10 AM and interview was conducted with RN 1. She stated, " We let them go a couple of days without a stool, then give them a suppository."

On 7/17/07 at 10:15 AM an interview was conducted with the DON. He stated, "we usually inform the doctor on the third day without a stool,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465141	A. BUILDING _____ B. WING _____	07/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OGDEN REGIONAL MEDICAL CENTER TCU	5475 SOUTH 500 EAST OGDEN, UT 84405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 157	Continued From page 2 but we treat the second day." There was no documentation that the doctor was notified of these two events.	F 157		
F 279 SS=E	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 1 of 4 sample residents the facility did not develop comprehensive care plans for each resident based on their individual needs identified by the facility staff. Specifically, resident's wound care, diet and use of respiratory equipment was not care planned. (Resident identifier: 2)	F 279		8/17/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465141	A. BUILDING _____ B. WING _____	07/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OGDEN REGIONAL MEDICAL CENTER TCU	5475 SOUTH 500 EAST OGDEN, UT 84405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 279	Continued From page 3	F 279		

Findings included:

Resident 2 was admitted to the facility on 7/12/07 with diagnoses that included congestive heart failure, lumbar spondylosis with fusion of L3 to L5, morbid obesity, diabetes mellitus, and hypertension.

1. The physician orders for 7/12/07 has a regular diet listed for resident 2.

The cardex care plan, labeled TCU Patient Care Plan, for resident 2 had an American Diabetic Association (ADA) and an American Heart Association (AHA) diet listed. It was not addressed in the electronic care plan.

On 7/17/07 at 7:20 AM in an interview with resident 2, he stated that he received a "diabetic and a special heart diet."

On 7/17/07 at 8:30 AM an interview with RN 1 was conducted. She stated that resident 2 received an AHA and ADA diet.

2. On 7/17/07 at 7:30 AM resident 2's wounds were observed during a dressing change. On each leg, below the knee, resident 2 had blisters. The right leg blister was scabbed over, approximately 8 centimeters in circumference, with a little drainage on the dressing. The left leg had a blister approximately 6 centimeters in size that was full of liquid. The dressing had a moderate amount of drainage on the dressing.

Resident 2 was interviewed about the blisters. He stated that they came up after his surgery 1 week ago. He stated that he changes the dressings

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465141	A. BUILDING _____ B. WING _____	07/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OGDEN REGIONAL MEDICAL CENTER TCU	5475 SOUTH 500 EAST OGDEN, UT 84405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 279	Continued From page 4 with the help of his wife. The facility staff gave him the dressing supplies. On 7/17/07 the clinical record for resident 2 was reviewed. There was not an order for the dressing changes. The electronic care plan was reviewed. The knee wounds were not care planned. On 7/17/07 at 8:40 AM an interview was conducted with the Director of Nurses. He stated that the dressing changes for resident 2 should have been ordered and care planned, but were not. 3. On 7/17/07 at 7:20 AM resident 2 was interviewed. He stated that he used a CPAP (continuous positive airway pressure) machine at night. He stated that it was his machine. On 7/17/07 the clinical record for resident 2 was reviewed. There was not an order for the CPAP. The electronic care plan was reviewed. The CPAP was not care planned. On 7/17/07 at 8:40 AM an interview was conducted with the Director of Nurses. He stated that the CPAP for resident 2 should have been ordered and care planned, but was not.	F 279		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		8/17/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465141	A. BUILDING _____ B. WING _____	07/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OGDEN REGIONAL MEDICAL CENTER TCU	5475 SOUTH 500 EAST OGDEN, UT 84405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 309	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility did not provide the care and services necessary to attain or maintain the highest practicable physical well-being for 2 of 4 sample residents. Resident identifiers: 2 and 4 Finding included: 1. Resident 2 was admitted to the facility on 7/12/07 with diagnoses that included congestive heart failure, lumbar spondylosis with fusion of L3 to L5, morbid obesity, diabetes mellitus, and hypertension. On 7/17/07 at 7:30 AM resident 2's wounds were observed during a dressing change. On each leg, below the knee, resident 2 had blisters. The right leg blister was scabbed over, approximately 8 centimeters in circumference, with a little drainage on the dressing. The left leg had a blister approximately 6 centimeters in size that was full of liquid. The dressing had a moderate amount of drainage on the dressing. Resident 2 was interviewed about the blisters. He stated that they came up after his surgery 1 week ago. He stated that he changes the dressings with the help of his wife. The facility staff gave him the dressing supplies. On 7/17/07 the clinical record for resident 2 was reviewed. There was not an order for the dressing changes. The care plan was reviewed. The knee wounds were not care planned.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465141	A. BUILDING _____ B. WING _____	07/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OGDEN REGIONAL MEDICAL CENTER TCU	5475 SOUTH 500 EAST OGDEN, UT 84405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 309	Continued From page 6 On 7/17/07 at 8:40 AM an interview was conducted with the Director of Nurses (DON). He stated that the dressing changes for resident 2 should have been ordered and care planned, but were not. 2. Resident 4 was admitted to the facility on 6/21/07 with diagnoses that included stroke, left foot surgery, dysphasia, hypertension, constipation, and neuropathy. A. On 7/17/07 at 12 PM resident 4's left foot was observed at the pin sites. There were 6 pins in the foot. The pins on the right side of the foot on the top had approximately 1\4 inch of red inflammation around the pins and a moderate amount of drainage. The pins on the proximal, left side of the foot had about 1/4 inch of red inflammation around the pins with a small amount of drainage. The physicians orders for 6/23/07 from Podiatry read: . . . Dry Sterile Dressing change daily, hydrogen peroxide to pin sites, apply gauze, secure with Kerlix and ace wrap. The electronic and cardex TCU care plan for resident 4 was initiated on 6/21/07 and was reviewed on 7/17/07. It read: DAILY Clean pin sited with hydrogen peroxide . gauze around pin sites. secure with Kerlix/ace to protect right leg from injury. On 7/17/07 at 10:15 AM and 12:50 PM an interview with RN 1 was conducted. She stated: "I look at the ankle everyday, if it need hydrogen peroxide I do it. How often I use it depends on how it looks. Today it looks inflamed. I use it at least every other day. We don't have an order for	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465141	A. BUILDING _____ B. WING _____	07/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OGDEN REGIONAL MEDICAL CENTER TCU	5475 SOUTH 500 EAST OGDEN, UT 84405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 309	Continued From page 7 every other day, I just go by policy and procedure." On 7/17/07 the facility "Nursing Standard of Skeletal Traction and Pin Care" was reviewed. Under the section Decrease Potential for Infection, it reads: "Provide pin care as ordered/routine protocol: Routine protocol for pin care: 1. With sterile cotton-tipped applicator dipped in hydrogen peroxide, swab pin sites, using a sterile applicator for each insertion site. Allow hydrogen peroxide to break up serous exudate. 2. Use normal saline with sterile applicators to cleanse. 3. If ordered, apply medication to insertion sites. On 7/17/07 at 11 AM in an interview with the Director of Nurses, he stated: " we do pin care every day." B. Resident 4's medical record was reviewed on 7/17/07. A form titled TCU PATIENT CARE PLAN was reviewed. This care plan was in a cardex. On the upper page of the same care plan was a note that read: "1. To avoid further impaction please give lactulose bid (two times a day) until normal BM (bowel movement) occurs 2. Following daily therapy have P.T. (physical therapy) put (resident 4) on the commode and give her a chance to go independently. 3. Night Shift can you please give (resident 4 a suppository before AM report to help her go? 4.(Resident 4) has horrible hemorrhoids---- let's give her an Anusol suppository daily and place a Tuck's pad for help in shrinking them and give her	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465141	A. BUILDING _____ B. WING _____	07/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OGDEN REGIONAL MEDICAL CENTER TCU	5475 SOUTH 500 EAST OGDEN, UT 84405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 309	Continued From page 8 more comfort. Any further suggestion, I'm all for. Enemas and digital stimulation are so very painful for her. Lets work together to keep her from another impaction like she had on Sunday" Review of the electronic medical record was done with the assistance of the DON and RN 1. A listing of the dates that resident 4 had a stool was printed. It revealed that resident 4 had a stool on 6/26/07 then did not have another until 6/30/07. A 4 day span. Electronic nursing documentation for those dates, revealed that a bowel program was not addressed. The electronic medical record also revealed that resident 4 had a stool on 7/11/07, then did not have another until 7/16/07. A 5 day span. Electronic nursing documentation for those dates also revealed that a bowel program was not addressed. On 7/17/07 at 8:45 AM and at 12:50 PM an interview was conducted with resident 4 and her husband. Her husband stated and resident 4 agreed that the weekend nurse kept track of resident 4's BM's. Resident 4 was always irregular with her BM's. Resident 4 was very uncomfortable on Sunday (7/15/07) with a pain level of 5. "The weekend nurse cleaned her out." Her husband stated that stool was removed with the nurses fingers. On 7/17/07 at 10 AM and interview was conducted with RN 1. She stated that the sign in	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465141	A. BUILDING _____ B. WING _____	07/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OGDEN REGIONAL MEDICAL CENTER TCU	5475 SOUTH 500 EAST OGDEN, UT 84405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 309	Continued From page 9	F 309		

the cardex care plan was placed there over the weekend (7/15/07) She stated, "we discuss bowel events in report with stroke patients. We let them go a couple of days without a stool, then give them a suppository."

On 7/17/07 at 10:15 AM an interview was conducted with the DON. He stated, "we usually inform the doctor on the third day without a stool, but we treat the second day." When asked for the policy and procedure for how long a resident should go without a stool, he stated, "we don't have one."

The electronic medication administration record was reviewed. Resident 4 had the following stool softeners ordered:
Lactulose 10-20 grams oral every 6 hours as needed
Senna 187 milligrams twice a day as needed
Bisacodyl 10 milligrams (1 suppository) rectal as needed, every other day
as needed bowel care
Colace 100 milligrams oral twice a day

The electronic medication administration record revealed that resident 4 received the following stool softeners for the July 11 to July 16:

July 11 colace 2 times and senna 1 time
July 12 colace 2 times and senna 1 time
July 13 Lactulose 1 time and colace 2 times
July 14 colace 2 times
July 15 colace 2 times and lactulose 2 times

The electronic care plan in the medical record was reviewed. It did not address bowel movements or bowel training.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465141	A. BUILDING _____ B. WING _____	07/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OGDEN REGIONAL MEDICAL CENTER TCU	5475 SOUTH 500 EAST OGDEN, UT 84405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 309	Continued From page 10 There was no documentation that the doctor was notified.	F 309		
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 on observation it was determined that the facility did not store, prepare and serve food under sanitary conditions. On 7/17/07 at 7:15 AM, observations were done in the kitchen which revealed the following: 1. In a walk in refrigerator was a large stainless steel container of cooked onions and peppers not covered, labeled or dated. 2. There were 30 pork chops on large cookie sheets, not covered, labeled or dated. 3. In an other walk in refrigerator was a lage bowl of whipped topping, not covered, labeled or dated. 4. The hood over the range was greasy and had built up dirt. 5. There was an open bag of cookies on a shelf above the tray line, not labeled or dated. 6. The large mixer had dried food stuck to the neck.	F 371		8/1/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465141	A. BUILDING _____ B. WING _____	07/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OGDEN REGIONAL MEDICAL CENTER TCU	5475 SOUTH 500 EAST OGDEN, UT 84405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 371	Continued From page 11 7. Five spice jar lids were open. Observation of the refrigerator in the Transitional Care Unit revealed: 1. A bowl of chopped peaches was not labeled or dated. 2. A container of pudding was not labeled or dated.	F 371		
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, observation and interview, it was determined that the facility did not maintain accurate medical records for 2 of 4 sample residents. Resident identifiers 2 and 4. Findings included: 1. Resident 2 was admitted to the facility on 7/12/07 with diagnoses that included congestive heart failure, lumbar spondylosis with fusion of L3 to L5, morbid obesity, diabetes mellitus, and	F 514		8/17/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465141	A. BUILDING _____ B. WING _____	07/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OGDEN REGIONAL MEDICAL CENTER TCU	5475 SOUTH 500 EAST OGDEN, UT 84405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 514	Continued From page 12 hypertension. The physician orders for 7/12/07 has a regular diet listed for resident 2. The cardex care plan, labeled TCU Patient Care Plan, for resident 2 had an American Diabetic Association (ADA) and an American Heart Association (AHA) diet listed. It was not addressed in the electronic care plan. On 7/17/07 at 7:20 AM in an interview with resident 2, he stated that he received a "diabetic and a special heart diet." On 7/17/07 at 8:30 AM an interview with RN 1 was conducted. She stated that resident 2 received an AHA and ADA diet. On 7/17/07 at 7:30 AM resident 2's wounds were observed during a dressing change. On each leg, below the knee, resident 2 had blisters. The right leg blister was scabbed over, approximately 8 centimeters in circumference, with a little drainage on the dressing. The left leg had a blister approximately 6 centimeters in size that was full of liquid. The dressing had a moderate amount of drainage on the dressing. Resident 2 was interviewed about the blisters. He stated that they came up after his surgery 1 week ago. He stated that he changes the dressings with the help of his wife. The facility staff gave him the dressing supplies. On 7/17/07 the clinical record for resident 2 was reviewed. There was not an order for the dressing changes. The care plan was reviewed. The knee wounds were not care planned.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465141	A. BUILDING _____ B. WING _____	07/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OGDEN REGIONAL MEDICAL CENTER TCU	5475 SOUTH 500 EAST OGDEN, UT 84405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 514	Continued From page 13 On 7/17/07 at 8:40 AM an interview was conducted with the Director of Nurses. He stated that the dressing changes for resident 2 should have been ordered and care planned, but were not. On 7/17/07 at 7:20 AM resident 2 was interviewed. He stated that he used a contiguous positive airway pressure machine (CPAP) at night. He stated that it was his machine. On 7/17/07 the clinical record for resident 2 was reviewed. There was not an order for the CPAP. The care plan was reviewed. The CPAP was not care planned. On 7/17/07 at 8:40 AM an interview was conducted with the Director of Nurses. He stated that the CPAP for resident 2 should have been ordered and care planned, but was not. 2. Resident 4 was admitted to the facility on 6/21/07 with diagnoses that included stroke, left foot surgery, dysphasia, hypertension, constipation, and neuropathy. The physicians orders for 6/23/07 from Podiatry read: . . . Dry Sterile Dressing change daily, hydrogen peroxide to pin sites, apply gauze, secure with Kerlix and ace wrap. . The electronic and cardex TCU care plan for resident 4 was initiated on 6/21/07 and was reviewed on 7/17/07. It read: DAILY Clean pin sited with hydrogen peroxide . gauze around pin sites. secure with Kerlix/ace to protect right leg from injury.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465141	A. BUILDING _____ B. WING _____	07/19/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OGDEN REGIONAL MEDICAL CENTER TCU	5475 SOUTH 500 EAST OGDEN, UT 84405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 514	Continued From page 14 On 7/17/07 at 10:15 AM and 12:50 PM an interview with RN 1 was conducted. She stated: "I look at the ankle everyday, if it need hydrogen peroxide I do it. How often I use it depends on how it looks. Today it looks inflamed. I use it at least every other day. We don't have an order for every other day, I just go by policy and procedure." On 7/17/07 the facility "Nursing Standard of Skeletal Traction and Pin Care" was reviewed. Under the section Decrease Potential for Infection, it reads: "Provide pin care as ordered/routine protocol: Routine protocol for pin care: 1. With sterile cotton-tipped applicator dipped in hydrogen peroxide, swab pin sites, using a sterile applicator for each insertion site. Allow hydrogen peroxide to break up serous exudate. 2. Use normal saline with sterile applicators to cleanse. 3. If ordered, apply medication to insertion sites. On 7/17/07 at 11 AM in an interview with the Director of Nurses, he stated: " we do pin care every day."	F 514		