STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465090	A. BUILDING _____ B. WING _____	10/05/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD PARK CARE CENTER	740 NORTH 300 EAST OREM, UT 84057

(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 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 record review and interview it was determined that the facility did not immediately consult with the resident's physician, regarding a significant change in physical condition, for 1 of	F 157	F 157 The DON will complete a mandatory in-service on November 10, 2006, on identification of appropriate change of condition, notification and documentation, and physician response policy. The DON will audit the pass down logs bi-monthly for two months to ensure that appropriate identification, notification & documentation are occurring. Results of the audit will be reported in the Quality Assurance meeting. If after two months no concerns are noted, reports to the committee will be made on as needed basis. This process will ensure the physicians of resident #8, as well as all other residents physicians, are properly notified of change in condition. Correction Date: November 10, 2006 Utah Department of Health OCT 2 7 2006 Bureau of Health Facility Licensing, Certification and Resident Assessment	

10/30/06 POC acceptable Completion date 11/10/06 CBuenconsejo RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/26/06

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 15 residents. Resident identifier: 8. Findings included: Resident #8 (R#8) was admitted to the facility 11/03/04 with diagnoses that included congestive heart failure, diabetes mellitus, hypertension, anemia, asthma, arthritis, chronic obstructive pulmonary disease, anxiety disorder, transient ischemic attacks and chronic renal insufficiency. A nurse's note dated 02/09/06 1:10 PM stated that R#8 suffered a fall. "Nurse called to pt (patient) room by CNA, found pt. kneeling on floor beside bed. Pt says was transferring self from w/c (wheelchair) to bed, denies pain. Pt assisted x2 (times two) assist, enc. (encouraged) to walk forward to bed, pt could (empty set "not") perform. knees sl. (slightly) red, (empty set "no") other injuries noted or reported. Pt alert, LOC (level of consciousness) WNL (within normal limits). BS (blood sugar) 188. Notified MD (medical doctor) of fall, also pt c/o (complained of) (up arrow) arthritis pain today. Notified son (son's name) msg (message) left for Dr. (physician's name). will cont (continue) to monitor." On 02/09/06 at 6:00 PM a nurse's note indicated "Res (resident) up in w/c. Keeps leaning to left. Pillow proped (sic) up to assist res to proper (sic) body alignment. Still continues to lean head toward left. Do not know if this is related to fall. Theraphy (sic) to look into it tomorrow. Continue to monitor." At 10:45 PM on 02/09/06 a nurse's note stated "Assessed pt. (illegible) (circled L "left") side weakness. Pt had unequal grips (circled L) hand	F 157		

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F 157	Continued From page 2	F 157		

weaker than (circled R "right"). Pupils reactive to light but seemed somewhat sluggish. Pt speech is clear (without symbol) slurring. Pt able to move toes on command. Pt has (empty set "no") c/o HA (headache) and states that she "feels fine." Will continue to monitor pt for s/s (signs and symptoms) of TIA (transient ischemic attack) or stroke."

No documentation of physician consultation, regarding resident's change in physical status, starting on 02/09/06 at 6:00 PM, was found until the following day 02/10/06 at 10:45 AM. The nurse's note stated "I contacted Dr. (physician's name) nurse to report recent findings ie: no strength in LLE (left lower extremity) grip strength (circled L) slightly weaker, speech slurred but able to convey her needs. Family was (illegible) notified (and sign) her son (son's name) will come in to discuss her condition. Per (nurse's name) (Dr. physician's name's nurse) he would like her transported to the ER (emergency room) for diagnostic testing."

A CT (computerized tomography) scan of the residents brain was conducted at name of (acute care hospital) on 02/10/06. "Impressions" portion of a report from the hospital stated "Findings are consistent with multiple strokes, bilaterally - right greater than left. I feel that there have (sic) been a new stroke since the last exam of November 2004. The lesion involving the right frontal lobe, anterior to the sylvian fissure is new and likely represents a new stroke with gliosis and encephalomalacia. However, the lesion is somewhat spherical in appearance. If the patients symptoms warrant, I would recommend a brain MRI for further evaluation."

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F 157	Continued From page 3 An interview was conducted with the facility DON on 10/03/06 at 5:00 PM. The DON stated that the facility's policy is to contact a resident's physician as soon as a change in the resident's condition is noted. The DON further stated that the facility schedules in such a way as to always have 2 licensed nurses in the facility so as to provide nurses with the ability to contact a physician.	F 157		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility did not provide services based on professional standards of quality for 1 of 15 residents. Resident Identifier: 8. Findings included: Resident 8 (R#8) was admitted to the facility 11/03/04 with diagnoses that included congestive heart failure, diabetes mellitus, hypertension, anemia, asthma, arthritis, chronic obstructive pulmonary disease, anxiety disorder, transient ischemic attacks and chronic renal insufficiency. R#8 had been receiving 14 U (units) of Lantus insulin each morning until 07/28/06 when the order was changed to Humalog mix 75/25 10 units each morning and 8 units each evening.	F 281	F 281 In a mandatory inservice for all nursing staff on November 10th, staff will be trained by the Staff Development director on the physician response policy, the need to order new medications as soon as are prescribed, and the appropriate medication administration process (as it relates to insulin administration). To ensure compliance with this plan of correction, the DON will audit a random sample of 10 patient insulin orders bi-monthly & report audit results to the QA committee for three months. If no concerns are found through these audits, they will be discontinued at that time. This process will ensure resident #8 and all other residents receive only physician ordered insulin prescriptions. Correction date: November 10, 2006.	

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A nursing note dated 07/29/06 at 12:00 PM indicated that the Humalog insulin had not been received by the facility on the morning of 07/29/06. The note stated "haven't received new insulin humalog 75/25 pt (patient) not given anything this am (morning) per reporting RN (registered nurse)." Documentation on the diabetic monitoring sheet dated 07/29/06 at 7:30 AM indicated that the residents blood sugar was 90, and no insulin was given.

An interview with the Director of Nursing (DON) was conducted on 10/04/06 at 3:13 PM. The DON stated that she had spoken with the nurse who reported off on the morning of 07/29/06, and that the nurse did not provide the resident with any insulin because the newly ordered Humalog 75/25 was not available. The DON also stated that the nurse had indicated to her that she did not make a nursing note regarding the insulin.

The nursing note of 07/29/06 12:00 PM further stated "BS (blood sugar) (check symbol) @ (at) 11:30 AM showed BS of 443. Dr. (physician's name) called for okay to give something. (empty set symbol (no)) return call attempts x2 (times two). Pt given Lantus + (plus) Regular insulin as previously ordered. Will re ("check" symbol) BS + (and) f/u (follow up) ("with" symbol) Dr. (doctor)."

Documentation on the diabetic monitoring sheet dated 07/29/06 at 11:30 AM indicated that the resident's blood sugar was 443, and that 14 units of Lantus, and 8 units of Regular insulin had been given.

The next nursing note dated 07/29/06 at 1:30 PM

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F 281	Continued From page 5 stated "rechecked blood sugar. Reading 442. Call made to Dr. (physician's name)." Documentation on the diabetic monitoring sheet for 07/15/06-07/28/06 indicated that the resident received Lantus insulin at about 7:30 AM during those dates. The 9:30 PM BS documentation for 07/15/06-07/28/06 ranged from 100-309. Documentation on the diabetic monitoring sheet for 07/29/06 at 9:30 PM indicated that the resident's blood sugar was 55, and that the resident received a snack to bring the residents blood sugar level to 98 at 10:45 PM. Documentation in the nurse's notes for 07/30/06 at 12:15 AM indicated that "pt's blood sugar level was 75. Pt given 120 cc (cubic centimeters) of ensure to maintain pt's blood sugar lever above 70." At 4:15 AM the nurse's notes indicate "check pt's blood sugar, and it was 50. Pt lethargic, yet responsive. Pt give (sic) 1 tube of glucose gel." At 4:35 AM the nurse's notes indicate "Rechecked pt's blood sugar level and it was 114. Pt more awake/alert." During the 10/04/06 3:13 PM interview with the DON it was stated that the nurse on duty was able to make contact with a physician who was providing coverage. The DON stated that the nurse on duty encountered difficulty in obtaining clarification of the insulin orders. No physician's order was found for the one time administration of the previously ordered Lantus and Regular insulin, nor was any further documentation found indicating that the physician had responded to the nurse's calls.	F 281		

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F 281	Continued From page 6 According to Fundamentals of Nursing Concepts, Process, and Practice, seventh edition, pg 804 "There are six aspects of medication administration which are important for the nurse to check each time a medication is administered", under Six "Rights" of Medication Administration, bullet points 1-3 state: "Right Medication- The medication given was the medication ordered."; "Right Dose" and "Right Time-Give the medication at the right frequency and at the time ordered...".	F 281		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interviews it was determined that in 1 of 15 sampled residents, the facility did not provide the necessary comprehensive assessment, diagnosis or services to attain or maintain the highest practicable physical well-being of a skin condition. Resident Identifier 6. Findings Include: Resident #6 (R#6) was admitted to the facility on 6/20/06 with diagnoses that included acute renal	F 309	F 309 By November 1, 2006, DON will educate treatment nurse team on new process which requires all treatment nurses to record and include in pass down log any staged ulcer changes. The DON will do monthly wound care rounds with treatment nurses and review their bi-monthly reports and pass down log for accuracy. This process will resolve any communication breakdowns and ensure proper treatment for resident #6 as well as all residents at Orchard Park Care Center. To ensure compliance with the new process, findings will be reported at the QA meetings as concerns are identified. The QA committee will be uses as a CQI group to address these concerns. Correction Date: November 1, 2006	

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F 309	Continued From page 7	F 309		

failure, hypertension, congestive heart failure, and depression.

R#6's admitting Minimum Data Set (MDS) section M1 dated 6/28/06 documents a Stage 2 pressure ulcer. The Resident Assessment Protocol (RAP) dated 6/28/06 documents "a stage II ulcer to his coccyx, with Tx's (treatment) applied by nursing as ordered." The treatment record and physician orders dated 6/20/06 show "apply Miconazole 2% cream BID/AM, PM & PRN to groin rash until healed. " and "apply barrier cream to coccyx ulder TID until healed." The treatment record shows documentation that this was healed 8/5/06.

The next documentation of treatment to a Stage 2 pressure ulcer on the coccyx is dated 8/24/06 when a short term resident care plan states "open wound coccyx & peeling skin." Nurses' treatment notes state ".1 cm long x .2 cm wide x .05 cm deep open wound coccyx surrounded by wet peeling skin - wound also draining serrous fluid. Excoriation noted on buttocks." Nursing notes of 8/24/06 2:15PM written by S#2 states "c/o pain rated @ 3/10 for tailbone/coccyx area. Coccyx sl. (slightly) red with no open areas." Nursing notes of 8/24/06 2:50PM written by S#9 state "New order from Dr. (physician's name) for open wound coccyx. Cleanse-abx (antibiotic) and dry dsg (dressing) QD (every day) and PRN (per registered nurse) until healed. Also barrier cream applied QD to buttocks/scrotum excoriation and right hip redness. Patient and family notified." A physician's order was received on 8/24/06 that stated "wound coccyx, clean w/30cc (with) NS (normal saline) and 4x4 (dressings) using aseptic tech. (technique), apply abx oint (antibiotic ointment) and dry drsg (dressing) QD/AM & PRN

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F 309	Continued From page 8 until healed." The treatment record for R#6 for the dates of 8/24/06 to 9/14/06 (22 days) show the ordered treatment for the coccyx wound was documented as being done 16 times. On 9/15/06 the treatment was noted as being held on the treatment record and treatment nurses resumed treating with barrier cream QD and PRN. The treatment notes dated 9/1/06, written by S#9 states "coccyx wound dark blue in color over cocyx .75 cm wide x 1.25 cm long below coccyx raw and bleeding skin 3 cm long x 1.25 cm wide. tx applied." The treatment notes dated 9/15/06, written by S#9 state "wounds on coccyx draining-duoderm/other dressings not sticking well. Applied calmoseptive and Dr. order to TID (three times daily) barrier cream." The treatment notes dated 9/23/06, written by S#9 state "coccyx open area cont (continues) to drain yellowish brown with blueish tissue in middle." The treatment notes dated 10/1/06, written by S#7 state "excoriation on peri-anal skin has gotten more excoriated today-abraded also." Nurse's notes for the dates of 8/1/06 to 9/26/06 document 19 separate entries in which R#6 complained of severe coccyx/tailbone pain. No documentation was found that physical examinations were done at the times of the complaints. R#6 was routinely given oral pain medications following the complaints.	F 309		

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On 10/3/06 (9:00AM) this surveyor was present when S#3 and S#7 repositioned, cleaned and redressed R#6's peri-anal and coccyx area. Extensive excoriation was noted in the peri-anal area. S#7 examined the gluteal fold and a partial thickness wound with surrounding area of dark colored tissue was noted in the sacral area. S#7 redressed the open area and applied cream to the areas of dermal breakdown. S#7 stated they had not observed an open area prior to this examination and felt the darkened area was a bruise.

On 10/3/06 (15:30) the attending physician's residents (S#5, S#6) examined R#6. Orders were obtained for R#6 to be evaluated at the local wound clinic regarding a "decubitus ulcer Grade 3." An interview with S#6 was conducted on 10/3/06 (15:45). S#6 stated that they were unaware of any open wounds until being notified upon arriving at the facility on 10/3/06.

R#6 was sent to the local wound clinic on 10/5/06 (8:30AM). R#6 was "seen in clinic for partial thickness wound in sacral area. Large area of dermal breakdown with a central area with 3cm x 1.6cm of black ischar (sic)." R#6 was to receive daily dressing changes to wound, to be cleansed with normal saline, Xenaderm to redness BID, Accuzyme to eschar, cover with adaptic and gauze daily and return to the wound clinic in one week.

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F 514 SS=B	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 it was determined that the facility did not maintain or accurately transcribe clinical records for 6 of 15 residents. Resident identifiers: 1, 2, 3, 6, 8, 15 Findings Included: Resident #1(R#1) was admitted to the facility on 8/15/06 with a diagnosis of left rib fracture, Parkinson' s disease, renal insufficiency and dementia. R#1's medical record did not include a POLST (Physician Ordered Life Sustaining Treatment) or advance directive. Admitting orders written 8/15/06 by the physician included a DNR (do not resuscitate). No resident or family request was included. Resident #2 (R#2) was admitted to the facility on 9/7/06 with diagnoses that included pneumonia	F 514	F 514 • Upon receipt of admission papers for a new resident, the Social Service director reviews them to see if there is any previous advance directive order for the patient. • Medical Records director creates a face sheet and patient chart with the advance directive notification. • If no advance directive order is included in the admission paperwork, Orchard Park Care Center assumes the resident is full code, until a POLST is filled out by the patient or family members. • Medical Records director puts advance directives on residents face sheet, in the physicians orders, on the spine of the chart (noted by a white "dot" sticker indicating "full code", or a black "dot" sticker indicating "do not resuscitate"), and finally on the patients identification bracelet, • If the initial advance directive changes because of a family request, the new advance directive or POLST must be signed by the residents physician before any change may become affective. • Once the resident's physician signs the new POLST or advance directive, (signifying approval of the change of code status), the Medical	

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F 514	Continued From page 11 and fracture of femur. R#2 had a signed POLST form dated 9/8/06 with a DNR choice selected. Physician orders dated 9/7/06 stated "patient is a full code". Resident# 3(R#3) was re-admitted to the facility on 7/22/06 with diagnosis of kidney stones, urinary tract infection, diabetes, anxiety and asthma. R#3's medical record included a POLST stating that the resident wished to be resuscitated. The physician's admitting order stated that the resident was a DNR. Resident #6 (R#6) was admitted to the facility on 6/26/06 with diagnoses that included acute renal failure, hypertension congestive heart failure and depression. R#6's medical record included a POLST form dated 7/17/06 stating that the resident did not wish resuscitation. A physician order signed 6/20/06 stated "patient is full code." Resident# 8 (R#8) was admitted to the facility 11/03/04 with diagnoses that included congestive heart failure, diabetes mellitus, hypertension, anemia, asthma, arthritis, chronic obstructive pulmonary disease, anxiety disorder, transient ischemic attacks and chronic renal insufficiency. R#8 had a physicians order, dated 09/22/06, changing Humalog 75/25 mix insulin from 10	F 514	Records director changes all previous records including the residents face sheet, the physicians orders, the spine of the residents chart, and the patients identification bracelet to reflect the new code status. • To ensure accuracy and compliance with this plan of correction, the Medical Records Director will audit all status codes within the facility each month when she prints physician's orders. This monthly audit will be a part of the admissions process. • This process will be utilized to ensure status code accuracy for residents 1, 2, 3, 6, 8, and 15, as well as all residents at Orchard Park Care Center. • The QA team is responsible for overseeing the compliance of this regulation, and the Administrator and Director of Nursing are responsible for overseeing the QA team. Medical Records director will report on a quarterly basis the results of the monthly audits for two consecutive quarters. If the QA team concludes that the inconsistency problem has been resolved, the Medical Record may discontinue her quarterly reports. • Correction Date: October 16, 2006	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465090	A. BUILDING _____ B. WING _____	10/05/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARD PARK CARE CENTER	740 NORTH 300 EAST OREM, UT 84057

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F 514	Continued From page 12 units each morning to 12 units each morning. The order was transcribed to one side of the diabetic monitoring sheet of the Medication Administration Record (MAR) on 09/22/06. The new dosage was not transcribed to the other side of the MAR, and the resident received 10 units of Humalog 75/25 on 09/30, 10/01 and 10/02/06 instead of 12 units. Resident #15 (R#15) was admitted to the facility on 7/24/06 with diagnoses that included total hip replacement and constipation. R#15's medical record included a POLST form stating that the resident did not wish to be resuscitated. The doctor's admitting order stated that the "patient is a full code."	F 514		