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	465102	A. BUILDING _____ B. WING _____	08/31/2006

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PARKDALE CARE CENTER	250 EAST 600 NORTH PRICE, UT 84501

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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 record review and interview, it was determined that the facility did not immediately inform the resident's physician or interested family member when there was a significant	F 157 9/28/06 POC acceptable Completion date 10/27/06 UBusenbark RN	9/28/06 Call to Administrator per telephone call- Completion date for all tags is 10/27/06 added with permission. UBusenbark RN This Plan of Correction is submitted as the facility's credible allegation of compliance. **This plan of correction is prepared as part of the quality assurance process for the provider. This plan of correction and any attached documents are prepared with substantial reliance upon privileged peer review information and/or reports and as such are protected from discovery.** **This plan of correction is prepared, submitted and/or executed solely because it is required by local, state and/or federal regulations, codes and/or guidelines. As this transmission is required by law, it is not a waiver of the provisions within applicable laws and regulations or any other codes, statutes or regulations.** Utah Department of Health 155990 SEP 2 2 2006 Bureau of Health Facility Licensing, Certification and Resident Assessment	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David C Bloechle	Executive Director	9/22/06

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 change in the resident's physical and mental status. Resident Identifier 7. Findings include: Resident 7 was admitted to the facility on 3/3/02 with diagnoses that included hypertension, Alzheimer's disease, senile delirium and senile depression. A records review was done on 8/30/06 and 8/31/06. Documentation in the patient's medical records(s) indicated that the patient had been transferred to a local hospital during the late morning of 8/23/06 for signs and symptoms of unresponsiveness, failure to eat or drink for five days and abdominal pain. Documentation indicated that the resident's blood sodium level on admission to the acute facility was 167 mEq/L. Normal ranges for this test was from 136-145 mEq/L. An admitting xray of the resident's abdomen on admission showed a rectal fecal impaction. No documentation was provided to indicate that the resident's physician or family were informed of the resident's change in condition until the morning of 8/23/06, when a telephone call was made to the resident's son. Nurses' notes on 8/21/06 note that resident 7 was lethargic and had "spells" like this in the past but would "perk up" after a few days. No documentation was provided to indicate modifications made to the resident's care plans or new nursing intervention during this time period. In an interview conducted by telephone on 8/31/06 with the resident's son, he stated that he received a telephone call from the facility at 8AM on 8/23/06 informing him that his mother was	F 157	**F-tag 157** **Immediate Action for Affected Resident:** Resident #7 was sent to the acute care hospital for treatment on August 23, 2006. **Identification of other residents at risk:** All the facility Residents with a significant change of condition have the potential to be affected. **Systemic Changes** Residents who experience a significant change of condition will be notified of treatment changes; the resident's attending physician will be consulted; and the resident's surrogate decision maker and/or a family representative will be notified within 1 hour of determining the change of condition. A change of condition audit will be done Tuesday thru Friday covering the past 24 hours and on Mondays covering the past 72 hours by Medical Records. The change of condition audit will be reviewed daily at stand-up by the Director of Nursing or designee in the absence of the Director of Nursing Services.	

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F 157	Continued From page 2 unresponsive and not doing well. He came to the facility immediately and upon arrival was told that his mother had a scheduled doctor's appointment that afternoon. He was then asked if he wanted to have his mother keep that appointment or be sent to the local hospital emergency room. He told the facility staff that he wanted his mother transferred immediately. He further stated that he and his daughter had visited his mother late in the evening on Sunday, 8/20/06 and they found her to be quite unresponsive. When questioned if he notified any of the facility staff regarding this, he stated, "no, I just thought it was because we visited later than usual and she was sleepy." When interviewed regarding his notification when there had been changes in his mother's condtion in the past, he stated that they had always been prompt to let him know until "this last event" and that "the family was upset they weren't notified sooner." Further documentation showed that resident 7 had advanced directives in place stating that she was to be treated aggressively with full resuscitation and any additional treatments necessary to sustain life. Chart documentation showed a fax sent on 8/23/06 to the resident's physician stated the resident had been lethargic for "going on 5 days" and had not eaten or had fluids. It was further stated that the staff had talked to the resident's son and he wanted all treatments done and for the resident to be sent to the emergency room. A resident transfer form completed at 8:00 AM on 8/23/06 stated the resident was not responding except to painful stimuli, had not been eating or drinking for 5 days, and that the family requested full treatment to be done.	F 157	The change of condition audit will be reviewed at the daily department head meeting that is held Monday thru Friday by the Director of Nursing Services or designee. Resident's with a change of condition will be reviewed by the Interdisciplinary Team daily Monday through Friday. All Licensed Nurses will be in serviced in regards to immediate notification of the resident, the resident's attending physician, and the resident's surrogate decision maker when a change of condition occurs by 9/22/2006. **Monitor:** The Director of Nursing Services will review results of the audit performed by medical records or designee if the DNS is not available. The results of the audit and any corrective action that was taken to correct any deficiency found will become a part of the quarterly QI/QA committee meeting records and minutes.	

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F 157	Continued From page 3 Resident 7 was readmitted to the facility on 8/28/06 from the acute care hospital with a transfer discharge diagnosis of sepsis with urinary tract infection/hypernatremia.	F 157	**F-tag 221** **Immediate Action for Affected Resident:** Entrapment assessment was conducted again on 9/1/06. (Original entrapment completed on 6/15/06) Care plan was completed and reviewed on 9/5/2006. Physician's orders were signed and placed in chart on 9/5/06. Resident has verbally consented to use of S/R to the DNS and is unable to sign. Nursing note documents conversation and was placed in chart. **Identification of other residents at risk:** Residents who use of side rails as an enabler or a restraint have the potential to be affected. **Systemic Changes** The facility will follow a systematic process of evaluation and care planning before using restraints. The resident's medical symptoms will be reviewed; rehabilitative/restorative care will be considered; alternatives to restraints will be used; if restraints are deemed necessary, the facility will start with the least restrictive device for the least amount of time. If a restraint is deemed appropriate, a physician's order will be obtained. The resident or surrogate decision maker will be educated in order to
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility did not provide documentation of medical necessity for siderails, for 1 of 14 residents. Resident identifier: 2 Findings included: 1. Resident 2 was readmitted to the facility on 06/15/06 with diagnoses that included: congestive heart failure, urinary tract infection, diabetes mellitus, hydronephrosis, hypertension, and decubitus ulcer. Review of resident 2's medical record occurred from 08/29/06-08/30/06. Resident 2 was observed in bed on 08/30/06 at 2:00 PM with 3/4 siderails up on both sides of the bed. The resident was asked at this time about the use of the rails, and stated that the rails were	F 221		

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F 221	Continued From page 4 used to help in transferring out of bed with staff assistance. No documentation of entrapment risk, care planning, consent form, or doctors orders could be found in resident's medical records. An interview was conducted with a staff LPN on 08/30/06 at 2:10 PM. The LPN stated that the rails were used for resident 2 to assist with bed mobility, and that 1/2 rails are routinely used without doctors orders for bed mobility. It was also stated that the rails used for resident 2 were of an older style, were sizable, and had not been appropriately adjusted.	F 221	make an informed choice about the use of restraints. The use of the restraint will be re-evaluated in order to eliminate its use and maintain the resident's strength and mobility. Licensed nursing staff and certified nursing assistants will be in-serviced in the appropriate use of restraints by 9/22/06. **Monitor:** Medical records will do a weekly restraint audit. The Director of Nursing Services will review results of the audit performed by medical records or designee if the DNS is not available. The results of the audit and any corrective action that was taken to correct any deficiency found will become a part of the quarterly QI/QA committee meeting records and minutes.	

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F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review it was determined that the facility did not accurately identify weight loss, on the Minimum Data Set (MDS) assessment, for 2 of 14 residents. Resident identifiers: 3, 12. Findings included:	F 278	**F-Tag 278** **Immediate Action for Affected Resident:** Resident 3's MDS dated 6/28/06 did not reflect a significant weight loss because there was none. The significant weight loss occurred and was reflected on the August 19, 2006 MDS. Resident 12's MDS dated 1/26/06 and 7/12/06 do not reflect a significant weight loss because there was none. The significant weight loss occurred and was reflected in the MDS dated 3/13/06 and was reflected in the MDS dated 4/12/06. Resident's weight has stabilized between April and July. **Identification of other residents at risk:** Residents with unplanned weight loss/ gain. **Systemic Changes** Each resident will receive an accurate assessment by staff that are qualified to assess relevant care areas and knowledgeable about the resident's status, needs, strengths, and areas of decline. Weight loss/gain in percentages will	

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F 278	Continued From page 6 1. Resident 3 was admitted to the facility on 06/21/06 with diagnoses that included: humerus fracture, carpal fracture, hearing loss, diabetes mellitus, chronic ischemic heart disease, and edema. A review of resident 3's medical records occurred from 8/29/06-08/30/06. Documentation of resident 3's weights from the first week in June to the third week of July showed a 12.2% weight loss. The 07/20/06 30 day medicare MDS assessment, section k3 (weight change), was coded as zero indicating no weight loss. 2. Resident 12 was readmitted to the facility on 01/13/06 with diagnoses that included: pelvic fracture, essential hypertension, neoplasm of the digestive system, senile dementia and malignant neoplasm of the rectosigmoid junction. A review of resident 12's medical records occurred on 08/30/06. Documentation of resident 12's weights from 01/06 to 07/06 showed an 11.7% weight loss. Section k3 of resident 12's 07/12/06 quarterly MDS, and 01/26/06 admit MDS, were both coded as zero indicating no weight loss.	F 278	be recorded on the MDS as follows: 5% or more in the last 30 days, or 10% or more in the last 180 days. All qualified health professionals will correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status. **Monitor:** The Director of Nursing Services and/or designee will take a sample of 5 resident assessments monthly X 3 months and review for accuracy. If the review shows at least 95% accuracy then the review will be discontinued. If the threshold of 95% is not met another 3 months will be reviewed to meet the threshold of 95% accuracy. The results of the review and any corrective action that was taken to correct any deficiency found will become a part of the quarterly QI/QA committee meeting records and minutes. The Director of Nursing Services and/or designee at these meetings will present the information.	

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F 281 SS=E	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 observation and record review it was determined that the facility did not store medications based on professional standards of quality and for 2 of 14 residents did not administer medications based on professional standards of quality. Resident identifiers: 2, 3. Finding included: 1. Resident 2 was readmitted to the facility on 06/15/06 with diagnoses that included: congestive heart failure, urinary tract infection, diabetes mellitus, hydronephrosis, hypertension, and decubitus ulcer. Review of resident 2's medical record occurred from 08/29/06-08/30/06. Resident 2's current MAR (medication administration record) shows an order for Lasix 40 mg (milligrams) po (by mouth) qam (each morning) and 20 mg qpm (each evening) dated 07/28/06. Physician recertification orders dated 08/01/06 through 08/31/06 list Lasix 40 mg 1 tab po qd (daily) ordered 07/28/06 and Lasix 40 mg 1 tab po qhs (at bedtime) ordered 07/28/06. Documentation on resident 2's MAR indicated that the resident has been receiving 20mg of Lasix each evening, rather than the 40mg qhs written on the physician's order.	F 281	**F-Tag 281** **Immediate Action for Affected Resident:** Resident #2 is receiving the correct dose of Lasix per physician's orders on 8/30/06. Resident #3's orders for Lunesta have been clarified to include the dose, route and schedule time on 8/30/06. Injectable vial of Ativan was discarded in medical waste on 8/30/06. The 5 vials of insulin were discarded in medical waste on 8/30/06. **Identification of other residents at risk:** Resident with ordered medications and changes in dose or route. **Systemic Changes** The facility will ensure that services being provided meet professional standards of quality and are provided as ordered by the attending physician. Licensed nursing staff will be in service by the Pharmacy consult and/or the Director of Nursing Services regarding following doctor's orders in the administration of	

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F 281	Continued From page 8 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 point 2 states "Right Dose". 2. Resident 3 was admitted to the facility on 06/21/06 with diagnoses that included: humerus fracture, carpal fracture, hearing loss, diabetes mellitus, chronic ischemic heart disease, and edema. A review of resident 3's medical records occurred from 8/29/06-08/30/06. Resident 3's current MAR listed an order for Lunesta. No documentation of dosage, route, or schedule was documented on the MAR. Resident 3's physician recertification orders dated 09/01/06 through 09/30/06 listed Lunesta ordered 06/26/06. No documentation of dosage, route, or schedule was documented on the physician recertification orders. The original physician order dated 06/26/06 stated: DC (discontinue) Ambien and start Lunesta 2 mg qhs prn. Documentation on the residents MAR indicated that the resident received Lunesta 2mg po routinely at bedtime rather than on an as needed basis as ordered. According to Fundamentals of Nursing Concepts,	F 281	physician ordered medications, indicating date opened on multi-dose vial of medication, and discarding insulin vials prior to or by the 28th day after being opened; by 9/22/06. The pharmacy consultant will check the medication room for expired or undated medications monthly. The Director of Nursing Services or a designated licensed nurse will check medication room and medication carts twice a month X 3 months for expired or undated multi-dose medications. If 100% compliance is met then the review will be discontinued. If the threshold of 100% is not met another 3 months will be reviewed to meet the threshold of 100% accuracy. The results of the review and any corrective action that was taken to correct any deficiency found will become a part of the quarterly QI/QA committee meeting records and minutes. The Director of Nursing Services and/or designee at these meetings will present the information.	

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F 281	Continued From page 9 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 2-4 state "Right Dose, Right Time, Right Route". Additionally, Fundamentals of Nursing Concepts, Process, and Practice, seventh edition, pg 796 lists "Essential Parts of a Drug Order" and includes: "Dosage of the drug. Frequency of administration. Route of administration." 3. Observation of the facilities medication refrigerator took place on 08/30/06 at 1350. The security seal on a vial of injectable Ativan 2mg/ml (milligrams per milliliter) was noted missing, there was no date noted on the vial indicating the date the vial had been opened. 4. Observation of the two medication delivery carts on 8/30/06 revealed 5 viles of insulin that had been opened longer than 28 days. Textbook of Basic Nursing, Seventh Edition, Caroline Bunker Rosdahl, RN-C, BSN, MA page 746 under section of Setting up Medications, bullet point 5 states "Check the medication to make sure it is not spoiled or outdated. (Rationale: the medication may lose its effectiveness or become toxic.)"	F 281	(BLANK)	

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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. 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 14 sample residents. Resident Identifier 7. Findings include: Resident 7 was admitted to the facility on 3/3/02 with diagnoses that included hypertension, Alzheimer's disease, senile delirium and senile depression. A review of resident 7 ' s medical record was done on 8/30/06 and 8/31/06. On 5/24/06, facility staff completed a quarterly Minimum Data Set (MDS) assessment for resident 7. At that time, facility staff assessed that resident 7 required extensive assistance for eating and that she was not resistive to cares. On 8/22/06 (no time), a registered nurse documented the following nurse' s note, " pt. (patient) up for meals. Episodes of lethargy. Ate some, not very much, will continue to monitor."	F 309	**F-tag 309** **Immediate Action for Affected Resident:** Resident #7 was sent to the acute care hospital for treatment on August 23, 2006. **Identification of other residents at risk:** All the Residents with a significant change of condition. **Systemic Changes** The facility will ensure that each resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process. This will be done by: 1. The use of an accurate and complete assessment; 2. Implementation of a care plan which is based on information from the assessment; and 3. Evaluation of the results of the interventions and revising of the interventions as necessary. Residents who experience a significant change of condition will be notified of treatment changes; the resident's attending physician will be consulted; and the resident's	

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F 309	Continued From page 11 On 8/22/06, documentation in the tracking record for assistance and percentages of meals eaten indicated that resident 7 consumed 5% of the breakfast meal, but that she refused the noon and evening meal as well as all other nourishment offered. On 8/23/06, a licensed practical nurse documented a late entry nurse's note for 8/21/06 at 9:00 AM. The licensed practical nurse documented, " pt. (patient) lethargic, has had spells in past of this et (and) will perk [up] after few days, responds verbal stimuli et (and) upon movement, cont. (continue) push fluids po (by mouth), monitor , eating small amount food, accepting 200cc fluid @ (at) this x (time)." On 8/21/06, documentation in the tracking record for assistance and percentages of meals eaten indicated that resident 7 consumed 20% of the breakfast meal, but that she refused the noon and evening meal as well as all other nourishment offered. On 8/23/06 at 8:00 AM, a registered nurse documented the following in a nurse' s note, " pt. (patient) cont. (continues) to become more lethargic. Not eating/drink, tried to push fluids. Pt (patient) dripped it all back out. Contacted son [name of son] and stated send to ER." On 8/23/06 at 8:00 AM, a registered nurse documented the following on a Resident Transfer Form/Inter-Agency Referral, " Pt. (patient) not responding. Will respond to pain stimuli. Pt (patient) not eating or drinking going on 5 days. Family request full tx (treatment) to be done."	F 309	surrogate decision maker and/or a family representative will be notified within 1 hour of determining the change of condition. A change of condition audit will be done Tuesday thru Friday covering the past 24 hours and on Mondays covering the past 72 hours by Medical Records. The change of condition audit will be reviewed daily at department head meeting by the Director of Nursing or designee in the absence of the Director of Nursing Services. All Licensed Nurses will be in serviced in regards to notification of the resident, the resident's attending physician, and the resident's surrogate decision maker when a change of condition occurs by 9/22/06. **Monitor:** The Director of Nursing Services will review results of the audit performed by medical records or designee if the DNS is not available. The results of the audit and any corrective action that was taken to correct any deficiency found will become a part of the quarterly QI/QA committee meeting records and minutes.	

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F 309	Continued From page 12 The reason for the transfer was documented to be, "Lethargic. No eating/drinking." On 8/22/06, at an unspecified time, a registered nurse filled out a fax form to be sent to resident 7's attending physician. The registered nurse documented, " Going on 5 days the pt. has be lethargic. Will arrouese[sic] with verbal & pain stimuli. She hasen't [sic] ate or drank anything. I tried a glass of water this morning & pt. 'dripples' it back out. Talked to son [name of son]. Stated he wants all tx's (treatments) done. IV ' s & possible feeding tub [sic] if needed. He can be reached at [two telephone numbers for son]. What do you want to do?" NOTE: This form did not include information regarding the actual date and time the form was faxed. Additionally, across the top right of this form was a note documenting, "Sent to ER (emergency room) per family request." Documentation on the tracking record for assistance and percentages of meals eaten, from 8/18/06 through 8/22/2006, resident 7's meal intake was 20%, 15%, 40%, 20% and 5% for the breakfast meal. For the noon meal resident 7 consumed 10% and 20% on 8/18/06 and 8/19/06, respectively. She refused the noon meal on 8/20/06, 8/21/06, and 8/22/06. For the evening meal, resident 7 consumed 50% and 10% on 8/18/06 and 8/19/06, respectively. She refused the evening meal on 8/20/06, 8/21/06, and 8/22/06. All nourishments offered during the morning, afternoon and at bedtime were refused for six days prior to resident 7's hospitalization on 8/23/06, with the exception of 8/20/06, which was not charted.	F 309	(BLANK)	

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F 309	Continued From page 13 On 8/23/06, following resident 7's transfer to the emergency room, she was admitted to the acute care hospital. She remained an inpatient of the acute care hospital until her readmission to the facility on 8/28/06. Resident 7's diagnoses at the acute care hospital were sepsis with urinary tract infection and hypernatremia. While at the acute care hospital, on 8/23/06, an abdominal Xray was performed on resident 7 due to her complaints of abdominal pain. The findings of the radiology exam was, "A very large amount of stool is present in the rectum, up to 11.5 cm (centimeters) wide and 9.6 cm thick from top to bottom. This is producing a rectal fecal impaction with air backed up in portions of the large and small bowel." Additionally, on 8/23/06, a complete metabolic profile was completed for resident 7. Resident 7's sodium level was 167 mEq/L, a "CRITICAL VALUE" per documentation on the laboratory form. The normal range for sodium, as indicated on the laboratory form was 136 to 145 mEq/L. A telephone interview was conducted with resident 7's son on 8/31/06. Resident 7's son stated that he received a telephone call from the facility at 8:00 AM on 8/23/06, informing him that his mother was unresponsive and not doing well. He stated that he came to the facility immediately and upon arrival was told that his mother had a scheduled doctor's appointment that afternoon. Resident 7's son stated that he was then asked if he wanted to have his mother keep that appointment or if he would prefer her to be sent to the local hospital emergency room. He stated that he told the facility staff that he wanted his mother transferred immediately. Resident 7 stated that he and his daughter came to visit his	F 309	(BLANK)	

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F 309	Continued From page 14 mother on 8/20/06 in the late evening. He stated that his mother was in bed at that time and was difficult to arouse. He stated that he believed she was difficult to arouse because it was bedtime. He stated that he did not question the staff about his mother's condition at that time, nor did staff attempt to discuss his mother's condition with him. Resident 7's son stated that the facility did not contact him to inform him that his mother was not eating or drinking until the morning of 8/23/06. In the five days preceeding resident 7's admission to the hospital on 8/23/06, facility staff document that the resident's meal and fluid intake decreased and that her level of consciousness decreased. There was no indication that facility staff consulted the resident's son until the morning of 8/23/06. If the facility faxed the resident 7's attending physician of resident 7's change of condition on 8/22/06, there were no additional recommendations for treatment until after the resident's son arrived on 8/23/06.	F 309	**F-Tag 323** **Immediate Action for Affected Resident:** The doors to all utility rooms that contain any hazardous material were locked on 8/28/06. The janitor's closet was locked on 8/28/06. **Identification of other residents at risk:** All the residents who resident at Parkdale Care Center **Systemic Changes** All storage areas/janitor closets that contain any hazards will be locked so that residents of the facility do not have access.	
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility did not ensure the environment was free of accident hazards by securing hazardous chemicals and equipment.	F 323	The Administrator and/or the Maintenance Supervisor will do rounds 2 times a week times 3 months to ensure that all storage areas with hazards are locked. If a threshold of 100% is met then the rounds will be done at the discretion of the Administrator and/or the Maintenance Supervisor. **Monitor:** The results of the storage area rounds will be presented at the quarterly QI/QA committee meeting	

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F 323	Continued From page 15 Findings included: Observations of the facilities environment took place from 08/28/06-08/31/06. The utility room on the 300 hall was observed on 08/28/06 at 2:50 PM. The door to the room was unlocked. The room contained a hammer, utility scraper, and other assorted tools. On the counter was a can of polycrylic paint, a 2.3 liter bottle of Bituthene System 4000 surface conditioner, and three 32 ounce cans of laquer thinner. The janitors closet on the 200 hall was observed on 08/28/06 at 2:58 PM. The door to the room was unlocked. The room had a container of comet cleanser sitting on a table.	F 323	and any corrective action that was taken and will become a part of the records and minutes of said committee. **F-Tag 329** **Immediate Action for Affected Resident:** Resident #7 had her Seroquel reduced from 300mg per day to 200mg per day on 8/28/06. **Identification of other residents at risk:** All residents who receive a psychoactive medication.	
F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation it was determined that the facility did not insure that 1 of 14 sampled residents was free from unnecessary drugs. Resident identifier	F 329	**Systemic Changes:** The facility will initiate therapy at the lowest therapeutic dose to control the resident's behavior. The dose will be gradually increased only as necessary and with the appropriate documentation. Residents who are on psychoactive drugs will be reviewed at least once every 6 months in an attempt to initiate a trial dose reduction of the medication. Documentation of the success or failure of the trial dose reduction will be contained in the resident's medical record.	

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F 329	Continued From page 16 7. Findings include: Resident 7 was admitted to the facility on 3/31/02 with diagnoses that included Alzheimers, senile delirium, and hypertension. Resident 7 has been prescribed Seroquel 150mg twice daily since 6/19/04 for a diagnosis of uncontrolled spitting and senile delirium. Record review showed that the last documented review by the physician for continued need for this medication was done on 5/6/05. Documentation from the physician on 5/12/05 states that the resident may need an increase in the medication since the spitting was a behavior that was not exhibited in the past when dementia was not a diagnosis. The physician stated that the spitting was also a possible danger for infection to people around her. Behaviors observed for continuing the medication were listed as spitting (continuous at times) which was last documented three times during the month of April 2005. R#7 has been receiving Seroquel 300mg daily which is deemed as an excessive dose. Recommended daily doses for residents with organic mental syndromes is 200mg daily. Record review revealed that the last updated care plan for the need for psychoactive medications was done on 5/31/06. The care plan remained unchanged with no new interventions added since 12/1/04. The care plan also listed monitoring for possible side effects of this drug included dry mouth, constipation with special attention for chronic constipation. There is no documentation to indicate monitoring for side effects of the drug . Record review of monitoring for alternative methods attempted prior to use of psychoactive medication indicate no interventions attempted	F 329	Resident who are undergoing antipsychotic drug therapy will received adequate monitoring for significant side effects of such therapy at least every shift with documentation on the Medication Administration Record. Alternative methods to control the resident's behavior without the use of psychoactive intervention will be attempted and documentation of the success or failure of the attempts will be noted in the medical record. **Monitor:** Medical Records will provide the Director of Nursing Services and/or the MDS Coordinator with a list of all residents who are taking psychoactive medications. This list will be reviewed for any resident who has been on a psychoactive medication for 6 months or less and would possibly benefit from a dose reduction. The Interdisciplinary Team will review the residents who are due for trial dose reduction. The physician will be consulted and an order obtained for a dose reduction when appropriate. Medical Records will audit those residents' charts that are due for trial dose reductions. The Director of Nursing Services will review results of the audit completed	

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F 329	Continued From page 17 during the months of 7/06 or 8/06. There is no documentation to indicate that a gradual dose reduction has been attempted since the drug was initiated.	F 329	by medical records or designee if the DNS is not available. The results of the audit and any corrective action that was taken to correct any deficiency found will become a part of the quarterly QI/QA committee meeting records and minutes.	
F 371 SS=C	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 observations of meal services and meal facilities, it was determined that the facility staff did not consistently distribute food under sanitary conditions. Findings included: On 8/29/06 at 7:00 AM, in the dining area, breakfast was observed being served from a portable serving cart. The food server was observed to place toast on to the plates that were to be served to the residents. The food server was not using a kitchen utensil to handle the food. The food server was also observed to touch the diet tray cards, eggs, and cereals. Additionally, staff were observed to help residents with preparing food, such as buttering toast then touch plates, cups, clothing protectors and residents while serving multiple residents without hand washing/sanitizing or wearing gloves. Several residents had numerous flies crawling on drinking	F 371	**F-Tag 371** **Immediate Action for Affected Resident:** There were no specified residents. **Identification of other residents at risk:** All residents who take their meals at Parkdale Care Center. **Systemic Changes** Facility staff will be in-serviced in the appropriate storing, preparation, distribution, and service of meals under sanitary conditions by 9/22/06. The Director of Staff Development or designee will do 2 meal observations a week for 3 months to determine if employees are effectively cleaning their hands prior to serving and distributing food to the residents. If a Threshold of 100% is met then the weekly meal observation can be	

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F 371	Continued From page 18 glasses, plates and tinsels. During observation of the lunch meal on 08/30/06 at 12:44 PM a facility CNA was observed providing feeding assistance to an agitated resident. The CNA was holding the hand of the agitated resident in an attempt to de-escalate the resident. The CNA then turned and took a fork from another residents hand, to cut the residents food, and returned the fork to the residents hand. The CNA was then observed to return to the previously agitated resident, picked up the residents cookie with bare hands and offered the resident part of the cookie. The CNA was not observed to wash or use hand sanitizer between resident contacts. During observation of the lunch meal on 08/30/06 at 12:48 PM a facility CNA was observed providing feeding assistance to a facility resident. The CNA took a spoonful of soup, blew on the spoonful of soup and offered it to the resident. The resident moaned when offered the soup, and the CNA was observed returning the spoonful of soup to the bowl of soup. During group interview on 08/29/06 at 1400, conducted in the cafeteria, several flies were observed in the room. One particular resident was repeatedly observed to be bothered by flies, and attempting to wave the flies away.	F 371	discontinued and done at the discretion of the DSD. **Monitor:** The results of meal observation and any corrective action taken will be presented at the quarterly QI/QA meeting by the DSD or designee in the DSDs absence and become a part of the record and minutes of the committee meeting.	

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F 387 SS=B	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, it was determined that 3 out of 14 residents (resident # 1,5,6) were not seen by a physician at least once every 60 days. Findings included: 1. Resident 1 was admitted on 10/21/05 with diagnoses of hypothyroid, GERD, dementia with depression, anemia and COPD with anxiety. Record review on 8/29/06 documented that the resident was seen by his physician on 1/23/06, 4/19/06 and 7/28/06. The resident should have been seen in March and May of 2006. 2. Resident 5 was admitted on 2/11/06 with diagnoses of multiple sclerosis, pneumonia and mood disorder. Record review on 8/29/06 documented that the resident was seen on 4/19/06 and 8/16/06. The resident should have been seen in June 2006. 3. Resident 6 was admitted on 2/26/04 with diagnoses of dementia, COPD, black lung	F 387	**F-Tag 387** **Immediate Action for Affected Resident:** Resident #1's physician was informed of the required frequency of physician visits on 9/22/06. Resident #5's physician was informed of the required frequency of physician visits on 9/22/06. Resident #6's physician was informed of the required frequency of physician visits on 9/22/06. **Identification of other residents at risk:** All resident who resident at Parkdale Care Center and receive medications. **Systemic Changes** Attending physician visits will be made within the first 30 days after the resident is admitted and then at 30-day intervals up until 90 days after the admission date. Visits will then be at 60-day intervals, permitting up to 10 days slippage. Medical records will do a monthly audit to determine compliance with frequency of physician visits. The Director of Nursing Services and the Administrator will review the audit.	

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F 387	Continued From page 20 disease and extreme age. Record review on 8/29/6 documented that the resident was seen by his physician on 1/23/06, 4/19/06 and 7/28/06. The resident should have been seen in March and May of 2006.	F 387	Medical Records will write a letter to any physician who is out of compliance with the frequency of physician visits requirement and place a copy of each letter in the resident's medical record. Results of the audit and any corrective action taken will present at the quarterly QI/QA meeting and become a part of the records and minutes of the meeting.	
F 444 SS=B	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation of the facility medication administration it was determined that the facility did not ensure that the facility nurses were washing their hands during the medication pass. Findings include: Observations were made during a medication pass on 8/29/06 from 8:00 AM to 8:30 AM and at random times from 8/29/06 to 8/31/06. It was determined that 3 facility nurses passing both oral and injectable medications were not washing or sanitizing their hands between residents or wearing disposable gloves. The nurses touched residents to administer insulin; handed souffle cups to the residents; assisted residents to place souffle cups to their mouths; mixed crushed medications with applesauce; and handed water glasses to residents. Each time the nurse	F 444	**F-tag 444** **Immediate Action for Affected Resident:** There were no specified residents. **Identification of other residents at risk:** All resident who resident at Parkdale Care Center and receive medications. **Systemic Changes:** Procedures will be followed to prevent cross-contamination, which includes hand washing or changing gloves after providing personal care, or when performing tasks among residents which provide the opportunity for cross-contamination to occur.	

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F 444	Continued From page 21 returned to the medication cart and set up medications for the next resident without washing or sanitizing their hands or wearing gloves.	F 444	Licensed nursing staff will be in-serviced to assure that they use appropriate hand washing techniques to prevent the spread of infection from one resident to another by 9/22/06.	
F 465 SS=B	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on obervation it was determined that the facility did not provide a sanitary, comfortable environment for residents, staff, and the public. Findings included: Observations of the facility environment took place from 08/28/06-08/31/06. A facility exit door located between the kitchen and laundry room, and exiting to the dumpster area, was observed to not hang correctly from the door frame. The door would not fully close without being pulled closed, and was ajar during numerous observations at different times on different days. The facility was observed to have numerous flies in various parts of the building. A ceiling tile above the exit door at the end of the 300 hall was observed to have fallen, and was caught on the exit sign. Cracked and damaged ceiling tiles were observed	F 465	**Monitor:** The Director of Nursing Services, the Pharmacy Consultant or the Director of Staff Development will do monthly medication pass observation X 3 months to observe for proper hand washing technique. If a threshold of 100% is achieved each month then the observation will be discontinued. The Director of Nursing Services will present the results and any corrective action that was taken to the quarterly QI/QA committee meeting and will become a part of the record and minutes. **F-Tag 465** **Immediate Action for Affected Resident:** There were no specified residents **Identification of other residents at risk:** All residents who reside at Parkdale Care Center.	

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F 465	Continued From page 22 outside the central supply room, the empty oxygen storage room in the 300 hall, above the door to room 100 in the hallway, and above the communication board in the main hallway. The utility room in the 200 hall was observed with a bare concrete floor, and had a gouge in the wall approximately 3 feet up from the floor, and extending approximately 8 feet in length. The counter and sink area in the cafeteria was used during tray line, and noted to have numerous scratches and paint chips. Three areas of paint on the wall, above the handrail, between the utility and shower rooms in the 300 hall were noted to have approximately 12 inches of damage each. The doors to rooms 306, 307 and 308 were noted to have numerous scratches extending approximately 3 feet up from the bottom of the door.	F 465	**Systemic Changes:** Exit door by laundry room was adjusted and repaired by maintenance on 9/1/06. A new door is scheduled as part of a remodeling project scheduled at end of '06 and first part of '07. Electronic flytraps will be installed by 9/29/06. They will be service by facilities current pest control company. All noted damaged ceiling tiles, will be replaced by 10/27/06 Utility room in the 200 hall, will have linoleum installed on its concrete floor by 10/27/06. The counter and sink in the cafeteria will be repaired by 10/27/06. The damage to walls in the 300 hall will be repaired by 9/29/06.	
F 467 SS=B	483.70(h)(2) OTHER ENVIRONMENTAL CONDITIONS - VENTILATION The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility did not provide adequate ventilation for 3 resident restrooms.	F 467	The doors to rooms 306, 307, and 308 will be repaired by 9/29/06. **Monitor:** The maintenance supervisor will do weekly walking rounds to ensure that the facility is providing a safe, functional, sanitary, and comfortable environment for resident, staff and the public.	

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	465102	A. BUILDING _____ B. WING _____	08/31/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 467	Continued From page 23 findings included: Observation of the facilities environment occurred from 08/28/06-08/31/06. The ceiling vents in the bathrooms in resident rooms 201, 202 and 205 did not provide adequate air movement to cause a piece of toilet tissue to adhere to the vents.	F 467	There will be a maintenance log kept at the nurses' station for staff to document items that need repair. The Maintenance Supervisor will review this log daily Monday thru Friday, indicating on the log when the item has been repaired. The Administrator will review the log and present the findings at the quarterly QI/QA committee meeting and the corrective action that was taken. The results will become part of the committee records and minutes. **F-Tag 467** **Immediate Action for Affected Resident:** There were no specified residents. **Identification of other residents at risk:** All the residents who resident at Parkdale Care Center. **Systemic Changes:** The vents in the bathrooms of rooms 201, 202, and 205 will be repaired by 10/27/06 **Monitor:** The Maintenance Supervisor will do monthly checks of all ventilators to	
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 accurately document medications administered, transcribe medication orders accurately or document information as called for by physician's order for 2 of 14 residents. Resident identifiers: 2, 3. Findings included:	F 514		

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F 514	Continued From page 24 1. Resident 2 was readmitted to the facility on 06/15/06 with diagnoses that included: congestive heart failure, urinary tract infection, diabetes mellitus, hydronephrosis, hypertension, and decubitus ulcer. Record review for R#2 revealed an order for Novolog sliding scale insulin subtract FSBS (fingerstick blood sugar) from 150 then divide by 30 equal units to give ACHS (before meals and at bedtime). Doses of Novolog insulin could not be reconciled as to dates, times or dosages given for each of the blood sugars listed on the medication administration record (MAR). An interview with a staff LPN (licensed practical nurse) occurred on 08/29/06 at 1045. LPN 1 stated that the Novolog insulin had been documented in several different places on the MAR, that some doses had not been charted by other nurses and that some doses given did not include times given. Resident 2 was noted with the following orders: Alternative methods attempted prior to use of psychoactive medication: 1. one on one 2. walks outside 3. remove from stressor. Alternative methods attempted prior to use of psychoactive medication: 1. back rubs 2. offer snack 3. quiet environment(sic). Ativan 0.5 mg (milligram) 1 tab po (by mouth) Q4h (every four hours) PRN (as needed) verb (verbalization) of anxiety. No documentation of alternative methods attempted prior to use of psychoactive medication	F 514	ensure that they are working properly. The results of the ventilator checks and any repair issues that were found and corrected will be presented by the Maintenance Supervisor at the quarterly QI/QA committee meeting and will become a part of the record and minutes. **F-Tag 514** **Immediate Action for Affected Resident:** Resident #2's orders for Lasix and Lisinopril have been verified and updated as of 8/30/06. Resident #3's order for Lunesta was corrected and updated in the MAR on 8/30/06 **Identification of other residents at risk:** All the residents who resident at Parkdale Care Center. **Systemic Changes:** The facility will ensure that services being provided meet professional standards of quality and are provided as ordered by the attending physician. Licensed nursing staff will be	

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F 514	Continued From page 25 was found on the residents current MAR. An interview with a staff LPN was conducted on 08/29/06 at 1100. LPN 2 stated that the nurses are responsible for documenting the behavioral interventions ordered, on the MAR, prior to giving Ativan, but that they have not been getting documented. Resident 2's current MAR shows an order for Lasix 40 mg po qam (each morning) and 20 mg qpm (each evening) dated 07/28/06. Physician recertification orders dated 08/01/06 through 08/31/06 list Lasix 40 mg 1 tab po qd ordered 07/28/06 and Lasix 40 mg 1 tab po qhs (at bedtime) ordered 07/28/06. Resident 2's current MAR shows an order for Lisinopril 20 mg po qd (daily) dated 06/15/06. Recertification orders dated 08/01/06 through 08/31/06 list Lisinopril 40 mg 1 tab po qd ordered 07/26/06. An interview with a facility RN (registered nurse) took place on 08/30/06 at 9:05 AM. RN 1 stated that the order for Lisinopril should read 40 mg po qd on the MAR. 2. Resident 3 was admitted to the facility on 06/21/06 with diagnoses that included: humerus fracture, carpal fracture, hearing loss, diabetes mellitus, chronic ischemic heart disease, and edema. A review of resident 3's medical records occurred from 8/29/06-08/30/06. Resident 3's current MAR listed an order for	F 514	In-serviced by the Pharmacy consult and/or the Director of Nursing Services regarding following doctor's orders in the administration of insulin per sliding scale coverage by 9/22/06. Facility ordered a simplified form for the administration of insulin to go in the MAR. Form to be implemented by 10/10/06. Licensed Nurses will be in serviced regarding the correct documentation of alternative methods attempted before the use of psychoactive medications by 9/22/06. Changes made in a resident medication regimen will be noted in the medical record with a physician order. A sticker that indicates that there has been a change in the dose will be attached to the medication card. Licensed Nurses will be in serviced regarding the correct documentation of a change in medication dose or time by 9/22/06. The Pharmacy Consultant will conduct a monthly drug regimen review. **Monitor:** Medical Records will do weekly audits of all residents who are receiving insulin per sliding scale	

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F 514	Continued From page 26 Lunesta. No documentation of dosage, route, or schedule was documented on the MAR. Resident 3's physician recertification orders dated 09/01/06 through 09/30/06 listed Lunesta ordered 06/26/06. No documentation of dosage, route, or schedule was documented on the physician recertification orders. The original physician order dated 06/26/06 stated: DC (discontinue) Ambien and start Lunesta 2 mg qhs prn.	F 514	coverage X 3 months. If a threshold of 100% is met then the audit can be discontinued. The Pharmacy Consultant and/or the Director of Nursing Services will present the findings of the drug regimen review at the quarterly QI/QAS meeting where the results will become a part of the committee record and minutes.	