POC Acceptable 5/1/01 AM

Orig. Mailed to Shawna Blende 4-30-01 per phone call

DEPARTMENT OF HEALTH AND HU. N SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 4/3/01
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465137	A. BUILDING _____ B. WING _____	C 3/20/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED CLIFFS REGIONAL	1745 EAST 280 NORTH ST GEORGE, UT 84770

COMPLAINT NUMBER. 5064, 5217, 5268

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F 314 SS=G	483.25(c)QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined that the facility did not ensure that a resident having pressure sores received the necessary treatment and services to promote healing and prevent new sores from developing for 1 of 6 sample residents. Resident 4 was admitted to the facility with a pressure on the left heel. Resident 4 developed a pressure on the coccyx while at the facility. The facility staff did not ensure that resident 4 received the physician ordered daily dressing changes and the services of turning, positioning, heel protectors and nutritional interventions, as assessed and care planned, to promote healing and prevent new sores from developing. Resident 4 Findings include: Resident 4 was admitted to the facility on 2/5/01 with diagnoses that included, pneumonia, urinary tract infection, congestive heart failure, decubitus ulcer and malnutrition. 1. Observations of resident 4 on 3/20/01 revealed the following: At 8:36 AM, resident 4 was observed to be lying on	F 314 OK 5/1/01 AM	Our plan of correction will Serve as our facility's allegation Of compliance with all State/Federal Regulations pertaining to LTC Facility's. F314 – The facility will insure Residents who enter the facility Do not develop pressure sores Unless the residents clinical condition Demonstrates that they were unavoidable And a resident having pressure sores Receives necessary treatment and Services to promote healing, prevent Infection and prevent new sores from Developing. Inservice will be given to all licensed Nurses by 4-19-01 regarding pressure Sore prevention, staging, treatment and Care planning. This inservice will include Documentation of treatments and all Preventative measures such as Turning, repositioning nutritional status, Weight status, hydration status, mobility, Pressure relieving devices for bed and Chair and circulation status. Inservice will be given to all certified Nursing assistants by 4-19-01 regarding Pressure sore prevention including Turning, positioning, repositioning, Protective equipment such as barrier Creams incontinence care and grooming, Heel protectors, pillows, nutrition and Offering fluids. Inservice will be given to all Nursing Staff by 4-19-01 regarding nutrition and Documentation of meal percentages and Documentation of needed assistance with Meals.	

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

Tameshia Huddleston Administrator 4-17-01

Deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

04/30/01 HT

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F 314	Continued From page 1 his back, rolled up in bed leaning to the left side. There was food debris in resident 4's bed. Resident 4's call light was at the top of the bed hanging down over the siderail approximately 1 1/2 feet behind resident 4's head. Resident 4 was observed to be yelling for help. When asked, by the surveyor, what help the resident needed, resident 4 asked for a drink of water and stated that he could not reach the water. Observation of resident 4 revealed that his left foot was resting on a folding blanket, but resident 4's left heel was lying directly on the mattress of the bed. There was no dressing or heel protector observed on resident 4's left heel. At 9:10 AM, resident 4 was observed to be lying in the same position, as observed at 8:36 AM. Resident 4's left heel and foot were observed to be in the same position. Resident 4 was observed to be yelling "help me, help me." At 9:52 AM, resident 4 was observed to be lying in the same position, as observed at 9:10 AM. There was a foul odor in the room. Resident 4's left foot remained on the folded blanket with the heel touching the bed. There was no dressing or heel protector observed on resident 4's left heel. At 10:50 AM, resident 4 was observed to be groomed, rolled down in bed, and lying slightly on his left side. There was no foul odor noted in the room. The call light remained on the left side of the bed, wrapped in the side rail, 1 1/2 feet behind resident 4's head. There was no dressing or heel protector observed on resident 4's left heel. Prior to this observed change in resident 4's position, resident 4 had been observed to be in the previous position for 2 hours and 20 minutes.	F 314	These inservices will be repeated Monthly times 3 months then quarterly Thereafter. Inservice will be given to all staff Regarding accommodation of need and Answering resident call lights by Resident satisfaction surveys will be Conducted during resident council Meetings and on an individual basis To determine resident satisfaction With staff response to their needs. Quality assurance rounds will be Conducted 3-5 times per week to assure Call lights and water pitchers are within Reach. This will be done by the Department Heads. These round reports will be reviewed By the DON and Administrator with Appropriate follow up actions as necessary. All residents in the facility have had A head to toe assessment to insure all Skin problems have been identified. Orders For care and treatment have been obtained And preventative measures implemented And an appropriate plan of care developed. A wound care specialist has assessed all Residents with pressure sores and made Recommendations for care and treatment. These recommendations have been carried Out and residents care plans updated. The licensed staff will monitor that Residents with pressure sores are turned At a minimum of every 2 hours.	

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F 314	Continued From page 2 At 12:15 PM, resident 4 was observed to be lying slightly on the left side. The head of the bed was rolled up in a sitting position. Resident 4's lunch tray was placed in front of the resident. Resident 4 was observed to be lying with his eyes closed and the bowl of salad from the lunch tray was sitting in resident 4 lap. Resident 4's hand was observed to be resting in the bowl of salad. The call light remained behind resident 4's head. There was no dressing or heel protector observed on resident 4's left heel. A 12:35 PM, resident 4 was observed to be in the same position as observed at 12:15 PM. Resident 4 remained lying slightly on the left side with eyes closed. Resident 4's hand remain in the salad bowl, lying in resident 4's lap. Resident 4's left foot was observed to be on a folded blanket with the left heel resting directly on the bed. There was no dressing or heel protector observed on resident 4's left heel. At 1:00 PM, resident 4 was observed to be in the same position as observed at 12:35 PM. Resident 4 remained lying slightly on the left side with his eyes closed. Resident 4's hand remained in the salad bowl, lying in resident 4's lap. The food on the lunch tray remained uneaten. At 1:117 PM, a facility staff member was observed leaving resident 4's room. Observation of resident 4 at this time revealed that resident 4's lunch tray had been moved closer to the resident. The salad bowl had been returned to the lunch tray and resident 4 was observed trying to use a fork to pick up noodles from the plate. Resident 4 was observed to be in the same position as observed at 1:00 PM. There was no dressing or heel protector observed on resident 4's left heel.	F 314	A Malnutrition Risk Assessment form Will be implemented on all new admissions, Upon change of condition and quarterly Thereafter. Prevention protocols will be Implemented and documented on the Residents plan of care. The skin committee will review all Residents with pressure sores on a weekly Basis. This committee will make Recommendations for care and treatment And the plan of care will be updated. The medical records Ward Clerk will Audit all residents with pressure sores on A weekly basis with a written report to The DON. The Registered Dietitian will review All residents with multiple stage 2 and Stage 3 and stage 4 pressure sores with Recommendations on a monthly basis With a written report to the Administrator And Dietary Supervisor. The facility will Act upon these recommendations and Up date the plan of care. The Medical Records consultant will Review random residents with pressure Sores on a monthly basis with a written Report to the DON and Administrator.	

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F 314	Continued From page 3 During the observation of the lunch meal, no assistance by the staff to encourage or assist resident 4 with his meal was observed. At 2:20 PM, resident 4 was observed to be in the same position as observed at 1:17 PM. The lunch tray had been removed from resident 4's room. Food debris was observed in resident 4's lap and on the bed. Resident 4's left foot was observed to be off the folded blanket. The left heel was observed to be lying directly on the bed. The toes on resident 4's left foot were observed to be wedged into the footboard of the bed. There was no dressing or heel protector observed on resident 4's left heel. At 3:00 PM, resident 4 was observed to be lying in the same position as observed at 2:20 PM. AT 3:30 PM, observation, during a check of resident 4's skin, with a facility staff nurse present, resident 4 was observed to be lying in the same position as observed at 3:00 PM. Resident 4 was observed to not have a dressing or heel protector on his left heel. The left heel was observed to be lying directly on the bed and the toes on resident 4's left foot were observed to remain wedged into the footboard of the bed. Prior to this observed change in resident 4's position, resident 4 had been observed to be in the previous position for 4 hours and 40 minutes. Resident 4's left heel was observed to have a pressure sore, with black eschar (dead tissue) present. There were large red blotches on both feet. Observation of resident 4's buttocks area revealed a pressure sore on the coccyx area. The facility nurse removed the dressing from resident 4's coccyx area exposing the pressure sore.	F 314	The Quality Assurance Committee Will review Skin Meeting reports, Quality Assurance Round reports, Resident Satisfaction Surveys, Resident Council minutes, Registered Dietitian reports, Medical Records audits, Medical Record Consultant reports and Staff training records to determine the need For alternative interventions. The Director Of Nursing will monitor for compliance. Done 4-26-01 JH quarterly JH 4-30-01 per phone call from Shawn Glende 5-7-01 per letter	

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F 314	Continued From page 4 During the observation of resident 4's coccyx pressure sore, the nurse was asked by the surveyor, the stage of the pressure sore. The nurse stated that the pressure sore was a stage III (a full thickness loss of skin, exposing the subcutaneous tissues-presents as a deep crater with or without undermining adjacent tissue). The nurse stated that she would have to consult the facility polices on the treatment of a stage III pressure sore. The nurse further stated that she would need to call resident 4's physician to ask him if the treatment orders for resident 4's coccyx pressure sore needed to be changed. Observation of the left side of resident 4's body revealed that resident 4's skin on the left side had multiple indentations and red marks. The indentations and red marks matched crinkles in the pad and sheets that were lying directly under resident 4. The color of the red marks and the depth of the indentations did not change during the 5 minute observation. During this skin observation, a facility nursing assistant stated that resident 4 needed to be turned every 2 hours. The nursing assistant further stated that resident 4 required assistance with all ADL's. In Brunner and Suddarth's "Textbook of Medical -Surgical Nursing, 8th Edition, copyright 1996, page 345, Promoting Pressure Ulcer Healing", it documents, "Regardless of the stage of the pressure ulcer, the pressure on the area must be eliminated. The ulcer will not heal until all pressure is removed. The patient must not lie or sit on the pressure ulcer, even for a few minutes. Individualized positioning and turning schedules must be written in the nursing care plan and followed meticulously. In addition, inadequate nutrtional status and fluid and	F 314		

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F 314	Continued From page 5 electrolyte abnormalities must be corrected to promote healing...." The resident was not provided these services as observed on 3/20/01. 2. Review of resident 4's medical record on 3/20/01, revealed the following: The admitting nursing assessment, dated 2/5/01, documented that resident 4 had a pressure sore on the left heel, that resident 4's skin had red areas and was intact. In the "Special Treatments and Procedures" section of the assessment, the assessment documented that resident 4 needed to have pressure kept off his heels and that the staff needed to continue to monitor resident 4's skin. The assessment further documented that resident 4 needed assistance with meals and required 2 person assist with transfers and ambulation. The "Patient Physical Examination", dated 2/8/01, documented that resident 4 required assistance with eating. The examination further documented that resident 4 had a "reddened/purplish" area to the left heel, that resident 4's legs needed to be up on pillows and that resident 4's heels needed to be kept off the bed. On the ADL flow sheet for February 2001,documented that up until 2/19/01 resident 4 was assisted or fed by staff his meals. From 2/19/01 through 2/28/01, the ADL flow sheet documented that resident 4 did not receive assistance with most of his meals as per his assessed and care planned needs. The March 2001 ADL flow sheet, documented from	F 314		

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F 314	Continued From page 6 3/1/01 through 3/19/01 that resident 4 did not receive assistance with most of his meals as per his assessed and care planned needs. The February 2001 ADL (Activities of Daily Living) flow sheet documented on 2/8/01, "Pt [patient] has bed sores [pressure sores]on bottom ...needs to be turned q [every] hr [hour]." The nursing notes from 2/5/01 through 3/18/01 were reviewed. A nurse note dated 2/10/01, documented, " DQ II [decubitus/pressure sore-stage 2] 0.5 x [by] 0.5 cm [centimeters] coccyx [lower end of spine at the buttocks area] - turned 2 [hours] - Spec [special] mattress, supplements ordered - Replicare [pressure sore dressing] protocol." Review of the physician orders, for resident 4, from 2/5/01 through 3/20/01 revealed the following documented orders: An order, dated 2/5/01, for Ensure (a high calorie/protein liquid nutritional supplement) twice a day. An order, dated 2/10/01, to cleanse the pressure sore on resident 4's coccyx with normal saline and apply a Replicare dressing. The order further stated that this dressing was to be changed every 3 days and as needed. An order, dated 2/14/01, to cleanse resident 4's left heel with normal saline apply a gauze and kerlix (a gauze wrapping) dressing every day. The order further documented that the facility staff were to apply a heel protector and put a pillow under resident 4's left leg and knee. An order, dated 2/20/01, to continue treatment of resident 4's decubitus (pressure) ulcers. An order, dated 2/23/01, for a wound care change to the left heel. The order documented that the nursing	F 314		

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F 314	Continued From page 7 staff was to gently clean the left heel ulcer with normal saline, pat dry, apply "Accuzyme" (a ointment use to dissolve dead tissue from a wound) and a gauze and kerlix dressing every day. The order further documented that the facility staff was to replace the current heel protector with a multipodus boot (a boot the keeps pressure of the resident's heel) to resident 4's left heel. An order, dated 3/2/01, to discontinue the multipodus boot and that the use of a sheep skin heel protector was okay to use. The "Pressure Ulcer Risk Assessment", dated 2/8/01, documented that resident 4's total assessment score was 16. The assessment documented that a total score of 8 or above represented that the resident was a high risk for pressure sores. Resident 4's comprehensive resident assessment, dated 2/15/01, documented the following: Section G.1.a (Physical Functioning and Structural Problems- ADL self performance-Bed Mobility) documented that resident 4 required extensive assistance of one person for moving to and from a lying position, turning from side to side, and positioning while in bed. Section G.1.h. (Physical Functioning and Structural Problems-ADL self performance-Eating) documented that resident 4 required extensive assistance of one person for eating and drinking. Section M.1. (Skin Condition-Ulcers) documented that resident 4 at a stage I [1] ulcer (persistent area of skin redness that does not disappear when pressure is relieved), and a stage II [2] ulcer (a partial thickness loss of skin layers that presents as an abrasion, blister, or shallow crater). Section M.2. (Type of Ulcer) documented that these ulcers were pressure ulcers.	F 314		

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F 314	Continued From page 8 Section M.5, (Skin Treatments) documented that resident 4 required a pressure relieving device for the chair, a pressure relieving device for the bed, a turning and positioning program, nutritional or hydration intervention to manage skin problems, ulcer care and application of dressings. Resident 4's comprehensive care plan, dated 2/17/01, documented the following: Care Plan problem number 2, dated 2/5/01, documented, "Alteration in skin integrity r/t [related to] Immobility and DQ Stage II on coccyx and heels", The goal documented, "Pt will have 0 [zero] skin breakdown by the x [next] 90 days. The approaches the facility had identified as needing to be implemented to reach this goal were documented as, " 1. Reposition q 2 hr. 2. Teach bed mobility with the use of rails. 3. Skin assessment with the showers qod [every other day] and prn [as needed]. 4. Maxie flow [pressure relieving mattress] in bed. 5. Wound care per MD [medical doctor] orders and facility policy and protocol. 6. Vit [Vitamin] C, zinc, and multi [multiple] vit with min [minerals]. 7. Keep heel of [off] bed. 8. Encourage Pt to keep heel protector on. 9. Encourage fluids. 10. Encourage intake of all meals. 11. Notify MD of any abnormal s/s [signs or symptoms]." Care Plan problem number 3, dated 2/5/01, documented, "Alteration in nutrition r/t Pt is Blow[below] IBW [ideal body weight] and has a DQ. Pt also received fluids in the hospital Pt is at risk for wt [weight] loss." The goal documented, " Pt will eat and drink 75% of what is served with 0 wt loss during the x 90 days." The approaches the facility had identified as needing to be implemented to reach this goal included the following documentation, " 1. Diet as ordered by Md. 2. Offer alternative meal if Pt dislikes the main meal. 3. Offer House supplement if	F 314		

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F 314	Continued From page 9	F 314		

refuses the alternative meal with a Md order. 4. Offer with a Md order the Resource [high calorie/protein liquid nutritional supplement], if refuses house supplement...."
Care plan problem number 7, dated 2/5/01, documented, " Self care deficit r/t pneumonia m/b [manifested by] weakness, Parkinson's and Urosepsis." The goal documented, " Pt will have needs met evident by being clean and free from odor, well groomed, well nourished for the x 90 days." The approaches included, "1. Assist with all ADL's...."

Review of the treatment administration records (TAR) for February 2001 and March 2001 revealed the following documentation:
The February 2001 TAR documented the following orders:

"Keep wt off L heel and evaluate decubiti Heel Protectors". The order documented that this was to be charted by the nurse at 8:00 PM each day. Review revealed that the nursing staff had not documented that this had been done for the days of 2/6/01, 2/8/01, 2/9/01, 2/10/01, 2/11/01, 2/16/01, 2/17/01, 2/18/01, 2/20/01, 2/21/01, 2/22/01, and 2/23/01.
Documentation on the TAR revealed that this order had been discontinued on 2/24/01.

"Put legs - elevated heels off bed". There was no documentation from 2/5/01 through 2/28/01, to indicate that the facility nursing staff had followed through on this order for resident 4.

"Dress L heel c [with] tegasorb, tegaderm after cleansing c NS [normal saline] and quaze [sic] Secure c roller quaze [sic]". There was no documentation that the nursing staff had done this treatment on resident 4 on 2/9/01, 2/10/01, 2/11/01, 2/12/01, and

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F 314	Continued From page 10 2/13/01. " L heel decubitus: Cleanse c NS, 4x4 [gauze], kerlix QD [every day]. Apply heel protector, pillow under L leg/knee. This order was written on 2/14/01. There was no documentation on 2/19/01, 2/22/01 and 2/24/01 that the nursing staff had done this dressing change as ordered. There was documentation that this order was discontinued on 2/23/01. "Gentle cleanse L heel DQ c NS, Pat dry - Accoryzme [sic] to wound, qauze, kerlix." This order was written to be started on 2/23/01. There was no documentation that the nursing staff had done this treatment on resident 4's left heel on 2/23/01, 2/24/01, 2/25/01, 2/26/01 and 2/28/01. "Multipodus boots to L L E [left lower extremity]". This order was written by the physician to begin on 2/23/01. There was no documentation that the nursing staff had applied the boots to resident 4's left lower leg from 2/23/01 through 2/28/01. The March 2001 TAR's documented the following orders: "Stage 1 decubitus: L heel cleanse w [with] NS, pat dry accuzyme cream to wound, Kerlix". There was no documentation by the nursing staff this wound care was done on resident 4 for the days of 3/11/01, 3/12/01, 3/14/01, 3/15/01, 3/19/01, and 3/20/01. "Multipodus boots L leg". There was no documentation that the nursing staff applied this boot to resident 4's left leg on 3/1/01. This order was discontinued on 3/2/01. Review of the March 2001 TARs revealed that the order for sheepskin heel protectors, written on 3/2/01,	F 314		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED CLIFFS REGIONAL	**1745 EAST 280 NORTH ST GEORGE, UT 84770**

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F 314	Continued From page 11	F 314		

could not be found on the March TAR. There was no documentation that the facility nursing staff followed through on this physician's order for the days of 3/2/01 through 3/20/01.

The "Skin Integrity Sheet" (a pressure sore tracking form), beginning date of 2/5/01, for tracking resident 4's left heel pressure sore, documented the following:
2/5/01 - "Site-L heel, Stage-I..." This form described a stage I pressure sore as, "A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is applied."
2/27/01 - "Site-L heel, Stage-II. Necrosis-black..." This form described a stage II pressure sore as, "A partial thickness of skin is lost (epidermal layer has been lost, but the dermis is a lest partially intact): may present as blistering surrounded by an area of redness and/or induration." This form described necrosis as, "Death of areas of tissue (scar/slough). If present should be described (including color), Measured and documented."
3/3/01 - "Site-L heel, Stage-II, Necrosis-black..."
3/5/01 - "Site-L heel, Stage-II, Necrosis-yes..."
3/8/01 - "Site-L heel, Stage-III, Necrosis-yes, black with whitish around edge...". This form described a stage III pressure sore as, "A full thickness of skin is lost, exposing the subcutaneous tissues; presents as a shallow crater (unless covered by eschar - thick brown, black or yellow crust); may be draining."
3/18/01 - "Site-L heel, Stage-III, Necrosis-yes, black..."

The "Skin Integrity Sheet", beginning 2/10/01, for tracking resident 4's coccyx pressure sore, documented the following:
2/10/01 - "Site-Coccyx, Stage-II, Necrosis-no, Wound Bed-red..."
2/27/01 - "Site-Coccyx, L Buttocks, Stage-II,

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F 314	Continued From page 12 Necrosis-0 [zero], Wound Bed-dark red..." 3/4/01 - "Site-Coccyx, L Buttocks, Stage-none documented, Necrosis-0, Wound Bed-white/pink..." 3/5/01 - "Site-Coccyx, Stage-II, Necrosis-0, Wound Bed-pink..." 3/8/01 - "Site-Coccyx, Stage II, Necrosis-0, Wound Bed-white..." 3/13/01 - "Site-Coccyx, Stage-II, Necrosis-0, Wound Bed-white..." 3/19/01 - "Site-Coccyx, Stage-II, Necrosis-slight [the word slight was crossed through and the word error was written above it], Wound Bed-white..." The "Physician's Progress Notes" from 2/5/01 through 3/13/01 revealed the following documentation regarding resident 4's pressure sores. 2/5/01 - "Admit note...Decubitus L heel..." 2/20/01 - "O. [Objective]... Coccyx Decubiti [more than one pressure sore], heel decubiti...Multiple Round Skin Lesions over feet...A. [Assessment]... Multiple Decubiti...." 2/23/01 - "Podiatry [diagnosis, treatment, and prevention of conditions of the human feet] F/U [Follow-up] of L heel DQ ulceration. [decreased] pain reported. Ulceration now measures 20 x 23 mm [millimeters] on L post [posterior] heel. No drainage at this time. No erythema [diffuse redness of the skin] or infection. Black eschar cap now present. No sharp debridement indicated. 3+ edema [swelling of the body tissues with fluids] LLE. A) Decubitus ulceration L heel. Edema. P) [Plan]...Change wound care orders: Gentle cleanse c NS, Accuzyme, gauze, kerlix, QD. Apply multipodus boot to LLE...." 3/2/01- "Podiatry Pt still using sheepskin heel protector. Ulceration now 23 x 16 mm L post heel. Black Eschar cap present. No signs of infection. Still 3+ edema...."	F 314		

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F 326 SS=G	483.25(i)(2)QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined that the facility did not ensure that a resident received physician ordered thickened liquids for 1 of 6 sample residents causing the resident to choke on the unthickened liquids. Resident 4 Findings include: Resident 4 was admitted to the facility on 2/5/01 with diagnoses that included pneumonia, dysphasia [difficulty swallowing] urinary tract infection, congestive heart failure, decubitus ulcer and malnutrition. Review of the physician's orders, dated 3/1/01 through 3/31/01, revealed a physician order with an original order date of 2/5/01. The order was documented as "Diet: Step 3 mechanical soft w/ [with] nectar thick liquids sips of clear liquids w ice okay". 1. Observations on 3/20/01, of resident 4, revealed the following: At 8:36 AM, resident 4 was observed to be rolled up in bed, leaning to the left side with his head on the edge of the mattress. The resident had an overbed table across the bed with a pitcher of water sitting on the table. When the surveyor picked up resident 4's water pitcher, there was no ice observed in the water	F 326 OK 5/1/01 ND	F326 – The facility will insure that all residents Receive therapeutic diets when there is a Nutritional problem. Inservice will be given to all Nursing staff By 4-19-01 regarding nutrition, following MD orders for therapeutic diets, providing Assistance with meals, providing thickened Liquids as ordered and documentation of Meal percentages and needed assistance With meals. Inservice will be given to all staff by 4-19-01 Regarding accommodation of needs And answering resident call lights. These Inservices will be conducted monthly times 3 months and quarterly thereafter. Resident satisfaction Surveys will be Conducted during Resident Council Meetings and on an individual basis to Determine resident satisfaction with Staff response to their needs. The Quality Assurance Committee Will review Resident Satisfaction Surveys, Resident Council meeting minutes, Quality Assurance Rounds reports, Registered Dietitian Reports, High Risk weight committee Minutes, and staff training records to Determine alternative interventions. The DON to monitor for compliance. gmoorth.RA Done 4-26-01.RA 4-30-01 per phone call Shawna Glade	

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F 326	Continued From page 14 and the outside of the water pitcher was warm to the touch. The water inside of the pitcher was observed to be of regular consistency. Resident 4 was observed to be yelling out, "Help me. Help me." When asked by the surveyor what type of help he needed, the resident stated that he wanted a drink of water. The surveyor left resident 4's room to find a nursing staff member. As the surveyor left resident 4's room, resident 4 continued to yell out for help. As the surveyor was standing in the hallway, a nursing assistant walked past resident 4's room. The nursing assistant did not respond to resident 4's calls for help. The surveyor asked this nursing assistant to assist resident 4. The nursing assistant went into resident 4's room and asked him what he needed. The surveyor then told the nursing assistant that the resident had been requesting a drink of water. The nursing assistant picked up the water pitcher on resident 4's overbed table and gave him a drink. Resident 4 was observed to choke and cough on the drink of water. The nursing assistant gave resident another drink and again resident 4 choked and coughed. At 9:55 AM, a nursing assistant was observed to be passing fresh ice water to residents residing in the same hallway as resident 4. At 10:50 AM, observation of resident 4's water pitcher revealed that the there was no ice water in the pitcher and that the temperature and consistency remained that same as observed at 8:36 AM. At 12:15 PM, resident 4 was observed to be lying slightly on the left side. The head of the bed was rolled up in a sitting position. Resident 4's lunch tray was placed in front of the resident. Resident 4 was observed to be lying with his eyes closed and the bowl of salad from the lunch tray was sitting in resident 4's	F 326	Quality Assurance Rounds will be Conducted 3-5 times per week by Department Head staff to assure Call lights and water pitchers are Within resident reach. Quality Assurance Rounds will be conducted 3-5 times per Week by the restorative aides to insure Residents receive thickened liquids As ordered by their attending MD. The Registered Dietitian will review Random residents with therapeutic diets And or thickened liquids to assure Compliance with MD orders with a Written report to the Administrator And the Food Service Supervisor. 8 week 4-30-01 The High Risk Weight committee Will review all residents with significant Weight losses or gains on a weekly basis, Make recommendations for care and Treatment and update the plan of care. per phone call Shawna Glenda 5-7-01 per letter	

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lap. Resident 4's hand was observed to be resting in the bowl of salad. the liquids served with the lunch was observed to be 4 ounces of unthickened milk and 4 ounces of apricot nectar. Both the glass of milk and nectar remained full. The water pitcher remained on the overbed table. The pitcher contained water without ice and was observed to be of regular consistency.

At 12:35 PM, resident 4 was observed to be in the same position as observed at 12:15 PM. Resident 4's hand remain in the salad bowl, lying in resident 4's lap and the glasses of milk and nectar remained full.

At 1:00 PM, resident 4 was observed to be in the same position as observed at 12:35 PM. Resident 4 remained lying slightly on the left side with his eyes closed. Resident 4's hand remained in the salad bowl, lying in resident 4's lap. The food on the lunch tray remained uneaten. The glasses of milk and nectar remained full.

At 1:17 PM, a facility staff member was observed leaving resident 4's room. Observation of resident 4 at this time revealed that resident 4's lunch tray had been moved closer to the resident. The salad bowl had been returned to the lunch tray and resident 4 was observed trying to use a fork to pick up noodles from the plate. Resident 4's water pitcher contained water without ice and was observed to be of regular consistency.

During the observation of the lunch meal, no assistance by the staff to encourage or assist resident 4 with his meal was observed.

At 3:30 PM, the water in resident 4's water pitcher was observed to be at the same level as was observed

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F 326	Continued From page 16 at 1:17 PM. Resident 4's water pitcher contained water without ice and the water was observed to be of regular consistency. 2. In an interview with a facility nursing assistant on 3/20/01 at 3:30 PM, she stated that resident 4 was to have thickened liquids, but because resident 4's family wanted comfort care only and the family stated that tit was okay to give thin liquids, the facility was not giving resident 4 thickened liquids. 3. Review of resident 4's medical record on 3/20/01, revealed the following: The "Nutritional Assessment and Progress Notes, dated 2/9/01, documented that resident 4 required a mechanical soft diet with thickened liquids. The "Food Texture" section of the "Nutritional Intervention Assessment Worksheet", undated, documented that resident 4 had been identified as having "problems with chewing/swallowing with current diet." Resident 4's comprehensive resident assessment, dated 2/15/01, revealed the following documentation: Section J.1. (Health Conditions-problem conditions) documented that resident 4 had "Recurrent lung aspirations in the last 90 days". Section K.1. (Oral/Nutritional Status-Oral Problems) documented that resident 4 was identified as having a chewing and swallowing problem. Section K.5. (Oral/Nutritional Status-Nutritional Approaches) documented that in the last 7 days resident 4 received a mechanically altered diet and a therapeutic diet. Review of resident 4's comprehensive care plan, dated	F 326		

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F 326	Continued From page 17 2/17/01, revealed the only documentation regarding resident 4's difficulty swallowing and need for thickened liquids was in care plan problem #3. Problem #3, dated 2/5/01, documented, Alteration in nutrition related to the resident being under his ideal body weight and a risk for weight loss. The goal documented that resident 4 would eat and drink 75% of the meal served and would not loose any weight during the next 90 days. The approaches to reach this goal were for the facility to give resident 4 a diet as ordered by resident 4's attending physician. There was no further documented care plan problems, goals, or interventions addressing resident 4 swallowing problems and need for the physician ordered thickened liquids. A Physician's progress note, dated 2/20/01, documented, " ...A. [Assessment... Dysphasia...P. [Plan] Discussed status c family. They would like long term comfort care only...." A physician order, dated 2/20/01, documented, "Transfer to Long Term Care - Comfort Care only..." Review of the physician orders dated from 2/5/01 through 3/20/01, revealed that there was no documented physician order to discontinue the thickened liquids or mechanical soft diet for resident 4 as order on 2/5/01 by resident 4's attending physician.	F 326		