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

PRINTED: 12/16/02
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 ______	12/5/02

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 242 SS=E	483.15(b) QUALITY OF LIFE The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, individual interviews and a confidential interview with a group of alert and oriented residents, it was determined that for 3 of 18 sample residents and 3 additional residents the facility did not allow the residents the right to make choices about aspects of their life in the facility that was significant to them. Specifically, residents were served foods that the residents had informed the facility that they did not like. Resident identifiers: 2, 9, 15, 16, 17, and 18 Findings include: 1. Observations of the breakfast meal were made on 12/3/02, the following resident trays were observed: a. Resident 9's meal card documented dislikes including oatmeal. Oatmeal was observed on resident 9's tray. She stated that she did not like hot cereal and did not want to eat it. b. Resident 15's meal card documented dislikes including oranges. Orange juice and an orange slice were observed on resident 15's tray. They were left uneaten by the resident. c. Resident 16's meal card documented dislikes including oatmeal. . Oatmeal was observed on	F 242 Acceptable BD	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 is protected from discovery. This Plan of Correction is prepared , submitted and/or executed solely because it is required by local, state and/or federalregulation codes and/or guidelines. As this transmission is required by law, it is not waiver of provisions within applicable laws and regulations or any other codes, statutes or regulations. Utah Dept. of Health JAN [illegible] 2003 Bur. of Medicare/Medicaid Prog. Certification and Res. Assessment	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Archibald
TITLE: Administrator
(X6) DATE: 1-6-03

Any 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 is 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 242	Continued From page 1 resident 9's tray. Resident 15 did not eat the oatmeal. d. Resident 17's meal card documented dislikes including oatmeal. Oatmeal was observed on resident 17's tray and left uneaten. e. Resident 18's meal card documented dislikes including oatmeal. Oatmeal was observed on resident 18's tray and left uneaten. Observations of the lunch meal were made on 12/3/02, the following resident tray was observed: a. Resident 17's meal card documented wheat bread as a dislike. A wheat dinner roll was observed on resident 17's tray and left uneaten. 2. Observations of the breakfast meal were made on 12/4/02. The following residents tray were observed: a. Resident 17's meal card documented dislikes including oatmeal. Oatmeal was observed on resident 17's tray and left uneaten. b. Resident 15's meal card documented dislikes including oranges. Orange juice and an orange slice were observed on resident 15's tray. They were left uneaten by the resident. 3. After resident 2 was observed to leave her food on her plate during a prior meal, she was interviewed on 12/4/02 at 11:45 AM. She stated that she really likes her bread toasted. "But I never get it toasted. I would eat it if it were."	F 242	The facility will ensure that residents have the right to make choices about aspects of his or her life in the facility. An audit has been completed to ensure that all residents have been interviewed for dietary likes and dislikes. Inservices will be held on 1-2-03 and 1-10-03 with all Dietary Staff to review tray line accuracy for resident likes and dislikes. This inservice was conducted by the Dietary Manager. The Dietary Manager will audit 1 meal each day (5 days per week) for 3 weeks to ensure that the dietary staff is adhering to the residents prefernces. As ongoing quality assurance, the trayline is audited by the Dietary Manager 3 meals per week to ensure accuracy. The Consultant Dietitian will also review trayline accuracy during monthly visit and will review with Dietary Manager and Administrator. The Dietary Manager is responsible to perform audits and will review with Administrator weekly.	01-31-03
F 287 SS=B	483.20(f)(1-4) Resident Assessment Within 7 days after a facility completes a resident's	F 287 see p. 6		

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F 287	Continued From page 2 assessment, a facility must encode the following information for each resident in the facility: Admission assessment; Annual assessment updates; Significant change in status assessments; Quarterly review assessments; A subset of items upon a resident's transfer, reentry, discharge, and death; Background (face-sheet) information, if there is no admission assessment; Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by HCFA and the State. A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month, including the following: Admission assessment; Annual assessment; Significant change in status assessment; Significant correction of prior full assessment; Significant correction of prior quarterly assessment;	F 287 see p. 6		

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Quarterly review;

A subset of items upon a resident's transfer, reentry, discharge, and death;

Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.

The facility must transmit data in the format specified by HCFA or, for a State which has an alternate RAI approved by HCFA, in the format specified by the State and approved by HCFA.

This REQUIREMENT is not met as evidenced by:
Based on record reviews and interviews, it was determined that the facility did not maintain MDS (minimum data set) assessments completed within the previous 15 months in the resident's active record for 4 of 18 sampled residents. (Residents 5, 7, 8, 9 and 13.)

Findings include:

1. Resident 7 was readmitted to the facility on 1/10/01 with the diagnoses of cerebral vascular accident, congestive heart failure, hypertension, chronic ischemic heart disease, osteoporosis, chronic insomnia, coronary artery disease, aphasia, right hemiparesis, seizures and dementia with anxiety and depressive features.

A complete review of resident 7's active medical record was done on 12/3/02. The medical record contained an annual MDS dated 1/24/02 and three quarterly MDS's dated 3/28/02, 6/20/02 and 9/12/02. The active medical record did not contain any assessments that had been completed after 1/24/02.

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F 287	Continued From page 4 Resident 7's active medical record contained 8 months of MDS's 2. Resident 13 was readmitted to the facility on 9/19/01 with the diagnoses of dementia in Alzheimer with depressive features, urinary retention, constipation, hip fracture, atrial fibrillation, benign prostatic hypertrophy and total hip arthroplasty. A complete review of resident 13's active medical record was done on 12/4/02. The medical record contained two annual MDS dated 12/20/01 and 11/21/02 and three quarterly MDS's dated 3/14/02, 6/6/02 and 8/28/02. The active medical record did not contain any assessments that had been completed after 12/20/01. Resident 13's active medical record contained 11 months of MDS's 3. Resident 8 was admitted to the facility on 4/30/01 with the diagnoses of fibromyalgia, dementia, joint pain pelvis, closed fracture lumbar, paralytic ileus, peptic ulcer disease, arterioscleroses depressive, major depression, left hip pain, back pain and chronic obstructive pulmonary disease. A complete review of resident 8's active medical record was done on 12/3/02. The medical record contained two annual MDS's dated 12/13/01 and 11/14/02 and 4 quarterly MDS's dated 9/20/01, 3/7/02, 5/30/02 and 8/22/02. The active medical record did not contain any assessments that had been completed after 9/20/01. Resident 8's active medical record contained 14 months of mds's. 4. Resident 5 was admitted to the facility on 5/09/00 with the diagnoses of hiatal hernia, dysphagia, hypertension, gastroesophageal reflex disease, nausea and vomiting, dehydration, congestive heart failure, and depressive features.	F 287		

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F 287	Continued From page 5 A review of resident 5's medical record was done on 12/2/02. Resident 5 had 8 months of MDS in her active medical record. The active medical record contained an annual MDS dated 3/28/02, a significant change MDS on 8/22/02 and two quarterly MDS dated 11/14/02 and 6/20/02. The active medical record did not contain any assessments that been after 3/28/02. Resident 5's other MDS were found in her overflow medical chart that was kept in the medical records department. 5. Resident 9 was re-admitted to the facility on 8/12/01 with the diagnoses of peripheral vascular disease, peptic ulcer disease, legally blind with depressive features, atonic bladder, fracture, osteoporosis and hypertension. A review of resident 9's medical record was done on 12/2/02. Resident 9 had 14 months of MDS in her active medical record. The active medical record contained two annual assessment dated 7/18/02 and 8/23/01, and four quarterly assessments dated 10/10/02, 4/25/02, 1/31/02 and 11/15/01. The active medical record did not contain any assessments that been after 8/23/01. A nurse was interview on 12/3/02 at 3:00 PM. The nurse stated that there was no separate book for the MDS. All of the residents MDS were to be in the resident's medical record. The MDS coordinator was interviewed on 12/4/02 at 9:35 AM. The MDS coordinator stated that the 15 months of MDS's were kept in the resident's charts.	F 287 Acceptable BB	The facility will ensure that they maintain 15 months of of MDS data in each active residents record. Medical Records will audit all residents active records to ensure that 15 months of MDS Assessments are in each residents record. Medical Records have been educated on the requirement and will ensure that when thinning residents records that the appropriate amount of data remain on the current record. Administrator will monitor.	01-15-03

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F 287	Continued From page 6	F 287		
F 325 SS=G	483.25(i)(1) QUALITY OF CARE	F 325 see p. 14		

Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.

This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview and observations it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by 2 of 18 sampled residents plus an additional closed record, experienced significant weight loss with either no dietary interventions or inadequate dietary interventions implemented to prevent further weight decline. Residents 2, 7 and CR 3.

Calculating weight loss percentages is done by subtracting the current weight from the previous weight, dividing the difference by the previous weight and multiplying by 100. Significant wight losses are as follows: 5% in one month, 7.5% in 3 months and 10% in 6 months. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000).

Findings include:

1. Resident 7 was readmitted to the facility on 1/10/01 with the diagnoses of cerebral vascular accident, congestive heart failure, hypertension, chronic ischemic heart disease, osteoporosis, chronic

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insomnia, coronary artery disease, aphasia, right hemiparesis, seizures and dementia with anxiety and depressive features.

A review of resident 7's weights documented the following.

August 4, 2002	108 lbs. (pounds)
September 1, 2002	106 lbs.
October 6, 2002	105 lbs.
1st week of November	98 lbs.
December 5, 2002	97.75 lbs.

Between the months of August and December resident 7 lost 10.25 lbs. (9.49%) which is significant.

Between the months of September and December resident 7 lost 8.25 lbs (7.78%) which is significant.

Between the months of October and November resident 7 lost 7 lbs (6.66%) which is significant.

A review of resident 7's "Nutrition/Hydration Risk Assessment" forms, dated 6/20/02 and 9/12/02, placed resident 7 at high nutritional risk.

A review of resident 7's care plan , dated 12/27/01 and updated 8/27/02 was completed. It was documented that resident 7 had an alteration in nutrition related to being less than her ideal body weight and experiencing progressive weight loss. The documented goal was, "Pt (patient) will eat and drink 75% of what is served weight [plus] or [minus] 5%...". Approaches documented included, "Refer to RD if loss or gain 5% of weight".

On 7/22/02, the following was documented in the interdisciplinary progress notes, "Pt (patient) loss 5% loss 7 llb (pounds). Referred to RD (registered

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F 325	Continued From page 8 dietitian)." On 7/22/02, a physician's order documented, "pt (patient) has lost 5%- was 116 now 109 (-7) she is on Resource [and] BID (twice a day) snacks [at] AM [and] PM. Referred to RD (registered dietitian)." On 8/27/02, the following was documented in the interdisciplinary progress notes, "Pt (patient) has progressive wt (weight) loss she is eating [at] 10% of meal but will take supplement. Refer to RD (registered dietitian)...". On 8/27/02, a physician's order documented, "Pt (patient) has progressive wt (weight) loss [increase] resource to TID (three times a day). Refer to RD (registered dietitian). Cont (continue) [with] wkly (weekly) wt (weight)." On 9/10/02, the following was documented in the interdisciplinary progress notes, "Refer to RD (registered dietitian) due to refuses eat." On 9/12/02, the following was documented in the interdisciplinary progress notes, "...Resident's wt (weight) has been on a steady moderate decline for the past 6 wks (weeks)...". On 9/20/02, the following was documented in the interdisciplinary progress notes, "Pt (patient) has unstable wt (weight) has had 4 llb (pound) loss. Refer to RD (registered dietitian)...". On 9/20/02, a physician's order documented, "Pt (patient) has loss progressively [and] this wt (weight) loss 4 lb (pounds). Refer to RD (registered dietitian). [and] put pt (patient) on feeder table." On 10/24/02, the following was documented in the	F 325		

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F 325	Continued From page 9 interdisciplinary progress notes, "Pt (patient) has had 7 llb (pound) wt (weight) loss she refuses to eat...Refer to RD (registered dietitian)...". On 10/24/02, a physician's order documented, "[increased] cal (calories) [increased] protein TAT (texture as tolerated) mech (mechanical) soft. pt (patient) has -7 lb (pound) wt (weight) loss- pt (patient) refuses to eat. Refer RD (registered dietitian)." An additional physician's order, dated 10/24/02, documented, "Med pass 6 oz (ounces) QID (four times a day) [with] snacks QD (every day)." On 11/7/02, the following was documented in the interdisciplinary progress notes, "Pt (patient) weight 98 lb (pounds) 4 lb (pound) weight loss in 1 week...". On 11/26/02, the following was documented in the interdisciplinary progress notes, "...Wt (weight) RD (registered dietitian) referral". On 11/26/02, a physician's order documented, "Pt (patient) on hi (high) cal (calories) hi (high) pro (protein) TAT (texture as tolerated) mech (mechanical) soft med pass 2.0 6 oz (ounces) QID (four times a day) continues to lose wt (weight) RD (registered dietitian) referral." A review of the dietary section of the chart was completed. On 6/20/02, the food service supervisor (FSS) documented, "Pt (patient) is on a mech (mechanical) soft fortified diet, weight is unstable weight is 104 lb (pounds)...". On 10/24/02, the FSS documented, "...is [decreased] 7 lbs - won't eat very little will drink...RD (registered dietitian) consult requested...".	F 325		

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F 325	Continued From page 10 There were no further documented dietary notes completed by the FSS or RD. During this time resident 7 had experienced a significant weight loss. On 10/24/02, the DON (director of nursing) and FSS documented, on their Weight/Skin RD referral form, that resident 7 has had a progressive weight loss "-7 lbs" and that the RD needs to "finish assessment". On 11/14/02, 21 days later, the RD documented on the RD referral form, "Cont (continue) m/soft (mechanical soft) [increased] cal (calories) [increased] pro (protein), small portions [with] med pass 2.0 6 oz (ounces) QID (four times a day) consider recreational feeding." This same day, the RD completed a nutrition assessment, 115 days after the initial physician's order dated 7/22/02. The RD checked off that resident 7's weight was acceptable. The RD also documented "PO (by mouth) very poor, takes dessert [and] med pass. Would get recreational fdg (feeding). Cont (continue) m/s (mechanical soft), [increased] cal (calories) [increased] pro (protein), small portions [with] med pass 2.0, 6 oz (ounces) QID (four times a day)." There was no other documentation to provide evidence that the RD had addressed the significant weight loss resident 7 had been experiencing. There was no documented evidence that the RD completed the referrals per the physician orders dated 7/22/02, 8/27/02, 9/20/02 and 10/24/02. Review of resident 7's diet card on 12/3/02 documented she was receiving a high calorie, high protein, mechanical soft diet with ground meat and she was to have 8 ounces of 2% milk with each meal. On 12/3/02 resident 7's breakfast and lunch meals	F 325		

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F 325	Continued From page 11 were observed. For breakfast resident 7 was served a bowl of hot cereal, 1 piece of french toast with butter and syrup, 1 slice of an orange, 180 cc of orange juice and 180cc of 2% milk. Resident 7 was observed to eat 1 bite of the french toast, while she was drinking her 2% milk the nurse came in at 8:08 AM and took her milk away stating "I'm going to get you something else to drink." At 8:09 AM the nurse was observed to return with approximately 4 ounces of 2.0 Med Pass. Resident 7 was observed to drink 100% of the 2.0 Med Pass. The nurse was not observed to offer resident 7 the other 2 ounces of ordered 2.0 Med Pass. The nurse was not observed to offer resident 7 the 2% milk she had taken from her. For lunch resident 7 was served a scoop of chicken, a bowl of beans, a dinner doll, a bowl of zucchini, a bowl of green pear jello and 180 cc of juice. Resident 7 was observed to drink 100% of the juice. Resident 7 was not served the 2% milk. On 12/4/02 resident 7's breakfast and dinner meals were observed. For breakfast resident 7 was served 1 poached egg, 1 piece of toast with butter, 2 peach slices, 180 cc of orange juice and 180 cc of 2% milk. Resident 7 was observed to drink 100% of her 2% milk. For dinner resident 7 was served a ground hot dog on a bun, tator tots, onions, ketchup, a bowl of mixed vegetables, ice cream with syrup, 180 cc of 2% milk and 180 cc of water. Resident 7 was observed to eat 50% of the ice cream with syrup and drink 100% of her 2% milk. On 12/5/02 resident 7's breakfast meal was observed. For breakfast resident 7 was served a scoop of corned beef hash, a bowl of hot cereal, 1 pancake, 1 orange slice, 180 cc of 2% milk and 180 cc of apple juice.	F 325		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 325	Continued From page 12 Resident 7 was observed to eat a few bites of the hot cereal and drink 100% of the 2% milk. At 9:05 AM a CNA (certified nursing assistant) was observed to bring resident 7 to the nursing desk and ask the nurse to give resident 7 some 2.0 Med Pass. Resident 7 was observed from 9:05 AM until 9:25 AM. The nurse was observed to give resident 7 her medications but no 2.0 Med Pass. At 9:25 AM, the CNA asked the nurse if she had given resident 7 the 2.0 Med Pass and the nurse replied "yes". According to the dietary policy and procedures, which became effective at the facility on 11/15/02, a high calorie, high protein diet consists of a regular diet with whole milk three times a day, 2 eggs at breakfast, large meat portions at lunch and dinner. During the observations of resident 7's meals she was not observed to get whole milk with her meals, she was not observed to receive 2 eggs at breakfast or large meat portions for lunch and dinner. On 12/4/02 at 7:55 AM, during an interview with the DON, she stated that the staff work with getting resident 7 to eat and she refuses. She also stated that they are trying to get her on a recreational feeding where she can eat what she wants when she wants, which is what she is already doing. She further stated the RD only saw her on 11/14/02 and did not see her on any of the physician referrals. On 12/4/02 at 10:00 AM, during an interview with the DON, she stated that the Skin/Weight committee would give the dietary referrals to the dietary staff who would give the referrals to the RD. From there the RD would check on the identified residents which she wasn't doing. She further stated that the RD was coming in after hours, for 2 to 3 hours and was not leaving any notes on the residents she had checked	F 325		

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 ______	12/5/02

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 325	Continued From page 13 on. 2. Resident 2 was admitted to the facility on 10/5/02, with the diagnoses of fractured neck of femur, hypertension, brief depressive reaction, glaucoma, and joint pain-pelvis. On 12/3/02, resident 2's medical record was reviewed. On 10/9/02, the RD completed an initial dietary assessment that documented resident 2 was 5' 1" (61 inches) tall and weight 129. The diet ordered was regular. A review of resident 2's weekly weights, documented on Monthly/Weekly Weight Recap Sheets were as follows: First week in October: 129 pounds Second week in October: 119 pounds This represents a significant weight loss of 10 pounds, or 7.75% in one week. Third week in October:nu 115 pounds Fourth week in October: 116 pounds First week in November: 114 pounds This represents a significant weight loss of 15 pounds, or 11.62% in one month. A review of resident 2's MDS (minimum data set) assessment, dated 11/1/02, was completed. Under section K3., Weight Change, resident 2 was documented as having a weight loss of 5% or more in the last 30 days. Resident 2's weight was documented at 116 pounds. On 10/5/02, a "Nutritional/Hydration Risk Assessment" form was completed for resident 2. It	F 325 Acceptable PD	The facility will ensure that residents maintatain a acceptable parameter of nutritional status. The facility contracted with Crandall & Accociates on 11-15-02 to provide consultant dietitian services. All residents will be assessed using the Nutritional Risk Review(form 103) by 01-31-03. Recommendations will be made to nursing for nutritional interventions (form 107). All nutritional assessments are completed using the Crandall & Associates Clinical Charting Handbook and Best Practice Guidelines, which follows ADA Guidelines and Crandall Clinical policies and procedures. Any resients who have experienced significant weekly and monthly weights will be monitored with weekly weights. Per Crandall policy and procedures, all nutritionally high risk residents (significat weight changes, pressure sores, abnormal nutritionally related labs, and tube fed residents) are assessed at least monthly by Consultant Dietitian.	01-31-03

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F 325	Continued From page 14 documented that resident 2 was at high nutritional risk. On 10/16/02, a physician's telephone order documented a change in resident 2's, diet to "NAS (no added salt), [increased] cal (calorie) [increased] pro (protein) TAT (texture as tolerated) [(regular)]." Review of resident 2's diet card on 12/3/02 documented she was to receive a high calorie, high protein, NAS diet with 8 ounces of whole milk with each meal. On 12/3/02, breakfast and lunch was observed. On 12/4/02, breakfast and dinner were observed. Resident 2 was not observed to receive 2 eggs at breakfast or large meat portions at lunch and dinner. A review of the dietary progress notes was completed on 12/3/02. On 10/16/02, the FSS documented, "RD (registered dietitian) consult requested." There is no documented evidence that the dietitian completed a consult or nutrition assessment for resident 2. On 11/12/02, a physician's telephone order for resident 2, documented "[increace] med pass to 4 oz QID pt (patient) has had wt. (weight) loss Refer to RD for progressive wt. Loss." On 11/12/02, the following was documented in the interdisciplinary progress notes, "Pt. has progressive wt. loss & is refer to RD." There is no documented evidence that the RD completed the nutrition consult ordered on 11/12/02.	F 325	Nutritional interventions for weekly significant weight changes are completed by the Dietary Manager within 3 days and cosigned by the Consultant Dietitian. A weekly Nutrition At Risk meeting is conducted and these residents are reviewed and recommendations made to nursing/physician based on the Best Practice Guidelines. Nutrition At Risk meeting minutes are reviewed by Consultant Dietitian as part of monthly visit and report. Any progress or concerns are reported to the Administrator during monthly exit review. The Dietary Manageris notified within 24 hours by nursing when a physician orders a dietary referral. The Dietary Manager has 3 days from the time the order is written to complete an assessment. The Consultant Dietitian will be notified by the Dietary Manager for any tube feeding assessments and any other assessments deemed necessary by the Dietary Manager. When Consultant Dietitian referral is needed, the Dietary Manager will notify.	

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F 325	Continued From page 15 There is no documented evidence that the RD re-assessed resident 2's nutritional needs or made recommendations to increase the calories provided to resident 2 after she experienced significant weight loss. 3. Resident CL-3 was an underweight, 80 year old male who had a number of heart related diseases, chronic obstructive pulmonary disease with recurrent pneumonia, and asthma. He did not receive the diet ordered by his physician. This 5 foot 5 inch male weighed only 117 pounds when he was admitted on 9/06/02. On 9/18/02 the physician requested in a Telephone order, that resident CL-3's diet be changed to what the registered dietician ordered: "Per RD - change diet to Fortified cardiac diet with Health Shakes at meals vs. milk." On 9/24/02, the physician acknowledged the resident 's 10 pound weight loss in 18 days and again ordered a "Fortified diet with assorted supplements BID" [supplements twice a day]. On 9/30/02, the registered dietician complained in her Nutritional Progress Notes that the resident "...has not received his 200 'Homemade Milkshake.' See recs [record entry] of 9/18/02. Record PO [food consumed by mouth] accurately. Wt 107#."	F 325	The SpecialNutrition Program has been implemented to replace the "high calorie, high protein" diet orders. It consist of 8 oz super cereal at breakfast 4 oz high cal/pro pudding and 8 oz whole milk tid. It provides approximately 1000 calories and 40 gramsof protein All residents who have high calorie, high protein diet orders have had these orders clarfied to "SNP" and tray cards have been changed to reflect the super cereal, super pudding and whole milk tid. Administrator will monitor	
F 361 SS=G	483.35(a)(1)-(2) DIETARY SERVICES The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently	F 361 see p. 30		

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scheduled consultation from a qualified dietitian.

A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.

This REQUIREMENT is not met as evidenced by:

Based on staff interview, record review, and observations, it was determined that the facility failed to utilize their part-time consultant dietitian in a manner which provided adequate supervision to the facility staff regarding: accurately monitoring and assessing residents at risk for weight loss, and pressure sores: a. Three of 18 sample residents and one closed record experienced significant weight loss. (Residents 2, 7, 15 and CR 3). Per interview with the Director of nursing on 12/3/02 and 12/4/02, the dietician had been notified by the facility of the resident's weight loss. Please also refer to tag F-325: b. Based on observation, interview and medical record, review the facility did not have proper individualized therapeutic diets for its residents to correct nutritional problems. (Resident2, 7, 5, 15 and CR-3.) Also refer to F-367; and c. The facility failed to provide dietetic supports and services, which maintained the body weights and promote healing of pressure sores for each resident.

Findings include:

1. Resident 7 was readmitted to the facility on 1/10/01 with the diagnoses of cerebral vascular accident, congestive heart failure, hypertension, chronic ischemic heart disease, osteoporosis, chronic insomnia, coronary artery disease, aphasia, right hemiparesis, seizures and dementia with anxiety and

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depressive features.

A review of resident 7's weights documented the following.

August 4, 2002	108 lbs. (pounds)
September 1, 2002	106 lbs.
October 6, 2002	105 lbs.
1st week of November	98 lbs.
December 5, 2002	97.75 lbs.

Between the months of August and December resident 7 lost 10.25 lbs. (9.49%) which is significant.

Between the months of September and December resident 7 lost 8.25 lbs (7.78%) which is significant.

Between the months of October and November resident 7 lost 7 lbs (6.66%) which is significant.

A review of resident 7's "Nutrition/Hydration Risk Assessment" forms, dated 6/20/02 and 9/12/02, placed resident 7 at high nutritional risk.

A review of resident 7's care plan , dated 12/27/01 and updated 8/27/02 was completed. It was documented that resident 7 had an alteration in nutrition related to being less than her ideal body weight and experiencing progressive weight loss. The documented goal was, "Pt (patient) will eat and drink 75% of what is served weight [plus] or [minus] 5%...". Approaches documented included, "Refer to RD if loss or gain 5% of weight".

On 7/22/02, the following was documented in the interdisciplinary progress notes, "Pt (patient) loss 5% loss 7 llb (pounds). Referred to RD (registered dietitian)."

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F 361	Continued From page 18 On 7/22/02, a physician's order documented, "pt (patient) has lost 5%- was 116 now 109 (-7) she is on Resource [and] BID (twice a day) snacks [at] AM [and] PM. Referred to RD (registered dietitian)." On 8/27/02, the following was documented in the interdisciplinary progress notes, "Pt (patient) has progressive wt (weight) loss she is eating [at] 10% of meal but will take supplement. Refer to RD (registered dietitian)...". On 8/27/02, a physician's order documented, "Pt (patient) has progressive wt (weight) loss [increase] resource to TID (three times a day). Refer to RD (registered dietitian). Cont (continue) [with] wkly (weekly) wt (weight)." On 9/10/02, the following was documented in the interdisciplinary progress notes, "Refer to RD (registered dietitian) due to refuses eat." On 9/12/02, the following was documented in the interdisciplinary progress notes, "...Resident's wt (weight) has been on a steady moderate decline for the past 6 wks (weeks)...". On 9/20/02, the following was documented in the interdisciplinary progress notes, "Pt (patient) has unstable wt (weight) has had 4 llb (pound) loss. Refer to RD (registered dietitian)...". On 9/20/02, a physician's order documented, "Pt (patient) has loss progressively [and] this wt (weight) loss 4 lb (pounds). Refer to RD (registered dietitian). [and] put pt (patient) on feeder table." On 10/24/02, the following was documented in the interdisciplinary progress notes, "Pt (patient) has had 7 llb (pound) wt (weight) loss she refuses to	F 361		

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F 361	Continued From page 19 eat...Refer to RD (registered dietitian)...". On 10/24/02, a physician's order documented, "[increased] cal (calories) [increased] protein TAT (texture as tolerated) mech (mechanical) soft. pt (patient) has -7 lb (pound) wt (weight) loss- pt (patient) refuses to eat. Refer RD (registered dietitian)." An additional physician's order, dated 10/24/02, documented, "Med pass 6 oz (ounces) QID (four times a day) [with] snacks QD (every day)." On 11/7/02, the following was documented in the interdisciplinary progress notes, "Pt (patient) weight 98 lb (pounds) 4 lb (pound) weight loss in 1 week...". On 11/26/02, the following was documented in the interdisciplinary progress notes, "...Wt (weight) RD (registered dietitian) referral". On 11/26/02, a physician's order documented, "Pt (patient) on hi (high) cal (calories) hi (high) pro (protein) TAT (texture as tolerated) mech (mechanical) soft med pass 2.0 6 oz (ounces) QID (four times a day) continues to lose wt (weight) RD (registered dietitian) referral." A review of the dietary section of the chart was completed. On 6/20/02, the food service supervisor (FSS) documented, "Pt (patient) is on a mech (mechanical) soft fortified diet, weight is unstable weight is 104 lb (pounds)...". On 10/24/02, the FSS documented, "...is [decreased] 7 lbs - won't eat very little will drink...RD (registered dietitian) consult requested...". There were no further documented dietary notes	F 361		

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completed by the FSS or RD. During this time resident 7 had experienced a significant weight loss.

On 10/24/02, the DON (director of nursing) and FSS documented, on their Weight/Skin RD referral form, that resident 7 has had a progressive weight loss "-7 lbs" and that the RD needs to "finish assessment".

On 11/14/02, 21 days later, the RD documented on the RD referral form, "Cont (continue) m/soft (mechanical soft) [increased] cal (calories) [increased] pro (protein), small portions [with] med pass 2.0 6 oz (ounces) QID (four times a day) consider recreational feeding." This same day, the RD completed a nutrition assessment, 115 days after the initial physician's order dated 7/22/02. The RD checked off that resident 7's weight was acceptable. The RD also documented "PO (by mouth) very poor, takes dessert [and] med pass. Would get recreational fdg (feeding). Cont (continue) m/s (mechanical soft), [increased] cal (calories) [increased] pro (protein), small portions [with] med pass 2.0, 6 oz (ounces) QID (four times a day)." There was no other documentation to provide evidence that the RD had addressed the significant weight loss resident 7 had been experiencing.

There was no documented evidence that the RD completed the referrals per the physician orders dated 7/22/02, 8/27/02, 9/20/02 and 10/24/02.

Review of resident 7's diet card on 12/3/02 documented she was receiving a high calorie, high protein, mechanical soft diet with ground meat and she was to have 8 ounces of 2% milk with each meal.

On 12/3/02 resident 7's breakfast and lunch meals were observed. For breakfast resident 7 was served a bowl of hot cereal, 1 piece of french toast with butter

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

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and syrup, 1 slice of an orange, 180 cc of orange juice and 180cc of 2% milk. Resident 7 was observed to eat 1 bite of the french toast, while she was drinking her 2% milk the nurse came in at 8:08 AM and took her milk away stating "I'm going to get you something else to drink." At 8:09 AM the nurse was observed to return with approximately 4 ounces of 2.0 Med Pass. Resident 7 was observed to drink 100% of the 2.0 Med Pass. The nurse was not observed to offer resident 7 the other 2 ounces of ordered 2.0 Med Pass. The nurse was not observed to offer resident 7 the 2% milk she had taken from her.

For lunch resident 7 was served a scoop of chicken, a bowl of beans, a dinner doll, a bowl of zucchini, a bowl of green pear jello and 180 cc of juice. Resident 7 was observed to drink 100% of the juice. Resident 7 was not served the 2% milk.

On 12/4/02 resident 7's breakfast and dinner meals were observed. For breakfast resident 7 was served 1 poached egg, 1 piece of toast with butter, 2 peach slices, 180 cc of orange juice and 180 cc of 2% milk. Resident 7 was observed to drink 100% of her 2% milk.

For dinner resident 7 was served a ground hot dog on a bun, tator tots, onions, ketchup, a bowl of mixed vegetables, ice cream with syrup, 180 cc of 2% milk and 180 cc of water. Resident 7 was observed to eat 50% of the ice cream with syrup and drink 100% of her 2% milk.

On 12/5/02 resident 7's breakfast meal was observed. For breakfast resident 7 was served a scoop of corned beef hash, a bowl of hot cereal, 1 pancake, 1 orange slice, 180 cc of 2% milk and 180 cc of apple juice. Resident 7 was observed to eat a few bites of the hot cereal and drink 100% of the 2% milk. At 9:05 AM

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F 361	Continued From page 22 a CNA (certified nursing assistant) was observed to bring resident 7 to the nursing desk and ask the nurse to give resident 7 some 2.0 Med Pass. Resident 7 was observed from 9:05 AM until 9:25 AM. The nurse was observed to give resident 7 her medications but no 2.0 Med Pass. At 9:25 AM, the CNA asked the nurse if she had given resident 7 the 2.0 Med Pass and the nurse replied "yes". According to the dietary policy and procedures, which became effective at the facility on 11/15/02, a high calorie, high protein diet consists of a regular diet with whole milk three times a day, 2 eggs at breakfast, large meat portions at lunch and dinner. During the observations of resident 7's meals she was not observed to get whole milk with her meals, she was not observed to receive 2 eggs at breakfast or large meat portions for lunch and dinner. On 12/4/02 at 7:55 AM, during an interview with the DON, she stated that the staff work with getting resident 7 to eat and she refuses. She also stated that they are trying to get her on a recreational feeding where she can eat what she wants when she wants, which is what she is already doing. She further stated the RD only saw her on 11/14/02 and did not see her on any of the physician referrals. On 12/4/02 at 10:00 AM, during an interview with the DON, she stated that the Skin/Weight committee would give the dietary referrals to the dietary staff who would give the referrals to the RD. From there the RD would check on the identified residents which she wasn't doing. She further stated that the RD was coming in after hours, for 2 to 3 hours and was not leaving any notes on the residents she had checked on.	F 361		

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F 361	Continued From page 23 2. Resident 2 was admitted to the facility on 10/5/02, with the diagnoses of Fx (fractured) neck of femur, hypertension, brief depressive reaction, glaucoma, and joint pain-pelvis. On 12/3/02, resident 2's medical record was reviewed. On 10/9/02, the food service manager completed an initial dietary assessment that documented resident 2 was 5' 1" (61 inches) tall and weight 129. The diet ordered was regular. On 10/16/02, a Physician's Telephone Order documented for resident 2, to have a diet change to "NAS (no added salt), [increased] cal (calorie) [increased] pro (protein) TAT (texture as tolerated) [(regular)]." On 10/16/02, the dietary manager documented on the Nutritional Progress Notes for resident 2, "RD (registered dietitian) consult requested." There is no documentation in the chart of the RD consulting on resident 2. On 11/12/02, a Physician's Telephone order for resident 2, documented "pt (patient) has had wt. (weight) loss Refer to RD for [unreadable] wt. Loss." On 11/12/02, the Interdisciplinary Progress Notes documented "Pt. has progressive wt. loss & is refer to RD." There is no documentation in the chart of the RD consulting on resident 2. 3. Resident 5 was admitted to the facility on 5/09/00 with the diagnoses of hiatal hernia, dysphagia, hypertension, gastroesophageal reflex disease, nausea and vomiting, dehydration, congestive heart failure, and depressive features.	F 361		

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F 361	Continued From page 24 Resident 5's medical record was reviewed on 12/2/02. i. The facility's "Nutritional Progress Notes" written by the registered dietitian dated 12/26/01, documented "Wound f/u (follow up) Pt noted to have some breakdown on coccyx, almost resolved now. She still has cellulites in legs, she is on ABT (antibiotic). Wt (weight) @ (at) 136 # (pounds). Diet is Mech (mechanical) soft [with] HS (hour of sleep) snack. 11/28/01 S (serum) Alb (albumin) 3.0 [low]. Make sure HS snack has a good protein source in it." A physician's telephone order and Interdisciplinary Progress Notes dated 1/9/02 documented that resident 5 had lost 5 pounds in 1 month and to change her diet to a regular fortified diet. . A nutritional progress note written by the dietitian dated 1/29/02 documented, "Wound f/u. Pt conts (continues) [with] breakdown on coccyx, Stage II. She is on ABT for ® leg cellulites, also. Jan 02 wt -131, WNL(within normal limits) 0 new SAlb Make sure HS snack has good source of protein. Encourage PO (by mouth) check SAlb in 2/02 (February 2002)." The facility's "Malnutrition Risk Assessment" dated 3/28/02 documented that staff had assessed resident 5 as being a high risk for malnutrition. ii. The "Nutritional Assessment" dated 11/12/02 was not signed by a registered dietitian and did not document the following areas: Ideal Body Weight Range, BMI (Body Mass Index), Current Weight, Bladder and Bowel Function, Skin, Relevant Medications, Relevant Laboratories, Admit Weight, Estimating Calorie Needs, Activity Factors, Estimating Protein Needs, Protein Intake, Assessment, Comments, Recommendations	F 361		

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F 361	Continued From page 25 U.S. Department of Health and Human Services, Number 15, Treatment of Pressure Ulcers, December 1994, p. 21; states, "The initial assessment of patients with pressure ulcers has several dimensions: (a) Assessment of the pressure ulcer, (b) complete history and physical examination, (c) assessment for complications and comorbidities, (d) nutritional status assessment, (e) pain assessment, (f) psychosocial evaluation, and (g) assessment of risk for developing additional pressure ulcers." A physician order dated on 11/7/02 documented, " [change] med pass to 4 ounces QID to help slow down wt loss." The facility's "Skin Integrity Sheet" dated on 11/17/02 documented that resident 5 had a stage II sore on her coccyx. The nurse note documented that it measured 1 cm (centimeter) in length." A physician order dated 11/19/02 documented "[increase] med pass to 6oz. Qid due to weight loss. Refer to RD (registered dietitian)." No further nutritional documentation was found. Resident 5 was observed on 12/4/02 at 4:45 PM in her room drinking a blue cup filled with a supplement. Resident 5 was interviewed and she stated she only gets one cup of supplement. The nurse who administered the supplement to resident 5 was interviewed on 12/4/02 at 4:45 PM. The nurse stated that she only gave one glass of supplement. On 12/4/02 at 6:00 PM, two surveyors used one of the blue cups that the nurses were administrating the supplement in and measured how many ounces of fluid a blue cup could hold. One blue cup could hold	F 361		

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F 361	Continued From page 26 only 4 ounces of supplement if filled to the very top. Resident 5's pressure sore on her coccyx was observed on 12/4/02 at 1:00 PM. The treatment nurse stated that her pressure sore was a stage III, that measured 2.5 cm by 2 cm. Resident 5's meal card was observed on 12/3/02 at 11:45 AM. The meal card on resident 5's tray stated that resident 5 was to receive an increase calorie and protein diet and 8 ounces of whole milk. Resident 5's breakfast was observed on 12/3/02 at 7:30 AM. Resident 15's meal had no higher calories or protein than another resident receiving a regular diet. Refer to tag 367. Resident 5's lunch was observed on 12/3/02 at 11:45 AM. Resident 15's meal had no higher calories or protein than another resident receiving a regular diet. Refer to tag F 367. Resident 5 was observed eating her dinner on 12/4/02 at 6:00 PM. Resident 15's meal had no higher calories or protein than another resident receiving a regular diet. Refer to tag 367. U.S. Department of Health and Human Services, Number 15, Quick Reference Guide for Clinicians Pressure Ulcer Treatment, December 1994 page 4-7. "The goal of nutritional assessment and management is to ensure that the diet of the individual with a pressure ulcer contains nutrients adequate to support healing.... Nutritional support: Encourage dietary support intake or supplementation if an individual with a pressure ulcer is malnourished. If the dietary intake continues to be inadequate, impracticable, or impossible, nutritional support should be used to place the patient into positive nitrogen balance	F 361		

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(approximately 30 to 35 calories/kg/day/ and 1.25 to 1.50 grams of protein/kg/day) according to the goals of care. As much as 2.00 grams of protein/kg may be needed. "

The DON (Director of Nursing) was asked on 12/3/02 for any more dietary assessments and on 12/5/02 for any more nutritional interventions for resident 5. The facility was unable to provide any more information.

4. Resident 15 was re-admitted to the facility on 9/12/02 with the diagnoses of hypertension, senile dementia and glaucoma.

Resident 15's medical record was reviewed on 12/4/02.

The facility's "Monthly/Weekly Weight Recap Sheet" documented the following weights for resident 15
- 9/12/02 88 lbs (pounds)
- 10/02 83 lbs
- 11/02 81 lbs

Between the months of September and November 2002, resident 15 lost 7 lbs or 8.64% of her total weight, which is defined as "significant" by federal survey standards.

The "Pressure Ulcer Risk Assessment' dated 9/13/02, documented resident 15 was a high risk for developing a pressure sore.

The "Nutrition/Hydration Risk assessment" dated 9/13/02, documented resident 15 was a high risk for developing a pressure sore.

A physician's orders dated 9/16/02 documented that

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F 361	Continued From page 28 resident 15 was to be placed on hospice. The recertification of physician orders dated October 2002 documented that resident 15 was to receive a pureed fortified diet. A physician order dated 10/1/02 documented, "[decrease IBW (Ideal body weight). Reg TAT (texture as tolerated). Pureed diet assorted supp (supplements 2 oz q (every) a (before meals). Refer to RD. loss 7.5 lbs." A physician's order dated 10/15/02 documented, [Increase] cal (calorie) [increase] protein TAT pureed add med pass 2.0 2 oz QID refer to RD. Gain 5 lbs." A physician order dated 10/24/02 documented, "Med pass 6 oz add vanilla ice cream BID (twice a day)." A physician order dated 10/24/02 documented, "Pt is on hospice and cont with wt loss of 7 lbs. Refer to RD." A physician order dated 11/7/02 documented. "DC Med Pass QID - pt on hospice" The facility's "Interdisciplinary Progress Notes" (IDT) documented the following for resident 15: 1. On 10/4/02, the IDT progress note documented "Pt has a weight gain 5 lbs this (week). Refer to RD Did diet change to [increase] cal [increase] pro TAT pureed. Add med pass 2.0 2 oz QID. Dr notified of weight gain." 2. On 10/24/02, the IDT progress note documented that resident 15 had weight loss of 7 pounds and that she refuses to eat but will eat ice cream and consume liquids. The note also documented that to increase med pass 6 ounces. The note documented that	F 361		

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F 361	Continued From page 29 physician was notified of the weight loss and a referral to dietitian. 3. On 11/12/02 the IDT note documented "pt has lost 3 lb. She is on hospice and refuses to eat and drink. Med pass dc due to refusal to drink." The facility's "Nutritional Progress Notes" dated 10/24/02, signed by the dietary manager documented, "[Decrease] in wt. 7 lbs in 1 week-on hospice- refuses to eat-will drink fluids –will [change] med pass to 6 ounces QID-will continue diet of [increase] cal [increase] pro pureed. Will add vanilla ice cream BID -AM/HS. She likes that-encouragement and assist given with very little acceptance. RD referral requested –current wt 81 lbs. Will continue to monitor and encourage." The "Nutritional Assessment and Progress Notes" dated 11/14/02, signed by the dietitian documented, "Pt on hospice. Pt lethargic, refuses most PO intake but will take some fluids. Cont to offer meals fluids as tolerated." The same nutritional assessment, dated 11/14/02 documented that resident 15 's ideal body weight was 110 lbs. The assessment or progress notes did not calculate the protein or calorie needs for resident 15. Three physician orders were documented to have referrals for resident 15 to be seen by a registered dietitian. The dietitian assessment was documented 45 days after the first referral was made. Resident 15's diet card was observed on 12/4/02 at approximately 5:45 PM. Resident 15 diet card documented that resident 15 was on a increase protein and calorie diet with 8 ounces of whole milk. Resident 15's meal had no higher calories or protein than another resident receiving a regular diet. Refer to tag F 367.	F 361	Acceptable PB The facility will utilize the Consultant Dietitian in a manner which provides adequate supervision to the facility staff: regarding accurately monitoring and assessing residents for weight loss and pressure sores. The facility contracted with Crandall & Associates on 11-15-2002 to provide consultant dietitian services. All nutritionally high risk residents will be assessed using the Nutritional Risk Review (form 103) by 01-31-2003. Recommedations will be made to nursing for nutritional interventions. All nutritional assessments are completed using the Crandall & Associates Clinical Charting Handbook and Best Practice Guidelines are used in the calculations. These guidelines also specify appropriate recommendations for nutritional interventions for pressure ulcers. Recommendations are made to nursing for nutritional interventions. Per Crandall policy and procedures, all residents with pressure ulcers will be assessed at least monthly by the Dietary Manager and cosigned by the Consultant Dietitian. All residents with pressure ulcers are also	01-31-03

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F 361	Continued From page 30 5.. Resident CL-3 was an underweight, 80 year old male who had a number of heart related diseases, chronic obstructive pulmonary disease with recurrent pneumonia, and asthma. He did not receive the diet ordered by his physician. This 5 foot 5 inch male weighed only 117 pounds when he was admitted on 9/06/02. On 9/18/02 the physician requested in a Telephone order, that resident CL-3's diet be changed to what the registered dietician ordered: "Per RD - change diet to Fortified cardiac diet with Health Shakes at meals vs. milk." On 9/24/02, the physician acknowledged the resident 's 10 pound weight loss in 18 days and again ordered a "Fortified diet with assorted supplements BID" [supplements twice a day]. On 9/30/02, the registered dietician complained in her Nutritional Progress Notes that the resident "...has not received his 200 'Homemade Milkshake.' See recs [record entry] of 9/18/02. Record PO [food consumed by mouth] accurately. Wt 107#."	F 361	cont from page 30 reviewed at least once per month in the facility's weekly skin and weight meeting. Minutes will be kept by the Director of Nursing. The Dietary Manager is notified within 24 hrs by nursing when a physician orders a Dietary referral. The Dietary Manager has 3 days from the time of the order being written to complete an assessment. The Dietary Manager will be responsible for notifing the Consultant Dietitian for all tube feedings and any other assessments the Dietary Manager deems necessary. As part of our ongoing Quality Assurance program, skin and weight minutes will be reviewed monthly. Administrator will monitor.	
F 367 SS=G	483.35(e) DIETARY SERVICES Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, it was determined that 5 out of 18 sampled residents, one closed record and 28 out of 90 additional residents did not receive a therapeutic diet as ordered by the physician or assessed as being necessary by an interdisciplinary team. (Residents 2, 5, 7, 13, 15 and CR 3.)	F 367 see p. 38		

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F 367	Continued From page 31 Findings include: 1. In an interview with the dietary manager on 12/2/02 she stated that a new menu program had been started in November. A list of current diets for all the residents in the facility was obtained. Twenty-eight of the 90 residents in the facility were listed as being on a high protein/high calorie diet. An observation of two breakfast meals revealed the following menus: 12/3/02: Juice of the day Cereal of the day French toast Bacon 2% milk, coffee or tea 12/5/02: Juice of the day Cereal of the day Pancakes Sausage 2% milk, coffee or tea Observation of the dinner meal on 12/4/02 revealed the following menu: Hamburger or hot dog with a bun Tator tots Lettuce and onions Buttered mixed vegetables 2% milk Ice cream In an interview with a cook on 12/4/02 she stated that in an enriched diet or a high protein/high calorie diet	F 367		

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F 367	Continued From page 32 she would add extra gravy or extra butter to a meal for dinner or lunch and breakfast had a mixture of extra butter, sugar and milk added to the cereal. She stated that this was done on an individual basis. She stated that she knew there was a new menu but had no new information on the high protein/high calorie diet yet so she was still doing what she used to do. In an interview with the dietary manager on 12/4/02 she stated that the high protein/high calorie diet had not been started yet. The surveyor was provided a copy of the recommendations for the high protein/high calorie diet from the policy and procedure diet manual. The diet description documented that a high protein/high calorie diet was a "regular diet plus whole milk tid (three time a day), 2 eggs at breakfast, large meat at lunch and dinner..." The two breakfasts observed lacked the extra eggs and whole milk and the dinner observed lacked the extra portions of meat and the whole milk. This would cause the meals to be lacking in the extra calories and protein recommended. 2. Resident 7 was readmitted to the facility on 1/10/01 with the diagnoses of cerebral vascular accident, congestive heart failure, hypertension, chronic ischemic heart disease, osteoporosis, chronic insomnia, coronary artery disease, aphasia, right hemiparesis, seizures and dementia with anxiety and depressive features. On 12/3/02 resident 7's medical record was reviewed. On 10/24/02, a physician's order documented, "[increased] cal (calories) [increased] protein TAT (texture as tolerated) mech (mechanical) soft. pt (patient) has -7 lb (pound) wt (weight) loss- pt (patient) refuses to eat. Refer RD (registered dietitian)." An additional physician's order, dated	F 367		

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F 367	Continued From page 33 10/24/02, documented, "Med pass 6 oz (ounces) QID (four times a day) [with] snacks QD (every day)." Review of resident 7's diet card on 12/3/02 revealed she was on a high calorie, high protein mechanical soft diet with ground meat and she was to have 8 ounces of 2% milk with each meal. On 12/3/02 resident 7's breakfast and lunch were observed. For breakfast resident 7 was served a bowl of hot cereal, 1 piece of french toast with butter and syrup, 1 slice of an orange, 180 cc of orange juice and 180cc of 2% milk. Resident 7 was observed to eat 1 bite of the french toast, while she was drinking her 2% milk the nurse came in at 8:08 AM and took her milk away stating "I'm going to get you something else to drink." At 8:09 AM the nurse was observed to return with approximately 4 ounces of resident 7 2.0 med pass. Resident 7 was observed to drink 100% of the 4 ounces of 2.0 med pass. The nurse did not return to offer her the other 2 ounces of her 2.0 med pass that was ordered for resident 7 nor did the nurse return to offer resident 7 the 2% milk she had taken from resident 7. For lunch resident 7 was served a scoop of chicken, a bowl of beans, a dinner doll, a bowl of zucchini, a bowl of green pear jello and 180 cc of juice. Resident 7 was observed only to drink 100% of the juice. Resident 7 was not served the 2% milk. On 12/4/02 resident 7's breakfast and dinner were observed. For breakfast resident 7 was served 1 poached egg, 1 piece of toast with butter, 2 slices of peaches, 180 cc of orange juice and 180 cc of 2% milk. Resident 7 was observed to drink 100% of her 2% milk. For dinner resident 7 was served a ground hot dog on a bun, tatar tots, onions, ketchup, a bowl of mixed vegetables, ice cream with syrup, 180 cc of 2% milk and 180 cc of water. Resident 7 was	F 367		

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F 367	Continued From page 34 observed to eat 50% of the ice cream with syrup and 100% of her 2% milk. On 12/5/02 resident 7's breakfast was observed. For breakfast resident 7 was served a scoop of corned beef hash, a bowl of hot cereal, 1 pancake, 1 orange slice, 180 cc of 2% milk and 180 cc of apple juice. Resident 7 was observed to eat a few bites of the hot cereal and 100% of the 2% milk. At 9:05 AM the CNA (certified nursing assistant) brought resident 7 out to the nursing desk and asked the nurse to give resident 7 some med pass. Resident 7 was observed from 9:05 AM until 9:25 AM. The nurse gave resident 7 her medications but no med pass was observed as being given during this time. At 9:25 AM the CNA asked the nurse if she gave the med pass and the nurse replied "yes". 3. Resident 13 was readmitted to the facility on 9/19/01 with the diagnoses of dementia in Alzheimer with depressive features, urinary retention, constipation, hip fracture, atrial fibrillation, benign prostatic hypertrophy and total hip arthroplasty. On 10/8/02, a physician's order documented, "Diet clarification hi (high) pro (protein) hi (high) cal (calorie) large portion TAT (texture as tolerated) mech (mechanical) soft...D/C (discontinue) resourse give med pass 2oz (ounces) QID (four times a day)..." Review of resident 13's diet card on 12/4/02 revealed he was on a high calorie high protein, large portions, mechanical soft, ground meat diet with 2.0 med pass 2 ounces four times a day. The diet card also stated that resident 13 disliked eggs. On 12/4/02 resident 13's dinner was observed. For dinner resident 13 was served one ground hot dog on a bun, tatar tots, onions, ketchup, a bowl of mixed	F 367		

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F 367	Continued From page 35 vegetables, ice cream with syrup, 240 cc of hot chocolate and 180 cc of 2% milk. On 12/5/02 resident 13's breakfast was observed. For breakfast resident 13 was served 1 pancake, 1 scoop of corned beef hash, 1 orange slice, 1 bowl of hot cereal 180 cc of 2% milk and 180 cc of apple juice. According to the dietary policy and procedures, which became effective at the facility on 11/15/02, a high calorie high protein diet consists of a regular diet with whole milk three times a day, 2 eggs at breakfast, large meat at lunch and dinner. Add special nutritional program. During the observations of resident 13's meals he was not observed to receive larger portions. 4. Resident 2 was admitted to the facility on 10/5/02, with the diagnoses of Fx (fractured) neck of femur, hypertension, brief depressive reaction, glaucoma, and joint pain-pelvis. On 12/3/02, resident 2's medical record was reviewed.f On 10/16/02, a Physician's Telephone Order documented for resident 2, to have a diet change to "NAS (no added salt), [increased] cal (calorie) [increased] pro (protein) TAT (texture as tolerated) [(regular)]." Observation of resident 2 from 12/2/02 to 12/5/02 reveled that she received a regular meal with whole milk. Observation of resident 2 from 12/2/02 to 12/5/02 revealed that she ate 60-80% at her meals. 5. Resident 5 was admitted to the facility on 5/09/00 with the diagnoses of hiatal hernia, dysphagia,	F 367		

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F 367	Continued From page 36	F 367		

hypertension, gastro-esophageal reflex disease, nausea and vomiting, dehydration, congestive heart failure, and depressive features.

Resident 5's medical record was reviewed on 12/2/02.

A physician's order dated 10/8/02 documented, "PT is on hospice. PT refuse wt expected wt loss, skin breakdown 0 labs 0 Xray. She eats 56% Rec (recreation) feedings. DC (discontinue) resource and [increase] calorie and [increase] protein TAT Reg Med pass 2.0 QID 2 oz (ounces)."

A physician's order dated on 11/7/02 documented, " [change] med pass to 4 ounces QID to help slow down wt loss."

A physician's order dated 11/19/02 documented, "[increase] med pass to 6 oz Qid due to weight loss. Refer to RD (registered dietitian)."

Resident 5's meal ticket was observed on 12/3/02 at 11:45 AM. The meal ticket on resident 5 tray stated that resident 5 was to receive a increase calorie and protein diet and 8 ounces of whole milk.

Resident 5's breakfast was observed on 12/3/02 at 7:30 AM. Resident 5 was given 2 pieces of french toast, a piece of bacon, a bowl of cold cereal, 8 ounces of juice, 8 ounces of milk and a orange slice." Resident 5 was observed to have eaten 1 piece of her french toast, few bites of the cold cereal, her orange slice and all of her juice. Resident 5 's bowl of cereal was not fortified nor was the meal any different than a regular meal.

Resident 5's lunch was observed on 12/3/02 at 11:45 AM. Resident 5 was given a scoop of corn, one piece of chicken, a watermelon slice, a scoop of beans, a

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	465137	A. BUILDING ______ B. WING ______	12/5/02

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 367	Continued From page 37 roll, a bowl of pears, and 8 ounces of milk. Resident 5 was observed to have eaten all of her chicken, all of her pears and half of her roll. She did not consume her milk. Resident 5's meal had no higher calories or protein than another resident receiving a regular diet. Resident 5 was observed on 12/4/02 at 4:45 PM in her room drinking a blue cup filled with a supplement. Resident 5 was interviewed and she stated she only gets one cup of supplement. The nurse who administered the supplement to resident 5 was interviewed on 12/4/02 at 4:45 PM. The nurse stated that she only gave one glass of supplement. On 12/4/02 at 6:00 PM, two surveyors used one of the blue cups that the nurses were administrating the supplement in and measured how many ounces of fluid a blue cup could hold. One blue cup could hold only 4 ounces of supplement if filled to the very top. Resident 5 was observed eating her dinner on 12/4/02 at 6:00 PM. Resident 5 was served ice cream, hot dog with a bun, tator tots, vegetable mix and milk. Resident 5's meal had no higher calories or protein than another resident receiving a regular diet. 6. Resident 15 was re-admitted to the facility on 9/12/02 with the diagnoses of hypertension, senile dementia and glaucoma. Resident 15's medical record was reviewed on 12/4/02. A physician's order dated 10/15/02 documented, "[Increase] cal (calorie) [increase] protein TAT pureed add med pass 2.0 2 oz QID refer to RD. Gain	F 367 Acceptable BP	The facility will ensure that residents will be assessed for and will receive therapeutic diets as order by physician. The Dietary Manger held an inservice on 12-06-2002 with all dietary staff and reviewed the Special Nurtrition Program (SNP) which was instituted in place of all"high calorie, high protein" diet orders. It consist of 8 oz super cereal at breakfast, 4 oz high cal/pro pudding and 8 oz whole milk tid. It provides approximately 1000 calories and 40 gram of protein. All residents who have "high calorie, high protein" diet orders have had these orders clarified to "SNP" and their tray cards have been changed to reflect the super cereal, super pudding and whole milk tid. - Any resident who receive the "homemade milkshake" have had the orders written to change this supplement to SNP. Additional inservicing will done by the Consultant	01-31-03

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F 367	Continued From page 38 5 lbs" Resident 15's diet card was observed on 12/4/02 at approximately 5:45 PM. Resident 15 diet card documented that resident 15 was on a increase protein and calorie diet with 8 ounces of whole milk. Resident 15's dinner was observed on 12/4/02 at approximately 5:45 PM. Resident 15 received 8 ounces of milk, 8 ounces of water, a hot dog, a serving of vegetable mix, tator tots and a bowl of ice cream. Resident 15's meal had no higher calories or protein than another resident receiving a regular diet. 7. Resident CL-3 was an underweight, 80 year old male who had a number of heart related diseases, chronic obstructive pulmonary disease with recurrent pneumonia, and asthma. He did not receive the diet ordered by his physician. This 5 foot 5 inch male weighed only 117 pounds when he was admitted on 9/06/02. On 9/18/02 the physician requested in a Telephone order, that resident CL-3's diet be changed to what the registered dietician ordered: "Per RD - change diet to Fortified cardiac diet with Health Shakes at meals vs. milk." On 9/24/02, the physician acknowledged the resident 's 10 pound weight loss in 18 days and again ordered a "Fortified diet with assorted supplements BID" [supplements twice a day]. On 9/30/02, the registered dietician complained in her Nutritional Progress Notes that the resident "...has not received his 200 'Homemade Milkshake.' See recs [record entry] of 9/18/02. Record PO [food consumed by mouth] accurately. Wt 107#."	F 367	cont page 38 Dietitian with nursing staff and dietary staff on 01-24-03 to review Special Nutrition Program and large portions. As follow up to these inservices the Dietary Manager will audit 1 meal each day (5 days per wk) for 3 weeks to ensure that the dietary staff is adhering to the therapeutic diet orders. As ongoing quality assurance, the trayline will be audited by the Dietary Manager 3 meals per week to ensure accuracy. The Consultant Dietitian will also review trayline accuracy during her monthly visit and will review her findings with the Dietary Manager and Admin during exit interviews. The Dietary Manager is responsible to perform the audits and will review with Administrator on weekly basis. The Director of Nursing will inservice nursing staff on the necessity for measuring and administration of Med pass 2.0 per physicianorders. Inservice will be conducted by 01-16-03. Director of Nursing will monitor weekly to ensure accuracy.	

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F 368	Continued From page 39	F 368		
F 368 SS=E	483.35(f)(1)-(3) DIETARY SERVICES Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on comments in a confidential group meeting from 8 of 8 alert and oriented residents, it was determined that the facility did not offer every resident a bedtime snack daily. Findings include: During a confidential resident group meeting, held 12/3/02 at 10:30 AM, 8 of 8 participating residents stated that they were not offered a bedtime snack daily. One of the residents stated, "They have them, but they are placed in the activity room and we have to go and get them if we want them".	F 368 Acceptable BB	The facility will ensure thatall residents are offered a bedtime snack. A dietary inservice will be held on 01-10-03 with all dietary staff and will be conducted by the Dietary Manager. Inservice will be regarding the constitution and preparation of nutritionally appropriate bedtime snacks. All residents are offered a bedtime snack which includes a variety of appropriate nutritional bedtime snacks. Every resident will be offered a bedtime snack by nursing. Staff Developer will inservice nursing staff that all residents are to offered a bedtime snack. Inservice will be conducted by 01-10-03. Staff Developer will monitor/audit twice weekly for 3 weeks to ensure that snacks are being offered and random checks to ensure nursing is adhering to requirement. Administrator will monitor	01-10-03
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions.	F 371	As part of the monthly visit the Consultant Dietitian reviews the ADL records to ensure it is being recorded if residents are accepting or refusing HS snacks. Information will be reviewed monthly with Administrator	

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F 371	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on observations in 1 of 1 kitchens, it was determined that the facility did not store, serve and distribute food under sanitary conditions as evidenced by a dietary staff member observed to cross contaminate between the dirty and clean side of the dish room. Findings include: During the initial inspection of the kitchen on 12/02/02 a dietary employee was observed to place dirty plates and utensils into the dish machine. The dietary aide was observed to be wearing gloves. After the pans and utensils were washed, the dietary employee was observed to take the clean items and put them away without having changed her gloves or washing her hands between handling dirty and clean dishes.	F 371 Acceptable BB	The facility will ensure that proper procedures for handling of dirty and clean dishes to avoid cross contamination. A mandatory dietary inservice was conducted on 12-06-02 by the Dietary Manager. The inservice reviewed for following items: Proper procedures for cleansing hands when moving between the dirty and clean areas of the dish room. The Consultant Dietitian performs a sanitation check in the kitchen at least monthly Part of the sanitation check involves monitoring staff as they clean their hands when moving between the dirty and clean sides of the dish room. This audit will be reviewed with Administrator and Dietary Manager monthly at exit interview. The Dietary Manager is responsible to-ensure that the dietary staff follow proper procedure on hand washing.	12-06-02
F 426 SS=D	483.60(a) PHARMACY SERVICES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility nurse did not ensure that medications were being given according to standards of practice to meet the needs for 1 of 18 sampled residents. (Resident 13.) Findings include:	F 426 see p. 42		

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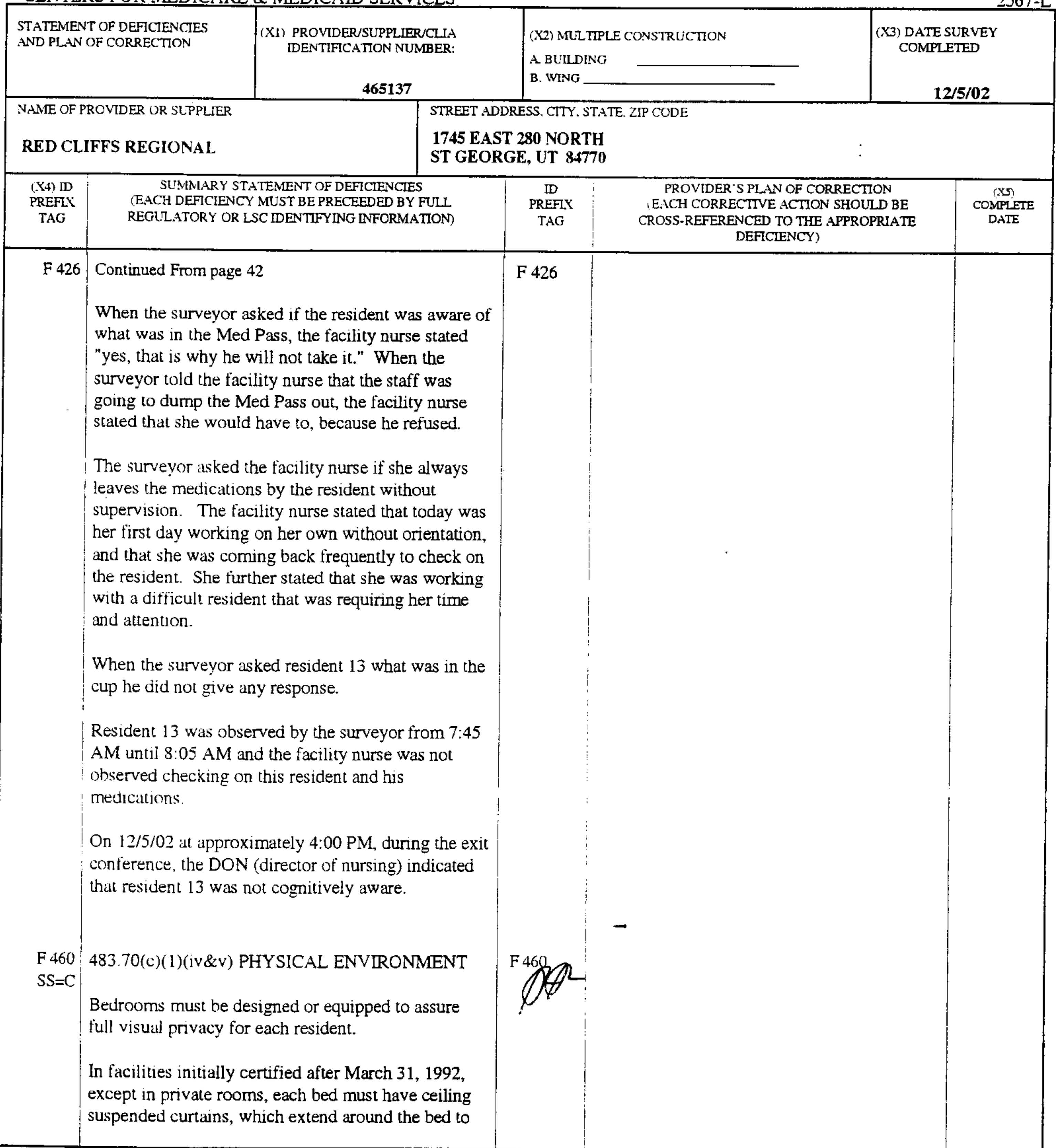
F 426	Continued From page 41 Resident 13 was readmitted to the facility on 9/19/01 with the diagnoses of dementia in Alzheimer with depressive features, urinary retention, constipation, hip fracture, atrial fibrillation, benign prostatic hypertrophy and total hip arthroplasty. Resident 13's active medical record was reviewed on 12/4/02. The medical record contained an annual MDS (minimum data set) dated 11/21/02. Under section B4, Cognitive Skills for Daily Decision Making, resident 13 was scored at a 3, severely impaired (never/rarely made decisions). Observation on 12/5/02 from 7:45 AM to 8:05 AM, resident 13 was in the dining room with his breakfast tray infront of him. He had a cup of Med Pass with small colored particles in it. At 8:05 AM the surveyor asked the ADON (assistant director of nursing) what was in the Med Pass, and the ADON stated that she did not know. The ADON then asked the aide next to her if she was aware what was in the Med Pass, the aide stated that she did not know. The ADON and aide were going to dump out the Med Pass. The surveyor then asked to see the cup of Med Pass and took it to resident 13's nurse. The surveyor asked the facility nurse what was in the Med Pass. The facility's nurse stated that she put resident 13's medications in the Med Pass because he would not take his medications. The facility nurse gave the surveyor a list of medications that were in the Med Pass. The medications included: Pepcid 20mg. (milligrams), norvasc 2.5mg, iron 325mg, multivitamin, digoxin .25mg, and risperdal .5mg.	F 426 Acceptable RB	The facility will ensure accurate acquiring, receiving, dispensing and administering of drugs and biologicals. The nurses will ensure that residents take all their medication and will remain with resident until administration of medication is completed. Director of Nursing will inservice nursing staff regarding protocol for proper administration of drugs and biologicals. Inservice will be conducted on 01-16-03. Random audits will be done by Director of Nursing to ensure accuracy of administration. As part of our ongoing Quality Assurance, audits will be reviewed monthly.	01-16-03



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F 426	Continued From page 42 When the surveyor asked if the resident was aware of what was in the Med Pass, the facility nurse stated "yes, that is why he will not take it." When the surveyor told the facility nurse that the staff was going to dump the Med Pass out, the facility nurse stated that she would have to, because he refused. The surveyor asked the facility nurse if she always leaves the medications by the resident without supervision. The facility nurse stated that today was her first day working on her own without orientation, and that she was coming back frequently to check on the resident. She further stated that she was working with a difficult resident that was requiring her time and attention. When the surveyor asked resident 13 what was in the cup he did not give any response. Resident 13 was observed by the surveyor from 7:45 AM until 8:05 AM and the facility nurse was not observed checking on this resident and his medications. On 12/5/02 at approximately 4:00 PM, during the exit conference, the DON (director of nursing) indicated that resident 13 was not cognitively aware.	F 426		
F 460 SS=C	483.70(c)(1)(iv&v) PHYSICAL ENVIRONMENT Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to	F 460		

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F 460	Continued From page 43 provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation the facility did not have resident rooms equipped to assure full visual privacy for each resident with curtains suspended from the ceiling which extended around the bed to provide total visual privacy in combination with adjacent walls and blinds by: Thirty eight of sixty four resident rooms did not have curtains that provided residents with full visual privacy. (Rooms 100, 101, 102, 103, 107, 108, 113, 112, 111, 202, 204, 206, 207, 208, 210, 211, 214, 216, 301, 303, 401, 402, 403, 404, 405, 407, 408, 410, 411, 412, 413, 414, 415, 417, 420 and 422.) Findings include: Observations of residents' rooms from 12/2/02 to 12/5/02, revealed the following in relation to privacy curtains. Room 100: Bed B, by the window, was approximately 36 inches short. Room 101: Bed B, by the window, was approximately 36 inches short. Room 102: Bed B, by the window, was approximately 6 inches short. Room 103: Bed B, by the window, was approximately 48 inches short. Room 107: Bed B, by the window, was approximately 36 inches short. Room 108: Bed B, by the window, was approximately 36 inches short. Room 111: Bed B, by the window, was approximately 36 inches short. Room 112: Private room, the curtain was approximately 24 inches short.	F 460		

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F 460	Continued From page 44 Room 113: Private room, the curtain got caught, and was approximately 36 inches short. Room 202: Bed B, by the window, was approximately 24 inches short. Room 204: Bed B, by the window, was approximately 30 inches short. Room 206: Bed B, by the window, was approximately 30 inches short. Room 207: Bed B, by the window, was approximately 30 inches short. Room 208: Bed B, by the window, was approximately 30 inches short. Room 210: Bed B, by the window, was approximately 30 inches short. Room 211: Bed B, by the window, was approximately 48 inches short. Room 214: There were no curtains in the room. Room 216: Bed B, by the window, was approximately 24 inches short. Room 301: Bed B, by the window, was approximately 12 inches short. Room 303: Bed B, by the window, was approximately 30 inches short. Room 401: Bed B, by the window, was approximately 12 inches short. Room 402: Had broken blinds on the window. Room 403: Bed B, by the window, was approximately 12 inches short. Room 404: Bed B, by the window, was approximately 42 inches short. Room 405: Bed B, by the window, was approximately 24 inches short. Room 407: Bed B, by the window, was approximately 6 inches short. Room 408: Bed B, by the window, was approximately 36 inches short. Room 410: Bed B had broken curtains and there were broken blinds on the window. Room 411: Bed B, by the window, was	F 460	The facility will ensure that resident rooms are equipped to provide full visual privacy Maintenance will evaluate rooms 100 - 422 and ensure all privacy curtins fit appropriately to ensure visual privacy. All privacy curtins will be marked to identify correct size of curtin. Monthly Quality Assurance Audits will be conducted by Maintenance to ensure privacy curtins are appropriately hung to ensure full privacy. Audits will be reviewed with Administrator monthly.	01-31-03

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F 460	Continued From page 45 approximately 36 inches short. Room 412: Bed B, by the window, was approximately 12 inches short. Room 413: Bed B, by the window, was approximately 36 inches short. Room 414: Bed B, by the window, was approximately 12 inches short. Room 415: Bed B, by the window, was approximately 18 inches short. Room 417: Bed B, by the window, was approximately 12 inches short. Room 420: Bed B, by the window, was approximately 36 to 48 inches short. Room 422: Bed B, by the window, was approximately 48 to 60 inches short.	F 460		