DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 8/9/01
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. BUILDING _____ B. WING _____	7/25/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST LAKE CARE CENTER	1001 N 500 W PROVO, UT 84601

(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 241 SS=E	483.15(a) QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on a confidential group interview with residents and a review of resident council minutes, it was determined that the facility did not ensure that cares were provided to residents in a manner and in an environment that maintained or enhanced each resident's dignity. Specifically, residents reported that call lights were not answered in a timely manner. Findings include: A confidential group interview was held with residents on 7/18/01 at 1:30 PM. Fifteen (15) residents participated in the interview. Twelve (12) of the 15 residents stated they have had to wait too long to have their call lights answered by facility staff. Eleven (11) of the 15 residents stated they have night time (after 10:00 PM) was when it took staff longest to answer the call lights. Seven (7) of the 15 residents stated that change of shift was when it took staff longest to answer the call lights. Seven (7) of the 15 residents stated that staff have turned the call lights off without asking the resident what service was needed. Ten (10) of the 15 residents stated that staff have responded to the call light and have said they would return in a few minutes, but did not come back. Eight (8) of the 15 residents stated that staff have taken so long to answer the call light that they forgot what they called for. Six (6) of the 15 residents stated they had felt uncomfortable	F 241 OK E tag POC acceptable 8/22/01 (Buenka RN	F241 1. No specific residents were identified, so this plan of correction will be for all current residents and those to be admitted. 2. Resident Council will provide an inservice to staff on 8-15-01 regarding the patient impact of slow response time to call lights. 3. Resident council will be involved in timing of call light response and will provide feed back to staff on a monthly basis. Emphasis will be to keep response time to a minimum. 4. Administrator and DON will work directly with resident council and staff to correct the problem. QA will discuss response times each month and assess outcome. 5. Inservice as to importance of call lights being answered within acceptable time limit of 3 to 5 minutes on 8-15-01. Will be monitored by DON & administrator monthly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Craig Johnson — TITLE: Administrator — (X6) DATE: 8/16/01

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 informati 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 241	Continued From page 1 remaining in the same position for extended periods of time while waiting for staff to respond to their call light. Residents stated that 20 to 30 minutes was frequently the amount of time they have had to wait to have their call light answered. Some of the residents expressed they have had to wait longer than one hour. A review of resident council minutes, from January through July 2001, was done. The following was documented: a. February 5, 2001 - "...Other residents still feel there is a lot of waiting when call lights are on. Residents feel they must always show a great deal of patience...." b. March 5, 2001 - "...Several women on south agreed that the men get their call lights answered first and the women end up waiting...." c. May 7, 2001 - "Resident 34 always has to wait too long to get any help when she needs to go to the	F 241		
	d. June 4, 2001 - "Aides are very slow getting to rooms on the 200 hall and where the call lights are split. Aides are stating that if it doesn't ring at their nurse's station, they are not responsible...." e. July 2, 2001 - "...Residents are very worried about having no help available when needed...."		F314	
F 314 SS=G	483.25(c) QUALITY OF CARE Based on the comprehensive assessment of a	F 314	1. Resident 2's coccyx wound is now healed. Patient has been placed on the following preventative measures due to high risk for breakdown: Turning &	

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	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 observations, interviews and record review, it was determined that for 1 of 17 sampled residents, the facility did not ensure that a resident with a pressure sore received the treatment necessary to promote healing. Specifically, resident 2 had a documented stage II pressure sore to his right buttock/coccyx on 7/6/01. Facility staff failed to implement treatment to the pressure sore until 7/17/01. Findings include: Resident 2 was admitted to the facility on 7/5/01, with diagnoses including a right hip fracture, prostate		repositioning q 2 hours, air mattress to bed for pressure relief, protective heel boots, dietary suppliment TID for increased protein for healing. NIT meeting held on 7-31-01 regarding pt's low dietary intake and desire for no additional enteral feedings. Advanced Behavioral Care was consulted regarding pt's depressive features as manifested by low dietary intake and loss of desire to eat. 2. Facility will implement skin care protocol on all residents, both current and future. All data collected during assessment will be shared & discussed in initial IDT and planned for preventative wound care or healing process for current wounds. Wounds identified upon admission will have tx initiated upon MD contact. All wounds will be considered urgent in nature and	
	On 7/18/01 at 10:30 AM, an observation of resident 2's skin condition was made. The observation was made in the presence of the resident's nurse. Resident 2 had a Duoderm dressing to his coccyx. The nurse removed the dressing. The resident had a sore on his right buttock. The nurse stated the sore was a stage II pressure sore and approximated the sore to be 1 centimeter (cm) x 1.5 cm. An interview with resident 2's nurse was held on 7/18/01 at 10:30 AM. The nurse stated she was going to obtain orders to discontinue the Duoderm to		3. Facility trained nursing personnel on 8-2-01 regarding skin care protocol. Emphasis placed on complete skin check upon admit and weekly with weekly skin assessment. All wounds will have MD notification for tx and follow through when noted. Preventative measures will be implemented on all high risk patients to avoid possible wound development.	

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F 314	Continued From page 3 the resident's buttocks, as she felt the Duoderm was not appropriate for the sore. This nurse was interviewed again on 7/25/01 at 2:15 PM. The nurse stated that on 7/15/01, she documented, on a nursing note, that resident 2 had an open sore on his coccyx. She stated she also documented the presence of the pressure sore on the physician's call list. The nurse described the physician's call list as a note about resident conditions that were not urgent in nature. She stated that if a need to call the physician did occur, information on the physician's call list would be given at that time. The nurse stated that she did not call resident 2's physician to obtain an order to treat the resident's pressure sore. An interview with a different nurse was held on 7/25/01 at 10:40 AM. This nurse stated she was familiar with resident 2's care needs and that she had been the resident's nurse a few days. This nurse reviewed resident 2's treatment record and physician orders with the surveyor. The nurse stated that the was dated 7/17/01. The nurse stated she did not recall when resident 2 developed the pressure sore on his buttock. A review of nursing notes, between 7/5/01 and 7/24/01, was done. Nursing staff documented the resident's pressure sore to his coccyx as follows: a. 7/6/01 - Sore on coccyx, dressed and dry, b. 7/8/01 - Skin fragile mild DQ (decubitus ulcer/pressure sore) on right buttock, c. 7/14/01 - Coccyx sore,	F 314	Dietary and nursing will discuss all high risk patients at least monthly during NIT meetings to implement nutritional measures for wound healing and / or prevention. QA nurse will review all weekly assessments to assure accuracy and follow through. Findings to be discussed each month in QA meeting. 4. Monitoring to be done by QA nurse and DON at least a weekly basis and prn to assure procedure is being followed. 5. Protocol was inserviced 8-2-01 and initiated immediately. Completion Date: August 2, 2001	

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F 314	Continued From page 4 d. 7/15/01 - Small open sore on coccyx noted on MD (physician) list for treatment, e. 7/17/01 - Order to apply Duoderm to the resident's coccyx, f. 7/18/01 - The nurse documented the pressure sore on the coccyx as being 1 x 1 cm. Physician notified for different treatment due to Duoderm smashed and not covering the stage II on left buttock/coccyx. g. 7/19/01 - Eggcrate mattress, all treatments done per orders, h. 7/20/01 - coccyx 1 x 1 cm, eggcrate mattress to bed, i. 7/21/01 - changed dressing on DQ, coccyx healing well On 7/5/01, facility staff completed a "Resident Assessment Data Collection Form". Per sores on that date. Facility staff completed two "Weekly Skin Assessment Forms" for resident 2; one on 7/16/01 and the other on 7/23/01. On 7/16/01, there was no documentation that the resident had a pressure sore on his buttock. On 7/23/01, nursing staff documented the resident had a small sore on his right buttock which was being treated with Silvadene and Telfa. A review of Minimum Data Set (MDS) assessments for resident 2 was done. Facility staff completed an MDS for resident 2 on 7/9/01 and 7/18/01. On both assessments, facility staff assessed resident 2 as	F 314		

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F 314	Continued From page 5 having a stage II pressure sore. Facility staff also documented on both MDS assessments that the resident was receiving ulcer care. A review of resident 2's care plan was done. Per documentation, on 7/9/01, facility staff implemented a "Skin Integrity Care Plan". The resident was assessed as having a stage II pressure sore to his left buttock. (Nursing notes and observation identified a pressure sore to the resident's right buttock.) One of the approaches for this identified problem was to notify the physician if the wound did not respond to the current treatment. A review of physician orders for resident 2 was done. On 7/17/01, a physician's telephone order was obtained to apply Duoderm to the resident's coccyx for skin breakdown. On 7/18/01, a physician's telephone order was obtained to change the Duoderm treatment to Silvadene and Telfa. Prior to 7/17/01, there were no physician ordered treatments for the pressure sore to resident 2's right buttock.	F 314		
	7/3/01 and 7/24/01, was done. Nursing staff documented pressure sore treatments on the treatment records. Per documentation, a Duoderm dressing was applied to resident 2's coccyx on 7/17/01. On 7/18/01, nursing staff began documenting that Silvadene and Telfa were being applied to the stage II pressure sore on resident 2's buttock. There was no documentation of any treatment to resident 2's pressure sore prior to 7/17/01.		F325 1. Resident 11 has been assessed for possible enteral feeding to avoid further wt. loss. Family meeting revealed their request to have no such treatment initiated. Resident 11 is being served in assisted dining with total staff assistance	
F 325 SS=G	483.25(i)(1) QUALITY OF CARE	F 325		

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	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 observation, interviews with facility staff and record review, it was determined the facility did not ensure that 1 of 17 sampled residents maintained acceptable parameters of nutrition. Resident 11 experienced significant a 14.6 pound, or an 11.5 percent weight loss in less than 30 days and a 26.7 pound, or a 19 percent weight loss in three months. Findings include: Resident 11 was admitted to the facility on 3/4/01, with diagnoses of pneumonia, hypertension, cardiac arrhythmia, Parkinson disease, history of gastrointestinal bleeding from peptic ulcer disease, and senile dementia.		to assure dietary intake. Supplements are also being offered to provide additional caloric intake. Resident 11 has since survey gained 2# and is on weekly weights. MD is aware of current status and plan of approach. 2. Facility will implement the risk management protocol for weight loss issues and wound healing. This protocol is for all residents, both current and future, with special emphasis on high risk patients. All data collected will be shared and discussed during initial IDT and planned for intervention to avoid further decline. All residents will be re-assessed quarterly and prn condition change that may cause a wt. loss concern. 3. Facility held inservice on 8-2-01 regarding protocol emphasis on MD notification of wt. loss and interventions required to avoid further loss of weight	
	order for a mechanical soft diet. Facility staff completed a malnutrition/dehydration/pressure sore assessment for resident 11 on 3/4/01. Per documentation, the resident was at high nutritional risk, with a score of 11. A second assessment, dated 6/1/01, also documented the resident was at high nutritional risk, with a score of 10. The assessment indicated high nutritional risk if the residents' score was 10 or higher. On 3/5/01, the facility's dietary manager completed a		4. DON and QA nurse to monitor wts. and meet monthly in NIT with dietary to discuss loss issues. 5. Plan was implemented 8-2-01.	

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F 325	Continued From page 7 nutritional assessment of resident 11. This assessment was co-signed by the facility's consultant dietitian. Per the nutritional assessment, resident 11 weighed 136.8 pounds on admission (3/4/01) and his ideal body weight was 157 to 163 pounds. The resident's estimated height was 5 foot 10 inches. The following was documented in the nutritional assessment: "Intake fair, but need to encourage fluids at times. Intake should meet needs. Will need to monitor however-as weight is <IBW [below ideal body weight] according to EST [estimated] HT [height]. May need to consider supplements. Pt [patient] at risk due to low body weight, senile dementia and HX [history] of GI [gastrointestinal] bleeding. Monitor weight and intakes. F/U [follow up] for recommendation of supplements if needed." On 6/1/01, the facility's dietary manager completed a quarterly nutritional reassessment for resident 11. This assessment was co-signed by the facility's consultant dietitian on 6/3/01. The dietary manager documented that resident 11 was receiving a [illegible] supplements. Facility staff completed an admission Minimum Data Set (MDS) assessment for resident 11 on 3/8/01. Facility staff assessed the resident as being totally dependent on staff for eating, had no oral problems, weighed 137 pounds and was 5 foot 6 inches tall. Facility staff also assessed that resident 11 had not experienced any weight loss or gain in the past 30 to 180 days, had no special nutritional approaches and was on a mechanically altered diet. A quarterly MDS, dated 5/31/01, documented that resident 11 required limited assistance with eating,	F 325		

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F 325	Continued From page 8	F 325		

had no oral problems, height was 5 foot 6 inches, weighed 133 pounds, had not experienced any weight loss or gain in the past 30 to 180 days, and had no special nutritional approaches.

A nutritional care plan, dated 3/13/01, documented that resident 11 was at nutritional risk. The goal for this identified problem was to have no significant weight loss and that weight gain was acceptable. Approaches for this identified problem included monitoring weight and intake.

Facility staff documented the administration of nutritional supplements on the residents' medication administration record (MAR). A review of resident 11's MAR's and treatment records, from 3/1/01 through 7/16/01, was done. There were no nutritional supplements documented on these records.

The physician recertification orders for resident 11, dated June 2001, and signed by the physician on 6/26/01, documented that staff were to monitor resident 11's weight on a weekly basis.

A review of resident 11's weight record revealed the following:

a. March 2001
3/4/01 - 136.8
3/13/01 - 137.1
3/20/01 - 139.7
3/27/01 - 137.1

b. April 2001
4/3/01 - 139
4/10/01 - 133.1
4/17/01 - 132.4
4/24/01 - no weight documented

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F 325	Continued From page 9 c. May 2001 (Specific date not documented) Week 1 - 133.4 Week 2 - 132.3 Week 3 - no weight documented Week 4 - 131.9 Week 5 - 130.3 d. June 2001 6/5/01 - 128.8 6/12/01 - 126.9 6/19/01 - 121.1 6/26/01 - 115.7 e. July 2001 7/3/01 - 114.3 7/10/01 - 112.3 Per facility weight records, resident 11 experienced a 14.6 pound, or an 11.5 percent weight loss in less than 30 days; from 6/12/01 through 7/10/01. Additionally, between 4/3/01and 7/10/01, resident 11 experienced a 26.7 pound, or a 19 percent weight	F 325		
	A review of Nutritional Intervention Team meeting minutes was done. On 6/7/01, the Nutritional Intervention Team documented that resident 11 had experienced a 9 pound weight loss from 4/01 to 6/01. (Per weight record documentation, during this time, resident 11 experienced a 10.2 pound weight loss.) The team identified possible causes of the resident's weight loss to be, "progressive disease process: eats well however." The team recommended, "Already enriched diet and Nubasic will start on snacks." Resident 11's medical record contained no documentation to support that resident 11 was			

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F 325	Continued From page 10 receiving an enriched diet or nutritional supplements. During an interview with a facility staff nurse on 7/18/01 at 9:05 AM, she stated, that the weekly weights were documented on the residents treatment record by the nurses. If a resident was losing weight the physician and dietitian were notified. If a supplement was ordered by a physician, the supplement and the amount of supplement would be documented on the resident's treatment record. She stated that resident 11 did not have an order for supplements and that his diet was a regular mechanical soft. She stated that he was in the assisted dining room but usually only required set up and verbal cueing. Resident 11's medical record contained no documentation to indicate the resident's physician had been informed of the significant weight loss. Per documentation in the resident's medical record, the physician had not seen the resident since 3/12/01. Following 6/7/01, there were no dietary notes to document additional interventions to assist resident prevent a further decline in weight.	F 325		
F 328 SS=G	483.25(k) QUALITY OF CARE The facility must ensure that residents receive proper treatment and care for the following special services: Injections Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care;	F 328	F328 1. Resident 2 receives O2 therapy if saturation levels < 90%. O2 sats are checked prior to, during, and following therapy treatments to assure adequate oxygenation. Sats checked by therapy and / or nursing. O2 runs continuously at night for sleep apnea.	

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	Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined that for 1 of 17 sampled residents, the facility did not ensure that a resident with orders for oxygen therapy, received the proper treatment to maintain oxygen saturations greater than 90 percent. (Resident 2.) Findings include: Resident 2 was admitted to the facility on 7/5/01, with diagnoses including a right hip fracture, prostate cancer, coronary artery disease, chronic obstructive		2. Facility provided training through Advanced Life Support to all personnel regarding use of O2 and ventilation equipment. Reviewed respiratory system and importance of proper and adequate air flow and exchange. Training received on how to check sats level, apply O2, how to assess for O2 need and how to assess for adequacy. 3. Inservices were held 8-1 and 8-2-01 to all facility personnel. Sats to be documented on MARs and on PT notes during therapies. 4. DON, QA nurse, and therapy coordinator to monitor, and findings reviewed in QA meeting each month until is assured, and then quarterly. 5. Systems implemented for documentation and monitoring 8-15-01.	
	during sleep. Observations of resident 2 were made on 7/17/01. Resident 2 was in bed, lying on his back, and wearing oxygen at 2.5 liters per nasal cannula at the time of the observations. Resident 2 had his eyes closed. Between 10:21 AM and 10:26 AM, resident 2 had four episodes of apnea. The duration of apnea was 26, 28, 30, and 26 seconds, respectively. On 7/17/01 at 1:42 PM, resident 2 was observed lying in bed, on his back, and wearing oxygen at 2.5 liters per nasal cannula. His eyes were closed. Resident 2's			

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F 328	Continued From page 12 nurse entered the room. The surveyor requested the nurse monitor the resident's respirations prior to waking the resident. The resident was observed to have an episode of apnea. The nurse stated the apnea lasted 30 seconds. On 7/17/01 at 2:51 PM, resident 2 was observed to be returning from physical therapy in his wheelchair. He was being assisted by a physical therapy aide. Resident 2 was not using oxygen at that time. The surveyor requested that resident 2's nurse check the resident's oxygen saturations. The resident's oxygen saturations were 76 percent. At 2:54 PM, the nurse applied oxygen at 3 liters per nasal cannula to resident 2. At 3:33 PM, the surveyor requested the resident's oxygen saturations be checked again. At that time, the resident's oxygen saturations were 93 percent. On 7/17/01 at 3:00 PM, an interview was held with the physical therapist aide who had been assisting resident 2. The physical therapy aide stated he brought resident 2 to therapy at approximately 2:10	F 328		
	therapy. The physical therapy aide stated resident 2 did not do well in therapy, that the resident seemed to fatigue easily. On 7/17/01 at 2:51 PM, an interview was held with resident 2's nurse. She stated she had not been able to check resident 2's oxygen saturations that day because the facility's pulse oximeter was being used by other staff members. On 7/18/01 at 10:20 AM, an interview was held with a family member of resident 2. This family member stated she had been visiting the resident six days a week since his admission to the facility. The family			

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F 328	Continued From page 13 member stated she had observed the resident go to physical therapy on several occasions. She stated she had never observed the resident go to therapy with oxygen. She stated he always went without oxygen. A review of resident 2's medical record was done. On 7/5/01, resident 2 had a physician order to receive oxygen at 2 liters, per nasal cannula, to keep oxygen saturations greater than 90 percent. There were no other physician orders relating to the resident's oxygen use. A review of treatment records for resident 2 was done. Facility staff documented resident 2's oxygen saturations on the treatment record. The treatment record had an entry to document the resident's oxygen saturations at 10:00 AM and at 8:00 PM. Per documentation on the treatment record, resident 2's oxygen saturations on 7/17/01 were 94 percent at 10:00 AM, and 98 percent at 8:00 PM. (Per interview with resident 2's nurse on 7/17/01 at 2:51 PM, the resident's oxygen saturations had not been monitored that day.) A review of nursing notes for resident 2 was done. Per documentation on 7/17/01, resident 2's respiratory status was assessed as, "Sl [slight] congestion heard thru out to all fields - clears [with] purposeful cough/nicotine patch in place." There was no documentation that the resident had at least one episode of apnea which had been observed by the resident's nurse, nor was there documentation to describe when the resident's oxygen saturations decreased to 76 percent following physical therapy.	F 328		

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F 329 SS=K	483.25(l)(1) QUALITY OF CARE Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined that for 8 of 17 sampled residents plus 7 supplemental residents, the facility failed to ensure that laboratory services were available to residents whose medication regimen required laboratory monitoring for therapeutic effects. Specifically, 10 residents had orders and where scheduled to have PT/INR laboratory tests to monitor therapeutic levels of the medication, Coumadin. Four (4) residents had orders and were scheduled to have potassium or digoxin levels tested to monitor for therapeutic effects [illegible] have a complete metabolic panel (CMP) drawn to monitor possible adverse liver effects of the medication, Diflucan. One (1) resident had orders and was scheduled to have a Dilantin level drawn to monitor therapeutic levels of the medication, Dilantin. One (1) resident had orders and was scheduled to have Vancomycin peak and trough levels drawn to monitor for a therapeutic level and to prevent toxicity to the medication, Vancomycin. (Residents 1, 2, 3, 4, 5, 8, 10, 12, 13, 14, 15, 16, 17, 18, and 20.) Findings include:	F 329	F329 1. Letters were sent out to all attending physicians regarding the lack of lab services from 7-9 through 7-12. Letters were returned with the physician's signature stating that there was no harm done to the patient under their care during this time period due to labs not available or drawn during that time. All labs that were scheduled during the specified time frame were drawn and called into the physicians, and I.J. was removed on 7-18-01. 2. QA nurse will audit charts and lab slip copies to assure all labs are drawn as ordered. Records to be reviewed every pm for early am lab draws to be completed. 3. Monthly meetings are being held with the lab to address issues or concerns. Lab personnel held an inservice with the licensed staff on 7-[illegible] forms for lab pick-up. 4. QA nurse to report to DON weekly regarding all lab issues and findings. 5. System was put into place 8-1-01. This was presented to the QA committe 7/31/01	

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F 329	Continued From page 15 PROTIME/INTERNATIONAL NORMALIZED RATIO MONITORING: Coumadin is an oral anticoagulant used to control and prevent blood clotting disorders. Prescribing the dose that both avoids bleeding complications and achieves therapeutic range of clotting times requires monitoring through laboratory tests. The protime time (PT) is a laboratory test used for monitoring blood clotting time in a specific individual. (Reference Guidance: Brunner and Suddarth's textbook of Medical-Surgical Nursing, 8th edition, copyright 1996, Lippincott, pages 802-803.) The International Normalized Ratio (INR), another laboratory test, is used in conjunction with the protime in determining if therapeutic doses of anticoagulant medications are being administered. (Reference Guidance: Physicians' Desk Reference, 53rd edition, copyright 1999, Medical Economics Company, page 932.)	F 329		
	missed PT/INR laboratory tests were as follows: 1. Resident 2 was admitted to the facility on 7/5/01 with diagnoses that included right hip fracture, chronic obstructive pulmonary disease, sleep apnea, transient ischemic attacks, coronary artery disease and hypertension. A review of resident 2's medical record was done on 7/25/01. Upon admission to the facility, resident 61 had a physician order to receive Coumadin 2 to 13 mg, everyday. The specific dose of Coumadin was to be determined by the resident's PT/INR, which was to be checked on a daily basis for two weeks.		F329 continued The following identified residents have been discharged: 1, 3, 10, 13, 15, 16 Resident 2 had a protime of 19.7 on 7-6. Coumadin was discontinued and ASA started on 7-12-01. PT was drawn on 7-13-01, and level was 16.1 No problems were noted d/t lab missed. No order changes d/t missed lab.	

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F 329	Continued From page 16 A review resident 2's July 2001, medication administration record (MAR) was done. Per documentation, nursing staff administered the following doses of Coumadin to resident 2: a. 7/6/01 - No Coumadin documented as being administered, b. 7/7/01 - Coumadin 2 mg, c. 7/8/01 - No Coumadin was documented as being administered. Per documentation on the MAR, Coumadin was held due to the resident's PT being high at 21. d. 7/9/01, 7/10/01, 7/11/01 - No Coumadin was documented as being administered. Per documentation on the MAR, Coumadin was held due to no lab draw (PT/INR), waiting for the corporation to hire another lab. A review of nursing notes for resident 2 was done. Between 7/9/01 and 7/11/01 [illegible] was notified that the ordered PT/INR laboratory tests had not been completed. Additionally, there was no documentation that nursing staff consulted resident 2's physician prior to holding the Coumadin. Per documentation, on 7/12/01, resident 2's physician was contacted. At that time, the physician discontinued the Coumadin. A review of laboratory results for resident 2 was done. There were no PT/INR results on 7/7/01, 7/9/01, 7/10/01, and 7/11/01. On 7/6/01, resident 2's PT/INR were 19.7 and 2.5, respectively. On 7/8/01, resident 2's PT/INR were 21.4 and 3, respectively. (Per documentation, on 7/8/01, resident 2's Coumadin was	F 329		

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F 329	Continued From page 17 held on 7/8/01, secondary to an elevated PT/INR.) An interview was held with resident 2's nurse on 7/12/01, at 9:30 AM. This nurse stated that resident 2's Coumadin was being held because there were no laboratory services to draw the resident's PT/INR. This nurse stated that the resident's physician had not been notified that the Coumadin was being held or that the PT/INR laboratory tests had not been completed. 2. Resident 1 was admitted to the facility on 6/4/01 with diagnoses that included, coronary artery disease, congestive heart failure, dysrhythmia, coronary artery bypass surgery and mitral valve replacement. Review of resident 1's medical record, on 7/12/01, revealed that resident 1's admitting physician had ordered for resident 1 to receive Coumadin 3 mg, three times a week, and Coumadin 2.5 mg, four times a week. The admitting physician also ordered that a PT/INR laboratory test be done one time a month. attending physician changed the PT/INR laboratory test order to have the test done weekly. Further review of resident 1's medical record revealed that on 6/27/01, a PT was done on resident 1 and the results were recorded as high at 62.7 seconds. A nurse's note, dated 6/27/01 at 9:10 AM, documented that the nurse had contacted the laboratory regarding the PT results of 62.7 and lack of INR results. The note documented that the laboratory staff had told the nurse that when the PT result is "that high" the laboratory does not do the INR test. The note further stated that the nurse had called resident 1's attending physician to report the PT results. The note	F 329		

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F 329	Continued From page 18 documented that the attending physician's nurse practitioner had ordered the nurse to discontinue the medications, Coumadin, Vioxx, and vitamin E for resident 1. The physician's order section revealed an order dated 6/27/01at 12:10 PM, to give resident 1 vitamin K 10 mg (a medication to help the blood clot) now, due to the increased PT and to draw another PT/INR at 5:00 PM on 6/27/01. Per documentation in resident 1's medical record, there was no PT/INR results on 6/27/01 after 5:00 PM. On 6/28/01 at 12:28 PM, resident 1's PT had decreased to 17.3 seconds and the INR was 1.9 seconds. A physician's order, dated 7/3/01, documented that resident 1 was to have PT/INR laboratory test done every Monday and to resume giving resident 1 Coumadin 2 mg on 7/3/01 and then Coumadin 1 mg every day, thereafter. On 7/5/01, resident 1's physician changed the Coumadin order to Coumadin 2.5 mg every Friday and Coumadin 1 mg every day except Friday. Laboratory results revealed that there were no results for the PT/INR due to be done on 7/9/01. Resident 1 had a documented episode of a high protime resulting in resident 1 requiring the discontinuing of the blood thinning medication, Coumadin, and a medication to increase clotting time and prevent excessive bleeding. When the Coumadin and protime testing were resumed on resident 1, the resident received Coumadin as ordered from 7/3/01 through 7/13/01, 10 days. During that time, the PT/INR monitoring did not occur as ordered.	F 329		

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F 329	Continued From page 19 3. Resident 10 was admitted to the facility on 4/27/01 with diagnoses that included, cerebral vascular accident, pulmonary embolus (blood clot in the lung), hypertension, and encephalitis. Resident 10's medical record revealed the resident had a physician's orders for Coumadin 5 mg to be given on 7/3/01; Coumadin 3 mg every day from 7/4/01 through 7/6/01; and Coumadin 2.5 mg every day starting 7/8/01. Resident 10 also had a physician's order for PT/INR testing every week. Review of resident 10's medical record revealed that resident 10 had received Coumadin 5 mg on 7/3/01, Coumadin 3 mg 7/5/01 and Coumadin 2.5 mg every day from 7/8/01 through 7/16/01. Review of the laboratory section of resident 10's medical record revealed, PT/INR results for 6/27/01, 7/2/01, and 7/16/01. There was no result for the PT/INR, that was ordered to be done on 7/9/01.	F 329	F329 continued	
	accident, atrial fibrillation, hypertension and chronic obstructive pulmonary disease. Resident 5's medical record revealed that resident 5 had a physician's order to receive Coumadin 3 mg every day and for a PT/INR laboratory test to be done every Monday. Review of resident 5's medical record revealed that resident 5 had received the Coumadin 3 mg every day as ordered. The laboratory section revealed that there were results of PT/INR laboratory tests dated 7/2/01 and 7/13/01. No laboratory result of the weekly PT/INR due Monday 7/9/01 was found. Review of the nurse's notes in resident 5's record		which is one week (7 days) after was 20.9. Orders were to be drawn every week - this was completed as ordered PT redrawn 7-16 with level of 19.6, on 7-20 level of 14.7, and on 7-23 15.1. Dialantin level was drawn on 7-13 with a level of 12.0 (WNL) No problems noted or orders changed due to lab draws not available.	

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F 329	Continued From page 20 revealed a nurse's note, dated 7/11/01, which documented resident 5's physician had been informed by the nurse that the PT/INR, ordered to be drawn 7/9/01, had not been drawn due to the unavailability of laboratory services at the facility. 5. Resident 20 was admitted to the facility on 8/30/99 with diagnoses that included atrial fibrillation, and transient ischemic attack. Resident 20's medical record revealed that resident 20 had a physician order to receive Coumadin 5 mg every Monday and Friday and Coumadin 2.5 mg every Tuesday, Wednesday, Thursday, Saturday and Sunday. Resident 20 also had an order for PT/INR laboratory tests to be done every month, on the 9th of the month. Review of laboratory results section of resident 20's medical record revealed that the PT/INR, ordered to be completed 7/9/01, was not done. Review of the nurse's notes in resident 20's medical record revealed a nurse's note dated 7/12/01, which	F 329	F329 continued Resident 20 has protimes drawn monthly. The facility specified the date of the draw. The physician did not require a specific date, only that it be drawn every month. Protime was drawn 7-16 with a level of 19.4, and again on 8-10 with levels of 17.5 INR 2.0 There were no changes in orders or problems noted due to the changed date of the lab draw.	
	that the PT/INR was not done on 7/9/01, due to the facility not having laboratory services and that the facility corporation was looking for another laboratory service. 6. Resident 13 was admitted to the facility on 1/27/01, with diagnoses which included a cerebrovascular accident, atrial fibrillation, diabetes mellitus, and congestive heart failure. A review of resident 13's medical record was done on 7/19/01. On 3/8/01, a physician order was obtained to administer Coumadin 5 mg on Mondays and			

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F 329	Continued From page 21 Fridays, and Coumadin 2.5 mg on Sundays, Tuesdays, Wednesdays, Thursdays, and Saturdays. On 2/27/01, a physician order was obtained to complete a PT/INR every three weeks. Resident 13 was scheduled to have a PT/INR drawn on 7/12/01. A review of resident 13's July 2001, MAR was done. Per documentation, resident 13 received Coumadin in accordance with the 3/8/01, physician order. A review of resident 13's laboratory results was done on 7/19/01. There was no PT/INR laboratory test completed for resident 13 on 7/12/01, as ordered by the physician. 7. Resident 14 was admitted to the facility on 10/9/00, with diagnoses which included Alzheimer's disease, colostomy, and a knee replacement. A review of resident 14's medical record was done on 7/19/01. On 7/6/01, a physician order was obtained to administer Coumadin 4.5 mg on Thursdays and Saturdays, and Coumadin 5 mg on Sundays,	F 329	F329 continued Resident 14 had a protime check 7-16 with a level of 17.1INR 1.9. 7-16 PT wrote "since INR has been more that stable we will increase his time between PT checks to q 2 weeks" 7-23 PT 15.4 INR 1.5 8-2 PT 16.9 8-14 PT 19.6 No change in orders were needed or problems noted due to lab non availability.	
	7/6/01, a physician order was written to draw a PT/INR every week on Monday, with the next PT/INR due on 7/9/01. A review of resident 14's July 2001, MAR was done. Per documentation, resident 14 received Coumadin in accordance with the 7/6/01, physician order. A review of nursing notes for resident 14 was done. On 7/11/01, resident 14's physician was notified that the PT/INR, ordered to be drawn on 7/9/01, was not completed secondary to no laboratory services. A review of resident 14's laboratory results was done on 7/19/01. There was no PT/INR laboratory test			

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F 329	Continued From page 22 completed for resident 14 on 7/9/01, as ordered by the physician. 8. Resident 16 was readmitted to the facility on 7/6/01, with the diagnoses which included diabetes mellitus, coronary artery disease, degenerative joint disease, and hypertension. A review of resident 16's medical record was done on 7/19/01. On 7/6/01, a physician was obtained to administer Coumadin 2.5 mg everyday for two weeks. On 7/6/01, a physician order was written to draw a PT/INR every Monday, for two weeks. Per documentation on resident 16's July 2001 treatment record, the PT/INR was scheduled to be drawn on 7/9/01. A review of resident 16's July 2001, MAR was done. Per documentation, resident 16 received the Coumadin in accordance with the 7/6/01, physician's order. A review of nursing notes for resident 16 was done. On 7/12/01, resident 16's physician was notified that the ordered PT/INR had not been completed. A review of resident 16's laboratory results was done on 7/19/01. There was no PT/INR laboratory test completed for resident 16 on 7/9/01, as ordered by the physician. 9. Resident 17 was admitted to the facility on 12/1/96, with the diagnoses which included a cerebrovascular accident, hypertension, and depression.	F 329	F329 continued Resident 17 has draws every month. Physician states it does not require a specific date to be done, only that it be done on a monthly basis. Protime was drawn on 7-16 19.6 INR 2.5 No problems noted or orders changed.	

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F 329	Continued From page 23 A review of resident 17's medical record was done on 7/19/01. On 6/27/01, a physician order was obtained to administer Coumadin 7mg everyday. (The resident was previously on Coumadin 8 mg everyday.) On 6/27/01, a physician order was written to obtain a PT/INR in two weeks. Per documentation on resident 17's July 2001 treatment record, the PT/INR was to be drawn on 7/11/01. A review of resident 17's July 2001, MAR was done. Per documentation, resident 17 received the Coumadin in accordance with the 6/27/01, physician order. A review of nursing notes for resident 17 was done. On 7/11/01, a nurse documented that the PT/INR was not drawn secondary to no laboratory services. On 7/12/01, resident 17's physician was notified that the resident's PT/INR was not drawn as ordered. A review of resident 17's laboratory results was done on 7/19/01. There was no PT/INR laboratory test	F 329		
	the physician. 10. Resident 18 was admitted to the facility on 5/15/00, with the diagnoses which included a cerebrovascular accident, pneumonia, hypertension, and a urinary tract infection. A review of resident 18's medical record was done on 7/19/01. On 6/26/01, a physician order was obtained to administer Coumadin 2.5 mg everyday. (The resident was previously on Coumadin 2.5 mg everyday except Fridays, and Coumadin 5 mg every Friday.) On 6/26/01, a physician order was written to		F329 continued Resident 18 has lab draws every month with no specification of the actual date No new orders due to lab not drawn on specified date. Protime drawn on 7-16 13.8 No problems noted.	

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F 329	Continued From page 24	F 329		

obtain a PT/INR in two weeks. Per documentation on resident 18's July 2001 treatment record, the PT/INR was to be drawn on 7/10/01.

A review of resident 18's July 2001, MAR was done. Per documentation, resident 18 received the Coumadin in accordance with the 6/26/01, physician order.

A review nursing notes for resident 18 was done. On 7/12/01, resident 18's physician was notified that the PT/INR ordered to be drawn on 7/10/01, was not done.

A review of resident 18's laboratory results was done on 7/19/01. There was no PT/INR laboratory test completed for resident 18 on 7/10/01, as ordered by the physician.

POTASSIUM and DIGOXIN MONITORING

may be decreased by diuretic agents that often are used to treat congestive heart failure. A decrease in potassium causes cardiac irritability and predisposes the patient receiving digitalis preparation to digitalis toxicity and to the development of dysrhythmias. Elevated serum potassium has a myocardial [heart muscle] depressant effect and a ventricular irritability effect. Hypokalemia [low potassium level] and hyperkalemia [high potassium level each can lead to ventricular fibrillation and cardiac standstill." (Reference Guidance: Brunner and Suddarth's Textbook of Medical-Surgical Nursing, 8th edition, copyright 1996, Lippincott, page 606.)

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F 329	Continued From page 25 The "Nursing 2001 Drug Handbook, Spring house Corporation, copyright 2001, page 217, documents, "Digoxin ...Toxic effects on the heart may be life-threatening and require immediate attention...Monitor serum digoxin levels. Therapeutic levels range from 0.5 to 2 ng/ml...Monitor serum potassium levels carefully. Take corrective action before hypokalemia occur. Residents who were receiving potassium supplements, Lanoxin (a digitalis preparation), or non-potassium sparing diuretics and had missed potassium , or Digoxin level laboratory tests were as follows: 1. Resident 12 was admitted to the facility on 7/11/95 with diagnoses that included, congestive heart failure, chronic obstructive pulmonary disease and deafness. Resident 12's physician orders included an order for resident 12 to receive a potassium supplement 40 mEq (milliequivalent) four times a day and a potassium level laboratory test every two weeks. Per [illegible] on 7/11/01. Review of resident 12's medical record revealed that resident 12 had been receiving the potassium supplement four times a day. There was no potassium level result, dated 7/11/01, found in resident 12's medical record. 2. Resident 15 was admitted to the facility on 5/2/01 with diagnoses that included, pancreatitis, hypertension, and diabetes mellitus. Resident 15's physician's orders included an order, dated 6/25/01 for the resident to receive hydrochlorothiazide,	F 329	F329 continued Resident 12 had a K+ level drawn on 7-16. Results were 4.4 WNL K+ level 7-27 4.1 K+ level 8-10 4.5 Draws are to be done every two weeks. No order changes or problems noted due to lab date rescheduling.	

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F 329	Continued From page 26 HCTZ. The physician also ordered a basic metabolic panel (BMP) to be drawn on 7/9/01. HCTZ is a diuretic medication that can have the side effect of lowering potassium levels in the blood. A BMP laboratory tests contains the evaluation of serum potassium levels. Review of the physician orders for resident 15 revealed that resident 15 was not receiving a potassium supplement. Review of the laboratory section of resident 15's medical record revealed that there was no results for a BMP laboratory test, dated 7/9/01 Review of the nurse's note section revealed a nursing note, dated 7/12/01, which documented resident 15's attending physician was notified that the facility had not done the BMP laboratory test that was ordered to be done on 7/9/01 due to the fact the facility was in the process of finding a new laboratory service.	F 329		
	3. Resident 13 was admitted to the facility on 1/27/01, with diagnoses which included a cerebrovascular accident, atrial fibrilation, diabetes mellitus, and congestive heart failure. A review of resident 13's medical record was done on 7/19/01. On 5/8/01, a physician order was written to administer Potassium 20 mEq, four times a day. (This was an increase from the previous order of Potassium 20 mEq, three times a day.) On 4/23/01, a physician order was written to draw a Potassium level every two months. Per documentation on resident 13's July 2001 treatment record, the Potassium level was scheduled to be drawn on 7/12/01.			

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F 329	Continued From page 27 A review of resident 13's July 2001, MAR was done. Per documentation, resident 13 received the Potassium in accordance with the 5/8/01, physician order. A review of resident 13's nursing notes was done. On 7/12/01, resident 13's physician was notified that the resident's Potassium level was not drawn secondary to the facility not having laboratory services. A review resident 13's laboratory results was done on 7/19/01. There was no Potassium level completed for resident 13 on 7/12/01, as ordered by the physician. 4. Resident 8 was admitted to the facility on 10/27/00 with diagnoses that included atrial fibrillation, congestive heart failure and hypotension. Resident 8's physician's orders included that resident 8 was to receive Lanoxin 0.125 mg every day. (Lanoxin is a brand name of the medication Digoxin, this medication increases heart muscle contraction and	F 329	F329 continued Resident 8's physician orders dated 7-10 for lab draws do not specify a date the lab draw was to be done. Labs were drawn on 7-18 and all levels were within normal limits. No change in orders or problems noted.	
	Review of resident 8's medical record revealed a physician's order, dated 7/10/01, for laboratory tests of a BMP and a Digoxin level to be done. Per documentation on the facility's Laboratory Services Daily Worksheet, the BMP and Digoxin levels were scheduled to be drawn on 7/11/01. Review of the laboratory section of resident 8's medical record revealed that the BMP and Digoxin levels, ordered on 7/10/01, were not obtained until 7/18/01; eight days after they had been ordered by the resident's physician.			

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F 329	Continued From page 28 LIVER FUNCTION MONITORING Resident 3 was admitted to the facility on 4/10/01 with diagnoses that included chronic obstructive pulmonary disease, hypertension and breast cancer. Resident 3's physician's orders included, a complete metabolic panel (CMP) laboratory test every Monday for four weeks while the resident was receiving the intravenous medication, Diflucan. Diflucan is an antifungal medication that can harm the resident's liver. A CMP laboratory test includes liver enzyme values. Review of resident 3's medical record on 7/17/01 and again on 7/25/01, revealed the CMP laboratory test had been done on 7/4/01, 7/13/01 and 7/16/01. Resident 3's medical record contained no documentation that the CMP, ordered and scheduled to be drawn on 7/9/01, had been completed. Dilantin is a medication that is indicated for the use in the control of tonic-clonic (grand mal) seizures. The blood levels of the Dilantin medication should be monitored as ordered. (Reference Guidance: Nursing 2001 Drug Handbook, 21st edition, copyright 2001, Springhouse Corporation, pages 416 and 417.) Resident 5 was admitted to the facility on 7/3/97 with diagnoses that included seizure disorder, cerebral vascular accident, atrial fibrillation, hypertension and chronic obstructive pulmonary disease. Resident 5's medical record revealed that resident 5 had a physician's order to receive Dilantin 400 mg every	F 329	F329 continued Resident 3 is no longer on the IV med which requires the weekly CMP so all labs are now discontinued. Resident 5 has a dilantin level drawn on 7-13 of 12.0 WNL Protime on 7-13 was 20.9 7-16 PT 19.6 7-20 PT 14.7 7-23 PT 15.1 All subsequent lab draws have been done as ordered with no change in	

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F 329	Continued From page 29 Monday, Thursday and Saturday and Dilantin 300 mg every Tuesday, Wednesday, Friday and Sunday. Resident 5 also had a physician's order, dated 7/10/01, for a Dilantin level to be done on 7/10/01. Review of resident 5's medical record revealed that resident 5 had been receiving the Dilantin medication as ordered. The laboratory results section revealed the Dilantin level was not drawn on 7/10/01, as ordered. Review of the nurse's note section of resident 5's record revealed a nurse's note, dated 7/11/01, which documented the nurse had notified resident 5's physician that the Dilantin level, ordered to be drawn 7/10/01, had not been done due to the unavailability of laboratory services at the facility. VANCOMYCIN MONITORING Vancomycin is a strong antibiotic that is used to treat serious or severe infections when other antibiotics are ineffective or contraindicated. The adverse reactions super-infections, ringing in the ears, hearing damage, difficulty breathing, low blood pressure and anaphylactic shock. The Vancomycin peak and through laboratory test is used by the physician to ensure that the resident is receiving a therapeutic dose of this medication and that the resident does not have side effects or receive a toxic level of the medication. (Reference Guidance: Nursing 2001 Drug Handbook, 21st edition, copyright 2001, Springhouse Corporation, pages 213-214.) Resident 4 was admitted to the facility on 7/5/01 with diagnoses that included, closed head injury, diaphragmatic injury, pancreatitis, and pneumonia.	F 329	F329 continued Resident 4 had IV medication discontinued with no further need for blood levels to be drawn to monitor the medication.	

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F 329	Continued From page 30 Resident 4's physician's orders included an order, dated 7/5/01, for Vancomycin 1 gram intravenously every twelve hours. Resident 4 also had a physician's order, dated 7/10/01, for a Vancomycin peak and through laboratory tests. Per documentation on the facility's Laboratory Services Daily Worksheet, the Vancomycin Peak and Trough were to have been drawn on 7/11/01. Review of resident 4's medical record revealed that resident 4 had been receiving the Vancomycin medication as ordered until the Vancomycin was discontinued on 7/14/01. Review of the laboratory result section of resident 4's medical record revealed that the Vancomycin peak and though, ordered 7/10/01, was not completed.	F 329		
F 332 SS=D	483.25(m)(1) QUALITY OF CARE The facility must ensure that it is free of medication	F 332		
	This REQUIREMENT is not met as evidenced by: Based on observations and record review, it was determined the facility did not ensure that residents were free from medication administration errors. The facility's medication administration error rate was 6 percent and was observed to occur with 1 of 17 sampled residents plus 2 additional residents. (Resident 22, 23, and 24.) Findings include: Observations of medication administration were made on 7/18/01, during the morning medication pass.		F332 1. MARs for residents 24 and 22 have areas blacked out for parameter documentation. Resident 24's family has requested all meds be discontinued after discussion with the physician.	

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F 332	Continued From page 31 Three licensed nursing staff were observed passing medications. During the medication pass, 48 opportunities for error were observed. Three errors were made in medication administration. The medication error rate was 6 percent. The following medication errors were observed: 1. A facility nurse was observed to administer medication to resident 24. The nurse prepared and administered Lisinopril 5 milligrams (mg) to the resident. Lisinopril is a medication used to control blood pressure. The nurse administered the Lisinopril without first monitoring the resident's blood pressure. A review of resident 24's medication administration record (MAR) was done. On the MAR, nursing staff were directed to monitor the resident's blood pressure daily. The MAR also listed parameters for when the Lisinopril should be held. The medication was to be held if the resident's systolic blood pressure was below 110.	F 332	2. All residents with medications requiring specified parameters prior to med administration will have area on MAR blocked to bring attention to the nurse of the need for parameters to be checked. QA nurse will audit med books at least weekly to assure parameters are being monitored as specified. QA nurse and DON will also perform med pass observations on licensed staff to monitor performance. 2xq week until Complian is achieved. 3. Inservice was held 8-2-01 regarding parameters for medication administration . Best Practice Guidelines for Medication Administration given to all licensed nurses. 4. Med pass observations will be reviewed in QA as well as the audits from med books. 5. Completion date 8-10-01.	
	2. The same nurse was observed to administer medications to resident 23. The nurse was observed to dispense one 10 milliequivalents (mEq) capsule of Potassium Chloride (Kcl) for resident 23. As the nurse gave resident 23 the medications, the resident stated she was supposed to receive two of the Kcl capsules. The nurse then rechecked the MAR and dispensed a second 10 mEq capsule of Kcl. Resident 23 took both 10 mEq capsules of Kcl. Potassium chloride (Kcl), is an electrolyte replacement medication. A review of resident 23's MAR was done. The MAR directed staff to administer Kcl 10 mEq, two capsules,			

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F 332	Continued From page 32 two times a day. If resident 23 had not informed the nurse that she was to receive two capsules of Kcl, the resident would have only received half of the prescribed Kcl. 3. A different facility nurse was observed to administer medications to resident 22. The nurse was observed to dispense and administer Lanoxin 0.125 mg to resident 22. Prior to administering the Lanoxin, the nurse did not monitor the resident's heart rate. Lanoxin is a medication used to increase heart muscle contraction and slows the heart rate. A review of resident 22's MAR was done. On the MAR, nursing staff were directed to monitor the resident's heart rate and to hold the medication if the resident's heart rate was less than 60.	F 332		
F 354 SS=F	483.30(b)(1)-(3) NURSING SERVICES Except when waived [illegible] registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:	F 354	OK 8/8 The corporate DON has been assigned as the permanent DON of East Lake Care Center. Corporate DON is a Registered Nurse with a current Utah license and has had many years experience as a skilled facility DON. This was effective 7-25-01. Staff was informed in an inservice that Glenda was indeed the DON 7/25/01	

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F 354	Continued From page 33 Based on interviews and record review, it was determined that the facility did not designate a registered nurse (RN) to serve as the Director of Nursing (DON). The facility designated a licensed practical nurse (LPN) to serve as the DON from January 2001 through June 2001. Findings include: An interview was held with the facility's Administrator on 7/12/01 at 9:10 AM. At that time, the Administrator identified employee 1 as being the facility's Director of Nursing (DON). A review of the facility's licensed staff roster was done on 7/18/01. Employee 1 was identified as being a LPN. On 7/16/01 at 12:30 PM, the Administrator provided the surveyors a list of department heads for the facility. Employee 1 was identified on the list as being the DON. stepping down from the DON position effective 7/17/01. The DON stated that employee 2, a corporate registered nurse (RN), was going to assume DON responsibilities. An interview with employee 3 was held on 7/12/01 at 10:00 AM. Employee 3, a licensed practical nurse (LPN), stated that employee 1 was the facility's DON. An interview was held with the facility's Assistant Director of Nursing (ADON) was held on 7/16/01 at 1:30 PM. The ADON stated that employee 1 was going to step down from the DON position.	F 354		

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F 354	Continued From page 34 An interview with a employee 4 was held on 7/17/01 at 3:00 PM. Employee 4, an LPN, stated that employee 1 had been the DON for a couple of months. Employee 4 stated that employee 2 was going to assume DON responsibilities. A Follow-up interview was held with the Administrator on 7/25/01 at 3:25 PM. At that time, the Administrator stated that employee 1 was never officially the facility's DON. He stated that employee 5, an RN, had been the facility's DON since December 2000. (During the Exit Conference, 7/25/01 at 4:30 PM, the Administrator clarified that employee 5 had been DON since April 2001.) The Administrator stated that employee 6, an RN, had been the facility's DON in October 2000, until employee 5 became DON. An interview with employee 5 was held on 7/25/01 at 3:40 PM. Employee 5 stated she was the facility's Minimum Data Set (MDS) Coordinator. She stated she had held that position since the mid to end of [illegible] prior to becoming the MDS Coordinator. Employee 5 stated she was a floor nurse, and had been for about five years. Employee 5 was asked who the facility's DON was. She replied that employee 2 was the current DON and that employee 1 was employee 2's predecessor. Employee 5 was asked if she had been assigned any administrative tasks. She replied that her job was to complete the MDS assessments and to go to Medicare meetings to discuss resident cares. Employee 5 stated that she had never attended the facility's quality assurance meetings (A responsibility of the DON). Employee 5 stated that employee 1 and the ADON had informed her one time that employee 5's name	F 354		

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F 354	Continued From page 35 would be identified as the RN over the building. Employee 5 stated she was unsure what that meant. An interview with employee 6 was held on 7/25/01 at 3:50 PM. Employee 6 stated that employee 2 was the current DON and had been for the past few weeks. She stated that employee 1 was the DON prior to employee 2. She stated that employee 1 had been the DON since January 2001. Employee 6 stated she had been the facility's DON from October 2000, through the first few weeks in January 2001. An interview was held with employee 7 on 7/25/01 at 3:55 PM. Employee 7 was an LPN at the facility. Employee 7 stated that she was uncertain who the current DON was. She stated the DON was either employee 1 or employee 2. She stated that employee 1 had been the DON since January 2001. A follow-up interview was held with employee 1 on 7/25/01, during the Exit Conference. When asked what staff member attended the facility's quality assessment and assurance committee meetings [42 Code of Federal Regulation 483.75(b)(1)(i)], employee 1 stated she attended. Employee 1 stated that employee 5 had not attended the quality assessment and assurance committee meetings. A review of the facility's, March 13, 2001, quality assessment and assurance committee meeting minutes was done. Employee 1 was identified as being in attendance. Employee 5 was not identified as being in attendance. A review on 7/23/01, of the Division Occupational and Professional Licensing (DOPL) list of current registered nurses (RNs) and licensed practical nurses	F 354		

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F 354	Continued From page 36 (LPN's) was done. Per documentation, employee 1 was currently licensed with DOPL as a licensed practical nurse. No documentation of a current registered nurse license, for employee 1, could be found.	F 354		
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of documentation, and temperature checks it was determined the facility did not store, prepare and distribute food under sanitary conditions. Findings include: 1. The initial observation of the kitchen was performed on 7/17/01 at 10:45 A.M. The walk-in	F 371	F371 1. No specific residents were identified, so that the plan of correction will be for	
	Review of the refrigerator/freezer temperature records showed no temperatures recorded from July 14 through July 17, 2001. Interview of the Food Service Supervisor revealed the temperatures of the refrigerator had been too high since July 14, 2001. He said, "I did not record the temperatures since Friday because they are not cold enough. The temps of the walk-in refrigerator have been in the range of about 50 to 57 degrees since Friday." Refrigerator temperatures should be maintained at 40 degrees Fahrenheit and below. 2. Observations of the kitchen were made on 7/17/01,		examined. 1. The walk-in refrigerator was serviced on the night of July 17 and was brought into compliance. The new FSS will require that a temperature log be kept and will monitor compliance. Those records will be reviewed in the quarterly QA meeting. 2. There is a cleaning schedule in place, that will be enforced and monitored by the cooks and the FSS to assure	

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F 371	Continued From page 37 7/18/01 and 7/25/01. Observations revealed that a large mixer had old, dried food particles on it which could fall into a new batch of food during preparation or mixing. The mixer was covered with a large green plastic bag. A mixer plastic cover should only be clear or white. Green and black plastic bags are made of recycled plastic and should not be used for food or food preparation equipment. 3. On 7/17/01, 7/18/01, and 7/25/01, it was observed that the kitchen floor, under the steam table and under the cereal cart, there were packets of seasoning, sweetener, food particles, paper scraps, pieces of dry cereal, and spilled dried liquids. On 7/25/01 at 2:15 PM, there were also 4 forks on the floor under the steam table and utensil counter. 4. On 7/17/01 at 10:45 AM, observation of the storage room revealed spilled bacon-bits. Any open and spilled food products attract insects and other pests. 5. On 7/18/01 at 10:30 AM, the following items were unlabeled and undated in the walk-in refrigerator; one tray of 17 individual open uncovered fruit cups, lettuce salad, cut pieces of cantaloupe and honeydew melon. There were 3 quart cartons of expired Non-dairy Coffee Creamer, dated 6/22/01. 6. On 7/18/01 at 10:30 AM, on a spice cart, there was an open box of cornstarch with the lid up. Food containers must be kept sealed or covered so the contents do not have the possibility of contamination.	F 371	compliance with sanitary practices. 3. The dietary floor will be cleaned at the end of each shift to ensure that articles are not left on the floor. Spills will be cleaned up as soon as possible. This will be monitored by FSS. 4.Compliance with cleaning of this area, as well as the entire dietary department will be monitored by the FSS. 5. Inservice was held with Dietary staff regarding the proper and safe storage of all items, as well as the labeling and dating of items. 6. This was discussed with the dietary staff on safe storage and will be monitored by FSS.	

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F 371	Continued From page 38 7. On 7/25/01 at 2:15 PM, the following observations were made: a. The Wolf Circulating Heat Oven had 13 large pieces of black rusted ash and many small pieces of black ash on the top outer surface of oven. Toward the back of the oven was a vent edge that was covered with grease and dust deposits. b. The reach-in refrigerator had 5 sandwiches unlabeled and undated, one expired Nutren 2.0 supplement 250 ml can, dated use by July 1, 1998, and one expired gallon of whole milk dated 7/17/01. c. Both the toaster and tray under the toaster had thick layers of bread crumbs. d. The can opener had deposits of food particles. e. The walk-in refrigerator had the following unlabeled, undated food items; 4 tossed salads in individual bowls, 4 small cups of covered food tomatoes and lettuce leaves. f. There were raw eggs stored above melons and onions in the walk-in refrigerator. Eggs should be stored on lowest shelf or above meat which will be cooked before serving. g. The floors of the walk-in refrigerator and freezer were soiled with sticky dried liquid, plastic tape, pieces of paper wrapper, tin foil scraps, dried meat juice, and food particles.	F 371	7. The dietary inservice covered the sanitation requirements for the dietary, including the cleaning of all equipment, overall cleanliness of the department and the safe storage and handling of all products. This will be monitored by the FSS. weekly - Area information was taken to QA meeting Completed effective 8-10-01	

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F 490 SS=L	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility's administration failed to maintain an agreement with a laboratory to ensure that each resident attained or maintained their highest practicable physical well being. The facility was without laboratory services from 7/9/01 through 7/12/01. During that time, all residents in the facility had a potential need for laboratory services which the facility would have been unable to provide. Findings include: On 7/12/01, an abbreviated survey was initiated. Based on the preliminary findings of the abbreviated survey, a recertification survey began on 7/16/01. On	F 490	F490 The administrator has been replaced. The new administrator has already met with the lab, and will continue to do so on a monthly basis. In this meeting lab issues as well billing issues were discussed and decisions made. The Administrator will monitor the bills to assure that they are paid and that this issue does not reoccur. This was corrected on 8-8-01. Information on the change was taken to the meeting.	

elements of Immediate Jeopardy to resident health and safety and Sub-Standard Quality of Care. The determination of Immediate Jeopardy was based on the findings of significant non-compliance in the areas of Quality of Care [42 Code of Federal Regulations (CFR) 483.25(l)(1), Tag F-329], and Administration/Laboratory Services [42 CFR 483.75 (j)(1), Tag F-502].

Failure of the facility to address problems identified in these areas were present to such an extent that residents were residing in an environment in which the potential for significant resident harm was likely to occur.

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F 490	Continued From page 40 Residents of this facility received laboratory services from Laboratory 1. An interview with the Director of Laboratory services for Laboratory 1 was held on 7/12/01 at 11:35 AM. He stated that Laboratory 1 stopped providing laboratory services to the facility effective 7/9/01. He stated Laboratory 1 began providing laboratory services to the facility in March 2001. The Director cited failure to receive payment as the reason laboratory services were terminated. The Directore stated that on 7/6/01, he spoke with the facility's Director of Nursing (DON) to inform her that laboratory services would terminate after Sunday, 7/8/01. The Chief Financial Officer (CFO) for the parent company of Laboratory 1 was interviewed on 7/12/01 at 11:50 AM. The CFO stated that laboratory services for the facility was terminated on 7/9/01, due to lack of payment. The CFO stated the facility had been receiving two letters a month for several months [illegible] letters to the facility documented that all services provided by the parent company of Laboratory 1 would be terminated. An interview was held with the facility's Administrator on 7/12/01, at 4:00 PM. The Administrator stated that the facility had no current laboratory services. He stated the facility had not had laboratory services since 7/9/01. The Administrator stated that he became aware the laboratory services were going to be terminated on 7/7/01. The Administrator stated the President of the facility's parent corporation was currently in the process of	F 490		

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F 490	Continued From page 41 delivering a check to the parent company of Laboratory 1. The Administrator said he was uncertian if, or when, laboratory services would resume for residents in the facility. The Administrator stated on 7/11/01, he contacted other laboratories. He stated there were no other laboratories that would be willing to provide laboratory services to residents of the facility. The facility's administration failed to maintain an agreement with a laboratory to provide laboratory services to residents in the facility. Refer to Tag F-502. The facility's failure to maintain laboratory services effect the facility's ability to monitor residents' response to medications. Residents of the facility were receiving medications such as Coumadin, Potassium Chloride, Digoxin, Dilantin, and Vancomycin which, per physician order, required laboratory testing to monitor therapeutic effects and to prevent medication toxicity. Refer to Tag F-329.	F 490	F 502 This applies to all current and future patients. The lab resumed services on July 13, 2001. At that time the labs that were missed were drawn and the immediate jeopardy was removed effective July 18th. The monthly meetings with the lab and the DON of the facility and the facility Administrator will assure that issues and concerns are being addressed and resolved. The Administrator will monitor the billing to see continued compliance occurs, monthly. The first meeting held with the new administrator was on 8-8-01. Completion date 8-8-01	
F 502 SS=L	483.75(j) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based interviews and record review, it was determined that the facility did not maintain an agreement for the provision of laboratory services. The facility was without laboratory services from 7/9/01 through 7/13/01, during which time, 11 of 17	F 502 CK GS	Residents # 1, 3, 10, 13, 15 & 16 have been discharged. Residents # 2, 4, 5, 6, 7, 8, 9, 11, 12, 14, 17, 18, 19, 20, 21, 22, 23, 24, all had their lab work completed	

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F 502	Continued From page 42 sampled residents plus 9 additional residents had orders for, and were scheduled to receive laboratory services. (Residents 1, 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, and 21.) Additionally, all residents in the facility had a potential need for laboratory services which the facility had no provision to obtain. Findings include: An interview with a facility charge nurse was held on Thursday, 7/12/01, at 9:30 AM. The nurse stated she had last worked at the facility on Monday, 7/9/01. She stated that laboratory tests, which were supposed to have been drawn 7/9/01, 7/10/01, 7/11/01, or 7/12/01, had not been done. She also stated that no laboratory tests had been done since 7/9/01. The nurse identified eight residents, on her section, who had laboratory tests ordered and scheduled to have been drawn, which had not been completed. The nurse was asked if she had contacted the physicians of these eight residents to explain that ordered	F 502	and physicians notified of results. These were all completed by 7/18/01.	
	said that she had not contacted any of the physicians. She stated that Laboratory 1 had been providing laboratory services for the facility. An interview with a different facility charge nurse was held on Thursday, 7/12/01, at 9:55 AM. The nurse stated she had last worked at the facility on Wednesday, 7/11/01. She explained that on Wednesday, there were some laboratory tests that were scheduled to have been collected, which were not. She stated the laboratory tests had still not been collected on 7/12/01. This nurse stated she had not contacted the physician of residents with ordered laboratory tests to inform them the tests had not been			

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F 502	Continued From page 43	F 502		

completed. This nurse stated that, on the morning of 7/11/01, she was shown a note that the laboratory services had been terminated because of lack of payment. She stated that Laboratory 1 had been providing laboratory services for the facility.

An interview with a different facility charge nurse was held on Thursday, 7/12/01, at 10:00 AM. The nurse stated that laboratory tests which had been ordered and scheduled to drawn had not been done. She stated it had been a couple of days since the laboratory tests had been done. She stated she was not informed by administration why the laboratory services had been terminated, but had been told by other nursing staff that laboratory services were terminated due to lack of payment. The nurse stated that the facility's Director of Nursing (DON) and the facility's corporate nurse were in the process of getting laboratory services reinstated.

An interview with the DON (employee 1), as identified by the Administrator and facility nursing staff, was held on 7/12/01, 12:20 PM. Employee 1 stated that she was informed, by the facility's corporate nurse, of the termination of the facility's laboratory services. Employee 1 explained that on Friday, 7/6/01, she was informed, by the director of Laboratory 1, that laboratory services would be terminated as of 7/9/01. Employee 1 stated that she immediately contacted the facility's corporate nurse to appraise of the pending termination of laboratory services. Employee 1stated when she entered the facility on 7/9/01, none of the scheduled laboratory services had been completed. Employee 1 clarified that no laboratory was currently providing laboratory services for residents in the facility.

A telephone interview was held with the facility's Medical Director on 7/12/01, at 2:15 PM. The

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F 502	Continued From page 44 Medical Director stated that the facility had no laboratory services since 7/9/01. He stated he was not informed that laboratory services were terminated until he came into the facility on a routine visit on 7/10/01. The Medical Director stated that failure to provide laboratory services was a direct threat to resident safety and , "Out and out dangerous" . The Medical Director stated that he expressed his concerns about the lack of laboratory service to the facility's Administrator on 7/10/01. The Medical Director stated that several residents in the facility were receiving medications that required monitoring with laboratory tests. He stated the needs of these residents could not be met in the facility unless laboratory services were reinstated. The Medical Director stated that he had not contacted the attending physician of any resident in the facility to inform them of the lack of laboratory services. An interview was held with the Director of Laboratory 1 on 7/12/01, at 11:35 AM. The Director of Laboratory 1 stated that on 7/6/01, he contacted the facility's DON and explained that laboratory services	F 502		
	the DON that the laboratory would continue to provide laboratory services through the weekend , but that Sunday, 7/8/01, would be the last date of service. An interview was held with the facility's Administrator on 7/12/01, at 4:00 PM. The Administrator stated that the facility had no current laboratory services. He stated the facility had not had laboratory services since 7/9/01. The Administrator stated that he became aware the laboratory services were going to be terminated on 7/7/01. The Administrator stated that he was uncertain when laboratory services would resume.			

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F 502	Continued From page 45. Residents with orders and scheduled to receive laboratory services were as follows: 1. Resident 1 was admitted to the facility on 6/4/01, with diagnoses that included, coronary artery disease, congestive heart failure, dysrhythmia, coronary artery bypass surgery and mitral valve replacement. Review of resident 1's medical record, on 7/25/01, revealed that resident 1's admitting orders included an order for a Protime and International Normalizing Ratio (PT/INR) laboratory test to be done one time a month. The record revealed that on 6/26/01, resident 1's attending physician changed the PT/INR laboratory test order to weekly. Review of resident 1's medical record revealed that on 6/27/01, a PT/INR was done on resident 1. The results of the PT were recorded as high at 62.7 seconds. The INR value was not determined. Per nursing note documentation on 6/27/01, the INR was not tested secondary to the PT being elevated. 6/27/01at 12:10 PM, to give resident 1 vitamin K 10 mg (a medication to help the blood clot) now, due to the increased PT and to draw another PT/INR at 5:00 PM on 6/27/01. Per documentation in resident 1's medical record, there was no PT/INR results on 6/27/01 after 5:00 PM. On 6/28/01 at 12:28 PM, resident 1's PT had decreased to 17.3 seconds and the INR was 1.9 seconds. A physician's order, dated 7/3/01, documented that resident 1 was to have PT/INR laboratory tests done every Monday and to resume giving resident 1 Coumadin 2 mg on 7/3/01 and then Coumadin 1 mg every day thereafter. On 7/5/01, resident 1's	F 502		

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physician changed the Coumadin order to Coumadin 2.5 mg every Friday and Coumadin 1 mg every day except Friday. Laboratory results revealed that PT/INR tests were done on 6/30/01 and 7/2/01. There were no results for the PT/INR due to be done on 7/9/01.

2. Resident 10 was admitted to the facility on 4/27/01 with diagnoses that included, cerebral vascular accident, pulmonary embolus (blood clot in the lung), hypertension, and encephalitis. Review of resident 10's medical record revealed a physician's order for PT/INR testing every week.

Review of resident 10's medical record, on 7/25/01, revealed, PT/INR results for 6/27/01, 7/2/01, and 7/16/01. There was no result found in resident 81's medical record for the weekly PT/INR that was due to be done on 7/9/01.

3. Resident 5 was admitted to the facility on 7/2/97

accident, atrial fibrillation, hypertension, seizure disorder and chronic obstructive pulmonary disease. Resident 5's medical record revealed that resident 5 had a physician's order for a PT/INR laboratory test to be done every Monday. Resident 5 also had an order for a complete metabolic panel (CMP) and Dilantin level to be done on 7/10/01.

Review of resident 5's medical record on 7/25/01, revealed that there were results of PT/INR laboratory tests dated 7/2/01 and 7/13/01 and a CMP and Dilantin level results dated 7/13/01. No laboratory result of the weekly PT/INR due Monday 7/9/01 or the CMP and Dilantin level due 7/10/01 was found in

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F 502	Continued From page 47 resident 5's record. Review of the nurse's notes in resident 5's record revealed a nurse's note, dated 7/11/01, that documented that resident 5's physician had been informed by the nurse that the PT/INR, CMP and Dilantin level that had been ordered had not been drawn due to the unavailability of laboratory services at the facility. 4. Resident 20 was admitted to the facility on 8/30/99 with diagnoses that included atrial fibrillation, and transient ischemic attack. Resident 20's medical record revealed that resident 20 had a physician order for PT/INR laboratory tests to be done every month on the 9th of the month. Review of resident 20's medical record, on 7/25/01, revealed PT/INR results dated 6/27/01 and 7/13/01. No laboratory result of the PT/INR laboratory test due to be done on 7/9/01 was found in resident 20's record. Review of the nurse's notes in resident 20s medical record revealed a nurse's note dated 7/12/01, that documented that resident 20's physician had been notified that the PT/INR was not done on 7/9/01, due to the facility not having laboratory services and that the facility corporation was looking for another laboratory service. 5. Resident 12 was admitted to the facility on 7/11/95, with diagnoses that included, congestive heart failure, chronic obstructive pulmonary disease and deafness. Resident 12's physician orders included an order for resident 12 to have a potassium	F 502		

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F 502	Continued From page 48 level laboratory test done every two weeks. Review of resident 12's medical record, on 7/25/01, revealed that resident 12 had a potassium level scheduled to be done on 7/11/01. There was no result of a potassium level drawn on 7/11/01 found in resident 12's medical record. Review of nurses' notes in resident 12's medical record revealed a nurse's noted dated 7/11/01. The nurse documented, "Dr called and notified of pts lab due today [not] drawn but will be when problem is resolved." 6. Resident 15 was admitted to the facility on 5/2/01 with diagnoses that included, pancreatitis, hypertension, and diabetes mellitus. Resident 15's physician's orders included an order, dated 6/25/01, for the resident to have a basic metabolic panel (BMP) laboratory test to be done on 7/9/01. Review of resident 15's medical record, on 7/19/01 test dated 7/9/01 found in resident 15's medical record. A BMP laboratory test result, dated 7/13/01, was found in resident 15's record. Review of the nurse's note section revealed a nursing note, dated 7/12/01, that documented that resident 15's attending physician was notified that the facility had not done the BMP laboratory test that was ordered to be done on 7/9/01, due to the fact the facility was in the process of finding a new laboratory service. 7. Resident 8 was admitted to the facility on 10/27/00	F 502		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST LAKE CARE CENTER	1001 N 500 W PROVO, UT 84601

(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 502	Continued From page 49 with diagnoses that included atrial fibrillation, congestive heart failure and hypotension. Resident 8's physician's orders included an order, dated 7/10/01, for laboratory tests of a BMP and a Digoxin level to be done. Review of resident 8's medical record, on 7/19/01, revealed that there was no result for the BMP and Digoxin laboratory tests ordered on 7/10/01 found in resident 8's medical record. A result for a BMP and Digoxin level, dated 7/18/01, was present in the resident's record. Resident 8's medical record contained no documentation that the resident's physician had been notified that the BMP and Digoxin laboratory tests were not completed on 7/10/01, as ordered and scheduled. 8. Resident 3 was admitted to the facility on 4/10/01 with diagnoses that included chronic obstructive pulmonary disease, hypertension and breast cancer.	F 502		
	CMP laboratory test every Monday for 4 weeks. Review of resident 3's medical record, 7/18/01, revealed laboratory test results for CMP done on resident 3 for the dates of 7/4/01, 7/13/01 and 7/16/01. There were no results for the CMP that was to be done on Monday, 7/9/01 found in resident 3's medical record. Further review of resident 3's medical record, on 7/25/01, revealed a physician's order dated 7/17/01, for resident 3 to have a complete blood count (CBC) and BMP done to check for anemia and a low potassium level. Review of resident 3's medical			

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F 502	Continued From page 50 record revealed that no laboratory test results for these tests could be found. In an interview with a facility staff nurse, on 7/25/01, regarding the ordered CBC and BMP laboratory tests, she stated that she was not sure if these laboratory tests had been done as ordered. The nurse reviewed resident 3's medical record, consulted the laboratory request book used by the facility and stated that she could not see any results that these tests had been completed. The nurse then telephoned staff at Laboratory 1 regarding whether these tests had been done. She stated that the laboratory staff had told her they had never received a request to complete a CBC or BMP on resident 3. 9. Resident 4 was admitted to the facility on 7/5/01 with diagnoses that included, closed head injury, diaphragmatic injury, pancreatitis, and pneumonia. Resident 4 had a physician's order, dated 7/10/01, for a CBC, CMP, and Vancomycin peak and through laboratory tests. Review of resident 4's medical record, 7/19/01, revealed results of a CBC and CMP dated 7/18/01. There was no laboratory test results for the CBC, CMP, and Vancomycin peak and through, ordered 7/10/01 found in resident 4's record. Resident 4's medical record contained no documentation that the resident's physician had been notified that the CBC, CMP, and Vancomycin peak and through laboratory tests were not completed on 7/10/01, as ordered and scheduled. 10. Resident 11 was admitted to the facility on 3/4/01	F 502		

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F 502	Continued From page 51 with diagnoses that included pneumonia, Parkinson's disease, hypertension, and cardiac arrhythmia. Resident 11's physician's orders included an order dated 7/9/01 for a CBC to be done on 7/9/01. Review of resident 11's medical record, 7/19/01, revealed results of a CBC dated 7/13/01. There was no laboratory test result for the CBC ordered 7/9/01 found in resident 11's record. Review of the nurse's note section of resident 11's medical record revealed a nurse's note, dated 7/12/01, that documented that resident 11's physician had been notified that the CBC ordered to be done on 7/9/01 was not done due to unavailability of laboratory services at the facility. 11. Resident 9 was admitted to the facility on 6/12/01 with diagnoses that included cerebral vascular accident, rectal cancer, and hypertension. Resident 9's physician orders included an order, dated 6/28/01, to have a PT/INR done in 2 weeks on 7/11/01. Review of resident 9's medical record 7/19/01, revealed that no results of the PT/INR ordered to be done on 7/11/01 were found. The record further revealed that resident 9 expired at the facility on 7/14/01. Resident 9's medical record contained no documentation that the resident's physician had been notified that the PT/INR laboratory test was not completed on 7/11/01, as ordered and scheduled. 12. Resident 21 was admitted to the facility on 9/1/00 with diagnoses that included cardiomyopathy,	F 502		

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F 502	Continued From page 52 diabetes mellitus, atrial fibrillation, and anemia. Resident 21's physician orders included an order, dated 7/12/01, for resident 21 to have a PT/INR, BMP, and an A1C (glyosylated hemoglobin) done. Review of resident 21's medical record, on 7/25/01, revealed results of a PT/INR, BMP, and A1C, dated 7/17/01, 5 days after they were ordered to be done. Review of the nurse's notes section of resident 21's medical record revealed a nurse's note, dated 7/12/01, that documented that the facility was unable to do the laboratory test ordered on 7/12/01 due to the facility not having a laboratory service "at this time". 13. Resident 2 was admitted to the facility on 7/5/01 with diagnoses that included right hip fracture, chronic obstructive pulmonary disease, sleep apnea, transient ischemic attacks, coronary artery disease and hypertension. Upon admission resident 2 had physician orders for a PT/INR to be drawn daily for two weeks, and a hematocrit level and a BMP also to to be drawn on 7/12/01. Review of resident 2's medical record on 7/25/01, revealed that a PT/INR was not completed on 7/7/01, 7/9/01, 7/10/01, 7/11/01, and 7/12/01. The hematocrit and BMP laboratory tests were not completed until 7/13/01. Review of the nurses' notes section of resident 2's medical record revealed a nurse's note dated 7/12/01, which documented, "[Resident 2's physician] office was called concerning [no] lab avail. yet. Pt [patient] on Coumadin. PT/INR schedule....[Resident 2's physician]'s office was called again. Received orders	F 502		

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F 502	Continued From page 53 from [physician] to D/C [discontinue] Coumadin [and] PT/INR daily blood draws, start ASA [aspirin] 325 mg [milligrams] [one by mouth every day]...." 14. Resident 6 was admitted to the facility on 6/20/01, with diagnoses that included a gastro-intestinal bleed, late effect polio, diabetes mellitus, and atrial fibrilation. On 7/12/01, a review of the facility's laboratory services daily worksheet was done. Per documentation on the worksheet, resident 6 was to have a PT/INR drawn on 7/9/01. In addition, facility staff completed a "Clinical Laboratory Requisition" for a PT/INR to be drawn on 7/9/01. Review of resident 6's medical record on 7/19/01, revealed that a PT/INR was not completed on 7/9/01. The PT/INR was not completed until 7/13/01. Resident 6's medical record contained no documentation to demostrate the resident's physician 15. Resident 13 was admitted to the facility on 1/27/01, with diagnoses which included a cerebrovascular accident, atrial fibrilation, diabetes mellitus, and congestive heart failure. A review of resident 13's medical record was done. On 7/2/01, a phsyician telephone order was obtained for a Thyroid Stimulating Hormone (TSH) to be drawn with the next scheduled PT/INR. In addition, resident 13 had physician orders for a PT/INR to be drawn every three weeks, and a potassium level to be	F 502		

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F 502	Continued From page 54 drawn every two months. Review of resident 13's July 2001, treatment record revealed the PT/INR, potassium, and TSH levels were to be drawn on 7/12/01. Review of laboratory results revealed that the PT/INR, potassium, and TSH levels were not completed until 7/13/01. Review of the nurses' notes section of resident 13's medical record revealed a nurse's note dated 7/12/01, which documented the resident's physician was notified that resident 13's potassium level was not drawn that day because there was no laboratory services. The nurse documented, "...The corp [corporation] is looking for another lab." 16. Resident 14 was admitted to the facility on 10/9/00, with diagnoses which included Alzheimer's disease, colostomy, and a knee replacement. [illegible] a physician telephone order was obtained to continue PT/INR laboratory draws every Monday, with the next one scheduled to be drawn 7/9/01. Review of laboratory results revealed the PT/INR ordered to be drawn on 7/9/01, was not completed until 7/13/01. A review of nursing notes for resident 14 was done. On 7/11/01, a nurse documented, that resident 14's PT/INR was not drawn on Monday due to the lack of laboratory services. The nurse documented that resident 14's physician was aware the laboratory test	F 502		

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F 502	Continued From page 55 was not completed and that the resident remained on the same dose of Coumadin. 17. Resident 16 was readmitted to the facility on 7/6/01, with the diagnoses which included diabetes mellitus, coronary artery disease, degenerative joint disease, and hypertension. A review of resident 16's medical record was done on 7/19/01. Resident 16's admission physician orders included a PT/INR to be drawn every Monday for two weeks. Per documentation on resident 16's July 2001, treatment record, a PT/INR was to have drawn on 7/9/01. Review of laboratory results revealed the PT/INR ordered to be drawn on 7/9/01, was not completed until 7/13/01. A review of nursing notes for resident 16 was done. On 7/12/01, a nurse documented that resident 16's physician was notified that the ordered PT/INR was [illegible] corporation was in the process of finding a new lab. 18. Resident 17 was admitted to the facility on 12/1/96, with the diagnoses which included a cerebrovascular accident, hypertension, and depression. A review of resident 17's medical record was done on 7/19/01. On 6/27/01, a physician's telephone order was obtained to recheck resident 17's PT/INR in two weeks. Per documentation on resident 17's July 2001, treatment record, the PT/INR was scheduled to be drawn on 7/11/01.	F 502		