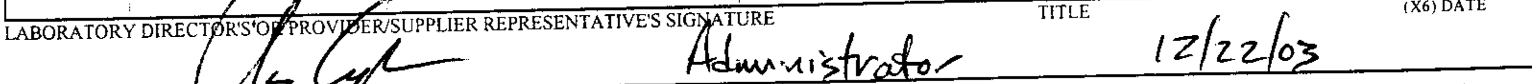
DEPARTMENT OF HEALTH AND HUM SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 ______	12/8/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST LAKE CARE CENTER	1001 NORTH 500 WEST 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 221 SS=E	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, resident record reviews and facility staff interviews, it was determined that the facility failed to assess resident medical symptoms that would necessitate the implementation and use of physical restraints for 6 of 15 sample residents and 1 of 5 supplemental residents. (Resident identifiers 1, 30, 34, 39, 54, 72, Cl 1) Findings include: 1. Resident 72 was admitted to the facility on 11/12/03 with diagnose which included COPD (chronic obstructive pulmonary disorder) respiratory failure and pneumonia. On 12/02/03 at approximately 2:10 PM resident 72 was observed in his bed with full side rails in the upright position. Resident 72 was awake, lying on his side. A review of resident 35's MDS (minimum data set), dated 11/25/03, documented the following: Section B, 4 Cognitive skills for Daily Decision Making: The resident was assessed as being independent [with] decisions consistent/reasonable. Section G1, Ab. Transfer: The resident was assessed as requiring extensive assistance with one-person physical assist.	F 221 ok 12/24/03 [initials] compliance date all tags 1/23/04 [signature]	PHYSICAL RESTRAINTS Residents 35, 34, 49, C1, 54 and 72 have all had the necessary assessments, resident consent forms and care plans updated for their restraints. Resident 30 was discharged before this could be completed for him. An inservice will be held on restraints on January 9, 2004. A restraint meeting will be held monthly where resident restraints will be evaluated. This will be monitored by the DON in her monthly QA rounds for continued compliance. This will be completed by January 23, 2004. Utah Department of Health A10000CR DEC 23 2003 Bureau of Medicare/Medicaid Program Certification and Resident Assessment	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	12/22/03

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

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Section P, 4. Devices and Restraints: The resident was assessed as using full side rails on all open sides of bed.

There were no care plans in resident 72's medical record.

On 12/03/03 at approximately 9:20 AM and 3:25 PM and again on 12/04/03 at 9:00 AM resident 72 observed in his bed lying on his back, with full bedrails in the upright position.

On 12/03/03 at approximately 9:30 AM a facility CNA familiar with resident 72's care was interviewed. She was asked why resident 72 had both rails up. She stated that she was new to the facility and he had them up when she started working there approximately two weeks ago she stated that she thought the resident felt safer with them up.

Resident 72's medical record was reviewed on 12/03/03 the restraint evaluation form and the physical restraint consent form was was not filled out and signed by the IDT (interdisciplinary team), doctor, or the resident.

A review of the physician orders for resident 72 revealed no current doctors order for the use of bed rails and no assessment by physical therapy or the interdisciplinary team with a medical symptom that would warrant the use of physical restraints for resident 72.

2. Resident 34 was admitted to the facility on 11/27/02 with diagnoses of traumatic brain injury, pneumonia, and septicemia.

Resident 34 was observed on 12/1/03 at 12:45 PM to be restrained in her wheelchair, with the use of two

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trunk restraints, used to hold her in an upright/straight position. Resident 34 was also observed multiple times throughout the survey in her wheelchair, restrained in this manner. Resident 34 was unable to take the restraint off due to contractures in her hands, and the waist restraints were tied behind the wheelchair.

Resident 34 was observed on 12/1/03, at 2:00 PM to be in her bed with full side rails up on both sides of the bed.

On 12/1/03, during an interview with facility OT (occupational therapist) and a facility nurse aide, the state surveyor asked why resident 34 required the use of full side rails on both sides. The OT and nurse aide stated that the side rails were used to prevent her "from falling out of bed."

On 12/3/03 at 09:50 AM, the facility OT was interviewed regarding resident 34's wheelchair. The OT stated that he was aware that two trunk restraints were used to keep resident 34 in her wheelchair. The OT then explained in detail how the facility had been trying to assist resident 34 to obtain a better wheelchair. The OT explained that the restraints were used for positioning of resident 34 in her wheelchair.

On 12/1/03 resident 34's medical record was reviewed. A review of resident 34's Quarterly MDS (minimum data set) assessment, dated 11/17/03, documented the following: Section B,4. Cognitive Skills for Daily Decision Making: The resident was assessed as being severely impaired.

Section G1, Ab. Transfer: the resident was assessed as requiring total assistance with two person physical assist.

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Section P, 4. Devices and Restraints: The resident was assessed as using full bed rails on all open sides of bed, used daily, and trunk restraint used daily.

Resident 34's medical record was reviewed. On 2/3/03 the facility PT assessed resident 34 for " Admission Restraint/Side Rail Evaluation and Bed Entrapment Hazard Risk Assessment.". Resident 34 was assessed as being confused. Resident 34's bed was found to not be at risk for bed entrapment. The admission evaluation by the PT documents the following: Both side rails up when in bed. Patient needs straps around legs to hold into her chair. (She has extension pattern in limbs).

The assessment does not document the medical symptom for the use of full side rails on both sides. There was no documentation in resident 34's medical record that least restrictive measures had been attempted, prior to the use side rails. There was no documentation of consent signed by resident 34 or resident 34's family, for the use of side rails, or trunk restraints.

There was no documentation of a physician's order for the use of full side rails and trunk restraints for resident 34.

3. Resident 49 was admitted to the facility on 10/01/03 with diagnoses of pneumonia, urinary tract infection, alzheimer disease, and pulmonary congestion.

Resident 49 was observed on 12/1/03 at 12:45 PM to be in bed with full side rails up on both sides.

Resident 49 was observed on 12/2/03, at 11:00 AM to be in bed with full side rails up on both sides.

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Resident 49 was observed on 12/4/03 at 09:00 AM, and 1:00 PM to be in bed with full side rails up on both sides.

On 12/1/03, during an interview with facility nurse aide, she stated that side rails were used to prevent resident 49 from falling out of bed.

On 12/1/03 resident 49's medical record was reviewed. A review of resident 49's Admission MDS (minimum data set) assessment, dated 10/06/03, documented the following: Section B,4. Cognitive Skills for Daily Decision Making: The resident was assessed as being severely impaired.

Section G1, Ab. Transfer: the resident was assessed as requiring total assistance with two person physical assist.

Section P, 4. Devices and Restraints: The resident was assess as using full bed rails on all open sides of bed, used daily.

Resident 49's medical record was reviewed. On 10/1/03, a facility staff member assessed resident 34 for " Fall Risk Assessment/Side Rail and Restraint use." Resident 49 was scored as a "21". (Total score of 10 or greater = high fall risk). Resident 49 was assessed as a good candidate for side rail use while in bed.

The assessment does not document the medical symptom for the use of full side rails on both sides. There was no documentation in resident 49's medical record that least restrictive measures had been attempted, prior to the use side rails. There was documentation of consent signed by resident 49 or resident 49's family, for the use of side rails.

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F 221	Continued From page 5 There was no documentation of a physician's order for the use of full side rails and trunk restraints for resident 49. 4.Resident 1 was admitted to the facility on 10/07/03 with the diagnosis of osteomyle AC Lowieg, thyroid disorder, left above the knee amputation, arthritis, depression and lymphedema. On 12/08/0, at approximately 10:00 AM, resident 1 was observed in her bed with full side rails in the upright position. Resident 1 was awake and lying on her back. Resident 1's medical record was reviewed on 12/08/03. A review of resident 1's MDS (minimum data set), dated 08/13/03, documented the following: Section B. 4. Cognitive skills for Daily Decision Making: The resident was assessed as having modified independence. Section P.4. Devices and Restraints: The resident was assessed to have full bed rails on all open sides of rails. Resident 1's care plans were reviewed. On 02/11/03, facility staff initiated a physical restraint care plan. The documented plan of approach, " Apply restraints only after PT (physical therapy) eval (evaluated), MD (medical doctor) order and IDT (inter -disciplinary team) approval unless an emergency then only for < (less than) 24 hours until evaluation and order completed." On 02/25/03 resident 1 was assessed by PT who wrote "no restraints" under the admission evaluation on the "Admission Restraint/Side Rail Evaluation & Bed	F 221		

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Entrapment Hazard Risk Assessment" form. The PT checked the response of "No" under the assessment area, "Are restraints and/or side rails recommended?"

A review of nursing notes revealed Resident 1 " ...was told to grab the r (right) rail to turn when the rail gave way causing her to fall out on the floor. She got a hematoma on back of head..."

A review of physician orders for resident 1 revealed no current doctor order for the use of bed rails with a medical symptom that would warrant the use of physical restraints for resident 1.

5.Resident C1 was admitted to the facility 09/23/03 with the diagnosis of colon cancer, rectum cancer, peripheral vascular disease and insulin dependent diabetes mellitus.

Resident C1's medical record was reviewed 12/03/03.

Resident C1 had a "Fall Risk Assessment/ Side Rail &Restraint Use" form dated 09/23/03. Resident C1's assessment documented "...is felt to be a good candidate for side rail use while in bed."

Resident C1's ADL (activities of daily living) flow sheet record was reviewed. On 09/24/03, the PM shift checked that "Pt may be restrained to prevent injury from fall."
On 09/25/03 the PM and the NOC (night) shifts checked that "Pt may be restrained to prevent injury from fall."

A review of the physician orders for resident C1 revealed no current doctor order for the use of bed rails and no assessment by physical therapy or the interdisciplinary team with a medical symptom that would warrant the use of physical restraint for resident

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F 221	Continued From page 7 C1. 6. Resident 54 was admitted to the facility 09/03/03 with the diagnosis of pneumonia, obesity, cor pulmonale, diabetes, dehydration, chronic respiratory failure, sleep apnea, anxiety disorder and major depressive disorder. On 12/01/03 at 2:20 PM resident 54 was observed in his bed sitting upright, with full bedrails in the upright position. On 12/02/03 at 8:00 AM resident 54 was observed in his bed sitting upright, with full bedrails in the upright position. On 12/03/03 at 10:00 AM resident 54 was observed sitting upright, with full bedrails in the upright position. Resident 54's medical record was reviewed on 12/01/03. A review of resident 54's MDS dated 09/17/03, documented the following: Section B.4. Cognitive skills for Daily Decision Making: The resident was assessed as having modified independence. Section G1, AB. Transfer: The resident was assessed as being totally dependent. Section P. 4. Devices and Restraints: The resident was assessed as using full bed rails on all open sides of bed. A review of resident 54's physician orders revealed no current order for use of bed rails with a medical	F 221		

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symptom that would warrant the use of a physical restraint for resident 54.

7. Resident 30 was admitted to the facility 07/16/03 with the diagnosis of Parkinson's with multiple complications, aspiration pneumonia, respiratory failure, dysphasia, depression, renal insufficiency and anemia.

On 12/01/03 at 2:20 PM resident 30 was observed in his bed lying flat, with full bed rails in the upright position.

On 12/02/03 at 8:00 AM resident 30 was observed in his bed lying flat, with full bedrails in the upright position.

A review of resident 30's MDS dated 07/22/03, documented the following:

Section B. 4. Cognitive Skills for Daily Decision Making: The resident was assessed as having modified independence.

Section G1. Ab. Transfer: The resident was assessed as totally dependent.

Section P. 4. Devices and Restraints: The resident was assessed as full bed rails on all open sides of bed.

A review of physician orders for resident 30 revealed no current doctor order for the use of bed rails with a medical symptom that would warrant the use of physical restraints for resident 30.

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F 241 SS=D	483.15(a) QUALITY OF LIFE	F 241		

The facility must promote care for residents in a

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F 241	Continued From page 9 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 observation and interview on 12/02/03 the facility failed to treat resident with dignity and respect by providing incontinence care in the resident's room with the window blind open , and raised approximately eight inches from the bottom of the window sill. Findings include: On 08/28/03 resident 6 was admitted to the facility with the diagnosis of edema,obesity,congestive heart failure, hypertension, hypoxia,depression,anxiety,post gastric by-pass,agoraphobia . On 12/02/03 at 4:00 PM. an observation of resident 6 receiving incontinence care while in bed in the supine position was noted. It was also noted that the window blind in resident 6's room was closed , and raised approximately eight inches from the bottom of the window sill. On 12/02/03 at 10:40 AM a phone interview with resident 6's mother was conducted , revealing that on a recent phone conversation with her daughter, she overheard a facility staff person with a rude attitude state to resident 6 that "you are here because you never want to cooperate with anything."	F 241 ok 12/24/03 [handwritten initials]	QUALITY OF LIFE An inservice was held on December 10, 2003 regarding resident dignity and respect. All staff was instructed to make sure all blinds were completely closed, doors shut and curtains closed when resident cares were being done to ensure every resident's dignity was maintained. This will be monitored for complaints by the DON in her monthly QA rounds. This will be completed by January 23, 2004.	
F 250 SS=D	483.15(g) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each	F 250		

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F 250	Continued From page 10 resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and resident family interview it was determined that the facility did not provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for 1 of 15 sampled residents. Resident identifiers: 34, Findings include: 1. Resident 34 was admitted to the facility on 11/27/02 with diagnoses which include, head injury, pneumonia and septicemia. Resident 34 was a 29 year of female resident who sustained a head injury in an automobile accident approximately one year ago. Resident 34 's had two daughters. One daughter was killed in the automobile accident, her other daughter was living with her husband in another state. Resident 34 was presently separated from her husband, and resident 34 has not been allowed to visit/see her surviving daughter for approximately 1 year now. Resident 34's family member was interviewed on 12/3/03 at 3:30 PM. Resident 34's family member stated that resident 34 had been in an "abusive and volatile" relationship with her husband. Resident 34's family member stated that she (resident 34) has not seen her surviving daughter for about a year now. The family had requested that resident 34's daughter fly to Utah for a visit. Resident 34's husband said no, and denied them visitation. Resident 34's family has attempted to get visitation, and they stated that they had to deal with 2 states and 2 sets of state laws. Resident 34's family members stated that resident 34 had "repressed emotional things". Resident 34's	F 250 OK 12/24/03 [handwritten initials]	SOCIAL SERVICES Resident 34's care plan has been updated to address depression and mood. Resident 34 was also referred to a psychologist on December 2, 2003. An initial evaluation was completed on December 11, 2003 by the psychologist. 24 hour chart checks will be implemented to ensure that all referrals are followed through in the future. There will be an inservice on December 23, 2003 to inform all nurses of this new procedure. This will be monitored by the DON in her monthly QA rounds. This will be completed by January 23, 2004.	

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family members stated that they felt that if resident 34 had someone to talk to about these things, she (resident 34) might be more verbal. Resident 34's family member stated that it would "be good to have someone for her (resident 34) to talk to." Resident 34's family members stated that they had asked the facility physician if resident 34 (their daughter) could have a psychologist evaluate their daughter. The request was made by family on 11/13/03.

The facility physician wrote a physician's order on 11/13/03 which reads, "Her mother wonders if a psychologist can see her - please check."

Resident 34's medical record was reviewed on 12/2/03. There was no mention about the psychologist visit in the nurses notes or the SS (social services) section of the medical record. There was no initial evaluation available for review.

Resident 34 was interviewed on 12/3/03 at 4:00 PM. The nurse surveyor asked resident 34 if she would like to talk to someone, like a psychologist, about all that has happened to her in the last year and resident 34 nodded her head yes.

On 12/2/03 a facility nurse and two facility aides were interviewed regarding resident 34. A facility aide stated that resident 34's appetite had been decreased because "she's depressed". The facility nurse stated that there was a period of time when resident 34 would not eat or take medications.

Resident 34's medical record was reviewed on 12/2/03. Resident 34's Nursing Monthly Summary for November 2003, documents that resident 34 is sad at times, and has depression secondary to condition. (traumatic brain injury). Resident 34's care plan addresses the use of Effexor for resident 34. Resident

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F 250	Continued From page 12 34's care plan did not have any interventions that specifically addresses resident 34's depression and mood. There was no current entry made by facility Social worker. The facility SW (social worker) was interviewed on 12/2/03 at 11:20 AM. She stated that she wasn't aware that resident 34 needed a psychologist evaluation, and that she would check on it today. During an interview with the facility DON on 12/2/03, she stated that she had contacted the psychologist's office on 11/26/03, and there was "no response". The facility DON stated that she contacted the psychologist's office on 12/2/03 to make an appointment for resident 34.	F 250		
F 272 SS=E	483.20(b) RESIDENT ASSESSMENT A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272 ok 12/24/03 [initials]	RESIDENT ASSESSMENT The RAP sections of the MDS for residents 72, 52 and 54 have been corrected. Resident 30 was discharged before this section could be corrected in his MDS. An inservice will be held with the MDS Coordinators on the proper way to fill out and date the RAPs section of the MDS. This will be monitored by the DON in her monthly QA rounds. This will be completed by January 23, 2004.	

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F 272	Continued From page 13 Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on resident record review, it was determined that the facility did not complete comprehensive Minimum Data Set (MDS) assessments which included documentation of summary information regarding an additional assessment performed through the Resident Assessment Protocols (RAP) for 2 of 15 residents in the survey sample and 2 supplemental residents. Resident identifiers: 30, 52, 54, 72 Findings include: The RAPs (Resident Assessment Protocols; Section VA a and b) of the Resident Assessment Instrument (RAI - the combined MDS and RAP assessments) are	F 272		

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used to identify areas of a resident's care that have been triggered from the MDS assessment and require further assessment in order to provide an individualized care plan for the resident. Documentation relevant to the assessment information regarding the resident's status should include a description of the nature of the resident's condition, complications and risk factors to use in deciding to proceed with care planning, and factors that must be considered in developing individualized care plan interventions, as well as the possible need for further evaluation by appropriate health professionals.

The care planning decision-making column must be completed within 7 days of completing the RAI.

Potential problem areas that may trigger on a RAP from an MDS include:
1. Delirium
2. Cognitive loss
3. Visual Function
4. Communication
5. ADL (activities of daily living) functional/rehabilitation potential
6. Urinary incontinence and indwelling catheter
7. Psychosocial well-being
8. Mood state
9. Behavioral symptoms
10. Activities
11. Falls
12. Nutritional status
13. Feeding tubes
14. Dehydration/fluid maintenance
15. Oral/dental care
16. Pressure ulcers
17. Psychotropic drug use
18. Physical restraints

1.Review of medical records for resident 72

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documented an incomplete RAI assessment dated 11/25/03, which did not include the dates of RAP assessment documentation.

Problem areas 4 identified that RAP documentation could be located in nursing assessment notes and the care plan but no specific date was documented to reference any particular note. Problem area 5 identified that RAP documentation could be located in the ADL's (activities of daily living) and the care plan but no specific date was documented to reference any particular note. Problem areas 10 identified that RAP documentation could be located in the recreation care plan notes. Problem area 12 identified that RAP documentation could be located in the dietary care plan. Problem areas 15 identified that RAP documentation could be located in the nursing assessment care plan and problem area 16 identified that RAP documentation could be located in the skin assessment care plan.

The RAP referred to the care plan in several instances, which is not an assessment tool.

2. Review of medical records for resident 52 documented an incomplete RAI assessment dated 10/01/03, which did not include the location and dates of RAP assessment documentation.

Problem areas 1, 2, 3, 8, 9, 10, and 14 identified that RAP documentation could be located in nursing notes but no specific date was documented to reference any particular note. Problem area 5 and 6 identified that RAP documentation could be located in the ADL's (activities of daily living) nurses notes, but no specific date was documented to reference any particular note. Problem areas 16 identified that RAP documentation could be located in the skin check nurses notes, but no specific date was documented to reference to any

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F 272	Continued From page 16 particular note. 3. A review of resident 30's medical record documented an incomplete RAI (Resident Assessment Instrument) dated 07/22/03, which did not include the dates of RAP assessment documentation. The facility's documentation under "Location and Date of RAP Assessment Documentation" column referred back to the care plan. The care plan was referred to as the assessment. 4.A review of resident 54's medical record 54 documented an incomplete RAI dated 09/16/03, which did not include the dates of RAP assessment documentation.	F 272		
F 279 SS=D	483.20(k) RESIDENT ASSESSMENT The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under s483.25; and Any services that would otherwise be required under s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4).	F 279 OK 12/29/03 with addendum SS	RESIDENT ASSESSMENT A care plan has been developed to address resident 39's psychosocial needs. An inservice was held on December 10, 2003 to educate the staff on the proper way to handle resident 39's inappropriate behavior. This will be monitored for complaints by the DON in her monthly QA rounds. This will be completed by January 23, 2004.	

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This REQUIREMENT is not met as evidenced by:

Based on record review , and interviews on 12/02/03 the facility did not develop a comprehensive care plan that meet the psychosocial needs of a resident with sexually inappropriate behavior.

Findings include :

On 07/10/00 resident 39 was admitted to the facility with the following diagnosis,blindness, dementia , incontence, glycoma, unsteady gait,hypothyroidism .

On 12/02/03 a record review was conducted .

On 08/29/03 a social service noted stated "Pt [patient] has been reported to be acting inappropriate with aides , and other staff , touching them inappropriately ."

On 09/15/03 a social service quarterly progress note stated, " when aides and staff tend to his care needs he attempts to touch in inappropriate areas,and is suggestive in speech ."

On 10/06/03 a nurses note stated, " pt was in his room with the door open , masturbating,was asked to stop this, he did,does make inappropriate suggestions also ."

On 10/07 /03 a nurses note stated, "pt was found in his room masturbating, door was open..."

On 10/19/03 a nurses note stated, " when they went in he masturbated in front of them. Staff reported they are uncomfortable going to his room now . "

On 10/22/03 a nurses note stated , "is very inappropriate with female staff ."

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F 279	Continued From page 18 On 10/ 26/03 a nurses note stated ,"inappropriate with female staff ." On 12/02/03 a interview with 2 CNA'S and 1 LPN [licenced practical nurse] was conducted. All stated resident 39's inappropriate sexual behavior was uncomfortable for them to deal with , we tell him to stop ." On 12/02/03 the record review evidenced no comprehensive care plan for resident 39's sexually inappropriate behavior.	F 279		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview it was determined that the facility did not ensure that 1 of 15 sample resident who entered the facility received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care. Specifically, resident 2 was admitted to the facility with a stage I pressure sore, which progressed into a stage II pressure sore. Findings include:	F 309 OK 12/24/03 [illegible]	QUALITY OF CARE A pressure relieving device was placed on resident 2's wheel chair on December 8, 2003. An inservice was held on December 10, 2003 with the staff regarding pressure relieving devices. A skin and weight meeting will be held weekly to discuss all residents with skin issues and the preventions that are in place. This will be monitored by the DON in her monthly QA rounds. This will be completed on January 23, 2004.	

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F 309	Continued From page 19 Resident 2 was admitted to the facility on 10/8/03 with diagnoses that included pneumo-thorax, and diabetes mellitus. Resident 2's medical record was reviewed on 12/8/03. On 10/8/03, a facility nurse completed a "Resident Assessment – Data Collection form". It was documented that resident 2 had a stage I pressure sore on his left buttock. On 10/14/03, an initial admission Medicare MDS (minimum data set) was completed. It was documented under section M1. Skin Condition that resident 2 had a stage 1 pressure sore. It was documented under section M5. Skin Treatments that resident 2 used a pressure – relieving device on his bed. On 11/21/03, facility staff initiated a "Skin Integrity Care Plan". A documented problem was that resident 2 had a stage II pressure sore to his buttocks. A documented goal was that resident 2's pressure sore would show evidence of improvement and healing without signs and symptoms of infection every day. One documented approach was to "apply necessary protective equipment as deemed necessary by diagnoses and patient need: cushion to chair, and treatment as ordered by MD, (Doctor of Medicine). On 11/4/03 there was a telephone order written by the facility physician that reads: Check with physical therapy regarding chair cushion/padding. This order was signed off by facility staff member, and signed by the facility physician. On 12/8/03, the facility physical therapist was interviewed regarding the assessment of resident 2's	F 309		

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F 309	Continued From page 20 wheelchair for a cushion. The facility physical therapist stated that he was not aware there had been an order written for resident 2, to have his wheelchair evaluated for a cushion on 11/4/03. The therapist also stated that resident 2 did not currently have a wheelchair cushion, and that he would evaluate resident 2's wheelchair for a cushion today. On 12/8/03, resident 2 was observed sitting in his wheelchair, at 10:50 AM. There was no pressure relieving device/cushion in his wheelchair. On 12/8/03, a facility RN (registered nurse) and a nurse surveyor completed a skin check on resident 2. Resident 2 was observed to have a stage II pressure sore on his left buttock. During resident 2's skin check it was observed that resident 2 did not have a pressure-relieving device/cushion to his wheelchair.	F 309		
F 312 SS=D	483.25(a)(3) QUALITY OF CARE A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility did not ensure that 1 supplemental resident was given appropriate services to maintain personal hygiene. Specifically, resident 53 was not toileted. Findings include: Resident 53 was admitted to the facility on 12/10/00 with the diagnosis of gastrointestinal bleed, osteoarthritis, hypertension, cerebral vascular accident,	F 312 ok 12/22/03 ? addendum [initials]	QUALITY OF CARE An inservice was held on December 10, 2003 and incontinent care was discussed. The staff was reminded to check and change every resident every 2 hours. They were also reminded to change the residents clothing whenever it was soiled or dirty. This will be monitored for complaints by the DON. This will be completed on January 23, 2004.	

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F 312	Continued From page 21 fractured femur and dementia. Observation of resident 53's sweat pants on 12/08/03 revealed a wet spot on the front and back of the pants. The wet area on the front of the pants down the right leg was approximately 24 inches long and the entire width of the leg. The wet spot on the left leg extended approximately 40 inches in length and the entire width of the pant. The backside of the pants had a wet spot approximately 12 inches in the seat portion of the pants. An interview with resident 53's wife was completed on 12/08/03. She stated that the pants were removed on 12/07/03 at approximately 1:00 PM by the Certified Nursing Assistant. She reported that dry pants were placed on resident 53 but his shirt and under garment were not changed and were also wet. She observed that the shirt and undergarment were wet and changed them herself. A review of resident's 53 medical record on 12/08/03 revealed that resident 53 had a Activity of Daily Living Care Plan with a plan of approach to " every 2h (hour) change briefs if wet or soiled and "dress in clean cloths everyday and change clothing prn (as needed) soiled or dirty."	F 312		
F 314 SS=G	483.25(c) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from	F 314 ok 12/24/03 DD	QUALITY OF CARE Resident 72 and 54 have both been placed on pressure relieving mattresses and have had their treatments and diets reviewed to ensure they are appropriate.	

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F 314	Continued From page 22 developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of resident medical records and review of facility policies and procedures, it was determined that for 2 of the 15 sample residents, the facility did not ensure that residents who entered the facility without pressure sores did not develop pressure sores. The facility also did not ensure that residents who had pressure sores received the necessary treatment and services to promote healing and prevent new sores from developing. (Residents 54 and 72.) Findings include: Resident 72 was admitted to the facility on 11/12/03 with diagnose which included COPD (chronic obstructive pulmonary disorder) respiratory failure and pneumonia. A review of resident 72's medical record revealed an admission assessment dated 11/12/03, which documented a healed wound on resident 72's coccyx. A lab (laboratory) value done at the hospital, dated 11/12/03, was reviewed and revealed a serum albumin (protein) level of 2.6. An albumin level of less than 2.4 g/dl is considered a severe visceral protein deficit, an albumin level of 2.4 g/dl- 2.9 g/dl is considered a moderate visceral protein deficit and an albumin level of 3.0 g/dl-3.5 g/dl is considered a mild visceral protein deficit. . (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000, page 22). A nurse's note dated 11/19/03 documented "... PA (physician assistant) notified of breakdown on coccyx new order given et (and) noted for abx (antibiotic)	F 314	An inservice was held on December 10, 2003 in which turning and pressure reliving devices were discussed. A skin and weight meeting will be held every week where every resident with a skin issue will be discussed. This will be monitored by the DON in her monthly QA rounds. This will be completed by January 23, 2004.	

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ointment et telfa island dressing". It was also documented that resident 72 liked ensure with his meals.

A review of the medical record revealed that between 11/12/03 and 11/26/03 (14 days) resident 72 lost 16 lbs., a 16.56% weight loss.

There is no documentation in the medical record during the month of November that a nutrition assessment by a registered dietitian had been completed to assess the calorie and protein needs and to address the adequacy of the supplements provided to ensure they were appropriate to prevent skin break down.

A Malnutrition/Dehydration-Pressure Sore Risk Assessment form was completed on 11/23/03 approximatley four days after the discovery of the pressure sore. The total score was 18, which indicated that resident 72 was at a high risk of developing a pressure sore.

The medical record was reviewed on 12/01/03 no evidence of a care plan for the skin break down was noted in resident 72's chart.

Observations of resident 72 were made on the following days and times:

12/2/03 at 2:10 PM
12/03/03 at 9:20 AM and 3:25 PM
12/04/03 at 9:00 AM

Resident 72 was observed on his back during each of these observations.

A discharge order from the hospital dated 11/12/03 and an admitting order dated 11/12/03 documented

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that the coccyx wound was healed and that the resident was to be kept off the site and turned from side to side every two hours.

A review of the treatment record dated November 2003 documented that resident 72 was turned at 6:00 AM and 6:00 PM (every twelve hours). Between 11/12/03 and 11/30/03 there were 8 mornings of missing documentation and 4 evenings missing docume

Resident 54 was admitted to the facility on 09/03/03 with the diagnosis of pneumonia, obesity, cor pulmonale, sleep apnea, diabetes, chronic respiratory failure, anxiety disorder and major depressive disorder.

Resident 54's medical record was reviewed on 12/01/03.

On 09/03/03 the Resident Assessment- Data collection Form documented, "old scars dry flaky skin" on the buttocks. Under the functional status section of the form the resident was assessed as requiring "total assist". Under the Psychosocial aspects section of the form resident 54 was assessed as being "oriented".

On 09/03/03 resident 54's Skin Integrity Care plan identified the following problems. "Based upon pressure sore risk assessment –pt (patient) found to be at risk. Total score 13, from Pressure Sore Risk Assessment form, Turgor: fair, Integrity: fair, skin condition dry, scaly. Edema: yes, Incontinence: yes, stage 1 on coccyx."

The documented Plan of Approach on the skin integrity care plan was: " Apply necessary protective equipment as deemed necessary by dx (diagnosis) and pt (patient) need: heel protectors, special air mattress, elbow protectors, cushion to chair."

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Resident 54's MDS (minimum data set), dated 09/17/03, Section M.1a assessed his skin as having 1 stage pressure ulcer. Section M. 5b Skin treatments documented resident 54 was to have "pressure relieving device (s) for bed."

On 10/13/03, the Weekly Skin Assessment Form documented that resident 54 had red open sores to the buttocks and posterior thighs, each approximately 1 cm (centimeter).

On 10/28/03, the Weekly Skin Assessment Form documented "multiple sores to buttocks et (and) medial thighs 1-2 cm each, red et open. Sore to L (left) upper back red with 1 cm open sore."

On 10/29/03 a physician ordered "triple antibiotic ointment to bottom et posterior thigh sores."

On 12/01/03 at approximately 3:00 PM, resident 54's room was observed. Resident had a new pressure relieving mattress in his room, propped up against the wall. The nurse stated they were waiting for a frame for this mattress.

On 12/04/03 at approximately 10:00 AM a facility Certified Nursing Assistant stated that the mattress had been propped up against the wall the two weeks that she had been working there.

On 12/08/03, at 10:00 AM resident 54 was interviewed. He was asked if he was assisted in turning every 2 hours. He said no. Resident 54 was asked if he could turn himself. He demonstrated that he could use his right arm in pulling himself to the left by lifting his right leg. He could not demonstrate keeping the position. Resident 54 was asked if he was aware he had a sore on his buttocks. He stated yes and that it

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 ____	12/8/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST LAKE CARE CENTER	1001 NORTH 500 WEST 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 314	Continued From page 26 hurt. Resident 54 had a foam mattress on his bed this AM.	F 314		
F 325 SS=G	483.25(i)(1) QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by 1 of 15 sampled residents experienced weight loss with inadequate dietary interventions implemented to prevent further unplanned weight decline. Resident identifier: 72. Calculating weight loss percentages is done by subtracting the current weight from the previous weight, dividing the difference by the previous weight and multiplying by 100. Weight losses are as follows: 5% in one month, 7.5% in 3 months and 10% in 6 months. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000). Findings include: Resident 72 was admitted to the facility on 11/12/03 with diagnose which included COPD (chronic obstructive pulmonary disorder) respiratory failure and pneumonia. A review of resident 72's medical record revealed the	F 325 OK 12/29/03 with addendum [initials]	QUALITY OF CARE Resident 72 was assessed by the RD on 12/2/03 with increased calorie and protein needs for weight loss, healing of the pressure ulcer and repletion of visceral protein sores. Best Practice Guidelines were followed in recommendations to the doctor for supplements, vitamins and minerals. A care plan was written for weight loss, poor po intake, the pressure ulcer and hypoalbuminemia. The skin and weight meeting is held weekly with the dietary manager, diet technician and a representative from nursing. All residents with significant weekly weight loss are reviewed at this meeting. Residents who have experienced significant monthly weight loss are reviewed at the meeting after the monthly weights are completed. Best Practice Guidelines are followed in recommendations made for each resident discussed. The minutes from the meeting are kept in the NAR manual. The RD will ensure that these meetings are being held during the monthly consultant visit. This will be completed January 23, 2004.	

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F 325	Continued From page 27	F 325		

following weights:

11/12/03 96.6 lbs (pounds)
11/19/03 83.6 lbs.
11/26/03 80.6 lbs.

Between 11/12/03 and 11/26/03 (14 days) resident 72 lost 16 lbs., a 16.56% weight loss.

A lab (laboratory) value done at the hospital, dated 11/12/03, was reviewed and revealed a serum albumin (protein) level of 2.6. An albumin level of less than 2.4 g/dl is considered a severe visceral protein deficit, an albumin level of 2.4 g/dl- 2.9 g/dl is considered a moderate visceral protein deficit and an albumin level of 3.0 g/dl-3.5 g/dl is considered a mild visceral protein deficit. . (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000, page 22).

Nurse's notes dated 11/18/03 and 11/19/03 documented that resident 72 was able to stand with assistance.

A nurse's note dated 11/19/03 documented "... PA (physician assistant) notified of breakdown on coccyx new order given et (and) noted for abx (antibiotic) ointment et telfa island dressing". It was also documented that resident 72 liked ensure with his meals.

A nurse's note dated 11/26/03 documented that resident 72 had a diagnoses of Malnutrition with a poor appetite and was too weak to stand.

There is no documentation in the medical record during the month of November that a nutrition assessment by a registered dietitian had been completed to assess the calorie and protein needs and

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F 325	Continued From page 28 to address the adequacy of the supplements provided to ensure they were appropriate to prevent further weight loss and skin break down.	F 325		
F 332 SS=E	483.25(m)(1) QUALITY OF CARE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview it was determined that the facility did not ensure that it was free of a medication error rate of less than 5%. It was determined that the facility medication error rate was 6.9% during an observed medication pass. Resident identifiers: 38, and 2 Findings include: On 12/2/03 medication administration was observed as the facility nurse prepared and delivered the morning medications. Resident 2 was given Simethicone 80 mg. The medication was administered to the resident as resident 2 was eating breakfast. The December, 2003 re-certification order for resident 2's Simethicone reads, Simethicone 80 mg (milligrams) AC (before meals) three times a day. The MAR (medication administration record) reads, Simethicone 80 mg, AC. The medication Simethicone was administered to resident 2 during his breakfast meal, the medication was not administered before resident 2's breakfast meal. On 12/2/03 in the morning, it was observed that resident 38 was administered her morning medications, and did not receive Lisinopril 5 mg	F 332 OK 12/24/03	QUALITY OF CARE Resident 2 and 38's orders have been clarified and are now documented correctly in the MAR. A 24 hour chart check will be implemented. This will prevent orders being taken off and documented incorrectly. This will be monitored by the DON in her monthly QA rounds. This will be completed by January 23, 2004.	

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F 332	Continued From page 29	F 332		

(milligrams) as ordered. Lisinopril is a medication used to lower blood pressure.

On 12/2/03 resident 38's medical record was reviewed. It was noted that resident 38 had an order for Lisinopril 5 mg to be given every day. The order was a telephone order dated 10/14/03. The order was signed off by the facility physician. The telephone order had not been signed off by a facility nurse. The order was also written on resident 38's November re-certification orders. The re-certification orders had been signed off by a facility nurse.

On 12/2/03, resident 38's MAR's (medication administration record) were reviewed for October, November, and December 2003.

The Lisinopril order was not written/transcribed onto resident 38's October, 2003 MAR. There was no documentation by facility nursing staff that resident 38 had received the prescribed medication Lisinopril as ordered, from October 14 through October 31, 2003, (17 days).

The Lisinopril order was written/transcribed onto resident 38's November, 2003 MAR. The following was written on resident 38's November, 2003 MAR: Prinivil (another name for Lisinopril) 5 mg PO (by mouth) Q (every) day, scheduled to be given at 8:00 AM. A facility nurse has initialed and circled their initials on November 1,2, indicating that the medication had not been given on those days. November 3-30 the medication had not been initialed as given. There was writing on the MAR, which said,"No order for this med (medication)". There was no documentation by facility nursing staff that resident 38 had received the prescribed medication Lisinopril as ordered for the entire month of November, 2003. (30 days).

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465119	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/8/03

NAME OF PROVIDER OR SUPPLIER: **EAST LAKE CARE CENTER**

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F 332	Continued From page 30 The Lisinopril order was written/transcribed onto resident 38's December, 2003 MAR. The following was written on resident 38's December, 2003, MAR: Lisinopril 5 mg PO (by mouth) Q (every) day, at 8:00 AM. There was no documentation by facility nurses that resident 38 had received the ordered Lisinopril December 1-4. There was writing on the MAR which said," No order for this med". There was no documentation by facility nursing staff that resident 38 had received the prescribed medication Lisinopril as ordered for the first 4 days of December, 2003. (4 days). On 12/4/03 at 11:30 AM, the facility DON (Director of Nursing) was interviewed regarding resident 38's Lisinopril order. The facility DON stated that the nurse who was responsible for signing off the order for resident 38's Lisinopril was no longer employed at the facility. The DON stated that this nurse had been working on a restricted license, and had a history of being impaired while on the job. The facility DON acknowledged that resident 38 had not been receiving Lisinopril 5 mg every day as ordered	F 332		
F 333 SS=E	483.25(m)(2) QUALITY OF CARE The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and medical record review, it was determined that the facility did not ensure that 1 of 15 sample residents was free of any significant medication errors. Resident identifier: 38. Findings include:	F 333 ok 12/29/03 with addendum [illegible]	QUALITY OF CARE Resident 38's order for Lisinopril has been clarified and documented correctly in the MAR. A 24 hour chart check will be implemented which will prevent orders from not being documented correctly in the future. This will be monitored by the DON in her monthly QA rounds. This will be completed by January 23, 2004.	

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F 333	Continued From page 31	F 333		

Resident 38 was admitted to the facility on 10/6/03 with diagnoses of congestive heart failure, cardiomyopathy, obesity, edema, pressure ulcer, cellulitis, and psychological disorder.

On 12/2/03 in the morning, it was observed that resident 38 was administered her morning medications, and did not receive Lisinopril 5 mg (milligrams) as ordered. Lisinopril is a medication used to lower blood pressure.

On 12/2/03 resident 38's medical record was reviewed. It was noted that resident 38 had an order for Lisinopril 5 mg to be given every day. The order was a telephone order dated 10/14/03. The order was signed off by the facility physician. The telephone order had not been signed off by a facility nurse. The order was also written on resident 38's November re-certification orders. The re-certification orders had been signed off by a facility nurse.

On 12/2/03, resident 38's MAR's (medication administration record) were reviewed for October, November, and December 2003.

The Lisinopril order was not written/transcribed onto resident 38's October, 2003 MAR. There was no documentation by facility nursing staff that resident 38 had received the prescribed medication Lisinopril as ordered, from October 14 through October 31, 2003, (17 days).

The Lisinopril order was written/transcribed onto resident 38's November, 2003 MAR. The following was written on resident 38's November, 2003 MAR: Prinivil (another name for Lisinopril) 5 mg PO (by mouth) Q (every) day, scheduled to be given at 8:00 AM. A facility nurse has initialed and circled their initials on November 1,2, indicating that the

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F 333	Continued From page 32 medication had not been given on those days. November 3-30 the medication had not been initialed as given. There was writing on the MAR, which said,"No order for this med (medication)". There was no documentation by facility nursing staff that resident 38 had received the prescribed medication Lisinopril as ordered for the entire month of November, 2003. (30 days). The Lisinopril order was written/transcribed onto resident 38's December, 2003 MAR. The following was written on resident 38's December, 2003, MAR: Lisinopril 5 mg PO (by mouth) Q (every) day, at 8:00 AM. There was no documentation by facility nurses that resident 38 had received the ordered Lisinopril December 1-4. There was writing on the MAR which said," No order for this med". There was no documentation by facility nursing staff that resident 38 had received the prescribed medication Lisinopril as ordered for the first 4 days of December, 2003. (4 days). On 12/4/03 at 11:30 AM, the facility DON (Director of Nursing) was interviewed regarding resident 38's Lisinopril order. The facility DON stated that the nurse who was responsible for signing off the order for resident 38's Lisinopril was no longer employed at the facility. The DON stated that this nurse had been working on a restricted license, and had a history of being impaired while on the job. The facility DON acknowledged that resident 38 had not been receiving Lisinopril 5 mg every day as ordered Resident 38 's Lisinopril was omitted for 51 days, making this a significant medication error.	F 333		

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F 371	Continued From page 33	F 371		
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 observations in the kitchen the facility did not store food under sanitary conditions as evidenced by storage of outdated food items. Findings include: Observations during the initial inspection of the kitchen on 12/1/03 at 9:00 AM revealed the following items: Three cases of Ultra Cal (a tube feeding product) dated November 1, 2003 and two cases of Resource (a nutritional supplement) dated February 1, 2003. Both products were open and being used by the facility.	F 371 ok 12/24/03 [initials]	DIETARY SERVICES The outdated products have been removed from the food storage area. The Food Service Supervisor will inservice her staff on proper storage and use of food. This will be monitored by the Food Service Supervisor in her monthly QA rounds. This will be completed by January 23, 2004.	
F 460 SS=B	483.70(c)(1)(iv&v) PHYSICAL ENVIRONMENT Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observations , and a interview with the facility ADON[assistant director of nursing] it was	F 460 ok 12/24/03 [initials]	PHYSICAL ENVIRONMENT All resident rooms that did not have privacy curtains that extended completely around the bed have been fixed. An inservice will be held with the housekeeping and maintenance staff to ensure they do not put up more curtains that do not extend completely around the bed.	

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F 460	Continued From page 34 determined that the facility did not assure full visual privacy for each resident . 39 of 223 currently occupied beds with ceiling suspended privacy curtains did not extend around the occupied residents bed to provide full visual privacy. On 12/04/03 during a exit , the ADON stated " when we took those curtains down to launder them , we must of not put them all back up ." On 12/03/03 it was observed on the 100 hall that the ceiling suspended privacy curtains did not extend around the occupied residents beds to provide full visual privacy which varied from 1 foot to 8 foot . The following rooms are included: 108 A 108 B 109 B 110 B 111 B 111 B 112 A 112 B 113 A 113 B 114 B The 200 hall: 203 A 203 B 204 A 209 B 210 B 212 A 212 B 213 A	F 460	This will be monitored by the Plant Operations Supervisor in his monthly QA rounds. This will be completed by January 23, 2003.	

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F 460	Continued From page 35 213 B 214 A 214 B 215 B 216 A The 300 hall: 300 B 301 A 301 B 305 A 305 B 307 A 308 B 310 A 310 B 312 B 313 A 313 B 316 B 323 A the 400 hall: 404 A 404 B	F 460		
F 505 SS=D	483.75(j)(2)(ii) ADMINISTRATION The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview it was determined that the facility did not notify the physician, in a timely manner, of a critically low	F 505 ok 12/24/03 [illegible]	ADMINISTRATION An inservice will be held on December 23, 2003 with the nurses. Reporting lab results to the physician in the appropriate amount of time will be discussed. A 24 hour chart check will also be implemented to ensure that all lab results are reported to the physician.	

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F 505	Continued From page 36 hemoglobin and hematocrit results for 1 of 15 sample residents. Resident 30. Findings include: Resident 30 was admitted to the facility 07/16/03 with the diagnosis of Parkinson's with multiple complications, aspiration pneumonia, respiratory failure, dysphasia, depression, renal insufficiency and anemia. Resident 30's medical record was reviewed on 12/01/03. On 08/21/03 a CBC (complete blood count) was ordered for 08/26/03. On 08/26/03 the Hgb (hemoglobin) result was 11.4 and the Hct (hematocrit) was 35.2. Normal range for an Hgb was 13.5-17.5. Normal range for a Hct was 41.0-53.0 per the facility lab. There was no documented evidence that the physician was aware of the low Hgb and Hct until 09/02/03 , (7 days later). On 11/11/03 a CBC was obtained and the documented results were Hgb 6.8 and Hct 20.7. There was no documented evidence that the physician was made aware of the critically low Hgb and Hct until 11/13/03 (2 days later). On 11/14/03 a CBC was obtained and the documented results were Hgb 6.0, Hct 18.0. There was no documented evidence that the physician was made aware of the critically low Hgb and Hct until 11/18/03 (4 days later).	F 505	This will be monitored by the DON in her monthly QA rounds. This will be completed by January 23, 2004.	

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F 505	Continued From page 37 On 11/20/03 a CBC was obtained and the documented results were Hgb 5.7 and Hct 16.8. There was no documented evidence that the physician was made aware of the critically low Hgb and Hct until 11/22/03 (2 days later). On 11/25/03 a CBC was obtained and the documented results were Hgb 6.4 and Hct 19.2. There was no documented evidence that the physician was made aware of the critically low Hgb and Hct until 12/01/03 (5 days later). An interview with a facility nurse was completed on 12/03/03. She stated that when the lab is noted then the nurse is acknowledging that the doctor has been notified. She also stated that she did not know why this last lab had not been called and that the PA (physician assistant) was not aware that the Hct and Hgb had dropped so low. He asked her to see if the family wanted a blood transfusion. .	F 505		

December 29, 2003

Health Program Survey Coordinator
P.O. Box 144103
Salt Lake City, UT 84114

Dear

I have made the addendums you requested on F 279, F 312, F 325, F 332, F 333 and F 505 below. Please call with any questions.

F 279 All care plans will be written that trigger on the RAPs sheet of the MDS. Care plans will also be reviewed quarterly in the IDT meeting and will be updated as needed at that time. This will ensure that resident care plans address all of the residents needs.

F 332, 333 and 505 The grave yard nurse will complete the 24 hour checks every night.

F 312 This will be monitored daily for complaints by the DON.

F 325 This will be reviewed by the QA committee on or before January 23, 2004.

Thank you for your help.

Sincerely,

Chris Cunningham, Administrator
East Lake Care Center