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 _____	C 9/23/2004

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

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F 271 SS=D	483.20(a) RESIDENT ASSESSMENT At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on record review it was determined that the facility did not have physician's orders to provide immediate care at the time of admission for resident 3. Finding includes: Review of the nurse's notes revealed the following documentation: Resident 3 arrived at the facility on 9/9/04 at 8 PM via a pick up service with out an order from a physician. It was noted that the resident brought her own oxygen and her own b-pap machine. The nurse's note documented that she contacted the DON (director of nurses) and was instructed to call her doctors until she could find one that would give admission orders. Further documentation revealed that a physician was located and orders were given to admit with current medication and instructions to contact the doctor's office in the morning. A nurse's note dated 9/10/04 at 3 PM documented resident 3 as being anxious and saying that she can't breathe. She requested to be sent to the emergency room. The physician was called to get a transfer. The resident was transferred at 4:20 PM.	F 271	F271 Resident 3 was discharged to hospital within 24 hours. All new admits will be informed by the Admission Coordinator prior to admission of the need to have a history and physical and signed Physicians orders prior to the time of admission and will verify receipt of same prior to giving permission to admit. In the event of an emergency admission, the house physician will be called for orders, upon arrival of the patient. This procedure will be reviewed in the nursing inservice on October 25th. Medical records will audit the charts and present findings to the QA committee. This will be completed by 10/25/04. 10/13/04 Acceptable POC Compliance date 10/25/04 [illegible] RN Receipt #A24 [illegible] OCT 12 2004 [illegible] and Resident [illegible]	
F 279 SS=D	483.20(k) RESIDENT ASSESSMENT The facility must develop a comprehensive care	F 279	F279 Care plan complete for resident 4 and her behavioral issues on 9/28/04. A care plan	

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

[signature] | [signature] | 10/12/04

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 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). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility did not develop a comprehensive care plan that met the mental and psychosocial needs for 1 of 10 sample residents. Resident identifiers: 4 Findings include Resident 4 was admitted to the facility on 9/9/04 with diagnoses which included anxiety, post traumatic head injury and insomnia. A physicians note dated 9/21/ 04 documented "Pt. (patient) request klonopin & (and) Ativan. I explained risk/benefits, alternatives, and that she is sig. (significantly) more alert off them. Also, she was mixing Rx's (prescriptions) [with] marijuana. She has poor insight into issues? quickly becomes angry & attacking; refuses anything else & has tried everything; Refuses new medications.	F 279	from each interdisciplinary team member will be in each chart by the 14th day after admission. Medical record audit will be completed and turned in to QA committee. All care plans will be reviewed in IDT meeting to assure that all resident needs have been addressed. This will be completed by 10/25/04	

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F 279	Continued From page 2 Doesn't accept that she is any more alert off them. Promises to quit marijuana. Rec (recommend) Lexapro & [psychological evaluation] if she will try. In an interview on 9/22/04 at 1:22 PM with a CNA (certified nurses aide) she stated that resident can be very angry at any time for no particular reason. She stated that she calls the staff names and yells at other residents as well as the staff. She stated that the staff has been instructed to go into her room in twos and if she is angry and yelling then they are to tell her they will come back after she has calmed down. They will leave and return in about 10-15 minutes. On 9/22/04 a review of resident 4's comprehensive care plan revealed no care plan addressing resident 4's behaviors.	F 279		
F 698 SS=J	This REQUIREMENT is not met as evidenced by: The deficiency is citing the facility with past non-compliance at the level of Immediate Jeopardy. 42 CFR 483.25 Tag F - 309 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.	F 698	F698 Resident 7 was discharged to hospital. For all other residents currently in the facility, or that will be admitted, the nurses will be instructed at their inservice on 10/25/04 that all medication are to be given as ordered by the physician. When there is a question on an order it will still be followed until the physician can be contacted for verification. The nursing 24 hour chart check will be increased to include verification of medications orders, MAR orders, and that the medication is in the med cart, administration. The nurse that finds a error will be responsible to follow through and correct the problem.	

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F 698	Continued From page 3 42 CFR 483.75 Tag F - 490 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. Scope/Severity - J These REQUIREMENTS are not met as evidenced by: Based on interviews and review of resident medical records, it was determined that the facility failed to provide the necessary services to attain the highest practicable physical well-being for 1 of 10 sample residents. Also, the facility was not administered in a manner that enabled it to use its resources effectively or efficiently to attain the highest practicable physical well-being for this same resident. Resident identifier: 7. The State Survey Agency determined through medical record review that resident 7 was discharged to the hospital on 8/27/04. Because resident 7 was no longer in the care of East Lake Care Center, immediate jeopardy to that resident was removed at the time of his discharge. Findings include: The medical record for resident 7 was reviewed on 9/22/04 and 9/23/04. Resident 7 was a 70 year old male who was discharged from the hospital on 8/18/04 and admitted to the facility on the same day with his payment source as Medicare. The primary diagnosis for resident 7 was brain cancer	F 698	The DON will review all MARS monthly for verification of accuracy. Her review will be reported to the QA committee. This will be completed by 10/25/04.	

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F 698	Continued From page 4	F 698		

(glioblastoma).

Physician notes document that resident 7 had an MRI (magnetic resonance imaging) of the brain on 8/1/04 and underwent brain surgery on 8/4/04.

The resident's physician, an oncologist (specializes in cancer), wrote a note dated 8/6/04, which documented the following:

Resident 7 "was noted to have, however some intermittent confusion. As a consequence, the patient had an MRI of the brain. He was found to have a 6 X 7 cm (centimeter) right inferior frontal brain tumor...On August 4, 2004 the patient had a craniotomy. He had an excision of a large tumor. Subsequently, he has felt reasonably well...The patient is in fair reasonable health with a glioblastoma multiforme. This is a dismal cancer. The long-term survival rate is historically in the 1 - 2% range. There have been some recent studies looking at Concomitant Temodar. A study by the French showed a two year survival rate as high as 65%. I recommend this aggressive approach. RECOMMENDATION: Temodar 75 mg per m2 p.o. (by mouth) daily for five days a week before the duration of radiation. Afterwards, we will treat him with five days of Temodar monthly for six months. The above was discussed in detail with the patient. He indicates he wants to be aggressive."

An additional physician, the radiation oncologist, wrote a note on 8/12/04 stating, resident 7 "has a glioblastoma multiforme. Postoperative radiation therapy in conjunction with Temodar is indicated..."

Review of the medical record for resident 7 on 9/22/04 revealed a physician's order (from the

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oncologist) dated 8/20/04 which read "Temodar 140 mg QD (everyday)".

Review of the August 2004 Medication Administration Record (MAR) for resident 7 revealed that he received only one dose of Temodar while in the facility, on 8/26/04. Notes on the back of the August 2004 MAR for resident 7 documented, "Temodar not given" "not available".

The director of nurses (DON) was interviewed on 9/22/04 at 1:55 PM. She was asked why the Temodar had not been given as ordered by the physician. The DON stated that the Temodar was "too expensive" costing "about $6000" and "we would only get about $3000 for his stay from Medicare". The DON stated that they would "lose money". The DON stated that she tried to call the doctor to see if there was an alternative drug besides Temodar, but was not able to get through. She stated that some Temodar did get to the facility "on accident" and the resident received "a few doses".

The assistant administrator was interviewed on 9/22/04 at 2:25 PM. She stated that the remainder of the Temodar was sent back to the pharmacy for credit.

The physician (oncologist) for resident 7 was interviewed in person at his office by two surveyors on 9/23/04 at 1:45 PM. The doctor stated that he was not aware that the facility had not provided the Temodar for resident 7. The doctor was asked what the ramifications would be for resident 7 because he had not received the Temodar as ordered. The doctor replied that resident 7's "best chance for survival" would be with the Temodar and the radiation together. The

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doctor also stated that he spoke to someone at the facility who said, "Do you know how expensive this medication (Temodar) is?" The doctor responded that "yes" he did know. The person at the facility was said to respond saying, "It will break our nursing budget." The doctor said he responded "That's part of my treatment plan." The doctor then told the surveyors that if the facility was not going to follow through with his order, "they should have transferred him somewhere else."

The DON was interviewed a second time (by two surveyors) on 9/23/04 at 3:10 PM. She was asked who had decided not to provide the Temodar as ordered for resident 7. The DON stated that she spoke to the administrator who told her "We can't." The DON then stated "we would be paying out more than we would be getting for the patient." The DON stated that she had told the pharmacy to "hold" the Temodar until she could get a hold of the doctor. She stated that she never did get a hold of the doctor. When the DON was told about the conversation with the doctor as documented above, the DON stated that the doctor had left a message saying there was "no alternative drug". When the DON was asked why resident 7 was not started on Temodar then, she responded that she was trying to reach the doctor again to place the resident on hospice. She stated that shortly afterwards, resident 7 was admitted to the hospital.