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

PRINTED: 03/07/2006
FORM APPROVED
OMB NO. 0938-0391

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 ____	02/22/2006

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) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was completed on 2/22/06. This is the 3rd recertification survey in East Lake Care Center's Medicare recertification cycle where deficiencies have been written in the regulatory grouping of "Resident Behavior and Facility Practices" (42 CFR 483.13). Based on the facility's failure to achieve and maintain regulatory compliance, the State Survey Agency is recommending to CMS that a Denial of Payment for New Admissions (DPNA), a Directed Plan of Correction (DPoC), and a single instance civil money penalty (SICMP) be utilized as enforcement tools.	F 000	F225 As a result of the survey resident 21 was interview by the Social Service Director and a investigation was initiated. Prior to this a meeting was held on 02/20/06 and it was determind that no abuse was found. We have hired a new Social Service Director to follow through with corrective plan of correction. All new employees will be inserviced at orientation on facility policies on abuse. All active staff will be inserviced semi-annually on facility abuse policies. All staff will attend Adult Protective Services inservice on recognizing abuse and being pro active in the prevention of abuse by 03/31/06.	3/24/06 3/27/06
F 225 SS=G	483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law	F 225	All staff will attend Ombudsman inservice on residents rights and the right to voice grievances, be heard and the responsibility of the facility to promptly resolve the grievance by 03/31/06. All administrative and supervisory staff will attend Disability Law center inservice keeping resident free from abuse and neglect, to include immediately reporting and investigation, intervening in a timely manner and correct follow up. Review administrative responsibilities and tracking procedures 03/31/06. Administrator will be appointed the new abuse coordinator and will meet	3/22/06 3/28/06

Handwritten annotations: "3/14/06 POC acceptable completion date 3/27/06"

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tracy [signature] TITLE: Administrator (X6) DATE: 3/10/06

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 225	Continued From page 1 through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility staff did not timely report an allegation of potenial staff to resident verbal abuse involving resident 21, and did not investigate and report a resident to resident physical abuse with injury involving resident 9, to the facility administrator or to the State Agency as required. Findings included: 1. Investigate and Report Potenial Staff to Resident Verbal Abuse Resident 21 was admitted to the facility in July of 2000 with diagnoses that included muscular dystrophy, respiratory failure, quadriplegia and depression. Resident 21 is alert and oriented. A nurse surveyor was approached on 2/21/06 by	F 225	with Social Service Director to review and discuss follow up and plan of action for all investigations of resident to resident, staff to resident, community/family to resident daily. Will be completed by 03/10/06. All of resident 9's resident to resident incidents were reported to APS and all incident reports were followed through with. Social Service Director will review resident to resident log daily at census meeting. All resident to resident incidents will be reported to APS by fax each Wednesday with a copy of the transmittal filed with the reports. All incidents will be followed up within a timely manor and findings reported to the administrator daily. A committee will be formed to provide solutions when a pattern of two or more incidents are reported or a resident is a high risk for incidents. We will incorporate the "Circle of Learning" as taught by well springs/ Health insight modules in these committee meetings, meetings will be held weekly. Social service Director will compile a plan of action with behavior modifications and will continue to monitor situations, adjust plan as needed. All of these findings will be reported at the next scheduled QA meeting Monthly by the Social Service Director Starting	injuries of unknown origin ? 3/9/06 3/22/06

03/13/2006 MON 16:41 [TX/RX NO 8733] 003

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F 225	Continued From page 2 a CNA and on 2/22/06 by a RN indicating that resident 21, who was not a sample resident, wanted to talk to a surveyor. Resident 21 was interviewed on 2/22/06 at 10:55 AM. Resident 21 stated that that a "few weeks ago" nurse 1 made him feel uncomfortable by a comment that was made. Resident 21 stated that nurse 1 came into his room with an enema that resident 1 had requested for later that evening. (A nurse on the night shift was to administer the enema.) Nurse 1 then put the enema bag in a drawer and stated that they hoped that resident 1 had "pleasure" receiving the enema but not too much "pleasure". Resident 21 stated that this comment made him feel very uncomfortable. Resident 21 stated that CNA 3 (certified nursing assistant) and CNA 4 were in his room and had witnessed this conversation. Resident 21 went on to say that he had asked someone, he couldn't remember who, to tell the DON (director of nursing) that he wanted to speak with her about the incident. Resident 21 stated that the DON never came. On 2/22/06 at 12:50 PM, CNA 3 and CNA 4 were interviewed. They stated that a few weeks ago (they were unable to give an exact date) they were in resident 21's room when nurse 1 came into the room with an enema for resident 21. They stated that after nurse 1 put the enema in a drawer, nurse 1 stated that they hoped that resident 21 would receive great "pleasure" from the enema but not too much "pleasure". CNA 3 and CNA 4 then stated that resident 21 became very quiet. They stated that after nurse 1 left the room, resident 21 stated that he was offended and felt harassed.	F 225	03/27/06 and thereafter monthly. This will be monitored by the administrator. completion date 03/27/06. Need 3/27/06 QA meeting notes	

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F 225	Continued From page 3 CNA 3 and CNA 4 were asked if they had reported this potential verbal abuse to anyone. They stated that at first they didn't think anything of it, but then resident 21 kept talking about it. They stated that on 2/18/06, approximately 3 1/2 weeks after the incident occurred, CNA 3 wrote a letter about the incident and put it under the ADON's (assistant director of nursing) office door. On 2/23/06 resident 21's January and February 2006 MARs (medication administration record) were reviewed. It was documented that resident 21 received an enema on January 22nd at 10:00 PM. There was no other documentation that any other enemas were administered in January or February of 2006. According to the MAR documentation the incident most likely occurred on 1/22/06. On 2/22/06 the facility's "Anti-Abuse Policy for Residents" was reviewed. It was documented in their abuse policy that, "When a case of abuse is noted by an employee, they must immediately report it to their Department Head or the nursing supervisor." On 2/22/06 at 3:00 PM, the Social Services Director (SSD) was interviewed. She stated that she found out about the incident with resident 21 and nurse 1 on 2/22/06. The SSD stated that she started her investigation of the incident at approximately 1:00 PM on 2/22/06. On 2/22/06 at 3:15 PM, the DON was interviewed. She stated that she found out about the alleged incident on 2/20/06 approximately 20 minutes before a scheduled meeting involving herself, the ADON, CNA 3, CNA 4 and nurse 1. The DON stated that the incident was discussed as a	F 225		

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F 225	Continued From page 4 "conflict between staff" members and that she didn't investigate the incident any further. The DON also stated that she did not share this information with the SSW until 2/22/06. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). 2. Investigate and Report Potenial Resident to Resident Abuse. Resident 9 was admitted to the facility February 2005 with diagnoses that included Alzheimer's dementia and wander risk. On 2/15/06 at 9:45 AM, during initial tour, resident 9 was observed to be lying in another resident's bed. Resident 9 had a small, closed laceration above her right eye. The resident's right eye, eyebrow and cheek were swollen and were dark purple. On 2/16/06 at 1:25 PM, two nursing assistants were asked how resident 9 got her black eye. The nursing assistants stated, "She fell." The nursing assistants stated resident 9 had been in another resident's bed, the other resident pushed her out of his bed, and resident 9 fell on the floor. On 2/15/06, 2/16/06, 2/21/06 and 2/22/06, resident 9 was observed intermittently to ambulate independently within the secured special care unit.	F 225		

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F 225	Continued From page 5 On 2/16/06, resident 9's medical record was reviewed. The facility interdisciplinary team (IDT) documented a Minimum Data Set (MDS) assessment for resident 9, dated 1/27/06. The IDT documented that resident 9 was confused. The IDT documented resident 9 had behaviors of resisting cares at times which were easily redirected, and frequent wandering which was not easily redirected. The IDT documented that resident 9 ambulated independently and needed supervision. A nurse's note, dated 2/2/06 revealed resident 9 had received a hematoma to the back of her head from a fall. A nurse's note, dated 2/8/06 revealed resident 9 had been found to have a bruise on the front of her upper left arm and a scab on her elbow from an unknown source. A nurse's note, dated 2/12/06 revealed resident 9 had received a laceration above her right eye and that her eye was bruised and swollen. On 2/22/06 at 12:20 PM, the nurse who had documented the incident of 2/12/06, involving resident 9, was interviewed. The nurse stated that two nursing assistants were busy in another resident's room when they heard a noise and found resident 9 on the floor. The nurse stated that they "assumed" resident 9 had rolled out of the other resident's bed because no one saw the incident. The nurse stated that the other resident was in the room with resident 9. The nurse stated that the other resident told her that he may have pulled resident 9 out of his bed. On 2/22/06 at 3:00 PM, an interview was conducted with the Clinical Social Worker (CSW).	F 225		

03/13/2006 MON 16:46 [TX/RX NO 8734] 001

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F 225	Continued From page 6 The CSW stated that she couldn't remember the exact incident in which resident 9 received her black eye. The CSW stated that it was known that the male resident involved was very "particular" and liked a wide area of private space. On 2/22/06 at approximately 3:55 PM, the Director of Nursing (DON) provided three Incident Reports regarding resident 9's injury on 2/12/06. There was no documentation that an investigation had been conducted although the Incident Reports revealed resident 9 had sustained three unwitnessed injuries over a period of ten days. There was no documentation at the State Agency that the facility had notified the State Agency of the incidents. Adult Protective Services (APS) is to receive reports from Utah facilities weekly regarding resident to resident incidents. APS sends faxed copies of the reports weekly to the State Agency. The faxed reports from APS were reviewed at the State Agency on 2/14/06 and 2/23/06. There were no APS records that the incidents involving resident 9, between 2/2/06 and 2/12/06, had been reported by the facility.	F 225		
F 241 SS=E	483.15(a) DIGNITY 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	F 241		

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F 241	Continued From page 7 by: Based on observation, individual interview, and group interview it was determined that the facility did not promote the care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individually. This occurred for 3 out of 20 sampled residents, 2 supplemental resident, amd 8 out of 8 confidential group interview residents. (Resident identifiers: 6, 8, 19, 21, 23) Findings included: 1. Resident 8 was an 82 year old female admitted to the facility on 07/31/04 with diagnoses of CVA, TIA's, arterial fibrillation, CHF, Graves disease , hypertension, renal insufficiency, and hypothyroidism. On 2/15/06 at 2:41 PM, resident 8 was interviewed. When asked by the surveyor if her call light worked Resident 8 stated,"Yes", but has had to wait up to 4 hours for a call light to be answered. On 2/16/06 at 10:30 AM, the resident group interview was conducted. When asked by the surveyors, if there were any other issues they would like to discuss, the residents stated that the call lights are a concern. One resident stated that after pressing her call light it generally took 45 minutes to a hour to be answered. When asked by the surveyors if any other residents have had to wait more that 45 minutes, 8 out of 8 residents present at the group interview raised their hands. Three of the residents explained that the aides enter the rooms to turn off the call lights, but give them the 1 minutes finger, leave and never come	F 241	F241 A committee will be formed of both staff and residents to form on going solutions to the issues of call lights being answered in timely manner and improve relationships between staff and residents. Committee will meet twice monthly starting the week of 03/21/06. Call light audits will be performed weekly by managers and committee members. This will continue until the call lights are consistantly answered in a timely manor and the committee members agree that the issue has been resolved to the residents satisfaction. All of these findings will be reported at the QA meeting Monthly by the Assistant Director Of Nursing Starting 03/27/06 and thereafter monthly. CNA assignments and staffing has been adjusted at peak times as of 02/27/06 to better cover all halls (see attached) during meal times. Activity schedule has been adjusted to involve residents in activities after meal times to provide resident's with a stimulating alternative other than returning to their rooms directly following meals. This process will be reviewed in QA meeting monthly by the Assistant Director Of Nurses starting 03/27/06 It will be evaluated for effectiveness, re-evaluated and updated as needed.	3/24/06 next sch meeting 4/15 @ 1:30 Audits done on 3/20-23 by DON 2/2-2/15-21 2/20- DM A 3/1 thru 3/24 Housekeeping

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F 241	Continued From page 8 back. 2. Resident 21 was admitted to the facility in July of 2000 with diagnoses that included muscular dystrophy, respiratory failure, quadriplegia and depression. Resident 21 was interviewed on 2/22/06 at 10:55 AM. Resident 21 stated that he has had to wait 20 to 30 minutes for his call light to be answered. Resident 21 stated that the "nurses don't want to answer the call light." 3. On 2/21/06 at 8:35 AM, a "Resident Interview" was conducted with resident 6. Resident 6 stated that on Saturdays and Sundays it takes a long time for the call lights to be answered. She stated there are only two Certified Nursing Assistants (CNA) on the hall on the weekends. The resident stated she has had to wait up to "one hour" for someone to answer her call light, and that "sometimes they never answer it". Resident 6 also stated that "they turn it off at the nurses' station", so I don't get it answered that way. "It's happened about twice". 4. On 2/21/06, observations were made of call lights on the north and center wings. When the surveyor entered the wing at 9:06 AM, the call light for room 206 was visible in the hallway and audible at both the north and south nurses' stations. The call light was answered at 9:12 AM, after six minutes of observation. At 9:15 AM, the call light for room 307 was activated. The call light was answered at 9.22 AM, after 7 minutes of observation.	F 241	Resident 23 and 19 have had new clothing ordered (see attached). CNA/Laundry will assess resident clothing needs monthly; any clothing that no longer fits or is damaged will be replaced. Laundry/Housekeeping will keep schedule of monthly clothing assessment and will inform Social Service Director if replacements are needed. Social Service Director will coordinate with family/residents to replace clothing. This process will be reviewed in QA meeting monthly by the Social Service Director starting 03/27/06. Completion date 03/27/06.	

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F 241	Continued From page 9 At 9:25 AM, the call lights for rooms 300 and 306 were activated. At 9:29 AM, the call light for room 306 was answered. The call light for room 300 was not answered until 9:43 AM, 18 minutes after it had been activated. At 10:00 AM, a resident in room 300 stated that he had activated the call light to get assistance to go to the bathroom. At 9:34 AM, the call light for room 218 was activated. At 9:49 AM, the call light for room 218 was answered, 15 minutes after it had been activated. At 9:45 AM, the resident in room 218 was asked if she had activated her call light. The resident stated that she had. The resident, who was lying in bed, stated that she needed some water and wanted her room light turned off. 5. On 2/16/06 at 12:30 PM, resident 23 was observed to be ambulating in the Special Care Unit east dining room. Resident 23, who was dependent upon staff for dressing and all activities of daily living, was dressed in a khaki colored, one-piece coverall. The coverall had three to four inch holes in both knees and the pant bottoms were short, at his mid calf level. On 02/22/06 at 1:30 PM, resident 23 was observed to be wearing the khaki coverall that was too small and had the holes in both knees. 6. On 02/16/06 12:45 PM, resident 19 was observed to be wearing a blue, one-piece coverall that had a six to seven inch split in the seam at the bottom of his right pant leg. On 2/22/06 at 8:00 AM, resident 19 was observed to be wearing the blue coverall that still had the split in the right leg seam.	F 241		

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F 279	Continued From page 10	F 279		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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 services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that for 1 of 20 sample residents (Residents 3), the facility did not develop, review and revise comprehensive care plans for each resident based on their individual needs identified by the facility staff. Findings include: A. Resident 3 was admitted to the facility on 7/22/05 with the following diagnoses: chronic airway obstruction, acute respiratory failure, viral	F 279	F279 Resident 3 care plan has been updated. The Director Of Nurses and the MDS coordinator will utilize the MDS completion tool and IDT care plan meeting form to verify that RAPS triggered on the RAP summary sheet of the MDS matches the current care plans in the chart. This will be done weekly at IDT per those MDS's completed during the week. This process will be reviewed in QA meeting monthly by the Director of Nursing starting 03/27/06. Completion date 03/27/06. see care plans	

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

PRINTED: 03/07/2006
FORM APPROVED
OMB NO. 0938-0391

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 ______	02/22/2006

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F 279	Continued From page 11 pneumonia, urinary tract infection, osteoarthritis, and peptic ulcer disease. On 2/15/06, Resident 3's medical record was reviewed. Resident 3's admission Minimum Data Set (MDS) dated 9/20/05, triggered the following problem areas, on the Resident Assessment Protocol Summary: 1. Cognitive loss 2. Communications 3. Activities of daily living (ADL's) 4. Urinary incontinence 6. Psychosocial well-being 7. Mood state 8. Behavioral symptoms 9. Activities 10. Falls 11. Nutritional status 12. Feeding tubes 13. Dehydration 14. Dental care 15. Pressure ulcers 16. Psychotropic drug use "The Care-planning decision" column was not completed as to which triggered areas, were to be careplanned. On 02/22/06, the MDS coordinator was interviewed. She stated that she must have missed the checks in the care planning decision column, and that the resident is "total care, and should be care-planned" Review of resident 3's careplans showed no documentation that the following problem areas	F 279		

PRINTED: 03/07/2006
FORM APPROVED
OMB NO. 0938-0391

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 279	Continued From page 12 had been careplanned: 1. ADL's 2. Urinary incontinence 3. Activities 4. Nutritional status 5. Feeding tubes 6. Dehydration 7. Pressure ulcers 8. Psychotropic drug use	F 279		
F 371 SS=E	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility did not store, prepare, distribute and serve food under sanitary conditions. Findings include: On 2/15/06 at 9:00 AM, the dietary manager stated they were still cleaning up from breakfast. Observations included: A cleaning cloth bucket contained chlorine sanitizer at 200 parts per million. There were no trash containers with foot levers for the lid that would allow staff to dispose of items without touching the lids. The surveyor washed her hands and looked for a receptacle to	F 371		

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

PRINTED: 03/07/2006
FORM APPROVED
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F 371	Continued From page 13 dispose of her paper towel. The dietary manager showed the surveyor where the two trash containers were located. The trash receptacles had snap on plastic lids which did not have handles. A dietary staff washed her hands, and then was observed to lift the lid on the trash receptacle to dispose of her wet paper towel. More than twenty clear plastic glasses had been washed and stacked while they were still wet. The dietary manager advised staff dishes stacked wet can be the perfect place for bacteria to breed. Dried yellow squash was observed to be on the counter directly under the food preparation counter. The dietary manager stated that squash had been served for lunch the previous day. The lights above the stove were soiled with dusty grease. The area above the stove, where the hood touched the metal plate at the back of the stove, had a line of dark gold grease build up. Dust was on top of the oven. A dietary staff was putting foods on shelves from boxes that were directly on the floor of the pantry. The dietary manager stated the food had been delivered the previous day. On 2/16/06 at 12:15 PM, two test trays were requested by the surveyors to be delivered with the trays for the 100 hall and for the 400 hall. The meal was tested for palatability and temperature immediately after the final trays had been delivered to the residents. Results: Pizza was warm and tested to be 80 degrees F.	F 371	F371 Inservice given on 02/24/06 for sanitization and level that are appropriate. Dietary manager will test and record levels weekly (see attached form). New trash containers with foot pedals were purchased 03/09/06. Inservice was given on 02/24/06 on correct procedure for drying dishes. ok Inservicing will continue monthly on this issue as needed. Dietary manager will randomly check dishes for dryness throughout the month. (see attached form). Light covers were cleaned on 02/15/06. Top of stove and area around stove was cleaned 02/15/06. Both of these items are on the weekly cleaning checklist. This assignments will be checked weekly by the Dietary Manager (see attached form). Staff has been inserviced on 02/24/06 on the importance of putting away stock ok on the day of delivery if some reason this is not possible they have been	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	Continued From page 14 Cheese on one of the pizza slices was hardened. The lettuce, cucumber and tomato chunk were served on the same covered plate with the pizza. The salad tasted warm. The ranch style salad dressing was served on the plate in a separate cup. The dressing tested to be 66 degrees F. Milk tested to be 56 degrees F and drinking water was 60 degrees F. On 2/21/06 at 2:25 PM, observations included: Dishes were being cleaned by two dietary aides. Greater than twenty clear plastic glasses were observed to be stacked on each other. The glasses were wet with visible water drops on the insides. At 2:25 PM, an uncovered pan of left over green beans next to a covered, clear container of approximately two quarts of thinly sliced roast beef were observed to be cooling on the wooden counter. Open faced beef sandwiches and green beans had been served for the alternate choice lunch meal. Lunch was served from 12:00 PM until 1:00 PM. At 2:40 PM, a dietary staff was observed to put the green beans into a food processor. The dietary staff stated the green beans were going to be served for the pureed meals the following day. The dietary manager stated the beans could not be served because they had been sitting out too long. At 2:40 PM, the thinly sliced beef, which had been cooling on the counter, was observed to have been placed in the walk in refrigerator to be served at a later time. On 2/22/05 at 1:10 PM, two residents' food trays	F 371	instructed to set full cases on shelf until it can be put away. Dietary staff will be inserviced on 03/10/06 concerning palatability of food and the serving of hot and cold foods in separate dishes. Dietary manager will continue to test trays 3-6 times per week of all three meals. ok Inservice given on 02/24/06 and 03/10/06 on the use of left over food items and what can and can not be done with them, the importance of correct temperature and storage. ok Staff will be inserviced on 03/10/06 on the passing, cleaning of trays and the importance of keeping them separated due to cross contamination issues. All of these process will be reviewed in QA meeting monthly by the Dietary Manager starting 03/27/06. Completion date 03/24/06. Have audits been done?	

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

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F 371	Continued From page 15 were still on the tray cart which was just outside the Special Care Unit south dining room.. Staff and residents cleared three finished meal trays from the tables and put them back in the tray cart, above the trays that still needed to be served. On 2/22/05 at 1:12 PM, one resident's food tray was at the bottom of the tray cart which was in the Special Care Unit east side dining room.. Staff had cleared two finished meal trays from the tables and put them back in the tray cart, above the tray that still needed to be served	F 371		
F 496 SS=D	483.75(e)(5)-(7) REQUIRED TRAINING OF NURSING AIDES Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24	F 496		

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

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F 496	Continued From page 16 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on interview with the facility administrator, and review of facility personnel files, it was determined that the facility did not seek information from the nurse aide registry prior to allowing 1 of 5 CNA's (Certified Nursing Assistants) hired in 2005 to perform cares on facility residents. The nurse aide registry provides information on current aide certification and whether or not an aide has a history of abuse. Findings included: Employee 1 was hired on 9/14/05, and was permitted to work in the facility as a CNA with direct patient contact. Employee 1's personnel file contained a nurse aid registry check dated 11/9/05, nearly two months after she began working at the facility. During an interview with the facility administrator on 2/22/06, she stated that it's their policy to check the nurse aid registry before allowing a new CNA to work but it did not happen this time.	F 496	F496 All new direct care staff will be check on the Nurse aide registry prior to orientation. If computer print out from registry in not attached to orientation paperwork employee will not be permitted to attend orientation completed 03/10/06. This will be monitored by DON/~~ADON and reported~~ at monthly QA starting 03/27/05. Completion date 03/27/06.	
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS	F 514		

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OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 514	Continued From page 17 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on clinical record review, and staff interview, it was determined that the facility did not maintain clinical records on each resident that were complete or accurately documented. Specifically 3 out of 20 sampled residents and 2 supplemental, did not have physician re-certification orders, medication records, enteral records, or physician telephone orders that were complete or accurately documented. (Resident identifiers: 22, 14 and 2) Findings included: 1. On 2/25/05, resident 22 was admitted to the facility with the following diagnoses: schizoaffective disorder, left total knee, hypertension, hypothyroidism, and anxiety. On 2/16/06, resident 22's medical record was reviewed. Resident 22's telephone orders revealed that a physician telephone order was written on	F 514	F514 Resident 22 MAR and re-certs were fixed according to the Telephone orders on 02/22/06. After filling out the telephone orders they will be placed in medical records box. Medical records will pick up all telephone orders and input them daily. Physician re-certification orders will be printed and sent to nursing department to verify orders monthly. All hand written information on the physician re-certification will be verified by the telephone orders by Medical Records. Then all the orders will be input, re-certifications, MARS, TARS, and all other flow sheets will be printed and sent to the nursing department to be re-checked and sent back to the Medical Records Department Medical Records will check MARS for any changes and with telephone orders, this will be done on a monthly basis and reviewed every month in QA starting on 03/27/06. Completion date 03/27/06. Resident 14 enteral flow sheet and physician orders were clarified and re-written 02/22/06.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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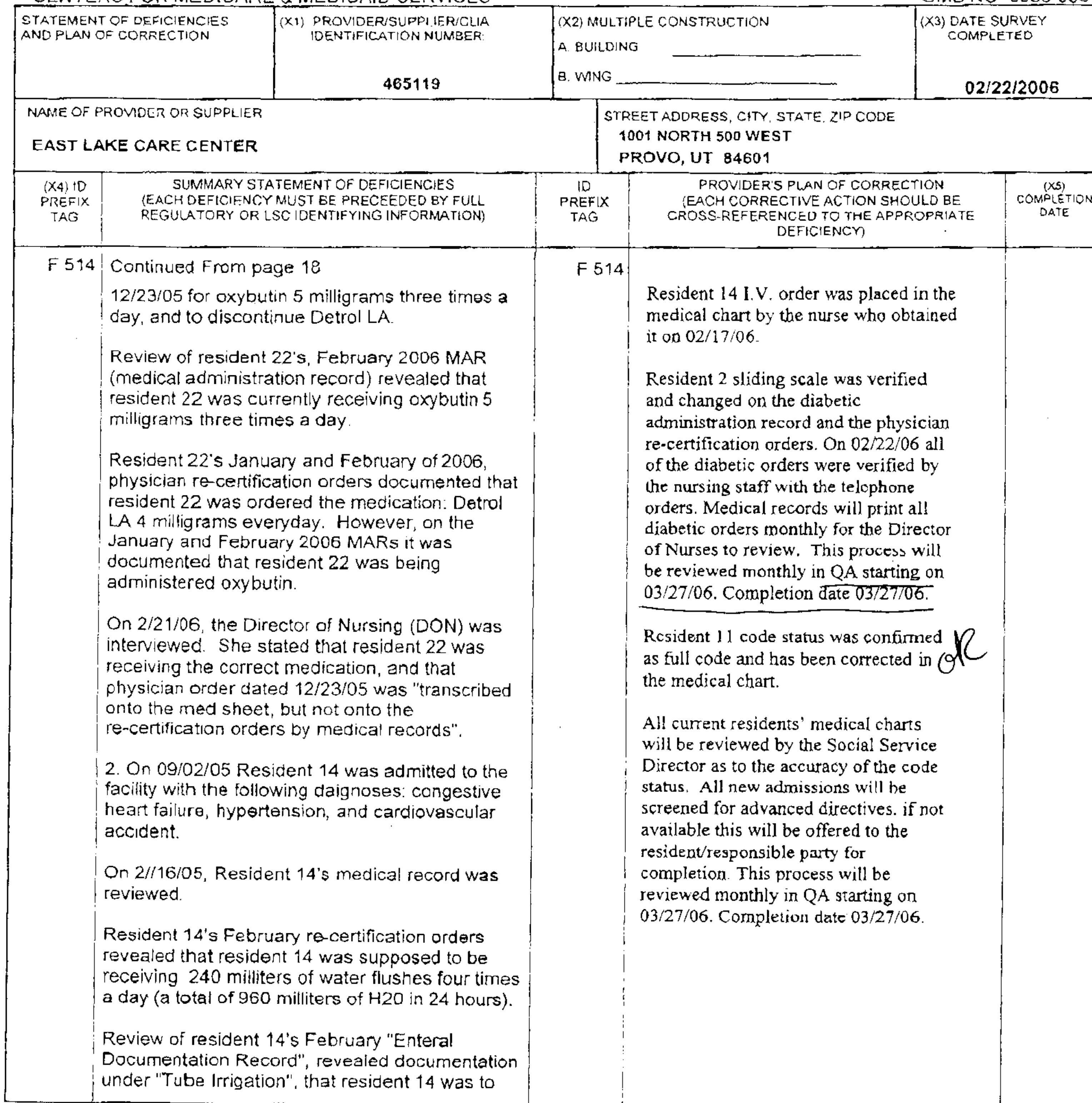

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F 514	Continued From page 18 12/23/05 for oxybutin 5 milligrams three times a day, and to discontinue Detrol LA. Review of resident 22's, February 2006 MAR (medical administration record) revealed that resident 22 was currently receiving oxybutin 5 milligrams three times a day. Resident 22's January and February of 2006, physician re-certification orders documented that resident 22 was ordered the medication: Detrol LA 4 milligrams everyday. However, on the January and February 2006 MARs it was documented that resident 22 was being administered oxybutin. On 2/21/06, the Director of Nursing (DON) was interviewed. She stated that resident 22 was receiving the correct medication, and that physician order dated 12/23/05 was "transcribed onto the med sheet, but not onto the re-certification orders by medical records". 2. On 09/02/05 Resident 14 was admitted to the facility with the following daignoses: congestive heart failure, hypertension, and cardiovascular accident. On 2//16/05, Resident 14's medical record was reviewed. Resident 14's February re-certification orders revealed that resident 14 was supposed to be receiving 240 milliters of water flushes four times a day (a total of 960 milliters of H20 in 24 hours). Review of resident 14's February "Enteral Documentation Record", revealed documentation under "Tube Irrigation", that resident 14 was to	F 514	Resident 14 I.V. order was placed in the medical chart by the nurse who obtained it on 02/17/06. Resident 2 sliding scale was verified and changed on the diabetic administration record and the physician re-certification orders. On 02/22/06 all of the diabetic orders were verified by the nursing staff with the telephone orders. Medical records will print all diabetic orders monthly for the Director of Nurses to review. This process will be reviewed monthly in QA starting on 03/27/06. Completion date 03/27/06. Resident 11 code status was confirmed as full code and has been corrected in the medical chart. All current residents' medical charts will be reviewed by the Social Service Director as to the accuracy of the code status. All new admissions will be screened for advanced directives. if not available this will be offered to the resident/responsible party for completion. This process will be reviewed monthly in QA starting on 03/27/06. Completion date 03/27/06.	

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F 514	Continued From page 19	F 514		

recieve the following: 240 milliters of H20 every 8 hours, (a total of 720 milliters in 24 hours). The nursing staff were initialing that resident 14 was receiving the 240 milliters only in the AM and PM, (which would only be a total of 480 milliters of H20 in 24 hours).

3. Review of resident 14's February "I.V. (intravenous) Medication Record", revealed that resident 14 was receiving an I.V. medication of tobramycin 100 milligrams everyday for 14 days.

No documentation could be found in resident 14's medical record that a physician order was written for the I.V. medication.

4. On 2/14/79 resident 2 was admitted to the facility with the following diagnoses: quadriplegia, urinary tract infection, diabetes mellitus, pneumonia, seizure disorder, and traumatic brain injury.

On 2/16/06 Resident 2's medical record was reviewed.

Review of resident 2's February 2006 "Diabetic Administration Record" revealed documentation of the following sliding scale as being given:

sliding scale

AM	PM
60-119 = 0 U	0 U
120-150 = 2 U	4 U
151-200 =4 U	0 U
201-250 = 6 U	2 U
251-300 = 8 U	4 U
301-350 = 10 U	5 U
351-400 = 14 U	7 U

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F 514	Continued From page 20 401-450 = 18 U 10 U > 450= Call MD Resident 2's 2006 February physician re-certification orders revealed that resident 2 was to receive a sliding scale documented as follows: sliding scale 60-119 = 0 U (units) 120-130 =2 U There was no documentation found as to what kind of insulin to administer for the sliding scale, or when to administer the sliding scale. 5. Resident 11 was a 69 year old male who was admitted to the facility September 2004. Resident 11's medical record was reviewed on 2/15/05. A red paper "Chart Alert," in resident 11's medical record, revealed the resident had been designated to be "DNR" (Do Not Resuscitate). The DNR notation had been lined out and "full code" was written above it. There was no date or initial of the person who had documented the change. The Physician's Recertification of Orders, dated February 2006, revealed that resident 11 was still ordered to be DNR. Staff would have had difficulty trying to determine how aggressive the resident wanted them to be in a rapid response emergency situation.	F 514		