

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


PRINTED: 04/24/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2006
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE CLEARFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 1450 SOUTH 1500 EAST CLEARFIELD, UT 84015
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 514 SS=E	<p>483.75(l)(1) CLINICAL RECORDS</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility did not maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented for 3 of 18 sample residents (residents 1, 2, and 8).</p> <p>Findings included:</p> <p>On 4/10/06 through 4/12/06 clinical medical records were reviewed.</p> <p>1. Resident 1 was admitted to the facility on 10/9/02 with diagnoses including: Amyotrophic Lateral Sclerosis, aphasia, dysphagia, hypertension and edema.</p> <p>Resident 1 had a physician's recertification order for the month of April 2006 signed by the physician on 4/3/06 for a tube feeding. The tube feeding order for resident 1 read: "Fibersource HN or equivalent over X (times) 15 hours 750 cc</p>	F 514	<p>SEE ATTACHED SHEET</p> <p>5/9/06 POC acceptable Completion date <u>5/31/06</u> Busenbank R</p> <p>5/9/06 - Per telephone call to adm completion date is 5/31/06 added with permission Busenbank RN</p> <p>Utah Department of Health 5-4-06 MAY 08 2006 7005 0390 0004 8855 1586 Bureau of Health Facility Licensing, Certification and Resident Assessment</p>	
---------------	--	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 5/3/06
--	------------------------	---------------------

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.

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

PRINTED: 04/24/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE CLEARFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1450 SOUTH 1500 EAST CLEARFIELD, UT 84015	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 514	<p>Continued From page 1</p> <p>(cubic centimeters)/day of Fibersource HN per day from 6 AM - 2 AM, 75 cc/hour. Fluid bolus 750 cc QID (four times a day) to feeding QD (every day)."</p> <p>The Medication Administration Record (MAR) for April 2006 for the tube feeding read: "Formula Fibersource HN. Rate 75 cc/hr. Tube irrigation 350 cc H2O (water) Q (every) 6 Hrs. 1300 (1:00 PM) Up. 2300 (11:00 PM) Down."</p> <p>The physician's recertification order and the MAR were not consistent.</p> <p>2. Resident 2 was admitted to the facility on 1/23/03 with diagnoses including: Parkinson's, dysphagia, multiple sclerosis, hemiplegia and edema.</p> <p>On 9/13/05, the registered dietitian made a dietary tube feeding recommendation telephone order, which was signed by the physician on 9/13/05. The dietary recommendation telephone order read to "ensure adeq. (adequate) hydration increase flush to 250 ml (milliliters) H2O (water) tid (three times a day)."</p> <p>Resident 2 had a physician's recertification order for the month of January 2006 signed by the physician on 1/23/06 for a tube feeding. The tube feeding order for resident 2 read: "Fibersource HN per GFT (gastric feeding tube) TF (tube feeding) 90 cc/hr X (times) 14 hrs CENT Flush 200 ml H2O TID"</p> <p>An order to reduce the 250 ml water flush three times a day (ordered 9/13/05) to 200 ml water flush three times a day (January 2006</p>	F 514		

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

PRINTED: 04/24/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/13/2006
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE CLEARFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1450 SOUTH 1500 EAST CLEARFIELD, UT 84015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 514	<p>Continued From page 2</p> <p>recertification order) could not be found in the medical record.</p> <p>A review of the January 2006 MAR revealed that resident 2 was receiving the 250 ml water flush three times a day.</p> <p>The physician's orders and the MAR were not consistent.</p> <p>3. Resident 8 was admitted to the facility on 8/10/05 with diagnoses including: Pneumonia, cellulitis, neurogenic bladder and multiple sclerosis.</p> <p>A physician order, dated 8/10/05, for resident 2 read: "Trunk restraint while in w/c (wheelchair)."</p> <p>No subsequent recertification orders were found regarding the trunk restraint.</p> <p>A discontinuation order for the truck restraint could not be located in the medical record.</p> <p>The Director of Nursing was interviewed on 04/10/06 at 1:30 PM. She stated that the wheelchair resident 8 was using had been changed and that there was no longer a need for the trunk restraint. The Director of Nursing stated later that the trunk restraint was in fact being used while resident 8 was in the wheelchair.</p> <p>Resident 8 was observed in the wheelchair, in the hallway, on 4/10/06 at 2:00 PM. The front release belt (trunk restraint) was observed to be in use at that time.</p>	F 514			

Rocky Mountain Care Center- Clearfield Plan of Correction

TAG	Plan of Correction	Responsible Party	Completion Date
<p>F 514 Inconsistency with Physician Recertification Orders and MAR</p>	<p>1. All new generated orders will be written on a 3 carbon copy form and distributed as follows: a. Medical Records b. Resident's chart (medical record) c. Clinical Coordinator</p>	<p>a. Medical Records Dept: Transfers new orders into computer generated physician recertification order form. b. Nursing: Places copy of new order into resident's chart c. Clinical Coordinator: double checks all new orders with the MAR for content and accuracy.</p>	<p>Implemented Implemented Implemented</p>
	<p>2. All new orders will be transcribed onto MAR</p>	<p>Nursing Team Leader receiving new order</p>	<p>Implemented</p>
	<p>3. At end of month new orders on MAR will be double checked with the order inputted on the computer for accuracy.</p>	<p>Medical Records Dept</p>	<p>Immediate Implementation (05/31/06)</p>
	<p>4. Dietary recommendation orders will be reviewed and double checked at IDT meetings</p>	<p>Dietary Dept.</p>	<p>Effective 05/09/06</p>
	<p>5. Process will be reviewed at quarterly Q. I meetings x 2 to assure accuracy & compliance.</p>	<p>Nursing, Dietary, Medical Records, Q.I. Committee</p>	<p>7/06 and 10/06</p>