STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465067	A. BUILDING ______ B. WING ______	04/20/2007

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

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F 000	INITIAL COMMENTS	F 000		

S/S = C
483.30 (e) - F356 - Posting Staffing
The facility must post the following information on a daily basis:
o Facility name.
o The current date.
o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
- Registered nurses.
- Licensed practical nurses or licensed vocational nurses (as defined under State law).
- Certified nurse aides.
o Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:
o Clear and readable format.
o In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

The Requirement is not met as evidenced by:

Based on observation and staff interview, the facility failed to post their nurse staffing information as required by this regulation. The findings included:

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

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 000	Continued From page 1 On 4/18/07 at 4:20 PM, in an interview with the Administrator, he indicated that the nurse staffing information was posted outside of the dining room. On 4/18/07 at 4:30 PM, observation of the nurse staffing posting revealed that the number of staff per shift were written on an erasable board. The posting did not include the date, facility name, resident census, and total number and actual number of hours worked, separated as Registered Nurses, Licensed Practical Nurses, and Certified Nurse Aides. The information was not located in a prominent place which was readily accessible to residents and visitors. It was located high on the wall in the beginning of the service hallway, outside of the dining room. Additionally, since this was written on an erasable board, the facility could not maintain the postings for 18 months.	F 000		
F 176 SS=D	483.10(n) SELF ADMINISTRATION OF DRUGS An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined that the facility failed to ensure that two of 17 sample residents (#10 and #12) and one supplemental resident (#24) were assessed by	F 176		

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F 176	Continued From page 2 the interdisciplinary team to self administer medications, had physician orders for self administration of medications, and/or had documentation of the doses of the medications which were actually taken by the residents. The findings included: 1. Review of Medical Records for Resident #10 revealed diagnoses that included: Dementia, Parkinson's Disease, Major Depresssion, Adjustment Disorder. On 4/17/07 at 9:07 AM, an observation of the resident's room revealed a bottle of Systane eye drops in a container with other personal items. On 4/17/07 at 10:00 AM, a review of the resident's Physician Orders summary and assessment for self administration of drugs revealed there was no order for Systane Lubricant Eye Drops. The resident was assessed as not appropriate for self administration of drugs. 2. On 4/16/07 at 4:15 PM, during the initial tour of the facility in the 100 Unit, sample resident #12 was observed to have Claritin D on the over bed table. The resident asked the surveyor if it was alright for him/her to take the medication. The resident stated that the facility had asked him/her to purchase the medication for his/her allergies since it was available over the counter. Review of the resident's record revealed no physician order for Claritin D. On 4/19/07 at 8:50 AM, the Director of Nursing was interviewed regarding the resident's self administration of Claritin D and the facility's policy for self medication assessment. Her reply was "I	F 176		

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F 176	Continued From page 3 can tell you that we did not do the assessment...." 3. On 4/18/07 at 8:00 AM, during the medication pass in the 100 Unit, the nurse was observed to give supplemental resident #24 all the 8:00 AM scheduled medications except for the Atrovent 0.06% nasal spray. The surveyor returned to the resident's room at 10:50 AM and observed the Atrovent 0.06% nasal spray on the bedside table. Review of the resident's Medication Administration Record (MAR) revealed a physician's order for "Atrovent 0.06% 2 puffs each nostril TID (three times a day) with meals allergies may keep at bedside". Review of resident #24's medical record revealed no documentation of an assessment for self administration of medication. On 4/18/07 at 11:00 AM, during an interview with the 100 Unit nurse, she confirmed that no documentation was available in the resident's chart to indicate that an interdisciplinary review had been done to determine the safety of self-administration of the medication. She stated that it would be located in the Care Plan Section. She proceeded then to review the entire resident's medical record. She was unable to find the form. On 4/19/07 at 8:50 AM, during an interview with the Director of Nursing regarding the resident's self-administration assessment form, she was also unable to locate it in the chart. Review of the facility's current policy, provided by the Director of Nursing, stated the followings:	F 176		

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F 176	Continued From page 4 "1. The facility allows self medication under the following conditions: a. A resident is capable of self medication administration as determined by the Interdisciplinary Team using the assessment on Medication Self Administration Assessment Form. 9. All residents on self meds (medication) will have a self med assessment form in their chart, located in the Care Plan section, specifying whether or not, the resident is eligible for self medication administration."	F 176		
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 by: Based on observation and resident and staff interview, it was determined that the facility failed to provide toilet facilities that allowed residents privacy and to assist residents with toileting in a manner that recognized and enhanced their dignity. The findings included: 1. On 4/17/07 during an observation of the evening meal in the dining room, six residents were seated at Restorative Table #9. The residents were served their food on trays. The staff had difficulty fitting the trays on the crowded table. Two of the residents were telling one resident to move his/her tray around the table. At this point staff moved the resident's tray and the resident's wheelchair so that all of the trays would fit on the table.	F 241		

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Review of the facility's posted table seating assignment sheet evidenced that these six residents were all listed to eat at this table.

2. On 4/17/07 at 10:45 AM, in a confidential resident interview, the resident indicated that the staff are good but they are short of staff, making him/her wait for assistance. The resident indicated that he/she had been incontinent of bowel movement and urine (after the catheter was removed). The resident stated that "I have to wait for staff so I have wet myself. It is humiliating to have these young girls changing me." He/she commented that sometimes he/she can not find the call light to use to call the staff.

3. A resident group meeting was held between 9:00 AM and 10:00 AM on 4/18/07. Ten residents attended the meeting.

a. Six residents attending the group stated "our bathrooms are too small". "You can't get your wheelchair through the door frame". "You have to position your wheelchair in such a manor that the door is always propped open and sometimes others observe you while you are in there".

b. Seven of ten residents attending the group meeting complained that staff did not always knock when they entered their individual rooms.

c. Five of ten residents complained that the showers were not warm enough. (Note: Temperatures were taken on 4/16/07 between 5:00 PM and 7:00 PM with the hot water ranging from 97 to 102 degrees Farenheit.)

4. On 4/17/07 at 10:40 AM, sample resident #3

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F 241	Continued From page 6 was observed standing by the bathroom sink. The resident's wheelchair was observed blocking the entrance of the bathroom with the door being kept opened. One of the Certified Nurse Aide (CNA) (I) came in to assist the resident. The resident just had a bowel movement. There was a strong odor coming from the bathroom. The bathroom door was observed to be too small to allow the wheelchair into the room. The CNA acknowledged that the bathrooms were too small for a wheelchair to enter the bathroom.	F 241		
F 244 SS=E	483.15(c)(6) PARTICIPATION IN RESIDENT & FAMILY GROUPS When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, it was determined that the facility failed to act upon grievances of the resident group in a timely manner and/or failed to provide feedback to the residents. The findings included: While conducting the group meeting on 4/18/07 three residents indicated that they had complained to staff that drinking glasses have a film on them and on one recent occasion in 2007 a glass was given to a resident with lipstick on it. According to the residents attending the meeting, this issue is still unresolved. Review of the resident council meetings minutes revealed:	F 244		

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F 244	Continued From page 7 On 2/1/2007 -one resident in the group stated that "glasses have film on them." and the others agreed. On 3/1/2007 - "glasses in the kitchen have film on them." On 4/20/07 at 9:00 AM, the Administrator verified at the exit that he was aware of the problem and will continue to pursue a solution to the ongoing problem.	F 244		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to provide maintenance services to ensure a comfortable, orderly, and cleanable environment for the residents. The findings included: 1. On 4/17/07 from 10:05 AM to 10:20 AM, during the observation of CNA B doing pericare and dressing sample resident #8, there was a strong urine odor in the room. This odor remained even after the resident's care was completed. Sample resident #7, who resided in the same room with resident #8, had a catheter. The odor was most noticeable close to the catheter bag. On 4/17/07 from 2:25 PM to 2:37 PM, during an observation and interview with sample resident #7, the urine odor was present in the room.	F 253		

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2.During observations on 4/16/ 07 thru 4/19/07 the following environmental concerns were noted:

a. The floor of all residents' rooms was observed to be dull and scuffed and were in need of stripping and buffing. The threshold between the common hallway and the residents' rooms was cracked and heavily soiled.

b. On 4/16/07 at 6:12 PM, a toilet riser was observed on the floor of the bathroom and a soiled incontinent brief was observed in the resident's trashcan in room 401.

c. Stool was observed in the toilet from 9:50 AM until 11:05 AM creating an odor in resident's room 405.

d. A discolored stain was observed on 4/16/07 between 4:30 PM and 6:00 PM on the ceiling of resident room 302. The stains measured two feet by one foot across.

On 4/19/07 at approximately 11:10 AM, the Environmental Services Manager explained that it was residue from a nutritional supplement from a tube feeding formula that was accidentally released when the tubing was disconnected while the pump was still running.

e.Window blinds were observed to be bent and disorderly on 4/16/07 between 4:30 PM and 6:00 PM in resident rooms 303 and 311. Also the heating and air conditioning vents were observed to be dirty and in need of cleaning.

f. The heating and air conditioning vents in room 305 was observed to be dirty and in need of

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F 253	Continued From page 9 cleaning between 4:30 PM and 6:00 PM on 4/16/07. g. On 4/17/07 at 10:05 AM a large area of scratched and damaged drywall was observed below the residents' bedroom window in room 114. Paint was observed to be chipped off of the wall behind the bed in room 409. h.On 4/18/07 at 9:30 AM, the bedside table in room 101 was observed to have cracking paint with peeling varnish and was in need of resurfacing. i.The toilet seat in the women's bathroom across from the Administrator's office was found to be loose. The above conditions were discussed and observed by the Environmental Services Manager while on tour with the surveyor on 4/18/07 between 11:00 AM and 11:45 AM.	F 253		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280		

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the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on record review and resident and staff interview, it was determined that the facility failed to update the care plans for four of 17 sample residents (#2, #7, #10, and #9) as their individual needs changed. The findings included:

1. On 4/17/07 at 4:00 PM, in an interview with the Administrator (Adm) and the Director of Nursing (DON), the DON revealed that care plan items are considered active until the items are crossed off of the care plan.

2. On 4/18/07 at 4:00 PM, in an interview with the Assistant Director of Nursing (ADON), she verified that she does the Minimum Data Set (MDS) assessments as the Coordinator and that she updates the care plans quarterly. She confirmed that there were no resolution or target dates listed on the care plans. The ADON commented that the nurses are supposed to change the care plans whenever it is appropriate.

3. Review of sample resident #2's care plan revealed that the care plan was not individualized to address this resident and was not updated when the resident's conditions changed. It contained approaches which did not currently apply to the resident, including:

"Foley cath (catheter) as ordered. Cath care as per facility protocol

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Enteral feedings per MD (physician) order. Flush with water as per MD order. Monitor I & O (intake and output) q (every) shift until stable.

Treatment as ordered (related to potential for skin breakdown).

Hospice care if ordered.

Small frequent meals. Keep Rt (resident) upright for 30 min. after meals.

PTOT (physical therapy and occupational therapy) eval (evaluate) and TX (treatment)."

a. On 4/18/07 at 9:07 AM, the resident's pommel cushion was observed lying on the shower chair in the resident's bathroom.

b. Review of the resident's Physician's Order sheet was signed on 4/11/07 evidenced an order to "use pommel cushion R/T (related to) recent fall & positioning as Pt (patient) tends to slide out of chair." The physician signed that "I have reviewed & approved the total program of care." The physician orders represent the physician's plan of care/treatment for the resident.

c. On 4/18/07 at 10:32 AM, during an interview with the Occupational Therapist (OT), he verified that sample resident #2 currently had a special Rojo cushion, which could have the four quadrants of the cushion adjusted, in use in his/her wheelchair. The OT indicated that they had tried a pommel cushion on the resident's wheelchair, but that it was uncomfortable for the resident and that it was not used very long.

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4. Review of sample resident #7's care plan revealed that the care plan was not individualized to address this resident and was not updated when the resident's conditions changed. It contained approaches which did not currently apply to the resident, including:

"Assist with transfers and ambulation as able.

Toilet every 2-3 hrs.(hours) and PRN (as needed).

Small frequent meals."

a. Record review of the resident's Physician's Orders revealed the following:

7/29/06 "Foley Catheter to DD (dependent drainage). Foley Catheter Care Q shift. Change Foley Q month." (Note: This order was signed on 4/9/07 for the April, 2007 monthly summary of physician orders.)

2/26/07 "Irrigate with wound cleanser and pack with Maxorb Alginate Silver. Change Q 5-7 days or PRN." (Note: This order was signed on 4/9/07 for the April, 2007 summary monthly summary of physician orders.) The physician signed that "I have reviewed & approved the total program of care." The physician orders represent the physician's plan of care/treatment for the resident.

3/1/07 "Ok to see Dr. ____ (name) @ wound clinic in Bountiful for pressure ulcer eval & tx."

b. Review of the resident's 3/21/07 Clinic Visit Progress Notes and Orders evidenced that the resident had a wound VAC treatment started. "We will do VAC change every Wed

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F 280	Continued From page 13 (Wednesday). VAC change your facility Mon (Monday) & Fri (Friday)." c. On 4/17/07 in an interview with the resident, he/she indicated that he/she is not able to walk and is transferred using the lift. The resident expressed dislike of the lift and of the sling which is used. d. On 4/19/07 at 11:27 AM, in an interview with the Director of Nursing (DON), she verified that the resident was on a Medline Supra Mattress (an air mattress rated for prevention and treatment of Stage I through Stage IV pressure sores). e. On 4/20/07 at 8:30 AM, in an interview with the Administrator and DON, the DON revealed that the resident had been on the air mattress since 2/20/06. Review of the resident's care plan revealed that the use of the wound VAC treatment, the use of the special mattress, and the use of the Hoyer lift for transfers were not addressed on the resident's care plan. Additionally, the resident's concerns about the use of the lift were not included in the care plan. 5. On 4/18/07 at 6:30 PM, in an interview with the Administrator and the DON, the need to update care plans and to make the care plans individualized was discussed. Sample resident #2's care plan approaches for the use of a pommel cushion and a feeding tube were examples of the need to update the care plans. The resident no longer had a feeding tube and was not using a pommel cushion, but these items were currently on the resident's care plan.	F 280		

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F 280	Continued From page 14 6. On 4/17/07 at 10:00 AM, a review of sample resident #10's care plan revealed that the care plan was not individualized to address this resident and was not updated when the resident's conditions changed. It contained approaches which did not currently apply to the resident or identify how the approaches were to be implemented, including: "Foley cath (catheter) as ordered. Cath care as per facility protocol" "Hospice Care if ordered" "Adaptive Equipment" "Therapy" 7. Review of sample resident #9's medical record revealed diagnoses that included chronic obstructive pulmonary disease, pacemaker, congestive heart failure, lungs cancer, anxiety, degenerative joint disease, seizures, coronary heart disease, depression, gout and insomnia. Review of the resident's 4/9/07 significant change Minimum Data Set (MDS) assessment and subsequent admission assessment dated 3/12/07, evidenced that the resident required total assistance with bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing by two staff members. The resident was assessed to have functional limitations of the hand due to a right wrist fracture with external pins and open reduction internal fixation. Review of the resident's physician order sheet for April 2007 revealed an order for Foley catheter care dated 3/26/07. The order stated " Foley	F 280		

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F 280	Continued From page 15 catheter care q (every) shift. Change Foley q month. Change Foley bag q Thursday". Review of the resident's care plan revealed no problem listed for "Urinary Incontinence" and no approach for the Foley catheter care.	F 280		
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility failed to follow professional standards of quality and facility best practice policies/procedures when administering medications and implementing nutritional interventions. The findings included: DIETARY BEST PRACTICE On 4/17/07 during the evening meal observation, the residents were observed to receive water in glasses which held six ounces of water when filled to the line where the surface of the plastic changes to a smoother texture. The glasses were filled approximately to the line, giving the residents six ounces of water. Review of the meal tray cards revealed that many of the residents were planned to receive eight ounces of water. On 4/18/07 at 8:12 AM, in an interview with the Dietary Manager (DM), she revealed that the plan for eight ounces of water came from the Crandall (dietary system utilized by the facility) Best	F 281		

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Practice Guidelines For Nutrition Intervention Protocol. These Guidelines noted that:

"Policy
When a resident is screened at nutritional risk, dehydration risk, or pressure ulcer risk, a clinically appropriate intervention should be implemented following Best Practice Guidelines. Best Practice Guidelines can be modified where clinically appropriate and per resident preferences and nutritional needs. Dietetic professionals should use their professional judgement.

Procedure
The following recommended dietitian/dietary interventions should be implemented within 72 hours of the risk being identified unless interventions are contraindicated by disease/diagnosis...

At Risk of Dehydration (High Risk)

1. Add additional 8 oz. (ounce) beverage to each meal or between meals

2. Encourage fluids sent from dietary to equal eight 8 oz servings per day. These fluids are in addition to bedside water...

Actual Dehydration

1. I & Os (intake and output) (Recommend to Nursing)

2. Encourage fluids sent from dietary to equal eight 8 oz servings per day. These fluids are in addition to bedside water..."

The glasses being utilized as eight ounce glasses

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were measured in the presence of the DM. She verified that the glasses held six ounces when filled to the line and eight ounces when filled to the top of the glass. She commented that these were marketed as nine ounce glasses.

STANDARDS OF PRACTICE

A. ADMINISTRATION OF MEDICATIONS:

Standards for nursing practice for administration of medication provide, in pertinent part that: The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's order unless they believe the orders are in error or would harm clients. Medications must be accurately administered and documented. Accurate administration includes, in the first instance, a physician order authorizing the administration of the medication; if an order is not clear, the nurse should communicate with the physician to seek clarification. Thereafter, accurate administration includes transcribing the drug order correctly, delivering the correct drug, to the correct resident, by the correct route, in the correct dose. Accurate documentation involves recording information on the drug administered, including the client's response to the medication. The physician may order a drug on a PRN basis (when a client requires it). The nurse uses objective assessments, subjective assessments, and discretion in determining the client's need. When medications are administered, the nurse documents the assessment made and the time of drug administration. The nurse should make frequent evaluation of the effectiveness of the drug and record findings in the appropriate place. See generally: Lippincott, Nursing Drug Guide,

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1998 (Lippincott) and Perry & Potter, Clinical Nursing Skills & Techniques; 1998, (Perry & Potter).

B. FOLLOWING PHYSICIAN ORDERS

Fundamentals Of Nursing, Potter and Perry, 4th Edition, 1997, Chapter 20, pg 341, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's order unless they believe the orders are in error or would harm clients."

C. MEDICATION DELIVERY

Reference for Professional Standards of Practice in medication delivery:
Fundamentals of Nursing, The Art & Science of Nursing Care, Fourth Edition, Taylor, Lillis, LeMone, Lippincott, 2001, Chapter 28: Medications, page 581: "After the nurse begins to prepare drugs for administration, they should not be left unattended. If it is imperative to leave for a short time, the drugs that have been prepared should be placed in a locked area. The nurse who prepares the medication also administers the drug and records the drug administration. When the nurse is not working at the medication cart, it should be locked."

MEDICATION

1. On 4/18/07 at 8:07 AM, a resident was observed in the dining room. The resident had a light green tablet of medication lying in full view on the abdomen area of his/her clothing. The CNA (C) wheeled the resident to the nurse (D) who identified the resident as _____ (supplemental resident #26). The nurse indicated

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F 281	Continued From page 19 that he/she had watched the resident take his/her medication and that perhaps the resident had held the medication in his/her mouth. The medication did not appear to be wet when the nurse removed it from the resident's clothing and placed it in a medicine cup. The nurse commented that the tablet looked like Digoxin (heart medication). On 4/19/07 at 1:48 PM, in an interview with the Director of Nursing (DON), she verified that she was aware of the medication found on resident #26. She indicated that no incident report/occurrence was done. 2. On 4/19/07 at 3:26 PM, sample resident #13 came to the nurses' desk on the 100/200 hallways and requested Tylenol. When the nurse (H) gave the resident the Tylenol, the resident said that they (the Tylenol) were regular ones, not extra strength. The nurse indicated that the resident would be getting additional medication in awhile. The resident questioned this again but then took the Tylenol. The nurse was then observed to check the strength of the Tylenol and said that it was regular strength that she gave. Review of the resident's Medication Administration Record (MAR) evidenced that the resident's order was for two extra strength Tylenol. 3. On 4/18/07 at 11:15 AM, during the medication pass in the 300 Unit, the medication nurse (J) was observed preparing a nebulizer treatment for supplemental resident #27. The nurse stated that the resident was to receive Albuterol with Atrovent via a nebulizer. The nurse pulled out a pre-mixed unit dose medication pack.	F 281		

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The surveyor asked the nurse for the pre-mixed unit dose container to verify the medication. The container revealed only one medication Albuterol 2.5 mg (milligram) in 3 cc (cubic centimeter) of normal saline. The nurse appeared confused when questioned about the pre-mixed medication. She thought that the pre-mixed medication was missing the normal saline solution. She asked another medication nurse (K) for a 3cc normal saline unit dose.

The nurse Unit Manager (L) was asked to verify the pre-mixed unit dose. She acknowledged that it only contained the Albuterol medication with the normal saline. A call was made to the physician for clarification.

Review of the resident's 3/07 and 4/07 MARs revealed a physician's order dated 3/30/07 for Albuterol/Atrovent svn (small volume nebulizer) qid (four times a day) 1 PO (by mouth). The MAR failed to list the dose for each of the two medications to be administered and for the normal saline solution.

Review of the resident's medical record revealed a Medication Reconciliation Summary form from the transferring hospital dated 3/28/07 and co-signed by the facility's nurse on 3/30/07. The document listed multiple medications with one for "Albuterol/Atrovent PO SVN's PRN (as needed)". The space for the documentation of the dose was left blank.

Review of the resident's medical record revealed a "Patient Transfer And Assessment Form" dated 3/30/07 with a physician's order for "Albuterol via svn qid". Again, the physician's order did not list

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F 281	Continued From page 21 the dosage of the medication or amount of normal saline solution to be administered via the nebulizer. On 4/18/07 at 2:40 PM, the DON provided the surveyor with a physician's clarification order for "Albuterol 0.83 mg c (with) 3 cc N.S (normal saline). Use 1 vial via nebulizer (pre-mix)". Reference for Professional Standards of Practice in transcribing orders: Taylor, Lillis, and LeMone, Fundamentals of Nursing, 1993, page 1199 states: "The nurse is responsible for checking that the transcription of the medication order is correct by comparing it with the original order."	F 281		
F 309 SS=G	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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident, family, and staff interview, it was determined that the facility failed to provide care in a manner to ensure adequate pain relief. This failure affected six of 17 sample residents' (#1, #9, #2, #8, #10, and #13) abilities to reach their highest practicable level of physical, mental, and/or psychosocial functioning. The findings included: Reference: Professional Standards of Practice in	F 309		

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Assessment of Pain:

a. Fundamentals of Nursing, The Art & Science of Nursing Care, Fourth Edition, Taylor, Lillis, LeMone, Lippincott, 2001, Chapter 40: Comfort, page 1047-1055 indicates that a comprehensive pain assessment would identify the causes of pain, how intensely the pain was experienced, when the resident experienced the pain, which pain medication was most effective in relieving the pain, and how the pain affected other needs such as agitation and adequate sleep. Factors to assess would include
1) The characteristics of the pain (location, duration, quantity, quality, chronology, aggravating factors, and alleviating factors),
2) The resident's physiologic response to the pain (vital signs, skin color, perspiration, pupil size, nausea, muscle tension and anxiety),
3) The resident's behavior responses (posture, gross motor activities, facial features and verbal expressions), and
4) Affective responses of the resident such as anxiety or depression.
Additionally the pain assessment should include how the pain experience affects the resident's interactions with others, how it interferes with activities of daily living, meaning of pain to the resident and the resident's expectations for pain relief. A system for comprehensive pain assessments should also include a means for assessment of pain in residents who are cognitively impaired and guides to validate pain cues and recognize pain when the resident is unable to verbalize pain.

b. According to World Health Organization (WHO) the use of pain medication should be guided by principle to "start low, go slow", which

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means start with a low dose and titrate carefully especially in frail, older individuals.

c. According to the U.S. Department of Health and Human Services Clinical Practice Guidelines "Management of Cancer Pain: Adults" (94-0593), "titration" means a medication is to be increased or decreased by one-quarter to one-half of the previous dose.

d. Reference for Professional Standards of Practice in medication orders:
Fundamentals of Nursing, Potter and Perry, Fourth Edition, 1997: "(Chapter 35, Pp. 804): "PRN ORDERS: The physician may order a drug on a PRN basis (when a client requires it). The nurse uses objective assessments, subjective assessments, and discretion in determining the client's need. When medications are administered, the nurse documents the assessment made and the time of drug administration. The nurse should make frequent evaluation of the effectiveness of the drug and record findings in the appropriate place. This may be on the medication administration record or in the client's medical record."

1. On 4/18/07 at 6:30 PM, in an interview with the Administrator (Adm) and the Director of Nursing (DON), the lack of pain assessments was discussed. The DON revealed that a pain assessment is done when the resident enters the facility, but not at any other time.

2. Review of sample resident #9's medical record evidenced that the resident was admitted to the facility on 12/29/06 with diagnoses that included chronic obstructive pulmonary disease, pacemaker, congestive heart failure, lungs

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cancer, anxiety, degenerative joint disease, seizures, coronary heart disease, depression, gout and insomnia.

a. Review of the resident's 4/9/07 significant change Minimum Data Set (MDS) assessment and subsequent admission MDS assessment dated 3/12/07, evidenced that the resident required total assistance with bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing by two staff members. The resident was assessed to have functional limitations of the hand due to a right wrist fracture and open reduction with internal fixation (ORIF). The resident's pain frequency was assessed as being daily, the pain intensity was coded as moderate, and the pain site was listed as joint pain. The pain coding did not reflect the resident's pain for other medical conditions including the right wrist fracture with ORIF, a unstageable pressure ulcer due to necrosis over the right hip, and lung disease.

b. Review of the resident's Pain Assessment Profile form dated 3/26/07 revealed the following:

"#2. Intensity of pain using scale of 0 to 10 (0 no pain, 10 worst pain)
Current level of pain: 10
Worst pain gets: 12
Best pain gets: 0
Acceptable level of pain: 0

#3. Patient's description of pain: throbbing pain

#4. Duration of pain: constant

#5. Pt (patient) uses non-verbal expressions of pain: Yes (was marked), looking tense, fidgeting,

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crying, grimacing and moaning.

#6. What causes or increases the pain: pressure moving (?)

#7. Effects of pain (note decreased function, decreased quality of life - check all that apply and explain). The followings were checked:
a. Accompanying symptoms (e.g., nausea, vomiting)
b. Sleep disturbances
c. Physical activity
d. Relationship with others (e.g., irritability, withdrawal)
e. Emotions (e.g., anger, suicidal, depressed, ect.)
f. Concentration."

c. Review of the resident's Care Plan dated 4/9/07 revealed the followings:

Problem #1 Pain:

"Resident is at end of life with anticipated ongoing decline and eventual death. Areas of decline would include: Pain.

Goal: Resident will direct end of life care AEB making daily care choices. Resident will indicate pain level of 0-1 at all times.

Approaches:
1. Offer choice and options
2. Offer Hospice care to resident and family
3. Offer choices regarding ADL's (activities of daily living) e.g
    1. Medication for pain as ordered
    2. Assess pain level q (every) 2-3 hrs (hours)
    3. Contract MD (medical doctor) if pain

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increases".

There was no evidence that this pre-printed section of the care plan was individualized for this resident.

d. Review of the resident's physician's order dated 3/26/07 revealed the following orders for pain and anxiety medications:

3/28/07 "Roxanol 20 mg/ml (milligram per milliliter) 1/4-1/2 cc (cubic centimeter) sl (sublingual) sb q (every) 3-4 hrs (hour) PRN (as needed) for pain". This order was changed on 3/29/07 to "Roxanol 20 mg/ml 1/2-1 ml po/sl q 2 o (hour) PRN air hunger".

3/26/07 Percocet 325/5 1 po (by mouth) q 4 hrs PRN pain. This order was discontinued on 4/4/07.

3/26/07 MS Contin 30 mg po bid DJD (degenerative joint disease). This order was discontinued on 4/11/07.

3/26/07 Ativan 1 mg 1-2 po q hs (at night) prn anxious features r/t (related to) end of life.

3/28/07 Ativan liquid 2 mg/ml 0.5 cc sl q 3-4 hrs prn anxiety related to air hunger.

e. Review of the resident's medical record and Interdisciplinary Progress Notes revealed:

1). 3/27/07 at 0300 (3:00 AM), the nurse wrote "heard res (resident) calling out entered room to find res c/o (complaining) pain Resp (respiration) ^ (increased) medicated c (with) 1 mg ativan + (and) Percocet ...02 (oxygen) sats (saturation)

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F 309	Continued From page 27 79% anxiety ^ (elevated) asking that Dr ... (name of physician) be called". The nurse contacted the physician who gave new orders. The physician ordered for the resident to receive Ativan 1 mg and to repeat the dose in half hour. The resident was not to receive more than 3 mg of Ativan and if the resident continued to struggle to give Percocet. At 0320 (3:20 AM), the resident was given Ativan 1 mg. The nurse documented that the resident continued to have varying 02 saturation levels from 65-79% with an increased respiratory rate of 40. At 0350 (3:50 AM), the nurse documented that the resident was given Ativan 1 mg. 2). 3/27/07 Daily Nursing Progress Notes Weekly revealed that the resident was rated to have on 3/28/07 at 1745 (5:45 PM) 8/10 pain. 3). On 4/3/07 at 1400 (2:00 PM) the nurse documented that the resident was having anxiety and pain. The resident was given a sublingual medication. Review of the resident's 4/07 Medication Administration Record (MAR) revealed that there was no pain or anti-anxiety medications documented as being given by the nurse at that time. However, review of a document titled "Shared Pharmacy Service Narcotic Record" form dated 3/28/07 with Morphine Sulfate handwritten below the title, showed one signed out medication at 5:00 PM for Morphine Sulfate (MS) 0.5 (without an unit measure). A second "Shared Pharmacy Service Narcotic Record" form with Ativan handwritten below the title showed one signed out medication at 5:00 PM for Ativan 0.5 (without an	F 309		

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F 309	Continued From page 28 unit measure). 4). 4/3/07 Daily Nursing Progress Notes Weekly revealed that the resident was rated to have 6-10 pain. The pain was "all over" and "painful". On 4/4, the nurse documented that there was a call from the Hospice nurse. 5). Fall: 4/6/07 Daily Nursing Progress Notes Weekly with fall handwritten revealed that the resident was rated to have 6-10 pain. The pain was documented to be "all over, R (right wrist)" and "painful". 6). On 4/6/07 at 2330 (11:30 PM) the nurse wrote "pt (patient) has been restless since 2200 (10:00 PM), has been sitting up c (with) legs down on side of bed, pt legs place back in bed + pt made comfortable many times, pt fell oob (out of bed) at 2230 (10:30 PM) placed back in bed noted small skin tear to L (left) about 5 mm (millimeter) round cleansed + stir strip applied". (steri strips are used to close opened skin instead of sutures) Review of the April 2007 MAR revealed that the resident was not medicated with MS medication from 4/5/07 at 8:00 PM until 4/8/07 at 8:00 PM (a total of 72 hours interval). The documentation on the MAR on 4/8/07 revealed that the resident was given a second dose of MS medication (without a unit dose) at 11:30 PM. This is during the same time frame where the nurse documented on 4/6/07 at 11:30 PM that the resident was complaining of pain, was restless and trying to get out of bed which resulted in the resident falling out of the bed and sustaining an injury. This resident while at the facility had already sustained a fall at the end of March 07	F 309		

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with fracture to the right lower extremity that required an ORIF with external pins.

7). 4/7/07 at 6:00 AM, the nurse documented that the resident had episodes of agitation and was attempting to get out of bed. The resident was given Ativan (anti-anxiety medication).

8). 4/9/07 at 9:00 PM, the nurse documented "Res (resident) calling for staff. found sitting on the edge of the bed. res was medicated for pain".

However, review of the April 2007 MAR revealed that the resident was medicated with MS 1 cc on 4/9/07 at 04:30 AM and then again on 4/10/07 at 05:30 AM (a total of 25 hours interval between doses).

9). 4/10/07 Daily Nursing Progress Notes Weekly revealed that the resident was rated to have "6/10 pain R wrist" with description: "painful".

10). 4/10/07 at 6:06 PM, the nurse documented "pt slowly declining, on hospice becomes restless often".

11). The next nurse's notes on 4/14/07 at 2:10 PM stated "res states in pain med given". At 3:15 PM, the nurse stated "res still pain". There were no nurse's notes to indicate that the resident was medicated for pain from 4/10 at 6:06 PM to 4/14 at 2:10 PM (a total of 92 hours interval). Review of the MAR revealed that the resident was medicated with MS medication (without a unit dose) on 4/14 at 2:45 PM and 6:00 PM.

f. Review of the April 2007 MAR and the March/April 07 Shared Pharmacy Service Narcotic Record forms revealed some

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discrepancies between the doses of MS signed out and the doses of MS administered on many of the days.

g. On 4/17/07 from 1:30 PM to 5:20 PM, the resident was observed calling out for the nurse at frequent intervals. There was almost no interaction noted from the staff during this almost continuous observation.

h. On 4/18/07 at 10:05 AM, resident was observed sitting on the side of the bed. The resident was evaluated by the facility to be at risk for falls and as being cognitively impaired including confusion.

i. Review of the April 2007 MAR revealed that the only documentation regarding the effect of the pain medication was "helpful". In addition, the nurses' notes from 3/26/07 to 4/17/07 lacked objective assessment of the pain medication effectiveness.

j. On 4/18/07 at approximately 10:30 AM during an interview with the DON, she stated that the resident was on hospice, declining fast, not eating and confused. The DON addressed a recent incident with the family about the resident not being medicated for pain. The family visited the resident frequently.

k. Two of the resident's family members were interviewed on 4/19/07 in the evening. They stated that they had filed a formal written complaint with the facility's Administrator regarding the lack of pain medication given to the resident.

l. On 4/20/07 at approximately 10:00 AM during

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an interview with the DON, the MAR and the Shared Pharmacy Service Narcotic Record forms were both reviewed to address the lack of pain medication given to the resident for extended time periods. The DON stated that she was aware of the 4/6 and 4/7 incident were the resident did not receive pain medication.

The facility failed to follow the physician's orders for pain management. In addition, the facility failed to do a comprehensive pain assessment for this resident who had ongoing use of PRN pain medications with an increased cause of pain. The failure to identify the need for appropriate pain management impacted the resident's quality of life and his/her ability to reach his/her highest practicable level of functioning. The resident's pain increased the resident's risk of physical functioning decline and of developing more pressure ulcers.

3. Review of sample resident #2's physician orders evidenced that the resident had Ultram (pain medication) on a prn basis for pain.

a. Review of the 3/07 and 4/07 Medication Administration Records (MARs) for resident #2 revealed that the resident was documented to have received a total of 35 doses of Ultram (in 3/07 and 4/07). The reason documented for giving the medication was "pain" and the results were charted as "helpful" or "effective". There was no notation of an objective assessment, such as utilizing a pain score, and the location or type of pain was not indicated.

b. Review of the resident's care plan for the problem of "Alteration in comfort r/t (related to) CVA (stroke), c/c (complaints of) leg pain."

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F 309	Continued From page 32 Approaches for this problem included "Assess for pain using the pain scale 1 - 10; Evaluate effectiveness of med (medication); and Pain management Program." The facility failed to assess the resident's pain according to the resident's plan of care, failed to follow the facility's pain scale for assessment of pain, and failed to follow current professional standards for assessing pain. These failures placed the resident at potential for experiencing inadequately managed pain and as a result of the pain, decreased quality of care and quality of life. 4. Record review for sample resident #8 revealed diagnoses that included Alzheimer dementia with psychotic and depressive features. a. Review of the resident's initial hospice physician visit, dated 2/8/07 evidenced an impression of "debility admitted to hospice due to recent acute functional decline, decreased verbalization, progressive dementia, and pneumonia January 8, 2007." b. Review of sample resident #8's physician orders evidenced that the resident had Lortab (pain medication) on a prn (as needed) basis for pain (with an order date of 11/20/05). c. Review of the 3/07 Medication Administration Record (MAR) for resident #8 revealed that the resident was documented to have received eight doses of Lortab. Two of the eight doses had documentation to indicate that the prn medication was given. The reason documented for giving the medication was "pain" and "crying in pain" and the results were charted as "better" and "helpful." There was no notation of an objective	F 309		

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assessment, such as utilizing a pain score for cognitively impaired residents, and the location or type of pain was not indicated.

d. Review of the resident's care plan for the problem of "Alteration in comfort r/t current DX (diagnosis), arthritis." Approaches for this problem included "Assess for pain using the pain scale 1 - 10; Evaluate effectiveness of med; and Pain management Program."

The facility failed to assess the resident's pain according to the resident's plan of care, failed to follow the facility's pain scale for assessment of pain, and failed to follow current professional standards for assessing pain. These failures placed the resident at potential for experiencing inadequately managed pain and as a result of the pain, decreased quality of care and quality of life.

5. Review of sample resident #13's physician orders evidenced that the resident had orders for OxyContin 10 mg (milligrams) twice a day, Percocet 5/325 two tabs three times a day as needed (do not give within 2 hrs of OxyContin), and Extra strength Tylenol 1-2 tabs every 4 hrs pain (not to exceed 4 grams q day).

a. Review of the 2/07, 3/07, and 4/07 Medication Administration Records (MARs) for the resident revealed that the resident was documented to have received the following doses of Percocet and Tylenol:

2/07 - 11 Percocet and 24 Tylenol with the pain scale rating for 4 of the 35 doses administered.

3/07 - 18 Percocet and 25 Tylenol with the pain scale rating for 12 of the 43 doses administered.

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4/07 - 14 Percocet and 17 Tylenol with the pain scale rating for 11 of the 31 doses administered.

The reason documented for giving the medication was "pain" and the results were charted as "helpful" or "effective". There was no notation of an objective assessment, such as utilizing a pain score, and for most doses the location or type of pain was not indicated.

b. Review of the resident's care plan for the problem of "Alteration in comfort r/t (related to) ___ (type of amputation) - phantom pain, chronic pain - generalized." Approaches for this problem included "Assess for pain using the pain scale 1 - 10; Evaluate effectiveness of med (medication); and Pain management Program."

The facility failed to assess the resident's pain according to the resident's plan of care, failed to follow the facility's pain scale for assessment of pain, and failed to follow current professional standards for assessing pain. These failures placed the resident at potential for experiencing inadequately managed pain and as a result of the pain, decreased quality of care and quality of life.

6. Record review revealed sample resident #1 had a diagnosis of colon cancer.

a. Review of the resident's physician's orders evidenced that the resident received OxyContin 20 mg PO BID and Roxinol 1/4 - 1/2 ml sl q hour prn for breakthrough pain. "Pain medication for relief of spasm of muscle".

b. Review of the resident's MDS assessment dated 2/14/07 revealed that the resident was

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given pain medication daily for frequent pain which was rated as moderate pain. This resident also had a decline in bed mobility, transfer, walk in room, walk in corridor and locomotion on unit.

c. Review of the resident's care plan evidenced that the resident "is at end of life with anticipated ongoing decline and eventual death. The resident will indicate pain level of 0 - 10 at all times."

d. Review of the resident's Pain Assessment Profile dated 2/2/07 revealed that his/her pain "is a 10+ (worst pain) which gets worse with movement."

e. During an interview on 4/17/07 at 8:17 AM, the resident stated "I am in pain everyday, I like to exercise but I have too much pain."

f. Review of the resident's Daily Nursing Progress Notes revealed that the weekly documentation of the pain scale assessment was blank or checked none (for no pain) for the week of 4/14/07.

7. Review of sample resident #10's physician orders revealed that the resident had orders for Percocet (Oxycodone and Acetaminophen) 5/325 TAB 1 PO QID (four times each day) PRN PAIN dated 1/19/07, Tylenol 500 MG 1-2 Q 4 HRS PO PRN PAIN dated 1/22/07.

a. Review of the 3/07 Medication Administration Record (MAR) for resident #10 revealed documentation that the resident received 12 doses of Percocet. Ten of the twelve doses had documentation to indicate that the prn medication was given. The reason documented for giving the medication was "pain" and "back pain" and the results were charted as "effective", "helpful" and

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"pending." Six of the twelve did not rate pain before or after the administration of the pain medication.

b. Review of sample resident #10's Care Plan dated 3/9/07 revealed under Problem 13. "Alterations in comfort R/T chronic pain, neuropathy, arthritis." Approaches for this problem included: 1. Assess pain using the pain scale 1-10. 2. Evaluate effectiveness of med.

The facility failed to assess the resident's pain according to the resident's plan of care, failed to follow the facility's pain scale for assessment of pain, and failed to follow current professional standards for assessing pain. These failures placed the resident at potential for experiencing inadequately managed pain, and because of the pain; decreased quality of care and quality of life.

Bowel Movement

Review of sample resident #9's medical record evidenced that the resident was admitted to the facility on 12/29/06 with diagnoses that included chronic obstructive pulmonary disease, pacemaker, congestive heart failure, lungs cancer, anxiety, degenerative joint disease, seizures, coronary heart disease, depression, gout and insomnia.

a. Review of the resident's 4/9/07 significant change MDS assessment and subsequent admission MDS assessment dated 3/12/07, evidenced that the resident required total assistance with bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing by two staff members.

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F 309	Continued From page 37 b. The resident's Bowel and Bladder Detail Report tracking form was reviewed. The record revealed that the resident did not have a bowel movement from 4/2/07 at 09:28 AM until 4/7/07 at 12:18 PM (five days) and again from 4/13/07 at 12:54 PM until 4/18/07 (five days). c. On 4/18 /07 at approximately 3:30 PM, the nurse (D) was interviewed about the resident's bowel movement documentation on the I&O (intake and output) sheet. He stated that he usually reviewed the residents' I&O forms and medicates the residents after 3 days of no bowel movement. The nurse was observed later that afternoon giving the resident a Dulcolax suppository. d. Review of the nurses' notes from 4/2/07 to 4/17/07 did not contain evidence the resident had been evaluated for constipation or a fecal impaction by a facility nurse during this time period. e. On 4/18/07 at approximately 3:30 PM, during an interview with the DON the resident's I&O report and the facility's Bowel Care Protocol policy were reviewed. She stated "the resident is not eating therefore wouldn't expect ___ (him/her) to have a bowel movement". The resident's two five days periods without a bowel movement were discussed. She agreed that the resident should have a bowel movement before the five days period. f. Review of the facility's Bowel Care Protocol policy dated October 13, 2005 stated under the section titled: Bowel Care Protocol For Constipation the followings:	F 309		

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F 309	Continued From page 38 Monitor Daily Bowel Activity: If no bowel activity or small activity for past three days and after assessing for abdominal disturbances, Place a "constipation tracking sheet" in MAR and initiate the followings: · Day 3: 6a-2p: p.o client's laxative of choice or Milk of Magnesia 30 ml · Day 3: 2p-10p: Dulcolax (Bisacodyl) suppository · Day 4: 6a-2p: Fleets Enema · Day 4: 2p-10p: 30 ml Milk of Magnesia in 8 oz (ounce) of warm prune juice · Day 5: 6a-6p: Notify MD for chronic and/or unresolved constipation, abnormal abdominal findings, abnormal vital signs, pain The facility failed to assess the resident and to follow their Bowel Care Protocol policy.	F 309		
F 364 SS=E	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff	F 364		

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interview, it was determined that the facility failed to provide attractive, palatable food served at a correct temperature. The findings included:

1. On 4/18/07 from 10:55 AM to11:27 AM, an observation was made of the noon meal preparation and service. The following was observed:

a. The steam table compartments contained pork chops, Western potatoes, cauliflower, pureed pork chops, pureed Western potatoes, pureed cauliflower, pureed bread, Polish sausage/hot dogs, carrots, and cheese sauce. The food was in the steam table and the temperatures had been checked prior to 10:55 AM.

b. The plates were stacked on the insulated plate holders prior to the beginning of the tray service. No plates were taken from the heating unit during the serving of the 100 and 200 hallway carts. At the time of the meal service, the plates were not hot.

c. The tray service began at 11:08 AM with the staff preparing the room trays on the 100 hallway, followed by the 200 hallway. A test tray, including a facility thermometer, was prepared for the surveyor and was placed as the last tray on the 200 hallway. The surveyor followed the 200 hallway tray cart out of the kitchen at 11:27 AM.

d. The nursing staff began delivering the 200 hallway trays at 11:28 AM. Three staff were observed to assist in passing these trays. (Note: On 4/16/07 starting at 5:50 PM, CNA E was observed to pass the meal trays from the 100 hallway meal cart. CNA F was observed to pass the trays from the 200 hallway meal cart. With

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(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
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only one staff member passing trays from each cart the serving time would be increased.)

e. The last tray was served at 11:42 AM. The test tray temperatures were checked at this point. Once the surveyor obtained the first temperature on the pureed food, the Dietary Manager was called. She came immediately and verified the temperatures. The DM also tasted the foods. The following were the temperatures [noted in degrees Farenheit (F) on the facility's thermometer]:

Pureed pork chop - 92 - barely warm to taste
Pureed potatoes - 110 - luke warm to taste
Pureed cauliflower - 92 - barely warm to taste
Pureed bread - 90 - barely warm to taste
Pork chop - 100 - lukewarm to taste
Potatoes - 120 - warm to taste
Cauliflower - 108 - lukewarm to taste.

Note: Pureed foods hold the temperature longer than regular texture foods due to the food density. It was not clear why the pureed food temperatures were lower than the regular texture food.

2. On 4/17/07 at 10:45 AM, in a confidential resident interview, the resident commented that breakfast was good, but "supper is bad and looks bad." The resident indicated that he/she has family bring in food to eat because the food is so bad. The resident requested that the surveyor view the appearance of the meal trays to verify the bad appearance.

3. On 4/17/07 at 2:25 PM, in a confidential resident interview, the resident, who eats in his/her room, stated "the food is not hot and food

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F 364	Continued From page 41 is just so so (for taste)." He/she indicated that it doesn't matter which meal it is, the temperature of the hot food is not hot. 4. During the resident group interview on 4/18/07, the residents made the following comments related to the quality of the food: One resident complained that "the facility follows a routine and that they need to mix it up". The residents were asked to comment on that statement and six out of ten residents agreed. One resident stated "they serve too much rice, lots of starch". A resident stated that "you must kill the food with salt and pepper." Another resident complained that they should not place the ice cream inside the food cart because it melts. A resident stated "the meat is steamed, but so dry you have to put gravy on the meats. They are so hard". 5. On 4/16/07 at 4:15 PM, during the initial tour of the facility in the 200 Unit, a resident stated that the food was sometimes cold. He/she stated that the ravioli the night before were cold.	F 364		
F 371 SS=F	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	F 371		

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F 371	Continued From page 42 by: Based on observation and staff interview, it was determined that the facility failed to store, prepare, and distribute food in a manner that minimized the potential for the spread of food-borne illness. The findings included: 1. On 4/16/07 at 5:08 PM, during the initial tour of the kitchen, the following observations were made: a. In the dry storage room: i) On the floor in the corner next to the canned vegetables, there were unidentifiable small objects (droppings? lint? insects?). ii) The floor edge next to the wall was dirty/dusty. There was cereal spilled on the floor under the moveable shelf where the small syrup containers were stored. b. In the corner of the kitchen, in front of the emergency exit door, there was a pile of cardboard boxes and an uncovered large trash container with food items in it. c. In the walk-in refrigerator: i) The lid was not closed tightly on a four liter plastic container of shredded cheese. ii) There was meat thawing with the package touching the carton of eggs. iii) There was a large bag of almonds which was not closed. d. In the walk-in freezer, there was ice piled on	F 371		

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top of boxes of meat. This was sitting directly under the refrigeration unit.

e. The hood and surfaces in the kitchen were greasy to touch.

f. The floor tiles were damaged. There was dirt build-up on the tiles, especially in the corner at the front of the walk-in refrigerator and around the edges of the kitchen.

g. The ice machine located outside of the kitchen in the dining room had red drips on the outside and on the inside wall of it.

h. In the hallway outside of the kitchen:

i) There were six food carts (three tall and three short).

ii) There were three three-shelf carts which contained dirty dishes and water pitchers. The food on the dirty dishes appeared to match the menu items posted for the noon meal.

2. On 4/16/07 at 7:13 PM, in the presence of the nurse (A), the following observations were made of the resident nourishment refrigerator located in the medication room on the 100/200 hallways:

a. There was staff food. The nurse confirmed that it was her lunch.

b. There was a lunch tray for supplemental resident (#25).

c. In the freezer section of the refrigerator, there were three unlabelled boxes of Girl Scout cookies. The thermometer registered 26 degrees

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F 371	Continued From page 44 Farenheit (F). 3. On 4/17/07 at 1:40 PM, during an observation of the kitchen with the Dietary Manager (DM) and consultant Registered Dietitian (RD), the following was observed: a. The ice machine located outside of the kitchen in the dining room had red drips on the outside and on the inside wall of it. b. In the walk-in refrigerator: i) The lid was not closed tightly on a large plastic container of peaches. ii) There was meat thawing next to the carton of eggs. The package of meat was not touching the carton of eggs. iii) There was a large bag of almonds which was not closed. c. In the walk-in freezer, there was ice piled on top of boxes of meat. This was sitting directly under the refrigeration unit. d. In the dry storage room: i) On the floor in the corner next to the canned vegetables, there was unidentifiable small objects (droppings? lint? insects?). The DM had these objects swept out of the corner so that they could be viewed. The DM and RD identified the substances as food which had been dropped and then molded. ii) The floor edge next to the wall was dirty/dusty. There was cereal spilled on the floor under the	F 371		

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F 371	Continued From page 45 moveable shelf where the small syrup containers were stored. e. The floors and surfaces in the kitchen remained the same as during the initial tour on 4/16/07.	F 371		
F 465 SS=F	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to provide a safe environment for the residents, the staff, and the public. These practices related to not ensuring safe hot water temperatures in resident and public areas. The findings included: On 4/16/07 starting at 6:05 PM and ending at 6:30 PM, the following water temperatures were taken [noted in Farenheit (F) degrees (°)]: Public restroom which was located next to room 114 - 133.3° F Room 401 - 131.2° F Room 404 - 129.2° F Room 407 - 131.9° F Dining Room sink - 134.2° F. On 4/16/07 at 6:55 PM, in an interview with the	F 465		

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Administrator (Adm) and Director of Nursing (DON), the Adm verified that he was not aware of any elevated water temperatures. He revealed that the boiler had been replaced in 1/07 and there had been a main water line break on 2/15/07. The Adm indicated that there were two boilers, one for the laundry and kitchen and one for the rest of the building. The DON commented that there had been no resident incidents related to hot water burns.

On 4/16/07 at 7:23 PM, in the utility room located at the 100/200 hallway across from the nurses' station desk, the water temperature was 124.7 degrees F. The door to this room was open and the sink was located at the end of the counter closest to the open door.

The following hot water temperatures were taken on 4/16/07 starting at approximately 6:10 PM:

At 6:10 PM in resident room 114 the hot water temperature was 132 degrees F.

At 6:11 PM resident room 119 was 125.7° F

At 6:14 PM resident room 117 was 125.2° F

At 6:16 PM resident room 116 was 129.8° F

At 6:18 PM resident room 115 was 128.5° F

At 6:21 PM resident room 110 was 130° F

At 6:22 PM resident room 107 was 124.7° F

At 6:25 PM resident room 102 was 123.6° F.

After discovering the high hot water temperatures

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on 4/16/07 at 6:05 PM, the Administrator and Director of Maintenance were notified of the potential risk to residents. The Director of Maintenance explained that a new boiler was purchased and installed in the building in January of 2007 that was more efficient at holding water temperatures constant throughout the building.

Record review of the water temperatures logs for January and February of 2007 evidenced that the temperatures ranged between 110 degrees to 117 degrees F. During the month of March, the hot water temperatures began to rise and ranged from 120 degrees to 125 degrees F. There was no evidence that the facility took precautions to lower the higher water temperatures to prevent possible burn injuries. The Director of Maintenance verified that there were no hot water temperatures taken for the month of April 2007.

On 4/16/07 starting at 6:08 PM and ending at 6:20 PM, the following resident room water temperatures were taken [noted in Farenheit (F) degrees (°)]:

At 6:08 PM in room 311 - 130° F

At 6:10 PM in room 306 - 128.5° F

At 6:12 PM in room 301 - 130.3° F

At 6:15 PM in room 210 - 131.0° F

At 6:20 PM in room 203 - 130.6° F

On 4/16/07 starting at 8:10 PM and ending at 8:16 PM, after the Maintenance Supervisor had adjusted the temperature of the water to the resident/public areas, the following resident room

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F 465	Continued From page 48 water temperatures were taken [noted in Farenheit (F) degrees (°)]: At 8:10 PM in room 301 - 111.1° F At 8:12 PM in room 311 - 111.0° F At 8:14 PM in room 210 - 113.9° F At 8:16 PM in room 201 - 113.2° F Room 406 - 112.5° F Room 407 - 110.8° F.	F 465		
F 492 SS=E	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure that when residents no longer met the requirements for Medicare skilled services, they received notification that they could request review of this decision. The residents affected were residents who remained in the facility, with different payment sources (such as Medicaid or private pay). The findings included: On 4/19/07 at 10:52 AM, in an interview with the Business Office Manager (BOM), she was requested to provide the signed notification letters	F 492		

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F 492	Continued From page 49 that indicated that residents whose Medicare benefits ended were given an option to request review of that decision. The facility list which was provided to the surveyor included nine current residents (sample residents #9, #3, and #2 and supplemental residents #18, #19, #20, #21, #22, and #23). The BOM indicated that none of these residents had been given the letter of notification. She revealed that the letters had been given only to residents that discharged from the facility when their Medicare benefits ran out. On 4/19/07 at 4:42 PM, in an interview with the Administrator (Adm) and the Director of Nursing (DON), the Adm verified that he was aware that residents who remained in the facility had not been provided the Medicare Denial of Benefits letters in the past.	F 492		