STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465089	A. BUILDING _____ B. WING _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - TOOELE	140 EAST 200 SOUTH TOOELE, UT 84074

(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 275 SS=B	483.20(b)(2)(iii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for 1 out of 15 sampled residents, the facility did not complete an annual minimum data set (MDS) at least every 12 months. Findings include: Resident 1 was admitted to the facility on 11/04/03 with diagnoses including: acute respiratory failure, septic shock, urosepsis, multilobar pneumonia, and CAD (coronary artery disease). On 12/13/05, the medical record contained 7 Quarterly MDS's dated 5/23/04, 8/24/04, 11/20/04, 2/24/05, 5/24/05, 8/24/05, and 11/24/05. An annual MDS should gave been completed on or about 2/24/05. On 12/13/05 at 2:45 PM, the MDS coordinator was interviewed. She stated that the last comprehensive assessment for resident 1 was completed February 2004.	F 275	F275 1. Medical Records will perform a quarterly audit to ensure MDSs are done in appropriate time frames. 2. MDS Coordinator will be responsible for checking residents' MDSs at each IDT meeting to ensure correct MDSs are completed. 3. F275 will be completed by January 31, 2006. 4. The Director of Nursing will monitor F275 and report the finds to the Quality Assurance Committee on a quarterly basis and as needed.	
F 279 SS=B	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

1/11/06 POC acceptable Completion date 1/31/06 KBrownbank RN

Utah Department of Health
A53
JAN 0 6 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 1-6-2006

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

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F 279	Continued From page 1 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 observation, it was determined that for 2 of 15 sample residents (Residents 6 and 12) the facility did not develop comprehensive care plans for each resident based on their individual needs identified by the facility staff. Findings include: 1. Resident 12 was admitted to the facility on 10/21/05 with diagnoses which included atrial fibrillation, urinary retention and dementia with psychotic features. On 12/14/05, resident 12's medical record review was completed.	F 279	F279 1. Resident 12's care plan will be reviewed. Geodon for agitation will be added to the care plan by the MDS Coordinator. 2. Resident 6's care plan will be reviewed by the nursing staff to ensure care plan approaches are followed appropriately. The resident 6's nurse will monitor the resident closely to ensure this occurs. 3. To prevent further problems, care plans will be more closely monitored to ensure all problems are identified on the care plans and all approaches will be followed. This will be done and monitored by the MDS Coordinator. 4. F279 will be completed by January 31. 5. The MDS Coordinator will report her findings to the Quality Assurance Committee on a quarterly basis and as needed.	

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F 279	Continued From page 2 The physician's admission orders revealed an order for Geodon 10 mg (milligrams) intramuscular every 2 hours as needed for agitation. A review of resident 12's October 2005, November 2005 and December 2005 medication administration records revealed resident 12 received Geodon on the following dates and times: 10/24/05 at 11:00 PM 10/25/05 at 2:00 AM 11/6/05 at 12:45 AM 12/5/05 at 11:50 PM A review of resident 12's plan of care revealed that the Geodon for agitation had not been incorporated into his plan of care. 2. Resident 6 was admitted to the facility on 9/7/00 with diagnoses which included Alzheimer, senile dementia, IBS (irritable bowel syndrome), Osteoarthritis, GERD (gastroesophageal reflux disease), and chronic back pain. On 12/13/05, resident 6's medical record review was completed. The medical record contained the following care plans: a. "Potential for skin breakdown [due to] incontinence of bowel/bladder....Stage 2 [left] heel." The interventions compiled by facility staff to implement the care plan were to reposition [every 2 hours] while in bed/chair. b. "Self care deficit [related to] resident total care [with] all ADL's (activities of daily living)." The	F 279		

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

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F 279	Continued From page 3 interventions compiled by facility staff to implement the care plan were to check resident [every 2 hours], and to reposition [every 1 hour] while in bed/chair. On 12/13/05, a continuous observation of resident 6 from 7:05 AM until 10:15 AM (3 hours and 10 minutes) by a nurse surveyor was completed. Resident 6 was not observed to be repositioned during this time.	F 279	F329 1. Documentation of PRN medications given will be monitored for complete and accurate information as to why the medication was given. 2. Medication Administration Record (MAR) will be audited weekly for 3 months. It will then be audited once a month for 9 months. The audit will be conducted to ensure complete and accurate documentation of medications. This will be done by the Director of Nursing or designee. 3. An in-service will be held on January 25 to instruct nurses on complete and accurate documentation on medications ordered. 4. Residents 7 & 11 orders for PRN Ambien were clarified to include "Give after 10:00 p.m. and try to hold 1-2 nights per week." 5. Nurses were in-serviced on documenting PRN medication requests including PRN Ambien given on consecutive days. This was completed on January 5, 2006. 6. F329 will be completed on January 25, 2006. 7. F329 will be monitored by the Director of Nursing. 8. The findings of F329 will be reviewed by the Quality Assurance Committee on a quarterly basis and as needed.	
F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, it was determined that facility staff failed to ensure that drugs (a hypnotic)were not used for excessive duration. This occurred for two of 15 residents in the survey sample, residents 7 and 11. Findings include: 1. Resident 7 was an 87 year old female admitted to the facility on 3/5/03 with diagnoses which included asthma, osteoarthritis, anemia	F 329		

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F 329	Continued From page 4 and congestive heart failure. Resident 7 was observed sleeping in her bed on 12/13/05 at 1:10 PM. During an interview with the Registered Nurse on 12/13/05 at 1:40 PM, she stated that resident 7 usually sleeps after lunch unless there was an activity that she wanted to attend. During a review of resident 7's re-certification orders dated October 2005 through December 2005, it was documented that resident 7 had a physician's order for "Ambien Tablets 5 mg. by mouth (PO) Q.H.S. [every night] PRN [as needed]" for insomnia. Each monthly re-certification order from October 2005 through December 2005 was signed by the physician. The original physician order for the ambien was dated 11/29/04. During a review of resident 7's Medication Administration Record (MAR) for October 2005, November 2005 and December 2005, it was documented that resident 7 was receiving "Ambien Tablets 5 mg. by mouth (PO) Q.H.S. PRN." Documentation provided evidence that resident 7 received the Ambien every night in October except the 7th; every night in November except the 1st; and every night in December through the 12th. The facility pharmacist completed the monthly drug regimen review and made a note dated September 22, 2005. The pharmacist documented the following, "PRN Ambien QHS? try hold 1/7 (after) 10 pm?" There was also an entry for January 27, 2005, which the pharmacist documented "Hold Ambien 1/7".	F 329		

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F 329	Continued From page 5 The Psychotropic Drug Review form for resident 7 completed for "July 2005" regarding the Ambien recommended the following, "Don't give before 10:00 PM, Try to sleep without it 1 or 2 nights per week." This form was signed by the physician on 11/9/05. A review of the "Sedative/Hypnotic Monthly Record" sleep monitoring form for October, November and December 2005, documented that resident 7 averaged between 7 and 8 hours of sleep each night and an average of 1 to 3 hours of sleep each day. 2. Resident 11 was a 90 year old female admitted to the facility on 6/6/05 with diagnoses which included depression, hypertension, weight loss, osteoporosis and insomnia. Resident 11 was admitted to the facility with a physician's order for "Ambien 10 mg. 1 Tab PO QHS (for) Insomnia." During a review of resident 11's MAR for October 2005, November 2005 and December 2005, it was documented that resident 11 was receiving "Ambien Tablets 10 mg. 1 Tab by mouth (PO) QHS." Documentation provided evidence that resident 11 received the Ambien every night in October 2005, November 2005 and through December 13, 2005. The facility pharmacist completed the monthly drug regimen review and made a note dated September 22, 2005. The pharmacist documented the following, "try (decrease) Ambien to prn?"	F 329		

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F 329	Continued From page 6 The Psychotropic Drug Review form for resident 11 completed for "July 2005" regarding the Ambien recommended the following, "Try to hold 2 nights per week..." This form was signed by the physician on 11/11/05. A review of the "Sedative/Hypnotic Monthly Record" sleep monitoring form for December 2005, documented that resident 11 averaged 10.25 hours of sleep combined for each night and day.	F 329	F371 1. Any and all food prepared or brought in by outside venders will be dated with date stickers or dated and labeled on hand written tape on the edge of the pans they are in. The deficiencies are being monitored on a daily basis either by the Dietary Supervisor or the Assistant Dietary Supervisor, if there are any non-compliances they are addressed immediately and resolved i.e. nothing outdated or unlabeled that is inside the pans, containers, and boxes. 2. There is a new monitoring form that went into effect on the 1st of Jan. 2006 to be filled out for tracking purposes of unlabeled or outdated items. 3. There was an in-service on the 23rd of December 2005 to address and re-educate the staff on the need for labels and dates. 4. F371 will be completed on January 1, 2006. 5. F371 will be monitored by the Dietary Manager. 6. These findings will be reviewed by the QA Committee on a quarterly basis and as needed.	
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 interview and observation of the kitchen it was determined that the facility did not store, prepare, distribute and serve food under sanitary conditions. Findings include: The following observations were made on 12/12/05 from 10:00 AM until 10:45 AM. 1. In freezer #1: a. Thirty-three individual containers of a white frozen substance, which were not labeled or dated. b. Two individual containers of a brown frozen	F 371		

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F 371	Continued From page 7 substance, which were not labeled or dated. c. One loaf of swirl bread, which was not labeled or dated. 2. In refrigerator #1: a. Opened white cheese, which was not labeled and dated. b. Two opened packages of white cheese, which were not labeled and dated 11/23/05. c. Opened orange cheese, which was not labeled and the date legible. d. Opened package of orange and white cheese, which was not labeled and dated 11/23/05. e. An opened non dairy whip topping, which was not dated. f. A container of tomato soup, dated 12/2/05. g. Twelve bowls of hi-pro chocolate pudding, dated 12/7/05. h. One bowls of hi-pro vanilla pudding, dated 12/2/05. i. Fourteen individual containers of applesauce, dated 12/4/05. j. Eleven bowls of chocolate pudding, dated 12/8/05. k. Eleven bowls of vanilla pudding, dated 12/5/05.	F 371		

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F 371	Continued From page 8 l. Thirteen individual container of applesauce, dated 12/5/05. m. A container of hard boiled eggs, not covered and dated 12/8/05. n. A container of BBQ pork, dated 12/7/05. o. A container of carrots, dated 12/7/05. p. Two pitchers of apple juice, which was not dated. q. Two pitchers of cranberry juice, which was not dated. r. A pitcher of grape juice, which was not dated. s. A pitcher of tea, which was not dated. t. A pitcher of orange substance, which was not labeled or dated. u. A pitcher of pink juice, which was not labeled or dated. v. A pitcher of orange juice, which was not dated. 3. The resident's refrigerator: a. An opened container of butter pecan medpass, dated 12/7/05. b. A bowl of hi-pro sugar free chocolate pudding, dated 12/5/05. c. An individual container of apple sauce, the date was not legible.	F 371		

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F 371	Continued From page 9 d. A bowl of chocolate pudding, dated 12/7/05. e. Six bowls of a greenish colored fruit, which were not labeled or dated. f. A pitcher of orange juice, which were not dated. g. An opened container of potato salad, dated 12/8/05. On 12/13/05 at approximately 10:00 AM, the dietary manager was interviewed and a second observation of the refrigerators and freezer was conducted. The dietary manager took the expired items out of the refrigerator. He stated that he thought the bowls of pudding were okay to be used for 6 days after they were opened.	F 371		
F 430 SS=D	483.60(c)(2) DRUG REGIMEN REVIEW The pharmacist must report any irregularities and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, it was determined that facility staff failed to act upon a pharmacist's recommendation regarding hypnotic medications. This occurred for two of 15 residents in the survey sample, residents 7 and 11. Findings included: 1. Resident 7 was an 87 year old female admitted to the facility on 3/5/03 with diagnoses	F 430	F430 1. Documentation of PRN medications given will be monitored for complete and accurate information as to why the medication was given. 2. Medication Administration Record (MAR) will be audited weekly for 3 months. It will then be audited once a month for 9 months. The audit will be conducted to ensure complete and accurate documentation of medications. This will be done by the Director of Nursing or designee. 3. An in-service will be held on January 25 to instruct nurses on complete and accurate documentation on medications ordered. 4. Residents 7 & 11 orders for PRN Ambien were clarified to include "Give after 10:00 p.m. and try to hold 1-2 nights per week." 5. Nurses were in-serviced on documenting PRN medication requests including PRN Ambien given on consecutive days. This was completed on January 5, 2006. 6. F~~329~~ 430 will be completed on January 25, 2006. 7. F~~329~~ 430 will be monitored by the Director of Nursing. 8. The findings of F430 will be reviewed by the Quality Assurance Committee on a quarterly basis and as needed.	

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F 430	Continued From page 10 which included asthma, osteoarthritis, anemia and congestive heart failure. During a review of resident 7's re-certification orders dated October 2005 through December 2005, it was documented that resident 7 had a physician's order for "Ambien Tablets 5 mg. by mouth (PO) Q.H.S. [every night] PRN [as needed]" for insomnia. Each monthly re-certification order from October 2005 through December 2005 was signed by the physician. The original physician order for the ambien was dated 11/29/04. During a review of resident 7's Medication Administration Record (MAR) for October 2005, November 2005 and December 2005, it was documented that resident 7 was receiving "Ambien Tablets 5 mg. by mouth (PO) Q.H.S. PRN." Documentation provided evidence that resident 7 received the Ambien every night in October except the 7th; every night in November except the 1st; and every night in December through the 12th. The facility pharmacist completed the monthly drug regimen review and made a note dated September 22, 2005. The pharmacist documented the following, "PRN Ambien QHS? try hold 1/7 (after) 10 pm?" There was also an entry for January 27, 2005, which the pharmacist documented "Hold Ambien 1/7". 2. Resident 11 was a 90 year old female admitted to the facility on 6/6/05 with diagnoses which included depression, hypertension, weight loss, osteoporosis and insomnia. Resident 11 was admitted to the facility with a	F 430		

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F 430	Continued From page 11 physician's order for "Ambien 10 mg. 1 Tab PO QHS (for) Insomnia." During a review of resident 11's MAR for October 2005, November 2005 and December 2005, it was documented that resident 11 was receiving "Ambien Tablets 10 mg. 1 Tab by mouth (PO) QHS." Documentation provided evidence that resident 11 received the Ambien every night in October 2005, November 2005 and through December 13, 2005. The facility pharmacist completed the monthly drug regimen review and made a note dated September 22, 2005. The pharmacist documented the following, "try (decrease) Ambien to prn?" During an interview with the Director of Nursing (DON) on 12/14/05 at 10:10 AM, she stated that the nurses should have implemented the pharmacist's recommendations for residents 7 and 11 but they did not.	F 430	F514 1. Medication Administration Record (MAR) will be audited weekly for 3 months. It will then be audited once a month for 9 months. The audit will be conducted to ensure complete and accurate documentation of treatments. This will be done by the Director of Nursing or designee. 2. The medical record will be audited by the Medical Records Clerk once a month to ensure the proper code status is in place on the physician's orders for all residents. 3. An in-service will be held on January 25 to instruct nurses on complete and accurate documentation on treatments ordered. 4. Resident 1's treatment order for "catheter flush with 60cc NS QD" was clarified with MD. 5. The treatment sheet for resident 1 was audited for accuracy with the clarification from the MD. 6. Nursing staff was in-serviced individually regarding the order and documenting the treatment. This was completed on January 4, 2006. 7. Resident 9's medical record was reviewed and DNR status noted. The Physician Order was corrected and clarified by the MD. This was completed on January 4, 2006.	
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS 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.	F 514		

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F 514	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on record review and facility staff interview, it was determined that the facility did not ensure that clinical records were completed and documentation was accurate for 3 of 15 sample residents (residents CL1, 1 and 9). Findings include: 1. Resident CL1 was admitted to the facility on 5/6/05 with several diagnoses which included hyperlipidemia, hypertension, diabetes and constipation. A review of resident 12's "Wound Addendum/Weekly Update" revealed resident 12 was admitted with a stage II pressure ulcer to her coccyx and developed a stage II pressure ulcer to her left thigh on 6/19/05, a stage II pressure ulcer to her left hip on 7/27/05 and a stage II pressure ulcer to her left upper leg on 11/8/05. On 11/13/05, the physician orders regarding these wounds were reviewed: a. Coccyx Pressure Ulcer: On 5/29/05, a physician order documented the following, "Stratasorb to wound on buttock. [Change] q (every) day until healed." There was no documentation that the dressing change was completed on 5/3/05 and 6/22/05. On 6/23/05, a physician order documented the following, "Silvabsorb/cover [with] gauze to coccyx- QD (every day)."	F 514	8. F514 will be completed on January 25, 2006. 9. F514 will be monitored by the Director of Nursing. 10. The findings of F514 will be reviewed by the Quality Assurance Committee on a quarterly basis and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465089	A. BUILDING _____ B. WING _____	12/15/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 13 There was no documentation that the dressing changes were completed on 6/23/05, 7/5/05, 7/23/05, 7/29/05, 7/31/05, 8/5/05, 8/11/05, 8/12/05, 8/19/05, 8/22/05, 8/23/05, 8/25/05, 8/27/05 through 8/31/05, 9/7/05 through 9/10/05 and 9/16/05. On 9/20/05, a physicians order documented the following, "ABX (antibiotic) oint (ointment) to wound on coccyx. Cover [with] border gauze [change] q (every) day." There was no documentation that the dressing change was completed on 9/22/05, 9/26/05 through 9/30/05, 10/3/05 through 10/6/05, 10/9/05 and 10/10/05. On 10/11/05, a physicians order documented the following, "tenderwet dressing to coccyx, cover [with] border gauze, [change] q (every) day." There was no documentation that the dressing change was completed on 10/24/05 through 10/27/05. On 10/27/05, a physician's order documented the following, "...Silvasorb patch to coccyx [with] border gauze." There was no documentation that the dressing s changes were completed on 10/27/05, 10/30/05, 10/31/05, 11/6/05 and 11/8/05. b. Left Thigh Pressure Ulcer: On 6/19/05, a physician's order documented the following, "Stratasorb to wound on [left] back of thigh [change] q (every) day until healed."	F 514		

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F 514	Continued From page 14 There was no documentation that the dressing changes were completed 6/22/05 through 6/25/05. c. Left Hip Pressure Ulcer: On 7/27/05, a physician's order documented the following, "Hydrocolloid to [left] hip [change] q (every) day until healed." There was no documentation that the dressing changes were completed 7/27/05 through 10/27/05. On 10/27/05, a physician's order documented the following, "Tenderwet to [left] hip [with] border gauze..." There was no documentation that the dressing changes were completed 10/27/05 through 10/31/05, 11/6/05 and 11/8/05. d. Left Upper Leg Pressure Ulcer: On 11/8/05, a facility nurse documented the following on the "Wound Addendum/Weekly Update", "...Current Treatment: Tenderwet to area QD (every day)..." A physician's order regarding this current treatment plan could not be located in the medical record. There was no documentation that the dressing changes were completed 11/8/05 through 11/13/05. On 11/14/05 at 2:45 PM, the director of nurses	F 514		

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F 514	Continued From page 15 was interviewed. She stated that resident CL1's dressing changes were daily and would be documented on the treatment records. 1. Resident 1 was admitted to the facility on 11/04/03 with diagnoses including: acute respiratory failure, septic shock, urosepsis, multilobar pneumonia, and CAD (coronary artery disease). On 12/13/05 a review of resident 1's clinical record was completed. On 3/15/05 a physician order was written for "catheter flush with 60 cc (cubic centimeters) NS (normal saline) QD (every day)." The monthly physicians re-certification orders through December 2005 revealed a physician order for "catheter flush with 60 cc (cubic centimeters) NS (normal saline) QD (every day)." Resident 1's Treatment records for November 2005 and December 2005 revealed no documentation that the catheter flushes were completed on November 16th, 19th, 20th, 21st, 22nd, 24th, 27th, 28th, 29th, or 30th; as well as, December 2nd, 3rd, 8th, or 10th. 3. Resident 9 was a 64 year old female admitted to the facility on 9/26/00 with diagnoses which included psychosis, congestive heart failure and mental retardation. A review of the physician's re-certification orders for resident 9 signed and dated 11/28/05 documented that resident 9 was a "Full Code." A review of resident 9's clinical record revealed that resident 9 had a signed Living Will in October	F 514		

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F 514	Continued From page 16 2005, documenting her preference as a DNR (Do Not Resuscitate).	F 514		