STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465075	A. BUILDING _____ B. WING _____	10/7/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - WEST VAL	4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120

(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) COMPLETE DATE
F 314 SS=G	483.25(c) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of resident medical records and review of facility policies and procedures, it was determined that for 3 of the 15 sample residents, the facility did not ensure that residents who entered the facility without pressure sores did not develop pressure sores. The facility also did not ensure that residents who had pressure sores received the necessary treatment and services to promote healing and prevent new sores from developing. (Residents 16, 21, and 44.) Findings include: 1. Resident 21 was a 74-year-old female admitted to the facility on 2/15/02 with diagnoses including diabetes mellitus, cerebral vascular accident, dementia, and osteoarthritis. An observation of resident 21's skin condition was made on 10/3/02 at approximately 4:30 PM. The treatment nurse was present during the observation. Resident 21 was observed to have a stage II pressure sore on her left ankle. An interview was held with the Director of Nursing (DON) on 10/2/02. The surveyor asked the DON if the facility utilized an assessment tool to identify if a	F 314	Acceptable BB **F 314** On 10/3/02 a nutritional assessment was completed for Resident 21. On 10/4/02 Resident 21's labs were done indicating the Albumin level was normal. Resident 21 was discussed in Skin and Weight meeting on 10/7/02. Resident's weight is stable. On 10/10/02, the resident was started on Alginaid 1 pkg with 6 oz water or juice BID and Resource 120cc po TID. Resident will continue with prior orders which include multidex gel, vitamin C q day, zinc q day and multivitamin q day. The facility continued with physician orders to give Resident 44 a multivitamin q day, vitamin C BID, zinc q day, resource 120cc BID and multidex gel. The pressure ulcer on Resident 44's heel is healed as of 10/28/02. Resident 16 was discharged from the facility on 10/14/02. Prior to discharge the following was completed: 10/3/02 abx. Ointment with DSD to right hip skin team; 10/7/02 Resumed skilled OT services for functional transfers training; 10/7/02 X-ray of femur AP and lateral, refer to Dr. Haught (plastic surgeon) for management of rt lateral calf stage II pressure ulcer; 10/8/02 Multidex gel to rt later knee; 10/9/02 Alginaid 1pkg w/ 6-8 oz water or juice BID; 10/9/02 Dr. Siggard d/c'd referral to plastic and vascular surgeon; 10/11/02 Glytrol 120cc po TID; 10/9/02 Dr Siggard came to examine patient; 10/11/02 Utah Dept. of Health Receipt 499993 NOV 0[illegible] 2002 Bur. of Medicare/Medicaid Prog. Certification and Res. Assessment	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/7/02

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days aft such information is 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 314	Continued From page 1 resident were at risk for the development of skin breakdown. The DON responded, "Like the Braden Scale?, No we don't use anything like that." The DON stated the night nurse would complete a nursing history and physical assessment and if the nurse found any skin breakdown he/she would start a care plan and report the pressure sore to me, as the DON, and that skin checks would be done, during showers, two times a week. The DON also stated that if a nurse aide discovered that a resident had a pressure sore, during a shower, the nurse aide would then report it to the nurse on duty. The DON stated the nurse on duty was to write a telephone order to the treatment nurse. The DON stated the treatment nurse was then to report the pressure sore to the DON. The DON stated that she would then call the physician and the registered dietitian. A review of resident 21's medical record was completed on 10/3/02. Facility nursing staff completed a "Nursing History and Physical Assessment" for resident 21 on 2/15/02. Resident 21 was assessed as having no pressure sores. The nurse documented that resident 21 bruised easily. Facility staff completed MDS assessments for resident 21 on 2/24/02, 5/21/02, and 8/20/02. On 2/24/02, facility staff assessed that resident 21 had no pressure sores, was receiving no skin treatments, and had no foot problems. On 5/21/02, facility staff assessed that resident 21 had no pressure sores, had abrasions or bruises, that the resident was on a turning and positioning program, and that the resident's nails/calluses had been trimmed in the previous 90 days. On 8/20/02, facility staff assessed that resident 21 had two stage II pressure sores, that the resident had a pressure relieving device for her chair, was on a turning and positioning program, had application of ointments/medications other than to her feet, had other	F 314	Upon admission, the facility will continue to complete an MDS, an "Nursing History and Physical Assessment," a skin "RAP" sheet and a nutritional assessment to assess residents who may be at risk for skin breakdown. As part of the QA process, a Skin and Weight meeting will be held monthly to review those residents at risk. Members of the Skin and Weight Committee typically will include: Director of Nursing, Unit Managers, Food Service Supervisor, RTA and Registered Dietician. A "Pressure Sore Management Record" will continue to be done weekly. Weekly skin assessment will be done to coincide with the resident's bath schedule. A copy will be given to the Director of Nursing and Administrator who will be responsible for monitoring in the future. **Completed on 11/8/02**	

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F 314	Continued From page 2 preventative/protective skin care other than to her feet, and that the resident's nail/calluses had been trimmed in the previous 90 days. A review of resident 21's care plan was completed on 10/3/02. On 2/26/02, facility staff implemented a care plan regarding resident 21's skin condition. On 2/26/02, facility staff documented that resident 21's, "Skin integrity remains intact." On 7/13/02, facility staff documented resident 21 had a, "Potential [and] actual alt [alteration] in skin integrity." Also on 7/13/02, facility staff documented resident 21 had a, "Potential for breakdown [due to] decreased mobility." On 7/13/02, facility staff did not identify any goals relating to resident 21's skin conditon. On 7/13/02, facility staff documented two interventions regarding resident 21's skin: Barrier cream to bottom; and, Turn every two to three hours while in bed. On 8/28/02, facility staff documented a goal for resident 21's skin condition. The goal was, "No DQ's [decubitus ulcers/pressure sores] TNR [through next review]. No other unreported alt. in skin integrity. LL [left lateral] ankle ulcer [and] r [right] heel ulcer." On 8/13/02, facility staff added the intervention of dressing changes as ordered to resident 21's care plan. On 8/16/02, facility staff added the following interventions to resident 21's care plan: Dressing changes as ordered; Monitor skin integrity every day and report changes; Avoid shear with transfers; Keep clean and dry; and, treatment as orders. A review of podiatry progress notes was completed on 10/3/02. On 5/31/02, a podiatrist documented that resident 21 had a new complaint of a painful right heel. The podiatrist documented that resident 21 had a stage II pressure sore to her right lateral heel that was through full thickness and 0.5 centimeters (cm) in diameter. The podiatrist documented that the resident was to be placed in a post operative shoe with her right	F 314		

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F 314	Continued From page 3	F 314		

foot to be elevated with pillows at night. On 6/7/02, the podiatrist documented that the stage II pressure sore was greatly improved at 0.1 cm. The podiatrist directed that staff could apply an antibiotic ointment and bandaide to the area for an additional week. On 8/19/02, the podiatrist documented that resident 21 had come to him with a complaint of a painful left lateral ankle unlceration that had been present for the past week. The podiatrist documented that resident 21 had a stage III ulcer that measured 1.5 cm in diameter to her left lateral malleolus with surrounding cellulitis extending one to two centimeters distal from the ulceration. The podiatrist documented that he debrided the ulceration down through the subcutaneous tissues and applied Iodasorb ointment and a sterile dressing. On 9/11/02, a physician progress note included documentation that resident 21's pressure sore to her right heel had resolved. The physician documented that resident 21 had a left lateral malleolus pressure sore, measuring at 1.2 x 1.3 cm with adherent yellow slough and erythema (redness) surrounding the wound, and that the area was tender to touch.

A review of the physician recertification orders, dated 9/4/02, was completed on 10/3/02. Per documentation, resident 21 was started on a multivitamin upon admission to the facility. On 8/15/02, Vitamin C 500 miligrams (mg) daily and Zinc 220 mg daily were added to the resident's medication regimen. Per documentation, there were no additional interventions added to increase calories or protein to aid in pressure sore healing for resident 21.

A review of the nurses notes, between 2/15/02 to 9/30/02, was completed on 10/3/02. The following entries were made by nursing staff regarding resident 21's right heel pressure sore: (Note: There were no nursing notes to address the pressure sore identified by

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F 314	Continued From page 4 the podiatrist on 5/31/02.) a. On 8/18/02 at 1:00 PM, a nurse documented, "found a blackened heel ulcer on pts [patients] R [right] heel size 1 x 1 cm [no] drainage [no] odor. T.O. [telephone order] for Multidex gel and DSD [change] QD until healed." b. On 9/11/02 a nurse documented, "Wound on R heel resolved. . ." A review of the nurses notes, between 2/15/02 to 9/30/02, was completed on 10/3/02. The following entries were made by nursing staff regarding resident 21's left lateral ankle pressure sore: a. On 8/13/02, a nurse documented, "Ulceration on L [left] lat [lateral] ankle. Multidex gel [with] DSD [dry sterile dressing] QD [everyday]. Will monitor for s/s [signs/symptoms] infections." b. On 8/14/02, a nursing note entry included documentation that resident 21's daughter was informed of the resident's left heel ulcer. c. On 8/15/02, a nurse documented, "Skin warm dry [and] pink. Dsg [dressing] intact to skin tear." d. On 8/16/02 at 6:00 PM, a nurse documented that resident 21's podiatrist ordered that the resident receive Levaquin (an antibiotic) every day for ten days for cellulitis in the resident's left ankle. e. On 8/17/02 at 12:30 PM, a nurse documented that resident 21's daughter was informed of the resident's cellulitis. The nurse also documented that the resident's dressing was changed by the treatment nurse. f. On 8/18/02 at 3:30 PM, a nurse documented, ". . . Ankle has some redness and small amount of drainage. [No] odor. . . ." g. On 8/19/02 at 4:00 PM, a nurse documented, ". . . Another culture obtained [and] prepared for lab. . . ." h. On 8/21/02 at 12:45 PM, a nurse documented, ". . . Ankle dressed by tx nurse - minimal drainage,	F 314		

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F 314	Continued From page 5 slightly red at the edges. . . ." i. On 8/22/02 at 8:30 AM, a nurse documented, "Results from wound culture - MRSA [Methicillin Resistant Staphylococcus Aureus] + 3 . . ." j. On 8/24/02 at 12:00 AM, a nurse documented, ". . . No drainage noted on left decub [decubitus ulcer/pressure sore] area (foot) . . . " k. On 8/25/02 at 3:30 PM, a nurse documented, ". . . pts continues on Levaquin for ankle wound cellulitis. [No] swelling or edema or redness noted [no] drainage. Dressing [changed] by tx [treatment] nurse. . . ." l. On 8/26/02 at 3:00 PM, a nurse documented, ". . . pt continues on Levaquin for ankle wound. Site is clean [no] s/s of infection. [No] drainage, has small amount of white sluff [sic] in outer - pink around edges - continues [with] tx daily. . . ." A review of "Photographic Wound Documentation" forms for resident 21 was completed on 10/3/02. Facility staff documented resident 21's pressure sores on this form as follows: a. 8/13/02 - Stage II left lateral ankle, 1.2 x 1.3 cm with an unknown depth and brown in color. b. 8/16/02 - Stage II left heel area, 1 x 1 cm with an unknown depth and black in color. c. 8/19/02 - Stage II right heel, 1.7 x 1.2 x 0.1 cm and brown in color. d. 9/18/02 - Stage II left lateral ankle, 0.6 x 0.5 x 2 to 3 cm, with surrounding redness 1.2 x 1 cm. A review of "Weekly Skin Integrity Action Sheet" forms for resident 21 was completed on 10/3/02. Facility staff documented resident 21's pressure sore on this form follows: a. 8/21/02 - Stage II right heel, 1.5 x 1.1 x 0.1 cm. The treatment documented was Multidex gel with a dry sterile dressing everyday. b. 8/21/02 - Stage II left later ankle, 1.3 x 1.2 x	F 314		

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F 314	Continued From page 6 0.1 cm. The treatment documented was Multidex gel with a dry sterile dressing everyday. c. 8/28/02 - Stage II right ankle, 1.8 x 1.5 x 0.1 cm with dry skin around area. The treatment documented was Multidex gel with a dry sterile dressing. d. 8/28/02 - Stage II left heel, 1 x 1 cm. The treatment documented was Multidex gel with dry sterile dressing. The entry documented that both pressure sores were improving. e. 9/4/02 - Stage II right ankle, 1.8 x 1.5 cm, healing. f. 9/4/02 - Stage II left heel , 1 x 1 cm, has small red area in center. The treatment documented was Multidex gel. g. 9/11/02 - Righ heel pressure sore had resolved h. 9/11/02 - Left lateral malleolus pressure sore, 1.2 x 1.3 cm, with yellow slough and erythema surrounding and tender to touch. The treatment identified was Multidex gel and Telfa and gauze wrap. i. 9/25/02 - Left lateral ankle, 1 x 1 x 0.3 cm, with a small amount of exudate. j. 10/3/02 - Left lateral ankle, 1 x 1 x 0.2 cm, with no odor or drainage. A review of the nutritional assessments for resident 21 was completed on 10/3/02. A "Nutritional Assessment" form was available in the resident's medical for review. However, this assessment was not signed or dated. This assessment did not include the resident's usual body weight, the resident's ideal body weight, or the resident's desired body weight range. This assessment also did not include the estimated nutritional needs of the resident, to include calories, protein, or fluids. A review of nutritional progress notes for resident 21 was completed on 10/3/02. On 8/7/02, the facility's Food Service Supervisor (FSS) documented that the	F 314		

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F 314	Continued From page 7 interdisciplinary team discussed the resident's weights and intake and that no changes were noted. The FSS documented the plan was to continue with the current plan of care. On 8/9/02, the FSS documented that the resident had experienced a 14 pound weight loss and that nursing staff was notified. The FSS documented that she would work with the resident to encourage greater meal intake and that if the weight loss continues, she would ask the nursing staff for an increase in supplements provided to the resident. A review of resident 21's weights, between 2/15/02 and 9/27/02, was completed on 10/3/02. Resident 21 experienced a significant weight loss from 176 pounds on admission to 159 pounds on 9/27/02. During that time period, the resident's weight was high at 180 pounds on 3/1/01, to a low of 155 pounds on 8/23/02. Following resident 21's pressure sore development on 5/31/02, and singificant weigth loss between her admission and 9/27/02, there were no nutritional assessments or to address her additional nutritional needs to aid in wound healing. 2. Resident 16 was a 78 year old who was admitted to the facility on 5/13/02, with the diagnoses of a fractured right femur, paraplegia, hypertension, insulin dependent diabetes mellitus, atrial fibrillation, and left above the knee amputation. An observation of resident 16's skin condition was made on 10/3/02 at approximately 4:30 PM. The observation was made in the presence of the treatment nurse. Resident 16 was observed to have a stage III pressure sore to the lateral portion of his right knee. A review of resident 16's medical record was completed on 10/3/02. On 5/13/02, a facility nurse	F 314		

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F 314	Continued From page 8 completed a "Nursing History and Physical Assessment" for resident 16. The nurse documented resident 16 was on bedrest and dependent for transfers, requiring the assistance of two staff members for bed mobility. The nurse also documented resident 16 had a red sore, the ". . . size of a quarter. . ." on his left buttock. There was no assessment for the risk of skin breakdown available for review in resident 16's medical record. Facility staff completed an admission Minimum Data Set (MDS) assessment for resident 16 on 5/19/02. Facility staff assessed resident 16 as having no skin ulcers. Facility staff documented the following skin treatments for resident 16: "turning/ repositioning program" and "other preventative/ protective skin care". Facility staff completed additional MDS assessments for resident 16 on 6/27/02, 7/4/02, 7/19/02, and 8/16/02. Facility staff assessed that resident 16 had no skin breakdown on the 6/27/02, 7/4/02, and 7/19/02 MDS assessments. On the 6/27/02, 7/4/02, and 7/19/02 MDS assessments, facility staff documented the following sking treatments: "Turning/repositioning program"; "Nutrition/Hydration intervention to manage skin problems"; "Surgical wound care"; "Application of ointments/medications (other than to feet)"; and, "Other preventative /protective skin care (other than to feet)". On the 8/16/02 MDS assessment, facility staff assessed that resident 16 had two stage II pressure sores. At that time, facility staff identified the following skin treatments: "Turning/repositioning program"; "Nutrition/Hydration intervention to manage skin problems"; "Ulcer care"; "Application of dressings (with or without topical medications) other than to feet"; "Application of ointments/medications (other than to feet)"; and, "Other preventative	F 314		

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F 314	Continued From page 9 /protective skin care (other than to feet)". A review of resident 16's care plan was completed on 10/3/02. On 5/15/02, facility staff documented that resident 16 had a potential for alteration in skin related to immobility, a cast, and a history of paraplegia. The goal for this identified problem was that resident 16 would have no skin breakdown. Facility staff documented the following interventions for resident 16: Monitor cast edges; Turn and reposition every two hours; Monitor skin during bath and shower time; Keep clean and dry; Avoid shear; and, vitamin C and Zinc per orders. (Although vitamin C and Zinc were identified on resident 16's care plan, they were not ordered or documented as being administered until 8/15/02.) A review of resident 16's admission "Nutritional Assessment" was completed on 10/3/02. The Nutritional Assessment was dated 5/19/02. Per documentation on the Nutritional Assessment, resident 16's ideal body weight was between 180 to 200 pounds and that his admission weight was questionable at 120 pounds. The Registered Dietitian documented resident 16's weight could not be done secondary to his leg fracture. The Registered Dietitian documented that resident 16's usual body weight was unknown. Resident 16's estimated weight upon admission was 66% of the low ideal body weight range. The registered dietitian documented the following for resident 16: "I rec [recommend] a multivitamin & mineral supplement and a minimum of 1000 mg [milligrams] vit [vitamin] C/ day divided into 2 doses ie [example] 500 mg vit C BID [twice per day]. This will aid in wound/ bone healing." The 2000, American Dietetic Association, "Manual of Clinical Dietetics, 6th edition", p. 15, considers below 69% of idea body weight IBW to be a "severe" sign of	F 314		

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ROCKY MOUNTAIN CARE - WEST VAL	4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120

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F 314	Continued From page 10 malnutrition in adult males. An interview was held with a facility nurse on 10/1/02 at 2:00 PM. This nurse stated that resident 16 was not weighed upon admission because of his right leg fracture and the fact that the resident had a cast on that extended from his thigh to above the ankle. The nurse stated that when resident 16 was admitted, he said he weighed 120 pounds. An interview was held with the Director of Nursing (DON) on 10/02/02, at 4:10 PM. The DON stated the facility did not use an at risk for skin break down assessment tool. The DON stated that if the resident was at risk or had skin break down, it would be identified in the "Nursing History and Physical Assessment" form and it would be identified in the "care plan". The DON also stated that she was aware of what the dietitian had recommended for resident 16 at the time of admission but did not implement the vitamin supplements because resident 16 did not have skin breakdown at that time. The DON stated that the vitamin supplements were implemented once resident 16 had a pressure sore. A review of the facility's policy and procedures for "Decubitus Ulcers" was completed on 10/3/02. The facility's policy stated the following under, "Assessment of Residents at Risk: Identify residents who are particularly prone to the development of pressure ulcers, including the following: residents whose general condition is rapidly deteriorating, residents with an alteration in mentation, residents with an alteration in mobility, obese residents, lethargic, unresponsive residents, residents with motor or sensory deficits, edematous residents, incontinent residents, residents with alteration in nutrition and fluid balance and febrile residents". The facility's policy also stated the following: "Documentation is	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465075	A. BUILDING _____ B. WING _____	10/7/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - WEST VAL	4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120

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F 314	Continued From page 11 made by licensed staff members as follows: Record treatment and photo documentation weekly. Record in clinical notes weekly or as condition or level of care warrants. Inform physician of adverse reactions as needed. Notes should include: treatment ordered, stage, site, size, shape, drainage, progress, date, and signature". On 6/20/02, resident 16 had a "Referral to Physicians and Clinics", at which time the resident's cast was removed. Per documentation of this physician visit, resident 16 was not noted to have any skin breakdown. A review of "Medicare Daily Charting" records for resident 16 was completed on 10/3/02. On 6/22/02, a facility nurse documented, "Blister top of R [right] foot [and] leg from cast. . . Blisters are open [and] draining - Protective dressing applied - Vaseline, 4 x 4 [and] wrapped [with] Kerlix." This was the first notation in resident 16's medical record of his skin breakdown. There was no documentation that resident 16's physician was notified of the resident's right leg blister. A review of resident 16's June, July, August, September, and October 2002 Medication Administration and Treatment records was completed on 10/3/02. The following treatments were documented for resident 16: a. On 6/26/02 through 6/30/02, there was a treatment order for staff to apply an antibiotic ointment and cover with Telfa and wrap with Kerlix to the open blister on resident 16's right leg. This treatment was to be applied every day. There were no treatment orders for the blisters on the resident's right leg documented on the treatment record prior to 6/26/02. b. On 7/1/02 through 7/14/02, there was a treatment order for staff to apply an ace wrap on	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465075	A. BUILDING _____ B. WING _____	10/7/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - WEST VAL	4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120

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F 314	Continued From page 12 resident 16's right foot and lower right leg and to use antibiotic ointment as necessary on blisters and ulcers. Staff were to keep the right lower extremity slightly elevated. Per documentation, this treatment was discontinued on 7/14/02, due to the wounds being healed. c. On 7/16/02 through 7/31/02, there was a treatment order for staff to apply a loose wrap and wash leg every day, check for skin intact. The treatment record documented a wound on resident 16's lateral leg, below knee. d. On 8/14/02, the medication record documented resident 16 was to receive vitamin C 500 mg everyday, Zinc 220 mg everyday, and a multi-vitamin everyday. Per documentation in resident 16's medical record, he was not receiving vitamin C, a multi-vitamin, or Zinc prior to 8/14/02. These interventions were implemented 87 days after the Registered Dietitian made the recommendations on 5/19/02. e. On 8/1/02 through 8/6/02, there was a treatment order for staff to apply a loose wrap and wash leg everyday and to check for skin problems. The treatment record documented the resident had a wound on his lateral knee, and that lamb's wool was used for padding. f. On 8/6/02 through 8/31/02, there was a treatment order for staff to apply Multidex gel and cover with Telfa and gauze everyday to a right leg pressure sore. g. On 9/1/02 through 9/5/02, there was a treatment order for staff to apply Multidex gel and Telfa and gauze to the resident's right leg pressure sore. Per documentation on the treatment record, this treatment was changed on 9/5/02. h. On 9/5/02 through 9/10/02, there was a treatment order for staff to apply Multidex powder with a dry, sterile dressing to the resident's right leg pressure sore. Per documentation on the treatment record, this treatment was changed on 9/11/02.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465075	A. BUILDING _____ B. WING _____	10/7/2002

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ROCKY MOUNTAIN CARE - WEST VAL	4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120

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F 314	Continued From page 13 i. On 9/11/02 through 10/2/02, there was a treatment order for staff to pack the resident's tunnelling wound with Multidex powder and to apply Multidex powder to the open wound area and to cover with Telfa pad, and wrap with gauze. Although resident 16 developed an open area on his right lateral knee on 7/16/02, per documentation on the treatment record, there was no measurement or assessment of this wound until 22 days later, on 8/07/02. Beginning 8/7/02, facility staff began weekly assessments of resident 16's right lateral knee pressure sore. On 8/7/02, facility staff documented the pressure sore to be 2.5 centimeters (cm) x 1.5 cm. On 8/14/02, the pressure sore was documented to be 2.2 cm x 1.5 cm. On 8/21/02, the pressure sore was documented to be 2 cm x 1.5 cm. On 8/28/02, the pressure sore was documented to be 2 cm x 1.9 cm. On 9/11/02, the pressure sore was documented to be 2 cm x 1.9 cm, with tunnelling at 1.2 cm, 1.4 cm. 2 cm, and 1.5 cm. On 9/18/02, the pressure sore was documented to be 2 cm x 1.9 cm. There was notation of tunnelling, however, no depths of the tunnelling were identified. On 10/2/02, the pressure sore was documented to be 4 cm x 3.8 cm, with tunnelling at .5 cm, 1 cm, .4 cm, and .3 cm. A review of physician progress notes was completed on 10/3/02. There were physician progress notes dated, 6/25/02, 7/30/02, 8/28/02, and 9/11/02. The first physician progress note to address resident 16's right lateral knee pressure sore was 9/11/02. On 6/25/02, 7/30/02, and 8/28/02, physician notes revealed no skin problems as evidenced by the physician marking a check mark in the box of "WNL" (within normal limits) under the section labeled, "Skin & SQ [subcutaneous] Tissue". Resident 16's stage II pressure ulcer progressed from a	F 314		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465075	A. BUILDING _____ B. WING _____	10/7/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - WEST VAL	4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120

(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) COMPLETE DATE
F 314	Continued From page 14	F 314		

measurement of 2.5 x 1.5 cm (centimeters) on 8/7/02 to 4 x 3.8 cm with four different areas of tunneling on 10/02/02. Resident 16 was not assessed upon admission for being at risk to develop pressure sores. Resident 16 had an 87 day delay in receiving his vitamin supplements after the facility's dietitian recommended it and assessed him as being malnourished. The facility's treatment nurse missed multiple assessments and measurements of resident 16's pressure ulcers. Resident 16's medical record lacked evidence of physician's being notified of his change in skin condition. All of these factors contribute to the progression of resident 16's pressure ulcer.

3. Resident 44 was a 75 year-old woman admitted to the facility on 1/15/02 with diagnoses including cerebral vascular accident, coronary artery disease, right heel pressure sore, anemia, renal insufficiency and protein malnutrition.

A review of the Nursing History and Physical Assessment dated 1/15/02 documented in the skin assessment "dry scab right heel..."

A review of the skin care plan dated 1/20/02 revealed problems documented as "Alteration in skin related to small scab right heel secondary to large heel blister" with interventions of "AFO boot right heel, monitor skin as needed, reposition as needed" There were no further preventative measure put in place to prevent further skin breakdown or to prevent the current breakdown from getting worse.

Review of the nutrition care plan dated 1/20/02 documented problems as "Alteration in nutrition related to decreased Albumin level 2.7" with interventions of "Diet as ordered, resource as ordered, Allow enough time to finish meal, encourage snacks"

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	465075	A. BUILDING _____ B. WING _____	10/7/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - WEST VAL	4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120

(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) COMPLETE DATE
F 314	Continued From page 15	F 314		

A nurse's note dated 2/6/02 documented "right heel ulcer some drainage-New treatment for right heel in treatment book." There was no documentation that the dietitian had been notified.

A doctor's note dated 2/15/02 documented a "dry scab right heel-open in center a little drainage 1cm stage II...Podiatry consult for heel ulcer"

Podiatry consult notes dated 2/21/02 documented "stage II-III ulcer on posterior right heel 1-2 cm in diameter. Foul odor present.... Ulceration on patient heel which should be debrided, probably infected." Further review of the consult report revealed that the DON refused to let the doctor treat the resident as recommended. She stated that she was going to have a wound care specialist look at the patient.

Review of the medical record could find no wound care specialist notes or assessment.

Further review of the medical record revealed podiatry consult notes dated 3/22/02 (37 days after the initial podiatry consult order), which documented " ulcer measures 3.0cmx1.5cmx1.5cm... stage III ulceration right heel"

A review of the skin care plan revealed interventions dated 5/01/02 documented as "podiatry consult, dressing change as ordered", interventions dated 5/20/02 documented as "dressing change as ordered" and interventions dated 6/15/02 documented as "bone scan as ordered"

Review of the nutritional assessment dated 1/21/02 documented resident 44's nutritional needs as follows: Calories 1800-2460 per day, protein 75-102 grams per day. Resident 44's meal intakes were documented with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465075	A. BUILDING _____ B. WING _____	10/7/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - WEST VAL	4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120

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F 314	Continued From page 16 an average of 37%, which provided 814 calories and 21 grams of protein. The dietitian documented that resident 44 received resource 2.0 three times a day for a combined calorie intake of 1534 calories and 53 grams of protein. The dietitian stated " both of which are still below estimated needs". The next two dietary assessments dated 1/30/02 and 4/10/02 recommended no changes and did not mention the worsening pressure sore and made no new recommendations to aide in healing.	F 314		
F 325 SS=G	483.25(i)(1) QUALITY OF CARE Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by 1 of 15 sampled residents (21) who experienced significant weight loss with no dietary interventions implemented to prevent further weight decline. Resident identifiers: 21. Calculating weight loss percentages is done by subtracting the current weight from the previous weight, dividing the difference by the previous weight and multiplying by 100. Significant weight losses are as follows: 5% in one month, 7.5% in 3 months and 10% in 6 months. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000). Findings include:	F 325	Acceptable BB **F 325** On 10/03/02 a nutritional assessment was completed for Resident 21 by the registered dietician. Resident 21 was reviewed during the Skin and Weight meeting held on 10/7/02. On 10/10/02, Resident 21's physician ordered Alginaid 1 pkg w/ 6 oz water or juice BID and Resource 120cc po TID. The resident's weight as of 10/4/02 was 160# and has remained stable since 8/02/02. Each resident will be weighed upon admission. The resident will be re-weighed after 24 hours. Weekly weights will be performed for one month or until the resident's weight is stable. A nutritional assessment will be completed by the registered dietician for each resident within 14 days of admission. As part of the QA process, a monthly Skin and Weight meeting will be held to identify residents who have experienced an unplanned weight loss and to develop a plan of care to address the weight loss. The Food Service Supervisor, Director of Nursing, Registered Dietician and Administrator will be responsible for monitoring. **Completed on 11/8/02**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465075	A. BUILDING _____ B. WING _____	10/7/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - WEST VAL	4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120

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F 325	Continued From page 17 a. Resident 21 was a 74-year-old female admitted to the facility on 2/15/02 with diagnoses including diabetes mellitus, cva (cerebral vascular accident) dementia, and osteoarthritis. A podiatry consult note dated 5/31/02 documented "Patient with new complaints of painful right heel. Ulceration stage II right lateral heel through full thickness, .05 cm (centimeters) in diameter... will place patient in post -op shoe right foot." A podiatry note dated 6/7/02 documented "ulcer greatly improved- only very small 0.1 area left... will follow up once more in one week." The next podiatry note dated 8/19/02 documented "There is a 1.5cm diameter stage III ulceration, lateral left malleolus. A review of the nurses notes between 6/7/02 to 8/19/02 revealed documentation on 8/13/02 stating " ulceration left lateral ankle..." documentation on 8/16/02 stating "found a blackened heel ulcer on patients right heel size 1x1 cm no drainage, no odor..." There is no documentation that the doctor or the dietitian was notified of the new pressure ulcer on the left ankle or the pressure on the right heel that had progressed from .05cm to 1x1cm. Review of resident 21's weight chart revealed the following weights: 3/01/02 180 lbs. (pounds) 3/08/02 178 lbs. 3/15/02 178 lbs. 4/05/02 175 lbs. 5/03/02 172 lbs. 6/01/02 172 lbs. 7/05/02 168 lbs.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465075	A. BUILDING _____ B. WING _____	10/7/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - WEST VAL	4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120

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F 325	Continued From page 18 8/02/02 158 lbs. 8/09/02 158 lbs. 8/16/02 158 lbs. 8/23/02 155 lbs. Between 3/01/02 and 8/23/02 (5 ½ months) there was a 25 lb weight loss, which represents a 13.8% decrease A review of the nutrition records revealed an undated, incomplete and unsigned nutritional assessment that did not address resident 21's steady weight loss or the pressure sores. There were no calorie needs or protein needs on the assessment. There were no nutritional assessments after 8/13/02 addressing additional calories or protein to aid in healing or to increase weight. There was no evidence that the dietitian had been notified of the pressure sores or weight loss. A review of the doctor's recertification orders dated 9/04/02 document no orders for any supplements to increase calories or protein to aid in healing in resident 21. A review of resident 21's nutritional care plan documented the following problems: 2/26/02 No nutritional concerns at this time 8/28/02 Potential for alteration in nutrition related to pancreatic disturbances and fluctuating appetite The interventions were documented as follows: 8/28/02 NCS (no concentrated sweets) diet, medication as ordered, provide pleasant environment during meals, monitor weight changes, assist with meals if necessary. There was no documentation of any pressure ulcers or nutrition interventions needed for the healing of the pressure ulcers. A doctor's note dated 10/04/02 documented "[Resident	F 325		

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	465075	A. BUILDING _____ B. WING _____	10/7/2002

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ROCKY MOUNTAIN CARE - WEST VAL	4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120

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F 325	Continued From page 19 21] is above her ideal body weight. She was drinking a lot of soda, which was restricted back in June 2002. She subsequently lost 10 lbs., which was expected... See calculations that support this; 10lbs.= (equals) 32,000 calories, 1 can of soda = 120 calories therefore 6 cans [of] soda per day = 44 days approximately 6 weeks." Soda which contains 120 calories would be a non-diet soda and would contain concentrated sugars. A review of the medical record revealed no documentation that resident 21 consumed six cans of soda a day. A review of the nurses notes revealed a nurses note dated 8/17/02 documenting a "need for more soda". A nutrition progress note dated 3/3/02 documented "...family request to keep with NCS, no caffeine diet. Dietary will provide de-caffeinated coffee, family will bring in dt (diet) caffine free coke and leave at nurses station and resident to get 1 pop a day at 2 PM daily." To provide resident 21 with six cans of non-diet soda a day would be contrary to the care plan, the families wishes and to the Doctor's diet order dated 2/15/02. Further review of the nutrition notes revealed no care plan, doctor's order or assessment for a weight loss for resident 21.	F 325		
F 361 SS=G	483.35(a)(1)-(2) DIETARY SERVICES The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian.	F 361	Acceptable BB **F 361** RMC-West Valley hired a registered dietician on 8/27/02. The registered dietician did perform a nutritional assessment on Resident 21 on 10/3/02. On 10/04/02, Resident 21's albumin level was within normal limits (3.70). Resident's weight loss has also been addressed on the care plan as of 10/4/02. Resident is also receiving several nutritional supplements (i.e. alginaid BID, Resource TID, multivitamin, vitC and zinc).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465075	A. BUILDING _____ B. WING _____	10/7/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - WEST VAL	4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120

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F 361	Continued From page 20 A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined that the facility did not employ a consultant dietitian for 3 months and therefore did not utilize a consultant dietitian to assess the nutritional status of residents. Specifically 1 newly admitted residents, who experienced significant weight loss and facility acquired pressure ulcers and had no nutritional assessments completed by a registered dietitian. Resident identifiers: 21 Findings include: a. Resident 21 was a 74-year-old female admitted to the facility on 2/15/02 with diagnoses including diabetes mellitus, CVA (cerebral vascular accident) dementia, and osteoarthritis. Review of the medical record revealed the following documentation: Podiatry consult notes: Dated 5/31/02 documented "Patient with new complaints of painful right heel. Ulceration stage II right lateral heel through full thickness, .05 cm (centimeters) in diameter... will place patient in post -op shoe right foot." Dated 6/7/02 documented "ulcer greatly improved-only very small 0.1 area left... will follow up once more in one week." The next podiatry note dated	F 361	The registered dietician will be a part of the facility QA process by participating in the monthly Skin and Weight meeting and making recommendations to the Quality Assurance committee. The registered dietician will complete a nutritional assessment within 14 days of admission on new residents. The Administrator will be responsible for ensuring that either a registered dietician is employed or that the Food Service Supervisor receives frequently scheduled consultation from a qualified dietician. **Completed on 11/8/02**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465075	A. BUILDING _____ B. WING _____	10/7/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - WEST VAL	4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120

(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) COMPLETE DATE
F 361	Continued From page 21 8/19/02 documented "There is a 1.5cm diameter stage III ulceration, lateral left malleolus Refer to tag F-314 Review of resident 21's weight chart revealed the following weights: 3/01/02 180 lbs. (pounds) 3/08/02 178 lbs. 3/15/02 178 lbs. 4/05/02 175 lbs. 5/03/02 172 lbs. 6/01/02 172 lbs. 7/05/02 168 lbs. 8/02/02 158 lbs. 8/09/02 158 lbs. 8/16/02 158 lbs. 8/23/02 155 lbs. Between 3/01/02 and 8/23/02 (5 ½ months) there was a 25 lb weight loss, which represents a 13.8% decrease A review of the nutrition records revealed an undated, incomplete and unsigned nutritional assessment that did not address resident 21's steady weight loss or the pressure sores. There were no calorie needs or protein needs on the assessment. There were no nutritional assessments after 8/13/02 addressing additional calories or protein to aid in healing or to increase weight. There was no evidence that the dietitian had been notified of the pressure sores or weight loss. Refer to tag F-325 and F-314 In an inter view with the dietary manager on 10/02/02 she stated they had a dietitian leave at the end of January 2002 and that she did not see another dietitian until April of 2002. She stated that that dietitian left sometime in June and they have not been able to find another dietitian until the beginning of September. She stated that she has been trying to keep up with some of	F 361		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465075	A. BUILDING _____ B. WING _____	10/7/2002

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F 361	Continued From page 22 the problems, but she was not sure what to do on some of the "bad" problems. In an interview with Administrator and the DON on 10/02/02 they were asked how long they have been without a dietitian. The Administrator stated that they loss the dietitian they had sometime in June and they just recently hired a dietitian at the beginning of September. The DON stated that there was a corporate dietitian available for their use after the dietitian left in January. A review of the medical records of the resident selected for the survey revealed no documentation from a dietitian until April of 2002.	F 361		
F 514 SS=E	483.75(l)(1) ADMINISTRATION 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. This REQUIREMENT is not met as evidenced by: Based on observation and medical record review, it was determined that the facility did not maintain clinical records on each resident in accordance with accepted professional standards and practices that were complete, accurately documented and readily accessible as evidenced by: 3 of 15 sampled residents had medical records that did not accurately reflect the residents status. Resident identifiers: 16, 12, 44 Findings include: Resident 21 was a 74-year-old female admitted to the facility on 2/15/02 with diagnoses including diabetes	F 514	**F 514** A complete medical treatment plan review for Resident 21 has been completed. A care plan was updated on 8/28/02, a physician progress note was done on 9/11/02 and registered dietician note was done on 10/03/02. Resident 44 was assessed on 10/03/02, 10/09/02, 10/16/02 and 10/28/02 which was the date in which the pressure ulcer was healed. On 8/02/02 a physician order was written to d/c Alginaid. Documentation per nursing note and tx sheet on 8/02/02 supports the patients refusal of supplement. A complete review of Resident 16' s closed chart was done by the physican and nursing on 11/04/02. All parties clarified the tx plan and clinical progress.	

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	465075	A. BUILDING _____ B. WING _____	10/7/2002

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F 514	Continued From page 23 mellitus, CVA (cerebral vascular accident) dementia, and osteoarthritis. A review of her medical record was completed 10/02/02. A podiatry consult note dated 5/31/02 documented "Patient with new complaints of painful right heel. Ulceration stage II right lateral heel through full thickness, .05 cm (centimeters) in diameter... will place patient in post -op shoe right foot." Review of resident 21's care plan revealed no documentation of the change in skin condition for resident 21 and no documentation of preventative measures in place. A podiatry note dated 6/7/02 documented "ulcer greatly improved- only very small 0.1 area left... will follow up once more in one week." The next podiatry note dated 8/19/02 documented "There is a 1.5cm diameter stage III ulceration, lateral left malleolus. A review of the nurses notes between 6/7/02 to 8/19/02 revealed documentation on 8/13/02 stating " ulceration left lateral ankle..." documentation on 8/16/02 stating "found a blackened heel ulcer on patients right heel size 1x1 cm no drainage, no odor..." There is no documentation that the doctor or the dietitian was notified of the new pressure ulcer on the left ankle or the pressure on the right heel that had progressed from .05cm to 1x1cm. The facility's policy on decubitus Ulcers states "Documentation is made by licensed staff members as follows: a. Record treatment and photo documentation weekly. b. Record in clinical notes weekly or as condition or level of care warrants. Inform physician of adverse	F 514	When a pressure sore is identified, the Unit Manager will : a. Assess the patient's skin and document findings b. Ensure an order for treatment and that the physician has been notified. c. Ensure the registered dietician has been notified. d. Ensure that a care plan has been started. As part of the QA process, notes from the Skin and Weight meeting will be provided to the Medical Director for any resident that has a pressure ulcer. Recommendations by the registered dietician will be forwarded to nursing and reviewed with Medical Director prior to implementation. Nursing will continue to chart weekly on residents with pressure ulcers. An inservice was held on 10/16/02 to review **Completed on 11/8/02**	

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F 514	Continued From page 24 reactions as needed. Notes should include: 1. Treatment ordered 2. Stage (circle I, II, III or IV) 3. Site 4. Size 5. Shape (diameter and depth in cm.) 6. Drainage 7. Progress 8. Date 9. Signature There was no weekly documentation on the progress of resident 21's pressure sore following the procedures of the facility's policy until 8/13/02. b. Resident 44 was a 75 year-old woman admitted to the facility on 1/15/02 with diagnoses including CVA, cad (cardiac artery disease) right heel decubitus, constipation, anemia, renal insufficiency and protein malnutrition. A review of the Nursing History and Physical Assessment dated 1/15/02 documented in the skin assessment "dry scab right heel..." Further review of the medical record revealed podiatry consult notes dated 3/22/02, which documented " ulcer measures 3.0cmx1.5cmx1.5cm... stage III ulceration right heel" There was no weekly documentation on the progress of resident 44's pressure sore following the procedures of the facility's policy until 4/30/02. A physician order dated 2/6/02 documented" Arginaid 1 packet twice a day with 8 ounces of water" A physician order dated 8/2/02 discontinued the Arginaid related to patient refusal. No documentation	F 514		

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F 514	Continued From page 25 of the Arginaid being given or being refused was found in the medical record. The facility was asked to provide the surveyors with the information on10/3/02, 10/7/02 and again on 10/8/02. No documentation on the missing information was provided. c. Resident 16 was a 78 year old who was admitted to the facility on 5/13/02, with the diagnoses of a fractured right femur, paraplegia, hypertension, insulin dependent diabetes mellitus, atrial fibrillation, and left above the knee amputation. Resident 16's medical record was not accurate concerning which one of his legs were amputated, incongruous dates as to when the cast was removed, lack of weekly skin wound assessments, incongruous dates and assessments of skin condition in the physician's notes, and inaccurate documentation on the Minimum Data Set (M.D.S.) for skin treatments. Amputated Leg: Resident 16 was observed on 10/03/02 by a nurse surveyor, who confirmed that his left lower leg was the amputated extremity and the right leg had been fractured. Resident 16's "Nursing History and Physical Assessment" that was completed by a facility nurse, dated 5/13/02, documented "acute R [right] femur fx	F 514		

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F 514	Continued From page 26	F 514		

[fracture]" for medical diagnosis. On the assessment for "General appearance..." the nurse documented resident 16 as a "78 yr [year] old male- R [right] AKA [above the knee amputation] amputee, L [left] leg on cast - toes warm & dry". On the same assessment for "Extremities", the facility nurse documented that resident 16 had a "R leg amputee, L cast".

Resident 16 has a podiatry note, dated 7/15/02, that documented the following: "Pt's [patient's] swelling has also gone down on the left foot and ankle and lower extremity."

Dates of Cast:

On a "Referral To Physicians and Clinics" form, dated 6/20/02 for resident 16, it was documented that the orthopedic physician removed the cast and ordered a brace. Resident 16's "Physical Exam", dated 6/25/02, documented the following: "Fx [fracture] R [right] femur: casted.....". Resident 16's "Physical Exam" was signed by the facility's medical director and an adult nurse practitioner (A.N.P.).

Weekly Skin Wound Assessments:

The July, 2002 MAR for resident 16, documented the following treatment, dated 7/16/02, "Loose wrapping & wash leg qd [everyday] [check] for skin intact. Wound on lateral leg [below] knee". This treatment order carried over to the August, 2002 MAR and was discontinued on 8/06/02. There was no measurement or assessment for resident 16's skin wound to his right lateral leg/knee, until 8/07/02. Resident 16 did not have his right lateral leg wound assessed for 22 days, after the initial finding.

The sore on his right lateral knee, did not have weekly assessments from 8/28/02 to 9/11/02. On 9/11/02,

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	Continued From page 27	F 514		

there was a change in condition of the sore due to tunneling. From 9/18/02 to 10/02/02, another 2 weeks between assessments, there was an increase in wound size, (from 2 x 1.9 cm to 4 x 3.8 cm).

An interview on 10/02/02 at 4:10 P.M. with the facility D.O.N., revealed that the facility treatment nurse was responsible to conduct, document and report weekly skin wound assessments.

The facility's policy and procedure for "Decubitus Ulcers" state the following: "Documentation is made by licensed staff members as follows: Record treatment and photo documentation weekly. Record in clinical notes weekly or as condition or level of care warrants. Inform physician of adverse reactions as needed. Notes should include: treatment ordered, stage, site, size, shape, drainage, progress, date, and signature".

Physician's Assessment of Skin Wound:

On 9/11/02, was the first documentation made by resident 16's physician in regard to his skin ulcer. Resident 16 was evaluated by his physician on 6/25/02, 7/30/02, and 8/28/02; each physician exam and notes revealed no skin problems as evidenced by the physician marking a check mark in the box of "WNL" (within normal limits) under the section labeled, "Skin & SQ [subcutaneous] Tissue". The 8/28/02, physician's "Physical Exam" stated the following: "Femur fx [fracture] improving. Working on transfer [with] goal of D/C [discharge] home."

M.D.S. Skin Treatments:

Resident 16 had a physician's order, dated 8/14/02, for a multivitamin, Vitamin C 500 mg [milligrams], and

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F 514	Continued From page 28 Zinc 220 mg by mouth everyday. The August, 2002 Medication Administration Record (M.A.R.) documented that this order was implemented on 8/15/02. Resident 16 had "Nutrition or hydration intervention to manage skin problems" documented as being implemented for "Skin Treatments" on the following M.D.S. dates: 6/27/02, 7/04/02, and 7/19/02. There was no documentation of resident 16 to have been receiving any form of nutritional supplements prior to 8/14/02.	F 514		