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

PRINTED: 10/18/2004
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465062	A. BUILDING ______ B. WING ______	7/15/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH DAVIS COMMUNITY CARE CTR	401 SOUTH 400 EAST BOUNTIFUL, UT 84010

(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 278 SS=B	483.20(g) - (h) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly-- Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility did not ensure the Minimum Data Set (MDS) assessments accurately reflected residents' status for 2 of 25 sampled residents. The MDS assessments did not document the use of restraints for both residents. Findings include: Resident 92 was re-admitted to the facility on 5/22/04 with diagnoses which included organic	F 278 11/16/04 Revised POC acceptable (Bruenbank RN) NOV 1 2004	The R.N. Coordinator will follow SDCH Policy & Procedure which is in accordance with Federal Guidelines for completing the MDS and will ensure the accuracy of the data Resident 92: The MDS was generated on 06/21/04 and signed by those completing the MDS. The R.N. Coordinator identified an error on 06/29/04 and corrected the side rail and trunk restraint section from 0 to 2. The correct information was transmitted to the State on 07/06/04. The R.N. Coordinator will continue to follow Hospital and Federal Guidelines in completing and, if necessary, correcting the MDS. Resident 50: As instructed in prior surveys, SDCH documents all devices used for positiong only, as positioning devices not restraints. Resident 50 is unable to wilfully exit her wheelchair or bed due to advanced stages of MS and her inability to control any body movements. This patient does experience extreme spasticity as well as the inability to maintain proper body alignment. Therefore, a positioning device was ordered by the physician to maintain proper body alignment and position. This device is not considered a restraint. All appropriate protocols are in	9/10/04

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jordan W. Bennett	ADMINISTRATOR	11/11/04

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 278	Continued From page 1 affective syndrome, hypertension, subarachnoid hemorrhage and seizures. On 6/20/04, resident 92 had an annual MDS (minimum data set) completed which documented that resident 92 did not use any restraints. A review of the medical record revealed that resident 92 had a consent for full side rails and a soft belt restraint. Resident 50 was admitted to the facility on 5/7/02 with diagnoses including multiple sclerosis, involuntary movements and a gastrostomy. On 7/14/04 at 8:30 AM, resident 50 was observed to be sitting in her wheelchair with a seat belt in place. Resident 50's medical record was reviewed on 7/12/04 and 7/14/04 through 7/15/04. On 5/7/02, resident 50's primary care physician ordered a "w/c (wheelchair) belt when in chair for positioning". Resident 50's quarterly MDS (Minimum Data Set) dated 6/23/04 and annual MDS dated 3/24/04 indicated that no trunk restraints were in use.	F 278	place to ensure the safety and well being of the patient, as outlined specifically in the Care Plan. The R.N. Coordinator will review a 10 percent sampling every 30 days for the next two months of completed MDS to ensure the accuracy of Section P-4	9/10/04
F 312 SS=D	483.25(a)(3) QUALITY OF CARE A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312	A staff meeting will be held in the next 30 days to review ADL policies and procedures. Topics to be reviewed will include, but not be limited to: toileting and call lights within reach.	9/10/04

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F 312	Continued From page 2 by: Based on observation, interview, and medical records review, it was determined the facility did not provide toileting care and did not ensure that call lights are within reach for 3 of 25 sampled residents. Findings include: 1. Resident 50 was admitted to the facility on 5/7/02 with diagnoses including multiple sclerosis, abnormal involuntary movements and a gastrostomy tube. Resident 50's medical record was reviewed on 7/12/04 and 7/14/04 - 7/15/04. Resident 50's quarterly MDS (Minimum Data Set) dated 6/23/04 and annual MDS dated 3/24/04 indicated that resident 50 was totally dependent on staff for performance of all activities of daily living (bed mobility, transfers, ambulation, dressing, eating, toilet use and personal hygiene). Observations of resident 50 on 7/12/04 and 7/14/04 through 7/15/04 included the following: On 7/12/04 at 10:35 AM, resident 50 was laying in bed. Resident 50's oral call light was not placed where she could reach it with her mouth. On 7/14/04 at 10:20 AM, resident 50 was laying in bed on left side. Resident 50's call light was not within her reach. On 7/14/04 at 11:05 AM, resident 50 remained laying in bed on left side. Resident 50's call light was not within her reach. Resident 50 shook her head up and down when asked if she needed assistance.	F 312	Resident 50: IDT will continue to evaluate and implement appropriate call light options that will meet Resident 50's needs. Resident 8: Resident's toileting needs will be assessed and addressed every two hours while awake and upon any request. Resident 3: The resident will be assessed for a bowel and bladder program. The QI coordinator will review twice a month for the next two months a 10% sampling of oral care, toileting needs, and bowel and bladder programs provided to residents, and results will be reported to the QI Committee on a monthly basis.	9/10/04

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F 312	Continued From page 3 was not within her reach. Resident 50 shook her head up and down when asked if she needed assistance. 2. Resident 8 was admitted to the facility on 1/14/98 with diagnoses including diabetes mellitus, late effect cerebrovascular accident, hypertension and dementia with anxious features. Resident 8's medical record was reviewed on 7/12/04 and 7/14/04 through 7/15/04. Resident 8's care plan indicated that she was to be toileted a minimum of every 2 hours and that she was to be praised for continent behaviors. Resident 8 was observed 7/14/04 from 7:15 AM to 12:15 PM without interruption. Resident 8 was observed to be sitting in her wheelchair with a lap buddy in place for five hours without being toileted. At 12:15 PM, two facility nurse aides assisted resident 8 back to her room to be changed before lunch. Resident 8's brief was wet, heavy and had a strong odor of urine. On 7/14/04 at 7:30 PM, a facility nurse assistant, assigned to care for resident 8 was interviewed. The nurse assistant stated that resident 8 had not been toileted since she got her up. The nurse assistant acknowledged that resident 8 was to be toileted every 2 hours and that resident 8 hadn't been toileted for five hours. The nurse assistant stated that she was "too busy" and "forgot". 3. Resident 3 was admitted to the facility on 4/30/98 with diagnoses including multiple sclerosis, intermediate coronary syndrome, hypertension and a history of urinary tract infections.	F 312		

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F 312	Continued From page 4 Resident 3's medical record was reviewed on 7/15/04. Resident 3's annual MDS (Minimum Data Set) dated, 5/14/04 indicated that resident 3 was independent in her ability to make daily decisions and that she was frequently incontinent of bladder and bowel. On 5/15/04, resident 3 was assessed by the patient care coordinator to be continent. On 7/15/04 at 7:06 AM, LPN 1 was interviewed. LPN 1 states that he is in charge of the toileting programs on the 1st floor. LPN 1 states that resident 3 has not been evaluated for a toileting program and is incontinent of bowel and bladder. LPN 1 further states that because resident 3 requires two people to transfer her, the staff frequently does not get her toileted quick enough. LPN 1 stated that he believes that it is possible to keep resident 3 continent. On 7/15/04 at 9:00 AM, resident 3 was interviewed. Resident 3 states that she feels the need to go to the bathroom. She states that when her call light is answered, the staff has to go and get someone else to help. Resident 3 states that because of the amount of time she has to wait, she is frequently incontinent of urine and bowel.	F 312		
F 323 SS=B	483.25(h)(1) QUALITY OF CARE The facility must ensure that the resident environment remains as free of accident hazards as is possible.	F 323	On 7/12/04 the lock to the identified cart was replaced. The staff member was given the new key and instructed that the cart was to be locked whenever	9/10/04

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F 323	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations and interview with facility staff, it was determined that the facility did not ensure that hazardous chemicals were secure against resident access on one of the facility's housekeeping carts. Specifically, on 7/12/04, the doors of a utility housekeeping cart containing hazardous chemicals were left open and the cart unattended for an extended period of time. Findings include: On 7/12/04 at approximately 8:05 AM, a housekeeping utility cart was observed on the first floor, west side, near resident rooms. On close inspections, the cart was discovered to be unlocked and the lock for the cart was observed to be broken. The cart was observed to contain several cleaning liquids and agents, including acid replacement concentrate, professional endust aerosol, comet cleaner with bleach, dumpster fresh deodorant granules, odor neutralizer, liquidator odor eliminator, Waxie Gum Away II aerosol, Steel-One stainless steel cleaner and polish towels, Fast & Easy cleaning compound, and Motsenbocker's Lift Off #2. The cart was observed to be opened approximately 2" and unattended at 8:05 AM, 8:35 AM, 9:05 AM, and periodically until 11:00 AM, when a housekeeping staff member was observed to be near the cart. An interview was conducted with the housekeeping staff member at 11:00 AM. The staff member stated that the lock had been	F 323	unattended. A Housekeeping Staff Meeting will be held in the next 30 days to review procedures regarding the security of housekeeping carts. The Environmental Service Manager will do random weekly checks on all Housekeeping carts to ensure that they are locked or attended at all times. Weekly checks will be monitored for the next 60 days, and results will be reported in the Monthly Q.I. Meeting.	8/31/04 9/10/04

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broken for "a long time" and that facility maintenance had not been notified of the broken lock. The surveyor requested that the facility staff member attempt to engage the lock. After the lock had been engaged, the facility staff member was not able to operate the lock to open the cart.

At 12:03 PM, the facility housekeeping staff member told the surveyor that the lock had been changed and demonstrated the working lock on the utility cart.

On 7/14/04, material safety data sheets (MSDS) were reviewed for each of the cleaning liquids and agents. The MSDS, Section V-Health Hazard Data, for each compound indicates:

1. Acid replacement concentrate: a thin, clear, blue liquid. Wintergreen fragrance
Do not take internally. Avoid eye and skin contact
Emergency first aid procedures: Eyes and skin: flush with water for 15
minutes. .Ingestion: DO NOT induce vomiting. Drink several glasses of water; call Physician immediately.

2. Professional Endust aerosol
Unusual fire and explosion hazards: contents under pressure, flammable
May cause irritation (to skin and eyes). Harmful or fatal if swallowed
If swallowed, or in case of persistent eye or skin irritation, call a poison control center physician immediately.

3. Comet cleaner with bleach
Eyes or skin: flush thoroughly with water for 15 minutes
Oral ingestion: dilute with fluids and treat symptomatically

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F 323	Continued From page 7 4. Dumpster fresh deodorant granules: primary route of entry is inhalation Eye and skin contact: irritation may occur. Wash with water Inhalation: Remove person to fresh air, give artificial respiration as needed. Medical conditions generally recognized as being aggravated by exposure: Lung fibrosis may create lung enlargement, heart/ pulmonary failure. Smoking aggravates the effects. 5. Odor neutralizer liquid: pink scented liquid Eyes and Skin: flush well with water. Ingestion: Call physician immediately. DO NOT induce vomiting 6. Liquidator odor eliminator: clear liquid, pleasant fragrance Eyes and skin: flush away with water Ingestion: Drink large quantities of water and call physician. Do not take internally 7. Waxie Gum Away II aerosol: a clear, odorless spray Eye and skin contact: flush with water for 15 minutes. If irritated, seek medical attention. If frost bitten, warm skin slowly. Inhalation: Remove to fresh air. Resuscitate if necessary. Get medical attention. Give oxygen. 8. Steel-One stainless steel cleaner and polish towels: clear, colorless liquid with a lemon scent. Eye and skin contact: immediately flush with plenty of water. Remove Contaminated clothing and shoes. Call a	F 323		

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F 323	Continued From page 8 physician if irritation develops and persists. Ingestion: Call a physician or poison control center immediately. Do NOT Induce vomiting unless directed. Inhalation: Get to fresh air. If breathing has stopped...administer artificial respiration. 9. Fast & Easy: yellow liquid, pleasant fragrance Eyes: flush with plenty of water for at least 15 minutes. Get medical attention. Skin: Wash skin thoroughly with soap and water. Get medical attention if Irritation persists. Wash contaminated clothing before reuse. Ingestion: Do not induce vomiting. Get medical attention. Inhalation: In case of respiratory irritation, move person to fresh air. Get medical attention if irritation persists. 10. Motsenbocker's Lift off: clear liquid, pungent odor Eyes and Skin: Flush immediately with plenty of cool running water. If SWALLOWED: Rinse mouth, then drink 1 or 2 large glasses of water. DO NOT induce vomiting.	F 323		
F 328 S=G	483.25(k) QUALITY OF CARE The facility must ensure that residents receive proper treatment and care for the following special services: Injections	F 328	Individual respiratory staff interviews/meetings will be held beginning 8/3/04 through 8/10/04 to review policy and procedure changes made to vent check protocols.	9/10/04

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F 328	Continued From page 9 Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facilities policy and procedures, it was determined that for 1 of 25 sampled residents (resident CL3); facility staff did not ensure that a resident, requiring the continuous use of a ventilator, received the necessary care and services. Specifically, resident CL3's ventilator alarm was not connected to the nurses call system. Findings included: Resident CL3 was re-admitted to the facility on 6/10/04 with diagnoses which included respiratory failure- ventilator dependent, pneumonia, acute poliomyelitis, type II diabetes mellitus, end stage morbid obesity, hypertension and acute renal failure. On 6/10/04 at 3:33 PM, a facility nurse documented that she completed an assessment of resident CL3 at 1:25 PM. The facility nurse documented that resident CL3 denied pain, felt	F 328	All newly admitted ventilator patients will be placed on the ventilator, and the assigned therapist will do the initial assessment and vent check. The new protocol adds a second therapist to reassess and perform a vent check 30 minutes after admission. Normal protocols will then follow as outlined in the policy and procedure. The respiratory manager will review the documentation within 72 hours of admit for every new ventilator-dependent patient for the initial vent check and the 30-minute vent check. Completion and accuracy of settings will be evaluated. The findings will be reported to the QI Coordinator and PIP Committee on a monthly basis for the next two months.	9/10/04

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F 328	Continued From page 10 anxious and had labored breathing. The facility nurse documented that resident CL3 was on a ventilator and that a respiratory therapist was in the room with the resident. The facility nurse documented that the A&B monitor was in place and was connected and functioning. Per interview with a facility paramedic on 6/10/04 at 9:35 AM, the A&B monitor measures a resident's heart rate and respirations. On 6/10/04 at 5:12 PM, the respiratory therapist documented that she completed resident CL3's ventilator check at 1:30 PM. The respiratory therapist documented that resident CL3 was on an assist control ventilator and that the A&B monitor was on and functioning. On 6/10/04 at 3:51 PM, a facility nurse documented that resident CL3 was sent to a local hospital by ambulance due to cardiac arrest at 3:15 PM. On 6/10/04, facility staff completed a "Cardiopulmonary Arrest Record" concerning resident CL3. Facility staff documented that the time of the arrest was 2:46 PM. Under comments the facility documented the following, "... [facility paramedic] heard A&B monitor go off [and] responded to alarm. Pt (patient) was found blue, yelled out to hallway code blue. Felt for pulse; saw that vent (ventilator) had popped off. No pulse was found. CPR (cardiopulmonary resuscitation) was initiated [and] code blue called. [Facility paramedic] started CPR [and] [facility respiratory therapist] started bagging. 1452 (2:52 PM) medics arrived. 1458 (2:58 PM) HR (heart rate) obtained. Pt shipped at 1459 (2:59 PM)..." On 6/10/04, an "Emergency Medical Incident	F 328		

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Report" was completed by the responding medics. The medics documented the following, "...Pt (patient) just admitted to [facility] [due to] renal failure. Pt last awake 10 mn (minutes) prior staff found pt [zero] pulse..."

On 6/10/04, a hospital physician documented the following in a "History and Physical, "...She was found in full cardiopulmonary arrest that was un-witnessed. We did not know for how long she had been pulseless...The patient was unarousable, not responding to pain...The patient with multiorgan failure with cardiopulmonary arrest that was un-witnessed..."

On 7/15/04 at 9:30 AM and again at 9:45 AM, the facility nurse who completed resident CL3 initial assessment on 6/10/04 was interviewed. She stated that she first assessed the resident when she was admitted at about 1:25 PM. She stated that the resident had labored breathing, pulses were strong and that a respiratory therapist completed a treatment right when resident CL3 was admitted to the facility. The facility nurse stated that resident CL3 was on a ventilator and appeared to be doing fine. She stated when the "Code Blue" was called she was in with another resident. She stated, at first resident CL3 had no heart rate and CPR was initiated. The facility nurse stated that when resident CL3 was sent to the hospital she had a faint heart rate. The facility nurse stated that it was the respiratory therapist's responsibility to ensure that the ventilators were connected to the call system.

On 7/15/04 at 9:35 AM, the paramedic who initiated the code blue for resident CL3 on 6/10/04 was interviewed. The paramedic stated that it was the end of his shift and he responded to an A&B monitor that was alarming. The paramedic

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F 328	Continued From page 12 stated that he went into resident CL3's room and saw she was blue, ashen color, had blood coming out of her mouth and her ventilator had popped off. He stated that he went into the hall yelled "Code Blue" and went back into the room and started bagging resident CL3. He stated that the ventilator was alarming, but the A&B monitor was alarming much louder and that was what he responded to. The paramedic further stated that the ventilator was not alarming in the hallway, through the call system. He stated if the ventilator had been alarming, through the call system, they would have known about the problem sooner. He stated that the "A&B doesn't alarm until respirations and heart rate are so low." The paramedic stated that he thought it was the respiratory therapist's responsibility to make sure the ventilator was connected into the call system. He further stated that other ventilators were alarming through the call system that day. On 7/15/04 at 9:50 AM, a respiratory therapist was interviewed. She stated, on 6/10/04 she set resident CL3 up on her ventilator, and she completed an initial assessment. She stated that resident CL3 acknowledged what was going on. She stated later she heard a "Code Blue" and when she responded resident CL3 was not breathing, was not responding and CPR was initiated. The respiratory therapist stated that resident CL3's ventilator was not connected into the call system. She stated that a ventilator alarm could not be heard in a hallway unless you were down by the resident's room. The respiratory therapist stated that it was her responsibility to ensure that the ventilator was plugged in so it would register in the call system and she "did not do that." On 7/15/04 at 10:15 AM, the unit manager was	F 328		

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	465062	A. BUILDING _____ B. WING _____	7/15/2004

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F 328	Continued From page 13 interviewed. She stated that on 6/10/04 a facility paramedic responded to resident CL3's A&B monitor. She stated that ventilators alarm in the resident rooms and in the hallway. She further stated that resident CL3's ventilator was alarming in her room, but she was told it was not alarming in the hallway through the call system. The unit manager stated that the respiratory therapist stated that the ventilator was not connected to the call system. On 7/15/04 at 10:30 AM, the DON (director of nurses) was interviewed. The DON stated that resident CL3 was re-admitted on 6/10/04 and her respiratory status was not stable. She stated that resident CL3 had labored breathing and respiratory was trying to get the resident stable. She stated that the ventilator was not connected to the call system "as of yet". She stated that the ventilator did alarm and the paramedic responded to the A&B monitor alarm. She stated that the A&B monitor, would alarm if a resident missed 2 breaths. The DON stated that everything was in place and the only piece missing was connecting the ventilator into the call system. On 7/15/04, the DON was asked by the nurse surveyor to provided documented evidence that the A&B monitor would alarm after 2 breaths were missed. The DON did not provide any documentation to the nurse surveyor. On 7/15/04 at 10:20 AM and again at 12:30 PM, the respiratory therapist supervisor was interviewed. He stated that he had conflicting stories regarding resident CL3's ventilator being connected to the call system. He stated, "Our system is to check it every 2 hours and with her being admitted there was no 2 hour check." He stated that the only respiratory documentation	F 328		

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F 328	Continued From page 14 concerning resident CL3's ventilator was the initial ventilator check at the time of admit. He further stated that resident CL3's ventilator indicated she was completely dependent on the ventilator for respirations. The respiratory therapist supervisor stated that the A&B monitor might not alarm until after 3 to 4 breaths had been missed. On 7/15/04, the respiratory supervisor provided the nurse surveyor with the facility's "Respiratory Care Policy and Procedure" which documented that, "...2. A patient assessment will be done whenever a therapist takes over care on a patient... d. Check ventilator alarms for proper function with nurses call system..." On 7/15/04 at 1:00 PM, the ventilator call system was checked by two nurse surveyors. It was determined that resident CL3's room was 25 feet from the nurse's station. A ventilator's alarm system was checked without being connected to the call system. When the ventilator's alarm was on low, it could barely be heard in the room. When the ventilator's alarm was on high, it was barely audible at the nurse's desk	F 328		
F 332 SS=E	483.25(m)(1) QUALITY OF CARE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation during a medication pass, medical record review and interview with a facility staff nurse, it was determined that for 47 opportunities, 5 medication errors occurred. This represents a 10.6 percent error rate. Resident	F 332	Nursing staff meetings will be held in the next 30 days to review proper medication administration policies and procedures. Resident 47: Staff have been instructed regarding manufacturer guidelines in reference to Metamucil administration.	9/10/04

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F 332	Continued From page 15 identifier: 37, 47, and 78. Findings Include: On 7/14/04 between 7:00 AM and 8:00 AM, four facility nurses were observed to prepare and administer medications. 1. On 7/14/04 at 7:30 AM, LPN 1 was observed to prepare and administer medications to resident 47. Resident 47 was admitted to the facility on 3/5/99 with diagnoses including Alzheimer's disease, essential hypertension, pneumonia and asthma. Two of the medications resident 47 recieved: (1) Metamucil 1 TBL (tablespoon) PO (by mouth) and (2) Aspirin 81 mg (milligrams) chewable tablet PO (by mouth). LPN 1 was observed to put 1 TBL of Reguloid in a blue water cup. Resident 47's medical record was reviewed. Resident 47 was to receive Aspirin 81 mg EC (enteric coated) tablet q.d. On 7/14/04 at 7:55 AM, LPN 1 was interviewed. LPN 1 was asked to measure the amount of water that was given with resident 47's Reguloid. LPN 1 measured out 120 cc's instead of the manufacturer recommendation of 8 ounces of water. LPN 1 further stated that resident 47's order for Aspirin 81 mg should have been enteric coated but that the pharmacy sent chewable tablets instead.	F 332	Aspirin 81 mg order has been reviewed with physician and clarified as chewable form on a physician order dated 8/02/04, which is located in the patient chart. Resident 37: Flonase 1 puff per nostril was administered to the resident during observation period with surveyor. The R.N. recobnized the short dosing, and returned to the resident and instructed her to administer a second puff in each nostril to ensure proper dosing. Resident 78: Staff have been reminded to be cautious when opening capsules, such as zinc, to prevent spillage and potential insufficient dosing. In response to the eye drops, the individual nurse was instructed on the five rights of medication administration: the right patient, the right medication, the right dose, the right time, and the right route. The nurse acknowledged her error, and expressed feeling very stressed and intimidated by the surveyor during the observation period. Quality Improvement Nurse and appointees will observe 10% of a daily med pass (total of 180 medication opportunities) four	9/10/04

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F 332	Continued From page 16 2. On 7/14/04 at 8:15 AM, RN 1 was observed to prepare and administer medications to resident 37. Resident 37 was admitted to the facility on 2/3/03 with diagnoses including senile dementia, bipolar affective disorder, depressive disorder and essential hypertension. One of the medications administered to resident 37 included Flonase one puff to each nostril q.d. (daily). Resident 37's medical record was reviewed. Resident 37 was to receive Flonase two puffs to each nostril q.d. On 7/14/04 at 8:15 AM, RN 1 was interviewed. RN 1 was asked if she was finished with the medication pass for resident 37. RN 1 stated "yes". RN 1 was then informed that resident 37 received 1 puff of Flonase to each nostril instead of the ordered 2 puffs. RN 1 stated "I didn't remind her to do two" and went back to resident 37's room and administered another puff of Flonase to each nostril. Resident 78 was re-admitted to the facility on 3/8/98 with diagnoses of pneumonia, pulmonary insufficiency, hypothyroidism, type II diabetes, hemiplegia, cerebral vascular disease and Down's syndrome. On 7/14/04 between 6:30 AM and 8:00 AM, a facility nurse was observed to administer medications to 7 residents. The nurse was observed to open a 220 mg (milligrams) of zinc sulfate into a cup and some of the capsule	F 332	times during the next 60 days to assess and evaluate the accuracy of medication pass. Criteria will include, but not be limited to, compliance with manufacturer's guidelines, accurate and appropriate application of eye drops, accurate and appropriate application of inhalation medications, proper preparation of capsules and/or powdered medications to prevent spillage and ultimate inaccurate dosing, and correct form of medication administration.	

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F 332	Continued From page 17 contents were spilled on the top of the medication cart. As the nurse disposed the zinc sulfate capsule in the garbage more of the zinc sulfate powder was observed in the air. The nurse was observed to administer the cup that contained the zinc sulfate to resident 78. The same facility nurse also was observed to give Pred mild 0.12% ophthalmic solution into both of resident 78's eyes. A review of resident 78's medical record documented the following physician's orders: A physician's order, dated on 11/5/01, documented that resident 78 was to receive Zinc Sulfate 220 mg one capsule for health maintenance. A physician's order dated 1/15/03 documented that 78 was to receive Pred Mild 0.12% ophthalmic solution one drop to resident 78 right eye every day for cornea transplant.	F 332		