PRINTED: 04/06/2006
FORM APPROVED
OMB NO. 0938-0391

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
	46A061	A. BUILDING _____ B. WING _____	03/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPANISH FORK NURSING AND REHAB	46 NORTH 100 EAST SPANISH FORK, UT 84660

(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 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not meet professional standards of quality. Specifically, the facility had in their medication refrigerator and available for use, a bottle of Lantus insulin which was opened in 12/05. Also, a facility nurse contaminated a lancet and then did not clean the finger of a resident prior to sticking them with a lancet to obtain blood. Findings include: 1. The contents within the facility's medication refrigerator were observed on 3/21/06 at 1:00PM. There was a bottle of Lantus insulin which was labeled as belonging to resident 5. A faded date was written on the bottle. The facility nurse was asked she thought the date read. The nurse stated "Something, something, 05." The writing appeared to the surveyor to read 12/7/05. The 2006 Physician's Desk Reference, pg. 2929, reads that an "Opened vial, either kept in a refrigerator or at room temperature, should be discarded 28 days after the first use even if it still contains Lantus." On 3/22/06 at 7:45 AM, a facility registered nurse was observed checking Resident 2's blood glucose level. The registered nurse obtained a lancet and removed the protective cap. The nurse then placed the lancet in a spring-loaded device. In doing so, the nurse used a fingernail to	F 281	QUALITY ASSURANCE COMMITTEE OUR MEDICATION REFRIGERATOR IS CLEANED AND INSPECTED ONCE A WEEK. AT THAT TIME, ALL EXPIRED MEDICATIONS ARE TO BE DISCARDED. THE DISCARDED DRUGS ARE THEN TO BE NOTED IN THE DRUG DISPOSITION SHEET IN THE PHARMACY BOOK LOCATED IN THE NURSES STATION. THE DON HAS BEEN ASSIGNED BY THE QA COMMITTEE TO INSERVICE ALL NURSING STAFF ON THE IMPORTANCE OF FOLLOWING OUR POLICY AND WILL CHECK THE CONTENTS OF THE REFRIGERATOR AND THE DRUG DISPOSITION SHEETS ON A MONTHLY BASIS TO ENSURE THAT OUR POLICIES ARE BEING FOLLOWED AND TO ENSURE THAT THIS PROBLEM WILL NOT OCCUR IN THE FUTURE. ALSO, A SIGN IS BEING PLACE ADJACENT TO THE REFRIGERATOR AS A REMINDER. WE ALSO HAVE PROCEDURES FOR BLOOD SUGAR MONITORING WHICH EVIDENTLY WERE NOT BEING FOLLOWED BY THE NURSE ON DUTY. THIS COMMITTEE WAS ALSO ASSIGNED THE D.O.N. THE RESPONSIBILITY OF INSERVING ALL NURSING PERSONEL ON THE PROPER METHOD OF BLOOD SUGAR MONITORING Utah Department of Health Utah Department of Health APR 20 2006 MAY 04 2006 Bureau of Health Facility Licensing, Certification and Resident Assessment Bureau of Health Facility Licensing, Certification and Resident Assessment	04-30-06

4/14/06 POC acceptable pending compliance date 5/5/06 KBuenbane RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ADMIN	04-18-06

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

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F 281	Continued From page 1 depress the lancet into the device, coming in contact with the sharpened edge of the lancet. The nurse then performed the blood glucose check without first cleansing the resident's finger. Lippincott Manual of Nursing Practice, (2006). Philadelphia, PA: Lippincott, Williams and Wilkins states: " Prepare the finger to be lanced by having the patient wash hands in warm water and soap. Dry thoroughly. " (p. 913).	F 281	AND TO CHECK INTERMITTENTLY TO ENSURE THAT PROCEDURES ARE BEING FOLLOWED AND TO AVOID THIS ACTION RECCURING. AND TO REPORT RESULTS TO THIS COMMITTEE.	
F 324 SS=G	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility did not provide adequate supervision and assistance to prevent accidents for 1 of 10 sample residents who fell and sustained injuries when he repeatedly climbed over side rails on his bed. Resident identifier: 6. Findings included: Resident 6 was a 92 year old male with diagnoses that included Parkinson's disease. On 3/20/06 during initial tour of the facility, resident 6 was observed to have a dark red crusted wound near the crown of his head.	F 324	UPON ADMISSION, RESIDENT 6's FAMILY SPECIFICALLY REQUESTED THE USE OF SIDERAILS DUE TO REPEATED FALLS FROM BED AT HIS PRIOR FACILITY. THE USE OF SIDERAILS WAS DISCUSSED BETWEEN ADMINISTRATION AND NURSING STAFF ASSUMING THAT AN EVALUATION HAD BEEN COMPLETED, IT WAS THE OPINION OF THE ADMINISTRATOR THAT DUE TO HIS HISTORY OF FALLING FROM BED THAT SIDERAILS SHOULD BE USED. THE QA COMMITTEE MET ON 03-24-06 AND INASMUCH 04/18-06 Utah Department of Health APR 20 2006 Bureau of Health Facility Licensing, Certification and Resident Assessment	

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F 324	Continued From page 2 Facility incident reports and the medical record for resident 6 were reviewed on 3/20/06 and 3/21/06. The Admission Nursing Assessment for resident 6, dated 10/22/05 at 11:00 AM, revealed the resident would have side rail restraints used when he was in bed. The Minimum Data Set (MDS) assessments for resident 6, dated 11/4/05 and 2/4/06, revealed the resident had short and long term memory deficits and his cognitive abilities were severely impaired. The MDS assessments revealed full side rails were used daily on both sides of resident 6's bed. A nurse's note, dated 10/22/05 from 4:00 PM until midnight, revealed resident 6 had been found walking in the hall and was assisted to the bathroom. The nurse documented that when resident 6 was back in bed, she "stressed [the] importance of not crawling over rails to get up." A nurse's note, dated 10/23/05 from noon until midnight, revealed resident 6 had been "up out of bed over rails X 1 [one time]. A nurse's note, dated 12/30/05 at 10:00 PM, revealed resident 6 had been found sitting on the floor, leaning against the wall next to his bed. Resident 6 complained of pain in the area of his left ribs. The nurse documented that the side rails had been up on resident 6's bed at the time of the incident. The nurse documented an incident report that resident 6 had been confused and had generalized weakness prior to his fall. Resident 6 was medicated for pain and was returned to his bed. The nurse documented that resident 6's side rails were put up.	F 324	AS HIS ONLY INJURY REQUIRING MEDICAL ATTENTION DID NOT INVOLVE THE USE OF SIDERAILS, ELECTED TO TRY A TEST PERIOD WITHOUT SIDE RAILS. RESIDENT 6 HAS FALLEN REPEATEDLY SINCE THE SIDE RAIL REMOVAL SO WE HAVE NOW GONE TO A LASER ALARM SYSTEM ON HIS BED. WE WILL MONITOR RESULTS OF THIS AND DISCUSS AND PROGRESS OR LACK OF IN OUR MAY MEETING IT IS OUR POLICY THAT SIDE RAIL EVALUTIONS ARE DONE AT THE TIME OF ADMISSION AND REVIEWED AT OUR IDT & A MEETINGS WITH THEIR QUARTERLY PLAN OF CARE REVIEW. ADMINISTRATION WILL ADDRESS THIS ISSUE WITH ALL NURSING PERSONELL AND MONITOR EACH NEW ADMISSION TO ENSURE THAT ALL EVALUATIONS ARE DONE AT THE TIME OF ADMISSION AND EVALUATED QUARTERLY,	

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F 324	Continued From page 3 A nurse's notation of an incident, dated 2/10/06 at 12:30 AM, revealed that a "thump" had been heard at the nurse's station. The nurse documented that resident 6 was found on the floor at the bottom of his bed. The nurse documented that resident 6 had climbed out of bed over the side rails. The nurse provided first aid for a cut on resident 6's right knee cap and reminded the resident to use the call light. The nurse documented that resident 6's condition prior to the fall was "confused." A nurse's note, dated 3/5/06 at 4:00 PM, revealed resident 6 was found in his room lying on the floor. The nurse documented that resident 6 was found with a "large cut on back left side of head bleeding." The nurse documented that resident 6 was transported by ambulance to a local hospital's emergency room. Resident 6's head wound was closed with five surgical staples. Between 12/30/05 and 3/5/06, resident 6 had 3 documented falls over side rails that resulted in injury. Resident 5's final fall had resulted in an injury that had to be treated in a hospital emergency room. On 3/21/06 at 7:10 AM, an interview was conducted with a nursing assistant who provided cares for resident 6 during the night shift. The nursing assistant stated that it was routine to put resident 6's side rails up at night. On 3/22/06 at 12:40 PM, an interview was conducted with the social services / activities staff and a nursing assistant regarding resident 6. When asked if resident 6 was ever put into bed	F 324		

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F 324	Continued From page 4 during the day, the staff responded that, "Sometimes we put him down after lunch." They were asked if they ever put the side rails up when they put resident 6 into bed. The staff stated that, "He crawls over them," pointed to resident 6's head and stated, "That's what happened last time he crawled over the side rails." They stated, "Yes," they still put the side rails up on resident 6's bed. Both confirmed that resident 6 had a history of trying to crawl over the side rails "on his bad days." Staff were then asked if other interventions had been attempted with resident 6 to prevent injuries from climbing over the side rails or from falling. Staff could not identify any other interventions attempted. Staff were then asked if the facility had ever used a low bed for resident 6 to which the aide replied, "I've never seen one of those." A facility form for "Evaluation of Need for Side Rails" had been placed in resident 6's medical record. The form had not been filled out and there was no evidence the facility had evaluated resident 6's needs or risk factors associated with the use of side rails. There was no evidence that the facility had reevaluated his plan of care or implemented interventions to protect resident 6 from injuries related to his propensity to climb over the side rails.	F 324		

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F 326 SS=D	483.25(i)(2) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that for 1 of 11 sampled residents, the facility did not provide therapeutic diets. Findings include: Resident 8 was admitted to the facility on 3/7/06, with the diagnoses of Parkinson's disease, dumping syndrome, irritable bowel syndrome, hyperthyroidism, and vagotomy. A review of Resident 8's medical record was completed on 3/22/06. Per physician orders, Resident 8 was to receive the following diet, " 6 small meals, ground meats, no raw vegetables, no nuts, no foods with seeds in them, no concentrated sweets, no added salt ". As of 3/23/06, over two weeks after being admitted, the medical record for resident 8 did not contain a care plan to address his special dietary needs. As of 3/23/06, over two weeks after being admitted, the medical record of resident 8 did not contain a dietary assessment to evaluate or address his special dietary needs. The dietary section within resident 8's medical record was	F 326	AT THE TIME OF RESIDENT 8'S ADMISSION OUR DIETICIAN HAD RETIRED AND WE WERE IN THE PROCESS OF SECURING THE SERVICES OF ANOTHER DIETICIAN. WE HAVE CONTRACTED WITH A CONSULTANT DIETICIAN AND RESIDENT 8's DIETARY NEEDS HAVE BEEN ASSESSED AND CARE PLANNED. THE DIETICIAN HAS CONTRACTED TO ASSESS THE DIETARY NEEDS OF OUR CURRENT RESIDENTS AND ALL FUTURE ADMISSIONS. OUR CONSULTANT DIETICIAN HAS MET WITH AND IS EDUCATING FOOD SERVICE STAFF ON THERAPEUTIC DIETS. OUR FSS WILL MONITOR EACH ADMISSION AND CURRENT RESIDENTS ON A MONTHLY BASIS.	04/18/06

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F 326	Continued From page 6 blank. On 3/20/06, the Food Service Supervisor was asked for a copy of the therapeutic menus served in the facility. The therapeutics menus were reviewed on 3/20/06 and 3/21/06. The therapeutic menus did not contain a diet which would provide guidance or instructions to the facility's dietary staff on how to meet the ordered diet for resident 8. On 3/20/06 at 9:00 AM, an interview was held with the facility's Food Service Supervisor (FSS). The FSS stated that Resident 8 was admitted to the facility about a week prior and she did was not certain how to meet the physician ordered diet. She stated she had a form that provided guidance for " Dumping Syndrome " to be used for Resident 8. The FSS asked the surveyors if it was permissible to give Resident 8 a concoction she had prepared. The FSS was told that she needed to consult with the dietitian to which she replied, "I haven't met her yet." On ——, during an interview with ———, she stated that resident 8 had been having diarrhea almost daily since his admission to the facility.	F 326		

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F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on interview and review of resident medical records, it was determined that for 1 of 10 sample residents, the facility did not ensure that each resident was free from unnecessary drugs. Resident identifier: 2. Findings included: Resident 2 was admitted to the facility on 6/29/04. The medical record of resident 2 was reviewed on 3/21/06. During review of the March 2006 physician's orders for resident 2, it was noted that there were orders for "Colace 100mg 1 cap QD (everyday) -constipation" and for "Lomotil 2.5mg 1 tab QAM (every morning) - diarrhea, D'C (discontinue) if constipation occurs". The March 2006 medication administration record was reviewed. It was documented by facility nurses that resident 2 received both Colace (for constipation) and Lomotil (for diarrhea) each morning at 7:00 AM on the following days: 2nd	F 329	RESIDENT 2' ORDERS FOR COLACE AND LOMOTIL WERE BROUGHT UP TO THE PHYSICIAN ON HIS VISIT ON 2-28-2006 AND SINCE HE REVIEWED HIS ORDERS EXACTLY AS THEY WERE, WE ASSUMED THAT THAT WAS WHAT WE WERE TO CARRY OUT. THE CONSULTANT PHARMACIST HAD ALSO QUESTIONED THIS. SINCE OUR SURVEY, WE HAVE BEEN ABLE TO HAVE HIM CHANGE THE ORDER FOR LOMOTIL TO A PRN ORDER. EACH RESIDENT'S MEDICATION ORDERS ARE REVIEWED MONTHLY BY OUR CONSULTANT PHARMACIST TO ENSURE THAT UNNECESSARY MEDICATIONS ARE NOT GIVEN. HE WILL CONTINUE TO MONITOR THEM AND GIVE US RECOMMENDATIONS. Utah Department of Health APR 20 2006 Bureau of Health Facility Licensing, Certification and Resident Assessment	04/5/06

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F 329	Continued From page 8 through the 12th, the 14th through the 21st. On 3/22/06, the director of nurses was asked why resident 2 received medications for both constipation and diarrhea each day. The director of nurses was unsure why these drugs had been ordered like this. Two nurse aides were interviewed the morning of 3/23/06. They were asked if resident 2 had problems with diarrhea or constipation. The aides stated that resident 2 "has diarrhea almost daily. You can count on it after breakfast." There was no explanation in the medical record of resident 2 to demonstrate why she needed Colace and Lomotil daily, especially when staff reported the frequent diarrhea.	F 329	~~RESIDENT 2's ORDERS FOR~~ COALSE	
F 330 SS=D	483.25(l)(2) ANTIPSYCHOTIC DRUGS Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the drug regimen was not free from unnecessary drugs for 1 of 10 sample residents who received an antipsychotic medication without a diagnosis. Specifically, one	F 330	ON RESIDENT 9, WE ASKED THE DR. FOR XANAX AND HE ORDERED RESPERDAL, THE CONSULTANT PHARMACIST NOTED ON HIS VISIT ON 02-28-06 THAT WE NEEDED A DIAGNOSIS FOR RESPERDAL. THE PHYSICIAN VISITED HER ON 03-31-2006 AND REORDERED RESPERDAL. SINCE RESIDENT 9 IS VERY ALERT AND KNOWS EACH MED. THAT SHE IS GIVEN, TO AVOID UPSETTING HER WE WILL CONSULT WITH THE PHYSICIAN ON HIS NEXT VISIT WHICH WILL BE BEFORE THE END OF APRIL AND HAVE HIM COUNSEL THE	05-05-06

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F 330	Continued From page 9 resident entered the facility without an antipsychotic medication, was prescribed an antipsychotic medication, and did not have adequate indications for its use. Resident indicator: 9. Findings included: Resident 9 was a 66 year old female who was admitted to the facility with diagnoses that included restless leg syndrome, anxiety and depression. Resident 9's medical record was reviewed on 3/22/06. A nurse's note, dated 2/24/06 on the 4:00 PM to midnight shift, revealed the resident had not slept and requested a "nerve pill." A nurse's note, dated 2/25/06, revealed the physician was contacted to request Xanax (an anxiolytic) or something to help resident 9 sleep. A physician's order was received to give Risperdal 0.5 mg (milligrams) each bedtime. As documented in Nursing 2006 Drug Handbook, 26th edition, Lippincott Williams & Wilkins, pg 495-6, the indications for Risperdal (risperidone) are treatment of schizophrenia and acute manic or mixed episodes from bipolar I disorder. The Director of Nursing (DON) was interviewed on 3/22/06. The DON stated that she got Risperdal to help resident 9 sleep. The DON stated it seemed to work until her restless leg syndrome started to bother her. The DON stated they, then, got a physician's order for Xanax and	F 330	RESIDENT AND D.C. THE RESPONSIBILITY. THE DON NOTIFIES THE PHYSICIAN OF ALL FINDINGS BY OUR CONSULTANT PHARMACIST AS TO MEDICATION DISCREPANCIES AND THE CONSULTANT PHARMACIST WILL MONITOR MONTHLY TO ENSURE THAT EACH MEDICATION GIVEN HAS A CORRESPONDING DIAGNOSIS. (THE RESPERDAL WAS D/C'D ON 04/9-06) OUR DON WILL THEN NOTIFY THE PHYSICIAN AND MONITOR TO ENSURE THAT THERE ARE NO MEDICATION DISCREPANCIES ON A MONTHLY BASIS	04/9-06

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F 330	Continued From page 10 that helped the resident to sleep more comfortably. Review of resident 9's Medication Administration Record (MAR), dated March 2006 revealed the resident continued to receive Risperdal 0.5 mg each evening at bedtime. In addition, resident 9 was receiving Xanax 0.5 mg twice a day as needed (administered 6 times between 3/12/06 and 3/21/06) for agitation/anxiety and Quinine 325 mg each evening at bedtime for restless leg syndrome. A telephone interview was conducted with resident 9's psychiatric consult, on 3/23/06. The consult stated that she had been treating resident 9 "for years" for the diagnoses of depression and anxiety. Resident 1's Level I evaluation, signed by the psychiatric consult, listed the resident's diagnoses which included anxiety and depression. There was no documentation that the resident had a diagnosis of schizophrenia or bipolar or a related disorder.	F 330		
F 371 SS=E	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility did not store or prepare foods under	F 371	Utah Department of Health APR 20 2006 Bureau of Health Facility Licensing, Certification and Resident Assessment	04/18-06

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A061	A. BUILDING _____ B. WING _____	03/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPANISH FORK NURSING AND REHAB	46 NORTH 100 EAST SPANISH FORK, UT 84660

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F 371	Continued From page 11 sanitary conditions. Findings included: Multiple observations of the kitchen were made on 3/20/06 and 3/21/06. The following observations were made on 3/20/06 between 9:00 AM and 9:45 AM: The temperature of the reach-in refrigerator was 53° Fahrenheit (F). This refrigerator which was not at the proper temperature was storing the following items: - Expired eggs dated 3/14/06, - BBQ chic dated 3/14/06, - ripped aluminum foil (several inches) on a container of food which was placed on the bottom shelf, - tapioca dated 3/15/06, - unlabeled cake covered with ripped foil, - cream cheese box dated 3/19/06, - a package of tortillas unopened and dated 3/08/06, - tartar sauce dated 3/15/06, - a package of chicken base dated 3/16/06, - tartar sauce labeled 2/25/06, - an unlabeled/undated container of pink liquid There was dried, crusty food matter on the mixer. The bucket the dietary staff were using to store their cleaning rags had less than 10 PPM of bleach in the water. The floor under neath the dishwasher had a build up of soap and debris. An open whole wheat flour bag had a scoop inside. The sugar bin had a scoop in it and the handle was in contact with the sugar. A bag of chips was opened and unsealed. The meat	F 371	THE FOOD SERVICE PERSON ON DUTY AT THE TIME OF SURVEY STATED THAT SHE INFORMED THE SURVEYORS THAT THE THERMOSTAT ON THE REFRIGERATOR DOOR DID NOT WORK PROPERLY AND THAT THERE WAS ANOTHER ONE INSIDE THE REFRIGERATOR. THE ADMINISTRATOR ALSO INFORMED THEM OF THIS AT THE EXIT CONFERENCE. THE ADMINISTRATOR HAS CHECKED THE THERMOSTAT EVERY DAY SINCE THE SURVEY AND IT IS ALWAYS AT 33°F. THE BOX OF CREAM CHEESE, THE TORTILLAS, THE TARTAR SAUCE AND THE CHICKEN BASE WERE ALL WELL WITHIN THE PACKAGE SHELF LIFE. THE UNLABELED PINK LIQUID WAS SUPPLEMENT THAT IS MIXED AND USED ON A DAILY BASIS. THE DISHWASHER HAD A LEAK IN THE REAR OF THE MACHINE WHICH WAS BEEN REPAIRED BY ECOLAB OUR LESSOR. THE MIXER IS USED FOR EVERY LUNCH AND IS CLEANED BY THE EVENING COOK.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPANISH FORK NURSING AND REHAB	45 NORTH 100 EAST SPANISH FORK, UT 84660

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F 371	Continued From page 12 freezer was located outside on the facility's back porch and did not have a locking mechanism. On 3/20/06 at 3:00 PM, the temperature of the reach-in refrigerator was 55° F. On 3/21/06 at 2:00 PM, the temperature of the reach-in refrigerator was 55° F.	F 371	WE HAVE A WEEKLY CHECKLIST THAT IS USED BY FOOD SERVICE PERSONELL AND CHECK BY THE FSS WHICH ADDRESSES ALL OF THE PROBLEMS THAT THE SURVEY UNCOVERED. SINCE THAT DID NOT SEEM TO CORRECT THE PROBLEM, THIS COMMITTEE WAS ELECTED TO GO TO A DAILY CHECKLIST THAT IS TO BE FILLED OUT AND POSTED IN THE FOOD SERVICE BOOK. THE F.S.S. WILL CHECK THESE ON A WEEKLY BASIS TO ENSURE THAT ALL POLICIES ARE BEING FOLLOWED. WE WERE UNAWARE THAT A LOCK WAS REQUIRED ON THE FREEZER IN THE PATIO AREA. ADMINISTRATION WILL INSTALL A HASP AND LOCK ON THE FREEZER. PROGRESS ON THESE DEFICIENCIES WILL BE BROUGHT BEFORE THE COMMITTEE AT OUR NEXT MEETING.	04/18-06
F 432 SS=D	483.60(e) STORAGE OF DRUGS AND BIOLOGICALS In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility did not store all drugs and biologicals in locked compartments. Findings included: The registered nurse (RN) surveyor was	F 432		

Utah Department of Health
APR 20 2006
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F 432	Continued From page 13 observing the facility nurse administer medications to the residents on 3/21/06 from 7:15 AM to 8:10 AM. During this time, it was observed that the facility nurse left the medication room door open. It was observed that no other employees were within proximity of the medication room to ensure it was not entered on two occasions during this time period. Also, the nurse kept several blister packs of medications (including Risperdal) on top of the medication cart. These also were left unattended at times during the medication pass.	F 432	F432 THE DON HAS BEEN DIRECTED BY OUR COMMITTEE TO INSERVICE ALL NURSES ON COMPLIANCE TO REGULATIONS CONCERNING CONTROLLED SUBSTANCES AND THE NEED TO KEEP THE MED ROOM DOOR CLOSED AT ALL TIMES. STAFF STATED THAT THE ONLY MEDS ALLOWED ON THE TOP OF THE CART ARE VITAMINS. THE RESPERDAL ALTHOUGH NOT A CONTROLLED SUBSTANCE WAS NOT MEANT TO BE THERE. THE NURSE ON DUTY STATED THAT SHE WAS ALWAYS WITHIN DIRECT SIGHT OF THE CART. STAFF HAS BEEN REMINDED THAT THE MED ROOM DOOR IS TO REMAIN CLOSED AT ALL TIMES. A SIGN HAS BEEN PLACED ON THE DOOR AS A REMINDER. THE DON WILL MONITOR EACH DAY TO ENSURE THAT THESE POLICIES HAVE BEEN FOLLOWED AND WILL REPORT REPORT PROGRESS AT OUR NEXT COMMITTEE MEETING.	
F 504 SS=D	483.75(j)(2)(i) LABORATORY SERVICES The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on interview and review of medical records, it was determined that for 2 of 10 sample residents, the facility did not obtain laboratory services only when ordered by the attending physician. Resident identifiers: 2 and 10. Finding included: 1. On 2/16/06, the facility obtained a urine sample from resident 2 and sent it to the laboratory in order for them to perform a urinalysis (UA). The medical record did not contain physician's orders to perform a UA.	F 504		

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F 504	Continued From page 14 The director of nurses was interviewed on 3/22/06 and stated that sometimes they send off a UA and forget to write an order. 2. On 12/21/05, the facility obtained a urine sample from resident 10 and sent it to the laboratory in order for them to perform a urinalysis (UA). The medical record did not contain physician's orders to perform a UA.	F 504	F504 & F505 WE HAVE POLICIES AND PROCEDURES IN PLACE FOR ALL LABS DONE. STAFF EVIDENTLY DID NOT FOLLOW THOSE PROCEDURES. THE DON HAS COUNSELED STAFF ON THE PROPER PROCEDURES AND OUR POLICIES.	
F 505 SS=D	483.75(j)(2)(ii) LABORATORY SERVICES The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on interview and review of medical records, it was determined that for 1 of 10 sample residents, the facility did not promptly notify the attending physician of the laboratory findings. Resident identifier: 2. Findings included: On 2/16/06, facility staff obtained a urine sample from resident 2 and sent it to the laboratory to have them perform a urinalysis (UA). On 2/17/06, the laboratory faxed the results to the facility which included the following abnormal results: - Bacteria 4+ - WBC's (white blood cells) "too numerous to count" - RBC's (red blood cells) "too numerous to count"	F 505	A COPY OF THESE PROCEDURES IS IN THE LAB BOOK ON THE FRONT PAGE WITH STEP BY STEP INSTRUCTIONS. THE DON WILL MONITOR ON A MONTHLY BASIS TO ENSURE THAT ALL POLICIES AND PROCEDURES ARE BEING FOLLOWED TO PREVENT REOCCURANCES OF LAB ERRORS - SEE ENCLOSED POLICY AND PROCEDURES	

SPANISH FORK NURSING & REHAB.
LAB WORK AND ORDER PROCEDURE

1. ALL LAB WORK NEEDS A DRS. ORDER. INCLUDING DX. EX.: U/A c C&S FOR S/S OF UTI; OR FOR ODOR, URGENCY, FREQUENCY.
2. IF NEEDED, SUCH AS FOR U/A's. WRITE A T. O.— INCLUDE LAB and REASON.
3. LABS ARE DONE ON SUNDAY and WEDNESDAY P.M.
4. IF IT IS STAT, OR FASTING ORDER, CALL THE LAB AND LET THEM KNOW.
5. FILL OUT THE LAB SLIP WITH ALL PERTINENT INFORMATION. INCLUDE NAME, SS#, BIRTHDATE AND BILLING INFORMATION. (THERE IS A SAMPLE IN THE LAB BOOK)
6. THE LAB TECHNICIAN WILL PICK UP ALL LAB ORDERS AND SIGN FOR THEM ON SUNDAY & WEDNESDAY.
7. THE LAB WILL FAX THE INITIAL REPORT.
8. WHEN YOU RECEIVE THE INITIAL REPORT, FAX IT TO THE DR. IMMEDIATELY. THEN DATE, TIME, AND SIGN THAT IT HAS BEEN FAXED. PLACE IT IN THE LAB BIN.
9. IF THE DR. HAS NOT RESPONDED BY 3:00 P.M. CALL THE DR. AND TRY TO GET A RESPONSE, YOU MAY HAVE TO PAGE THE DR.
10. WRITE A T.O. IF NEEDED, WRITE THE ORDER IN THE M.A.R., ORDER THE MED. FROM THE APPROPRIATE PHARMACY.
11. PLACE THE REPORT THAT HAS ALL THE TIMES FAXED AND ORDERS NOTED IN THE RES. CHART.

SPANISH FORK NURSING & REHAB
QUALITY ASSURANCE COMMITTEE

THE PLAN OF CORRECTION FOR THIS SURVEY HAS BEEN DONE BY OUR QUALITY ASSURANCE COMMITTEE AND WILL BE INCORPORATED INTO OUR QUALITY ASSURANCE PLAN.

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F 505	Continued From page 15 A nurse noted as reading the laboratory results on 2/17/06 and then noted that she faxed the results to the physician's office on 2/17/06 and on 2/20/06. There was no documentation in the medical record for resident 2 to evidence that facility staff had tried to reach the physician in another way. Resident 2 was not started on antibiotics until 2/21/06, which was four days after the abnormal results were available.	F 505		