FNWZB 4-5-04 The last date on POC is 4/9/04

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

Utah Departm of He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION
	465079	APR 1 2004 A. BUILDING _____ B. WING Bureau of Medicare/~~Medicaid Pr~~ Certification and ~~Resident Asses~~

Onsite follow up 4/1/04

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSHINE TERRACE FOUNDATION	225 NORTH 200 WEST LOGAN, UT 84321

(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 157 S=G	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for 1 of 24 sample residents (resident 68), the facility did not inform the resident's physician or family, in a timely manner, when she was found on the floor between her bed	F 157	F 157 *The Physician on call for the primary care Physician was notified of a fall on March 10, 2004 at 1800 and [redacted] (Primary Care) was notified on March 11, 2004 at 1400. * The Residents responsible party, [redacted] was notified 3/10/04 at 12:25 pm. *Director of Nursing (DON) performed audit of incident reports on 3/11/04. *Medical Assistant's and nurses educated on Accident/ report policy and procedure (See education protocol for care of resident after a fall/incident). Started 3/11/04. *Incident report form is changed and now includes Medical Director to be notified during AM rounds to ensure that a Physician is notified. This does not replace the primary care Physician. The new form was effective 3/29/04 (See example of incident report form). *Inservice on incident reports will be held quarterly by the Education Director. The first inservice will be 4/6/04.The Inservice will include: 1-Proper assessment of resident with an incident. 2- Proper completion of the incident report. 3-Proper notification of the physician and family. *Incident reports will be monitored daily for Physician notification by Director of Nursing and Nursing Office Secretary. * Safety Director will audit incident reports for MD notification's time and when signing incident reports.	3/10/04 and 3/11/04 3/11/04 3/11/04 and Ongoing 3/29/04 3/30/03 and Ongoing 3/30/04 and Ongoing 3/30/04 and Ongoing

4/9/04 acceptable POC addendum completion date 4/9/04 SWilson RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alyce Bosch RN NHA	Administrator	3/31/04

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 157	Continued From page 1 and the wall, with bruising to her right arm and swelling to the right side of her head. Finding include: Resident 68 was admitted on 1/30/04 with diagnoses which included hypothyroidism, diabetes mellitus type II, renal insufficiency, arthritis, gastrointestinal reflux disease, dementia and irritable bowel syndrome. Resident 68's medical record was reviewed on 3/10/04. A medical assistant (MA) documented the following in a nurse's progress note, on 3/9/04 at 10:35 PM, "Aide from another unit found Res. (resident) on floor between bed & (and) wall she had bruises on knees, hematomas on R (right) forearm, swollen R (right) eyebrow. Applied ice pack for 20 mins (minutes) to head..." A second MA documented the following in a nurse's progress note, on 3/10/04 at 6:25 AM, "Res (resident) slept approx (approximate) 6 hrs (hours) Noc (night). Res (resident) c/o (complained of) pain to L (left) eye. Res (resident) seemed agitated on this shift..." A third MA documented the following in a nurse's progress note, on 3/10/04 at 6:10 PM, "Sent resident to [acute care hospital] for x-ray on elbow et (and) wrist res (resident) has some swelling in both areas et (and) also c/o (complained of) px (pain)..." On 3/10/04 at 7:25 PM, resident 68's daughter came up to the nursing desk and told the MA that her mother was in tears because her right elbow was in pain. The MA asked resident 68's	F 157		

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F 157	Continued From page 2	F 157		

daughter if an x-ray of the right elbow was obtained and the daughter stated that only the left wrist was x-rayed. Resident 68's daughter further stated that the radiology department did not know which wrist to x-ray and the facility transport driver told them that the left wrist was to be x-rayed. At approximately 8:00 PM, an ambulance took resident 68 back to the hospital to be evaluated by the emergency room.

On 3/10/04, at approximately 11:00 PM, resident 68 returned to the facility with an order from the emergency room to follow up with an orthopedist in 4-5 days for wrist fracture. It also documented that resident 68 should wear a splint to her right wrist.

On 3/10/04 at 11:00 PM, a facility MA documented in a nursing progress note, that she obtained an order for Lortab 7.5 mg (milligrams) every 4 to 6 hours for pain. The MA also documented at 11:45 PM, that she obtained another order for extra strength Tylenol 500 mg every 4 to 6 hours for pain.

On 3/11/04 at 8:00 AM, the facility provided the survey team with an Incident/Accident report completed by a facility MA on 3/9/04 at 10:30 PM. The MA documented the following on the Incident/Accident Report, "...Res (resident) found face down between bed [and] wall. She had hematoma on [right] forearm, swollen [right] eyebrow, bruises on knees she reported her head hurt..." The Incident/Accident report documented that the family was called on 3/10/04 at 12:25 PM, approximately 14 hours after resident 68 was found on the floor. The Incident/Accident report documented that resident 68's physician was called on 3/10/04 at 6:00 PM, when the MA requested to send resident 68 for an x-ray of her

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F 157	Continued From page 3 right arm and wrist. This was approximately 19.5 hours after resident 68 was found on the floor. On 3/11/04 at 10:30 AM, the facility provided the survey team with a finalized radiology report, which documented the following, "...Some moderate degenerative changes obscure portions of the bones and give slight sclerosis to other portions, making it difficult to exclude distal scaphoid and distal radius region fractures entirely...No definite fracture, though osteopenic bones and degenerative changes make it difficult to clear a portion of the exam..." On 3/10/04 at 7:30 PM, resident 68's daughter was interviewed. Resident 68's daughter stated that she was not notified that her mother had fallen out of bed, until 3/10/04 at about 12:30 PM. She further stated that she would have wanted to be called when the incident happened so she could have come in to check on her mother. On 3/11/04 at 8:35 AM, the MA who assessed resident 68 on 3/9/04 was interviewed. The MA stated that she was the "Charge MA" for resident 68 during the evening shift of 3/9/04. The MA stated that resident 68 was found face down, between her bed and the wall. She stated that she did not know how resident 68 got into that position. The MA further stated that resident 68 had hit her right eye and that resident 68's right arm had a hematoma on the forearm and elbow, which were already dark purple. When asked if a nurse assessed resident 68, the MA stated that she did not inform the nurse of the fall because there was not a nurse on her wing. The MA further stated that she could have run to another wing for a nurse, "if I could have found one." The MA stated that she did not contact the physician because she wanted to first see how resident 68	F 157		

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F 157	Continued From page 4	F 157		

was doing. She stated that at 11:00 PM, the re-placement "Charge MA" came on and they felt they did not need to contact the physician. When the MA was asked if she knew when she should contact a physician, she stated that it would depend on the injury. When the MA was asked, due to the injury on the right side of resident 68's head, should she have contacted the physician, she stated "I am not sure; I am just too new at this."

On 3/11/04 at 9:40 AM, the LPN (licensed practical nurse) caring for resident 68 on 3/10/04 was interviewed. The LPN stated that she was the "medication nurse" for resident 68 during the AM shift of 3/10/04. She stated that she noticed resident 68 had a black eye and she went up to the nurse's desk and found an incident report concerning resident 68. The LPN stated, at that point, she went and informed the DON (director of nurses) about resident 68's fall. She stated that the DON assessed resident 68 and told the MA to contact the physician and family.

On 3/11/04 at 8:45 AM, the DON was interviewed. The DON stated that she assessed resident 68 on 3/10/04. She further stated that she would have expected the physician to be called when resident 68 was found on the floor. When the DON was asked why she did not contact the physician on 3/10/04, she stated that she told the MA to call resident 68's physician. She further stated that she did not know why the MA did not contact the physician. On 3/11/04, the DON documented her assessment in a nursing progress note, as a late entry for 3/10/04 at 10:00 AM.

On 3/11/04 at 9:35 AM, the MA caring for resident 68 on 3/10/04 was interviewed. The MA stated

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F 157	Continued From page 5 that she was the "Charge MA" for resident 68 during the AM shift of 3/10/04. The MA stated that she tried to call resident 68's physician but he did not answer the phone. She further stated that the facility's policy would be to try to contact the physician the next day, if there was not an injury. When asked if she tried to contact the on-call physician, the MA stated that she would not contact the on-call physician because there was nothing he could have done. On 3/11/04 at 9:40 AM, the LPN for resident 68 during the AM shift of 3/10/04, stated that she did not know the MA was not able to reach the physician. The LPN stated that she would not have waited until the next day to reach the physician, that she would have contacted the physician on-call.	F 157		
F 241 SS=E	483.15(a) QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility did not ensure that residents were provided care in a manner and an environment that promotes each resident's dignity. One sampled residents (resident 135) meal was placed in front of her and no assistance was provided for 19 minutes. Two residents (resident 131 and 148) weights were obtained in the dinning room during a meal. One residents	F 241	**F 241** *DON spoke with the Head Nurses of the wings regarding dignity issues on 3/12/04. Staff were educated by Head Nurses on proper techniques regarding dignity. *A Quality Improvement Action Team (QIAT), lead by the Director of Social Services was held on 3/25/04 with staff members present to determine ways of implementing corrections to survey deficient practices. *Quarterly inservices on dignity/resident rights will be implemented. It will also be addressed at new employee orientation. Inservices will be monitored by the Education Director. The first inservice will be 4/13/04.	3/12/04 3/25/04 3/30/04 and Ongoing

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F 241	Continued From page 6 (resident 124) hearing aide was replaced by a MA (medical assistant) prior to explaining what she was doing. Twenty-nine residents were lined up outside of the main dining room to await the doors being opened for the dinner meal. One resident (resident 57) was given her pill after it fell on a chair. Findings include: 1. On 3/9/04 at 7:45 AM, resident 135 was observed in wing 4's dining room. Resident 135 was observed to receive her breakfast tray at 7:45 AM. Resident 135 required assistance with her meals. The food sat uncovered in front of resident 135 until 8:04 AM, for 19 minutes, before a facility staff member attempted to assist resident 135. At 8:10 AM, after spending only 6 minutes with resident 135, the first facility aide went to assist another resident. At 8:14 AM, a second facility aide sat down to assist resident 135. At 8:16 AM, after spending only 2 minutes with resident 135, the facility aide went to assist another resident. At 8:21 AM, the facility aide went back to assist resident 135. At 8:24 AM, after spending only 3 minutes with resident 135, the facility aide left to remove other residents dishes from the tables. At 8:30 AM, a third facility aide sat down by resident 135, and asked the resident to eat. At 8:32 AM, the facility aide left the resident. At 8:37 AM, the facility aide offered resident 135 some food, and left at 8:39 AM. The facility aide spent a total of 4 minutes with resident 135. At 8:40 AM, the first facility aide returned to assist resident 135 and 3 minutes later the facility aide removed resident 135's breakfast tray.	F 241	*Quarterly inservices on proper medication procedures will be implemented. Monitored by the Education Director. The first inservice will be 4/20/04. *The weight scale in the dining room will be assessed by the maintenance department in conjunction with the DON to determine another more appropriate placement for it.. *Recreational Therapy and nursing staff will interact with residents prior to meal times effective 3/25/04. *Residents who require assistance with eating will have consistent help during meal time effective 3/25/04. This will be audited by the Head Nurse of the wing. * A mini survey will be given each month and a Quality Improvement Action Team on Dignity Issues to ensure that other staff members are aware of other residents who may have the same potential to be affected. Questions will also be asked at resident council. * Inservices will be made mandatory for all staff and mini inservices will be held during wing meetings held monthly by the Head Nurse. *Monthly unannounced spot checks by the Head Nurse will be completed on the wings to ensure the dignity of residents. *The lighting Candles Team (QIAT) will monitor progress made from the Quality Improvement Action Team. Questions regarding dignity issues will be discussed in resident council monthly by Social Services.	3/30/04 and Ongoing 3/30/04 and Ongoing 3/25/04 and Ongoing 3/25/04 and Ongoing 3/30/04 and Ongoing 3/30 04 and Ongoing 3/30/04 and Ongoing 3/31/04 and Ongoing

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F 241	Continued From page 7 Resident 135 had her tray in front of her for a total of 58 minutes with only 18 minutes of dining assistance from facility staff members. During the 58 minutes of the meal observation facility staff were not observed to re-heat resident 135's breakfast. 2. On 3/9/04, in wing 4's dining room, resident 148 was observed to be weighed by a facility staff member before being feed breakfast at 8:16 AM. Resident 131 was observed to be weighed by a facility staff member after breakfast was completed at 8:20 AM. There were 7 other residents present in the dining room when each of the resident's weights were obtained. 3. On 3/9/04 at 8:15 AM, during the breakfast meal in wing 4's dining room, an MA was observed to attempt to place a hearing aide in resident 124's left ear. Resident 124 was startled by the MA and stated "what are you doing to my ear". The MA then proceeded to explain to resident 124 that she was placing a hearing aide in the left ear so that the resident could hear better. 4. On 3/10/04 from 4:40 PM until 5:16 PM, there were 29 residents brought into the large activity room directly across from the main dining room. Each resident was brought by a staff member and their wheelchairs were lined up in two rows facing the doors of the dining room. Two of the residents became upset that the doors to the main dining room were closed and tried to open them. One of the residents trying to open the doors started to cry. At 5:04 PM, four facility aides were standing around the activity room waiting for the doors of	F 241		

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F 241	Continued From page 8 the main dining room to open. At 5:16 PM, the 29 residents were moved into the dining room by facility staff. 5. On 3/9/04, during the medication pass, resident 57 was sitting in a recliner in a TV room. Wing 2's medication nurse was observed to administer resident 57's medications. Resident 57's ativan fell onto the recliner next to her pants. The nurse did not observe the pill falling. After a different resident was administered her medication by the same nurse, the surveyor told the nurse about resident 57's pill that had fallen onto the recliner. The nurse checked the recliner and found the pill next to resident 57's right leg. The nurse took a spoon from the medication cart, scooped up the pill with the spoon and administered the pill to resident 57.	F 241		
F 323 S=G	483.25(h)(1) QUALITY OF CARE The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility did not ensure that a residents environment remained free from accident hazards. Specifically, the facility did not ensure that resident 68 had side rails up times two, per assessment and care plan. Additionally, the facility did not ensure that the brakes on the wheels of resident 68's bed would lock to prevent the bed from moving. As a result, resident 68 fell out of the bed, between the wall and the bed, and was injured.	F 323	**F323** *Side rails were placed on both sides of resident 68's bed on 3/11/04. *On 3/11/04 the DON reviewed all incident reports and found there were no falls between the bed and wall. An audit was completed on 3/16/04 to identify residents with side rails and to verify that both side rails were in place. 8 residents who needed side rails on the side of the be against the wall were identified. The side rails were place on the beds this same day (3/16/04). (See Enclosed audit report) *A policy and procedure has been set up for side rails and was implemented on March 18, 2004. (See Enclosed policy and procedure). All clients will be evaluated by the nurse prior to placing a full side rail. When side rails are deemed	3/11/04 3/16/04 3/18/04

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F 323	Continued From page 9 Findings include: Resident 68 was admitted on 1/30/04 with diagnoses that included hypothyroidism, diabetes mellitus type II, renal insufficiency, arthritis, gastrointestinal reflux disease. dementia and irritabie bowel syndrome. Resident 68's medical record was reviewed on 3/10/04. A physician's order, dated 2/12/04, documented the following under restraints; "Full side rail up when in bed for safety d/t (due to) dementia." An admission Minimum Data Set assessment, dated 2/12/04, documented under Section P., devices and restraints, Bed rails, a. Full bed rails on all open sides of bed. The current care plan in resident 68's medical record documented side rails up when in bed at all times for safety & (and) support. A medical assistant (MA) documented the following in a nurse's progress note, on 3/9/04 at 10:35 PM, "Aide from another unit found Res. (resident) on floor between bed & (and) wall she had bruises on knees, hematomas on R (right) forearm, swollen R (right) eyebrow. Applied ice pack for 20 mins (minutes) to head..." On 3/11/04 at 8:00 AM, the facility provided the survey team with an Incident/Accident report completed by a facility MA on 3/9/04 at 10:30 PM. The MA documented the following on the Incident/Accident Report, "...Res (resident) found face down between bed [and] wall. She had	F 323	appropriate we must also have a doctors order. The nursing office and maintenance will be notified of the order. Maintenance will place rails on both sides of the bed. Bed makers, Safety Director, Director of Nursing and Head Nurse will be responsible for ensuring the side rail policy is being followed *Housekeeping will have a list of clients with bed rails and beds will be audited weekly. A copy of weekly bed rail audits will be given to the Director of Nursing. (See Enclosed Audits) * The Safety director will do monthly audits on beds throughout the facility. implement on 3/11/04 in conjunction with contacting Physicians. Ongoing Inservices for OSHA including side rail will be quarterly. First inservice will be 4/21/04.	3/30/04 and Ongoing 3/30/04 and Ongoing

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F 323	Continued From page 10 hematoma on [right] forearm, swollen [right] eyebrow, bruises on knees she reported her head hurt..." An MA documented the follcwing in a nurse's progress note, on 3/10/04 at 6:25 AM, "Res (resident) slept approx (approximate) 6 hrs (hours) Noc (night). Res (resident) c/o (complained of) pain to L (left) eye. Res (resident) seemed agitated on this shift..." On 3/11/04 at 8:35 AM, the MA who assessed resident 68 on 3/9/04 was interviewed. The MA stated that she was the "Charge MA" for resident 68 during the evening shift of 3/9/04. The MA stated that resident 68 was found face down, between her bed and the wall. She stated that she did not know how resident 68 got into that position. The MA further stated that resident 68 had hit her right eye and that resident 68's right arm had a hematoma on the forearm and elbow, which were already dark purple. When asked if a nurse assessed resident 68, the MA stated that she did not inform the nurse of the fall because there was not a nurse on her wing. The MA further stated that she could have run to another wing for a nurse, "if I could have found one." The MA stated that she did not contact the physician because she wanted to first see how resident 68 was doing. She stated that at 11:00 PM, the re-placement "Charge MA" came on and they felt they did not need to contact the physician. When the MA was asked if she knew when she should contact a physician, she stated that it would depend on the injury. When the MA was asked, due to the injury on the right side of resident 68's head, should she have contacted the physician, she stated "I am not sure; I am just too new at this."	F 323		

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F 323	Continued From page 11 On 3/11/04 at 9:40 AM, the LPN (licensed practical nurse) caring for resident 68 on 3/10/04 was interviewed. The LPN stated that she was the "medication nurse" for resident 68 during the AM shift of 3/10/04. She stated that she noticed resident 68 had a black eye and she went up to the nurse's desk and found an incident report concerning resident 68. The LPN stated, at that point, she went and informed the DON (director of nurses) about resident 68's fall. The LPN further stated that she as the medication nurse did not provide treatments to the residents or do resident assessments. She stated that the "Charge Person" would provide treatments to the residents and do the resident assessments. On 3/11/04 at 8:45 AM, the DON was interviewed. The DON stated that she assessed resident 68 on 3/10/04. The DON stated that she provided range of motion on the resident's right arm and told the MA to call resident 68's physician. She further stated that resident 68 was not able to tell her how she ended up on the floor. The DON stated that she would have expected the physician to be called when resident 68 was found on the floor. She further stated that she did not know why the MA did not contact the physician. On 3/11/04, the DON documented her assessment in a nursing progress note, as a late entry for 3/10/04 at 10:00 AM. On 3/11/04 at 9:35 AM, the MA caring for resident 68 on 3/10/04 was interviewed. The MA stated that she was the "Charge MA" for resident 68 during the AM shift of 3/10/04. The MA stated that she tried to call resident 68's physician but he did not answer the phone. She further stated that the facility's policy would be to try to contact the physician the next day, if there was not an injury. The MA stated that they were placing ice on	F 323		

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F 323	Continued From page 12	F 323		

resident 68's right arm and eye due to swelling. When asked if she tried to contact the on-call physician, the MA stated that she would not contact the on-call physician because there was nothing he could have done.

On 3/11/04 at 9:40 AM, the LPN for resident 68 during the AM shift of 3/10/04, stated that she did not know the MA was not able to reach the physician. The LPN stated that she would not have waited until the next day to reach the physician, that she would have contacted the physician on-call. She further stated that if the MA had come to her she could have assessed the resident and had her sent to the hospital.

An MA documented the following in a nurse's progress note, on 3/10/04 at 6:10 PM, "Sent resident to [acute care hospital] for x-ray on elbow et (and) wrist res (resident) has some swelling in both areas et (and) also c/o (complained of) px (pain)..."

On 3/10/04 at 7:25 PM, resident 68's daughter came up to the nursing desk and told the MA that her mother was in tears because her right elbow was in pain. The MA asked resident 68's daughter if an x-ray of the right elbow was obtained and the daughter stated that only the left wrist was x-rayed. Resident 68's daughter further stated that the radiology department did not know which wrist to x-ray and the facility transport driver told them that the left wrist was to be x-rayed.

On 3/10/04 at approximately 7:30 PM, resident 68's daughter stated that her mother's bed has always been up against the wall with a side rail up on the side of the bed that was not against the wall. She stated that this was the bed her mother has always had. She further stated that today the

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F 323	Continued From page 13 facility put a second side rail up on the side of the bed that was up against the wall. On 3/10/04 at approximately 7:30 PM, resident 68's bed was observed by two nurse surveyors and a facility nurse. One side of the bed was up against the wall and the bed had two side rails in place. It was also observed that the brakes on the wheels of the bed would not lock to prevent the bed from moving. The facility nurse tried to lock the break and was not able to do so. The facility nurse stated that this was the bed that resident 68 had always used. On 3/10/04 at approximately 7:30 PM, resident 68 stated that the night before she was turning in bed and just rolled off the bed between the wall and the bed. She further stated that she was on the floor, yelling for help for 10 to 20 minutes. At approximately 8:00 PM on 3/10/04, an ambulance took resident 68 back to the hospital to be evaluated by the emergency room. This was approximately 21.5 hours after resident 68 was found on the floor between her bed and the wall. On 3/10/04, at approximately 11:00 PM, resident 68 returned to the facility with an order from the emergency room to follow up with an orthopedist in 4-5 days for wrist fracture. It also documented that resident 68 should wear a splint to her right wrist. On 3/10/04 at 11:00 PM, a facility MA documented in a nursing progress note, that she obtained an order for Lortab 7.5 mg (milligrams) every 4 to 6 hours for pain. The MA also documented at 11:45 PM, that she obtained another order for extra strength Tylenol 500 mg	F 323		

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F 323	Continued From page 14 every 4 to 6 hours for pain. On 3/11/04 at 10:30 AM, the facility provided the survey team with a finalized radiology report, which documented the following, "...Some moderate degenerative changes obscure portions of the bones and give slight sclerosis to other portions, making it difficult to exclude distal scaphoid and distal radius region fractures entirely...No definite fracture, though osteopenic bones and degenerative changes make it difficult to clear a portion of the exam..." On 3/11/04 at 9:20 AM, the administrator stated that he was aware that some of the beds are old and the breaks do not work. He further stated that when one side rail was placed on a bed a second side rail should have been placed.	F 323		
F 364 SS=E	483.35(d)(1)&(2) DIETARY SERVICES Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on individual interview, a confidential group interview and a test tray during the dinner meal on 3/10/04, it was determined that the facility did not serve food which was at proper temperature and palatable to the residents. Findings include: During a confidential family interview on 3/10/04,	F 364	**F 364** *Meal and temperature monitoring were started 3/18/04 and will be ongoing the dietary staff 4 times per week. *Plastic dishes have been replaced with glass dishes to preserve the heat. The new dishes were received and in use on 3/29/04. * The Registered Dietician will continue to do monthly checks and report these results to the Administrator. (See Enclosed Meal Monitor tool). *Quarterly Inservices will be held on serving and holding food temps given by the Director of Dietary. The first inservice was 3/10/04.	3/18/04 and Ongoing 3/29/04 3/30/04 and Ongoing 3/10/04 and Ongoing

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F 364	Continued From page 15 a family stated that they had eaten meals at the facility and that the hot food was served cold and the cold food was served warm. During a confidential group meeting, held on 3/10/04 at 1:30 PM, 10 of 10 resident actively participating in the group discussion stated that they were served cold food and the food was not palatable because of this. On 3/10/04, a test tray was obtained during the dinner meal. The test tray was placed on the last cart to be delivered from the kitchen at 6:00 PM. At 6:16 PM, the test tray was received and the temperatures were taken. The chicken was 92.7 degrees, the beets were 98.6 degrees, the hot potato salad was 101.1 degrees, the ranch dressing was 92.7 degrees, the rice pudding was 61.5 degrees, the milk was 51.4 degrees and the juice was 57.2 degrees.	F 364		
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not store, distribute and serve food under sanitary conditions. The following observations were made during the initial kitchen tour on 3/8/04 from 10:30 AM to 11:10 AM. Reach-in Freezer #2: a. There was one small bag of mixed vegetables,	F 371	F 371 * Inservices will be held for staff on how and why it is necessary to cover, label, and date foods within the refrigerator by food manager and/or food supervisor. Education on cross-contamination was included in this inservice. The first inservice was 3/12/04. *Magnets/Labels will be made by dietary for carts holding foods dished up on individual plates that are covered and to be used for the next meal. The label will state "Food to be served for next meal" -date. *Meat company was contacted by the Director of Dietary on 3/12/04. They will package frozen meats with the name of the meat product and the date.	3/12/04 and Ongoing 3/30/04 and Ongoing 3/12/04

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F 371	Continued From page 16 which were not labeled or dated. Walk-in Freezer #3: a. There were 12 raw meats that were in a clear package, which were not labeled or dated. b. There were 7 different raw meats that were in a clear package, which were not labeled or dated. c. There was one package of baby lima beans, which were opened and not dated. d. There were 3 different meats that were in a clear package, which were not labeled or dated. e. There were 5 packages of sliced meats, which were not labeled or dated. f. There were 2 large bags of meat patties, which were not labeled or dated. g. There was one bag of meat patties that was opened, which were not labeled or dated. Walk-in Refrigerator #1: a. There was one small bowl of meat dated 3/6, which was not labeled. b. There was 6 bags of sliced meat, which were not labeled or dated. c. There was 9 bags of ground meat, which were not labeled or dated. Walk-in Refrigerator #2: a. There was one cart with 7 trays of fruit and cottage cheese, which were not labeled or dated. Dishwasher: On 3/9/04 from 1:30 PM to 1:40 PM, the dishwasher was observed. The wash cycle was observed to reach 136 degrees. It should reach 140 degrees. The drying, which was a heat sanitizer machine, was observed to reach 172 degrees. It should get to 180 degrees. An interview was completed on 3/9/04 at 1:38 PM with a dietary aide who has worked at the facility	F 371	*According to federal regulations from Food Code 1999, 3-301.2, working containers holding food...that can be readily and unmistakable recognized...need not be identified. *Food manager and/or food supervisor will monitor the kitchen freezer/refrigerators daily for undated and unlabeled foods. RD to do cleaning inspection. *Meats [redacted] will be checked on delivery to assure its that food is coming in labeled and dated. The responsible party will be the food manager or food supervisor weekly. *Booster heater will be monitored to be sure that it is bringing temperatures up to acceptable levels of 150 degrees for washing and 180 degrees for rinsing. Staff will write down temperatures daily and will be monitored daily by dietary manager for food supervisor. *The dishwasher will be maintained by maintenance with repair as needed. Repairs will be completed by 4/9/04. *RD will include monitoring the dishmaster in cleaning inspection. This is completed weekly. *A memorandum containing information on proper labeling was placed on each wing refrigerators on 3/10/04 by the Director of Dietary. (See enclosed refrigerator memo) *Dietary and nursing will check the wing refrigerators every day to verify all items are labeled and dated. This was effective 3/10/04. (See enclosed fridge monitoring form) Form was implemented on 3/29/04.	3/30/04 and Ongoing 3/30/04 and Ongoing 3/12/04 and Ongoing 3/30/04 and Ongoing 4/9/04 and Ongoing 3/30/04 and Ongoing 3/10/04 3/30/04 and Ongoing

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F 371	Continued From page 17 for 2 years. The dietary aide stated that "the temps usually don't reach the 180 degrees or 140 degrees." The dietary aide also stated that it was an old machine and needs to be replaced. The following observations were made during the initial facility tour completed on 2/9/04 from 11:00 AM until 12:00 PM. Wing 1 Refrigerator: 1. Three containers of juice, which had no labels or dates. 2. Open can of V-8 juice, which had no open date or cover. 3. One container of juice, dated 12/27/03. 4. Half loaf of bread, dated 3/4/04. Wing 2 Refrigerator: 1. Tuna sandwich, which had no label or date. 2. Two containers of yogurt, which had expiration dates on 3/6/04. 3. A sandwich in a container with a resident's name, which had no label or date. 4. Two pieces of orange cheese, dated 3/3/04. 5. One bottle of chocolate syrup, which had an expiration date of 2/26/04. 6. One container of lemon flavored water, which had an expiration date of 2/1/04. 7. A 24 ounce bottle of mountain dew, which had no open date. 8. A two liter bottle of Pepsi with a resident's name, which had no open date. 9. One bowl of yogurt, which had no label or date. 10. One bowl of fruit, which had no label or date. 11. Two bags of crackers and cheese, which had no date. 12. A 1/2 of tuna sandwich, which had no date. 13. One bag of green grapes, which had no date.	F 371	*Director of Dietary, RD, DON or other designee will complete refrigerator spot checks on a daily basis. RD will include this on the weekly cleaning inspection sheet for all wings.	3/30/04 and Ongoing 3/30/04 and Ongoing

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F 371	Continued From page 18 Wing 3 Refrigerator: 1. An open can of Dr Pepper, which had no open date or cover. 2. One container of prune juice, dated 3/3/04. 3. One 20 ounce Pepsi bottle, which had no open date. 4. One liter of Dr. Pepper, which had no open date. 5. One bologna sandwich, which had no date. 6. A 1/2 peanut butter and jelly sandwich, which had no date. 7. One container of sour cream, which had an expiration date of 2/28/04. 8. Two bagels with a resident's name, which had no date. 9. An open diet coke, which had no open date or cover. 10. One vanilla ice cream, which had no date. 11. Four bowls of fruit, which had no label or date. 12. One harvest peach yogurt, which had an expiration date on 2/14/04. 13. One strawberry cream cheese with a resident's name, which had an open date of 2/19/04. 14. One container of strawberry yogurt, which had an expiration date of 2/25/04. 15. One mountain berry jam container with a sticky lid, which had no open date. 16. Six slices of meat, which had no label or date. 17. One opened package of bologna, which was not covered and had an open date of 3/3/04. 18. One container of butter with a resident's name, which had no open date. Wing 4 Refrigerator: 1. One container of applesauce, which had no date. 2. One loaf of bread, which was dated 3/4/04.	F 371		

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F 371	Continued From page 19 3. One forth loaf of white bread, which had no date. 4. One cup of fruit, which had no date. 5. One forth loaf of wheat bread, which had no date. 6. A 24 ounce diet coke, which had no open date. 7. A bottle of chocolate syrup, which had an expiration date of 3/1/04. 8. A bag of carrots and celery, which had no date. 9. An open bottle of Tropicana orange juice with a resident's name, which had no open date. Wing 5 Refrigerator: 1. One container of cranberry cocktail thickened, which was dated 2/11/04. 2. One container of apple juice thickened, which was dated 2/21/04. 3. One container of orange juice thickened, which was dated 1/24/04. 4. One peanut butter and jelly sandwich, which had no label or date. 5. One strawberry yogurt, which was dated 2/21/04. 6. One container of red parfaits, which had a sell date of 3/2/04. 7. One container of plain cream cheese, which had no open date. 8. One container of honey butter, which had no open date. 9. One bag of green grapes, which had no date. 10. One container of strawberry yogurt, which was dated 2/28/04. 11. One container of cheese curd, which had no open date and was packaged on 2/11/04. 12. One loaf of bread, which was dated 2/24/04. 13. One loaf of bread, which was dated 2/13/04. 14. Three jars of homemade jam with a resident's name, which had no open date.	F 371		

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F 371	Continued From page 20 15. A bottle of chocolate syrup, which had an open date of 2/7/04 and an expiration date of 11/03. Food Preparation: 1. On 3/9/04, from 7:25 AM until 8:40 AM, the aides were observed on tray line for the breakfast meal, in the kitchen. One aide was observed to be wearing gloves. She was observed to handle plates, bowls, trays, serving spoon, touch the counter tops, go over to the stove and handle pans and then without changing her gloves, she was observed to pick up with her gloved hands french toast, sausage and bacon, which was served to the facility residents. Another aide was not observed to be wearing gloves.. She was observed to handle juice containers, milk containers, coffee pots, countertops and then without putting any gloves on or washing her hands, she was observed to pick the glasses of juice, milk and water up by the rims, which were served to the facility residents. 2. On 3/9/04 at 7:30 AM, the tray line temperatures were obtained. The fried eggs in a milk bath were 113 degrees, the boiled eggs were 113 degrees and the puree sausage was 100 degrees. All of these item were sitting on top of a lids on the steam table. Potentially hazardous food shall be maintained at 140 degrees or above. Reference Guidance: U.S. Public Health Service, Federal Drug Administration 2001 Food Code, page 68.	F 371		
F 502 SS=D	483.75(j) ADMINISTRATION The facility must provide or obtain laboratory	F 502		

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F 502	Continued From page 21 services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that the facility did not obtain laboratory services to meet the needs for 2 of 24 sample residents (Residents 146 and 147). Findings include: 1. Resident 146 was re-admitted to the facility on 2/7/04, with diagnoses which included rectovaginal fistula post op wound infection, depression, anxiety and hypothyroidism. On 2/7/04, the re-admission orders documented that the physician ordered a CMP (complete metabolic panel) and a CBC (complete blood count) every week. There was no documentation in the medical record of resident 146 to evidence that a CBC was obtained on 2/18/04. On 3/9/04 at 3:30 PM, a facility RN (registered nurse) stated that according to the laboratory book a CBC on 2/18/04 had not been completed. 2. Resident 147 was admitted to the facility on 11/20/03, with diagnoses which included insomnia, congestive heart failure, failure to thrive, chronic respiratory failure, diabetes type II, renal insufficiency and emphysema. On 1/5/04, the physician ordered a pre-albumin, CMP, BNP, CBC and digoxin level every month. There was no documentation in the medical record of resident 147 to evidence that the pre-albumin, CMP, BNP or digoxin level were	F 502	**F 502** *The primary care MDs' were notified of missing labs on patients 146 and 147 on 3/17/04. *The wing medical record clerks checked charts to make sure there were no others missed labs completed 3/29/04. *Data entry clerk made sure all labs were updated on Physician order sheets completed 3/29/04 * Lab will be documented on a separate lab sheet (See enclosed Lab sheet form) and kept in a lab book on each wing. This will be in effect on April 1, 2004. *Medical records clerk will check lab book daily. *Every Friday the charge nurse and clerk will audit all patient records for completion of lab orders and make sure lab reports have been received back. *Data entry clerk will check lab book monthly when printing monthly orders. *Director of Nursing will monitor this process. Head nurse, medical records clerk and data entry coordinator are responsible for monitoring. (See enclosed Procedure for Labs).	3/17/04 3/29/04 3/29/04 4/1/04 3/30/04 and Ongoing 4/2/04 and Ongoing 3/30/04 and Ongoing 3/30/04 and Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465079	A. BUILDING _____ B. WING _____	3/11/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 502	Continued From page 22 obtained in January 2004. On 3/9/04 at 3:20 PM, a facility RN stated that there was no documentation in the laboratory book that the pre-albumin, CMP, BNP or digoxin level were completed in January 2004. She further stated that if they had been completed it would be marked in the laboratory book.	F 502		