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 _____	06/07/2007

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 PRECEDED 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 241 SS=E	483.15(a) DIGNITY 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 and interviews it was determined the facility did not promote care in a manner to maintain or enhance each resident's dignity for 2 of 24 sample residents and 5 of 7 alert and oriented residents in a group interview. Specifically, one resident was not transferred in a dignified and safe manner, and call lights were not answered promptly. Resident identifiers: 16 and 27. Findings included: 1. Resident 16 was admitted to the facility on 12/1/00 with a readmission date of 8/7/06 with diagnoses that include: Alzheimer's Disease, osteopenia, hypertension, asthma, arthritis, congestive heart failure, and diabetes mellitus. On 6/4/07 at 4:45 PM resident 16 was observed coming out of his room. Resident 16 was on the floor, sitting, and scooting with his hands and feet out of the doorway and into the hall. At 4:47 PM CNA 1 (certified nursing assistant) saw resident 16, grasped his wrists, turned him, and began to drag him down the hall towards his room. Resident 16 was dragged approximately 1 foot when another CNA stated, "lets get a chair." Resident 16's chair was delivered and placed about 3 feet away. Resident 16 was lifted under	F 241		7/31/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 _____	06/07/2007

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 PRECEDED 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 241	Continued From page 1	F 241		

his arm pits by the two CNA's. At the same time one CNA grasped Resident 16 by his belt and waist band. Resident 16 partly was partly walked and partly dragged to his chair and was dropped into it.

On 6/6/07 at 10:20 AM an interview was conducted with CNA 2.
CNA 2 stated that it was usual for resident 16 to crawl out of his low bed or the bean bag chair in his room and scoot around. When he did this, they would get him up with a 2 person assist, with 1 person lifting under each arm. Resident 16 would stand and walk into the wheelchair.

On 6/7/07 at 8:16 AM resident 16 was observed sitting on his roommates bed, being assisted by CNA 3 and 4 to dress. Resident 16's coveralls were placed on his legs while he was sitting. Then he was assisted to stand. Resident 16 was standing with assistance while the CNA's were pulling up the coveralls. Resident 16's wheelchair was placed approximately 3 feet away. The wheels were not locked. Resident 16 was then walked backward towards the wheelchair. The CNA grasped the waist of resident 16's coveralls and stated, "there is nothing to hold on to." Resident 16 was then dropped into the moving chair.

2. During a group resident interview on 6/5/07 at 9:30 AM, the following was revealed:

Five of seven alert and oriented residents interviewed showed by raise of hands that they had waited more than 15 minutes for their call lights to be answered, and that this had occurred on more than one occasion.

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 _____	06/07/2007

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 PRECEDED 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 241	Continued From page 2 3. The following observation was made: On 6/5/07 supplemental resident 27 activated their call light at 7:11 AM. The call light was turned off by a staff member at 7:15 AM. At 7:20 AM the surveyor went into the residents room and asked the resident if they had been helped. The resident stated that they were still waiting for someone to help them go to the bathroom. At 7:25 AM the resident still had not received assistance to the bathroom so they activated their call light again. It was then answered by a nursing assistant and assistance was provided.	F 241		
F 286 SS=B	483.20(d) RESIDENT ASSESSMENT - USE A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility did not maintain all resident assessments completed within the previous 15 months in the resident's active record. Resident identifiers: 7, 9, and 10 Findings included: 1. Resident 7 was admitted to the facility on 3/6/00 with readmission on 6/7/03 with diagnoses including: hypertension, severe psychosis, urinary incontinence, asthma, weight loss, chronic obstructive pulmonary disease and chronic cough.	F 286		7/31/07

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 _____	06/07/2007

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 PRECEDED 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 286	Continued From page 3	F 286		

Resident 7's medical record was reviewed on 6/4/07. The active record had MDS (Minimum Data Set) assessments from annual MDS dated 4/6/07 back to annual MDS dated 4/21/06. The January '06 quarterly MDS was not in the chart. The active record of resident 7 did not have all assessments completed within the previous 15 months.

2. Resident 9 was admitted to the facility on 5/7/04 with readmission on 12/28/04 with diagnoses including: bipolar disorder, esophageal reflux, Cerebral Meningioma with brain surgery, irritable colon, hemiparesis and cardiac dysrhythmias.

Resident 9's medical record was reviewed on 6/5/07. The active record had MDS assessments from Quarterly MDS dated 3/30/06 to Quarterly MDS dated 3/21/07. The active record of resident 9 did not have all assessments completed within the previous 15 months.

3. Resident 10 was admitted to the facility on 2/23/05 with readmission on 10/19/06 with diagnoses including: hypertension, depression, dementia, and gastric esophageal reflux disease.

Resident 10's medical record was reviewed on 6/6/07. The active record had MDS assessments from 10/26/06 to 4/21/07. The active record of resident 10 did not have all assessments completed within the previous 15 months.

An interview was done with the facility MDS coordinator on 6/6/07. She said that the records mentioned for residents 7, 9, and 10 did not have 15 months of MDS in the active chart. She thought they might have been thinned too soon.

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 _____	06/07/2007

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 PRECEDED 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 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility did not provide the care and services necessary to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 2 of 24 sample residents. Resident identifiers: 6 and 7 Findings include: 1. Resident 6 was admitted to the facility on 3/3/06 with diagnoses that included: Friedrich's Ataxia, (an inherited, progressive neurological disease), quadriplegia, speech disturbance, hypertension, spinal stenosis, xerostomia (dry mouth causing cavities), and decubitus ulcer. Resident 6's care plan dated 4/18/07 read: "# 1 Problems: (resident 6) requires assist with her daily cares. . . Goals: (resident 6) will continue to make some decisions about her daily cares as possible, and she will be kept clean, odor-free, and groomed daily . . ." Interventions: Establish a structured daily routine and continue to follow it as closely as possible. #14 Problems: Actual or potential for oral or	F 309		7/31/07

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 _____	06/07/2007

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 PRECEDED 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 309	Continued From page 5	F 309		

dental problems due to inability to brush own teeth, history of poor dental hygiene, missing teeth and minor oral sores. Needs 5 teeth fixed with composite restoration.
Goals: Resident will have no oral/dental complications through next care conference. teeth will be treated
Interventions: Assist resident as needed with oral care (minimum of BID) (two times a day) . . . .

The Consulting Physicians Progress Notes for Dental dated 4/18/07 read: "Debridement, exam, debris heavy, gingival infl. (inflammation) general, xerostomia, broken teeth and fillings present, not able to do x-rays, patient physical condition makes procedures difficult, suggest to see an office which can accommodate (resident 6) to help with xerostomia brush with Oasis toothpaste and let her sip on water if possible." The note and order was noted on 4/18/07.

On 6/4/07 at 3:05 PM resident 6 was observed in bed watching TV. Resident 6 had uncombed hair, crust in her eyes, and thick coated teeth. She was wearing a hospital gown that was soiled with yellow and pink spills. A fitted tan sheet was partially covering her. A soiled light tan pillow with two food spills was beside her. The bottom sheet was bunched under her back and legs.

On 6/5/07 at 7 AM resident 6 was observed in bed. She was observed again in the same place at 8:34 AM, 10:20 AM, 12:40 PM, and at 3:15 PM. The bottom sheet was bunched under her lower back and hips. She was covered with the same fitted sheet. Her teeth were not brushed. She had on the same soiled gown with the same yellow and pink spills. Her face had a coating of oil and skin cells. The same soiled pillow was

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 _____	06/07/2007

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 PRECEDED 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 309	Continued From page 6	F 309		

beside her.

On 6/6/07 at 8:30 AM resident 6 was observed eating breakfast in bed, in her room. She was being fed. Resident 6 was in the same soiled gown, covered with the same fitted sheet, with the same soiled pillow beside her.

On 6/6/07 at 10:05 AM an aide was observed going into resident 6's room. The aide put on her gloves and stated "we are going to take care of (resident 6)now." Then the aide left without performing any cares for resident 6.

On 6/6/07 at 10:12 AM and interview was conducted with RN (registered nurse) 1. She stated that resident 6 was turned and placed on the bed pan every two hours. She stated that resident 6 had asked to get up into her wheelchair on 6/5/07, but didn't know if she did.

On 6/6/07 at 11:55 AM an interview was conducted with LPN (licensed practical nurse) 1 after resident 6's dressing change. He stated that resident 6's dressing change was done every day around 10 AM after the bedpan was used.

On 6/6/07 at 1:25 PM resident 6 was observed up in the wheelchair reading a book that was placed on the same soiled pillow that was on her lap. Her teeth were brushed, her face was washed and she was dressed. The soiled sheets were off the bed.

On 6/6/07 at 1:35 PM an interview was conducted with CNA 5. She stated that the routine cares for resident 6 were that she was repositioned and placed on the bed pan or changed every two hours. Resident 6 was fed in the morning then

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 _____	06/07/2007

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 PRECEDED 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 309	Continued From page 7	F 309		

her face and teeth were cleaned and her gown was changed. CNA 5 showed the surveyor the toothettes (sponge swabs) that were used to cleanse resident 6's mouth with mouthwash. CNA 5 stated that resident 6 had a "delicate mouth", and "I (CNA 5) hardly ever use a toothbrush on resident 6." CNA 5 stated that resident 6 had asked to get up into her wheelchair yesterday 6/5/07, but didn't know if afternoon shift had gotten her up.

On 6/6/07 at 5:03 PM on the afternoon shift, CNA 6 was interviewed. She stated that resident 6's shower days were Tuesdays (6/5/07) and Fridays. She stated oral care was done in the evening with a mint toothpaste.

On 6/7/07 at 8:40 AM and at 9:10 AM an interview was conducted with the Director of Nurses. He stated that resident 6 received routine oral care and that she had a sensitive mouth. He stated that the Oasis toothpaste should have been put on the treatment sheet and the Medical Administration Record, but that it had been overlooked.

2. Resident 7 was admitted to the facility on 3/6/00 with a readmission of 6/7/03 with diagnoses that included: hypertension, urinary incontinence, major depressive disorder, weight loss, anemia, and hyperlipidemia.

The Dietary Progress Notes dated 1/18/06 read: " (resident 7) received new dentures on 1/16/06 and states that chewing is still a problem but better with new dentures." On 1/26/06 it read: " New dentures are hard on her gums. . .".

The Quarterly Nutritional Reassessment for 1/1

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 _____	06/07/2007

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 PRECEDED 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 309	Continued From page 8	F 309		

8/06 read: " new dentures - chewing better; bottoms don't fit well "

The Nutritional Assessment dated 4/27/06 under Oral Function read: "dentures irritating states 'can ' t eat' ".

The Nutrition Assessment Summary for 4/27/06 read: " . . . She (resident 7) has top dentures only but lower dentures irritate her and she does not wear them. Nursing agreed to get another dental appointment for her. "

The care plan originally written on 2/18/06 and reviewed and updated 5/19/06 and 4/12/07 read:
"Problem: Dental Care: Potential for oral/dental problems related to missing teeth and pain related to dentures
Goals: Resident will have no significant dental/oral problems through the next care conference.
Interventions . . . . Arrange for dental evaluation and follow-up as needed. Monitor for any problems related to chewing and swallowing. Intervene as needed. Assess fit of dentures. Provide follow-up as needed."

On 9/26/06 the weekly summary on the Nurses Notes read: "(Resident 7) has an upper plate of dentures."

On 11/12/06 the weekly summary on the Nurses Notes read: " . . . Has full set of dentures."

The IDT (interdisciplinary team) Progress Note dated 1/25/07 read:
" #10 goal met-wears dentures

The IDT Note dated 2/25/07 read: " #10 goal

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 _____	06/07/2007

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 PRECEDED 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 309	Continued From page 9	F 309		

met no problems noted "

The IDT Note dated 3/25/07 read: " #10 goal met no problems with teeth noted "

The IDT Note dated 4/24/07 read: " #11 no problem with teeth "

The IDT Note dated 5/25/07 read: #10 no oral or dental problems "

The Dental Assessment, signed by the dentist dated 1/12/07 read: all teeth missing, gums inflamed, both, upper dentures, no lower dentures. Is Patient able to wear dentures? Yes No (bottoms) Oral Hygiene: poor Is Patient happy with fit? No Patients Comments or complaints: take out denture and clean daily-soak in water overnight " No further dental assessments were found in the medical record.

On 6/7/07 at AM an interview was conducted with LPN (licensed practical nurse) 2. She stated that the dentist and resident 7 did not want dentures. " I think it was probably verbalized but not documented. A least she didn't say she wanted dentures. Most of them (other residents) usually don' t like dentures, actually. "

On 6/7/07 at AM resident 7 was interviewed by LPN 2. LPN 2 stated, " I just talked with (resident 7) and asked her if she wanted her dentures. She (resident 7) said no. I reminded her she had some. She (resident 7) said no. I told her we could get them fitted if she wanted. When I was leaving the room she (resident 7) said, 'I want them.' ".

Resident 7's weight was documented as:

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 _____	06/07/2007

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 PRECEDED 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 309	Continued From page 10 November '06 104.4 lbs. January '07 94.8 lbs. a decrease of 9% in 2 months March '07 89.4 lbs. May '07 94.4 lbs.	F 309		
F 328 SS=E	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility did not provide for 2 of 24 sampled residents, plus 2 supplemental residents, proper respiratory care and treatment. Resident identifiers: 19, 23, 25 and 26. {NOTE: Normally, CO2 (carbon dioxide) levels in the blood provide a stimulus for breathing. However, patients with COPD(chronic obstructive pulmonary disease), chronically retain CO2, and breathe on a hypoxic drive; i.e., their stimulus for breathing is the low oxygen levels in their blood. Keeping SaO2 (Saturation of oxygen in arterial blood) levels above 90%, in COPD patients, may suppress the hypoxic drive and lead to respiratory failure.} This principle can be found in the "Manual Nursing Practice, Eighth Edition" (2006),	F 328		7/31/07

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 _____	06/07/2007

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 PRECEDED 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 328	Continued From page 11	F 328		

by Sandra M. Nettina and published by Lippincott Williams & Wilkins, page 314.

An interview was held with the DON on 6/6/07 at 3:45 PM. The DON was asked about the facility's practice of monitoring SaO2 levels and liters of oxygen used by residents. The DON stated that every resident who had orders for oxygen was to be monitored once a shift with a SaO2 check to keep saturation levels greater than 90%. The DON stated that it was the facility's practice to include that order (oxygen via nasal cannula to keep SaO2 > 90%) on each resident's recertification orders.

An interview was held with RN 2, on 6/7/07 at 8:50 AM. RN 2 stated that she was responsible for transcribing the physician's original orders and placing them into the facility's computer. RN 2 stated that it was the facility practice to modify the physician's order for oxygen to include SaO2 checks to keep >90%.

The facility's Medical Director was interviewed on 6/7/07 at 9:00 AM. The Medical Director stated that the order to keep SaO2 greater than 90%, was not appropriate for every resident receiving oxygen and that the desired level of SaO2 should be prescribed by the resident's physician.

Finding included:

1. Resident 19 was readmitted to the facility on 4/29/05 with diagnoses that included; chronic obstructive pulmonary disease(COPD), hypertension, major depressive disorder, hyperlipidemia, osteoporosis and anemia.

Resident 19's medical record was reviewed on

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 _____	06/07/2007

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 PRECEDED 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 328	Continued From page 12	F 328		

6/7/07. It revealed physician readmitting orders dated 4/29/05 that stated, O2 (oxygen) (at) 2 lpm (liter per minute) all the time.

The facility generated recertification orders for May 2005 to May 2007 had orders for "O2 via NC (nasal cannula) to keep SaO2 (Saturation of oxygen in arterial blood) > 90%." No physician telephone orders were located to indicate that the original admitting orders for oxygen at 2 lpm at all times, had been changed.

A review of resident 19's treatment records, from March 2007 through May 2007, was completed. Facility staff documented resident 19's use of oxygen and oxygen saturation levels on the treatment record. Per documentation, facility staff did not provide oxygen, in accordance with physician orders as follows:

May 2007 - The resident was receiving oxygen in excess of 2 liters per minute 24 times in the AM, 27 times in the PM, and 19 times during the night. The liters of oxygen resident 19 was documented as receiving, in excess of the 2 liters prescribed, ranged from 2.5 to 5 liters per minute.

April 2007 - The resident was receiving oxygen in excess of 2 liters per minute 21 times in the AM, 29 times in the PM, and 25 times during the night. The liters of oxygen resident 19 was documented as receiving, in excess of the 2 liters prescribed, ranged from 2.5 to 4 liters per minute.

March 2007 - The resident was receiving oxygen in excess of 2 liters per minute 26 times in the AM, 27 times in the PM, and 20 times during the night. The liters of oxygen resident 19 was documented as receiving, in excess of the 2 liters

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 _____	06/07/2007

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 PRECEDED 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 328	Continued From page 13	F 328		

prescribed, ranged from 2.5 to 4 liters per minute.

2. Resident 23 was admitted to the facility on 1/12/07 with diagnoses that included; Alzheimer's disease and chronic obstructive pulmonary disease.

Resident 23's medical record was reviewed on 6/6/07. It revealed physician admitting orders dated 1/12/07 that stated, oxygen (at) 2 liters QHS (every hour of sleep).

The facility generated Recertification orders February 2007 and March 2007 had orders for "O2 via NC to keep SaO2 > 90%." No physician telephone orders were located to indicate that the original admitting orders for oxygen at 2 liters QHS, had been changed.

3. Resident 25 was admitted to the facility on 4/18/07 with diagnoses that included; chronic obstructive pulmonary disease, hip fracture, and diabetes mellitus.

Resident 25's medical record was reviewed on 6/7/07. It revealed physician admitting orders dated 4/18/07 that stated, O2 (at) 4 liters by NC.

The facility generated recertification orders May 2007 had orders for "O2 via NC to keep SaO2 > 90%." No physician telephone orders were located to indicate that the original admitting orders for oxygen at 4 liters, had been changed.

4. Resident 26 was admitted to the facility 2/1/07 with diagnoses that included chronic obstructive pulmonary disease, chronic respiratory failure, congestive heart failure, hypercholesterolemia and obstructive sleep apnea.

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 _____	06/07/2007

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 PRECEDED 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 328	Continued From page 14	F 328		

Resident 26's medical record was review 6/7/07. It revealed physician admitting orders dated 2/1/07 that stated, O2 NC to keep sats (SaO2) 89-93%. There was also an order for BiPAP (bilevel positive airway pressure) QHS at 10/4 (centimeters of water pressure) settings, pt (patient) has machine.

A review of resident 26's treatment records, for April and May 2007, was completed. Facility staff documented resident 26's use of oxygen and oxygen saturation levels on the treatment record. Per documentation, facility staff did not adjust the resident's oxygen to keep the SaO2 in the prescribed range.

April 2007 - The resident's SaO2 levels exceeded the prescribed range of 89 - 93%, 16 times in the AM, 9 times in the PM, and 12 times during the night. Exceeded SaO2 levels documented, ranged from 94 - 99%. Resident 26's oxygen should have been turned down to lower the SaO2 level to the prescribed range.

May 2007 - The resident's SaO2 levels exceeded the prescribed range of 89 - 93%, 3 times in the day, 4 times in the PM and 4 times during the night. Exceeded SaO2 levels documented, ranged from 94 - 97%. Resident 26's oxygen should have been turned down to lower the SaO2 level to the prescribed range.

An observation of resident 26's room was made on 6/7/07 at 9:30 AM. The resident's BiPAP machine could not be located.

An interview was held with LPN 1 on 6/7/07 at 9:35 AM. LPN 1 stated that he was aware that

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 _____	06/07/2007

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 PRECEDED 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 328	Continued From page 15 resident 26 had orders for BiPAP at night, but didn't know where the BiPAP was located. LPN 1 stated that the PM shift would know. An interview with resident 26 was held 6/7/07 at 9:45 AM. The resident was asked where his BiPAP machine was. Resident 26 stated that it was a nuisance and he gave it back to the home care company that had supplied it to him. Resident 26 was asked what date he gave the BiPAP machine back. He stated it was "a few months ago." Resident 26's treatment records from 3/1/07 to 6/6/07 revealed documentation that the resident was using his BiPAP at night. An interview was held with the DON on 6/7/07 at 10:00 AM. The DON was asked about the documentation on resident 26's treatment records each night at 8:00 PM for the BiPAP. The DON stated that the signature of the staff person on the treatment record each night at 8:00 PM indicated that the resident was using the BiPAP machine. The DON was informed by the surveyor that resident 26 no longer had the BiPAP. The DON was not aware that the resident had returned it. A telephone interview was held with the home care company that had supplied the BiPAP machine to resident 26. They confirmed that the resident had returned it on 2/25/07. However, facility staff continued to document all through March, April, May and up to June 6, 2007, that resident 26 was using the BiPAP machine at night.	F 328		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE	F 371		7/31/07

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 _____	06/07/2007

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 PRECEDED 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 371	Continued From page 16 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, the facility did not store or distribute food under sanitary conditions. Findings include: 1. On 6/4/07 at 9:30 AM, the following observations were made in the facility kitchen: a. Open spices including cream of tartar, "5 spice powder," onion salt, and garlic powder. b. One uncovered carton of decorative sprinkles. c. Six dented cans of grapefruit. 2. On 6/4/07 at 9:45 AM, the following observations were made in the facility's refrigerators: a. Nine hard boiled eggs which were not covered completely. b. One container of pears which were not dated or labeled. c. Two glasses labeled "smoothie 5/29/07." d. One gallon of milk without a lid. e. All handles of the refrigerators were sticky to the touch and had visible food particles on them. 3. On 6/5/07 at 8:40 AM dietary staff member (DSM) 1 was observed while serving breakfast to the residents in wing 1. After serving several of the residents, DSM 1 was observed to place one	F 371		

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 _____	06/07/2007

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 PRECEDED 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 371	Continued From page 17	F 371		

of her gloved hands on a resident's chair. She was then observed to continue to serve food to additional residents, touching resident plates. At no time was DSM 1 observed to change her gloves.

4. On 6/5/07 at 12:25 PM the following observations were made in the facility's kitchen:

a. A tray used to store clean dishes had several red and white food particles on it.

b. Greasy dust particles were found on the vent area over the door of a reach-in refrigerator.

c. The juice dispenser nozzle was visibly dirty and had a fermented smell.

d. The large mixer had spattered, dried food particles on it.

e. The reach-in freezer door handle was sticky to the touch and was visibly dirty. Inside of the freezer there was food spilled on the freezer floor.

f. The reach-in freezer contained an employee ice-cream-type food marked with the employee's name.

g. An electrical outlet next to a food preparation area was dusty and dirty as well as the large mixer cord plugged into it.

h. The storage racks in the dry storage area had a sticky food substance on the wire shelving in two areas.

i. The dry storage area had an open bag of powdered cocoa that was opened and not covered or closed.

j. A gallon bottle of Worcestershire sauce had large drips all the way down the outside of the bottle to the bottom of the container.

5. On 6/5/07 at 9:15 AM two CNAs (certified nurses aides) were observed in wing 2 of the facility while passing water to residents. Both

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 _____	06/07/2007

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 PRECEDED 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 371	Continued From page 18	F 371		

CNAs were observed to use a tattered paper cup that appeared to have been used several times. Both CNAs left the paper cup in the ice chest after using the cup to scoop ice into residents' mugs.

6. On 6/5/07 at 3:35 PM the ice scoop in the ice room was observed. The ice scoop was made of clear plastic and was missing the handle. The ice scoop was cracked and had jagged pieces of plastic where the handle had broken off. The ice scoop also had droplets of water on it, indicating it had been used recently.

7. On 6/7/07 at 9:15 AM CNA 7 was observed in wing 2 of the facility while passing water to residents. CNA 7 was observed to open an ice chest which contained a paper cup. The paper cup was tattered and appeared to have been used several times. CNA 7 was observed to use the tattered cup left in the ice chest to scoop ice into a resident's mug.

CNA 7 was asked how she gets ice into the ice chest from the ice machine. CNA 7 stated that she used the scoop that was currently sitting on top of the ice machine in the ice room. The ice scoop in the ice room was then observed. The same broken plastic scoop was observed on 6/7/07 that was observed on 6/5/07. The ice scoop had droplets of water in it, indicating that it had been used recently.

8. On 6/7/07 at 9:35 AM CNA 8 was observed in wing 2 of the facility while passing water to residents. CNA 8 was observed to use the same tattered cup to scoop ice out of the ice chest that CNA 7 had previously used.

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 _____	06/07/2007

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 PRECEDED 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 371	Continued From page 19 CNA 8 was then observed to set the cup on top of the cart after using it to scoop ice, deliver the resident's mug, and then use the cup again to scoop ice. This observation was made multiple times. CNA 8 also was observed to leave the lid of the ice chest up and leave the ice chest unattended in the hallway while entering residents' rooms. This observation was made multiple times.	F 371		
F 411 SS=D	483.55(a) DENTAL SERVICES - SNF The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on record review, and interview it was determined that the facility did not provide routine and prompt referral to dental services for 1 out of 24 residents. Findings include: Resident 7 was admitted to the facility on 3/6/00 with a readmission of 6/7/03 with diagnoses that	F 411		7/31/07

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 _____	06/07/2007

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 PRECEDED 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 411	Continued From page 20	F 411		

included: hypertension, urinary incontinence, major depressive disorder, weight loss, anemia, and hyperlipidemia.

The Dietary Progress Notes dated 1/18/06 read: " (resident 7) received new dentures on 1/16/06 and states that chewing is still a problem but better with new dentures." On 1/26/06 it read: " New dentures are hard on her gums. . .".

The Quarterly Nutritional Reassessment for 1/18/06 read: " new dentures chewing better; bottoms don't fit well ".

The Nutritional Assessment dated 4/27/06 under Oral Function read: "dentures irritating states 'can't eat' ".

The Nutrition Assessment Summary for 4/27/06 read: " . . . She (resident 7) has top dentures only but lower dentures irritate her and she does not wear them. Nursing agreed to get another dental appointment for her. "

The care plan originally written on 2/18/06 and reviewed and updated 5/19/06 and 4/12/07 read: "Problem: Dental Care: Potential for oral/dental problems related to missing teeth and pain related to dentures
Goals: Resident will have no significant dental/oral problems through the next care conference.
Interventions . . . . Arrange for dental evaluation and follow-up as needed. Monitor for any problems related to chewing and swallowing. Intervene as needed. Assess fit of dentures. Provide follow-up as needed."

On 9/26/06 the weekly summary on the Nurses

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 _____	06/07/2007

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 PRECEDED 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 411	Continued From page 21 Notes read: "(Resident 7) has an upper plate of dentures." On 11/12/06 the weekly summary on the Nurses Notes read: " . . . Has full set of dentures." The IDT (interdisciplinary team) Progress Note dated 1/25/07 read: " #10 goal met-wears dentures The IDT Note dated 2/25/07 read: " #10 goal met no problems noted " The IDT Note dated 3/25/07 read: " #10 goal met no problems with teeth noted " The IDT Note dated 4/24/07 read: " #11 no problem with teeth " The IDT Note dated 5/25/07 read: "#10 no oral or dental problems " The Dental Assessment, signed by the dentist dated 1/12/07 read: all teeth missing, gums inflamed, both, upper dentures, no lower dentures. Is Patient able to wear dentures? Yes No (bottoms) Oral Hygiene: poor Is Patient happy with fit? No Patients Comments or complaints: take out denture and clean daily-soak in water overnight " No further dental assessments were found in the medical record. On 6/7/07 at AM an interview was conducted with LPN (licensed practical nurse) 2. She stated that the dentist and resident 7 did not want dentures. " I think it was probably verbalized but not documented. A least she didn't say she wanted dentures. Most of them (other residents) usually don' t like dentures, actually. "	F 411		

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 _____	06/07/2007

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 PRECEDED 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 411	Continued From page 22 On 6/7/07 at AM resident 7 was interviewed by LPN 2. LPN 2 stated, " I just talked with (resident 7) and asked her if she wanted her dentures. She (resident 7) said no. I reminded her she had some. She (resident 7) said no. I told her we could get them fitted if she wanted. When I was leaving the room she (resident 7) said, 'I want them' ". Resident 7's weight was documented as: November '06 104.4 lbs. January '07 94.8 lbs. a decrease of 9% in 2 months March '07 89.4 lbs. May '07 94.4 lbs.	F 411		
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory 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 record review and interview, it was determined that the facility did not provide or obtain laboratory services to meet the needs of one of 24 sample residents. Resident identifier: 11 Findings included: Resident 11 was admitted to the facility on 1/4/06 with diagnoses including: diabetes mellitus, hypertension, congestive heart failure, arthritis, depression, coronary artery disease, and unsteady gait.	F 502		7/31/07

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 _____	06/07/2007

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 PRECEDED 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 502	Continued From page 23 Review of resident 11's records was done on 6/5/07. A physician order dated 12/27/06 ordered the following labs to be done for resident 7: Chemistry 7, lipid panel, and urine micro albumin. There was no documentation in the medical record that the labs were collected. The DON was interviewed on 6/6/07. He stated that those laboratory services were not done for resident 11 in December 2006 or January 2007. He said they had been missed.	F 502		
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that the facility did not maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for 3 of 24 sampled residents and 2 supplemental residents. Specifically, physician orders were not accurately transcribed when entered into the facility's computer. Additionally, one resident had	F 514		7/31/07

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 _____	06/07/2007

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 PRECEDED 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 514	Continued From page 24	F 514		

documentation on treatment records that a BiPAP machine was being used each night, when in fact it was not. Resident identifiers: 6, 19, 23, 25, and 26.

Findings included:

1. Resident 19 was readmitted to the facility on 4/29/05 with diagnoses that included; chronic obstructive pulmonary disease(COPD), hypertension, major depressive disorder, hyperlipidemia, osteoporosis and anemia.

Resident 19's medical record was reviewed on 6/7/07. It revealed physician readmitting orders dated 4/29/05 that stated, O2 (oxygen) (at) 2 lpm (litesr per minute) all the time.

The facility generated recertification orders for May 2005 to May 2007 had orders for "O2 via NC (nasal cannula) to keep SaO2 (Saturation of oxygen in arterial blood) > 90%." No physician telephone orders were located to indicate that the original admitting orders for oxygen at 2 lpm at all times, had been changed

2. Resident 23 was admitted to the facility on 1/12/07 with diagnoses that included; Alzheimer's disease and chronic obstructive pulmonary disease.

Resident 23's medical record was reviewed on 6/6/07. It revealed physician admitting orders dated 1/12/07 that stated, oxygen (at) 2 liters QHS (every hour of sleep).

The facility generated recertification orders February 2007 and March 2007 had orders for "O2 via NC to keep SaO2 > 90%." No physician

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 _____	06/07/2007

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 PRECEDED 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 514	Continued From page 25	F 514		

telephone orders were located to indicate that the original admitting orders for oxygen at 2 liters QHS, had been changed.

3. Resident 25 was admitted to the facility on 4/18/07 with diagnoses that included chronic obstructive pulmonary disease, hip fracture, and diabetes mellitus.

Resident 25's medical record was reviewed on 6/7/07. It revealed physician admitting orders dated 4/18/07 that stated, O2 (at) 4 liters by NC.

The facility generated Recertification orders May 2007 had orders for "O2 via NC to keep SaO2 > 90%." No physician telephone orders were located to indicate that the original admitting orders for oxygen at 4 liters, had been changed.

An interview was held with RN 2, on 6/7/07 at 8:50 AM. RN 2 stated that she was responsible for transcribing the physician's original orders and placing them into the facility's computer. RN 2 stated that it was the facility practice to modify the physician's order for oxygen to include SaO2 checks to keep >90%.

The facility's Medical Director was interviewed on 6/7/07 at 9:00 AM. The Medical Director stated that the order to keep SaO2 greater than 90%, was not appropriate for every resident receiving oxygen and that the desired level of SaO2 should be prescribed by the resident's physician.

4. Resident 26 was admitted to the facility 2/1/07 with diagnoses that included; chronic obstructive pulmonary disease, chronic respiratory failure, congestive heart failure, hypercholesterolemia and obstructive sleep apnea.

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 _____	06/07/2007

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 PRECEDED 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 514	Continued From page 26 Resident 26's medical record was review 6/7/07. It revealed physician admitting orders dated 2/1/07 that stated, BiPAP (bilevel positive airway pressure) QHS at 10/4 (centimeters of water pressure) settings, pt (patient) has machine. An observation of resident 26's room was made on 6/7/07 at 9:30 AM. The resident's BiPAP machine could not be located. An interview was held with LPN 1 on 6/7/07 at 9:35 AM. LPN 1 stated that he was aware that resident 26 had orders for BiPAP at night, but didn't know where the BiPAP was located. LPN 1 stated that the PM shift would know. An interview with resident 26 was held 6/7/07 at 9:45 AM. The resident was asked where his BiPAP machine was. Resident 26 stated that it was a nuisance and he gave it back to the home care company that had supplied it to him. Resident 26 was asked what date he gave the BiPAP machine back. He stated it was "a few months ago." Resident 26's treatment records from 3/1/07 to 6/6/07 revealed documentation that the resident was using his BiPAP at night. An interview was held with the DON on 6/7/07 at 10:00 AM. The DON was asked about the documentation on resident 26's treatment records each night at 8:00 PM for the BiPAP. The DON stated that the signature of the staff person on the treatment record each night at 8:00 PM indicated that the resident was using the BiPAP machine. The DON was informed by the surveyor that resident 26 no longer had the BiPAP. The DON	F 514		

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 _____	06/07/2007

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 PRECEDED 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 514	Continued From page 27	F 514		

was not aware that the resident had returned it.

A telephone interview was held with the home care company that had supplied the BiPAP machine to resident 26. They confirmed that the resident had returned it on 2/25/07. However, facility staff continued to document all through March, April, May and up to June 6, 2007, that resident 26 was using the BiPAP machine at night.

5. Resident 6 was admitted to the facility on 3/3/06 with diagnoses that included: Friedrich's Ataxia, (an inherited, progressive neurological disease), quadriplegia, speech disturbance, hypertension, spinal stenosis, xerostomia (dry mouth causing cavities), and decubitus ulcer.

The Consulting Physicians Progress Notes for Dental dated 4/18/07 read: "Debridement, exam, debris heavy, gingival infl. (inflammation) general, xerostomia, broken teeth and fillings present, not able to do x-rays, patient. physical condition makes procedures difficult, suggest to see an office which can accommodate (resident 6) to help with xerostomia brush with Oasis toothpaste and let her sip on water if possible." The summary and order was noted on 4/18/07.

On 6/6/07 at 1:35 PM an interview was conducted with CNA 5. She stated that resident 6 was fed in the morning then her face and teeth were cleaned. CNA 5 showed the surveyor the toothettes (sponge swabs) that were used to cleanse resident 6's mouth with mouthwash. CNA 5 stated that resident 6 had a 'delicate mouth', and "I (CNA 5) hardly ever use a toothbrush on resident 6."

On 6/6/07 at 5:03 PM on the afternoon shift, CNA

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 _____	06/07/2007

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 PRECEDED 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 514	Continued From page 28 6 was interviewed. She stated oral care was done in the evening with a mint toothpaste. On 6/7/07 at 8:40 AM and at 9:10 AM an interview was conducted with the Director of Nurses. He stated that resident 6 received routine oral care and that she had a sensitive mouth. He stated that the Oasis toothpaste should have been put on the treatment sheet and the Medical Administration Record, but that it had been overlooked.	F 514		