	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCT G	TION	СОМ	E SURVEY PLETED
		465082					<u> </u>	1/5/2002
	ROVIDER OR SUPPLIER IEW CARE CENTER		1053 WEST PROVO, UT	1020 SOUT	ATE, ZIP CODE	POC acc	epted 12-	.(2-02
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	483.10(b)(11) NOTI SERVICES	FICATION OF RIGH	rs and	F 157	Please	Also se	e adden	diem.
	consult with the resident's interested family mer involving the resident the potential for requisignificant change in psychosocial status (mental, or psychosocial status (mental, or psychosocial status) threatening condition need to alter treatment discontinue an existing adverse consequence treatment); or a decisive resident from the factor of the facility must also and, if known, the resinterested family mer room or roommate as \$483.15(e)(2); or a confederal or State law paragraph (b)(1) of the facility must reconditions and phone in the resident from the resident from the facility must recondition of the facility mus	diately inform the resident's physician; and if legal representative or inber when there is an at which results in injuriting physician interve the resident's physical area, a deterioration in legal status in either life is or clinical complication of treatment of the status of the	known, an accident y and has ntion; a mental, or health, hons); a heed to he to he form of harge the harive or hange in hin hardent ha					
	Based on record revi	IT is not met as evidence and interview, it we will be aliced and immediately did not immediately	as		: : : !	l	Jian Augi, c	i Health
	1 of 15 sample resid	acility did not immedia ent's physicians when a	change in		1		DEC 4	may)
	notified. Specificall prolapse and the phy days after the possib Resident Identifier:		ssible rectal until 5 observed.				lur, of Medicare/Me Itilication and Res	dicaid Prog. Assessment
ABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTA	TIVE'S SIGNATU	RE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days aft such information is plade available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CMS-2567L ATG

AFG112000

Event ID: 6HIP11

211

Facility ID: UT0017

If continuation sheet 1 of

DEPARTMENT OF HEALTH AND HUMA ERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES 2567 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 465082 11/5/2002 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1053 WEST 1020 SOUTH CRESTVIEW CARE CENTER PROVO, UT 84601 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 157 F 157 Continued From page 1 Resident Number 20 has been evaluated by a 1/5/02 Findings Include: physician and the current treatment plan has been communicated to the family. 1. Resident 20 was admitted to the facility on 6/20/02 with diagnoses of muscle ligament disease, decubitus ulcer, asphyxia, profound mental retardation and Residents with a change in condition have the weakness. potential to be affected. A review of resident 20's medical record was done on 10/31/02. The facility has completed an audit of the twenty-four hour report for the last month A nurse's note, dated 6/27/02, at 2:00 PM, documented comparing issues on the 24-hour report to the following, "During shower pt's [patient's] rectum physician contacts. The licensed professional 12/4/02 was bleeding. Upon examination pt [patient] had red staff has been colored tissue protruding from rectum..." re-inserviced on the need for timely reporting. During the in-service the American Medical A nurse's note, dated 6/29/02, at 11:00 AM. Directors Association stand for timely documented the following, "...Pt [patient] has bleeding reporting was reviewed and is kept at the from rectum [a minimal amount] red and some grayish nursing stations. The DON is reviewing the tissue protruding from anus, blood in brief noted..." ongoing 24-hour report and initialing it once reviewed to ensure timely physician involvement is During review of the medical record on 10/31/02 there being made. was no documentation to provide evidence that the 12/9/02 The results of the audit were reported to the physician had been made aware of the possible rectal record of care QA committee team for review prolapse. and identification of training needs. The review of the twenty-four hour report is done On 7/2/02 resident 20 was seen at the facility by a ongoing and the review will be completed physician for the possible rectal prolapse. once the record of care committee has determined compliance. During an interview on 10/31/02 at 1:30 PM, two facility nurses stated that if they were unsure if a resident had hemorrhoids or not they would call the The DON is responsible for ongoing physician. compliance. During an interview on 10/31/02 at 2:00 PM, with the facility nurse who wrote the note on 6/27/02 she stated

saw the physician.

that she did not remember the situation but she would inform the physician of the situation the next time she

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULT A. BUILDIN B. WING	COM	TE SURVEY IPLETED
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F 157	Continued From page 2	2		F 157		
F 241 SS=E	483.15(a) QUALITY	OF LIFE		F 241		
	manner and in an env	mote care for residents vironment that maintain nt's dignity and respect her individuality.	is or			
	This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not always care for residents in a manner that maintains or enhances each resident's dignity by not answering call lights timely or providing services timely according to the needs of the residents.			No individual residents were identified. The resident council has been asked to assist in monitoring call light response times and with report to the administration any issues goin forward.	12/12/02	
	Findings include:	amg to the needs of the		*	Residents requiring assistance in their room have the potential to be affected.	ns.
	participated in the me	:30 PM, a confidential p of residents. Twelve eeting. Six (6) of the 12 had to wait too long fo	residents 2 residents	;	Call light response time is being monitored during routine rounds and now we are doin formal written rounds those tests call light response time at least daily for four weeks	
	light to be answered. to wait 45 minutes fo call light and help hir	One resident stated the rastaff member to resmost off of the toilet. And the day she waited 4 hours	at he had pond to his other	•	then weekly and finally monthly. The staff has been re-inserviced on the need to respo to call lights in a timely fashion.	41/1
	call light to be answe	red. A third resident so roommate, who is dea	tated that		The results of the rounds and the resident council minutes will be reviewed by the	
		l light and had to wait 9			facility practices committee to ensure on going compliance and to identify trends an re-education opportunities.	d 1/1/03
	revealed that the call signaling. At 1:45 Pl observed to enter the	PM, observation of roo light above the door w M, a facility nurse aide room to assist the resid the surveyor observed y.	as was dent. This		The DON is responsible for ongoing compliance.	

2. On 10/30/02 at 12:55 PM, observation of room 118

DEPARTMENT OF HEALTH AND HUMA ERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES 2567 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 465082 11/5/2002 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1053 WEST 1020 SOUTH CRESTVIEW CARE CENTER PROVO, UT 84601 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX COMPLETE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 241 Continued From page 3 F 241 revealed that the call light above the door was signaling. At 1:04 PM, a facility maintenance man was observed to enter the room to assist the resident. This was 9 minutes after the surveyor observed the call light on in the hallway. 3. On 10/30/02, the call light above the room for resident 41 was observed to stay on from 12:47 PM to 12:55 PM. While the call light was ringing, the resident in this room, resident 41, was interviewed. Resident 41 was found to be alert and oriented to person, place and time. When asked how long it takes for staff to answer her call light, resident 41 responded that the average was "12 minutes or so". Resident 41 continued to say that she had once been left on the bed pan for 40 minutes when her aide had forgotten about her and that no other staff had responded to her call light. F 278 F 278 483.20(g) - (h) RESIDENT ASSESSMENT SS=D The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

willfully and knowingly--

Under Medicare and Medicaid, an individual who

Certifies a material and false statement in a resident

11/5/2002

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	OF DEFICIENCIES
AND DEAN OF	CODDECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE	CONSTRUCTION
A. BUILDING	

(X3) DATE SURVEY
COMPLETED

465082

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

CRESTVIEW CARE CENTER

NAME OF PROVIDER OR SUPPLIER

1053 WEST 1020 SOUTH PROVO, UT 84601

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE

F 278 Continued From page 4

assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by: Based on review of medical records, it was determined that 2 of 15 sample records did not have a minimum data set which accurately reflected the status of the

residents. Resident identifiers: 45 and C2.

Findings include:

1. Resident 45 was a 79 year old male who was admitted to the facility on 5/27/99 with the diagnoses of insulin dependent diabetes mellitus, atrial fibrillation, dementia, organic brain syndrome, congestive heart failure, venous insufficiency with chronic venous stasis.

Between the first week of June 2002 and the first week of August 2002, resident 45 lost 12% of his body weight. Resident 45 went from 153.5 pounds in the first week of June 2002 to 135 pounds in the first week of August 2002. A 12% weight loss in two months is significant.

The MDS, with the assessment reference date of 8/20/02, documented that resident 45 had not had a weight loss of 5% or more in the last 30 days or 10% or more in the last 180 days. This would not be accurate.

2. Resident C2 was an 86 year old female admitted on 5/14/02 with diagnoses: hypertension, arthritis, hip

F 278

Resident 45 has been reviewed and the MDS is current to the ARD. The plan of care team met to review the plan of care.

Resident C2 was a closed record.

Residents requiring an MDS assessment have the potential to be affected.

The MDS nurse has reviewed the RAI manual covering chapter three "completion of the MDS."

A competency test was administered and passed after the review. Staff completing the MDS is going through a competency test to ensure to identify further training needs.

The record of care committee reviews a sample of MDSs for accuracy and creates action plans when discrepancies occur, internal inconsistencies in the MDS are checked using a computer program called LTCQ after completing the MDS. The LTCQ reports are kept for review by the DON and the MDS nurse. The program identifies issues and offers suggestions for correction.

The DON is responsible for ongoing compliance.

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

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F 278	performed on 10/31/ quarterly review, dat C2 had four stage 2 previous day, the To dated 8/8/02, docum		vas Set resident , on the llow up, sure	278			
F 279 SS=D	for each resident tha and timetables to me	velop a comprehensive car t includes measurable obje tet a resident's medical, nu hosocial needs that are ide	re plan ectives ersing,	279			:
	The services that are maintain the residen	describe the following: to be furnished to attain of the transfer of the tran	sical,	• !			
	s483.25 but are not	ould otherwise be required provided due to the residender s483.10, including the under s483.10(b)(4).	nt's				
	Based on clinical redetermined that the comprehensive care medical, nursing and that are identified in	NT is not met as evidence cord review and interview facility did not maintain plans, that met the resider mental and psychologica the comprehensive assess cord for 1 out of 15 sample dentifier: 5	, it was nt's al needs sment, on				

DEPARTMENT OF HEALTH AND HUMA SERVICES

FORM APPROVE CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 465082 11/5/2002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1053 WEST 1020 SOUTH CRESTVIEW CARE CENTER PROVO, UT 84601 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 279 Continued From page 6 F 279 Findings include: Resident 5 was admitted to the facility on 5/6/2002 with diagnoses that included chronic obstructive pulmonary disease, convulsions, hypothyroidism, Resident number 5 has been reassessed and 11/6/02 hypertension, constipation, circulatory disease, care plans have been developed according to dementia, and congestive heart failure. the assessment. A review of resident 5's clinical record was done on A chart audit has been completed to ensure 10/31/02 at 11:00 AM. A review of the MDS care plan development for each resident can (minimum data set) section V - RAPS (resident be found in the chart. The medical records assessment protocol summary) indicated that areas clerk has the plan of care on the audit tool that 2-cognitive loss, 3-visual functions, 4 is used within 14 days of admit and then communication, 5- ADL (activities of daily living) quarterly. The record of care committee functional/rehabilitation potential, 6- urinary reviews a sample of MDS and care plans for incontinence and indwelling catheter, 10 - activities, accuracy and timeliness and creates action 16 - physical restraints were checked as triggered and plans when discrepancies occur. were checked for being care planned. No care plans were found on resident 5's chart addressing the above The results of the audit and record of review issues. committee is done by the full OA team to identify trends and further educational needs. A facility nurse was interviewed on 10/31/02 at 11:30 AM. The nurse reviewed resident 5's clinical record The DON is responsible for ongoing and stated that there were no care plans to be found in compliance. resident 5's clinical record. The nurse stated that the facility keeps each resident's care plans in the resident's clinical record. The DON (director of nursing) was interviewed on 10/31/02 at 1:00 PM. The DON stated that recently she had gone through all the resident's clinical records and had replaced all the care plans with newly created care plans and that she must have "missed" resident 5's chart.

Facility ID:

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		465082		B. WING_		11/5/2002
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE	
CRESTV	IEW CARE CENTER		1053 WES' PROVO, U	Г 1020 SOU Т 84601	TH	:
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F 325	Continued From page 7	7		F 325		
	483.25(i)(1) QUALITED Based on a resident's facility must ensure to acceptable parameter body weight and protections.		such as resident's	F 325	Resident 10, 16, 20, 21, 45, 48 have reviewed by the RD consultant with to care plans made to include weight albumin issues being addressed. Earesident has had their plan reviewed physician. Residents at risk for nutritional issue potential to be affected.	updates t loss and ch by a
	This REQUIREMEN	potential to be affected. nis REQUIREMENT is not met as evidenced by: A resident audit was completed along with a				
	Based on clinical rec was determined that the each resident maintain nutritional status as e residents experienced dietary interventions weight decline. Reside Additionally, 4 of 15 low albumin (a prote status) levels with no implemented to help prevent further protest 10, 21, 45, 48. Calculating weight less ubtracting the current weight, dividing the earn multiplying by 1 as follows: 5% in one 10% in 6 months. (Residuent each residuent earn multiplying by 1 as follows: 5% in one 10% in 6 months. (Residuent each residuent earn earn earn earn earn earn earn earn	ord review and staff in the facility did not ensited an acceptable paractividenced by 5 of 15 sall significant weight lost implemented to prevent dent identifiers: 10, 16, sampled residents expin and indicator of nuto dietary interventions increase the albumin lin depletion. Resident coss percentages is done in weight from the previous Significant weight emonth, 7.5% in 3 modeference guidance: Merican Dietetic Associated	atterviews, it ure that ameter of ampled as with no ont further, 20, 45, 48. Derienced ritional evels and identifiers:	And the second s	risk tool to determine risk levels for The audit looked for intervention implementation comparing delivery physician order and RD recommend Weekly weights are being done to rebase lines for residents. The residents staff has been re-inserviced on proper room and intake records as well as pweighing techniques. The dietary stabeen re-inserviced on proper food hand preparation. A lab audit has been completed to ensure albumin levels communicated to the Rd for timely intervention. The RD is aware of the for clinical dietetics and is using the develop current interventions. Recommendations are being tracked timely communication to the physical eventual implementation. Time from recommendation to implementation reported to the QA team for review	and dations. eeestablish at care er dining proper aff has andling en are being are being the manual to do to ensure than and m
	An albumin level of moderate visceral proof 3.0 g/dl-3.5 g/dl is protein deficit. Refe	2.4 g/dl-2.9 g/dl is con otein deficit and an alb s considered a mild vis rence Guidance: Manu merican Dietetic Assoc	isidered a oumin level ceral ual of		plan development. The weights are reviewed by the facility practices confor development of interventions and reporting to the QA team. The DON and the Administrator are responsible for ongoing compliance.	ommittee 12/3/02 d

11/5/2002

COMPLETE

DATE

(X3) DATE SURVEY

COMPLETED

DEPARTMENT OF HEALTH AND HUMA. **ERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 465082 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1053 WEST 1020 SOUTH **CRESTVIEW CARE CENTER** PROVO, UT 84601 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 325 F 325 Continued From page δ The facility was found to be providing sub-standard quality of care (a pattern of actual harm) in this area.

Findings include:

1. Resident 21 was a 85 year old female re-admitted to the facility on 7/27/95 with diagnoses including senile dementia, stomach ulcer, cerebrovascular accident and deep vein thrombosis. Resident 21 had a gastrostomy tube (G-tube) in place and received all of her nutrition via this tube. She was NPO (receiving nothing by mouth).

Resident 21's medical record was reviewed on 10/29/02.

On 10/29/02, a review of resident 21's laboratory (lab) values was completed. The following albumin (a protein and indicator of nutritional status) levels were documented:

9/10/01 3.0 g/dl (grams per deciliter) 9/11/01 2.7 g/dl 8/6/02 2.9 g/dl

Resident 21's albumin levels were low. The normal reference range, according to the lab use by the facility, was 3.3-4.8 g/dl.

A review of resident 21's nursing notes was completed on 10/29/02. On 5/6/01, it was documented that a stage II pressure ulcer to the coccyx had been identified. A stage II pressure ulcer to the back of the knee was documented as having been identified on 1/27/02.

Resident 21's "Skin Care and Pressure Ulcer Record", dated 1/26/02 through 10/26/02, was reviewed. It was

If continuation sheet 9 of

DEPARTMENT OF HEALTH AND HUM. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES 2567 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 465082 11/5/2002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1053 WEST 1020 SOUTH **CRESTVIEW CARE CENTER** PROVO, UT 84601 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) F 325 Continued From page 9 F 325 documented that resident 21 had a stage II pressure ulcer on her coccyx, which healed 10/12/02. It was also documented that resident 21 had a stage II pressure ulcer on the back of her left knee, which healed on 10/5/02. A nutrition care plan, which was not dated, documented that resident 21 had a potential for alteration in nutrition related to need for tube feeding and a low serum albumin level. The goals documented included resident 21 would maintain her serum albumin within normal limits through the next review. Approaches to meet this goal were included: formula as ordered, monthly nutritional evaluation and Promod (a protein supplement) in flush water as ordered. Nutrition assessments were completed on 10/24/01, 1/23/02, 4/25/02, 5/7/02, 7/25/02, 8/15/02 and 10/24/02. There were no documented nutritional assessments evaluation for the months of November 2001, December 2001, February 2002, March 2002, June 2002 and September 2002. A review of the dietary section of the medical chart was completed. A statement, dated 5/10/02, and written by the then director of nurses (DON), documented the following " several formulas were tried for [resident 21] feeding over a period of time. Compleat is the only formula that didn't cause diarrhea or vomiting... Isosource was one of formulas tried".

On 10/24/01, a quarterly nutrition progress note was completed by the dietary manager. The note was not co-signed by a registered dietitian. The dietary manager documented that resident 21 was receiving

DEDARTMENT OF HEATTH AND HUM/ EDVICES PRINTED: 11/12/20

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		465082				11.	/5/2002	
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	receiving 200 cc of wand 240 cc of cranbe also ordered 3 scoop (providing 18 grams scoop) to help promosore. The dietary mathere were no new lall. There was no docummanager was aware calbumin levels obtain. There was no docum of the current tube ferecommendations we resident 21 was received in the consigned by a register that resident 21 was tulcer on her coccyx a behind her left knee a available to review. evidence that the diet addressed the low althand 9/11/01. There we the adequacy of the cassessed or that reconsincrease the protein ron this day, 1/23/02 to a multi-vitamin with:	ag formula at 93 cc (cu for 12 hours. She was vater three times per da rry juice a day. Reside is of protein powder ea of protein and 30 calor of healing of her stage mager further document by values available to re- ented evidence that the of or had addressed the hed on 9/10/01 and 9/1 ented evidence that the eding order was assess re made to increase the ving. The note evidence that the eding order was assess re made to increase the ving. The note ented dietitian. It was do tube fed, had a stage II and a stage II pressure to and had no new lab val. There was no document fary manager was aware our nanager was aware	also y (600 cc) ent 21 was ech day ries per II pressure ted that eview. dietary low 1/01. adequacy ed or that e protein ote was e was not ocumented pressure ulcer ues ented e of or had on 9/10/01 dence that der was de to eng. Also, commended	F 325				
	a multi-vitamin with		idence mat					

On 4/25/02, a quarterly nutrition progress note was completed by the dietary manager. The note was not

DEPARTMENT OF HEALTH AND HUMA ERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		A. BUILDING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		465082		B. WING		11/	/5/2002	
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	TIEW CARE CENTER		1053 WEST PROVO, UT	1020 SOUT 84601	`H			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES ' MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
F 325	documented that residulcer to her coccyx a experienced significat months. The dietary resident 21 was receifor 12 hours. The tula a telephone order dat receiving 200 cc of we 240 cc of cranberry j powder each day. Recalculated and her programs. When the protein provided by and three scoops programs of protein 21. This was 6.4 grashe was estimated to not meeting her estimated to not meeting her estimated to meeting her estimated to not meeting her estimated to not meeting her estimated to mot meeting her estimated to meeting her estimated to meeting her estimated to be manager documented evolves obtained on 9/ addressed. There was recommendations were estimated to be manager documented 1335 calories, a difference would have the registion of 5/7/02, 12 days la completed a dietary gethat resident 21's weithad a stage II on her	ered dietitian. The note dent 21 had a stage II pand that resident 21 had ant weight loss over the manager documented twing Compleat at 104 cope feeding had been cheed 3/12/02. She was a vater three times per dautice a day and 3 scoope esident 21's nutritional otein needs were estimated at 104 cc for the intervent was determed as protein than the need per day. Resident at 104 cc an hour for 12 in provided by the protein needs what 104 cc an hour for 12 in provided by the protein day. It was documented by the protein that the low alb 10/01 and 9/11/01 were son documented evidented that the tube feeding provided. She documented that the tube feeding process note. She documentered dietitian follow up the protein that the tube feeding process note. She documentered dietitian follow up the protein that the tube feeding process note. She documentered dietitian follow up the protein that the tube feeding process note. She documentered dietitian follow up the protein that the registered dietitorogress note. She documented by the protein that the tube feeding process note. She documentered dietitian follow up the protein that the tube feeding process note. She documentered dietitian follow up the protein that the tube feeding process note. She documentered dietitian follow up the protein that the process note. She documentered dietitian follow up the protein that the tube feeding process note. She documentered dietitian follow up the protein that the tube feeding process note. She documentered dietitian follow up the protein that the tube feeding process note. She documentered dietitian follow up the protein that the tube feeding process note. She documentered dietitian follow up the protein that the tube feeding process note. She documentered dietitian follow up the protein that the tube feeding process note.	past 6 hat the per hour anged per diso y (600 cc), s of protein needs were ated to be the 12 hours mined that to resident to resident to 78 grams t 21 was tile hours plus in powder tinued to tumin the protein dorie needs tary provided which was ted that she p. tian tumented d that she nted that	F 325				

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

	T OF DEFICIENCIES OF CORRECTION	I(A) TROVIDERSOTTEIER (LIA		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE COMPL	
		465082		B. WING		11	/5/2002
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STAT	E. ZIP CODE		<u> </u>
CRESTV	TIEW CARE CENTER		1053 WEST PROVO, UT	1020 SOUTH ` 84601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES ' MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
F 325	She recommended a c formula resident 21 w designed "for healing	g/dl obtained in Septem change in the tube feed was receiving to one wh and protein repletion"	nber 2001. ling nich was	F 325			
!	completed a second d documented that the r change resident 21's t that she had experienc changed. She docume	ter, the registered dieti lietary progress note. So nursing staff did not wan ube feeding because of ced before when the for ented, "we do need to it ight of skin breakdown."	She ant to f problems rmula was increase				
	re-certification orders documented evidence	cian telephone orders as was completed. There that measures where to rovided to resident 21 v	e was no aken to				
	dated 6/4/02, an annual completed by the dieta co-signed by the regist documented that resid Compleat at 104 cc perfree water, 3 scoops of cranberry juice daily was resident 21 continued dietary manager made the registered dietitian change resident 21's to calculated resident 21's to calculated resident 21's and documented that to was only providing 53 grams less than resideng grams. When the surv	after the registered dietical nutrition assessment ary manager. The note tered dietitian. It was lent 21 continued to receive hour for 12 hours wife for tered powder and 2 via her g-tube. It was now with 2 "open areas". It has a made on 5/7/02 which tabe feeding formula. So so protein needs to be 9 the current tube feeding forms of protein, this not 21's estimated needs the tat 104 cc/hour for 12.	was was not ceive th 600 cc 40 cc of noted that The ation that n was to She 00 grams g regimen was 37 s of 90 protein				
	provided by Compleat	rey team calculated the at 104 cc/hour for 12 covided by the protein p	hours plus				

PRINTED: 11/12/20

DEPARTMENT			TCES		_	FOR!	M APPROVE 2567
CENTERS FOR STATEMENT OF DEF AND PLAN OF CORR	ICIENCIES	& MEDICAID SERVIO	/CLIA	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE S COMPL	
		465082		B. WING		11.	/5/2002
NAME OF PROVIDE	OR SUPPLIER		STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
CRESTVIEW C			1053 WEST PROVO, U	ST 1020 SOUTH UT 84601			
(X4) ID PREFIX (TAG R	EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(N5) COMPLETE DATE
was deproving the 90 would receive even protein she with album. Per right draw. On 8 assess stage document do	ded to resident of grams she wand not meet her eving. Compleat with the addition powder. The vould talk with ent 21's tube fernin level be drawn on 8/6/02, 12 /15/02, the registered with the entitle of the mented evident in level of 2.9 mented that residing 139 gramment on 12 hours as of protein powders of protein powders of 99 grams. In mendation to compleat at 118 survey team calcided by Compleated the protein powders of 12 hours of 13 hours of 14 hours of 15 hours of	71.6 grams of protein value 21. This was 18.5 grams is estimated to need. Restimated protein needs at 104 cc an hour for 1 and protein provided be dietary manager documents about a possible ding and would request with.	ms less than esident 21 s while 2 hours by the amented that le change in st an level was leted an 21 had a re was none low 12. She was leted her larvey team eat at 104 letin provided that 71.6 let	F 325			

in the tube feeding formula. There was no documented evidence that other recommendations

CMS-2567L

provided to resident 21. This was 20 grams less than her calculated needs of 99 grams. Resident 21 would not meet her estimated protein needs with the increase

Event ID:

_	S FOR MEDICARE	& MEDICAID SERVI	CES			TOK	2567_
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER SUPPLIER IDENTIFICATION NUM	/CLIA	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	SURVEY
		465082		B. WING			/5/2002
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATE	E, ZIP CODE		
CRESTV	IEW CARE CENTER		1053 WEST PROVO, U	Г 1020 SOUTH Т 84601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO THI	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
F 325	21. The dietitian recohelp meet nutritional A telephone order, d documented to incre	se the protein provided ommended a vitamin/m needs. ated 8/27/02, 12 days lase the Compleat tube for the start the	ineral to ater, feeding to	F 325			
	On 8/20/02, resident resident 21 had an "a low at 2.9". The documentation consult to retube feeds". A review of all nurse 10/29/02. On 8/20/0	in progress notes was con 21's doctor documente albumin level which was cor recommended "obtonake sure we are maximes" notes was completed 22, the nurse documented.	d that s slightly aining a nizing her on d that	,			
	recommended a "nut protein/albumin leve	had been in to see her the trition consult to maximals. Note left for [dietan [doctors] new orders."	nize ry manager]				
	completed a nutritio "continue [with] TF was no documented aware of the low alb There were no documented	rs later, the registered d n note. She documente [tube feeding] as order evidence that the dietiti numin level obtained on mented recommendation resident 21 was receiving	d, ed." There ian was 8/6/02. ns made to		•		
	Facility weight and stollowing:	skin meetings documen	ted the	:			
	nutritional risk relate	1 was identified as being to a recurrent stage I occyx and being tube fe	I				

cause was documented as, "Feeding needs adjustment for healing, repletion and nutrient maintenance". The

CENTED	S FOR MEDICARE	& MEDICAID SERVI	CES				2567
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	/CLIA	A. BUILDING	CONSTRUCTION	(X3) DATE COMPL	
		465082		B. WING		11	/5/2002
NAME OF PR	OVIDER OR SUPPLIER	10000	STREET ADDI	RESS, CITY, STATE	E, ZIP CODE	-	
	IEW CARE CENTER		1053 WEST PROVO, U	T 1020 SOUTH T 84601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
F 325	Continued From page documented recomn feeding formula to Is	nendation was to change	e the tube	F 325			
	re-certification orde	ician telephone orders are did not evidence that change resident 21's tubented.	the				:
	nutritional risk relat breakdown on coccy The cause was docu adjustment for heali maintenance. No lat recommendation was formula to Isosourc was, "[resident 21] formula".	as to change the tube fer e VHN. Hand written can only tolerate Comp	II ube fed. seds ent eding on this form leat	, where the second seco			
	re-certification order recommendation to formula was impler	sician telephone orders ers did not evidence tha change resident 21's tunented. There was no perate of the current tubbeing provided.	t the be feeding bhysician	,			
	nutritional risk rela resident and having her knee and coccy	I was identified as bein ted to weight loss, being recurrent stage II bream. The recommendationmmended last month	g a tube fed kdown to on was	·			
	re-certification ord	vsician telephone orders ers did not evidence that o change resident 21's to	it the				

April 2-3, 2002: The following was documented,

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

AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465082	CTDECT + DD	RESS, CITY, STAT	CE ZIP CODE	1 13	1/5/2002
	ROVIDER OR SUPPLIER IEW CARE CENTER			1020 SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES (MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI (ROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
F 325	pre-albumin to the ca correct this?" A review of all physic re-certification order	ed dietitian consultant] are plan. What is our p cian telephone orders a s did not evidence that ere implemented which	lan to and any	F 325			
	documented the follo offer this resident a l The Compleat just d	report, dated May 7, 2 owing, "Again I sugges high protein formula fooes not offer the nutriere". An alternative form	t that you r healing. nts that she				!
	re-certification order	ician telephone orders a s did not evidence that change resident 21's tub ented.	the	\			
	documented the folloadequate protein for	report, dated June 4, 2 owing, "Resident is not healing and repletion. tein in the current form	receiving Suggest	•	÷		
	re-certification order	ician telephone orders is did not evidence that change resident 21's tul mented.	the				•
	resident 21 was revi	no documented evider ewed by the skin and w d resident 21 was "start	eight team.				
	(?) looking better".	sician telephone orders	!				i .
		6/6/02, the physician of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER SUPPLIE IDENTIFICATION NU			A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	465082		B. WING		11	/5/2002
NAME OF PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, STAT	TE, ZIP CODE		
CRESTVIEW CARE CENTER		1053 WES PROVO, U	T 1020 SOUTH JT 84601	I		
PREFIX : (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(XS) COMPLETE DATE
healing) 500 mg twice was to be re-evaluate 6/25/02: "got order thealing skin is improvement". 7/9/02: "Arginade stimprovement". 7/16/02: "Wt stable, for arginaide". 8/1/02: minutes doct No recommendations resident 21. 8/9/02, 9/2/02, 9/9/0 no documentation the weight and skin team continued with a dechad an albumin level 10/11/02: Resident 2 there were no docum specific to her. 10/14/02 and 10/24/0 by the team. 2. Resident 10 was a the facility on 10/2/9 organic brain syndro obstructive pulmona record, on 5/9/02 res stasis ulcer on her le	cid thought to help with a day for I month. To dafter a month. for arg. [arginine] to priving. arted, bottom showing skin improving and showing arted. When the swere documented specific a despite documentation when the swere documentation are swere documentation. The same was written diented recommendation as the swere documentation are swere documentation. The same was written diented recommendation as the swere documentation are swere documentation. The swere documentation are swere documentation are swere documentation are swere documentation. The swere documentation are swere documentation are swere documentation are swere documentation. The swere documentation are swere documentation are swere documentation are swere documentation. The swere documentation are swere documentation are swere documentation are swere documentation. The swere documentation are swere documentation are swere documentation. The swere documentation are swere documentation are swere documentation are swere documentation. The swere documentation are swere documentation are swere documentation are swere documentation. The swere documentation are swere documentation are swere documentation are swere documentation. The swere documentation are swere documentation are swere documentation are swere documentation. The swere documentation are swere documentation are swere documentation are swere documentation. The swere documentation are swe	che wound omote signs of he has order patients". cific to here was ewed by the n that she cyx and n 8/6/02. Sown but his made ht reviewed htmitted to ding chronic dical ttage II	F 325			
On 10/28/02, resider reviewed.	nt 10's medical record v	was				

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

TATEMENT OF DEFICIENCIES (X1) PROVIDER SUPPLIER IDENTIFICATION NUM		/CLIA /BER:	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	COMPLI	(X3) DATE SURVEY COMPLETED		
			465082				11/	5/2002
NAME OF PR	OVIDER OR SUPPLI	ER			RESS, CITY, STATE	E, ZIP CODE		
	EW CARE CEN			1053 WES PROVO. U	T 1020 SOUTH T 84601			
(X4) ID PREFIX TAG	(FACH DEFIC	TENCY	ATEMENT OF DEFICIENCIE / MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 325	Continued From	page 1	18		F 325			
!	"Weight Chang	e His	10's weights, documentory" form and provide 0/02, were as follows:	nted on the ed to the				
	9/26/01 10	01 poi	unds.		:			
	10/26/01 96 weight loss of	6 pou 5 poui	nds. This represents a nds, or 5% in 30 days.	significant				
	11/26/01 9	4 pou	nds.		!			
	12/26/01 9 weight loss of	3 pou 8 pou	nds. This represents ands, or 7.9% in 90 day	significant s.	! !			
	1/26/02 9 2/12/02 9 3/5/02 4/23/02 9 5/7/02 5/20/02 9 5/28/02 6/3/02 6/10/02 16/17/02 9 6/25/02 9 7/1/02 significant we	7.5 pc 7.7 pc 97.5 pc 97.5 p 97.5 p 97.5 p 97.5 p 95.5 p 9; ight le	ounds. ounds. ounds. ounds. o pounds. ounds. ounds. ounds. sounds. sounds. ounds. ound	in 30 days.				
	7/15/02	91.5 p	oounds. This represent oss of 6 pounds, or 6%	ts a	:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER SUPPLIER CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465082		<u> </u>		11/5/2002	
NAME OF PR	OVIDER OR SUPPLIER			ESS, CITY, STATE.	. ZIP CODE		
CRESTVI	EW CARE CENTER		1053 WEST PROVO, UT	1020 SOUTH 84601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	'LD BE COMPLETE	
F 325	Continued From page l days.	19		F 325			
į	9/2/02 90 9/23/02 91 pour 9/30/02 88.5 po	ounds.					
		nds. This represents a nds, or 5.5% in 30 days					
	10/23/02 89 pour 10/29/02 95.5 po 11/5/02 93.5 po	ounds.		ı			
		w of resident 10's lab owing levels were doc		**			
	10/11/01 pre-albumir reference range 17-4 7/2/02 albumi range 3.3-4.8 g/dl.)	2 mg/dl.)	ormal	•			
	orders was complete	: 10's physician re-certi d. She was ordered a ith a house supplemen	mechanical	•			
	interviewed. She was consisted of. The di- receiving an enriche morning with extra lathe food served as a the house supplement supplement consiste mixed with one gallate team calculated that	PM, the dietary manages asked what an enrich letary manager stated to diet received super courter, gravies and saud ppropriate. She was as nt. She stated that the d of 1 can of Forta sha on of whole milk. The 113.5 calories and 7.3 ovided in a 4 ounce ser	ned diet hat anyone ereal in the ces added to ked about house ke and survey grams of				

DEPARTMENT OF HEALTH AND HUM SERVICES

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CENTER	S FOR MEDICARE	& MEDICAID SERVI	CES				<u> 2567</u>		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER SUPPLIER IDENTIFICATION NUM	/CLIA	(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION	(X3) DATE COMPL	ETED		
		465082		D. WING _		11.	/5/2002		
NAME OF D	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	TATE, ZIP CODE				
			1053 WEST 1020 SOUTH						
CRESTV	IEW CARE CENTER		PROVO, U	T 84601					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE LENCY)	COMPLETE DATE		
F 325	with resident 10's carasked how much hourselved. They both ounces three times a would drink 100% of Resident 10's MAR's records) for July 200 and October 2002 de 100% of the house s	PM, two facility nurses re were interviewed. The use supplement resident a stated that she was gived ay with meals and that if what they offered. It is (medication administration), August 2002, Septe occumented that she controlled.	they were to 10 ten 4 te	F 325					
	assessment. Resider pounds and it was denriched mechanica of her meals. It was	ary manager completed int 10's weight was reconcumented that she recoll soft diet and consumes documented that dietaen discontinued. The retered dietitian.	rded at 101 eived an ed 50-80%	,					
	quarterly nutrition a was documented at documented that thi past 6 months. Whe weight change, it was in three months from to 93 pounds in Designificant. The dies 10's meal intakes, owere 40% at breakf supper. She further received a house succonsumed 100%. (**	etary manager complete assessment. Resident 1 93 pounds. The dietar is was a 7% weight loss en the survey team calculates noted to be a 7.9% with 101 pounds in Septer cember 2001, which was etary manager document of a mechanical soft enreast, 40% at lunch and 3 redocument three times a This contradicted her puned the dietary supplement the dietary supplement three times a This contradicted her puned the dietary supplement three supplement three times a This contradicted her puned the dietary supplement three supplement three times a This contradicted her puned the dietary supplement three times a	O's weight y manager sover the culated the weight loss mber 2001 as need resident iched diet, 30% of lent 10 day and rior note						

dietary manager documented the low pre-albumin

DEPARTMENT OF HEALTH AND HUM. SERVICES

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CENTER	S FOR MEDICARE &	& MEDICAID SERVIO	CES			 	2307
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUM	/CLIA	(X2) MULTIPLE O	CONSTRUCTION	(X3) DATE SU COMPLET	
				B. WING		11/5/	/2002
		465082		The second second	ZID CODE	11/3/	2002
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STATE,	ZIPCODE		
CRESTV	TEW CARE CENTER		1053 WEST PROVO, U	1020 SOUTH F 84601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
	documented evidence needs, including calce re-calculated after reweight loss or a low documented evidence attempted to increase protein provided in a not co-signed by a reconstruction assessment documented at 96 per documented at 96 per documented resident mechanical soft enrich 40% of lunch and 3 documented that ressupplement three times are the supplement three times are documented evidented at 10 per albumin lever not documented evidented to increase in resident 10's diet dietitian. On 5/7/02, the region nutrition note. She cellulities of the ank documented that reservicially low on "we are doing what Maintain plan." Tile	btained 10/11/01. The e that resident 10's nutropie and protein needs, sident 10 experienced spre-albumin level. The e that interventions were the amount of calories resident 10's diet. The egistered dietitian. Ary manager completed and ary manager completed and the egistered dietitian. Ary manager completed and the egistered diet, were 40% at 20% of supper. She furtified that 10's meal intakes, of a ched diet, were 40% at 20% of supper. She furtified that 10 received a hour mented evidence that red been re-assessed second elemented that interventions are the amount of protein. The note was no cost stered dietitian completed documented that reside the and was eating poort sident 10's pre-albumin 10/11/01. She further of the energy of the further of the energy of	itional were significant ere was no re s and note was l a quarterly was nager t breakfast, her use d 100%. sident 10's ondary to the There was to were n provided highed by the led a ent 10 had ly. She hevel was documented, t healing. ed	F 325			
	On 6/17/02, the die	etary manager complete ent. She documented	ed a quarterly that resident				

10 disliked milk, however, she liked the can milk her

Facility ID:

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

STATEMENT	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER SUPPLIER IDENTIFICATION NUM		A. BUILDING	CONSTRUCTION	(X3) DATE COMP	
		465082		B. WING		11	/5/2002
NAME OF DD	OVIDER OR SUPPLIER	10002	STREET ADDR	RESS, CITY, STATE	E, ZIP CODE		
	IEW CARE CENTER		1053 WEST PROVO, U	: 1020 SOUTH Г 84601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED FO T DEFICIENC	TON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
F 325	Continued From page family provided. It ice cream for breakf her diet.	22 was documented that shat and lunch to increas	ne was sent	F 325			: :
	nutrition note. She was 88 pounds and to significant weight lo documented that resulter on her left and resident 10 consumers.	stered dietitian comple documented resident 10 that she had experience ass of 10% in 2 months. ident 10 had a stage II le. It was documented and 30-50% of her meals	o's weight d She pressure that and 100%	:			
	address resident 10's obtained on 7/2/02, evidence that reside calorie and protein	ment TID. The dietitian is low albumin level of There was no docume nt 10's nutritional need needs, were re-calculate	2.9 g/dl nted s, including ed after	,			
	albumin level. The that interventions w	nced significant weight I pressure ulcer and had re was no documented rere attempted to increa and protein provided in	I a low evidence se the	\			· :
	nutrition note. She	istered dietitian comple documented that reside gram (kg) weight incre	ent 10 had ase since		s'		İ
	that she consumed She documented "o [patient] meet kcal	r meal intakes were 10- 100% of the house sup- consider TF [tube feeding pro [calorie/protein] no	plement. ng] to help pt eeds." There				: ! ! !
	nutritional needs, is were re-calculated	I evidence that resident neluding calorie and pr after resident 10 develond nd had a low albumin le	otein needs, oped a stage				:
	was no documented attempted to increa protein provided in	d evidence that intervent use the amount of calor in resident 10's diet prior wasive recommendation	ntions were ies and r to the	:			1

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			A. BUILDING	CONSTRUCTION	(X3) DATE S COMPL	ETED
	465082		B. WING		11,	/5/2002
NAME OF PROVIDER OR SUPPLIER	<u> </u>	STREET ADD	RESS, CITY, STATE	E, ZIP CODE		-
CRESTVIEW CARE CENTER		1053 WEST PROVO, U	T 1020 SOUTH T 84601			
(FACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
F 325 Continued From page	23		F 325			
A nutrition care plandocumented that resideficits related to a intakes. One documents problem was the weight of 97.5 pour next review and that protein and calcium. Approaches include with meals and assident. There was not enriched diet or a homomention that resignificant weight I developed a stage I. A review of the fact as completed. The documented: On 6/18/02 and 6/2 as having been review or recommendations medical record, should also a stage I. 7/9/02: It was documented that residual record in the offer. There were made to increase to the rewas nothing significant weight from June 2002 to she had a stage II.	n, which was not dated, sident 10 was at risk for history of weight loss at resident 10 would mands within 5 pounds through the sources due to not liking a staff would assist resist as needed and be encomention of resident 10 rouse supplement TID. ident 10 had experience oss, had low albumin led ulcer on her left ankle weight skin meetifollowing regarding resident 10's namiewed but there were not made specific to her. Por had a stage II ulcer on the had a low albumin led sat at an assist table, esident 10 had a low albumin led sources where no documented that resident 10 had a low albumin led sat at an assist table, esident 10 had a low albumin led sources where no documented recombe protein in resident 10 documented which add loss resident 10 had expulcer on her left ankle.	nd poor it to address sintain her bugh the rnative ing milk. ident 10 ouraged to ecciving an There was id a vels and ident 10 was ident 10 ident				

DEPARTMENT OF HEALTH AND HUM. **BERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/12/20 FORM APPROVE 2567

		(X1) PROVIDER SUPPLIER IDENTIFICATION NUM		A. BUILDING	E CONSTRUCTION	(X3) DATE COMPI	
		465082		B. WING		11	/5/2002
NAME OF D	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
	IEW CARE CENTER		1053 WES PROVO,	ST 1020 SOUTH UT 84601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE. Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL.	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 325	interventions were in	24 not evidence any nutri nplemented which wou ein in resident 10's diet	ld increase	F 325			
	sleeping more and n documented which a loss resident 10 had	umented that resident 1 nore. There was nothing addressed the significan experienced from June nedical record, she had le.	t weight 2002 to				
	recommendations w	all patients" was docum ere documented specifi medical record, she ha de.	c to				
	no recommendation	o's name was listed but is were documented spe medical record, she had tle.	cific to				
	recommendations w	all patients" was docur vere documented specif e medical record, she ha de.	ic to	•	, i		
	9/9/02: Resident 10 reviewed.	was not on the list as h	aving been				
	was listed but there documented specifi	d 10/11/02: Resident : were no recommendat c to resident 10. Per th age II ulcer on her left	ions e medical				
	experienced a 7# (prefuse meals and do Recommended to the	ocumented that resident bound) weight loss, wor rank the house supplem ry finger foods and cha for 1 meal to see if she	ıld often ent. nge to a				

Facility ID:

		AND HUME SERVI			. <u></u>		2567
	 -	<u>& MEDICAID SERVI</u>	<u> </u>			(X3) DATE SURVEY	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION		COMPLETED	
AND PLAN O	OF CORRECTION	IDENTIFICATION SCS	IDEN.	A. BUILDING B. WING			
		465082				11/	/5/2002
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STAT			
CRESTV	IEW CARE CENTER		1053 WEST PROVO, U	Г 1020 SOUTH Т 84601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
F 325	Continued From page 2	25		F 325			
	10/24/02: Resident been reviewed.	10 was not on the list a	s having				
	On 10/28/02 and 10/ were not observed to	729/02, resident 10's lun consist of finger food	nch meals items.				
	10/31/02 at approxing was not familiar with was a record that she	the registered dietitian mately 4:00 PM, she stand the resident 10 and she fee had not yet fully assent the facility (this dietize).	ated that she at this ssed since				
	facility on 6/20/02 v	a 79 year old male adn vith diagnoses includin ent disorder, profound kness.	g decubitus	Ì			
	On 10/31/02, reside reviewed.	nt 20's medical record	was				
	Assessment", dated	t 20's "Initial Nursing 6/20/02, documented the facility with 3 stage	hat resident : II	•	;		
	manager completed which documented	after his admission, the an initial dietary assess resident 20 was 66" (5 ds. The diet ordered w	sment, '6") tall and				
	A review of resider documented on the	nt 20's admission weigh "Record of Vital Signs	it, s and				

team on 10/30/02, were as follows:

Weights" form, which was not dated, revealed that he weighed 152 pounds upon admission. A review of resident 20's weekly weights, provided to the survey

Event ID:

	C COD MEDICADE (CES				2567
CENTER	S FOR MEDICARE &	<u>& MEDICAID SERVIO</u> I		1	<u>, </u>		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		A. BUILDING	CONSTRUCTION	(X3) DATE S COMPLI	
		465082		B. WING		11/	5/2002
		403082	STREET ADDR	ESS, CITY, STATE	. ZIP CODE		
NAME OF PR	ROVIDER OR SUPPLIER			1020 SOUTH			
CRESTVI	IEW CARE CENTER		PROVO, UT				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
	Cartinual From page 5	76		F 325			
F 323	Continued From page 2			1 323			
	6/25/02: 149.5 p						
		2 pounds.					
		3.5 pounds.					
	7/15/02: 149.5 p						
	7/23/02: 147.5 p	oounds.			·		
	8/6/02: 12	7 pounds. This represe	ente a				
		r pounds. This represense of 20.5 pounds, or 1					•
	_	ss of 20.5 pounds, or r	J. J / 0 III 1 4				
	days.						
	8/28/02: 127 po	unds.			•		
	_	6 pounds.					
		7 pounds.					
	9/23/02: 127.5 p						
		oounds.					
	-	oounds.					
		0.5 pounds.		3			
		1.5 pounds.		:			
İ		0 pounds.					
		pounds.					
	(1/5/02. 150.5)	poulius.					
	record which attemp	nented evidence in the stated to explain the large red from 7/23/02 to 8/6	weight	•	;		
	manager on 6/24/02 eating less than 50% II pressure ulcers an would eat toasted ch The dietary manage been sending toaster regular meal. The d 20's calorie and pro- protein needs to be weight of 152 pound grams of protein to	sessment, completed by documented that reside of a regular diet, that had that his care giver states and car indicated that the kited cheese sandwiches allietary manager calculate in needs. She calculate in needs. She multiplieds in kilograms (69 kg determine this. This needs	hent 20 was he had stage ated that he corndogs. chen had ong with his ated resident ated his ied his by 1.1 ote was not				
1	co-signed by the reg	gistered dietitian. Ther	in among the				

documented interventions implemented to increase the

CENTER	S FOR MEDICARE	& MEDICAID SERVI	CES			2307	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	/CLIA	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/5/2002	
		465082		TEGO CITY STATE	ZIR CODE	11/5/2002	
NAME OF PI	ROVIDER OR SUPPLIER			RESS, CITY, STATE.	, ZIF CODE		
CRESTV	IEW CARE CENTER	ļ	1053 WEST 1020 SOUTH PROVO, UT 84601				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO) (PROSS-REFERENCED TO THE APPRODEFICIENCY)	ULD BE COMPLETE	
F 325	meal intakes with me This note was no co- On 10/31/02, the fact an interview that with ulcers she would use kilogram to help pro- 6/27/02, the dietary note. She document experienced no change	a resident 20's diet desputiple stage II pressure signed by the registere dility registered dietitiar ha resident with multipe at least 1.5 grams of promote healing. manager completed a med that resident 20 had ages. This note was not	d dietitian. n stated in ple pressure protein per	F 325			
	note. She document corn dogs or toasted a regular diet, that h that he continued wi a supplement BID (to increase protein a multi-vitamin with z interventions were r resident 20 was adm	ary manager completed ted that resident 20 was a cheese sandwiches in a sis meal intakes were 40 ith open areas. She rectwice a day) and high pland promote healing and rinc and vitamin C. The ecommended 28 days a nitted to the facility with leers. This note was no	s offered addition to 0-60% and ommended wrotein milk d a ese after h multiple				
	telephone order for C, a house supplem protein milk TID w	s later, there was a physical multi-vitamin with zincent BID after meals and ith meals. This was 40 mitted to the facility with	nc, vitamin d high days after			· : :	
	that the house supp zinc and vitamin C	AR for August 2002, do lement BID, multi-vitar were not started until 8	min with 8/9/02, 10			I	

after resident 20 was admitted to the facility.

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

PRINTED: 11/12/20 FORM APPROVE 2567

		(X1) PROVIDER SUPPLIER IDENTIFICATION NUM		A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465082		B. WING		11	/5/2002
NAME OF P	ROVIDER OR SUPPLIER		l .	ESS, CITY, STATE	, ZIP CODE		
CRESTV	TEW CARE CENTER		1053 WEST PROVO, UT	1020 SOUTH F 84601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX FAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
F 325	Continued From page	28		F 325			
	nutrition note. She of 150 pounds. The we	stered dietitian comple documented resident 20 eight history record doc as 127 pounds. There se th	o's weight as cumented				
	admitted to the facil of insulin dependent fibrillation, dementi	a 79 year old male who ity on 5/27/99 with the t diabetes mellitus, atrica, organic brain syndro lure, venous insufficients.	diagnoses al me,				
	comprehensive asset by facility staff, wit 8/20/02, documente making skills were	m Data Set), a mandato ssment of the resident of the assessment refere that resident 45's dec moderately impaired, he he needed supervision	completed nce date of dision e did not	1			:
	The weights for res record, documented	ident 45, kept in his me I the following:	edical	•	ş'		
	The second week of J The third week of J The first week of Ju	ane 2002 - 153.5 pound f June 2002 - 148.5 pou fune 2002 - 147.5 poun aly 2002 - 145.5 pound f July 2002 - 145 poun	unds ds s				
	fractured his elbow	fuly 2002 - The residen Nurses notes (7/18/0 bruised and edematous unds.	2) record "L				
	document "Pt's (pa	f July 2002 - Nurses no tient's) L arm is still ed Weight recorded at 143	ematous but				

6НІР11

Event ID:

Facility ID:

DEPARTMENT OF HEALTH AND HUM. SERVICES

CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER IDENTIFICATION NUM	/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			X3) DATE SURVEY COMPLETED	
		465082		B. WING _			11/	5/2002
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDR			, ZIP CODE		
	IEW CARE CENTER		1053 WEST PROVO, UT	1020 SOU F 84601	TH			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	!	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 325	Continued From page	29		F 325				
	The first week of Au The first week of Se	ngust 2002 - 135 pound eptember 2002 - 134.5 p	s Sounds					
	experienced a 12% is significant. As of experienced a weight which is significant in the medical reconveight loss, was 11 (within normal limit on 9/24/02, after the June and Septembe which reflects a mildepletion. Also duresident 45 was four the nurse's notes de	of August 2002, reside weight loss in two mon a September 2002, resident loss of 12.37% in 3 m. The last albumin levered of resident 45, prior of 10/01 and was found to the significant weight loss of 2002, and was found to moderate visceral ring this time period, or and to have a pressure sescribe as "1.5 cm (cent low in color, bad odor."	ths, which lent 45 had months, l recorded to the o be 3.4 was obtained is between to be 2.8 protein 1 8/3/02, ore which imeter) in					
	record on 5/20/02. documented within resident 45 until 8/should have identify significant weight (by the dietary markets). It did docum sandwich and 8 oz milk as 3 PM snach unch and dinner in	note was entered into the No additional entries of the dietary progress not 19/02, 19 days after the field this resident as have loss. The dietary note of the dietary	were otes for e facility staff ing a of 8/19/02 ny weight ered cheese (protein) andwich at e trayis also	•				
	a dietitian on 8/19 assessment comple it was noted that s	refer to an assessment of 702. During review of the ted by the registered during he had not addressed and ghout this time resident	the ietitian (RD), ny significant					

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2567 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 11/5/2002 465082 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1053 WEST 1020 SOUTH CRESTVIEW CARE CENTER PROVO, UT 84601 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 325 F 325 Continued From page 30 12% in two months. The RD had addressed a stage 1 pressure sore to the ulna of resident 45, but had not addressed the nurse's note of 8/15/02 which documented that resident 45 "still has stage 2" pressure sore on his left hand. The RD recorded the weight of resident 45 to be 143 pounds. It is unknown where the RD took this information as the last recorded weight in the medical record for resident 45 was the first week of August 2002 and was documented as 135 pounds. No other weights were recorded in August 2002. The RD did recommend a "MVI (multivitamin) with zinc and vit (vitamin) C 500mg for healing skin breakdown." There was no documentation that facility staff pursued this recommendation with the physician until 9/13/02, almost a month later, when a nurse's note documented, "Per dietary recommendation Dr. faxed with request for multiple vitamin with zinc and vitamin C 500 mg." Resident 45 did not begin receiving the multiple vitamin with zinc and vitamin C until 9/17/02. Also on 8/19/02, facility staff documented on the "Total Care Plan" quarterly update the following regarding resident 45: "wt. (weight) stable - at assisted table - gets extra food - fair appetite." In the August 2002 "Monthly Summary and Assessment of Nursing Care Needs" for resident 45, the nurse documented "weight last month 143.5" and "current weight 13,5". Under this section regarding weight, the nurse was prompted to answer four printed questions. The first question asked whether there had been a weight loss or gain greater than 5% in the last 30 days. The nurse circled "yes" regarding this question. The next question asked if there had been a weight loss or gain greater than 10% in the last 180

days. The nurse did not document an answer to this question. The third question asked whether new

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

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER SUPPLIER IDENTIFICATION NUM	/CLIA	A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465082		B. WING		11/	5/2002
NAME OF BR	ROVIDER OR SUPPLIER	403002	STREET ADD	RESS, CITY, STATE	, ZIP CODE		
	IEW CARE CENTER	.	1053 WES' PROVO, U	T 1020 SOUTH T 84601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
	Continued From page physician orders we document an answer question asked "Nu nurse did not document and formation was lower for the month of July information was lower for the month of Aless at 59 of the 93 documentation for For the month of Sor less at 43 of the documentation for The medical record have a problem with note documents "If then spit food." During interview aide who took cardrank better than The nurse stated that it (resident 45) spits. The next progress The RD did not medical necessary with the spit food."	ere given. The nurse did refer to this question. The rising/dietary conference ment an answer to this question and the second at 45's meal intake percented on ADL flow sheet ally 2002, resident 45 attemets. There was no mine of the meals. August 2002, resident 45 meals. There was no two meals. There was no two meals. There was no two meals. There was no two meals. There was no two meals. There was no two meals. There was no two meals. There was no two meals. There was no two meals. There was no two meals. There was no two meals. There was no two meals. There was no two meals. There was no two meals. There was no two meals. There was no two meals. There was no two meals. There was no two meals. There was no two meals. There was no two meals.	I not fourth ge?" The uestion. Intage was 2002. This et. 2 40% or ate 40% or ate 40% or t 45 ate 40% cent 45 did, a nurse's less to chew the and an lated that he deat his food well". The chat he decigned to so of	F 325	DEFICIENCY		
	the previous seve low albumin of 2	ral months, nor did she is 8 from 9/24/02. The Riotein and calorie require on his recent significan	mention the D did not ements of				

CENTERS	FOR MEDICARE &	& MEDICAID SERVIC	ES	T			2307
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUM	CLIA	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SU COMPLE	
		465082				11/2	72002
	OVIDER OR SUPPLIER EW CARE CENTER			ESS. CITY, STATE. 1020 SOUTH 6 84601	ZIP CODE		
(X4) ID PREFIX	SUMMARY ST.	ATEMENT OF DEFICIENCIES (MUST BE PRECEEDED BY I SC IDENTIFYING INFORMAT	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
1/ 325	enrichment to orders (nutritional) suppl. (day)." These recome after resident 45 had loss. The nutritional suppimplemented for an give it on 10/29/02 at the NAR (nutrition document the follow 6/18/02 - "wt. stable 6/25/02 - "he reques Sitting at rehab table 7/9/02 - "Broke his stable for 6 wks (we from NAR." At the lost 8 pounds since Resident 45 was no nutrition/skin meets when staff writes himotes. Another not resident 45 "medple nutritions as pressure sore resident 45 medple nutritional aspects pressure sore resident weight loss of 5% or more in the last accurate and would	the RD did document "ac. Consider denser nutr. supplement) tid (three timendations were made experienced significant lement three times a day additional 5 days. Staff at 5:00 PM. at risk)/skin committee ving for resident 45: at for the last 3 weeks." at scheese sandwiches at e." elbow, wts (weights) have eks) now. Team wants time of this note, reside the first week of June 2 time the first week of June 2 time down, but no ace, on 10/24/02, docume us 2.0" It should be not not the first week of June 2 time the first week of June 2 time address were needed for the stagent 45 acquired on 8/3/6 assessment reference deed that resident 45 had for more in the last 30 days. This would a dagain support the above ting that facility staff weeking the support that the su	imes a 7 weeks t weight y was not f began to minutes t meals. ave been f to D/C ent 45 had 2002. e 10/11/02 dditional ched ted that this what ge 2 02. date of not had a ays or 10% not be ve	F 325			

	MENT OF HEALTH						M APPROVE 2567	
AND PLAN OF CORRECTION IDENTIFICATION NU		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER 465082	VCLIA (X2) MULTIPLE		CONSTRUCTION	СОМРІ	(X3) DATE SURVEY COMPLETED	
NAME OF PR	OVIDER OR SUPPLIER	ST	REET ADDRESS	, CITY, STATE	, ZIP CODE			
	IEW CARE CENTER	1 P	053 WEST 103 ROVO, UT 84					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FUI LSC IDENTIFYING INFORMATIO		ID REFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
F 325	registered dietitian fer through August 14th new dietitian were induring this time that weight. 5. Resident 16 was admitted to the facility of delirium, paraple pressure sores, and on a regular, low cowas discharged from readmitted to the factor of the metal performed on 10/30. The MDS, dated 9/was independent in himself. The MDS did not resists cares behaviors. Review of the weight revealed that no we admission. During 2002, staff record pounds. The next documented the se	ted that the facility was with from the first week of June in, 2002. (Assessments from the observed until 8/15/02.) a resident 45 lost most of his a 40 year old male who was lity on 9/12/02 with the diagra, urinary tract infection major depression. Resider oncentrated sweet diet. Resident the facility on 10/14/02 a cility. dical record of resident 16 moderate and 10/31/02. 25/02, documented that resident of the decision making and feed also documented that resident summary sheet for resident the weight of resident 16 to weight of resident 16 to weight of resident 16 was cond week of October 200 is a weight loss of 11.2% if	chout a 2002 m the lit was is as agnoses nt 40 was sident and then was sident 40 ing dent 40 ing dent 40	325				
	A review of the nu 9/12/02, reveals re	rsing initial assessment, da sident 16 was admitted wi	ated th					

Four of the pressure sores were a stage 4 (having black

Facility ID:

multiple pressure sores. The first entry onto the "Skin Care and Pressure Ulcer Record", dated 9/13/02, documents that resident 16 had seven pressure sores.

BERVICES DEPARTMENT OF HEALTH AND HUMA

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DELYKL	CEOD MEDICADE	& MEDICAID SERVI	CES				256/
				(Y2) MUI TIPLE	CONSTRUCTION	(X3) DATE	
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	IBER:	A. BUILDING		COMPLETED	
-				B. WING		11	/5/2002
_		465082			ZID CODE	11	1314004
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STATI	L, AII (UDL		
CRESTV	IEW CARE CENTER		1053 WEST PROVO, U	r 1020 SOUTH r 84601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
F 325	Continued From page	34		F 325			
323	ecsar), two of the pro	essure sores were at a s	tage 3 and				
	one was at a stage 2.						
	The Clinical Guide	Wound Care, Fourth E	dition,				
	Kathy Thomas Hess	, Springhouse Corporat	tion, 2002,				
	pg. 58, defines a stag	ge four pressure ulcer a	s "full				
	thickness skin loss v	vith extensive destruction	on, tissue				
	necrosis, or damage	to muscle, bone, or sur	port				
	structures." A stage 3 is defined as "full thickness skin loss involving damage or necrosis of subcutaneous			٠			
	tions involving dama	stend down to but not	through.		·		
	tissue, which may extend down to, but not through underlying fascia. The ulcer presents clinically deep crater with or without undermining of adjacents.						1
	tissue." Page 42 of	this reference book rea	ds, "The				
Ì	chief dietary treatm	ent goal for wound hea	ling is to	1			•
1	provide adequate ca	lories and protein to pr	comote	4			
ļ	anabolism and the b	ouilding of new tissue.	ine very				
	hest local and nursi	ng care will not heal we ce of sufficient nutrition	nal substrate				
	from which to build		INI JUDULIAN	:			
	Hom which to build	i new tissue.					
	A nutritional assess	ment of resident 16 wa	s performed				
	on 9/18/02. This w	as performed 6 days af	ter resident	•	•		
	16 was admitted wi	ith 7 pressure sores. Th	uis				
	assessment was per	formed by the dietary t	nanager and				
	not a registered die	titian (RD). The dietar	y manager	;			
	documented in her	assessment/progress no eight) or Wt (weight) in	chart "The				
	dietary manager die	d not obtain a weight w	ith which to	!			
	nerform her assessi	ment. The dietary man	ager did not	-			
1.	document an estim	ate of protein, calorie o	r fluid needs				
	of resident 16. On	the second page of the	dietary	i			
	assessment, the die supplement QID (f	tary manager documen	ts "house				
	During interview v	vith a nurse on 10/30/0	2, she stated				
	that the nurses pro	vide the nutritional sup	plements.				

A review of a physician visit note, dated 9/26/02,

6HIP11

Event ID:

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/12/20 FORM APPROVE 2567_

CENTERS FOR MEDICARE & MEDICAID SERVE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER SUPPLIER IDENTIFICATION NUM 465082		/CLIA 1BER:	A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/5/2002	
	ROVIDER OR SUPPLIER		STREET ADDR 1053 WEST PROVO, UT	1020 SOUT	ATE, ZIP CODE		
(X4) ID PREFIX TAG	X4) ID SUMMARY STATEMENT OF DEFICIENCING (EACH DEFICIENCY MUST BE PRECEEDED B) REFIX DEFICIENCY OR USC IDENTIFYING INFORM			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 325	During review of the Administration Reconfacility staff did not supplement until 9/2 nutritional supplement dietary manager and by the physician. It is supplement intaked that when staff begoing through the end of the matter progress notes write was no documentate evaluated resident been completed, the had been calculated resident 16 were been to the mutritional deficits for the rapeutic dientificational care pleased in the protein to bring all limits). The approach was documentation to albumin level to earlier there was no documentation to albumin level to earlier the protein to the protein to the protein to the protein to the protein to the protein to the protein to the protein to the protein to bring all limits approach was documentation to albumin level to earlier the protein to the pro	sician requested "Proteiny) - choc. (chocolate)". The September 2002 Med ord (MAR), it was note to begin providing the nutritional and the protein and calorie red or that the assument and defense that the assument and defense that the assument protein and calorie red or that the nutritional assessment and defense that the assument protein and calorie red or that the nutritional assument and calorie red or that the nutritional assument and calorie red or that the nutritional	dication de that after the by the commended left and drank 100%. The dictary ager. The dictitian sessment had equirements needs of acility staff At risk for opetite, need alcers." This at adequate within normal to obtain reased protein onsible for obtained an resident 16. That the RD				

UT0017

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

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER SUPPLIER IDENTIFICATION NUM		A. BUILDING	CONSTRUCTION	(X3) DATE S COMPLI	ETED
		465082		B. WING		11/	/5/2002
	ROVIDER OR SUPPLIER IEW CARE CENTER		1	RESS, CITY, STATI Γ 1020 SOUTH Τ 84601	E, ZIP CODE		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES WHILE THE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(XS) COMPLETE DATE
F 325	Between the days of discharge (9/12/02 - weight and skin com	and skin meeting minual, 10/30/02 and 10/31/07 resident 16's admissio 10/14/02), the facility mittee meetings which 10/11/02 and 10/14/02.	02. n and held four	F 325			
	had 7 pressure sores	rst meeting of 9/24/02, Facility staff did not 16 in the 9/24/02 skin/v	document				
	16 still had 7 pressu document discussin skin/weight meeting	econd meeting of 9/30/hare sores. Facility staff g resident 16 in the 9/3 g and did not include him to the dictitian which wheeting minutes.	did not 0/02 s name on	*			
	16 continued to have experienced a signimonth. Facility state and next to his name. There were no further was no documents.	re multiple pressure sor ficant weight loss of 11 ff wrote the name of re the they wrote "wt. (weigher notes regarding resimentation to evidence t loss had been discussores.	res and had 1.2% in one sident 16 ght) loss". ident 16. that the		•		
	16's status from the changed. Facility:	Fourth meeting of 10/14 meeting of 10/11/02 h staff did not document 10/14/02 weight/skin m	nad not discussing				
	resident 16. Facili	ot obtain an admission ty staff did not begin a ident 16 until 9/18/02, ith 7 pressure sores. F	nutritional 6 days after				

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

STATEMENT	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER SUPPL IDENTIFICATION N 46508			(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	COMPL:	DATE SURVEY OMPLETED 11/5/2002	
				DEGG CITY STATE	7 7IB CODE	11/	3/2002	
	ROVIDER OR SUPPLIER IEW CARE CENTER			oress, city, state T 1020 SOUTH JT 84601	s. ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(NS) COMPLETE DATE	
F 325	16. Without the cale would not be possib regular diet and nutre his nutritional needs the use of nutritional after the dietary man assessment/progress Facility staff did not skin and weight meets tay in the facility. mention him, they we but did not document planned intervention the nutritional care stay, from 9/12/02 to f his body weight. own policies and predefined and predefined and predefined and predefined and policies and predefined and predefine	otein and calorie needs orie and protein calcular le to know whether or retitional supplements word. Facility staff did not a supplements until 9/2 nager had suggested the	tions, it not his add meet implement 7/02, 9 days on her 3 of the 4 tring his they did d "wt. loss" has ot follow uring his lost 11.2% ollow their he staff to	F 325				
	the facility on 9/3/0 diabetes, hypothyro	a 60 year-old female ac 22. Diagnoses included bidism, chronic obstruc- schizophrenia, arthrop ites of the leg.	type II tive	•	; ·			
	A review of resider data set) revealed the stage II pressure so	nt 48's admission MDS hat resident 48 was adr ore.	(minimum nitted with a	:				
	resident 48's weigh and was 264 lbs. or	one on 10/31/02 revealed twas 282 lbs. (pounds in 10/14/02 (18 lbs.), with loss of 6.38% in three ft.) on 9/24/02 hich					
		nt 48's labs dated 9/17/	02 revealed	:				

	S FOR MEDICARE	& MEDICAID SERVIO	CES				2567_
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	/CLIA	1' '	CONSTRUCTION	(X3) DATE S COMPLI	
AND LAND	, conduction	DENTIFICATION NOW		A. BUILDING			
		465082		B. WING		1 <u>1/</u>	5/2002
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATE	. ZIP CODE		
				1020 SOUTH			
CRESTVI	IEW CARE CENTER	10000000	PROVO, U		200 21 12 05 05	NRECTION.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(NS) COMPLETE DATE
F 325	The lab defined a no	38 2.2 gm/dl (grams per de ormal range to be 3.3-4. epresented a moderate d	8 gm/dl.	F 325			
	admission (10/7/02) from the registered of times a day, 2200 ca	ment completed 34 days, documented a recommedication of house suppleadories per day and prote was no documentation	nendation ement three ein needs of		·		
	A diet order form dated 9/3/02 documented that resident 48 was receiving a 1700 ADA (American Diabetes Association) diet. There were no diet chang documented to meet the increase calorie recommendations of the dietitian.		nerican	•			
	Resident 48's meal intake chart for the month of October documented 12 meals where 30% or less was consumed and 3 meals with no documentation.						
	administration reco protein powder sup given to resident 48 documentation that	tober 2002 MAR (medird) revealed documents plement of one scoop vs starting 10/8/02. Then the protein powder or ministered to resident 4	ntion that a was to be e was no the house		•		
	stated that the prote	h a nurse on 10/31/02, the contract of the con	n given and				
	at 4 PM, she stated recommendations f	h the facility dietitian o that she had not made for a protein powder for ot been aware that resid	any r resident 48				

not received any supplements.

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

PRINTED: 11/12/20 FORM APPROVE 2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	465082	B. WING	11/5/2002
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STATE, ZIP CODE	

CRESTVIEW CARE CENTER

1053 WEST 1020 SOUTH PROVO, UT 84601

(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)

COMPLETE DATE

F 325 Continued From page 39

Resident 48 was admitted with a pressure sore, had a low albumin level, was not consuming the recommended calories and not receiving the recommended supplement, placing the resident at a high nutritional risk.

Interviews:

An interview with the facility administrator, the director of nursing (DON) and the certified nurse aide coordinator, who was in charge of training the restorative aides to weigh residents, was held on 11/5/02 from 2:45 PM to 3:26 PM.

They stated that all residents are weighed at least once a month. Newly admitted residents and residents identified with weight loss are weighted weekly. The DON stated that any resident who has a weight variance of 3 pounds should be re-weighted.

They were asked about the weight and skin committee. They stated that residents are added to the weight and skin committee for review based on identified weight loss after review of the weekly/monthly weight sheets and that residents with skin breakdown should also be reviewed. They stated that residents identified as requiring review by the weight and skin committee continue to be followed until their weight is stable for 4 weeks. They reported that the weight and skin committee meets weekly and that the DON, the dietary manager, the CNA coordinator, the registered dietitian, if she's in that day, and the administrator, if she is available are the committee members.

When asked who was responsible for making sure that the dietitian's recommendations were followed through, the DON stated that she makes sure that recommendations involving nursing are acted upon.

F 325

CMS-2567L

ATG112000

Event ID: 6HIP11 Facility ID: UT0017 If continuation sheet 40 of

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NU 465082		/CLIA	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE COMPI		
NAME OF PR	ROVIDER OR SUPPLIER	1	STREET ADDI	RESS, CITY, STATE	E, ZIP CODE		
	IEW CARE CENTER		1053 WEST PROVO, U	Г 1020 SOUTH Г 84601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FUL.	ID PREFIX TAG	PROVIDERS PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
F 325	with recommendation enriching a diet or commendation. When asked how of	ietary manger follows to ms dealing with dietary hanging a snack order. ten the dietitian visits that ated that is was usually	such as	F 325			
F 361 SS=H	The facility must enfull-time, part-time, If a qualified dietitic facility must design director of food ser scheduled consultate.	inploy a qualified dietiti or on a consultant basi an is not employed full- ate a person to serve as vice who receives frequion from a qualified die	s. time, the the tently etitian.	F 361			į
	upon either registra Dietetic Registratio Association, or on texperience in identification	n is one who is qualified ation by the Commission of the American Diet the basis of education, the diffication of dietary need the mentation of dietary pro-	on on retic training, or ds,		<i>.</i>		:
	Based on staff interdetermined that the part-time consultant provided adequate or dietary staff regassessing residents protein status. Als registered dietitian	eNT is not met as evidence and observations facility did not utilize at dietitian in a manner supervision to the dietarding accurately monit at risk for weight loss to, the facility was wither from June 5, 2002 thredidentifiers: 10, 20, 16,	, it was their which ary manager toring and and low out a ough August				
	Findings include:	idenumers. 10, 20, 10,	D1, 10, 10.				

		(XI) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		465082		B. WING _		11/5/2	2002
	ROVIDER OR SUPPLIER IEW CARE CENTER			Γ 1020 SOUT	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
F 361	that the facility did n maintained an accept	record review it was do not ensure that each resitable parameter of nutroy 5 of 15 sampled resident	ident itional	F 361	Resident 10, 16, 20, 21, 45, 48 have reviewed by the RD consultant witto care plans made to include weight albumin issues being addressed.	th updates ght loss and	11/19/02
	experienced significations sampled resident exp	ant weight loss and 4 of perienced low albumin itional status) levels wi	f 15 (a protein		resident has had his or her plan resident has had his or her plan resident.	:	
	dietary interventions	implemented to help in the interest in the implement further protein of	ncrease the		Residents at risk for nutritional iss potential to be affected.	sues have the	
	registered dietitian fi through August 14th	nat the facility was with from the first week of Ju 1, 2002. (Assessments of observed until 8/15/	une 2002 from the		The RD is aware of the Manual for dietetics and is using the manual to current interventions. The RD has the residents and risk levels and direcommendations as appropriate a	o develop s reviewed eveloped	11/19/02
	services which main residents 10,20.16.4	provide dietetic supportained the body weight 5,48 as evidenced by: a 95-year-old female ac	s for	· · · · · ·	tracking recommendation time to implementation time and looking in outcomes. The weights are being by the RD as part of the facility pro- committee; this committee is resp	ng reviewed ractices onsible for	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	the facility on 10/2/9	98 with diagnoses incluome, osteoporosis and o	iding chronic		measuring outcome weights as corisk levels.		
	record, on 5/9/02 re on her left ankle.	ary disease. Per the me sident 10 developed a s	stasis ulcer	• ·	The Administrator is responsible compliance.	for ongoing	
	"Weight Change Hi	t 10's weights, docume story" form and provid 30/02, were as follows:	led to the				
	9/26/01 101 pe	ounds.					
		unds. This represents a unds, or 5% in 30 days.					
	11/26/01 94 po	unds.					
		unds. This represents a unds, or 7.9% in 90 day					

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER	VCLIA	(X2) MULTIP	LE CONSTRUCTION	COMPLETED		
AND PLAN C	LAN OF CORRECTION IDENTIFICATION NO		dBER:	A. BUILDING		-		
				B. WING		11/5/2002		
		465082			TE SID CODE	11/3/2002		
NAME OF PI	ROVIDER OR SUPPLIER			DRESS, CITY, STA				
CDECTV	IEW CARE CENTER			ST 1020 SOUT	H			
CRESIV	IEW CARE CENTER		PROVO,	UT 84601		CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE DATE		
F 361	Continued From page	42		F 361				
				!				
		ounds.						
		ounds.						
		ounds.						
		6 pounds.						
		oounds.						
		6.5 pounds.						
		oounds.		;				
	5/28/02 97 po			:				
		8 pounds.		:				
		ounds.		!				
		oounds.						
	6/25/02 95.5 p	oounds.						
	= = = = = = = = = = = = = = = = = = = =	3 pounds. This represe	into a					
	7/1/02 9	oss of 5 pounds, or 5%	in 30 davs	,				
	significant weight i	oss of 3 pounds, of 376	m 50 days	*				
	7/9/02 9	2 pounds. This represe	ents a	}				
	giomificant weight	loss of 8 pounds, or 8%	in 30 days					
	Significant wording	, , , , , , , , , , , , , , , , , , ,	•					
	7/15/02 91.5	pounds. This represent	s a		:			
	significant weight	loss of 6 pounds, or 6%	in 30 days	i.	:			
				•	•			
	7/23/02 87.5	pounds. This represer	nts a					
	significant weight	loss of 8 pounds, or 8.3	% in 30					
	days.				1			
	:	20						
		90 pounds.						
		90.5 pounds.			1			
		ounds.						
	9/30/02 88.5	pounds.						
<u> </u>	10/14/02 86 pe	ounds. This represents	a significat	nt				
[weight loss of 5 m	ounds, or 5.5% in 30 da	ıvs.					
1	weight 1039 of 2 be	Janas, 01 5.570 111 50 61	· y - ·		•			
	10/23/02 89 p	ounds.						
1		pounds.			1			
		pounds.						
	11/3/02 93.3	Pounds.						

CENTER	S FOR MEDIC	CARE	E MEDICAID SERVI	UE3					
STATEMENT	T OF DEFICIENCIE	S	(XI) PROVIDER SUPPLIER	/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE COMPL	
	OF CORRECTION		IDENTIFICATION NUM	IBER:	A. BUILDI			COMPL	
					B. WING			.,,	/5/2002
			465082	STREET ADD	RESS CITY	STATE	. ZIP CODE		312002
NAME OF P	ROVIDER OR SUPI	PLIER		1053 WEST			, Zii CODB		
CRESTV	IEW CARE CE	ENTER		PROVO, U		, 1 11			
				<u> </u>			DEOVIDED'S BLANCE	TORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DE	FICIENCY	ATEMENT OF DEFICIENCIE: 7 MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETE
F 361	Continued Fro	m nage 4	43		F 361				
1 201	· A review of a	ıll dietai	ry notes completed sinc	ce resident					
	10's admissio	n did no	ot evidence that the die	titian					
			tional needs based on h						
			ss. There was no docu						
			interventions were atte						
			esident 10's diet.						
	t Danidana)A .v	o 70 year old male adm	nitted to the					
	b. Resident	20 Was a	a 79-year-old male adn vith diagnoses including	decubitus					
	: racinty on 6/.	ZU/UZ W	ent disorder, profound r	nental					
	retardation a					1	• •		
	; retardation as	nu weak	LIIC33.						
	A review of	resident	20's admission weight	,					
	documented	on the "	Record of Vital Signs	and					
	Weights" for	m, whic	ch was not dated, revea	led that he					
	weighted 152	2 pound	s upon admission. A r	eview of					
			weights, provided to the	he survey					
	team on 10/3	30/02, w	ere as follows:		,				
	6/25/02:	149 5 1	pounds.						
	7/1/02:	-	52 pounds.						
	7/1/02:		53.5 pounds.					,	
	7/15/02:		pounds.						
,	7/23/02:		pounds.						
		•	•						
}	_; 8/6/02:	12	27 pounds. This repres	ents a					
İ	significant w	veight lo	oss of 20.5 pounds, or	13.9% in 14					
	days.								
	0.000.000	107	1.		:	1			
İ	8/28/02:	127 pc			•				
	9/2/02:		26 pounds.		:				
	9/9/02:		27 pounds.						
	9/23/02:		pounds.						
	9/30/02:		pounds.		:				
ļ	10/8/02:		pounds. 30.5 pounds.						
	10/14/02:		31.5 pounds.						
<u> </u>	10/23/02: 10/29/02:		30 pounds.						
	10/29/02:		pounds.						
I	11/5/02.	130.3	poulius.						

DEPART	MENT OF HEALTH	AND HUM: SERV					2567
STATEMENT	S FOR MEDICARE & FOR DEFICIENCIES OF CORRECTION	& MEDICAID SERVIO (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	/CLIA	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE S COMPLI	
		465082	STREET ADD	RESS, CITY, STATE	, ZIP CODE		
	ROVIDER OR SUPPLIER IEW CARE CENTER			Γ 1020 SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	COMPLETE DATE
F 361	Continued From page	44		F 361			
	record, which attempt decline, which occurs A review of all dieta 10's admission did no re-assessed his nutri significant weight to evidence that dietary increase calories in after he was admitted to the facility of insulin dependent fibrillation, dements	a 79-year-old male wh lity on 5/27/99 with the t diabetes mellitus, atri ia, organic brain syndro lure, venous insufficier	e weight 6/02. ce resident etitian nis imented tempted to 28 days o was e diagnoses al ome,	· decond			
	The weights for res record, documented	ident 45, kept in his me I the following:	edical				
	The second week of J The first week of J	une 2002 - 153.5 pound f June 2002 - 148.5 po June 2002 - 147.5 pound uly 2002 - 145.5 pound f July 2002 - 145 pound	unds ids is				
	fractured his elbow	July 2002 - The resider Nurse's notes (7/18/0 bruised and edematou unds.	02) record "L				
	document "Pt's (pa	f July 2002 - Nurses no ntient's) L arm is still ed Weight recorded at 143	lematous but				

The first week of August 2002 - 135 pounds

DEPART	MENT OF HEALTH	AND HUM, SERVICES			1010	2567
	_	& MEDICAID SERVICES	(V2) Last Tipl	E CONSTRUCTION	(X3) DATE	
TATEMENT	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	COMPL	ETED
VND LIVIN O	F COLORES (NO)	DENTINE ATION NO.	A. BUILDING B. WING			15/2002
		465082				/5/2002
NAME OF PR	OVIDER OR SUPPLIER	ı	ADDRESS, CITY, STA			
CRESTV	IEW CARE CENTER	1053 W PROVO	EST 1020 SOUTH), UT 84601			
(X4) ID PREFIX TAG	(FACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFLX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
F 361	Continued From page The first week of Se	45 ptember 2002 - 134,5 pounds	F 361			
	As of the first week	of August 2002, resident 45 had weight loss in two months, which	ı			
	is significant. As of	September 2002, resident 45 ha	d			
	experienced a weigh	it loss of 12.37% in 3 months,				:
	which is significant.	The last albumin level recorded d of resident 45, prior to the	u			
	weight loss was 11/	/10/01 and was found to be 3.4				0
	(within normal limit	ts). Another albumin was obtain	ed	-		•
	on 9/24/02, after the	e significant weight loss between	l ,			1
	June and September	r 2002, and was found to be 2.8				İ
	which reflects a mil	d to moderate visceral protein				
	depletion. Also dur	ring this time period, on 8/3/02,	L .			!
	resident 45 was fou	nd to have a pressure sore, which	<u>. </u>			·
	the nurse's notes de	scribe as "1.5 cm (centimeter) in	, \$			
	dia. (diameter), yeii	low in color, bad odor."	;			
	A review of all diet	ary notes completed since reside	ent			
	45's admission did	not evidence that the dietitian				÷
	re-assessed his nutr	ritional needs based on his				
	significant weight l	oss. There was no documented				
1	evidence that dietar	ry interventions were attempted t	to	•		i
	increase calories in	resident 45's diet until 10/29/02	., .			1
	months after he exp	perienced significant weight loss	·. d			
	since the second w	ht had been on a downward trend	•			
]	SINCE HIE SECOND W	cck in Julie 2002.				
[d. Resident 16 wa	s a 40-year-old male who was				:
1	admitted to the fac	ility on 9/12/02 with the diagnos	ses			1
	of delirium, parapl	legia, urinary tract infection,				
	pressure sores, and	l major depression. Resident 40	was			:
	on a regular, low of	concentrated sweet diet. Residen	ıt			ļ.
	was discharged fro	om the facility on 10/14/02 and the	nen			!
	readmitted to the f	facility.				
	Daniem afaka mai	oht summary sheet for resident 1	16	•		1
	Review of the wei	ght summary sheet for resident 1	· -			

revealed that no weight was obtained the week of admission. During the fourth week of September

CMS-2567L

6HIP11

Event ID:

DEPARTMENT OF HEALTH AND HUM. SERVICES

CENTER	RS FOR MEDICARE	& MEDICAID SERVIC	<u>ES</u> _					2307
STATEMEN	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIED IDENTIFICATION		LIA	A. BUILDIN		NSTRUCTION	(X3) DATE S COMPL	
		465082		B. WING			11,	5/2002
	ROVIDER OR SUPPLIER	403002	STREET ADDR	ESS, CITY, ST	TATE, ZI	P CODE		
			1053 WEST	1020 SOU	TH			
CRESTV	IEW CARE CENTER	Ì	PROVO, U					
(X4) ID PREFIX TAG	TEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY F SC IDENTIFYING INFORMAT	TULL TON)	ID PREFIX TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
TAG	Continued From page 2002, staff records to pounds. The next we documented the second 150 pounds. This is than a month. A review of the nurse 9/12/02, reveals resonable pressure so Care and Pressure Undocuments that resist Four of the pressure pressure sores were 2. A nutritional assession 9/18/02. This was admitted with assessment was pernot a registered die documented in her 9/18/02 "no Ht. (he dietary manager diperform her assession document an estimator of resident 16. On	he weight of resident 16 was ond week of October 200 a weight loss of 11.2% sing initial assessment, dident 16 was admitted wores. The first entry onto Dicer Record" dated 9/13 dent 16 had seven pressure sores were a stage 4, two at a stage 3 and one was as performed 6 days after th 7 pressure sores. This formed by the dietary material (RD). The dietary material (RD). The dietary material (RD). The dietary material (RD) are dietary manager documents the second page of the cetary manager documents.	to be 169 02 and was in less ated ith 0 the "Skin 3/02, are sores. wo of the s at a stage performed er resident s anager and manager e of chart." The th which to ger did not fluid needs dietary	F 361		DEFICIENCY		
	co-signed the nutri progress notes wri was no documenta evaluated resident been completed, the	imentation to evidence the tional assessment and ditten by the dietary managetion to evidence that a difference that a difference that a difference that the assumption and calorie read or that the nutritional region met.	etary ger. The ietitian essment had equirements	: : :				
		ot obtain an admission v	weight for					

DEPARTMENT OF HEALTH AND HUMA RERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIES (CRESTVIEW CARE CENTER) SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MCST BE PRECEDED BY BULL PRETATOR (EACH DEFICIENCY MCST BE PRECEDED BY BULL PRETATOR F361 F361 Communed From page 47 resident 16. Facility staff did not begin a nutritional assessment for resident 16 until 9/18/02, 6 days after he was admitted with 7 pressure sores. Facility staff did not calculate protein and calorie needs for resident 16. Without the calone and protein canculations. It would not be possible to know whether or not his regular diet and nutritional supplements would meet his nutritional needs. Facility staff did not implement the use of nutritional supplements until 9/27/02.9 days after the dietary manager had suggested them on her assessment/progress notes of 9/18/02. Facility staff did not discuss resident 16 in 3 of the 4 skin and weight meetings that were held during his stay in the facility. In the one meeting that they did mention him, they wrote down his name and "wt. loss" but did not document anything further (such as planned interventions). Facility staff did not follow the nutritional care plan for resident 16. During his stay, from 9/1/20/2 to 10/14/02, resident 16 in S1 11.2% of his body weight. Facility staff did not follow their own policies and procedures. e. Resident 48 was 3 60 year-old female admitted to the facility on 9/3/02. Diagnoses included type II diabetes, hypothyroidism, chronic obstructive pulmonary disease, schizophrena, arthropathy, lumbago and cellulities of the leg. A review of resident 48 was admitted with a stage II pressure sore. A record review done on 10/31/02 revealed that resident 48's weight was 282 lbs. (pounds) on 9/24/02 and was 264 lbs. on 10/14/02 (18 lbs.), which represents a weight loss of 6.38% in three weeks, which is significant.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE COMPL	ETED			
CRESTVIEW CARE CERTER 1963 WEST 10.0 SOUTH PROVO, UT 34601 REPORT (REACH DEPRICIENCY MIST BE PRECEDED BY BUILD, RECULATORY OR ISC IDENTIFYING INFORMATION) F 361 Continued From page 47 resident 16. Facility staff did not begin a nutritional assessment for resident 17. August 1978 of 2. days after he was admitted with 7 pressure sores. Facility staff did not calculate protein and calorie needs for resident 16. Whom whether or not his regular diet and nutritional supplements until 927702. 9 days after the dietary manager had suggested them on her assessment/progress notes of 91.8/02. Facility staff did not discuss resident 16 in 3 of the 4 skin and weight meetings that were held during his stay in the facility. In the one meeting that they did mention him, they wrote down his name and "wt. loss" but did not document anything further (such as planned interventions). Facility staff did not follow the nutritional care plan for resident 16. During his stay, from 91.202 to 10.1402, resident 16 in 30 fth. 4 skin and weight meetings that they did mention him, they wrote down his name and "wt. loss" but did not document anything further (such as planned interventions). Facility staff did not follow the nutritional care plan for resident 16. During his stay, from 91.202 to 10.1402, resident 16 in St. 11.2% of his body weight. Facility staff did not follow their own policies and procedures. e. Resident 48 was a 60 year-old female admitted to the facility on 93.02. Diagnoses included type II diabetes, hypothyroidism, chronic obstructive pulmonary disease, schizophrena, arthropathy, lumbago and cellulities of the leg. A review of resident 48 was admitted with a stage II pressure sore. A record review done on 10/31/02 revealed that resident 48 was admitted with a resident 48 was admitted with a stage II pressure sore. A record review done on 10/31/02 revealed that resident so is such as a such as a such as a such as a such as a such as a such as a such as a such as a such as a such as a such as a such as a such as a such			465082				11.	/5/2002		
SUMMARY STATEMENT OF DEFICIENCIES REACH DEFICIENCY MGST BE PRECEDED BY FULL TAG FAGULATORY OR LSC IDENTIFYING INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION INFORMATION				1053 WEST	3 WEST 1020 SOUTH					
PRETX TAG RECLECTION OF THE PRECEDED BY FULL PRED PROPERTY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CARD BY TAG RECLECTION SHOULD BE CARD BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CARD BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CARD BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CARD BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE CONSTRUCTED BY TAG RECLECTION SHOULD BE RECLECTED BY TAG RECLECTION SHOULD BY TAG RECLECTION SHOULD BY TAG RECLECTION SHOULD BY TAG RECLECTION SHOULD BY TAG RE						PROVIDER'S PLAN OF CORREC	TION	(X5)		
resident 1.6. Pacility staff did not begin a nutritional assessment for resident 16 until 9/18/02, 6 days after he was admitted with 7 pressure sores. Facility staff did not calculate protein and calorie needs for resident 10. Without the calorie and protein calculations, it would not be possible to know whether or not his regular diet and nutritional supplements would meet his nutritional needs. Facility staff did not implement the use of nutritional supplements until 9/27/02, 9 days after the dietary manager had suggested them on her assessment/progress notes of 9/18/02. Facility staff did not discuss resident 16 in 3 of the 4 skin and weight meetings that were held during his stay in the facility. In the one meeting that they did mention him, they wrote down his name and "wt. loss" but did not document anything further (such as planned interventions). Facility staff did not follow the nutritional care plan for resident 16. During his stay, from 9/12/02 to 10/14/02, resident 16 lost 11.2% of his body weight. Facility staff did not follow their own policies and procedures. e. Resident 48 was a 60 year-old female admitted to the facility on 9/3/02. Diagnoses included type II diabetes, hypothyroidism, chronic obstructive pulmonary disease, schizophrenia, arthropathy, lumbago and cellulites of the leg. A review of resident 48's admission MDS (minimum data set) revealed that resident 48 was admitted with a stage II pressure sore. A record review done on 10/31/02 revealed that resident 48's weight was 282 lbs. (pounds) on 9/24/02 and was 264 lbs. on 10/14/02 (18 lbs.), which represents a weight loss of 6.38% in three weeks, which is significant.	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETE		
A nutritional assessment completed 34 days after admission (10/7/02), documented a recommendation	F 361	resident 16. Facility assessment for reside he was admitted with did not calculate pro 16. Without the calculate would not be possibly regular diet and nutri his nutritional needs the use of nutritional after the dietary mar assessment/progress. Facility staff did not skin and weight meets tay in the facility, mention him, they we but did not document planned intervention the nutritional care stay, from 9/12/02 to f his body weight, own policies and proposed in the facility on 9/3/0 diabetes, hypothyro pulmonary disease, lumbago and cellul. A review of resider data set) revealed the stage II pressure so A record review do resident 48's weigh and was 264 lbs. Or represents a weight which is significant.	staff did not begin a ment 16 until 9/18/02, 6 on 7 pressure sores. Factein and calorie needs to be and protein calculate to know whether or ritional supplements wo. Facility staff did not I supplements until 9/2 mager had suggested the notes of 9/18/02. It discuss resident 16 in the one meeting that wrote down his name and anything further (such as). Facility staff did not plan for resident 16. Do 10/14/02, resident 16. Tacility staff did not foocedures. a 60 year-old female at 2. Diagnoses included oldism, chronic obstruct schizophrenia, arthropites of the leg. at 48's admission MDS that resident 48 was admire. The one on 10/31/02 revealed the was 282 lbs. (pounds) in 10/14/02 (18 lbs.), with loss of 6.38% in three the sement completed 34 dataset.	days after ility staff for resident tions, it not his old meet implement 7/02, 9 days on her 3 of the 4 uring his they did d "wt. loss" h as ot follow uring his is lost 11.2% follow their dmitted to type II tive athy, (minimum mitted with a sed that 0 on 9/24/02 nich weeks,	F 361					

DEPARTMENT OF HEALTH AND HUM. 3ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/12/20 FORM APPROVE 2567

STATEMENT AND PLAN O	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER SUPPLIER/CLIA IDENTIFICATION NUMBER: 465082		/CLIA IBER:	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		465082			TIN CORE	11/5/2002	\dashv		
	ROVIDER OR SUPPLIER IEW CARE CENTER			DDRESS, CITY, STATE, ZIP CODE EST 1020 SOUTH LIT 84601					
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPL	ETE		
F 361	times a day, 2200 ca 90-100 grams. There for weight loss.	48 lietitian of house supple lories per day and prote was no documentation at the desired 9/3/02 documented	ein needs of n of a plan	F 361					
	resident 48 was rece Diabetes Association	iving a 1700 ADA (Ann) diet. There were no e the increase calorie	nerican						
	administration recor protein powder supp given to resident 48 documentation that	ober 2002 MAR (medical) revealed documentary plement of one scoop wastarting 10/8/02. There the protein powder or the protein to resident 4	ition that a vas to be e was no the house						
	stated that the prote	n a nurse on 1931 02. (in powder had not been ocumentation of any su	n given and	•					
	services to maintain	o provide dietetic supp n or improve the protein and 48 as evidenced by	n status for		•				
,	organic brain synd obstructive pulmor	s a 95-year-old female a /98 with diagnoses incl rome, osteoporosis and nary disease. Per the m esident 10 developed a	luding chronic edical						
	Per the medical red developed a stage	cord, on 5/9/02 residen II stasis ulcer on her le	t 10 ft ankle.						
	On 10/28/02, a rev	view of resident 10's lab	o values was						

ATG112000

Event ID:

6HIP11

Facility ID:

CENTER	S FOR MEDICARE	<u>& MEDICAID SERVIC</u>	CES	T			2507	
STATEMENT OF DEFICIENCIES (XI) F		(XI) PROVIDER/SUPPLIER/	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 11/5/2002		
		465082		B. WING		11/	5/2002	
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STATE	E, ZIP CODE			
CRESTVIEW CARE CENTER PROVO,			1053 WEST PROVO, U	T 1020 SOUTH T 84601				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	COMPLETE DATE	
F 361	Continued From page completed. The following	49 owing levels were docu	mented:	F 361				
	10/11/01pre-albumin reference range 17-4 7/2/02 albumin range 3.3-4.8 g/dl.	2 mg/dl.	mal reference					
	g/dl- 2.9 g/dl is considered a mild via guidance: Manual of	less than 2.4 g/dl is contain deficit, an albumin lesidered a moderate visconin level of 3.0 g/dl-3.5 isceral protein deficit. of Clinical Dietetics, Analy, 6th edition, 2000, page	evel of 2.4 eral protein g/dl is (Reference nerican					
	10's admission did re-assessed her nutralbumin levels, whidepletion. There w	ary notes completed sind of evidence that the die itional needs based on he indicated moderate pas no documented evides were attempted to incresident 10's diet.	etitian ner low protein ence that	Š.				
	to the facility on 7/2 senile dementia, sto accident and deep v gastrostomy tube (0	an 85-year-old female 27/95 with diagnoses in omach ulcer, cerebrovas vein thrombosis. Reside 5-tube) in place and recis tube. She was NPO (1)	cluding cular ent 21 had a eived all of		•			
	on 10/29/02. On 5 stage II pressure ul identified. A stage	nt 21's nursing notes wa /6/01, it was documente cer to the coccyx had be II pressure ulcer to the ted as having been iden	ed that a een back of the					

6HIP11

On 10/29/02, a review of resident 21's laboratory (lab)

DEPARTMENT OF HEALTH AND HUM SERVICES

PRINTED: 11/12/20 FORM APPROVE

CENTERS	OR MEDICARE A	& MEDICAIL SERVI	CES				<u>2567</u>
STATEMENT OF	DEFICIENCIES	(XI) PROVIDER/SUPPLIER IDENTIFICATION NUM	/CLIA	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SUI COMPLET	
		465082		B. WING		11/5/	2002
NAME OF PROV	IDER OR SUPPLIER		STREET ADDR	ESS, CITY, STATE.	ZIP CODE		
CRESTVIE	W CARE CENTER		1053 WEST PROVO, UT	1020 SOUTH 84601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
F 361 C	ontinued From page 5	50		F 361			

F 361 Continued From page 50

values was completed. The following albumin (a protein and indicator of nutritional status) levels were documented:

9/10/01 3.0 g/dl (grams per deciliter) 9/11/01 2.7 g/dl 8/6/02 2.9 g/dl

A review of all dietary notes completed since resident 21's admission did not evidence that the dietitian re-assessed her nutritional needs based on her low albumin levels, which indicated moderate protein depletion. There was no documented evidence that appropriate dietary interventions were attempted to increase the protein provided to resident 10's via her G-tube.

c. Resident 45 was a 79-year-old male who was admitted to the facility on 5/27/99 with the diagnoses of insulin dependent diabetes mellitus, atrial fibrillation, dementia, organic brain syndrome, congestive heart failure, venous insufficiency with chronic venous stasis.

As of the first week of August 2002, resident 45 had experienced a 12% weight loss in two months, which is significant. As of September 2002, resident 45 had experienced a weight loss of 12.37% in 3 months, which is significant. The last albumin level recorded in the medical record of resident 45, prior to the weight loss, was 11/10/01 and was found to be 3.4 (within normal limits). Another albumin was obtained on 9/24/02, after the significant weight loss between June and September 2002, and was found to be 2.8 which reflects a mild to moderate visceral protein depletion. Also during this time period, on 8/3/02, resident 45 was found to have a pressure sore, which the nurse's notes describe as "1.5 cm (centimeter) in dia. (diameter), yellow in color, bad odor."

Facility ID: UT0017 If continuation sheet 51 of

CMS-2567L

CENTERS	FOR MEDICARE	& MEDICAID SERVIC	CES	т		(X3) DATE S	CUDVEV
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUM	/CLIA	(X2) MULTIPLE C	CONSTRUCTION	COMPL	
ANDICAMON	Onne	IDE.		B. WING			/= /200 <i>2</i>
		465082		·	TIP 0005		/5/2002
NAME OF PRO	VIDER OR SUPPLIER			ESS, CITY, STATE,	ZIP CODE		
	W CARE CENTER		1053 WEST PROVO, UT	1020 SOUTH Г 84601			
(X4) ID PREFIX TAG	SUMMARY ST	TATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION (ROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
F 301 (Continued From page	51		F 361			
1	45's low albumin le evidence that the di needs based on her a moderate protein documented eviden interventions were provided to resident. Resident 48 was the facility on 9/3/0 diabetes, hypothyro pulmonary disease lumbago and cellui		2 did not utritional ch indicated o ary see protein month later. dmitted to type II sive athy,				
	A review of reside data set) revealed t stage II pressure se	nt 48's admission MDS that resident 48 was adnore.	mitted with a				
	an albumin level of	nt 48's labs dated 9/17/0 f 2.2 gm/dl (grams per one) normal range to be 3.3-4 represented a moderate	deciliter). 4.8 gm/dl.	•			
	low albumin level	dmitted with a pressure and was not receiving to oplement, placing the rests.	the				; ;
F 371 SS=E		TARY SERVICES store, prepare, distribut	e, and serve	F 371			:
		MENT is not met as evi	denced by:				

CENTER	S FOR MEDICARE &	& MEDICAIL LERVICE	<u>es</u> _	-		 -	2507
STATEMENT OF DEFICIENCIES (X1) PROVIDER SUP		(X1) PROVIDER SUPPLIER/C IDENTIFICATION NUMB	LIA	(X2) MULT A. BUILDIN B. WING	G	X3) DATE SUR COMPLETE	D
		465082		-		11/5/2	1002
	ROVIDER OR SUPPLIER IEW CARE CENTER		STREET ADDR 1053 WEST PROVO, UT	1020 SOU	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES (MUST BE PRECEEDED BY FU SC IDENTIFYING INFORMATI	ULL ION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	D BE	(X5) COMPLETE DATE
F 371	and temperature ched determined that the findistribute food under by dish machine term 120 degrees Farenhelless than 50 parts permember was observed the dirty and clean such findings include: The following observed the dirty and clean such findings include: The following observed the dirty and clean such findings include: The following observed the dirty and clean such findings include: 1. At 8:38 AM, the was 96 degrees Farewas 114 degrees Farewas 114 degrees Farewas 110 degrees Farewas 110 degrees Farewas 110 degrees Farewas 110 parts per million). In order for bleach concentration must The following observed from 1:10 PM to 1:10 PM, the using the thermome was 112 degrees Farewas 112 degrees	as in the kitchen, record cks of the dish machine, acility did not store, server sanitary conditions as experatures which were lessit, the dish machine sanitar million (ppm) and a die do to cross contaminate bide of the dish room. The vations were made during done 10/28/02 from 8:20 dish machine wash temperature and the rinse temperature. The sanitizer was at the bean effective sanitizer. The sanitizer was at the bean effective sanitizer was at the bean effective machine wash temperature between 50 and the results of the dish machine wash temperature between 50 and the dish machine wash temperature between 50 and the dish machine wash temperature between 50 and the dish machine wash temperature between 50 and the dish machine wash temperature attached to the dish retered to the dish retered	review it was we and videnced ss than tizer was etary staff petween ag the AM to perature erature check the 10 ppm er, the 1200 ppm. 0/28/02 perature, machine,	F 371	Residents eating from the kitchen har potential to be affected. Temperatures are being monitored dishwashing times at the beginning, and end of use. This will be done for week if temperatures meet threshold temperatures will be logged at the bor use. The dietary staff has been reinserviced on the proper temperature basic sanitation requirements in the commercial kitchen. The in-service specifically covered what to do if temperatures fall during the dishwas process. The results of the audit will be reported to the proper temperature of the audit will be reported to the proper temperature of the audit will be reported to the proper temperature of the audit will be reported to the proper temperature of the audit will be reported to the proper temperature of the audit will be reported to the proper temperature of the audit will be reported to the proper temperature of the proper temperature	uring the middle or one is then eginning the estand in the estand in the estation of inistrator	11/5/02
ł.	2. At 1:14 PM, the	dish machine wash tem	perature				

was 114 degrees Farenheit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NO.		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	/CLIA	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		465082		B. WING		11/	5/2002	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE			
	IEW CARE CENTER		1053 WEST PROVO, U	T 1020 SOUT 84601	H			
(X4) ID PREFIX TAG	FACH DEFICIENC	FATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE)	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
F 371	Continued From page	53		F 371				
	Temperature Log" s	eview of the "Dish Mansheet kept by the dietaryne. The dish machine tend twice daily, once in the the sheet.	/ mperatures					
	The following dates documented: 10/5/0 10/19/02, 10/20/02	s had no dish machine to 22, 10/6/02, 10/11/02, 1	emperatures 0/13/02,	!				
	10/12/02, 10/26/02	2, 10/7/02, 10/8/02, 10/ and 10/27/02 there were eratures documented.	/10/02, re no AM	į				
	On 10/18/02, 10/2 were no PM dish n	1/02, 10/22/02 and 10/2 nachine temperatures do	3/02 there ocumented.	- - - - - -				
	The following date rinse temperatures degrees Farenheit:	s had dish machine was documented which wer	sh and/or re below 120					
	degrees Farenheit. 10/1/02 PM: wa 10/2/02 AM: wa degrees Farenheit.	ish 114 degrees Farenhe sh 110 degrees Farenhe	eit eit, rinse 115	٠				
	degrees Farenheit. 10/7/02 PM: wa 10/9/02 AM: wa degrees Farenheit 10/14/02 AM: wa	ash 112 degrees Farenhe ash 90 degrees Farenhei ash 100 degrees Farenhe	eit. it, rinse 112					
	degrees Farenheit 10/14/02 PM: wi 10/16/02 PM: rii 10/17/02 AM: wi degrees Farenheit	ash 118 degrees Farenh nse 118 degrees Farenh ash 110 degrees Farenh	eit. eit. eit, rinse 118		:			

CENTERS	FOR MEDICARE &	& MEDICAID SERVIC	CES				T -	
TATEMENT OF DEFICIENCIES (X1) PROVIDER SUPPLIES IDENTIFICATION NUMBER OF CORRECTION		CLIA	(X2) MULT A. BUILDIN B. WING		ONSTRUCTION	(X3) DATE S COMPLE	TED	
		465082					11/:	5/2002
NAME OF PRO	VIDER OR SUPPLIER		STREET ADDR			ZIP CODE		
	W CARE CENTER		1053 WEST PROVO, UT		ТН			
(X4) ID PREFIX TAG	JEACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPH DEFICIENCY)	ELD BL	(NS) COMPLETE DATE
•	10/22/02 AM: wash degrees Farenheit.	54 1118 degrees Farenheit 1110 degrees Farenheit 1118 degrees Farenheit 1115 degrees Farenheit	, rinse 115	F 371	i			
	warewashers that us less than 120 degree U.S. Public Health	the wash solution in spi e chemicals to sanitize es Farenheit. Reference Service FDA (Food and 01 Food Code, page 10'	may not be guidance: l Drug		;	-		
	place dirty pans and The dietary aide wa After the pans and a employee was obse	ietary employee was obdutensils into the dish ras not observed to washutensils were washed, threed to take the clean it having washed her han all mandil base.	her hands. he dietary tems and put	*	i			
F 431 SS=E	483.60(d) PHARM	IACY SERVICES		F 431				
33-E	labeled in accordant	eals used in the facility once with currently accepted, and include the aptionary instructions, and en applicable.	oted opropriate					
	This REOUIREM	ENT is not met as evid	lenced by:					
	Based on observat that the facility did with current accep Specifically, 3 out 8 multidose vials they had been ope	ion and interview, it want into date medications in ted professional principated of 3 medication carts to finsulin which were not med and continued to be 35, 37, 48 and 51.	as determined n accordance ples. nad a total of ot dated after					nuation sheet 55

DEPART	MENI OF REALIT	& MEDICALL SERVI	CES			2567
STATEMENT	S FOR MEDICARE OF DEFICIENCIES OF CORRECTION	& MEDICAIL SERVIO	/CLIA	(X2) MULT A. BUILDIN B. WING		TED
		465082				5/2002
NAME OF PI	ROVIDER OR SUPPLIER				TATE, ZIP CODE	
CRESTV	IEW CARE CENTER		PROVO, U	Г 1020 SOU Т 84601	ТН	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 431	Continued From page	55		F 431		
	cart, it was observed partially used multid	PM, in the north side r I that there was an open lose vial of 70/30 insuli	ed and in which		Residents 15, 33, 35, 37, and 51 have had their medication open and expiration dates reviewed and any unlabeled items are replaced.	11/30/02
	had resident 35's nar strips were also not review of the label of	me on the label. The glu dated after they were of on the glucose test strips	icose test pened. A s bottle		Residents using multi-dose medications have the potential to be affected.	ubalaa
	months after openin On 10/30/02 at 4:00	PM, in the west side n	nedication		The medication storage areas have been audited to ensure multi-dose items are dated, and initialed upon opening. The expiration date was also checked. Any findings were	11/30/02
	partially used multid had resident 15 and opened and partially insulin (long lasting 51's names on the la used multidose vials resident 15 and 33's	I that there were two op dose vials of regular ins 33's name on the labels y used multidose vials of insulin) which had resi abels, and two opened a sof Lantus insulin which anames on the labels. Those test strips which ha	ulin which to two of NPH ident 37 and nd partially th had here was		corrected at the time and the results reported to the QA team. The Licensed professional staff has been re- inserviced on proper opening and handling of multi-dose medications. During the formal documented rounds samples of multi-dose medicines are checked to ensure proper labeling is completed.	12/4/02
	On 10/30/02 at 4:30 was observed that the used multidose vial resident 48's name of	en opened. On, in the east side medicinere was an opened and of regular insulin which on the label. There was so which was not dated a	ation cart, it I partially h had also a bottle		The results of the initial audit and the formal rounds are reported to the QA team for follow up and re education as needed. The DON is responsible for ongoing compliance.	71/03
	facility pharmacist, insulin should be di expiration date cha special labels that we the opened multido	o PM, during an intervi- he stated that the multi- ated after they were open nges. He stated that he would help the facility to use vials of insulin to go 28 to 30 days. He expla	dose vials of ened as the would send o not allow past the			

each time the multidose vial is punctured with a needle

CENTERS	FOR MEDICARE	& MEDICAID SERVIC	ES				2307
STATEMENT (OF DEFICIENCIES CORRECTION	(XI) PROVIDER/SUPPLIER/ IDENTIFICATION NUM	CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SU COMPLE	
		465082		B. WING		11/5	5/2002
VALUE OF BRO	OVIDER OR SUPPLIER	403082	STREET ADDR	ESS, CITY, STATE,	ZIP CODE		
NAME OF PRO	ANDER OF SOLLTIER			1020 SOUTH			
CRESTVII	EW CARE CENTER		PROVO, UT	Г 84601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY I LSC IDENTIFYING INFORMAT	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) (ROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	COMPLETE DATE
	Continued From page it lends itself to the pinfection control.	56 possibility of a problem	with	F 431			
	dated February 2001 not possible, the 10	nufacturer instructions for the stated that, "If refriger mL [milliliter] vials rows period or they must be seen the state of the s	ration is must be				
	manufacturer's pham NPH insulin was do insulin vials stored a should be discarded document which pro American Diabetes though each insulin date, a slight loss of	AM, an interview with to macist of the 70/30, Regone. She stated that multipate room temperature and after 30 days. She also evided some information. Association. It revealed vial is stamped with an figure of potency may occur after more than 30 days, especiature."	gular and idose I in use, faxed a n from the that, "even expiration er the vial	3.			
F 465 SS=E	The facility must p	AL ENVIRONMENT rovide a safe, functional vironment for residents.	, sanitary, , staff and	F 465 °	i i		
	This REQUIREME	ENT is not met as evide	enced by:				
	safe, sanitary and c	ion, the facility did not post to comfortable environmen the public, by not main a, ceiling or walls.	t for				
	Findings include:						
	1. Throughout the hall floors, approx	facility halls, on both si imately one foot away f	des of the rom both				

PRINTED: 11/12/20 DEPARTMENT OF HEALTH AND HUM/ `SERVICES FORM APPROVE CENTERS FOR MEDICARE & MEDICAL JERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 11/5/2002 465082 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1053 WEST 1020 SOUTH CRESTVIEW CARE CENTER PROVO, UT 84601 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 465 Continued From page 57 F 465 No specific residents cited. degrees which made it unsanitizable. Residents living in the facility could be 2. In room 109, there was a damaged area in the

affected.

An audit has been done by the facility to

audit has been approved for capital improvements. The bids and contracts are

the first quarter of 2003.

has been repaired or replaced.

develops action plans as needed.

compliance.

identify areas needed for improvement. The

being completed. The finish project date is in

The floor tiles in halls and thresholds in 121

The ceiling tiles in 109, 110,111, 112, and 119

The environment of care committee reviews

The administrator is responsible for ongoing

the physical plant on a monthly basis and

and 213 will be replaced by March 2003.

ceiling which measured about 1 foot in diameter, there was another damaged area in the ceiling that measured about 2 feet in diameter, and .two damaged areas in the ceiling that measured about 6 inches in diameter.

3. In room 110, there was a damaged area in the ceiling which measured about 6 inches in diameter.

- 4. In room 111, there was a damaged area in the ceiling which measured about 6 inches in diameter and another area that measured 2 feet in diameter.
- 5. In room 112, there was a damaged area in the ceiling which measured about 6 inches in diameter.
- 6. In room 119, there was a 2 inch by 2 inch hole in the wall where the cable for the antennae of the television came through. This made the area unsanitizable.
- 7. In room 121 and 213, the seam of the threshold was open and coming apart making it unsanitizable.

F 490

F 490 483.75 ADMINISTRATION

SS=H

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:

Based on observation, interviews and review of residents medical records, and facility policies and procedures during the annual survey from 10/29/02

11/10/02

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

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUM	/CLIA IBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SUF	
		465082		B. WING _		11/5/	2002
NAME OF PR	OVIDER OR SUPPLIER	1 10233	STREET ADDR	ESS, CITY, ST	TATE, ZIP CODE		
	IEW CARE CENTER		1053 WEST PROVO, UT				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY .SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY))ULD BE	(X5) COMPLETE DATE
F 490	not administered in a resources effectively maintain the highest for each resident in the nutritional assessme was found to be proceed (a pattern of activity was cited in this deficiency. Findings include: 1. On October 31,2 Standard Extended resulted in the detern of Care. The detern of Care was based of and intervention for weight loss and or limited to the control of the co	vas determined that the a manner that enabled it and efficiently to attain practicable physical we the area of weight loss on the area of weight loss on the area of weight loss on the area of weight loss on the area of weight loss on the sub-Standard Quetual harm) in this area. In total of 11 areas, not survey was completed or mination of Sub-Standard on the lack of dietary as the fresidents who had significantly values reflect the sub-standard of the sub-standard of the lack of the sub-standard of the lack of the sub-standard of the lack of the sub-standard of the lack of the sub-standard of the lack of the sub-standard of the lack of the sub-standard of the lack of the sub-standard of the lack of the sub-standard o	t to use its in or sell-being with he facility he facility he facility had been selled and control of the selled and control of the heard Quality had Quality here facility had guilty here facilities and facilities had control of the facility had control	F 490	No individual resident was cited. Federal Tag 157, 241, 278, 279, 3 371, 431, and 465. Residents residing in the facility has potential to be affected. The administrator and department been re-inserviced on the QA proinvolvement of the proper departreach committee. A complete QA done to develop action plans. The reviewed and individual responsibility gone over. Outside consultants were used for services, physical plant review, many services, and Administration. The were involved in re-education as a man development. Individual audicompleted and reported to the QA QA team was charged with developlans to address issues as they are	25, 361, have the heads have head	12/03/02
	A pattern of actual (10, 16, 20, 21, 45 significant weight I reflected malnutriti but did not receive intervention. a. Resident 45 sho unplanned weight August 2002. Also the medical record loss, was 11/10/01 normal limits). Ar	harm was identified for and 48) who experience oss and/or whose labor on and/or who had presadequate nutritional as full have triggered for sloss of 12% during the form the last albumin lever of resident 45, prior to and was found to be 3 to the ralbumin was obtaining the loss of the last albumin was obtained to be 3 to the ralbumin was obtained to be 3 to the ralbumin was obtained to the significant weight loss by	ed atory values soure sores, sessment or significant first week of the weight 4 (within ained on		The actual QA minutes will be segeneral partners office by the last each month for the next quarter, Quality Indicators and the 802, 6 weights will be sent to the general monthly for oversight and re eduneeded. The RD contract has be ongoing consulting. The Administrator is responsible compliance.	t week of after that 172 and all partner cation as en signed for	1/8/03

CENTERS	S FOR MEDICARE	<u>& MEDICAID SERVIC</u> T	<u> </u>	1		(X3) DATE S	SURVEY
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER SUPPLIER/ IDENTIFICATION NUM	CLIA IBER:	i	E CONSTRUCTION	COMPLI	
AND PLAN O	F CORRECTION	IDEATH CATION ACM		A. BUILDING B. WING			15/2002
		465082				11/	/5/2002
NAME OF PR	ROVIDER OR SUPPLIER			ESS, CITY, STAT			
			1053 WEST	1020 SOUTH	I		
CRESTV	IEW CARE CENTER		PROVO, UT	04001	TO SUID FING DI ANI DE CO	DRECTION	(X5)
(X4) ID PREFIX TAG	/EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL .	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE DATE
F 490	reflects a mild to me	2, and was found to be 2 oderate visceral protein	depletion.	F 490			
	facility staff were a	r 10/8/02 did not docum ware of any weight loss ms and did not documen	or				
	resident 45.			į			
	pressure sores, show the unplanned weight I October 2002. The second week of October 2002 and week of October 2002. The second week of October 2002. The second week of North Second week of Nurses facility policy to wand weekly theread not follow this poladmission weight obtain a weight on weeks of his stay.	o was admitted 9/12/02 uld have triggered for si oss of 11.2% in the second QA minutes for 10/8/0 note 2002) did not document discussing with the Administrator on 11/5/02, they stated reigh each resident upon fter for four weeks. Facility as they did not obtain for resident 16. Staff all resident 16 the second	gnificant ond week of 22 (in the nument that is/nutrition resident 16. and that it was a admission ality staff did in an so did not or fourth				
	interventions for her for nearly a year, resident 21 with a her low albumins documentation in committee was avain treatment for rediscussing resident d. Resident 10 has significant weight along with low al	d continuous delays in the low albumin and prethe facility was not been dequate levels of protein and pressure sore. The QA minutes to evidence ware of the lack of treatment 21 and did not dent 21. and several documented in the loss over the previous libumin levels. The facilities to correct these situations and pressure and the previous libumin levels. The facilities to correct these situations and previous and previous libumin levels.	ssure sore. n providing n to address re was no e that the QA nent or delays ocument instances of 12 months lity did not	·			

Event ID: 6HIP11

SERVICES DEPARTMENT OF HEALTH AND HUM

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CENTER	S FOR MEDICARE	& MEDICAID SERVI	CES			··· · · · · · · · · · · · · · · · · ·	2567
	ATEMENT OF DEFICIENCIES (X1) PROVIDER SUPPLIER CI IDENTIFICATION NUMBER			(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE S COMPLE	ETED
		465082	CTREET + DR	BESS CITY STATE	ZID CODE	11/	5/2002
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STATE,	ZIPCODE		
CRESTV	IEW CARE CENTER		PROVO, U	T 1020 SOUTH T 84601			<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETF DATE
F 490	committee was aware	minutes to evidence the of the lack of treatment 10 and did not docu	nt or delays	F 490			
	weight loss on 8/6/02 weight in 14 days. The treatment for both his protein to aide healing was no documentation aware of the significant documentation in the evidence that the QA significant weight loss in his treatment for the f. Resident 48 was a the facility on 9/3/02 Resident 48's labs dalevel of 2.2 gm/dl gravisceral protein deple have documentation aware that resident 4 supplement as recommendation.	d have triggered for sight, having lost 13.9% of here were multiple delays weight loss and to ince gof his pressure sores, in that the physician was not weight loss. There QA minutes, dated 10% committee was aware as of resident 20 or of the weight loss. 60 year-old female admitted a stage 2 pressure ted 9/17/02 revealed are many per deciliter (mode etion). The QA committed show evidence that the was not receiving the mended by the dietitian and aide in healing her	his body ays in the rease There as made was no /8/02, to of the he delays mitted to e sore n albumin erate tee did not hey were protein n to bring				
	weight loss, malnutri pressure sores for res and did not document issues. On 10/29/02, the Adfacility's weight/skin first of 2002. The A	not identify concerns retion and nutrition aide sidents 10, 16, 20, 21, 4 t any type of plan to coministrator was asked homeeting had functioned diministrator stated that	to heal 45 and 48 correct these how the d from the they had				· .
	-	dietitian from January tian who consulted for	_				

Event ID: 6HIP11

Facility ID:

DEPARTMENT OF HEALTH AND HUM SERVICES

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CENTE	RS FOR MEDICARE	& MEDICALD SERVI	CES				2567
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB 465082		(X1) PROVIDER/SUPPLIER	/CLIA			1 ' '	SURVEY LETED
			B. WING		11	1/5/2002	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
CREST	/IEW CARE CENTER		1053 WEST PROVO, UT	1020 SOUT Γ 84601	Н		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 490	to the facility on Junstated that after that, "several weeks". The dictition did not apper This was 71 days, owe did not have a dictition after the dictition left weekly skin/weight reat Risk (NAR) Command procedure was possible to the Director of Nurshad been revised in a sthe new DON. The of the NAR committed manager, CNA (certification) and the manager, CNA (certification) and the manager, conditions. Based on review of the provided by the facility held the weeks of: June 30 - July 6, 200 July 21 - 27, 2002 August 11 - 17, 2002 August 18 - 24, 2002 August 25 - 31, 2002 September 15 - 21, 2002 Only monthly meeting through May 2002.	gh June 2002 made here 4, 2002. The Adminithey were without a dide enext notes by a regist ear in resident charts under two months, that the an. The Administrator in June, that they tried meetings. The facility's mittee (weight/skin team rovided to surveyors or ses (DON) stated that the August 2002, when she he policy stated that the ee included the DON, of iffied nurse aide) coordinator, and to stated that these included the these individuals or review resident's weight/skin meeting mixing weight/skin meeting mixing, weekly meetings weight.	strator etitian for ered ani 8 15 02. facility stated that to hold Nutrition n) policy n 11/5/02. ne policy was hired members dietary nator, the che iduals ght's and nutes ere not	F 490			
		h 10/24/02, 2 of the me					

minutes (8/1/02, 9/2/02) documented only "reviewed all patients". No other details or notes were included

DEPARTMENT OF HEALTH AND HUMA **ERVICES** PRINTED: 11/12/20 FORM APPROVE

CENTER	RS FOR MEDICARE	& MEDICAID SERVI	CES		<u> </u>		2567
		(X1) PROVIDER/SUPPLIER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465082		B. WING		11	/5/2002
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
	TEW CARE CENTER		1053 WEST PROVO, U	1020 SOUTH F 84601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EAC'H CORRECTIVE ACTH CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
F 490	to show evidence that weight loss, malnutris sores had been identified had been made and with the recommendations committee meetings documented only resissues of concern, or the 14 NAR (weight 8/9/02, 9/2/02, 9/9/0 presence of anyone of the dietary manager of the 14 NAR (weight included the presence the 14 meetings inche coordinator (a nurse significant change as There was no documentite was awar per facility policy. The facility was not procedure regarding meeting. There was no documy year of 2002 to evid aware that the NAR following facility policy meetings, not involve documenting the identifications.	at individuals at risk or ation (low albumin) or partition (low albumin) or partition (low albumin) or partition (low albumin) or partition (low are sponsible to so the second (8/9/02, 9/9/02, 9/24/0 (ident names and did not plans to address concertskin) meetings (6/11/02, 9/24/02) were held without the dietary departs or a registered dietition and the presence of the who performs quarterly seessments of the residentation to evidence the that weights were not following their own pothe NAR (weight/skin) mentation in the QA minence that the QA committed (weight/skin) committed	oressure endations implement (4 NAR 2) of include erns. Six of (2, 8/1/02, without the ment (either 1). Only 1 (24/02) an. None of the MDS (y) and ents). (at the NAR (t) being done (b) committee (b) committee (c) the mittee was (e) was not (f) tholding (g) and (g) plans for	F 490			
		ated 10/14/02, mention to do a dietary order for					

Facility ID:

new approaches on it as described by dietary

loss or malnutrition was noted.

manager". No further documentation regarding weight

DEPARTMENT OF HEALTH AND HUM. SERVICES F

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	CENTERS FOR MEDICARE & MEDICAID SERVICES									
STATEMENT OF DEFICIENCIES (X1) PRO		(XI) PROVIDER/SUPPLIER	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		465082		B. WING		11	/5/2002			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	ORESS, CITY, STATE	, ZIP CODE					
CRESTV	IEW CARE CENTER		1053 WES PROVO, U	ST 1020 SOUTH UT 84601						
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEEDED BY FUL		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(XS) COMPLETE DATE			
F 490	Continued From page	63		F 490						
	prior DON who was 2002, mentions "wei	rate audit, which mention employed through the ghts are missingI thin	end of July ak it would							

An additional corporate audit, which mentions the prior DON who was employed through the end of July 2002, mentions "weights are missing...I think it would be a good idea to QA this and identify it as part of your program, develop a plan of correction and show the state you picked it up and are correcting it." The QA minutes dated 7/9/02 documented that the QA committee was wondering "about scales...working properly." There was no mention of the committee being aware of missed weights, but rather the accuracy of the scales. The Administrator stated on 11/5/02 that the scale company had been out to the facility and found nothing wrong with the scale. A plan of correction to address the weights not being obtained was not found among the QA minutes.

There was no documentation to evidence that facility administration was aware of the concerns with weight loss, malnutrition and adequate nutrition to address pressure sore healing.

In addition to the Sub-Standard Quality of Care concerns with weight loss, malnutrition and those individuals with pressure sores needed nutritional intervention (please see F 325 within this document), 11 other deficient areas were identified within the facility. Seven of these other 11 deficient areas were not identified or addressed with a plan of correction by the QA committee.

- Facility administration failed to identify and establish a corrective action plan to ensure that a resident's physician was notified immediately when there was a significant change in the resident's condition.
- Facility administration failed to identify and establish a corrective action plan to ensure that a first response to call lights occurred within 5 minutes with

Facility ID: UT0017 If continuation sheet 64 of

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NO			A BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		465082		B. WING	_,		11,	/5/2002	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY,	STATE,	ZIP CODE			
CRESTVIEW CARE CENTER			1053 WEST 1020 SOUTH PROVO, UT 84601						
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEEDED B			ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	. N.5) C <mark>omplete</mark> Date	
F 490	Continued From page 6 assistance to the resid			F 490	1			:	
	a corrective action pl	ion failed to identify ar lan to ensure that reside ed and available for use	nt care						
	a corrective action pl administered in a ma resources efficiently residents were provide	ion failed to identify ar lan to ensure that the fa nner that enabled it to to or effectively to ensure ded the opportunity to a t practicable well-being	cility was use it's that uttain or		:	·			
	a corrective action pl dated when opened,	tion failed to identify are lan to ensure that insuling as recommended by the facility's pharmacist.	n was	*	1				
;	a corrective action pl	tion failed to identify ar lan to ensure the facility sumtation standards in	1		:				
	action plan to ensure serve the needs of its	tion failed to establish a that the facility had a c residents and that a di upervision to the dietary	lietitian to etitian			·			
F 520 SS=E	483.75(o)(1) ADMINISTRATION		ļ	F 520				:	
	assurance committee nursing services; a p	tain a quality assessment consisting of the direct hysician designated by dother members of the	tor of the		1				
	This REOUIREMEN	NT is not met as evider	iced by:						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER'SUPPLIER IDENTIFICATION NUM			A. BUILDE	NG	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		465082		B. WING _			11/5/2002	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, Z	ZIP CODE		
CRESTV	CORCOVICAL CARE CENTED		1053 WES PROVO, U	T 1020 SOU T 84601	TH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEEDED BY F		FULL	ID PREFIX TAG	· •	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPRODEFICIENCY)	CLD BE COMPLETE	
F 520	(QA) meeting minute facility did not maint assessment committe Specifically, 3 of the did not contain documents of the physician was presentation.	nd review of quality as is, it was determined the ain a quality assurance which included a phy 4 quarterly QA meeting nentation to evidence to	at the and vsician. egs minutes	F 520				
	of weight loss and nu into an extended surve meeting minutes were these minutes, the fact throughout 2002. The 1/8/02, 4/16/02, 7/9/0. There was no documphysician had attended QA committee for the 7/9/02.	entation to evidence the dor had been on alve a meetings held 1-8/02	ly entering cility's QA review of eting ags were at a d with the 4/16/02 or	** Advances				
	_	h the Administrator on been very hard getting meetings.						
F 521 SS=H	The quality assessme meets at least quarter to which quality asse are necessary; and de	oministration ont and assurance comment to identify issues with sament and assurance acceptance and implement action to correct identification.	th respect activities s	F 521				
		ary may not require dis					-	

DEPARTMENT OF HEALTH AND HUMA ERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/12/20 FORM APPROVE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER SUPPLIER:CLIA IDENTIFICATION NUMBER		A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465082			B. WING		11/5/2002
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	
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F 521	This REQUIREMEN Based on staff intervipolicies and procedur Assurance (QA) com 4/16/02, 7/9/02 and I the facility's QA com deficiencies regardin intervention and re-e significant unplanned resulting in actual has	of the compliance of surprise of this sector of this sector. The sector of this sector of the sector	tion. facility's facility's facility 1/8/02, fined that function function, fesidents.	F 521		
	Findings include:			\		
	Standard Extended so resulted in the determ of Care. The determ of Care was based or and intervention for weight loss and/or la	on the lack of dietary assistance of Sub-Standard the lack of dietary assistance of Sub-Standard the lack of dietary assistance of Sub-Standard the lack of dietary assistance of residents who had signoratory values reflect 1483.25 (i) Tag F - 325]	chich and Quality and Quality dessment anificant ing	•	i.	ı
	Weight loss/ Nutrition Please refer to F- 32:	onal Assessment and In 5.	tervention:			
	through 11/5/02, a pridentified for 6 resid who experienced sig laboratory values ref pressure sores, but d assessment or intervention	certification survey fro attern of actual harm wents (10, 16, 20, 21, 45 nificant weight loss and lected malnutrition and id not receive adequate ention.	as and 48) d/or whose d/or had nutritional			

7/9/02 and 10/8/02. The QA minutes were reviewed

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

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 521	by survey on 10/31/0 Standard Quality of C revealed the followin	2, after determining Su Care. A review of the C g:	ib- QA minutes	F 521			
	unplanned weight los August 2002. Also, the medical record of loss, was 11/10/01 ar normal limits). Anot 9/24/02, after the sign and September 2002,	d have triggered for signs of 12% during the first the last albumin level of resident 45, prior to the dwas found to be 3.4 the albumin was obtain inficant weight loss better and was found to be 2 derate visceral protein of	st week of recorded in ne weight (within ned on ween June .8 which				
		10/8/02 did not docume are of any weight loss of and did not document	or	:			
	pressure sores, should unplanned weight los October 2002. The Osecond week of Octofacility staff were aw concerns and did not Based on interview we Director of Nurses of facility policy to weight and weekly thereafter not follow this policy admission weight for	d have triggered for signs of 11.2% in the secon QA minutes for 10/8/02 ber 2002) did not document discussing rowith the Administrator and 11/5/02, they stated the gheach resident upon a for four weeks. Facility as they did not obtain resident 16. Staff also sident 16 the second or	nificant nd week of (in the ment that nutrition esident 16. and hat it was idmission ity staff did an				
	interventions for her For nearly a year, the	ontinuous delays in the low albumin and presso facility was not been p quate levels of protein t	ure sore. providing	:			

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DEPARTMENT OF HEALTH AND HUM. SERVICES FORM APPROVE CENTERS FOR MEDICARE & MEDICAID SERVICES 2567 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (N2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING _ 465082 11/5/2002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1053 WEST 1020 SOUTH CRESTVIEW CARE CENTER PROVO, UT 84601 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) PRITIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE EAG DEFICIENCY F 521 Continued From page 68 F 521 her low albumins and pressure sore. There was no documentation in QA minutes to evidence that the QA committee was aware of the lack of treatment or delays in treatment for resident 21 and did not document discussing resident 21. d. Resident 10 had several documented instances of significant weight loss over the previous 12 months along with low albumin levels. The facility did not implement actions to correct these situations or they implemented actions late. There was no documentation in QA minutes to evidence that the QA committee was aware of the lack of treatment or delays in treatment for resident 10 and did not document discussing resident 10. e. Resident 20 should have triggered for significant weight loss on 8/6/02, having lost 13.9% of his body weight in 14 days. There were multiple delays in the treatment for both his weight loss and to increase protein to aide healing of his pressure sores. There was no documentation that the physician was made aware of the significant weight loss. There was no documentation in the QA minutes, dated 10/8/02, to evidence that the QA committee was aware of the significant weight loss of resident 20 or of the delays in his treatment for the weight loss. f. Resident 48 was a 60 year-old female admitted to the facility on 9/3/02 with a stage 2 pressure sore.

Resident 48's labs dated 9/17/02 revealed an albumin level of 2.2 gm/dl grams per deciliter (moderate visceral protein depletion). The QA committee did not have documentation to show evidence that they were aware that resident 48 was not receiving the protein supplement as recommended by the dietitian to bring up her albumin level and aide in healing her pressure

sore.

DEPARTMENT OF HEALTH AND HUM SERVICES

	S EOD MEDICARE	& MEDICAID SERVI	CES			FORM	256 <u>7</u>
CENTER	3 FOR MEDICARE	NEDICAID SERVI	CES				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE S COMPLE	
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F 521	weight loss, malnutri pressure sores for res and did not documen issues. On 10/29/02, the Add	not identify concerns ration and nutrition aide sidents 10, 16, 20, 21, 4 at any type of plan to comministrator was asked I meeting had functioned	to heal 45 and 48 brrect these	F 521			
	first of 2002. The Admet monthly with the June 2002. The dietiduring January throught to the facility on June stated that after that, "several weeks". The dietitian did not apped This was 71 days, ow did not have a dietitian left weekly skin/weight nat Risk (NAR) Command procedure was pure The Director of Nurse had been revised in A as the new DON. The of the NAR committe manager, CNA (certification of the state of th	dministrator stated that a dietitian from January itian who consulted for gh June 2002 made here 4, 2002. The Administrator where two months, that the an. The Administrator in June, that they tried neetings. The facility's mittee (weight/skin team rovided to surveyors or less (DON) stated that the August 2002, when she are policy stated that the ee included the DON, offied nurse aide) coordinated to coordinate that the ee included the DON, offied nurse aide) coordinated that the ee included the DON, offied nurse aide) coordinated that the ee included the DON, offied nurse aide) coordinated that the ee included the DON, offied nurse aide) coordinated that the ee included the DON, offied nurse aide) coordinated that the ee included the DON, offied nurse aide) coordinated that the ee included the coordinated that the ee included the DON, offied nurse aide) coordinated that the ee included the coordinated that the ee included the coordinated that the entire that t	they had through the facility last visit strator etitian for ered till 8/15/02 facility stated that to hold Nutrition n) policy n 11/5/02. The policy was hired members dietary nator, the				
	dietitian. The policy	a set) coordinator, and to stated that these indivi- o review resident's wei	iduals				:
		veight/skin meeting mi ity, weekly meetings w					į

June 30 - July 6, 2002 July 21 - 27, 2002 August 11 - 17, 2002

	TATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 521			:	F 521			
	through May 2002.						
	from 6/11/02 through minutes (8/1/02, 9/2/0 all patients". No other to show evidence that weight loss, malnutrit sores had been identify had been made and with the recommendations committee meetings (documented only resistant of concern, or the 14 NAR (weight/s 8/9/02, 9/2/02, 9/9/02 presence of anyone from the first of the second of th	skin) meetings (6/11/02 2, 9/24/02) were held w from the dietary departm	eting reviewed included with actual oressure endations implement 4 NAR 2) t include 2, 8/1/02 without the nent (either				
	of the 14 NAR (weight included the presence the 14 meetings inclu-	or a registered dietitian) ht/skin) meetings (10/2- e of a registered dietitian ided the presence of the	4/02) in. None of MDS	·		:	
		who performs quarterly sessments of the resider		į ;		!	
	There was no docume	entation to evidence that weights were not	at the NAR	; ;			
	•	following their own poli the NAR (weight/skin)	-				
	year of 2002 to evide	entation in the QA minurace that the QA commitweight/skin) committee	ittee was	•			

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

AND BLANCE CORRECTION		(X1) PROVIDER SUPPLIER IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 521	meetings, not involving documenting the identification or follower implementation or follower involves of this common A corporate audit, da	icy and procedure, not ng dietary personnel, a ntification of residents, llow-up of residents ne nittee. ted 10/14/02, mentione	holding and not plans for reding the ed "wt.	F 521			
	(weight) loss - need to do a dietary order form with new approaches on it as described by dietary manager". No further documentation regarding weight loss or malnutrition was noted. An additional corporate audit, which mentions the prior DON who was employed through the end of July 2002, mentions "weights are missingI think it would be a good idea to QA this and identify it as part of your program, develop a plan of correction and show the state you picked it up and are correcting it." The QA minutes dated 7/9/02 documented that the QA committee was wondering "about scalesworking properly." There was no mention of the committee being aware of missed weights, but rather the accuracy of the scales. The Administrator stated on 11/5/02 that the scale company had been out to the facility and found nothing wrong with the scale. A plan of correction to address the weights not being obtained was not found among the QA minutes.						
) 			
				•	z'		
	concerns with weight individuals with press intervention (please si 12 other deficient are facility. Seven of the not identified or address the QA committee. - The facility's QA co	o-Standard Quality of Coloss, malnutrition and sure sores needed nutrities F 325 within this do as were identified with se other 12 deficient are essed with a plan of committee did not identification plan to ensure the	those tional ccument), in the reas were crection by				

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 521		2 vas notified immediatel at change in the residen	y when	F 521			
	establish a corrective	ommittee did not identi action plan to ensure t s occurred within 5 mir lents as needed.	hat a first				
	establish a corrective	emmittee did not identi action plan to ensure t ere established and ava	hat				
	- The facility's QA committee did not identify and establish a corrective action plan to ensure that the facility was administered in a manner that enabled it to use it's resources efficiently or effectively to ensure that residents were provided the opportunity to attain or maintain their highest practicable well-being.			,			
	- The facility's QA committee did not identify and establish a corrective action plan to ensure that insulin was dated when opened, as recommended by the manufacturer and the facility's pharmacist.						
	establish a corrective	emmittee did not identi action plan to ensure t anitation standards in	he facility				
	corrective action plan	ommittee did not estable to ensure that the facineeds of its residents are equate supervision to the staff.	lity had a nd that a				

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CRESTVIEW CARE CENTE CLESTVIEW CC POC ADDENDUM

accepted 12-12-02

December 5, 2002

Bureau of Medicaid/Medicare Program Certification and resident Assessment P.O. Box 144108 Salt lake City, Utah 84114-4103



I thought the best way to respond to your questions is to address each issue after the initial responses. I will be happy to discuss any of this further with you if you have other questions.

Marcia Lindelien Administrator

F 157

Resident number 20 has been evaluated by a physician and the current treatment plan has been communicated to the family.

Residents with a change in condition have the potential to be affected.

The facility has completed an audit of the twenty-four hour report for the last month comparing issues on the 24-hour report to physician contacts. The Licensed professional staff have been rein serviced on the need for timely reporting. During the in-service the American Medical Directors Association stand for timely reporting was reviewed and is kept at the nursing stations. The DON is reviewing the 24-hour report and initialing it once reviewed to ensure timely physician involvement is being made.

The results of the audit were reported to the record of care QA committee team for review and identification of training needs. The review of the twenty-four hour report is done ongoing and the review will be completed once compliance has been determined by the record of Care Committee.

The DON is responsible for ongoing compliance.

- 1. How often is the DON reviewing the 24-hour reports? Each day she works and she will assign a designee on her off days.
- 2. How long will she do this? It is an expectation of her job.

12/11/2002 16:55 8013732660

CRESTVIEW CARE CENTE

PAGE 03

- 3. Will this be your permanent system to ensure physician notification? Yes, the next level of the program is a system called the PAR (patients at Risk) meeting, which reviews residents and ensures timely notification.
- Please define timely fashion. The AMDA standard guides the nurse to define immediate consultation circumstances. The guidelines are defined by symptoms.

F 241

No individual residents were identified. The resident council has been asked to assist in monitoring call light response times and will report to the administration any issues going forward.

Residents requiring assistance in their rooms have the potential to be affected.

Call light response time is being monitored during routine rounds and now we are doing a formal written rounds that tests call light response time at least daily for four weeks then weekly and finally monthly. The staff have been re-in serviced on the need to responds to call lights in a timely fashion.

The results of the rounds and the resident council minutes will be reviewed by the Facility practices committee to ensure on going compliance and to identify trends and re education opportunities.

The DON is responsible for ongoing compliance.

- 1. Weekly for how long? Daily for four weeks, weekly for four weeks and then monthly.
- 2. Who will be in charge of performing audits? The administrative staff.
- 3. Please define timely fashion? Timely is within the Utah standard of five minutes.
- 4. Is anyone specific in the resident council that will monitor and record call light response? Yes, some residents did volunteer to time and record and others agreed to express their experience as to whether we are getting better, worse or the same from their prospective.
- 5. How often will the results of the resident council and facility audits be reviewed by your facility practices committee? Monthly
- 6. Who is on your facility practices committee? The required members are DON, Diet Manager, Rehab Director, Staff Development, ADM.

F 278

Resident 45 has been reevaluated and the MDS is current to the ARD. The Plan of care team met to review the Plan of care.

Resident C2 was a closed record.

Residents requiring an MDS assessment have the potential to be affected.

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12/11/2002 16:55

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CRESTVIEW CARE CENTE

PAGE

The MDS nurse has reviewed the RAI manual covering chapter three completion of the MDS. A competency test was administered and passed after the review. Staff completing the MDS is going through a competency test to ensure to identify further training needs.

The record of care committee reviews a sample of MDSs for accuracy and creates action plans when discrepancies occur, internal inconsistencies in the MDS are checked using a computer program called LTCQ after completing the MDS. The LTCQ reports are kept for review by the DON and the MDS nurse. The program identifies issues and offers suggestions for correction.

The DON is responsible for ongoing compliance.

- 1. What percentage of MDSs will the record of care committee review for accuracy and how often? The MDS review will be 5%, monthly.
- 2. Will a log be kept of those MDSs reviewed and the results? The QA audit tool will be kept as part of the committee minutes as well as action plans based on the results.
- 3. How will you involve the QA committee and how often? The Record of Care Committee reports monthly on the action plans they have in place to the QA team.
- Who is on the record of care committee? The required members are the DON, MDS, and Medical Records.

F 279

Resident number 5 has been reassessed and care plans have been developed accordingly to the assessment.

A chart audit has been completed to ensure care plan development for each resident can be found in the chart. The medical records clerk has the plan of care on the audit tool that is used within 14 days of admit and then quarterly. The record of care committee reviews a sample of MDS and care plans for accuracy and timeliness and creates action plans when discrepancies occur.

The results of the audit and record of review committee is done by the full QA team to identify trends and further educational needs.

The DON is responsible for ongoing compliance.

- What percentage of the care plans will the record of care committee review for accuracy and how often? At least 5 percent at least monthly.
- 2. How often will these audits be reviewed by the QA? The committee will review the audits and create action plans based on the results and report the action plans in progress to the QA monthly.

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F 325

Resident 10, 16, 20, 21, 45, 48 have been reviewed by the RD contractor with updates to care plans made to include weight loss and albumin issues being addressed. Each resident has had their plan reviewed by a physician.

Residents at risk for nutritional issues have the potential to be affected.

A resident audit was completed along with a risk tool to determine risk levels for residents. The audit looked for intervention implementation comparing delivery and physician order and RD recommendations. Weekly weights are being done to reestablish base lines for residents. The resident care staff have been re-in serviced on proper dining room and intake records as well as proper weighing techniques. The Dietary staff have been re-in serviced on proper food handling and preparation. A lab audit has been completed to ensure albumin levels are being communicated to the RD for timely intervention. The RD is aware of the Manual for Clinical dietetics and is using the manual to develop current interventions. Recommendations are being tracked to ensure timely communication to the physician and eventual implementation. Time from recommendation to implementation is being reported to the QA team for review and action plan development. The weights are being reviewed by the Facility practices committee for development of interventions and reporting to the QA team.

The DON and Administrator is responsible for ongoing compliance.

- 1. Were all residents assessed for nutritional risk? Yes, by the contract RD.
- 2. Who completed the nutritional risk assessment? The contracted RD.
- 3. Do you have a policy for routine re-evaluation to determine risk? Yes
- 4. What will be done for those resident who trigger for high nutritional risk? Residents at high risk are reviewed weekly to consider interventions such as: nutritionally dense foods, med pass supplements, routine labs, weekly weights, and pharmacy interventions. The physician is asked to address weight in a progress notes.
- Do you have a nutritional/weight committee? Yes, they meet weekly and report to the facility practices committee.
- Who are the members? The required members are the DON, ADM, and Dietary manager.
- 7. How often do they meet? The formal committee meets weekly, but food intake is reviewed in daily stand up meetings reviewed on the 24-hour report.
- 8. What will be discussed? The committee reviews the weekly weights, residents showing up at risk from the 24-hour report and abnormal labs associated with weights.
- 9. Will all residents be weighed weekly? No, studies show weekly weight fluctuations are normal, so only at high risk and prn residents will be weighed weekly.
- 10. Who is responsible for weekly weights? The DON is oversight and a restorative aide has been assigned the task.
- 11. What is your policy for intervention with residents with weight loss and signs of malnutrition? The policy is to review the causes of weight changes and determine which

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12/11/2002 16:55

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CRESTVIEW CARE CENTE

PAGE

interventions could assist (completed by the DON & RD) and then to offer these options to the physician for their approval.

- 12. Who is responsible to track dietary recommendations to ensure that they are communicated to the physician? The DON.
- 13. **Define timely for physician?** Timely is driven by the resident but we are meeting within 72 hours.
- 14. How often will this be done? Recommendations are done with admits and post reviews, so this is a daily task.
- 15. How often are audits related to F325 communicated to the QA committee? Monthly.

F 361

See F 325

Resident 10, 16, 20, 21, 45, 48 have been reviewed by the RD contractor with updates to care plans made to include weight loss and albumin issues being addressed. Each resident has had his or her plan reviewed by a physician.

Residents at risk for nutritional issues have the potential to be affected.

The RD is aware of the Manual for Clinical dietetics and is using the manual to develop current interventions. The RD has reviewed the residents and risk levels and developed recommendations as appropriate and is tracking recommendation time to implementation time and looking for progress in outcomes. The weights are being reviewed by the RD as part of the facility practices committee; this committee is responsible for measuring outcomes weights as compared to risk levels.

The ADM is responsible for ongoing compliance.

- Do you have a contract with a registered dietitian? No, we contracted with a group called Crandall & Associates, who has assigned us Ms Perkins RD for our RD.
- 2. Is your dietician full-time, part-time, or on a consultant basis? Consultant basis.
- 3. How often does your dietitian visit your facility? Until facility is in substantial compliance RD's hours and number of visits per month have not been limited.
- 4. How much time is spent with each vi\sit? This varies from visit to visit depending on what RD determines the need to be. RD has not been limited in time for consultation hours until facility is in substantial compliance.
- 5. How many hours are allotted to the dietitian per month by contract? 12 to 16 hours.
- 6. Does your dictitian spend time (how much) with the food supervisor? Yes on each visit. Our new dictary manager has had at least 24 hours of direct orientation and continues to be trained.
- 7. How often are weights and resident's nutritional status reviewed by the dietitian? Weights are being reviewed by the RD on each visit

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12/11/2002 16:55

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CRESTVIEW CARE CENTE

PAGE

8. How will the QA team be involved in monitoring this deficiency? The sub committee for weights will review weekly and then create action plans, which are tracked and trended by the QA team Facility practices on a monthly basis. If the trend goes in the wrong direction the survey investigative protocol is used to determine route cause and effects. The facility has a clinical call monthly where information that is sent from the facility to the General partner for review, and at that time if the facility has an issue then the General partners get involved.

F 371

No residents cited.

Residents eating from the kitchen have the potential to be affected.

Temperatures are being monitored during the dishwashing times at the beginning, middle, and end of use. This will be done for one week if temperatures meet thresholds then temperatures will be logged at the beginning of use. The dietary staff has been re-in serviced on proper temperatures and basic sanitation requirements in the commercial kitchen. The in-service specifically covered what to do if temperatures fall during the dishwashing process.

The results of the audit will be reported to the QA team for oversight and identification of education needs and action plans.

The Dietary manager and Administrator is responsible for ongoing compliance.

- 1. Will dishwasher temperatures be monitored each day? Yes
- 2. At the beginning of every use? Yes
- 3. Who provided the in service to the employees on temperatures and basic sanitation requirements? Crandall & Associates
- 4. Will someone do audits to ensure that dietary staff do not cross contamination while in the kitchen? Yes, the contract RD during their visit is doing audits of the kitchen and food preparation to ensure ongoing compliance has been achieved.
- 5. How often? With each visit from the RD
- 6. How often will the results of these audits be reported to the QA team? The RD audits as well as the QA team for environment of care will report results via action plans on a monthly basis.

F 431

Residents 15, 33, 35, 37, and 51 have had their medication open and expiration dates reviewed and any unlabeled items are replaced.

Residents using multi dose medications have the potential to be affected.

12/11/2002 16:55

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CRESTVIEW CARE CENTE

PAGE

The medication storage areas have been audited to ensure multi-dose items are dated, and initialed upon opening. The expiration date was also checked. Any findings were corrected at the time and the results reported to the QA team. The Lic. Professional staff have been re-in serviced on proper opening and handling of multi-dose medications. During the formal documented rounds a sample of multi-dose medicines are checked to ensure proper labeling is completed.

- 1. How often are formal documented rounds preformed? Daily.
- 2. Who is responsible to complete these? The DON or designee.
- 3. How often are the audits reported to the QA team? Monthly.

F 465

No specific residents cited.

Residents living in the facility could be affected.

An audit has been done by the facility to identify areas needed for improvement. The audit has been approved for capital improvements. The bids and contracts are being completed. The finish project date is in the first quarter of 2003.

The floor tile in halls and thresholds in 121 and 213 is to be replaced by March 2003.

The ceiling in 109, 110, 111, 112, and 119 has been repaired or replaced.

The Environment of care committee reviews the physical plant on a monthly basis and develops action plans as needed.

The ADM is responsible for ongoing compliance.

- We are requesting an extension of the floor tile due to the other work that is being bid out for the facility but we do plan on having the floor tile replaced by March 2003.
- Who is on the environmental of care committee? Dictary manager, housekeeping/laundry, maintenance, and Infection control officer.

F 490

The results of the initial audit and the formal rounds are reported to the QA team for follow up and re education as needed.

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CRESTVIEW CARE CENTE

PAGE 09

The DON is responsible for ongoing compliance. No individual resident was cited. But see Federal Tag 157, 241, 278, 279, 325, 361, 371, 431, and 465.

Residents residing in the facility have the potential to be affected.

The administrator and department heads have been re-in served on the QA process and involvement of the proper departments on each committee. A complete QA tool was done to develop action plans. The survey was reviewed and individual responsibilities were gone over.

Outside consultants were used for dietary services, Physical plant review, Nursing services, and Administration. These groups were involved in re education as well as action plan development. Individual audits were completed and reported to the QA team. The QA team was charged with developing action plans to address issues as they arise.

The actual QA minutes will be sent to the General Partners office by the last week of each month for the next quarter, after that Quality Indicators and the 802, 672 and weights will be sent to the General partner monthly for oversight and re-education as needed. The RD contract has been signed for ongoing consulting.

The Administrator is responsible for ongoing compliance.

 Who provided the In-service? RN, MBA, NHA Vice President of Operations Bond, Johnson, and Bond, Inc. the General Partner for Provo Associates Limited Partnership, dba Crestview Care Center.

Who is on the QA committee? The Department Heads, Medical Director, RD, Consultant Pharmacy.

F 520

The results of the initial audit and the formal rounds are reported to the QA team for follow up and re education as needed.

The DON is responsible for ongoing compliance. No individual resident was cited. But see Federal Tag 157, 241, 278, 279, 325, 361, 371, 431, and 465.

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A physician will attend QA meetings at least quarterly. The Administrator is responsible for ongoing compliance.

Completion date 1/5/03

Changes made with verbal permission of the Administrator vira phone call on 12/12/02 @ 9:50 Am.

12/11/2002 16:55

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CRESTVIEW CARE CENTE

PAGE 10

F 521

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Completion date