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FORM APPROVE
2567

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465082	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 11/5/2002
NAME OF PROVIDER OR SUPPLIER: CRESTVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 1053 WEST 1020 SOUTH PROVO, UT 84601	POC accepted 12-12-02 ETI	

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F 157 SS=D	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES	F 157	Please Also see addendum.	

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, it was determined that the facility did not immediately notify 1 of 15 sample resident's physicians when a change in the resident's condition warranted the physician to be notified. Specifically, resident 20 had a possible rectal prolapse and the physician was not notified until 5 days after the possible rectal prolapse was observed.
Resident Identifier: 20.

Utah Dept. of Health
DEC 4 2002
Bur. of Medicare/Medicaid Prog. Certification and Res. Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marcia Lindelien | TITLE: Administrator | (X6) DATE: 12/2/02

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 made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 Findings Include: 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 weakness. A review of resident 20's medical record was done on 10/31/02. A nurse's note, dated 6/27/02, at 2:00 PM, documented the following, "During shower pt's [patient's] rectum was bleeding. Upon examination pt [patient] had red colored tissue protruding from rectum..." A nurse's note, dated 6/29/02, at 11:00 AM, documented the following, "...Pt [patient] has bleeding from rectum [a minimal amount] red and some grayish tissue protruding from anus, blood in brief noted..." During review of the medical record on 10/31/02 there was no documentation to provide evidence that the physician had been made aware of the possible rectal prolapse. On 7/2/02 resident 20 was seen at the facility by a physician for the possible rectal prolapse. 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 physician. 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 that she did not remember the situation but she would inform the physician of the situation the next time she saw the physician.	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 has been re-inserviced 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 the record of care committee has determined compliance. The DON is responsible for ongoing compliance.	11/5/02 12/4/02 ongoing 12/9/02 1/1/03

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F 157	Continued From page 2	F 157		
F 241 SS=E	483.15(a) QUALITY OF LIFE	F 241		

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on observation and 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.

Findings include:

1. On 10/28/02, at 2:30 PM, a confidential interview was held with a group of residents. Twelve residents participated in the meeting. Six (6) of the 12 residents stated that they have had to wait too long for their call light to be answered. One resident stated that he had to wait 45 minutes for a staff member to respond to his call light and help him off of the toilet. Another resident stated that one day she waited 4 hours for her call light to be answered. A third resident stated that one night she and her roommate, who is deaf and blind, pushed the call light and had to wait 90 minutes for assistance.

On 10/28/02 at 1:35 PM, observation of room 210 revealed that the call light above the door was signaling. At 1:45 PM, a facility nurse aide was observed to enter the room to assist the resident. This was 10 minutes after the surveyor observed the call light on in the hallway.

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

Provider's Plan of Correction (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 goin forward. — 12/12/02

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 formal written rounds those tests call light response time at least daily for four weeks then weekly and finally monthly. — 11/18/02

The staff has been re-inserviced on the need to respond to call lights in a timely fashion. — 11/4/02

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. — 1/1/03

The DON is responsible for ongoing compliance.

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F 241	Continued From page 3 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 241		
F 278 SS=D	483.20(g) - (h) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly-- Certifies a material and false statement in a resident	F 278		

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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.	11/30/02 1/1/03

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F 278	Continued From page 5 fracture, osteoporosis, and allergies. Record review of resident C2's closed record was performed on 10/31/02. The Minimum Data Set quarterly review, dated 8/9/02, indicated that resident C2 had four stage 2 pressure ulcers. However, on the previous day, the Total Care Plan quarterly follow up, dated 8/8/02, documented that decubitus (pressure ulcers) were healed. The assessments were not consistent.	F 278		
F 279 SS=D	483.20(k) RESIDENT ASSESSMENT The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under s483.25; and Any services that would otherwise be required under s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility did not maintain comprehensive care plans, that met the resident's medical, nursing and mental and psychological needs that are identified in the comprehensive assessment, on the active clinical record for 1 out of 15 sampled residents. Resident identifier: 5	F 279		

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	Findings include:			
	Resident 5 was admitted to the facility on 5/6/2002 with diagnoses that included chronic obstructive pulmonary disease, convulsions, hypothyroidism, hypertension, constipation, circulatory disease, dementia, and congestive heart failure.		Resident number 5 has been reassessed and care plans have been developed according to the assessment.	11/6/02
	A review of resident 5's clinical record was done on 10/31/02 at 11:00 AM. A review of the MDS (minimum data set) section V - RAPS (resident assessment protocol summary) indicated that areas 2-cognitive loss, 3-visual functions, 4 - communication, 5- ADL (activities of daily living) functional/rehabilitation potential, 6- urinary incontinence and indwelling catheter, 10 - activities, 16 - physical restraints were checked as triggered and were checked for being care planned. No care plans were found on resident 5's chart addressing the above issues.		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 an d care plans for accuracy and timeliness and creates action plans when discrepancies occur.	11/6/02 1/1/03
	A facility nurse was interviewed on 10/31/02 at 11:30 AM. The nurse reviewed resident 5's clinical record and stated that there were no care plans to be found in resident 5's clinical record. The nurse stated that the facility keeps each resident's care plans in the resident's clinical record.		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.	1/1/03
	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.			

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F 325 Continued From page 7 F 325

F 325 SS=H — 483.25(i)(1) QUALITY OF CARE

Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.

This REQUIREMENT is not met as evidenced by:

Based on clinical record review and staff interviews, it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by 5 of 15 sampled residents experienced significant weight loss with no dietary interventions implemented to prevent further weight decline. Resident identifiers: 10, 16, 20, 45, 48. Additionally, 4 of 15 sampled residents experienced low albumin (a protein and indicator of nutritional status) levels with no dietary interventions implemented to help increase the albumin levels and prevent further protein depletion. Resident identifiers: 10, 21, 45, 48.

Calculating weight loss percentages is done by subtracting the current weight from the previous weight, dividing the difference by the previous weight and multiplying by 100. Significant weight losses are as follows: 5% in one month, 7.5% in 3 months and 10% in 6 months. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000).

An albumin level of 2.4 g/dl-2.9 g/dl is considered a moderate visceral protein deficit and an albumin level of 3.0 g/dl-3.5 g/dl is considered a mild visceral protein deficit. Reference Guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000, page 22.

F 325 — Provider's Plan of Correction

Resident 10, 16, 20, 21, 45, 48 have been reviewed by the RD consultant 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. — 11/19/02

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. — 11/30/02
Weekly weights are being done to reestablish base lines for residents. — 10/30/02
The resident care staff has been re-inserviced on proper dining room and intake records as well as proper weighing techniques. The dietary staff has been re-inserviced on proper food handling and preparation. — 11/5/02
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. — 11/30/02
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. — 1/1/03
The weights are being reviewed by the facility practices committee for development of interventions and reporting to the QA team. — 12/3/02

The DON and the Administrator are responsible for ongoing compliance.

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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

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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

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Compleat tube feeding formula at 93 cc (cubic centimeters) an hour for 12 hours. She was also receiving 200 cc of water three times per day (600 cc) and 240 cc of cranberry juice a day. Resident 21 was also ordered 3 scoops of protein powder each day (providing 18 grams of protein and 30 calories per scoop) to help promote healing of her stage II pressure sore. The dietary manager further documented that there were no new lab values available to review. There was no documented evidence that the dietary manager was aware of or had addressed the low albumin levels obtained on 9/10/01 and 9/11/01. There was no documented evidence that the adequacy of the current tube feeding order was assessed or that recommendations were made to increase the protein resident 21 was receiving.

On 1/23/02, a quarterly nutrition progress note was completed by the dietary manager. The note was not co-signed by a registered dietitian. It was documented that resident 21 was tube fed, had a stage II pressure ulcer on her coccyx and a stage II pressure ulcer behind her left knee and had no new lab values available to review. There was no documented evidence that the dietary manager was aware of or had addressed the low albumin levels obtained on 9/10/01 and 9/11/01. There was no documented evidence that the adequacy of the current tube feeding order was assessed or that recommendations were made to increase the protein resident 21 was receiving. Also, on this day, 1/23/02 the dietary manager recommended a multi-vitamin with zinc.

A review of all physician telephone orders and re-certification orders in the chart did not evidence that a multi-vitamin with zinc was ordered.

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

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F 325	Continued From page 11 co-signed by a registered dietitian. The note documented that resident 21 had a stage II pressure ulcer to her coccyx and that resident 21 had experienced significant weight loss over the past 6 months. The dietary manager documented that resident 21 was receiving Compleat at 104 cc per hour for 12 hours. The tube feeding had been changed per a telephone order dated 3/12/02. She was also receiving 200 cc of water three times per day (600 cc), 240 cc of cranberry juice a day and 3 scoops of protein powder each day. Resident 21's nutritional needs were calculated and her protein needs were estimated to be 78 grams. When the survey team calculated the protein provided by Compleat at 104 cc for 12 hours and three scoops protein power it was determined that 71.6 grams of protein were being provided to resident 21. This was 6.4 grams less protein than the 78 grams she was estimated to need per day. Resident 21 was not meeting her estimated protein needs while receiving Compleat at 104 cc an hour for 12 hours plus the additional protein provided by the protein powder given three times per day. It was documented that there were no new labs to assess. There continued to be no documented evidence that the low albumin levels obtained on 9/10/01 and 9/11/01 were addressed. There was no documented evidence that recommendations were made to increase the protein resident 21 was receiving. Resident 21's calorie needs were estimated to be 1500 per day. The dietary manager documented that the tube feeding provided 1335 calories, a difference of 165 calories, which was less that her estimated needs. She documented that she would have the registered dietitian follow up. On 5/7/02, 12 days later, the registered dietitian completed a dietary progress note. She documented that resident 21's weight had re-bounded and that she had a stage II on her buttocks. She documented that there were no recent labs but did make note of the low	F 325		

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albumin level of 2.7 g/dl obtained in September 2001. She recommended a change in the tube feeding formula resident 21 was receiving to one which was designed "for healing and protein repletion".

On 6/4/02, 28 days later, the registered dietitian completed a second dietary progress note. She documented that the nursing staff did not want to change resident 21's tube feeding because of problems that she had experienced before when the formula was changed. She documented, "we do need to increase her protein levels in light of skin breakdown. Will inform nrg. [nursing]."

A review of all physician telephone orders and re-certification orders was completed. There was no documented evidence that measures where taken to increase the protein provided to resident 21 via her g-tube.

On 7/25/02, 51 days after the registered dietitian's note dated 6/4/02, an annual nutrition assessment was completed by the dietary manager. The note was not co-signed by the registered dietitian. It was documented that resident 21 continued to receive Compleat at 104 cc per hour for 12 hours with 600 cc free water, 3 scoops of protein powder and 240 cc of cranberry juice daily via her g-tube. It was noted that resident 21 continued with 2 "open areas". The dietary manager made the same recommendation that the registered dietitian made on 5/7/02 which was to change resident 21's tube feeding formula. She calculated resident 21's protein needs to be 90 grams and documented that the current tube feeding regimen was only providing 53 grams of protein, this was 37 grams less than resident 21's estimated needs of 90 grams. When the survey team calculated the protein provided by Compleat at 104 cc/hour for 12 hours plus the addition protein provided by the protein powder, it

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was determined that 71.6 grams of protein were being provided to resident 21. This was 18.5 grams less than the 90 grams she was estimated to need. Resident 21 would not meet her estimated protein needs while receiving Compleat at 104 cc an hour for 12 hours even with the additional protein provided by the protein powder. The dietary manager documented that she would talk with nursing about a possible change in resident 21's tube feeding and would request an albumin level be drawn.

Per review of the medical chart, an albumin level was drawn on 8/6/02, 12 days later.

On 8/15/02, the registered dietitian completed an assessment. She documented that resident 21 had a stage II pressure ulcer on her coccyx. There was no documented evidence that she addressed the low albumin level of 2.9 g/dl obtained on 8/6/02. She documented that resident 21's tube feeding was providing 139 grams of protein and estimated her protein needs to be 99 grams. When the survey team calculated the protein provided by Compleat at 104 cc/hour for 12 hours plus the addition protein provided by the protein powder, it was determined that 71.6 grams of protein were being provided to resident 21. This was 27.4 grams less than her calculated protein needs of 99 grams. The dietitian made a recommendation to increase resident 21's tube feeding to Compleat at 118 cc per hour for 12 hours. When the survey team calculated the protein that would be provided by Compleat at 118 cc/hour for 12 hours plus the addition protein provided by the protein powder, it was determined that 79 grams of protein would be 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 in the tube feeding formula. There was no documented evidence that other recommendations

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were made to increase the protein provided to resident 21. The dietitian recommended a vitamin/mineral to help meet nutritional needs.

A telephone order, dated 8/27/02, 12 days later, documented to increase the Compleat tube feeding to 118 cc per hour for 12 hours and to start theravite liquid (a mutli-vitamin) everyday.

A review of physician progress notes was completed. On 8/20/02, resident 21's doctor documented that resident 21 had an "albumin level which was slightly low at 2.9". The doctor recommended "obtaining a nutrition consult to make sure we are maximizing her tube feeds".

A review of all nurses' notes was completed on 10/29/02. On 8/20/02, the nurse documented that resident 21's doctor had been in to see her that day and recommended a "nutrition consult to maximize protein/albumin levels. Note left for [dietary manager] in dietary about Dr's [doctors] new orders."

On 10/24/02, 65 days later, the registered dietitian completed a nutrition note. She documented, "continue [with] TF [tube feeding] as ordered." There was no documented evidence that the dietitian was aware of the low albumin level obtained on 8/6/02. There were no documented recommendations made to increase the protein resident 21 was receiving.

Facility weight and skin meetings documented the following:

1/15/02: Resident 21 was identified as being at high nutritional risk related to a recurrent stage II breakdown on her coccyx and being tube fed. The cause was documented as, "Feeding needs adjustment for healing, repletion and nutrient maintenance". The

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documented recommendation was to change the tube feeding formula to Isosource VHN.

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A review of all physician telephone orders and re-certification orders did not evidence that the recommendation to change resident 21's tube feeding formula was implemented.

2/5/02: Resident 21 was identified as being at high nutritional risk related to a recurrent stage II breakdown on coccyx and knee and being tube fed. The cause was documented as, "Feeding needs adjustment for healing, repletion and nutrient maintenance. No labs available". The recommendation was to change the tube feeding formula to Isosource VHN. Hand written on this form was, "[resident 21] can only tolerate Compleat formula".

A review of all physician telephone orders and re-certification orders did not evidence that the recommendation to change resident 21's tube feeding formula was implemented. There was no physician order to increase the rate of the current tube feeding formula which was being provided.

3/6/02: Resident 21 was identified as being at high nutritional risk related to weight loss, being a tube fed resident and having recurrent stage II breakdown to her knee and coccyx. The recommendation was "previous order reçommended last month" and a re-weight.

A review of all physician telephone orders and re-certification orders did not evidence that the recommendation to change resident 21's tube feeding was implemented.

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

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"Please ask [registered dietitian consultant] to add low pre-albumin to the care plan. What is our plan to correct this?"

A review of all physician telephone orders and re-certification orders did not evidence that any recommendations were implemented which would increase the protein in resident 21's diet.

A "Dietary Consult" report, dated May 7, 2002, documented the following, "Again I suggest that you offer this resident a high protein formula for healing. The Compleat just does not offer the nutrients that she needs to heal that sore". An alternative formula was suggested.

A review of all physician telephone orders and re-certification orders did not evidence that the recommendation to change resident 21's tube feeding formula was implemented.

A "Dietary Consult" report, dated June 4, 2002, documented the following, "Resident is not receiving adequate protein for healing and repletion. Suggest you increase the protein in the current formula".

A review of all physician telephone orders and re-certification orders did not evidence that the recommendation to change resident 21's tube feeding regimen was implemented.

6/11/02: There was no documented evidence that resident 21 was reviewed by the skin and weight team.

6/18/02: documented resident 21 was "started on arc (?) looking better".

A review of the physician telephone orders documented that on 6/6/02, the physician ordered

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Arginine (an amino acid thought to help with wound healing) 500 mg twice a day for 1 month. The wound was to be re-evaluated after a month.

6/25/02: "got order for arg. [arginine] to promote healing skin is improving".

7/9/02: "Arginade started, bottom showing signs of improvement".

7/16/02: "Wt stable, skin improving and she has order for arginaide".

8/1/02: minutes documented "Reviewed all patients". No recommendations were documented specific to resident 21.

8/9/02, 9/2/02, 9/9/02, 9/24/02, 9/30/02, : There was no documentation that resident 21 was reviewed by the weight and skin team despite documentation that she continued with a decubitus ulcer on her coccyx and had an albumin level of 2.9 g/dl obtained on 8/6/02.

10/11/02: Resident 21's name was written down but there were no documented recommendations made specific to her.

10/14/02 and 10/24/02: Resident 21 was not reviewed by the team.

2. Resident 10 was a 95 year old female admitted to the facility on 10/2/98 with diagnoses including organic brain syndrome, osteoporosis and chronic obstructive pulmonary disease. Per the medical record, on 5/9/02 resident 10 developed a stage II stasis ulcer on her left ankle.

On 10/28/02, resident 10's medical record was reviewed.

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A review of resident 10's weights, documented on the "Weight Change History" form and provided to the survey team on 10/30/02, were as follows:

9/26/01 101 pounds.

10/26/01 96 pounds. This represents a significant weight loss of 5 pounds, or 5% in 30 days.

11/26/01 94 pounds.

12/26/01 93 pounds. This represents a significant weight loss of 8 pounds, or 7.9% in 90 days.

1/24/02 97.5 pounds.
1/26/02 97.5 pounds.
2/12/02 97.7 pounds.
3/5/02 96 pounds.
4/23/02 97.5 pounds.
5/7/02 96.5 pounds.
5/20/02 97.5 pounds.
5/28/02 97 pounds.
6/3/02 98 pounds.
6/10/02 100 pounds.
6/17/02 97.5 pounds.
6/25/02 95.5 pounds.

7/1/02 93 pounds. This represents a significant weight loss of 5 pounds, or 5% in 30 days.

7/9/02 92 pounds. This represents a significant weight loss of 8 pounds, or 8% in 30 days.

7/15/02 91.5 pounds. This represents a significant weight loss of 6 pounds, or 6% in 30 days.

7/23/02 87.5 pounds. This represents a significant weight loss of 8 pounds, or 8.3% in 30

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days.

8/6/02 90 pounds.
9/2/02 90.5 pounds.
9/23/02 91 pounds.
9/30/02 88.5 pounds.

10/14/02 86 pounds. This represents a significant weight loss of 5 pounds, or 5.5% in 30 days.

10/23/02 89 pounds.
10/29/02 95.5 pounds.
11/5/02 93.5 pounds.

On 10/28/02, a review of resident 10's lab values was completed. The following levels were documented:

10/11/01pre-albumin 12.8 mg/dl (Normal reference range 17-42 mg/dl.)
7/2/02 albumin 2.9 g/dl (Normal reference range 3.3-4.8 g/dl.)

A review of resident 10's physician re-certification orders was completed. She was ordered a mechanical soft, enriched diet with a house supplement three times a day (TID).

On 10/29/02 at 1:15 PM, the dietary manager was interviewed. She was asked what an enriched diet consisted of. The dietary manager stated that anyone receiving an enriched diet received super cereal in the morning with extra butter, gravies and sauces added to the food served as appropriate. She was asked about the house supplement. She stated that the house supplement consisted of 1 can of Forta shake and mixed with one gallon of whole milk. The survey team calculated that 113.5 calories and 7.3 grams of protein would be provided in a 4 ounce serving.

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On 10/29/02 at 3:35 PM, two facility nurses familiar with resident 10's care were interviewed. They were asked how much house supplement resident 10 received. They both stated that she was given 4 ounces three times a day with meals and that she would drink 100% of what they offered.

Resident 10's MAR's (medication administration records) for July 2002, August 2002, September 2002, and October 2002 documented that she consumed 100% of the house supplement TID.

A review of the dietary section of the chart was reviewed.

On 9/15/01, the dietary manager completed a nutrition assessment. Resident 10's weight was recorded at 101 pounds and it was documented that she received an enriched mechanical soft diet and consumed 50-80% of her meals. It was documented that dietary supplements had been discontinued. The note was not co-signed by a registered dietitian.

On 12/17/01, the dietary manager completed a quarterly nutrition assessment. Resident 10's weight was documented at 93 pounds. The dietary manager documented that this was a 7% weight loss over the past 6 months. When the survey team calculated the weight change, it was noted to be a 7.9% weight loss in three months from 101 pounds in September 2001 to 93 pounds in December 2001, which was significant. The dietary manager documented resident 10's meal intakes, of a mechanical soft enriched diet, were 40% at breakfast, 40% at lunch and 30% of supper. She further documented that resident 10 received a house supplement three times a day and consumed 100%. (This contradicted her prior note where she discontinued the dietary supplements.) The dietary manager documented the low pre-albumin

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level of 12.8 mg/dl obtained 10/11/01. There was no documented evidence that resident 10's nutritional needs, including calorie and protein needs, were re-calculated after resident 10 experienced significant weight loss or a low pre-albumin level. There was no documented evidence that interventions were attempted to increase the amount of calories and protein provided in resident 10's diet. The note was not co-signed by a registered dietitian.

On 3/18/02, the dietary manager completed a quarterly nutrition assessment. Resident 10's weight was documented at 96 pounds. The dietary manager documented resident 10's meal intakes, of a mechanical soft enriched diet, were 40% at breakfast, 40% of lunch and 30% of supper. She further documented that resident 10 received a house supplement three times a day and consumed 100%. There was no documented evidence that resident 10's nutritional needs had been re-assessed secondary to the low pre-albumin level obtained 10/11/02. There was no documented evidence that interventions were attempted to increase the amount of protein provided in resident 10's diet. The note was no co-signed by the dietitian.

On 5/7/02, the registered dietitian completed a nutrition note. She documented that resident 10 had cellulitis of the ankle and was eating poorly. She documented that resident 10's pre-albumin level was "critically low" on 10/11/01. She further documented, "we are doing what is possible for resident healing. Maintain plan." There were no documented interventions attempted to further increase the protein in resident 10's diet.

On 6/17/02, the dietary manager completed a quarterly nutritional assessment. She documented that resident 10 disliked milk, however, she liked the can milk her

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F 325	Continued From page 22 family provided. It was documented that she was sent ice cream for breakfast and lunch to increase protein in her diet. On 8/15/02, the registered dietitian completed a nutrition note. She documented resident 10's weight was 88 pounds and that she had experienced significant weight loss of 10% in 2 months. She documented that resident 10 had a stage II pressure ulcer on her left ankle. It was documented that resident 10 consumed 30-50% of her meals and 100% of the house supplement TID. The dietitian did not address resident 10's low albumin level of 2.9 g/dl obtained on 7/2/02. There was no documented evidence that resident 10's nutritional needs, including calorie and protein needs, were re-calculated after resident 10 experienced significant weight loss, had developed a stage II pressure ulcer and had a low albumin level. There was no documented evidence that interventions were attempted to increase the amount of calories and protein provided in resident 10's diet. On 10/7/02, the registered dietitian completed a nutrition note. She documented that resident 10 had experience a 1 kilogram (kg) weight increase since 8/15/02 and that her meal intakes were 10-40% and that she consumed 100% of the house supplement. She documented "consider TF [tube feeding] to help pt [patient] meet kcal/pro [calorie/protein] needs." There was no documented evidence that resident 10's nutritional needs, including calorie and protein needs, were re-calculated after resident 10 developed a stage II pressure ulcer and had a low albumin level. There was no documented evidence that interventions were attempted to increase the amount of calories and protein provided in resident 10's diet prior to the potentially more invasive recommendation of a feeding tube placement.	F 325		

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A nutrition care plan, which was not dated, documented that resident 10 was at risk for nutritional deficits related to a history of weight loss and poor intakes. One documented goal documented to address this problem was that resident 10 would maintain her weight of 97.5 pounds within 5 pounds through the next review and that she would receive alternative protein and calcium sources due to not liking milk. Approaches included staff would assist resident 10 with meals and assist as needed and be encouraged to eat. There was no mention of resident 10 receiving an enriched diet or a house supplement TID. There was no mention that resident 10 had experienced a significant weight loss, had low albumin levels and developed a stage II ulcer on her left ankle.

A review of the facility's weight skin meeting minutes as completed. The following regarding resident 10 was documented:

On 6/18/02 and 6/25/02: resident 10's name was listed as having been reviewed but there were no recommendations made specific to her. Per the medical record, she had a stage II ulcer on her left ankle.

7/9/02: It was documented that resident 10 received a supplement TID and sat at an assist table. It was documented that resident 10 had a low albumin level of 2.9 and that they would "see what other things to offer". There were no documented recommendations made to increase the protein in resident 10's diet. There was nothing documented which addressed the significant weight loss resident 10 had experienced from June 2002 to July 2002. Per the medical record, she had a stage II ulcer on her left ankle.

A review of the physician re-certification orders and

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telephone orders did not evidence any nutrition interventions were implemented which would increase the calories and protein in resident 10's diet.

7/16/02: It was documented that resident 10 was sleeping more and more. There was nothing documented which addressed the significant weight loss resident 10 had experienced from June 2002 to July 2002. Per the medical record, she had a stage II ulcer on her left ankle.

8/1/02: "Reviewed all patients" was documented. No recommendations were documented specific to resident 10. Per the medical record, she had a stage II ulcer on her left ankle.

8/9/02: Resident 10's name was listed but there were no recommendations were documented specific to resident 10. Per the medical record, she had a stage II ulcer on her left ankle.

9/2/02: "Reviewed all patients" was documented. No recommendations were documented specific to resident 10. Per the medical record, she had a stage II ulcer on her left ankle.

9/9/02: Resident 10 was not on the list as having been reviewed.

9/24/02, 9/30/02 and 10/11/02: Resident 10's name was listed but there were no recommendations documented specific to resident 10. Per the medical record, she had a stage II ulcer on her left ankle.

10/14/02: It was documented that resident 10 had experienced a 7# (pound) weight loss, would often refuse meals and drank the house supplement. Recommended to try finger foods and change to a fortified liquid diet for 1 meal to see if she would eat.

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10/24/02: Resident 10 was not on the list as having been reviewed.

On 10/28/02 and 10/29/02, resident 10's lunch meals were not observed to consist of finger food items.

In an interview with the registered dietitian on 10/31/02 at approximately 4:00 PM, she stated that she was not familiar with resident 10 and she felt that this was a record that she had not yet fully assessed since she began working at the facility (this dietitian started at the facility 8/15/02).

3. Resident 20 was a 79 year old male admitted to the facility on 6/20/02 with diagnoses including decubitus ulcer, muscle ligament disorder, profound mental retardation and weakness.

On 10/31/02, resident 20's medical record was reviewed.

A review of resident 20's "Initial Nursing Assessment", dated 6/20/02, documented that resident 20 was admitted to the facility with 3 stage II decubitus ulcers.

On 6/24/02, 4 days after his admission, the dietary manager completed an initial dietary assessment, which documented resident 20 was 66" (5'6") tall and weighted 152 pounds. The diet ordered was regular.

A review of resident 20's admission weight, documented on the "Record of Vital Signs and 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 team on 10/30/02, were as follows:

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6/25/02: 149.5 pounds.
7/1/02: 152 pounds.
7/9/02: 153.5 pounds.
7/15/02: 149.5 pounds.
7/23/02: 147.5 pounds.

8/6/02: 127 pounds. This represents a significant weight loss of 20.5 pounds, or 13.9% in 14 days.

8/28/02: 127 pounds.
9/2/02: 126 pounds.
9/9/02: 127 pounds.
9/23/02: 127.5 pounds.
9/30/02: 127.5 pounds.
10/8/02: 134.5 pounds.
10/14/02: 130.5 pounds.
10/23/02: 131.5 pounds.
10/29/02: 130 pounds.
11/5/02: 130.5 pounds.

There was no documented evidence in the medical record which attempted to explain the large weight decline which occurred from 7/23/02 to 8/6/02.

An initial dietary assessment, completed by the dietary manager on 6/24/02, documented that resident 20 was eating less than 50% of a regular diet, that he had stage II pressure ulcers and that his care giver stated that he would eat toasted cheese sandwiches and corndogs. The dietary manager indicated that the kitchen had been sending toasted cheese sandwiches along with his regular meal. The dietary manager calculated resident 20's calorie and protein needs. She calculated his protein needs to be 76 grams. She multiplied his weight of 152 pounds in kilograms (69 kg) by 1.1 grams of protein to determine this. This note was not co-signed by the registered dietitian. There were no documented interventions implemented to increase the

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calories or protein in resident 20's diet despite his poor meal intakes with multiple stage II pressure ulcers. This note was no co-signed by the registered dietitian.

On 10/31/02, the facility registered dietitian stated in an interview that with a resident with multiple pressure ulcers she would use at least 1.5 grams of protein per kilogram to help promote healing.

6/27/02, the dietary manager completed a nutrition note. She documented that resident 20 had experienced no changes. This note was not co-signed by the registered dietitian.

On 7/18/02, the dietary manager completed a nutrition note. She documented that resident 20 was offered corn dogs or toasted cheese sandwiches in addition to a regular diet, that his meal intakes were 40-60% and that he continued with open areas. She recommended a supplement BID (twice a day) and high protein milk to increase protein and promote healing and a multi-vitamin with zinc and vitamin C. These interventions were recommended 28 days after resident 20 was admitted to the facility with multiple stage II decubitus ulcers. This note was not co-signed by the registered dietitian.

On 7/30/02, 12 days later, there was a physician telephone order for a multi-vitamin with zinc, vitamin C, a house supplement BID after meals and high protein milk TID with meals. This was 40 days after resident 20 was admitted to the facility with pressure sores.

A review of the MAR for August 2002, documented that the house supplement BID, multi-vitamin with zinc and vitamin C were not started until 8/9/02, 10 days after the physician ordered them and 50 days after resident 20 was admitted to the facility.

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On 8/15/02, the registered dietitian completed a nutrition note. She documented resident 20's weight as 150 pounds. The weight history record documented his weight on 8/6/02 as 127 pounds. There was no documented evidence th

4. 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.

The MDS (Minimum Data Set), a mandatory comprehensive assessment of the resident completed by facility staff, with the assessment reference date of 8/20/02, documented that resident 45's decision making skills were moderately impaired, he did not resist cares and that he needed supervision during meals.

The weights for resident 45, kept in his medical record, documented the following:

The first week of June 2002 - 153.5 pounds
The second week of June 2002 - 148.5 pounds
The third week of June 2002 - 147.5 pounds
The first week of July 2002 - 145.5 pounds
The second week of July 2002 - 145 pounds

The third week of July 2002 - The resident fell and fractured his elbow. Nurses notes (7/18/02) record "L (left) arm still very bruised and edematous" Weight recorded at 150 pounds.

The fourth week of July 2002 - Nurses notes (7/25/02) document "Pt's (patient's) L arm is still edematous but swelling is less." Weight recorded at 143.5 pounds.

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The first week of August 2002 - 135 pounds
The first week of September 2002 - 134.5 pounds

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."

A dietary progress note was entered into the medical record on 5/20/02. No additional entries were documented within the dietary progress notes for resident 45 until 8/19/02, 19 days after the facility staff should have identified this resident as having a significant weight loss. The dietary note of 8/19/02 (by the dietary manager) did not discuss any weight loss. It did document, "resident 45 is offered cheese sandwich and 8 oz (ounce) increased pro (protein) milk as 3 PM snack. We offer a cheese sandwich at lunch and dinner in addition to his regular tray...is also offered extra glasses of milk at meals...fed at assisted table."

The dietary notes refer to an assessment completed by a dietitian on 8/19/02. During review of the assessment completed by the registered dietitian (RD), it was noted that she had not addressed any significant weight loss although at this time resident 45 had lost

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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 135". 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

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physician orders were given. The nurse did not document an answer to this question. The fourth question asked "Nursing/dietary conference?" The nurse did not document an answer to this question.

A review of resident 45's meal intake percentage was performed for July, August and September 2002. This information was located on ADL flow sheet.

For the month of July 2002, resident 45 ate 40% or less at 59 of the 93 meals. There was no documentation for nine of the meals.

For the month of August 2002, resident 45 ate 40% or less at 61 of the 93 meals. There was no documentation for two meals.

For the month of September 2002, resident 45 ate 40% or less at 43 of the 90 meals. There was no documentation for two meals.

The medical record documented that resident 45 did have a problem with spitting. On 8/29/02, a nurse's note documents "face is slimmer - continues to chew then spit food."

During interview on 10/30/02, with a nurse and an aide who took care of resident 45, they stated that he drank better than he ate, but that he would eat his food. The nurse stated that resident 45 "drinks well". The aide stated that it was generally not food that he (resident 45) spits, but phlegm.

The next progress note by the RD was dated 10/24/02. The RD did not mention the significant weight loss of the previous several months, nor did she mention the low albumin of 2.8 from 9/24/02. The RD did not recalculate the protein and calorie requirements of resident 45 based on his recent significant weight loss

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and low albumin. The RD did document "add enrichment to orders. Consider denser nutr. (nutritional) suppl. (supplement) tid (three times a day)." These recommendations were made 7 weeks after resident 45 had experienced significant weight loss.

The nutritional supplement three times a day was not implemented for an additional 5 days. Staff began to give it on 10/29/02 at 5:00 PM.

The NAR (nutrition at risk)/skin committee minutes document the following for resident 45:

6/18/02 - "wt. stable for the last 3 weeks."
6/25/02 - "he requests cheese sandwiches at meals. Sitting at rehab table."
7/9/02 - "Broke his elbow, wts (weights) have been stable for 6 wks (weeks) now. Team wants to D/C from NAR." At the time of this note, resident 45 had lost 8 pounds since the first week of June 2002.

Resident 45 was not mentioned again in the nutrition/skin meeting minutes again until 10/11/02 when staff writes his name down, but no additional notes. Another note, on 10/24/02, documented resident 45 "medplus 2.0" It should be noted that this nutrition/skin committee did not address what nutritional aspects were needed for the stage 2 pressure sore resident 45 acquired on 8/3/02.

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 and would again support the above information reflecting that facility staff were not aware the significant weight loss.

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It should also be noted that the facility was without a registered dietitian from the first week of June 2002 through August 14th, 2002. (Assessments from the new dietitian were not observed until 8/15/02.) It was during this time that resident 45 lost most of his weight.

5. Resident 16 was a 40 year old male who was admitted to the facility on 9/12/02 with the diagnoses of delirium, paraplegia, urinary tract infection, pressure sores, and major depression. Resident 40 was on a regular, low concentrated sweet diet. Resident was discharged from the facility on 10/14/02 and then readmitted to the facility.

A review of the medical record of resident 16 was performed on 10/30/02 and 10/31/02.

The MDS, dated 9/25/02, documented that resident 40 was independent in decision making and feeding himself. The MDS also documented that resident 40 did not resists cares, or exhibit inappropriate behaviors.

Review of the weight summary sheet for resident 16 revealed that no weight was obtained the week of admission. During the fourth week of September 2002, staff record the weight of resident 16 to be 169 pounds. The next weight of resident 16 was documented the second week of October 2002 and was 150 pounds. This is a weight loss of 11.2% in less than a month, which is significant.

A review of the nursing initial assessment, dated 9/12/02, reveals resident 16 was admitted with 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. Four of the pressure sores were a stage 4 (having black

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ecsar), two of the pressure sores were at a stage 3 and one was at a stage 2.

The Clinical Guide, Wound Care, Fourth Edition, Kathy Thomas Hess, Springhouse Corporation, 2002, pg. 58, defines a stage four pressure ulcer as "full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or support structures." A stage 3 is defined as "full thickness skin loss involving damage or necrosis of subcutaneous tissue, which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue." Page 42 of this reference book reads, "The chief dietary treatment goal for wound healing is to provide adequate calories and protein to promote anabolism and the building of new tissue. The very best local and nursing care will not heal wounds without the existence of sufficient nutritional substrate from which to build new tissue."

A nutritional assessment of resident 16 was performed on 9/18/02. This was performed 6 days after resident 16 was admitted with 7 pressure sores. This assessment was performed by the dietary manager and not a registered dietitian (RD). The dietary manager documented in her assessment/progress note of 9/18/02 "no Ht. (height) or Wt (weight) in chart." The dietary manager did not obtain a weight with which to perform her assessment. The dietary manager did not document an estimate of protein, calorie or fluid needs of resident 16. On the second page of the dietary assessment, the dietary manager documents "house supplement QID (four times a day)."

During interview with a nurse on 10/30/02, she stated that the nurses provide the nutritional supplements.

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

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reveals that the physician requested "Protein - Boost - tid (three times a day) - choc. (chocolate)".

During review of the September 2002 Medication Administration Record (MAR), it was noted that facility staff did not begin providing the nutritional supplement until 9/27/02. This was 9 days after the nutritional supplement was recommended by the dietary manager and 1 day after it was recommended by the physician. Review of the nutritional supplement intake record for September 2002 revealed that when staff began to offer the supplement and through the end of the month, resident 16 drank 100%.

There was no documentation to evidence that a RD co-signed the nutritional assessment and dietary progress notes written by the dietary manager. The was no documentation to evidence that a dietitian evaluated resident 16 to ensure that the assessment had been completed, that protein and calorie requirements had been calculated or that the nutritional needs of resident 16 were being met.

The nutritional care plan established by facility staff for resident 16 stated the problem to be "At risk for nutritional deficits related to decreased appetite, need for therapeutic diet and healing pressure ulcers." This nutritional care plan had a goal of "will eat adequate protein to bring albumin levels to WNL (within normal limits)." The approach for this goal was to obtain "consult for weight loss program and increased protein intake." The person documented as responsible for this approach was the RD. There was no documentation to evidence that staff had obtained an albumin level to establish a baseline for resident 16. There was no documentation to evidence that the RD had performed a consult to evaluate the needs of resident 16.

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The facility's weight and skin meeting minutes were reviewed on 10/29/02, 10/30/02 and 10/31/02.

Between the days of resident 16's admission and discharge (9/12/02 - 10/14/02), the facility held four weight and skin committee meetings which were dated 9/24/02, 9/30/03, 10/11/02 and 10/14/02.

At the time of the first meeting of 9/24/02, resident 16 had 7 pressure sores. Facility staff did not document discussing resident 16 in the 9/24/02 skin/weight meeting.

At the time of the second meeting of 9/30/02, resident 16 still had 7 pressure sores. Facility staff did not document discussing resident 16 in the 9/30/02 skin/weight meeting and did not include his name on the list of referrals to the dietitian which were also included on these meeting minutes.

At the time of the third meeting of 10/11/02, resident 16 continued to have multiple pressure sores and had experienced a significant weight loss of 11.2% in one month. Facility staff wrote the name of resident 16 and next to his name they wrote "wt. (weight) loss". There were no further notes regarding resident 16. There was no documentation to evidence that the extent of his weight loss had been discussed or that he had any pressure sores.

At the time of the fourth meeting of 10/14/02, resident 16's status from the meeting of 10/11/02 had not changed. Facility staff did not document discussing resident 16 in the 10/14/02 weight/skin meeting.

Facility staff did not obtain an admission weight for 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

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did not calculate protein and calorie needs for resident 16. 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 as stated by the Administrator on 11/5/02, which required staff to obtain a weight upon admission and then weekly for four weeks.

6. 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.

A review of resident 48's labs dated 9/17/02 revealed

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an albumin level of 2.2 gm/dl (grams per deciliter). The lab defined a normal range to be 3.3-4.8 gm/dl. Resident 48's labs represented a moderate depletion of visceral protein.

A nutritional assessment completed 34 days after admission (10/7/02), documented a recommendation from the registered dietitian of house supplement three times a day, 2200 calories per day and protein needs of 90-100 grams. There was no documentation of a plan for weight loss.

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 changes documented to meet the increase calorie recommendations of the dietitian.

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.

A review of the October 2002 MAR (medication administration record) revealed documentation that a protein powder supplement of one scoop was to be given to resident 48 starting 10/8/02. There was no documentation that the protein powder or the house supplement was administered to resident 48.

In an interview with a nurse on 10/31/02, the nurse stated that the protein powder had not been given and that there was no documentation of any supplement given.

In an interview with the facility dietitian on 10/31/02 at 4 PM, she stated that she had not made any recommendations for a protein powder for resident 48 and that she had not been aware that resident 48 had not received any supplements.

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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.

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F 325	Continued From page 40 The stated that the dietary manger follows through with recommendations dealing with dietary such as enriching a diet or changing a snack order. When asked how often the dietitian visits the facility. The administrator stated that is was usually once a month for about 8 hours.	F 325		
F 361 SS=H	483.35(a)(1)-(2) DIETARY SERVICES The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs. This REQUIREMENT is not met as evidenced by: Based on staff interview and observations, it was determined that the facility did not utilize their part-time consultant dietitian in a manner which provided adequate supervision to the dietary manager or dietary staff regarding accurately monitoring and assessing residents at risk for weight loss and low protein status. Also, the facility was without a registered dietitian from June 5, 2002 through August 14, 2002. Resident identifiers: 10, 20, 16, 21, 45, 48. Findings include:	F 361		

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1. Based on clinical record review it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by 5 of 15 sampled residents experienced significant weight loss and 4 of 15 sampled resident experienced low albumin (a protein and indicator of nutritional status) levels with no dietary interventions implemented to help increase the albumin levels and prevent further protein depletion.

It should be noted that the facility was without a registered dietitian from the first week of June 2002 through August 14th, 2002. (Assessments from the new dietitian were not observed until 8/15/02.)

The facility failed to provide dietetic supports and services which maintained the body weights for residents 10,20,16,45,48 as evidenced by:

a. Resident 10 was a 95-year-old female admitted to the facility on 10/2/98 with diagnoses including organic brain syndrome, osteoporosis and chronic obstructive pulmonary disease. Per the medical record, on 5/9/02 resident 10 developed a stasis ulcer on her left ankle.

A review of resident 10's weights, documented on the "Weight Change History" form and provided to the survey team on 10/30/02, were as follows:

9/26/01 101 pounds.

10/26/01 96 pounds. This represents a significant weight loss of 5 pounds, or 5% in 30 days.

11/26/01 94 pounds.

12/26/01 93 pounds. This represents a significant weight loss of 8 pounds, or 7.9% in 90 days.

Provider's Plan of Correction (F 361):

Resident 10, 16, 20, 21, 45, 48 have been reviewed by the RD consultant 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. — 11/19/02

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 outcome weights as compared to risk levels. — 11/19/02

The Administrator is responsible for ongoing compliance.

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1/24/02 97.5 pounds.
1/26/02 97.5 pounds.
2/12/02 97.7 pounds.
3/5/02 96 pounds.
4/23/02 97.5 pounds.
5/7/02 96.5 pounds.
5/20/02 97.5 pounds.
5/28/02 97 pounds.
6/3/02 98 pounds.
6/10/02 100 pounds.
6/17/02 97.5 pounds.
6/25/02 95.5 pounds.

7/1/02 93 pounds. This represents a significant weight loss of 5 pounds, or 5% in 30 days.

7/9/02 92 pounds. This represents a significant weight loss of 8 pounds, or 8% in 30 days.

7/15/02 91.5 pounds. This represents a significant weight loss of 6 pounds, or 6% in 30 days.

7/23/02 87.5 pounds. This represents a significant weight loss of 8 pounds, or 8.3% in 30 days.

8/6/02 90 pounds.
9/2/02 90.5 pounds.
9/23/02 91 pounds.
9/30/02 88.5 pounds.

10/14/02 86 pounds. This represents a significant weight loss of 5 pounds, or 5.5% in 30 days.

10/23/02 89 pounds.
10/29/02 95.5 pounds.
11/5/02 93.5 pounds.

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A review of all dietary notes completed since resident 10's admission did not evidence that the dietitian re-assessed her nutritional needs based on her significant weight loss. There was no documented evidence that dietary interventions were attempted to increase calories in resident 10's diet.

b. Resident 20 was a 79-year-old male admitted to the facility on 6/20/02 with diagnoses including decubitus ulcer, muscle ligament disorder, profound mental retardation and weakness.

A review of resident 20's admission weight, documented on the "Record of Vital Signs and Weights" form, which was not dated, revealed that he weighted 152 pounds upon admission. A review of resident 20's weekly weights, provided to the survey team on 10/30/02, were as follows:

6/25/02: 149.5 pounds.
7/1/02: 152 pounds.
7/9/02: 153.5 pounds.
7/15/02: 149.5 pounds.
7/23/02: 147.5 pounds.

8/6/02: 127 pounds. This represents a significant weight loss of 20.5 pounds, or 13.9% in 14 days.

8/28/02: 127 pounds.
9/2/02: 126 pounds.
9/9/02: 127 pounds.
9/23/02: 127.5 pounds.
9/30/02: 127.5 pounds.
10/8/02: 134.5 pounds.
10/14/02: 130.5 pounds.
10/23/02: 131.5 pounds.
10/29/02: 130 pounds.
11/5/02: 130.5 pounds.

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There was no documented evidence in the medical record, which attempted to explain the large weight decline, which occurred from 7/23/02 to 8/6/02.

A review of all dietary notes completed since resident 10's admission did not evidence that the dietitian re-assessed his nutritional needs based on his significant weight loss. There was no documented evidence that dietary interventions were attempted to increase calories in resident 10's diet until 28 days after he was admitted to the facility.

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.

The weights for resident 45, kept in his medical record, documented the following:

The first week of June 2002 - 153.5 pounds
The second week of June 2002 - 148.5 pounds
The third week of June 2002 - 147.5 pounds
The first week of July 2002 - 145.5 pounds
The second week of July 2002 - 145 pounds

The third week of July 2002 - The resident fell and fractured his elbow. Nurse's notes (7/18/02) record "L (left) arm still very bruised and edematous" Weight recorded at 150 pounds.

The fourth week of July 2002 - Nurses notes (7/25/02) document "Pt's (patient's) L arm is still edematous but swelling is less." Weight recorded at 143.5 pounds.

The first week of August 2002 - 135 pounds

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The first week of September 2002 - 134.5 pounds

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."

A review of all dietary notes completed since resident 45's admission did not evidence that the dietitian re-assessed his nutritional needs based on his significant weight loss. There was no documented evidence that dietary interventions were attempted to increase calories in resident 45's diet until 10/29/02, 2 months after he experienced significant weight loss. Resident 45's weight had been on a downward trend since the second week in June 2002.

d. Resident 16 was a 40-year-old male who was admitted to the facility on 9/12/02 with the diagnoses of delirium, paraplegia, urinary tract infection, pressure sores, and major depression. Resident 40 was on a regular, low concentrated sweet diet. Resident was discharged from the facility on 10/14/02 and then readmitted to the facility.

Review of the weight summary sheet for resident 16 revealed that no weight was obtained the week of admission. During the fourth week of September

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F 361	Continued From page 46 2002, staff records the weight of resident 16 to be 169 pounds. The next weight of resident 16 was documented the second week of October 2002 and was 150 pounds. This is a weight loss of 11.2% in less than a month. A review of the nursing initial assessment, dated 9/12/02, reveals resident 16 was admitted with 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. Four of the pressure sores were a stage 4, two of the pressure sores were at a stage 3 and one was at a stage 2. A nutritional assessment of resident 16 was performed on 9/18/02. This was performed 6 days after resident 16 was admitted with 7 pressure sores. This assessment was performed by the dietary manager and not a registered dietitian (RD). The dietary manager documented in her assessment/progress note of 9/18/02 "no Ht. (height) or Wt (weight) in chart." The dietary manager did not obtain a weight with which to perform her assessment. The dietary manager did not document an estimate of protein, calorie or fluid needs of resident 16. On the second page of the dietary assessment, the dietary manager documents "house supplement QID (four times a day)." There was no documentation to evidence that a RD co-signed the nutritional assessment and dietary progress notes written by the dietary manager. The was no documentation to evidence that a dietitian evaluated resident 16 to ensure that the assessment had been completed, that protein and calorie requirements had been calculated or that the nutritional needs of resident 16 were being met. Facility staff did not obtain an admission weight for	F 361		

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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 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.

A nutritional assessment completed 34 days after admission (10/7/02), documented a recommendation

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from the registered dietitian of house supplement three times a day, 2200 calories per day and protein needs of 90-100 grams. There was no documentation of a plan for weight loss.

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 changes documented to meet the increase calorie recommendations of the dietitian.

A review of the October 2002 MAR (medication administration record) revealed documentation that a protein powder supplement of one scoop was to be given to resident 48 starting 10/8/02. There was no documentation that the protein powder or the house supplement was administered to resident 48.

In an interview with a nurse on [illegible]/31/02, the nurse stated that the protein powder had not been given and that there was no documentation of any supplement given.

The facility failed to provide dietetic supports and services to maintain or improve the protein status for residents 10,21,45 and 48 as evidenced by:

a. Resident 10 was a 95-year-old female admitted to the facility on 10/2/98 with diagnoses including organic brain syndrome, osteoporosis and chronic obstructive pulmonary disease. Per the medical record, on 5/9/02 resident 10 developed a stasis ulcer on her left ankle.

Per the medical record, on 5/9/02 resident 10 developed a stage II stasis ulcer on her left ankle.

On 10/28/02, a review of resident 10's lab values was

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completed. The following levels were documented:

10/11/01pre-albumin 12.8 mg/dl normal reference range 17-42 mg/dl.
7/2/02 albumin 2.9 g/dl normal reference range 3.3-4.8 g/dl.

An albumin level of less than 2.4 g/dl is considered a severe visceral protein deficit, an albumin level of 2.4 g/dl- 2.9 g/dl is considered a moderate visceral protein deficit and an albumin level of 3.0 g/dl-3.5 g/dl is considered a mild visceral protein deficit. . (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000, page 22).

A review of all dietary notes completed since resident 10'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 dietary interventions were attempted to increase the protein provided in resident 10's diet.

b. Resident 21 was an 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).

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.

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

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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."

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A review of all dietary notes completed since resident 45's low albumin level was obtained 9/24/02 did not evidence that the dietitian re-assessed his nutritional needs based on her low albumin levels which indicated a moderate protein depletion. There was no documented evidence that appropriate dietary interventions were attempted to increase the protein provided to resident 45's until 10/29/02, 1 month later.

d. 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 review of resident 48's labs dated 9/17/02 revealed an albumin level of 2.2 gm/dl (grams per deciliter). The lab defined a normal range to be 3.3-4.8 gm/dl. Resident 48's labs represented a moderate depletion of visceral protein.

Resident 48 was admitted with a pressure sore with a low albumin level and was not receiving the recommended supplement, placing the resident at a high nutritional risk.
(Refer to tag F-325)

F 371 SS=E — 483.35(h)(2) DIETARY SERVICES — F 371

The facility must store, prepare, distribute, and serve food under sanitary conditions.

This REQUIREMENT is not met as evidenced by:

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F 371	Continued From page 52 Based on observations in the kitchen, record review and temperature checks of the dish machine, it was determined that the facility did not store, serve and distribute food under sanitary conditions as evidenced by dish machine temperatures which were less than 120 degrees Farenheit, the dish machine sanitizer was less than 50 parts per million (ppm) and a dietary staff member was observed to cross contaminate between the dirty and clean side of the dish room. Findings include: The following observations were made during the initial kitchen tour, done 10/28/02 from 8:20 AM to 8:48 AM. 1. At 8:38 AM, the dish machine wash temperature was 96 degrees Farenheit and the rinse temperature was 114 degrees Farenheit. 2. At 8:43 AM, the dish machine wash temperature was 110 degrees Farenheit. 3. At 8:47 AM, a dietary aide was asked to check the dish machine sanitizer. The sanitizer was at 10 ppm (parts per million). In order for bleach to be an effective sanitizer, the concentration must measure between 50 and 200 ppm. The following observations were made on 10/28/02 from 1:10 PM to 1:20 PM. 1. At 1:10 PM, the dish machine wash temperature, using the thermometer attached to the dish machine, was 112 degrees Farenheit. 2. At 1:14 PM, the dish machine wash temperature was 114 degrees Farenheit.	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-inserviced on the 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 the Administrator are responsible for ongoing compliance.	11/5/02 1/1/03

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3. On 10/28/02, a review of the " Dish Machine Temperature Log" sheet kept by the dietary department was done. The dish machine temperatures were to be recorded twice daily, once in the AM and once in the PM per the sheet.

The following dates had no dish machine temperatures documented: 10/5/02, 10/6/02, 10/11/02, 10/13/02, 10/19/02, 10/20/02.

On 10/3/02, 10/4/02, 10/7/02, 10/8/02, 10/10/02, 10/12/02, 10/26/02 and 10/27/02 there were no AM dish machine temperatures documented.

On 10/18/02, 10/21/02, 10/22/02 and 10/23/02 there were no PM dish machine temperatures documented.

The following dates had dish machine wash and/or rinse temperatures documented which were below 120 degrees Farenheit:

10/1/02 AM: wash 105 degrees Farenheit, rinse 111 degrees Farenheit.
10/1/02 PM: wash 114 degrees Farenheit
10/2/02 AM: wash 110 degrees Farenheit, rinse 115 degrees Farenheit.
10/3/02 PM: wash 112 degrees Farenheit, rinse 116 degrees Farenheit.
10/7/02 PM: wash 112 degrees Farenheit.
10/9/02 AM: wash 90 degrees Farenheit, rinse 112 degrees Farenheit.
10/14/02 AM: wash 100 degrees Farenheit, rinse 110 degrees Farenheit.
10/14/02 PM: wash 118 degrees Farenheit.
10/16/02 PM: rinse 118 degrees Farenheit.
10/17/02 AM: wash 110 degrees Farenheit, rinse 118 degrees Farenheit.
10/18/02 AM: wash 105 degrees Farenheit, rinse 110

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degrees Farenheit.
10/21/02 AM: wash 118 degrees Farenheit.
10/22/02 AM: wash 110 degrees Farenheit, rinse 115 degrees Farenheit.
10/23/02 AM: wash 118 degrees Farenheit.
10/25/02 AM: wash 115 degrees Farenheit, rinse 100 degrees Farenheit.

F 371

The temperature of the wash solution in spray-type warewashers that use chemicals to sanitize may not be less than 120 degrees Farenheit. Reference guidance: U.S. Public Health Service FDA (Food and Drug Administration) 2001 Food Code, page 107.

4. At 1:16 PM, a dietary employee was observed to place dirty pans and utensils into the dish machine. The dietary aide was not observed to wash her hands. After the pans and utensils were washed, the dietary employee was observed to take the clean items and put them away without having washed her hands between [illegible]

F 431 SS=E 483.60(d) PHARMACY SERVICES

F 431

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined that the facility did not date medications in accordance with current accepted professional principles. Specifically, 3 out of 3 medication carts had a total of 8 multidose vials of insulin which were not dated after they had been opened and continued to be in use. Residents: 15, 33, 35, 37, 48 and 51.

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Findings include:

On 10/30/02 at 3:30 PM, in the north side medication cart, it was observed that there was an opened and partially used multidose vial of 70/30 insulin which had resident 35's name on the label. The glucose test strips were also not dated after they were opened. A review of the label on the glucose test strips bottle revealed that the strips were to be used, "within three months after opening."

On 10/30/02 at 4:00 PM, in the west side medication cart, it was observed that there were two opened and partially used multidose vials of regular insulin which had resident 15 and 33's name on the labels, two opened and partially used multidose vials of NPH insulin (long lasting insulin) which had resident 37 and 51's names on the labels, and two opened and partially used multidose vials of Lantus insulin which had resident 15 and 33's names on the labels. There was also a bottle of glucose test strips which had not been dated after it had been opened.

On 10/30/02 at 4:30, in the east side medication cart, it was observed that there was an opened and partially used multidose vial of regular insulin which had resident 48's name on the label. There was also a bottle of glucose test strips which was not dated after it had been opened.

On 11/04/02 at 3:00 PM, during an interview with the facility pharmacist, he stated that the multidose vials of insulin should be dated after they were opened as the expiration date changes. He stated that he would send special labels that would help the facility to not allow the opened multidose vials of insulin to go past the expiration date of 28 to 30 days. He explained that each time the multidose vial is punctured with a needle

Plan of Correction:

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

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

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 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. — 11/30/02; 12/4/02

The results of the initial audit and the formal rounds are reported to the QA team for follow up and re education as needed. — 1/1/03

The DON is responsible for ongoing compliance.

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it lends itself to the possibility of a problem with infection control.

F 431

A review of the manufacturer instructions for Lantus, dated February 2001, stated that, "If refrigeration is not possible, the 10 mL [milliliter] vials ... must be used within the 28 day period or they must be discarded."

On 11/5/02 at 9:30 AM, an interview with the manufacturer's pharmacist of the 70/30, Regular and NPH insulin was done. She stated that multidose insulin vials stored at room temperature and in use, should be discarded after 30 days. She also faxed a document which provided some information from the American Diabetes Association. It revealed that, "even though each insulin vial is stamped with an expiration date, a slight loss of potency may occur after the vial has been in use for more than 30 days, especially if stored at room temperature."

F 465 SS=E 483.70(h) PHYSICAL ENVIRONMENT

F 465

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:
Based on observation, the facility did not provide a safe, sanitary and comfortable environment for residents, staff and the public, by not maintaining or repairing the floors, ceiling or walls.

Findings include:

1. Throughout the facility halls, on both sides of the hall floors, approximately one foot away from both walls, the floor seam was coming apart at varying

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F 465	Continued From page 57 degrees which made it unsanitizable. 2. In room 109, there was a damaged area in the 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 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 tiles in halls and thresholds in 121 and 213 will be replaced by March 2003. The ceiling tiles 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 administrator is responsible for ongoing compliance.	11/10/02 3/31/03 1/5/03 1/1/03
F 490 SS=H	483.75 ADMINISTRATION 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	F 490		

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through 11/5/02, it was determined that the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical well-being for each resident in the area of weight loss with nutritional assessment and intervention. The facility was found to be providing Sub-Standard Quality of Care (a pattern of actual harm) in this area. The facility was cited in a total of 11 areas, not including this deficiency.

Findings include:

1. On October 31,2002 and November 5, 2002, a Standard Extended survey was completed which resulted in the determination of Sub- Standard Quality of Care. The determination of Sub- Standard Quality of Care was based on the lack of dietary assessment and intervention for 6 residents who had significant weight loss and/or laboratory values reflecting malnutrition. [CFR 483.25 (i) Tag F - 325]

Weight loss/ Nutritional Assessment and Intervention: Please refer to F- 325.

A pattern of actual harm was identified for 6 residents (10, 16, 20, 21, 45 and 48) who experienced significant weight loss and/or whose laboratory values reflected malnutrition and/or who had pressure sores, but did not receive adequate nutritional assessment or intervention.

a. Resident 45 should have triggered for significant unplanned weight loss of 12% during the first week of August 2002. Also, 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

F 490

F490, 520, 521

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 -inserviced 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. — 12/03/02

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. — 11/30/02

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. — 1/1/03; 11/8/02

The Administrator is responsible for ongoing compliance.

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and September 2002, and was found to be 2.8 which reflects a mild to moderate visceral protein depletion.

The QA minutes for 10/8/02 did not document that facility staff were aware of any weight loss or malnutrition concerns and did not document discussing resident 45.

b. Resident 16, who was admitted 9/12/02 with 7 pressure sores, should have triggered for significant unplanned weight loss of 11.2% in the second week of October 2002. The QA minutes for 10/8/02 (in the second week of October 2002) did not document that facility staff were aware of any weight loss/nutrition concerns and did not document discussing resident 16. Based on interview with the Administrator and Director of Nurses on 11/5/02, they stated that it was facility policy to weigh each resident upon admission and weekly thereafter for four weeks. Facility staff did not follow this policy as they did not obtain an admission weight for resident 16. Staff also did not obtain a weight on resident 16 the second or fourth weeks of his stay.

c. Resident 21 had continuous delays in the interventions for her low albumin and pressure sore. For nearly a year, the facility was not been providing resident 21 with adequate levels of protein to address 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

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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.

The QA minutes did not identify concerns regarding weight loss, malnutrition and nutrition aide to heal pressure sores for residents 10, 16, 20, 21, 45 and 48 and did not document any type of plan to correct these issues.

On 10/29/02, the Administrator was asked how the facility's weight/skin meeting had functioned from the first of 2002. The Administrator stated that they had met monthly with the dietitian from January through June 2002. The dietitian who consulted for the facility

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during January through June 2002 made her last visit to the facility on June 4, 2002. The Administrator stated that after that, they were without a dietitian for "several weeks". The next notes by a registered dietitian did not appear in resident charts until 8/15/02. This was 71 days, over two months, that the facility did not have a dietitian. The Administrator stated that after the dietitian left in June, that they tried to hold weekly skin/weight meetings. The facility's Nutrition at Risk (NAR) Committee (weight/skin team) policy and procedure was provided to surveyors on 11/5/02. The Director of Nurses (DON) stated that the policy had been revised in August 2002, when she was hired as the new DON. The policy stated that the members of the NAR committee included the DON, dietary manager, CNA (certified nurse aide) coordinator, the MDS (minimum data set) coordinator, and the dietitian. The policy stated that these individuals would meet weekly to review resident's weight's and skin conditions.

Based on review of weight/skin meeting minutes provided by the facility, weekly meetings were not held the weeks of:

June 30 - July 6, 2002
July 21 - 27, 2002
August 11 - 17, 2002
August 18 - 24, 2002
August 25 - 31, 2002
September 15 - 21, 2002

Only monthly meetings were held from January through May 2002.

Of the 14 NAR (weight/skin) committee meetings held from 6/11/02 through 10/24/02, 2 of the meeting minutes (8/1/02, 9/2/02) documented only "reviewed all patients". No other details or notes were included

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to show evidence that individuals at risk or with actual weight loss, malnutrition (low albumin) or pressure sores had been identified, whether recommendations had been made and who was responsible to implement the recommendations. Another 3 of those 14 NAR committee meetings (8/9/02, 9/9/02, 9/24/02) documented only resident names and did not include issues of concern, or plans to address concerns. Six of the 14 NAR (weight/skin) meetings (6/11/02, 8/1/02, 8/9/02, 9/2/02, 9/9/02, 9/24/02) were held without the presence of anyone from the dietary department (either the dietary manager or a registered dietitian). Only 1 of the 14 NAR (weight/skin) meetings (10/24/02) included the presence of a registered dietitian. None of the 14 meetings included the presence of the MDS coordinator (a nurse who performs quarterly and significant change assessments of the residents). There was no documentation to evidence that the NAR committee was aware that weights were not being done per facility policy.

The facility was not following their own policy and procedure regarding the NAR (weight/skin) committee meeting.

There was no documentation in the QA minutes for the year of 2002 to evidence that the QA committee was aware that the NAR (weight/skin) committee was not following facility policy and procedure, not holding meetings, not involving dietary personnel, and not documenting the identification of residents, plans for implementation or follow-up of residents needing the services of this committee.

A corporate audit, dated 10/14/02, mentioned "wt. (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.

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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

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assistance to the residents as needed.

- Facility administration failed to identify and establish a corrective action plan to ensure that resident care plans were established and available for use by staff.

- Facility administration failed to 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.

- Facility administration failed to 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.

- Facility administration failed to identify and establish a corrective action plan to ensure the facility maintained required sanitation standards in the kitchen.

- Facility administration failed to establish a corrective action plan to ensure that the facility had a dietitian to serve the needs of its residents and that a dietitian provided adequate supervision to the dietary manager and kitchen staff.

F 520 SS=E — F 520

483.75(o)(1) ADMINISTRATION

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

This REQUIREMENT is not met as evidenced by:

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F 520	Continued From page 65 Based on interview and review of quality assurance (QA) meeting minutes, it was determined that the facility did not maintain a quality assurance and assessment committee which included a physician. Specifically, 3 of the 4 quarterly QA meetings minutes did not contain documentation to evidence that a physician was present. Findings include: After determining a pattern of actual harm in the area of weight loss and nutrition and subsequently entering into an extended survey on 10/31/02, the facility's QA meeting minutes were reviewed. Based on review of these minutes, the facility held four QA meeting throughout 2002. The dates of these meetings were 1/8/02, 4/16/02, 7/9/02 and 10/8/02. There was no documentation to evidence that a physician had attended or had been involved with the QA committee for the meetings held 1/8/02, 4/16/02 or 7/9/02. During interview with the Administrator on 10/31/02, she stated that it had been very hard getting the physician to the QA meetings.	F 520		
F 521 SS=H	483.75(o)(2)&(3) ADMINISTRATION **The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.** A State or the Secretary may not require disclosure of the records of such committee except insofar as such	F 521		

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disclosure is related to the compliance of such committee with the requirements of this section.

This REQUIREMENT is not met as evidenced by:
Based on staff interviews and review of the facility's policies and procedures and the facility's Quality Assurance (QA) committee minutes (dated 1/8/02, 4/16/02, 7/9/02 and 10/8/02), it was determined that the facility's QA committee did not identify quality deficiencies regarding identification, assessment, intervention and re-evaluation for residents with significant unplanned weight loss and malnutrition, resulting in actual harm for 6 of 15 sample residents. Resident identifiers: 10, 16, 20, 21, 45 and 48.

Findings include:

1. On October 31,2002 and November 5, 2002, a Standard Extended survey was completed which resulted in the determination of Sub- Standard Quality of Care. The determination of Sub- Standard Quality of Care was based on the lack of dietary assessment and intervention for 6 residents who had significant weight loss and/or laboratory values reflecting malnutrition. [CFR 483.25 (i) Tag F - 325]

Weight loss/ Nutritional Assessment and Intervention: Please refer to F- 325.

During the annual recertification survey from 10/28/02 through 11/5/02, a pattern of actual harm was identified for 6 residents (10, 16, 20, 21, 45 and 48) who experienced significant weight loss and/or whose laboratory values reflected malnutrition and/or had pressure sores, but did not receive adequate nutritional assessment or intervention.

The facility's QA committee met on 1/8/02, 4/16/02, 7/9/02 and 10/8/02. The QA minutes were reviewed

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by survey on 10/31/02, after determining Sub-Standard Quality of Care. A review of the QA minutes revealed the following:

a. Resident 45 should have triggered for significant unplanned weight loss of 12% during the first week of August 2002. Also, 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.

The QA minutes for 10/8/02 did not document that facility staff were aware of any weight loss or malnutrition concerns and did not document discussing resident 45.

b. Resident [illegible], who was admitted [illegible] with 7 pressure sores, should have triggered for significant unplanned weight loss of 11.2% in the second week of October 2002. The QA minutes for 10/8/02 (in the second week of October 2002) did not document that facility staff were aware of any weight loss/nutrition concerns and did not document discussing resident 16. Based on interview with the Administrator and Director of Nurses on 11/5/02, they stated that it was facility policy to weigh each resident upon admission and weekly thereafter for four weeks. Facility staff did not follow this policy as they did not obtain an admission weight for resident 16. Staff also did not obtain a weight on resident 16 the second or fourth weeks of his stay.

c. Resident 21 had continuous delays in the interventions for her low albumin and pressure sore. For nearly a year, the facility was not been providing resident 21 with adequate levels of protein to address

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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.

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The QA minutes did not identify concerns regarding weight loss, malnutrition and nutrition aide to heal pressure sores for residents 10, 16, 20, 21, 45 and 48 and did not document any type of plan to correct these issues.

On 10/29/02, the Administrator was asked how the facility's weight/skin meeting had functioned from the first of 2002. The Administrator stated that they had met monthly with the dietitian from January through June 2002. The dietitian who consulted for the facility during January through June 2002 made her last visit to the facility on June 4, 2002. The Administrator stated that after that, they were without a dietitian for "several weeks". The next notes by a registered dietitian did not appear in resident charts until 8/15/02 This was 71 days, over two months, that the facility did not have a dietitian. The Administrator stated that after the dietitian left in June, that they tried to hold weekly skin/weight meetings. The facility's Nutrition at Risk (NAR) Committee (weight/skin team) policy and procedure was provided to surveyors on 11/5/02. The Director of Nurses (DON) stated that the policy had been revised in August 2002, when she was hired as the new DON. The policy stated that the members of the NAR committee included the DON, dietary manager, CNA (certified nurse aide) coordinator, the MDS (minimum data set) coordinator, and the dietitian. The policy stated that these individuals would meet weekly to review resident's weight's and skin conditions.

Based on review of weight/skin meeting minutes provided by the facility, weekly meetings were not held the weeks of:

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

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August 18 - 24, 2002
August 25 - 31, 2002
September 15 - 21, 2002

Only monthly meetings were held from January through May 2002.

Of the 14 NAR (weight/skin) committee meetings held from 6/11/02 through 10/24/02, 2 of the meeting minutes (8/1/02, 9/2/02) documented only "reviewed all patients". No other details or notes were included to show evidence that individuals at risk or with actual weight loss, malnutrition (low albumin) or pressure sores had been identified, whether recommendations had been made and who was responsible to implement the recommendations. Another 3 of those 14 NAR committee meetings (8/9/02, 9/9/02, 9/24/02) documented only resident names and did not include issue[illegible] of concern, or plans [illegible] Six of the 14 NAR (weight/skin) meetings (6/11/02, 8/1/02, 8/9/02, 9/2/02, 9/9/02, 9/24/02) were held without the presence of anyone from the dietary department (either the dietary manager or a registered dietitian). Only 1 of the 14 NAR (weight/skin) meetings (10/24/02) included the presence of a registered dietitian. None of the 14 meetings included the presence of the MDS coordinator (a nurse who performs quarterly and significant change assessments of the residents). There was no documentation to evidence that the NAR committee was aware that weights were not being done per facility policy.

The facility was not following their own policy and procedure regarding the NAR (weight/skin) committee meeting.

There was no documentation in the QA minutes for the year of 2002 to evidence that the QA committee was aware that the NAR (weight/skin) committee was not

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following facility policy and procedure, not holding meetings, not involving dietary personnel, and not documenting the identification of residents, plans for implementation or follow-up of residents needing the services of this committee.

A corporate audit, dated 10/14/02, mentioned "wt. (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 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.

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), 12 other deficient areas were identified within the facility. Seven of these other 12 deficient areas were not identified or addressed with a plan of correction by the QA committee.

- The facility's QA committee did not identify and establish a corrective action plan to ensure that a

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resident's physician was notified immediately when there was a significant change in the resident's condition.

- The facility's QA committee did not identify and establish a corrective action plan to ensure that a first response to call lights occurred within 5 minutes with assistance to the residents as needed.

- The facility's QA committee did not identify and establish a corrective action plan to ensure that resident care plans were established and available for use by staff.

- 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.

- The facility's QA committee did not identify and establish a corrective action plan to ensure the facility maintained required sanitation standards in the kitchen.

- The facility's QA committee did not establish a corrective action plan to ensure that the facility had a dietitian to serve the needs of its residents and that a dietitian provided adequate supervision to the dietary manager and kitchen staff.

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POC ADDENDUM

accepted 12-12-02

December 5, 2002

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Bureau of Medicaid/Medicare Program
Certification and resident Assessment
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[redacted]

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 re-in 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.

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.
4. **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.

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.
4. **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.

1. **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.

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.
5. **Do you have a nutritional/weight committee?** Yes, they meet weekly and report to the facility practices committee.
6. **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

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

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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.

1. **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 dietitian spend time (how much) with the food supervisor?** Yes on each visit. Our new dietary 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

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.

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.

1. **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.**
2. **Who is on the environmental of care committee?** Dietary 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.

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.

1. **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.
2. **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.

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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 via phone call on 12/12/02 @ 9:50 AM.

F 521

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