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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465082	A. BUILDING _____ B. WING _____	02/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY MISSION HEALTH & REHAB OF PROVO, LP	1053 WEST 1020 SOUTH PROVO, UT 84601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=G	483.10(b)(11) NOTIFICATION OF CHANGES 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 §483.12(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 §483.15(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 review of one closed record and interview, it was determined that the facility did not immediately inform or consult with the resident's physician when the resident	F 157	**How will the corrective action be accomplished for affected residents?** Resident #15 no longer resides at the facility. Member of nurse management team immediately inserviced nursing staff on proper notification of physicians. **How will the facility identify other residents having potential to be affected?** Resident's residing in the facility has the potential to be affected. **What measures will be taken or changes made to ensure deficient practice will not recur?** Facility will implement the use of Resident Care Managers (RCM) to be located at each nursing unit who will review the change in status report and any items of concern with the charge nurse for follow through of new or needed orders and labs with the physician. **What plans are implemented to ensure corrective action is achieved and sustained?** DON will receive regular reports from the RCM for evaluation and further direction to ensure compliance. **How will the facility monitor its performance to ensure solutions are sustained?** As reports are reviewed findings will be reported to the Quality Assurance committee for evaluation on continued monitoring.	

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

Jason Murray — ADMINISTRATOR — 3/6/2006

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

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F 157	Continued From page 1 experienced a significant change in physical status which required the need to alter treatment significantly. Specifically, resident 15 had complaints of not feeling well, shortness of breath, low oxygen saturation levels, a jaundiced appearance and other complaints that were not conveyed to the physician to allow him the opportunity to consult with the resident or family regarding treatment. In addition, resident 15 was treated with supplemental oxygen for four days without staff consulting with his physician. Findings include: Resident 15 was readmitted to the facility on 8/19/05 with diagnosis which included, myelodysplasia, pancytopenia, hypertension, hypoparathyroidism, and diabetes mellitus type II. On 2/16/06 resident 15's closed medical record was reviewed. The following entries were documented in the "Nurses Notes" on the "Daily Patient Assessment": a. 9/4/05 ...."pt. (patient) c/o (complains of) shortness of breath d/t (due to) high activity had res. (resident) go back to room and use O2 (oxygen) - this did help res. ... Sats (oxygen saturation) [up] to 90% on 2L (liters) O2." b. 9/5/05 "Pt. looked pale and slightly yellow. Pt. complains of general malaise and was lying in bed. O2 sats at 88%, put nasal cannula on. pulses weak in all extremities." c. 9/6/05 ..."fatigues after minimal activity. skin and sclera appear jaundiced. SOB (short of	F 157	**How often will the monitoring be done?** Weekly during change of status review, also residents with a change in status will be evaluated and referred to PAR (Person at Risk) meeting as necessary findings will be forwarded to the QA committee to be evaluated for continued monitoring and or additional measures. **Who will be responsible?** RCM, DON, or designee.	04/03/2006

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F 157	Continued From page 2 breath). O2 NC (nasal cannula) on 2L ....desats when takes O2 off..." d. 9/7/05 (1140) 11:40 AM ..."c/o [complains of] not feeling well....now he has general malaise....has been jaundiced last 2 days but is "pale" today...." (17) 5:00 PM .."pts. (patients) brother called about 1400 (2:00 PM) to inquire about pts. condition [and] that he was concerned. He'd been into facility yesterday evening to visit [and] pt was SOB. He requested more checks to make sure his O2 is on....He (resident 15) c/o being cold so blanket placed over him....TX (treatment) nurse reported O2 sats 83% - humidifier was [changed] at that time...." 19-07 (7:00 PM to 7:00 AM) ...." O2 applied was 80 % RA (room air) - late sat 0200 (2:00 AM) - [checked] on res. his O2 was off. sat [checked] was 97 % left O2 off." 0430 (4:30 AM) "Sat [checked' - 85% applied O2 per CN - 2.5 liters." e. 9/8/05 (1050) 10:50 AM "pt c/o [not] feeling well [and] needed help [with] transfers. Jaundiced color very apparent today. Abd (abdomen) is asymmetrical L>R (left greater than right)... O2 85% on 2L per N/C. O2 [up] [and] sats [up] to 92%. pt. SOB on exertion. Skin is waxy/yellow [and] pt is c/o being cold...Dr. office contacted regarding pt condition this AM [and] told of pt's. condition [and] that he needed to be seen. NP (nurse practioner) will see him today [at] 1:30 PM....." It should be noted that resident 15 was not admitted with a physician's order to wear oxygen. Resident 15 was admitted to the hospital on 9/8/05 after seeing the physician. During his two day hospital admission, resident 15 received 5	F 157		

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F 157	Continued From page 3 units of packed red blood cells for a low hematocrit of 17.6%. According to the Nurse's Manual of Laboratory and Diagnostic Test . Third edition. Bonita Morrow Cavanaugh 1999, page 24, a normal hematocrit reference value for an adult male is 40-54%. Resident 15 was readmitted back to facility on 9/10/05 at 2:00 PM. On 9/13/05 a BMP and CBC were collected for resident 15. Laboratory documentation in the medical record revealed a laboratory results report indicating resident 15 had a critical platelet level of 11. On 2/22/06 at 8:30 AM an individual who works for the laboratory service was interviewed. She stated that the laboratory (lab) received the specimen on 9/13/05 at 1:30 PM. She further stated that the nursing facility is set up through the lab to receive their lab results at the same time every day. On 2/22/26 at 8:45 AM the assistant director of nurses (ADON) of the nursing facility was interviewed. He stated that the lab results come in at various times throughout the day and it is the nurse's responsibility to go and check to see if the lab result have come in, because the nurse knows which residents have gotten labs that day. According to the Nurse's Manual of Laboratory and Diagnostic Test . Third edition. Bonita Morrow Cavanaugh 1999, page 55, a normal reference value for platelets is 150,000-450,000 units per liter. Critical values for platelets are less	F 157		

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F 157	Continued From page 4 than 20,000 units per liter or greater than 1,000,000 units per liter. No entries could be found in the medical record indicating that the physician was notified of the critical lab values on either 9/13/06 or 9/14/06. Review of the nurses notes in resident 15's medical record revealed the following entry on 9/15/05. ..."Pt. very pale, labs abnormal will be faxed to MD,, addressed to night nurse to call MD in AM No answer for answering service." On 9/16/05 at 3:00 PM the following entry was found in resident 15 's medical record in the nurses' notes: "Nurse called in critical lab values to doctor and faxed lab sheets to doctor when platelets [at] 11, pt. bruises easily. Was assured there would be a notification to the doctor." No documentation could be found in resident 15's medical record that facility staff tried to notify the MD or follow -up with MD for the critical lab platelet value on 9/17/05, 9/18/05, or 9/19/05. On 9/20/05 the following entry was documented in resident 15's medical record in the nurses' notes: ..."Pale, c/o pain tylenol given. Followed up [with] lab abnormal results from 9/16/05 called attending MD's office to inquire regarding orders for critical lab results Platelets = 11, ... attending MD's nurse not aware of results or if attending MD had seen results. RN (Registered Nurse) requested to speak [with] MD unavailable [with] pt. Assured that MD would receive message." 1400 (2:00 PM) "MD called [and] informed regarding lack of communication of his staff's office. Order CBC stat (immediately) [with] differential. Blood drawn [and] sent to lab at 1440	F 157		

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F 157	Continued From page 5 (2:40 PM)" ..... Facility staff documented in the nurses notes on 9/20/05 that the lab results were received at the facility at 5:00 PM and the staff nurse had called the attending MD's office and was awaiting a call back. When the facility did not receive a call from the attending MD's office by 6:00 PM, the DON (Director of Nurses) of the facility called the attending physician's on call service and requested that the facility be called. At 7:35 PM on 9/20/05 an MD with the on-call service returned the call and gave an order for the facility to notify the attending physician in the morning of the critical lab values. Review of resident 15's medical record revealed a physician's order dated 9/20/05 with the instructions to, "No new orders. Call attending MD in AM [with] lab results." No documentation could be found in the medical record to show that facility staff notified resident 15's attending physician on the morning of 9/21/05 or at anytime on 9/21/05. On 9/22/05 at 11:20 AM the following entry was documented in the nurses' notes in resident 15's medical record: "Called attending MD's office, spoke [with] receptionist regarding critical abnormal lab results faxed to office on 9/20/05. Stated pt. needs to see [different] MD on 9/23/05...."	F 157		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in	F 241		

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F 241	Continued From page 6 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for 1 of 15 sampled residents, the facility did not 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. Specifically, facility staff were observed to feed and interact with resident 10 in a manner which did not maintain or promote resident 10's dignity. Findings include: Resident 10 was admitted to the facility on 9/30/02 with diagnosis which included, cerebral palsy, benign prostatic hypertrophy, gastroesophageal reflux disease and urinary retention. On 2/14/06 at 8:28 AM resident 10 was observed trying to speak with a certified nursing assistant (CNA). Although the dialogue from resident 10 was not heard the response from the CNA was, "You're such a silly boy." On 2/15/06 at 7:40 AM resident 10 was observed to sneeze and dispel copious amounts of mucous from his nose and mouth. A facility licensed practical nurse (LPN) was observed at an adjacent table distributing medications. LPN 1 was observed to look over at resident 10 during the sneezing episode but did not offer assistance. At 7:42 AM resident 10 was observed to attempt to clean his face of mucous with his napkin. LPN 1 was observed to still be in the area and look	F 241	**How will the corrective action be accomplished for affected residents?** C.N.A. #1and 2 and L.P.N. #1 were inserviced when administration was made aware of concern. On 2/20/2006 staff meeting was held and employees were inserviced regarding dignity. On 3/06/2006 meeting will be held where Social Services will inservice regarding dignity. The facility will perform ongoing inservices as needed. **How will the facility identify other residents having potential to be affected?** Resident's residing in the facility has the potential to be affected. **What measures will be taken or changes made to ensure deficient practice will not recur?** Meal Monitors will audit dining room on a on a routine basis to ensure the dignity of residents occurs in the dining room dining room. Quality Audits will be performed at various times throughout the day.	

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F 241	Continued From page 7 over at resident 10. LPN 1 did not offer assistance but did proceed to walk back to her medication cart. On 2/15/06 the morning meal was observed. Resident 10 was observed being fed by a certified nursing assistant (CNA). During the meal, resident 10 was observed to have food spilling out of his mouth and down his chin. Resident 10 was observed to hand his napkin to CNA 1 during the time frame when food was spilling out of his mouth. CNA 1 did not wipe resident 10's face but was observed to take the napkin and brush the crumbs from resident 10's clothing. CNA 1 was observed to feed resident 10 his entire morning meal without wiping resident 10's face. When resident 10 indicated to CNA 1 that he was finished eating, CNA 1 was observed to not clean or wipe resident 10's face. Resident 10 was observed to sit with food on his face from 8:15 AM to 8:30 AM. At 8:30 AM resident 10 was observed to try and wipe the remaining food from his face with his napkin. Food was observed to remain on resident 10's face after his attempt to clean his face for an additional 10 minutes, at which time this nurse surveyor left the dining area. On 2/16/06 at 8:00 AM the morning meal was observed. CNA 2 was observed feeding resident 10. At 8:02 AM CNA 2 was observed to try and put a bite of sausage patty into resident 10's mouth . The bite was so large CNA 2 had to shove the sausage into resident 10's mouth. At 8:06 AM CNA 2 was observed to give resident 10 a large bite of biscuit. Resident 10 was unable to open his mouth wide enough to accomodate the food resulting in CNA 2 putting the food back on the plate and cutting into a smaller size. At 8:12	F 241	**What plans were implemented to ensure corrective action is achieved and sustained?** Meal monitoring reports will be during stand-up meeting on a regular basis. **How will the facility monitor its performance to ensure solutions are sustained?** Quality of life will report the findings to the QA committee. **How often will the monitoring be done?** Meal monitoring will occur five times a week X four weeks, also Quality Audits will be performed randomly through out the week and the findings will be forwarded to the QA committee for further evaluation. **Who will be responsible?** NHA SSW	04/03/2006

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F 241	Continued From page 8 AM CNA 2 was observed to give resident 10 another bite of biscuit. Resident 10 was unable to open his mouth wide enough to accomodate the bite of food. When resident 10 was attempting to get the biscuit in his mouth the biscuit fell off of the fork onto the plate. On 2/16/06 at 3:30 PM the occupational therapist was interviewed during the exit conference. He stated that the facility did have a problem with the CNA's giving resident 10 too large of bites during meal times. He further stated that resident 10 likes large bites of food and some of the textures of his foods had been changed due to this but that staff did give resident 10 bites of food that were too large.	F 241		
F 278 SS=B	483.20(g) - (j) 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 assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual	F 278	**How will the corrective action be accomplished for affected residents?** One on one inservice has been to MDS nurses. Resident # 3 MDS for 12/28/05 signed by RN who reviewed and assessed for accuracy of the MDS for completion. Resident #1 MDS is correct and accurately portray the resident's wound. A significant change has completed on Resident #7 MDS. **How will the facility identify other residents having potential to be affected?** Resident's residing in the facility has the potential to be affected.	

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F 278	Continued From page 9 to certify a material and false statement in a resident assessment is subject to a civil money penalty of 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 record review and interview, it was determined that the facility did not ensure that the MDS (minimum data set) accurately reflected each residents' condition for 3 of 15 residents. Specifically,the facility did not document that a nurse reviewed and completed a MDS for resident 3, resident 1's MDS had a stasis ulcer documented as a pressure ulcer, and resident 7's MDS did not reflect her history of falls. Findings include: 1. Resident 3 was admitted to the facility on 12/24/05, then readmitted on 2/6/06 after a hospital stay to repair fractures sustained from a fall. The following diagnoses were obtained from her medical record: GERD (gastroesophageal reflux disease), constipation, Left hip fracture with a total hip replacement, headaches, confusion, and memory loss. On 12/28/05, an admission MDS assessment was performed for resident 3. The MDS was completed by staff; however, there was no documentation of a RN (registered nurse) having reviewed the MDS or having certified the accuracy of the MDS. Without the R2a signature (signature of RN Assessment Coordinator), the	F 278	**What measures will be taken or changes made to ensure deficient practice will not recur?** Medical Records Clerk will pull forward new admissions and readmissions' MDS's. Current charts will be audited to ensure that all MDS's are pulled forward. Medical Records Clerk will verify that all MDS's and other information for new admissions will be pulled forward regularly. A weekly report of audits of new admissions will be given to the Administrator and will ensure that information is accurate and follow up as necessary. **What plans were implemented to ensure corrective action is achieved and sustained?** Qulity Audits for the completion of the MDS will be performed by the MDS Coordinator to ensure corrective action is sustained. **How often will the monitoring be done?** Weekly X 4 weeks and findings will be reported to the QA committee for evaluation of continued monitoring. **Who will be responsible?** MDS Coordinator and Medical Records Clerk 04/06/2006	

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F 278	Continued From page 10 MDS remains incomplete. 2. Resident 1 was admitted to the facility on 6/10/04 with diagnoses including: edema, Hypothyroidism, Dementia and failure to thrive. On 1/5/06 a quarterly review MDS was completed for resident 1. The MDS documented that resident 1 had one stage 3 pressure ulcer at that time. A review of resident 1's clinical record revealed documentation by nurses, physicians, and members of the wound care team that the ulcer located on resident 1's right foot was a stasis ulcer. On 2/13/06 at 10:46 AM an interview was conducted with the nurse in charge of wound care. The nurse explained that resident 1's wound was a stasis ulcer, not a pressure ulcer. 3. Resident 7 had a fall on 9/7/05. The next MDS completed by staff was dated 12/5/05. This MDS reflected that resident 7 had had no falls in the last 31 - 180 days. This would not be accurate.	F 278		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309	**How will the corrective action be accomplished for affected residents?** Resident #15 no longer resides in the facility.	

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F 309	Continued From page 11 Based on review of one closed record and interview it was determined that the facility did not provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing. Specifically, resident 15 had complaints of not feeling well, shortness of breath, low oxygen saturation levels, a jaundiced appearance and other complaints that were not conveyed to the physician from 9/4/05 until 9/8/05, when resident 15 went to see the nurse practioner of the attending physician which prompted an admission to the hospital. Findings include: Resident 15 was readmitted to the facility on 8/19/05 with diagnosis which included, myelodysplasia, pancytopenia, hypertension, hypoparathyroidism, and diabetes mellitus type II. On 2/16/06 resident 15's closed medical record was reviewed. Resident 15 was admitted to the facility on 8/19/05. It was documented on the admission physician orders that resident 15 was to have routine laboratory blood draws for a complete blood count (CBC) done every two weeks and a basic metabolic panel (BMP) done in two weeks. These orders reveal that resident 15 should have had the CBC and BMP done on 9/2/05. Review of the medical record revealed that on 8/23/05 resident 15 complained of having a lack of energy and feeling as if he needed a blood transfusion. Facility staff obtained a CBC to evaluate resident 15's need for a blood transfusion. The laboratory results were received by the facility and sent with resident 15 to his	F 309	**How will the facility identify other residents having potential to be affected?** Resident's residing in the facility has the potential to be affected. **What measures will be taken or changes made to ensure deficient practice will not recur?** Nursing staff was re-inservice on 02/20/06 & 03/06/06 on change in status and Quality of Care. Facility will implement the use of Resident Care Managers (RCM) to be located at each nursing unit who will review the change in status report and items of concern with the charge nurse for follow through of new or needed orders and labs with the physician. **What plans were implemented to ensure corrective action is achieved and sustained?** RCM will perform rounds with the charge nurse and on new admissions and with resident's with a change in status to ensure that assessments are addressed and followed through with reporting change in status of residents to the Physicians. **How will the facility monitor its performance to ensure solutions are sustained?** RCM's will receive a report of residents with a change in status from the charge nurse at the end of the day shift for any needed follow through of resident's with a change in status.	

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F 309	Continued From page 12 physician appointment on 8/24/05. No documentation could be found in the medical record to show that the CBC and BMP were done on 9/2/05. The following entries were documented in the "Nurses Notes" on the "Daily Patient Assessment": a. 9/4/05 ...."pt. (patient) c/o (complains of) shortness of breath d/t (due to) high activity had res. (resident) go back to room and use O2 (oxygen) - this did help res. ... Sats (oxygen saturation) [up] to 90% on 2L (liters) O2." b. 9/5/05 "Pt. looked pale and slightly yellow. Pt. complains of general malaise and was lying in bed. O2 sats at 88%, put nasal cannula on. pulses weak in all extremities." c. 9/6/05 ..."fatigues after minimal activity. skin and sclera appear jaundiced. SOB (short of breath). O2 NC (nasal cannula) on 2L ....desats when takes O2 off..." d. 9/7/05 (1140) 11:40 AM ..."c/o [complains of] not feeling well....now he has general malaise....has been jaundiced last 2 days but is "pale" today...." (17) 5:00 PM .."pts. (patients) brother called about 1400 (2:00 PM) to inquire about pts. condition [and] that he was concerned. He'd been into facility yesterday evening to visit [and] pt was SOB. He requested more checks to make sure his O2 is on....He (resident 15) c/o being cold so blanket placed over him....TX (treatment) nurse reported O2 sats 83% - humidifier was [changed] at that time...." 19-07 (7:00 PM to 7:00 AM) ...." O2 applied was 80 %	F 309	**How often will the monitoring be done?** Upon admission and with any change in status through out the week and referred to PAR (Persons at Risk) the findings will be reported to the Quality Assurance Committee for evaluation and continued monitoring. **Who will be responsible?** RCM, DON and or designee.	04/03/2006

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F 309	Continued From page 13 RA (room air) - late sat 0200 (2:00 AM) - [checked] on res. his O2 was off. sat [checked] was 97 % left O2 off." 0430 (4:30 AM) "Sat [checked' - 85% applied O2 per CN - 2.5 liters." e. 9/8/05 (1050) 10:50 AM "pt c/o [not] feeling well [and] needed help [with] transfers. Jaundiced color very apparent today. Abd (abdomen) is asymmetrical L>R (left greater than right)... O2 85% on 2L per N/C. O2 [up] [and] sats [up] to 92%. pt. SOB on exertion. Skin is waxy/yellow [and] pt is c/o being cold...Dr. office contacted regarding pt condition this AM [and] told of pt's. condition [and] that he needed to be seen. NP (nurse practioner) will see him today [at] 1:30 PM....." It should be noted that resident 15 was not admitted with a physician's order to wear oxygen. According to Fundamentals of Nursing Concepts, Process, and Practice (Seventh Edition, Copyright 2004 by Pearson Education, Inc., Upper Saddle River, New Jersey 07458, Page 517) normal oxygen saturation levels range from 95% to 100%. Further, Brunner & Suddarth's Textbook of Medical-Surgical Nursing (10th Edition edited by Suzanne C. Smeltzer and Brenda Bare, Copyright 2004, Lippincott Williams & Wilkins, Page 484) states, "Values less than 85% indicate that the tissues are not receiving enough oxygen, and the patient needs further evaluation." Resident 15 was admitted to the hospital on 9/8/05 after seeing the physician. During his two day hospital admission resident 15 received 5 units of packed red blood cells for a low hematocrit finding of 17.5%.	F 309		

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F 309	Continued From page 14 According to the Nurse's Manual of Laboratory and Diagnostic Test . Third edition. Bonita Morrow Cavanaugh 1999, page 24, a normal hematocrit reference value for an adult male is 40-54%. Resident 15 was readmitted back to the facility on 9/10/05. Medical record review revealed the following entries in the nurses' notes of resident 15's medical record after his readmission: a. 9/10/05 "Patient readmitted from hospital.....Pt. appears pale but reports feeling "much better"." b. 9/13/05 (1345) 1:45 PM ..."pt. says he feels much better [after] receiving blood transfusion last week [at] the hospital.""....	F 309		
F 332 SS=D	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not ensure that it was free of medication error rates five percent or greater. The medication error rate for three medication passes with observation of three nurses and 54 opportunities for error equaled 5.5%.	F 332	**How will the corrective action be accomplished for affected residents?** Involved nurses were inserviced upon knowing about the medication. Inservice nurses on 2/20/06 concerning med pass. **How will the facility identify other residents having potential to be affected?** Resident's residing in the facility has the potential to be affected.	

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F 332	Continued From page 15 Findings included: On 2/14/06, a facility nurse was observed to administer 8:00 AM medications to resident 16. The nurse administered the following medications: Bumex Diflucan Metoformin Digoxin Singular Protonix Allegra Lopressor Amiodarone Lisinopril multivitamin vitamin C zinc Nystatin During reconciliation of the medication pass for resident 16 on 2/14/06 at approximately 3:30 PM, it was discovered that two medications ordered to be received at 8:00 AM had not been administered and had not been signed off as having been administered. Those medications were Levothyroxine and potassium chloride. During interview with this same nurse the next day (2/15/06), the nurse confirmed the medication errors and stated that it would "not happen again." During another required medication pass, a facility nurse was observed to administer 8:00 AM medications to resident 13. One of those medications was a Flovent Inhaler. The nurse was observed to shake the inhaler, administer	F 332	**What measures will be taken or changes made to ensure deficient practice will not recur?** A meeting is scheduled for 03/06/06. The Pharmacy Consultant is scheduled for an inservice on Medication administration and will assist with medication administration audits and education. When inhalers are ordered for a resident, the nursing staff will be instructed to give one puff of the inhaler administer the PO medications and then deliver the second puff of the inhaler to allow the appropriated time recommended between each puff. New LN will be inserviced and a return demonstration will be done. **What plans were implemented to ensure corrective action is achieved and sustained?** RCM/Pharmacy Consultant will monitor med pass two times a week for four weeks to be reevaluated. Issues that arise will be immediately addressed by RCMs and a one on one inservice will be given. **How will the facility monitor its performance to ensure solutions are sustained?** Findings of audits will be forwarded to the Quality Assurance Committee for evaluation. **How often will the monitoring be done?** Two times a week for four weeks and to be evaluated by the Quality Assurance Committee for continued monitoring.	

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F 332	Continued From page 16 one puff to the resident, wait 6 seconds and then administer a second puff. The manufacturer's instruction sheet recommends that you "wait about 30 seconds" and then administer another puff. The facility nurse did not wait the recommended time between the administration of each puff.	F 332	**Who will be responsible?** DON and SDC or designee.	04/03/2006
F 371 SS=E	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on interview and observation of the kitchen it was determined that the facility did not store, prepare, distribute and serve food under sanitary conditions. Findings include: The following observations were made on 2/13/06 from 6:00 AM until 6:45 AM. 1. In the freezer: a. An opened unidentified meat, which was not labeled or dated. b. One package of beef patties which were not dated. 2. In the refrigerator or cold storage:	F 371	**How will the corrective action be accomplished for affected residents?** No residents were directly affected by the deficient practice. All dietary staff have been inserviced concerning proper dating of products and the proper storage of food. **How will the facility identify other residents having potential to be affected?** Resident's residing in the facility has the potential to be affected. **What measures will be taken or changes made to ensure deficient practice will not recur?** Revision of dietary aide checklist which will be completed daily for four weeks and then reevaluated. **What plans were implemented to ensure corrective action is achieved and sustained?** Dietary Manager will audit checklists and ensure that items are properly dated, food items stored properly, and that food be prepared properly.	

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F 371	Continued From page 17 a. Beef Hamburger package thawed sitting in red fluid dated 2/9/06. b. An unidentified meat product on the bottom of the refrigerator which was not dated. c. An opened package of oven roasted turkey breast, which was not dated. d. An opened package of ham, which was not dated. e. A package of sausage pork patties thawing on top of opened packages of oven roasted turkey breast lunch meat and ham lunch meat. f. A gallon of 2 % milk with the best used by date as 2/11/06. g. One opened package of white cheese, which was not dated. h. Ground pork in a sealed plastic container, dated 2/7/06. i. 30 vanilla Sysco mighty shakes, with no thaw date. j. Four containers of vanilla yogurt with the best used by date as 2/1/06. k. Four apples and four oranges sitting in approxiamately one inch of water. l. An opened, empty 4 ounce juice container sitting next to unopened juice containers. m. An opened package of cheese dated 2/5/06.	F 371	Consultants will perform additional random and on going audits. **How will the facility monitor its performance to ensure solutions are sustained?** Results from the monitoring will be presented by the Environmental committee and reviewed by the QA Committee. **How often will the monitoring be done?** Task list will be completed daily for four weeks and then reevaluated Audits will be performed weekly for four weeks and then reevaluated **Who will be responsible?** Dietary Manager or designee.	04/03/2006

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F 371	Continued From page 18 3. Dry Storage: a. A container of Lowry's seasoned salt with the lid unsecured and lying in the seasoning. b. An opened bottle of honey butter not in the refrigerator, the bottle of honey butter is labeled, "Keep Refrigerated." c. An opened unsecure bag of Hershey's cocoa with the contents spilling out of the bag. d. The floor of the dry storage area contained cookie sprinkles, a pop can and plastic bags. 4. On 2/13/06 at 7:34 AM the facility's admission coordinator was observed to serve milk to four residents from a gallon of 2 % milk. Observation revealed the best use by date on the 2 % milk to be 2/11/06. On 2/13/06 at 7:45 AM the admissions coordinator was interviewed. She stated that prior to serving beverages to the residents she washes her hands and she checks the dates on the containers. She further stated that the kitchen normally puts dates on the pitchers of juice. 5. On 2/13/06 at 12:15 PM during tray line the refrigerator was observed to be left open and the refrigerator temperature was measuring 53 degrees Farhenheit. On 2/14/06 at 1:20 PM an additional observation was made of the refrigerator and kitchen area.	F 371		

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F 371	Continued From page 19 The refrigerator was observed to be open and the refrigerator temperature was measuring 44 degrees Fahrenheit. The refrigerator contained: a. 3 containers of vanilla yogurt with the best use by date as 2/1/06. b. 10 vanilla Sysco mighty shakes with no thaw date on the box or individual shakes. c. 23 strawberry Sysco mighty shakes with the date on the box being 1/30. 6. On 2/14/06 at 1:25 PM 3 of 12 spice containers above the stove were observed to have unsecured lids and 4 of 17 spice containers above the food preparation area were observed to have unsecured lids. In addition on 2/14/06 at 1:33 PM a dirty glass was observed to be stacked with the clean glasses. The glass contained a red substance not unlike juice on the side of the glass.	F 371		
F 496 SS=E	483.75(e)(5)-(7) REQUIRED TRAINING OF NURSING AIDES Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry.	F 496	**How will the corrective action be accomplished for affected residents?** No residents were directly affected by the deficient practice.	

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F 496	Continued From page 20 Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on interview with the facility administrator, and review of facility personnel files, it was determined that the facility did not seek information from the nurse aide registry prior to allowing 3 of 5 CNA's (Certified Nursing Assistants) hired in 2005 to perform cares on facility residents. The nurse aide registry provides information on current aide certification and whether or not an aide has a history of abuse. Findings include: Employee A was hired 7/25/05, and was permitted to work in the facility as a CNA with direct patient contact. Employee A's personnel file contained a nurse aid registry check dated	F 496	**How will the facility identify other residents having potential to be affected?** Resident's residing in the facility has the potential to be affected. **What measures will be taken or changes made to ensure deficient practice will not recur?** Current employees have been audited to ensure registry checks have been completed on each. Human Resources Director will ensure that new hired employees have registry checks prior to working the floor. **What plans were implemented to ensure corrective action is achieved and sustained?** Human Resources Director will perform weekly audits on newly hired employees during that week to ensure that registry checks have been completed. **How will the facility monitor its performance to ensure solutions are sustained?** Results from the audits will be presented and reviewed in the facility QA meeting. **How often will the monitoring be done?** Weekly for four weeks and then reevaluated. **Who will be responsible?** Human Resources Director or designee.	04/03/2006

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F 496	Continued From page 21 10/24/05,nearly three months after she began working at the facility. Employee B was hired 12/2/05, and was permitted to work in the facility as a CNA with direct patient contact. Employee B's personnel file contained a nurse aid registry check dated 12/28/05, nearly a month after she began working at the facility. Employee C was hired on 7/6/05, and was permitted to work in the facility as a CNA with direct patient contact. Employee C's personnel file contained a nurse aid registry check dated 8/2/05, nearly a month after she began working at the facility. During an interview with the facility administrator on 2/15/06 2:50 PM, he stated that he could not explain the delay in contacting the nurse aide registry.	F 496		
F 502 SS=G	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and review of medical records, it was determined that for 4 of 15 sample residents, the facility did not provide or obtain laboratory services to meet their needs. Resident identifiers: 9, 1, 5 and 15.	F 502	**How will the corrective action be accomplished for affected residents?** Resident #9's labs and orders are being obtained as directed. Resident #5's labs and orders are being obtained as directed. Resident #15 no longer resides at the facility. **How will the facility identify other residents having potential to be affected?** Resident's residing in the facility has the potential to be affected.	

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	465082	A. BUILDING _____ B. WING _____	02/16/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY MISSION HEALTH & REHAB OF PROVO, LP	1053 WEST 1020 SOUTH PROVO, UT 84601

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F 502	Continued From page 22 Findings include: 1. Resident 9 was a 50 year old female who was admitted to the facility on 9/12/05. Resident 9 had a foley catheter. On 10/6/06, facility nurses recieved a physician's order to obtain a "UA (urinalysis) with C & S (culture and sensitivity) if indicated. Dx (diagnosis) - burning, frequency". On 10/7/06, the lab faxed the results of the UA to the facility. The UA included the following abnormal results: WBC, urine - 10 (normal is 0-5) Bacteria - 4+ (normal is negative) Leukocyte esterase, urine - moderate (normal is negative) At the bottom of this laboratory result, a facility nurse documented "no culture was ordered - new UA sample to be obtained." The requisition form sent to the laboratory by the facility was reviewed on 2/22/06. Facility staff had requested a UA with microscopic analysis if indicated, but had not requested that the lab perform a culture and sensitivity if indicated. A staff member from the laboratory was interviewed on 2/22/06 at 8:35 AM. She stated that if the facility had wanted a culture and sensitivity, they would have needed to check the "urine culture" box or written the request to the right side of the form. A nurse's note on October 6,7 and 8, 2006, facility nurses documented under the "behavior" section	F 502	**What measures will be taken or changes made to ensure deficient practice will not recur?** General inservice of staff was held on 2/20/06 & 03/06/06 pertaining to proper follow-through on labs. RCM will have separate direct fax lines where all labs for their unit will be sent and reviewed. **What plans were implemented to ensure corrective action is achieved and sustained?** RCM/charge nurse will check fax machine throughout the day to ensure follow-though on all ordered labs. **How will the facility monitor its performance to ensure solutions are sustained?** Log has been created to track ordered labs to ensure the obtaining, receiving, reporting of labs, and the notification and response from physician. Findings of audits will be reported to the Quality Assurance Committee for evaluation. **How often will the monitoring be done?** RCM will conduct Bi-weekly ongoing audits. **Who will be responsible?** RCM and DON are responsible for overall compliance.	04/03/2006

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F 502	Continued From page 23 of the nurse's notes that resident 9 was cooperative. On October 9 and 10, 2006, facility nurse's documented under the "behavior"section of the nurse's notes that resident 9 was "withdrawn and crying". A narrative nurse's note for 10/9/06 read "Pt. (patient) had been very withdrawn and crying today. She c/o (complains) that her 'catheter burns'." The order to obtain the "repeat UA for C&S, dx: burning & frequency" was not obtained until 10/9/06. Staff did not collect and send the urine sample for the repeat UA to the laboratory until 10/11/06. Client 9 was not started on any antobiotics (Levaquin) until 10/11/06. In addition to the above, the facility also received orders on 1/2/06 to perform a PT/INR (protime and international normalized ratio) every week while resident 9 was on coumadin (blood thinner) therapy. There was no documentation to evidence that the facility had performed the PT/INR as ordered for the following dates: 1/10/06, 1/31/06 or 2/10/06. Also, there was a physician's order to obtain a baseline lithium level, TSH (thyroid stimulating hormone), and a complete blood count (CBC) on 10/7/06. There was no documentation to evidence that the facility had performed these labs as ordered. The administrator was informed of all missing laboratory results. He was asked if he could locate results for any of these ordered labs to	F 502		

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F 502	Continued From page 24 indicate that they had been performed. The administrator was unable to locate any of these missing lab results for resident 9. 2. Resident 5 was admitted to the facility on 12/19/03 with diagnoses including: Diabetes, dysphagia, Gastritis, hypertension, tremors, depressive disorder, Schizophrenia, and Mental Retardation. On 2/13/05, resident 5's medical record was reviewed. The Physicians recertification orders for the month of January 2006 contain the following orders: a. Albumin q (every) 3 months - due on 11/1/05. b. CMP (comprehensive metabolic panel) q 6 months - started on 10/7/05, due in 2/06. c. BMP q month - started 9/27/04, due on 10/27/05. d. Hgb A1C in 6 months - started on 6/3/05, stop date of 12/6/05. The laboratory results located in resident 5's medical record document the following labs, and the frequency in which each lab was drawn. a. An Albumin level was drawn on 10/27/05. The order is for q 3 months; however, there is no documentation of a level being drawn in January. b. A CMP was drawn on 8/4/05, and 8/25/05. The order is for q 6 months, to be due in February. c. A BMP was drawn on the following dates: 2/10/05, 2/15/05, 4/12/05, 5/12/05, 6/02/05, 6/14/05, 7/12/05, 7/19/05, 9/20/05, 10/27/05, and 12/1/05. The order is for q month; however, there was no documentation of a BMP being drawn in 3/05, 8/05, 11/05, or 1/06.	F 502		

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F 502	Continued From page 25 d. A Hgb A1C was drawn on 6/2/05, and 7/26/06. The order is for q 6 months; however, there was no documentation of a level being drawn in 12/05. On 2/14/06 at 11:03 AM, a list of the missing labs was presented to the Administrator, as requested. As of exit on 2/16/06, the facility was unable to provide documentation that the labs were performed. Information was given to the nurse surveyor which stated the following: 10/7/05 T.O. (telephone order) clarified labs with MD. MD likes CMP's not BMP's wanted baseline and q 6 months. The clarification would explain some of the missing labs; however, the physicians recertification orders were never changed, and the facility continued to draw BMP's routinely. 3. Resident 15 was readmitted to the facility on 8/19/06 with diagnosis which included, myelodysplasia, pancytopenia, hypertension, hypoparathyroidism, and diabetes mellitus type II. On 2/16/06 resident 15's closed medical record was reviewed. Resident 15 was admitted to the facility on 8/19/06. It was documented on the admission physician orders that resident 15 was to have a complete blood count (CBC) done every two weeks and a basic metabolic panel (BMP) done in two weeks. These orders reveal that resident 15 should have had the CBC and BMP done on 9/2/06. No documentation could be found in the medical record to show that the CBC and BMP were done	F 502		

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F 502	Continued From page 26 on 9/2/06.	F 502		
F 504 SS=B	483.75(j)(2)(i) LABORATORY SERVICES The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the facility did not obtain a physician's order before drawing labs on 2 of 15 residents. Specifically, a urinalysis was performed on resident 10, and a CMP (Comprehensive metabolic panel) was performed on resident 11. There was no documentation that either of these labs were ordered by a physician. Findings include: 1. Resident 11 was admitted to the facility on 12/26/05 with diagnoses which include: CHF (Congested Heart Failure), Transient mental disorder, and Breast cancer. On 2/16/06, resident 11's medical record was reviewed. Resident 11's record documented a CMP drawn on 1/5/06. No documentation of a physicians order could be located by either the nurse surveyor, or the facility. Resident 10 was admitted to the facility on 9/30/02 with diagnoses which include: Cerebral Palsy, GERD (Gastroesophageal Reflux Disease), BPH (Benign Prostatic Hypertrophy), MI (Myocardial Infarction), debility, and urinary	F 504	**How will the corrective action be accomplished for affected residents?** A clarification order was obtained for labs from physician for Resident #11. A clarification order was obtained for labs from physician for Resident #10. **How will the facility identify other residents having potential to be affected?** Resident's residing in the facility has the potential to be affected. **What measures will be taken or changes made to ensure deficient practice will not recur?** Staff has been re-inservices on the policies and procedures of obtaining lab. On 2-20-06 and 3-06-06. On going inservices will be performed as needed. Reverse audit will be performed by RCMs (Resident Care Managers). Copies of orders will be given to the RCM to validate that the order was received for a lab. **What plans were implemented to ensure corrective action is achieved and sustained?** The RCM will perform a reverse audit of received labs and new orders for labs to ensure that an order has been obtain for labs by using the copies of the orders for any labs.	

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F 504	Continued From page 27 retention. On 2/16/06, resident 10's medical record was reviewed. Resident 10's record documented a urinalysis performed on 8/22/05. No documentation of a physicians order could be located by either the nurse surveyor, or the facility.	F 504	**How will the facility monitor its performance to ensure solutions are sustained?** RCM s will forward results from the audits and will be presented and reviewed by the Quality Assurance committee. **How often will the monitoring be done?** Bi-Weekly and as orders are obtained for labs and entered into the log for collection. **Who will be responsible?** RCM, DON or designee.	04/03/2006

TRINITY MISSION HEALTH & REHAB OF PROVO L.P.
1053 WEST 1020 SOUTH
PROVO, UT 84601
801-373-2630

March 6, 2006

Ann E. Lee, Manager
Long Term Care Survey Section
Bureau of Medicare/Medicaid Program
Certification and Resident Assessment
PO Box 144103
Salt Lake City, Utah 84114-4103

Dear Ms. Lee,

Attached is our Plan of Correction for the deficiencies noted during our annual life safety code survey, ending February 16, 2006.

At Trinity Mission Health and Rehab of Provo L.P. we work to abide by the federal and the state regulations. We take great provide in providing care for the residents that reside in our facility and take this role very serious.

We continue to assess and review the programs and systems at this facility, utilizing our quality assurance programs. We are working on the areas that your team identified and are alleging compliance on April 3, 2006.

If you have any questions regarding our plan of correction, please feel free to contact me at your convenience.

Respectfully,

Jason H. Murray
Administrator

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged of conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.