STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465084	A. BUILDING _____ B. WING _____	9/12/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTS CARE AND REHAB. Plan of Correction Revised per EOR original approved 10/08/02	187 WEST LAGOON STREET ROOSEVELT, UT 84066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 221 SS=E	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined that the facility was using side rails on 2 of 14 sampled residents and geri-chairs on 1 of 14 sampled residents without a current physicians order, proper assessment and care planning. Resident Identifier: 6, 37, and 50. Findings include: 1. Resident 6 was admitted to the facility on 8/6/02 with the diagnoses of a recent right leg below the knee amputation, depressive features due to health problem, hypokalemia, cellulitis, peptic ulcer disease, anemia, yeast infection, diabetes, chronic vascular insufficiency, hypertension, congestive heart failure, candidiasis of skin/nails, osteomyelitis, constipation, pressure ulcer, peptic ulcer, insomnia, gangrene and bone involvement in other disease. Observation of resident 6 on 9/9/02 at 8:25 PM until 9:00 PM, revealed resident 6 was laying in bed with 3/4 side rails up times two. Observation of resident 6 on 9/10/02 at 8:10 PM, revealed resident 6 laying in bed with 3/4 side rails up times two. On 9/9/02, resident 6's medical record was reviewed and revealed the following documentation:	F 221	The facility reviewed restraint policies (especially side rails and gerichair use) with nursing staff per nursing inservice on 9-20-02. A monitoring log was designed for Licensed nurses to sign for monitoring side rails according to M.D.'s orders - every shift. Licensed nurse meeting was held to address log requirement. DON will perform weekly night rounds unannounced to nursing staff X 6 weeks to ensure compliance. Resident 37 recieved an order per M.D. for geri-chair and 2 side rails while in bed to prevent self injury. Restraint information & assessments were completed at that time. All requirements were completed on resident 37 before the survey team left the building. Resident 6 and 50 both had orders for one side rail to assist with in bed mobility. Both residents were care planned for one side rail use. The other side rail was secured to the bed to prevent usage. All residents will continue to be assessed on admission. Orders for restraints only after alternative	10/12/02 10-12-02

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy Jensen	Administrator	10/10/02

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 after 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTS CARE AND REHAB.	187 WEST LAGOON STREET ROOSEVELT, UT 84066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 221	Continued From page 1 A physician's order, dated 8/6/02, documented , "one side rail up while in bed to assist." An "Evaluation of need for Side Rails as Restraints", form dated 8/6/02, documented "one side rail." A "Risk for Bed Entrapment" form, dated 8/28/02 gave resident 6 a score of 3- low risk. An admission MDS (minimum data set) assessment for resident 6 was completed by facility staff on 8/20/02. The staff assessed resident 6 as being independent in cognitive skills for daily decision making. Resident 6's bed mobility was assessed as needing extensive assistance and she required extensive assistance with transfers. The staff assessed resident 6 as needing other types of side rails (e.g. half rails, one side) as restraints. Review of resident 6's medical record on 9/9/02, revealed no current physician order for the use of 2 side rails, no signed family consent form for the use of 2 side rails, no restraint evaluation for the use of 2 side rails, and no care plan that addressed the use of 2 side rails. Further review of resident 6's care plans on 9/9/02, revealed no documentation that side rails were used for mobility. 2. Resident 37 was re-admitted to the facility on 9/6/02 with the diagnoses of schizoaffective disorder, personality disorder, diabetes, obesity, osteoarthritis, hypertension, constipation, urinary incontinence and depressive features due to schizoaffective disorder. Observation of resident 37 on 9/9/02 at 8:20 PM until 9:00 PM, revealed that resident 37 was sitting in the	F 221	continued... measures have been tried. Restraint documentation continue to be done on all residents using restraints. All residents requiring restraints will be care planned for restraint usage. Residents' using one side rail for in-bed mobility will have unused side rail secured to the bed. Use for one side rail will be re-assessed and changed according to residents condition. The use of one side rail will also be care planned. Resident using no side rails will have both side rails secured to the bed. All nursing staff will continue to be inserviced at least 2 x's per year. The Quality Assurance team will continue to monitor restraints used in the facility, and assure facility policies are followed. 10-12-02	

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F 221	Continued From page 2 front day room in a geri chair. A facility nurse's aide pointed resident 37 out to the surveyor at 8:20 PM and stated that resident 37 is usually in a wheelchair, but today threw herself out of her wheelchair onto the floor, so they placed her in the geri chair. Observation of resident 37 on 9/10/02 at 8:32 AM, revealed resident 37 was laying in bed. Resident 37's bed was up against the wall and the 3/4 side rail away from the wall was pulled up. A review of resident 37's medical record, on 9/10/02 at 8:45 AM, revealed the following: An "Evaluation of need for Side Rails as Restraints" form, was in the medical record, it was not dated nor completed. A "Risk for Bed Entrapment" form, was in the medical record, it was not dated nor completed. A physician's order for the use of side rails or a geri chair was not in the medical record. There were no nursing notes in the medical record to provide documentation of the need for a side rail or geri chair. On 9/10/02 at 9:05 AM, the facility staff member who takes care of the medical records came and placed a physician's order in resident 37's medical record, dated 9/10/02 at 8:00 AM, that documented "1 (one) SR (side rail) [up] while in bed for bed mobility" Observation of resident 37 on 9/10/02 at 1:10 PM, revealed resident 37 was laying in bed. Resident 37's bed was up against the wall and the 3/4 side rail away from the wall was pulled up.	F 221		

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F 221	Continued From page 3 Observation of resident 37 on 9/10/02 at 4:00 PM, revealed resident 37 was laying in bed. Resident 37's bed was up against the wall and the 3/4 side rail away from the wall was pulled up. Observation of resident 37 on 9/10/02 at 8:23 PM, revealed resident 37 was laying in bed. Resident 37's bed was up against the wall and the 3/4 side rail away from the wall was pulled up. Review of resident 37's medical record on 9/10/02, revealed no current physician's order for the use of a side rail away from the wall, no signed family consent form for the use of side rail away from the wall, no restraint evaluation for the use of side rail away from the wall, and no care plan that addressed the use of side rail away from the wall. Review of the medical record on 9/10/02, revealed no current physician's order for the use of a geri chair, no signed family consent for the use of a geri chair, no restraint evaluation for the use of a geri chair and no care plan that addressed the use of a geri chair as a restraint to protect the resident from self harm. Observation of resident 37 on 9/11/02 at 9:45 AM, revealed resident 37 on the floor in the front day room. There were two facility nurse aides and one facility nurse with the resident. The nurse aides lifted the resident into the geri chair. The facility nurse stated that resident 37 was on the floor out of her wheelchair, she did not fall out of the wheelchair. The facility nurse also stated they have to put her (referring to resident 37) in the geri chair when she does this (referring to being on the floor out of her wheelchair). The facility nurse further stated, last summer she (referring to resident 37) had to be in the geri chair a few days.	F 221		

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F 221	Continued From page 4 Observation of resident 37 on 9/11/02 at 10:00 AM, revealed resident 37 in the geri chair in the front day room. Observation of resident 37 on 9/11/02 at 10:30 AM, revealed resident 37 in the geri chair in the TV room. Observation of resident 37 on 9/11/02 at 1:30 PM until 2:30 PM, revealed resident 37 in the geri chair in the front day room. On 9/12/02 at 10:00 AM a second review of the medical record was completed. The review revealed the following: A "Restraint Approval by Resident or Surrogate" form was revealed in resident 37's medical chart. The form documented a geri chair was recommended for the following reasons, "will not stay in wheelchair; keeps throwing self onto floor." The form also documented that the restraint may result in the following benefits, "to prevent self injury." The facility documented that the resident was "cognitively unable to sign for self" and the family member was "unavailable/out of state." A "Risk for Bed Entrapment" form dated 9/11/02 gave resident 37 a score of 13-high risk. A nursing progress note dated 9/10/02 at 2:40 PM documented, "...Pt (patient) found on floor, undressed clothes all over room w/c (wheelchair) @ (at) bedside 0 (zero) c/o (complaints of) pain or discomfort, small open area bleeding." No other progress notes could be found in the chart concerning resident 37 falling out of her wheelchair or causing self harm.	F 221		

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F 221	Continued From page 5 Further review of resident 37's care plans on 9/12/02, revealed no documentation that side rails were used for mobility or the use of the geri chair as a restraint to protect the resident from self harm. 3. Resident 50 was admitted to the facility on 8/13/02 with the diagnoses of biliary cirrhosis, dyspepsia, hypothyroidism, psychological stress, constipation, edema, arthritis and anxious features. Observation of resident 50 on 9/10/02 at 4:20 PM, revealed resident 50 laying in bed with 1/2 side rails up times two. Observation of resident 50 on 9/10/02 at 8:10 PM, revealed resident 50 laying in bed with 1/2 side rails up times two. Observation of resident 50 on 9/11/02 at 1:30 PM, revealed resident 50 being put into bed by a facility aide. The side rail on one side was already placed up and the facility aide was observed to place the other side rail up after placing the resident into bed. Observation of resident 50 on 9/11/02 at 2:30 PM, revealed resident 50 laying in bed with 1/2 side rails up times two. On 9/11/02, resident 50's medical record was reviewed and revealed the following documentation: A physician's order, dated 8/13/02, documented , "one side rail up while in bed to assist." An "Evaluation of need for Side Rails as Restraints, form dated 8/13/02, documented "one side rail." A "Risk for Bed Entrapment" form, dated	F 221		

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F 221	Continued From page 6 8/28/02 gave resident 50 a score of 2- low risk. An admission MDS assessment for resident 50 was completed by facility staff on 8/20/02. The staff assessed resident 50 as being moderately impaired in cognitive skills for daily decision making. Resident 50's bed mobility was assessed as needing extensive assistance and he required extensive assistance with transfers. The staff assessed resident 50 as needing other types of side rails (e.g. half rails, one side) as restraints. Review of resident 50's medical record on 9/11/02, revealed no current doctor order for the use of 2 side rails, no signed family consent form for the use of 2 side rails, no restraint evaluation for the use of 2 side rails, and no care plan that addressed the use of side rails. Further review of resident 50's care plans on 9/11/02, revealed no documentation that side rails were used for mobility.	F 221		
F 279 SS=C	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	F 279		9/15/02

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F 279	Continued From page 7 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 observation, interview and record review, it was determined that the facility did not develop comprehensive care plans that met the medical, nursing, mental and psychosocial needs for 7 of 14 sample residents. Resident identifiers: 2, 6, 11, 17, 37, 38, and 50. Findings include: 1. Resident 2 was admitted to the facility on 9/1/95 with the diagnosis arthropathy, hypertension, gout, diabetes and mild mental retardation. Observation of resident 2 on 9/10/02 at 4:05 PM until 5:00 PM, revealed resident 2 laying in bed with one 3/4 side rail up. Observation of resident 2 on 9/11/02 at 10:00 AM, revealed resident 2 laying in bed with one 3/4 side rail up. Observation of resident 2 on 9/11/02 at 1:30 PM, revealed resident 2 laying in bed with one 3/4 side rail up. On 9/11/02, resident 6's medical record was reviewed and revealed the following documentation: A physician's order, dated 3/22/01, documented , "one side rail up while in bed to assist." An "Evaluation of need for Side Rails as	F 279	The ADON was educated to the need to address 1 side rail in patients care plans for the use of in-bed mobility. The ADON made necessary changes in care plans of residents addressed by survey team. Documentation included the use of 1 SR while in bed to assist with in bed mobility in the care plans for resident #2, #6, #11,50. The side rail for #17 was discontinued due to resident currently not using. The side rail for resident #38 was discontinued, due to the use of a low bed. Resident #37 recieved orders for 2 side-rails and geri-chair while survey team remained in the building, and restraint documentation completed. Resident #37 us of geri-chair and 2 side-rails was addressed in her care plan. All future residents that are assessed for the need for 1 side rail for in bed mobility (per M.D. order) will have intervention addressed on current care plan, and will be reassessed quarterly and prn.	9-15-02

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F 279	Continued From page 8 Restraints", form dated 3/22/01, documented "one side rail." A "Risk for Bed Entrapment" form, dated 6/30/01, gave resident 2 a score of 2- low risk. A quarterly MDS assessment for resident 2 was completed by facility staff on 8/20/02. The staff assessed resident 2 as being moderately impaired in cognitive skills for daily decision making. Resident 2's bed mobility was assessed as needing no assistance and she required no assistance with her transfers. The staff assessed resident 2 as needing other types of side rails (e.g. half rails, one side) as restraints. A review of resident 2's comprehensive care plan revealed there was no documented care plan problem for resident 2's use of one side rail while in bed for assistance. 2. Resident 6 was admitted to the facility on 8/6/02 with the diagnoses of a recent right leg below the knee amputee, depressive features due to health problem, hypokalemia, cellulitis, peptic ulcer disease, anemia, yeast infection, diabetes, chronic vascular insufficiency, hypertension, congestive heart failure, candidiasis of skin/nails, osteomyelitis, constipation, pressure ulcer, peptic ulcer, insomnia, gangrene and bone involvement in other disease. Observation of resident 6 on 9/9/02 at 8:25 PM until 9:00 PM revealed resident 6 was laying in bed with 3/4 side rails up times two. Observation of resident 6 on 9/10/02 at 2:40 PM revealed resident 6 was laying in bed with one 3/4 side rail up. Observation of resident 6 on 9/10/02 at 8:10 PM,	F 279	continued... All future residents requiring the use of a geri-chair (per M.D. order), will have intervention addressed on resident care plan. The use of the geri-chair will be reassessed quarterly and prn. The medical records department and the D.O.N. will audit residents records to assure the care planning process is completed. The Quality Assurance team will review this deficiency and continue to monitor on a quarterly basis X 6 months. 09-15-02	

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F 279	Continued From page 9 revealed resident 6 laying in bed with 3/4 side rails up times two. Observation of resident 6 on 9/11/02 at 10:00 AM, revealed resident 6 laying in bed with one 3/4 side rail up. Observation of resident 6 on 9/11/02 at 1:30 PM, revealed resident 6 laying in bed with one 3/4 side rail up. Observation of resident 6 on 9/11/02 at 2:30 PM revealed resident 6 laying in bed with one 3/4 side rail up. On 9/9/02, resident 6's medical record was reviewed and revealed the following documentation: A physician's order, dated 8/6/02, documented , "one side rail up while in bed to assist." An "Evaluation of need for Side Rails as Restraints", form dated 8/6/02, documented "one side rail." A "Risk for Bed Entrapment" form, dated 8/28/02 gave resident 6 a score of 3- low risk. An admission MDS assessment for resident 6 was completed by facility staff on 8/20/02. The staff assessed resident 6 as being independent in cognitive skills for daily decision making. Resident 6's bed mobility was assessed as needing extensive assistance and she required extensive assistance with transfers. The staff assessed resident 6 as needing other types of side rails (e.g. half rails, one side) as restraints. A review of resident 6's comprehensive care plan revealed there was no documented care plan problem	F 279		

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F 279	Continued From page 10 for resident 6's use of one side rail while in bed for assistance. 3. Resident 11 was admitted on 6/1/98 with diagnoses of congested heart failure, diabetes, hypertension, convulsive disorder, cerebral vascular accident with cognitive deficits, constipation, and gout. Resident 11 was observed, on 9/9/02 at 8:20 PM, in bed with one side rail up. Physician's order, dated 9/02, was for on side rail up when in bed for assist. Review of resident 11's active medical record, on 9/9/02, revealed no care plan that addressed the use of side rails. A quarterly MDS assessment for resident 11 was completed by facility staff on 9/5/02. The staff assessed resident 6 as being independent in cognitive skills for daily decision making. Resident 11's bed mobility was assessed as needing extensive assistance and she required extensive assistance with transfers. The staff assessed resident 11 as needing other types of side rails (e.g. half rails, one side) as restraints. 4. Resident 17 was readmitted on 6/3/02 with diagnoses of status post fractured hip, dementia, Parkinson's, arthritis, hernia, psycho stress, constipation, and aneurysm. Resident 17 was observation, on 9/10/02 at 8:00 PM, with one side rail up. Physician's order, dated 9/02, was for one side rail up when in bed to assist. Review of resident 17's active medical record on	F 279		

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F 279	Continued From page 11 9/11/02, revealed no signed family consent form and no care plan that addressed the use of side rails. An admission MDS assessment for resident 17 was completed by facility staff on 6/3/02. The staff assessed resident 17 as being severely impaired with cognitive skills for daily decision making. Resident 17's bed mobility was assessed as needing extensive assistance and he required extensive assistance with transfers. The staff assessed resident 17 as needing other types of side rails (e.g. half rails, one side) as restraints. 5. Resident 37 was re-admitted to the facility on 9/6/02 with the diagnoses of schizoaffective disorder, personality disorder, diabetes, obesity, osteoarthritis, hypertension, constipation, urinary incontinence and depressive features due to schizoaffective disorder. Observation of resident 37 on 9/9/02 at 8:20 PM until 9:00 PM, revealed that resident 37 was sitting in the front day room in a geri chair. A facility nurse's aide pointed resident 37 out to the surveyor at 8:20 PM and stated that resident 37 is usually in a wheelchair, but today threw herself out of her wheelchair onto the floor, so they placed her in the geri chair. Observation of resident 37 on 9/10/02 at 8:32 AM, revealed resident 37 was laying in bed. Resident 37's bed was up against the wall and the 3/4 side rail away from the wall was pulled up. A review of resident 37's medical record, on 9/10/02 at 8:45 AM, revealed the following: An "Evaluation of need for Side Rails as Restraints" form, was in the medical record, it was not dated nor completed.	F 279		

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	465084	A. BUILDING _____ B. WING _____	9/12/2002

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STEWARTS CARE AND REHAB.	187 WEST LAGOON STREET ROOSEVELT, UT 84066

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F 279	Continued From page 12 A "Risk for Bed Entrapment" form, was in the medical record, it was not dated nor completed. A physician's order for the use of side rails or a geri chair was not in the medical record. There were no nursing notes in the medical record to provide documentation of the need for a side rail or geri chair. On 9/10/02 at 9:05 AM, the facility staff member who takes care of the medical records came and placed a physician's order in resident 37's medical record, dated 9/10/02 at 8:00 AM, that documented "1 (one) SR (side rail) [up] while in bed for bed mobility" Observation of resident 37 on 9/10/02 at 1:10 PM, revealed resident 37 was laying in bed. Resident 37's bed was up against the wall and the 3/4 side rail away from the wall was pulled up. Observation of resident 37 on 9/10/02 at 4:00 PM, revealed resident 37 was laying in bed. Resident 37's bed was up against the wall and the 3/4 side rail away from the wall was pulled up. Observation of resident 37 on 9/10/02 at 8:23 PM, revealed resident 37 was laying in bed. Resident 37's bed was up against the wall and the 3/4 side rail away from the wall was pulled up. Observation of resident 37 on 9/11/02 at 9:45 AM, revealed resident 37 on the floor in the front day room. There were two facility nurse aides and one facility nurse with the resident. The nurse aides lifted the resident into the geri chair. The facility nurse stated that resident 37 was on the floor out of her wheelchair, she did not fall out of the wheelchair. The facility nurse also stated they have to put her	F 279		

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F 279	Continued From page 13 (referring to resident 37) in the geri chair when she does this (referring to being on the floor out of her wheelchair). The facility nurse further stated, last summer she (referring to resident 37) had to be in the geri chair a few days. Observation of resident 37 on 9/11/02 at 10:00 AM, revealed resident 37 in the geri chair in the front day room. Observation of resident 37 on 9/11/02 at 10:30 AM, revealed resident 37 in the geri chair in the TV room. Observation of resident 37 on 9/11/02 at 1:30 PM until 2:30 PM, revealed resident 37 in the geri chair in the front day room. On 9/12/02 at 10:00 AM a second review of the medical record was completed. The review revealed the following: A "Restraint Approval by Resident or Surrogate" form was revealed in resident 37's medical chart. The form documented a geri chair was recommended for the following reasons, "will not stay in wheelchair; keeps throwing self onto floor." The form also documented that the restraint may result in the following benefits, "to prevent self injury." The facility documented that the resident was "cognitively not able to sign for self" and the family member was "unavailable/out of state." A "Risk for Bed Entrapment" form dated 9/11/02 gave resident 37 a score of 13-high risk. A nursing progress note dated 9/10/02 at 2:40 PM documented, "...Pt (patient) found on floor, undressed clothes all over room w/c (wheelchair) @ (at) bedside 0 (zero) c/o (complaints of) pain or	F 279		

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F 279	Continued From page 14 discomfort, small open area bleeding." No other progress notes could be found in the chart concerning resident 37 falling out of her wheelchair or causing self harm. A review of resident 37's comprehensive care plan on 9/10/02 and 9/12/02 revealed there was no documented care plan problem for resident 37's use of one side rail for bed mobility or the use of a geri chair as a restraint to protect her from self harm. 6. Resident 38 was admitted on 6/3/02 with diagnoses of senile dementia, lower extremity weakness, spinal stenosis, hypertension, cardiac disease and constipation. Resident 38 was observed, on 9/10/02 at 8:10 PM, in bed with one side rail up. Physician's order, dated 9/02, was for one side rail up when in bed to assist. Review of resident 38's active medical record, on 9/11/02, revealed no care plan that addressed the use of side rails. 7. Resident 50 was admitted to the facility on 8/13/02 with the diagnoses of biliary cirrhosis, dyspepsia, hypothyroidism, psychological stress, constipation, edema, arthritis and anxious features. Observation of resident 50 on 9/10/02 at 4:20 PM, revealed resident 50 laying in bed with 1/2 side rails up times two. Observation of resident 50 on 9/10/02 at 8:10 PM, revealed resident 50 laying in bed with 1/2 side rails up times two. Observation of resident 50 on 9/11/02 at 1:30 PM,	F 279		

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F 279	Continued From page 15 revealed resident 50 being put into bed by a facility aide. The side rail on one side was already placed up and the facility aide was observed to place the other side rail up after placing the resident into bed. Observation of resident 50 on 9/11/02 at 2:30 PM, revealed resident 50 laying in bed with 1/2 side rails up times two. On 9/11/02, resident 50's medical record was reviewed and revealed the following documentation: A physician's order, dated 8/13/02, documented , "one side rail up while in bed to assist." An "Evaluation of need for Side Rails as Restraints, form dated 8/13/02, documented "one side rail." A "Risk for Bed Entrapment" form, dated 8/28/02 gave resident 50 a score of 2- low risk. An admission MDS assessment for resident 50 was completed by facility staff on 8/20/02. The staff assessed resident 50 as being moderately impaired in cognitive skills for daily decision making. Resident 50's bed mobility was assessed as needing extensive assistance and she required extensive assistance with transfers. The staff assessed resident 50 as needing other types of side rails (e.g. half rails, one side) as restraints. A review of resident 50's comprehensive care plan revealed there was no documented care plan problem for resident 50's use of one side rail while in bed for assistance.	F 279		

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F 325	Continued From page 16	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 interview it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by 4 of 14 sampled residents who experienced significant weight loss. These four residents also had laboratory values reflecting malnutrition and were not adequately assessed by the facility's dietitian. Resident identifiers: 2, 6, 17 and 50. 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). Findings include: 1. Resident 2, a 75 year old female, was admitted to the facility on 9/1/95 with the diagnosis arthropathy, hypertension, gout, diabetes and mild mental retardation. A review of resident 2 weights revealed the following :	F 325	**A plan of correction for resident identifiers 2, 6, 17 & 50:** 1. Residents weight orders have been changed to every week per MD, after September weight losses were identified. 2. Resident will continue to have re-checks on Albumin levels as was done prior to survey. Monitoring levels will assess results with current nutritional interventions in place. 3. Residents will continue to receive nutritional supplements as were ordered prior to survey. Facility dietary personnel and nursing personnel will assess response to supplements ordered. Changes will be made per recommendations of Dietician and Physician orders. 4. Additional vitamin/mineral supplements will be recommended to MD and administered if Physician chooses to implement. 5. Advance Directives of all residents will continue to be upheld regarding aggressive nutritional treatments (such as feeding tubes). 6. Dietician & Physician will continue to be notified of any significant weight changes.	10/12/02

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F 325	Continued From page 17 June 2002 179.1 lbs. (Pounds) July 2002 173.4 lbs. August 2002 172 lbs. September 2002 159.6 lbs. Between the months of June 2002 and September 2002 resident 2 lost 19.5 lbs. (10.9%) which is significant. Between the month of August and September resident 2 lost 12.4 lbs. (7.2%) which is significant. A review of resident 2's medical record dietary notes revealed that no RD assessment addressing the weight loss had been completed for resident 2. Resident 2 had a nutritional assessment completed by the RD on 6/24/02. The dietitian continues with the no added salt, no concentrated sweets and diabetic snack TID(three times a day) that was originally ordered for resident 2 on 5/29/98. The dietitian had not calculated an estimation of fluid requirements, caloric requirements and/or protein requirements for resident 2. Without a calculation of the fluid, caloric or protein requirements it would not be possible for facility staff to know whether or not the diet would meet the needs of this resident. A care plan could not be found in resident 2's clinical record addressing a desired weight loss program. Review of resident 2's diet card on 9/10/02, revealed she was on a no added salt, no concentrated sweets diet with diabetic snacks TID. It did not indicate that resident 2 was on any desired weight loss program. Review of resident 2's care plans revealed a care plan dated 5/30/02, documenting the following problem,	F 325	7. Nutritional status of all residents will continue to be strictly monitored by facility dietician, dietary supervisor, and nursing supervisors per facility policy. 8. Residents will be assessed by physician to determine if the use of pharmaceuticals could improve the intake of these residents (e.g. Remeron use). 9. The QA team will continue to monitor the residents addressed by the survey team X 3 months. 10. Resident #6 will continue to have Restorative feeding program per Restorative Aide. 11. All residents addressed have had protein/calorie & hydration needs assessed per dietician. All residents and future admits will continue to have nutritional status monitored closely per facility policies. (Enclosed is a copy of our new policies) If residents are at risk they will continue to be care planned for this risk. All nutritional interventions will continue to be addressed on residents' care plans.	10-12-02

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F 325	Continued From page 18 "At risk for altered nutrition R/T (related to) DX (diagnoses) of NIDDM (non insulin dependent diabetes mellitus) M/B (manifested by) compliance to therapeutic diet: has poor appetite at meals or asks for soup instead of meal served." The care plan also documented the following approach, "...3. Monitor/record wt (weight) Q (every) month and PRN (as needed). Notify physician of 5% wt (weight) loss/gain in one month or 10% in 180 days." In an interview with the ADON (assistant director of nurses) on 9/10/02, she stated, the monthly weights on the residents were done the first week of the month. A review of resident 2's "Resident Weight Record" form on 9/10/02 documented the above mentioned weights. It did not document that the physician caring for resident 2 had been notified of the recent significant weight loss. A quarterly MDS assessment was completed on resident 2 on 8/20/02. The MDS documented that resident 2 had not had any significant weight loss or gain in the past 30 or 180 days. The MDS also documented that resident 2 leaves 25% or more of her food uneaten at most meals and that resident 2 is independent with her eating, requiring no assistance. The MDS did not document that resident 2 was on a planned weight change program. On 9/10/02, resident 2's dinner was observed. For dinner resident 2 was served tomato soup, peanut butter sandwich, pears, a pickle, fries, 120 cc of milk and 240 cc of juice. During the meal resident 2 requested watermelon, which the facility did provide for her. Resident 2 was observed to eat 100% of the tomato soup, 100% of the pears, 120 cc of the milk and 100% of the watermelon.	F 325		

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F 325	Continued From page 19 On 9/11/02, resident 2's breakfast was observed. For breakfast resident 2 was served Special K cold cereal, sausage, french toast with butter and syrup, 240 cc of juice, 240 cc of milk and 120 cc of water. Resident 2 was observed to eat 100% of the Special K, 50% of the sausage, 50% of the french toast with butter and syrup, 240 cc of the juice, 240 cc of the milk and 60 cc of the water. During both meal observations resident 2 was observed to feed herself with no encouragement or assistance from the facility staff. A review of resident 2's Nursing Monthly Summary, dated 7/31/02, documented, "Eating Habits- Poor- Feeds self/ Dining Room." Under problem number 6 they documented, "R/T (related to) alter nutrition. Appetite poor; 6# (pound) wt (weight) loss; needs encouragement to eat more." There was no documentation about edema in this monthly summary. A review of resident 2's Nursing Monthly Summary, dated 8/6/02, documented, "Eating Habits- Usually good- Feeds self/ Dining Room." Under comments they documented, "...Pt (patient) wt (weight) has declined a total of 2.1 lbs in the last month. Legs remain with edema, ted hose used daily, feet elevated daily to reduce swelling in [lower] extremities." Under problem number 6 they documented, "...Encouragement given to eat meals." In a nursing progress note dated 8/23/02 at 7:00 PM, a facility nurse documented "...Edema noted in [lower] ext (extremities)..." In the nursing progress notes dated 7/1/02 through 8/24/02, facility nurses documented that resident 2's	F 325		

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F 325	Continued From page 20 appetite was good 3 times, good to fair 2 times, fair to good 2 times and fair 1 time. A review of resident 2's ADL (activities of daily living) sheets from 8/1/02-9/11/02 revealed resident 2 consumed less than 75% of her meals 65 times out of 129 meals. A review of the July 2002 medication administration record (MAR) documented resident 2's pitting edema as plus two, 21 out of 31 days and plus one, 9 out of 31 days. A review of the August 2002 MAR documented resident 2's pitting edema as plus two, 31 out of 31 days. A review of the September 2002 MAR documented resident 2's pitting edema as plus one, 11 out of 11 days. Review of the MAR from July 2002 through September 2002 revealed no documentation that resident 2 was taking any diuretics to reduce resident 2's pitting edema. The RD did not calculate fluid or caloric requirements to ensure resident 2 was receiving adequate nutritional requirements as needed. The RD did not calculate protein requirements for resident 2 to address the mild visceral protein depletion to ensure that her diet met her protein needs. The facility did not notify the physician or RD about resident 2's significant weight loss. The facility did not notify the RD about resident 2's mild visceral protein depletion. 2. Resident 6, a 90 year old female, was admitted to the facility on 8/6/02 with the diagnoses of a recent	F 325		

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F 325	Continued From page 21 right leg below the knee amputation, depressive features due to health problem, hypokalemia, cellulitis, peptic ulcer disease, anemia, yeast infection, diabetes, chronic vascular insufficiency, hypertension, congestive heart failure, candidiasis of skin/nails, osteomyelitis, constipation, pressure ulcer, peptic ulcer, insomnia, gangrene and bone involvement in other disease. A review of resident 6 weights revealed the following: August 6, 2002 123.4 lbs September 2002 113.5 lbs Between the months of August 6, 2002 and September 2002 resident 6 lost 9.9 lbs. (8.0%) which is significant. A review of resident 6's medical record dietary notes revealed that no assessment addressing the weight loss had been completed for resident 6. Resident 6 had a nutritional assessment completed by the RD on 8/9/02. The dietitian records the diet as being a no added salt, no concentrated sweets diet with a diabetic snack TID , two cal supplement 2 ounces TID and 4 ounces of diabetic instant breakfast TID at snack time that was originally ordered for resident 6 on 8/6/02. The dietitian had not calculated an estimation of fluid requirements or caloric requirements . Without a calculation of the fluid or caloric requirements it would not be possible for facility staff to know whether or not the diet would meet the needs of this resident. The RD did document resident 6's recent below the knee amputation. The RD had not calculated an estimation of protein requirements for resident 50, although her most recent albumin reflected mild malnutrition. Resident 50 would also require	F 325		

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F 325	Continued From page 22 increased protein needs due to wound healing of her recent below the knee amputation. Without a calculation of protein requirements it would not be possible for facility staff to know whether or not the diet would meet the protein needs of this resident. A physician's order on 8/16/02 was written to include 8 ounces of diabetic IB TID with meals to resident 6's diet. A care plan could not be found in resident 6's clinical record addressing a desired weight loss program. Review of resident 6's diet card on 9/10/02, revealed she was on a no added salt, no concentrated sweet diet with diabetic snacks TID and 8 ounces of diabetic instant breakfast TID. It did not indicate that resident 6 was on any desired weight loss program Review of resident 6's care plan revealed a care plan dated 8/20/02, documenting the following problems, "Potential for impaired nutritional status/weight loss D/T (due to) [resident 6] consumes less than 75% of food offered and DX (diagnoses) of diabetes, hypokalemia, anemia and peptic ulcer disease." The care plan also documented the following approaches, "...2. Set up tray for easy feeding. Restorative feeding program. Assist as needed if [resident 6] is not feeding self. 3. Monitor and record intake QD (every day) for all meals/supplements. Encourage to eat at least 75% of meals and 100% of supplements. 4. Monitor/record wt (weight) Q (every) month and PRN (as needed). Notify physician of 5% wt (weight) loss/gain in one month or 10% in 180 days..." In an interview with the ADON on 9/10/02, she stated, the monthly weights on the residents were done the first week of the month.	F 325		

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F 325	Continued From page 23 A review of resident 6's "Resident Weight Record" form on 9/10/02 documented the above mentioned weights, it did not document that the physician caring for resident 6 had been notified of the recent significant weight loss. An admissions MDS assessment was completed on resident 6 on 8/13/02. The MDS documented that resident 6 had not had any significant weight loss or gain in the past 30 or 180 days. The MDS also documented that resident 6 required limited assistance while eating. Review of the medical record on 9/10/02 revealed that resident 6 was to receive restorative nursing for dining twice a day five times a week. On 9/10/02, resident 6's lunch was observed, resident 6 was not in the restorative dining room. For lunch resident 6 was served chicken and dumplings, mixed vegetables, cherry pie, yogurt, 120 cc of water, 240 cc of diabetic instant breakfast and 60 cc of two cal supplement. Resident 6 was observed to eat 10% of the chicken and dumplings, 50% of the mixed vegetables, less than 10% of the cherry pie, 50% of the yogurt, 20 cc of the water, 40 cc of the diabetic instant breakfast and 45 cc of the two cal supplement. Resident 6 was assisted by the staff with her meal and encouraged to eat her meal. Resident 6 did not continually have an aide sitting down with her during the meal. Many different aides assisted resident 6 throughout the meal. On 9/10/02, resident 6's dinner was observed, resident 6 was not in the restorative dining room. For dinner resident 6 was served sloppy joe, corn, applesauce, 240 cc of diabetic instant breakfast and 120 cc of water. Resident 6 was observed to eat less than 10% of the sloppy joe, 100% of the corn, 100% of the	F 325		

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F 325	Continued From page 24 applesauce, 10 cc of the water and 200 cc of the diabetic instant breakfast. Resident 6 was assisted by the staff with her meal and encouraged to eat her meal. On 9/11/02, resident 6's breakfast was observed, resident 6 was not in the restorative dining room. For breakfast resident 6 was served hot cereal, yogurt, watermelon, 240 cc of diabetic instant breakfast, 120 cc of milk, 120 cc of water, 120 cc of juice and 60 cc of two cal supplement. Resident 6 was observed to eat 100% of the yogurt, 50% of the watermelon, 100 cc of the diabetic instant breakfast, 50 cc of the water and 45 cc of the two cal supplement. Resident 6 was not assisted by facility staff with her meal. The facility staff did cue resident 6 four times to eat her meal. A review of resident 6's admission "Nursing History and Assessment, " dated 8/6/02, provided no documentation to provide evidence that resident 6 was admitted with any pitting edema. A review of the August 2002 MAR did not document any pitting edema for resident 6. A review of resident 6's September 2002 MAR documented resident 6's pitting edema as plus one, 10 out of 10 days. Review of the MAR for August 2002 through September 2002 revealed resident 6 was admitted on Lasix, a diuretic. The Lasix was held until further notice on 8/20/02. The September MAR documented that the Lasix had been given 9/1/02 through 9/4/02. On 9/4/02 the Lasix was discontinued. Documentation on the MAR provided evidence that resident 6's pitting edema on admit was a zero and increased to plus one pitting edema on September 1,	F 325		

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F 325	Continued From page 25 2002. The pitting edema remained a plus one through September 10, 2002. In the nursing progress notes from 8/6/02 though 9/5/02, facility nurses documented that resident 6's appetite was good 1 time, fair 12 times and poor 6 times. A review of resident 6's ADL sheets from 8/6/02-9/11/02 revealed resident 6 consumed less than 75% of her meal 83 times out of 103 meals. In an interview with the FSS (food service supervisor) on 9/10/02, she stated that she was aware of resident 6's recent weight loss. The RD was not aware of the recent weight loss because she is in one time a month. The FSS further stated that she did not call the RD concerning the weight loss because "I've been here for twelve years" and am comfortable with dietary problems. The FSS also stated that resident 6 has had lots of pain and that is why she [resident 6] is not eating well. In an interview with the FSS on 9/11/02 at 2:05 PM, she stated that the dietitian does recommend Zinc and vitamin C but the physicians will not always order them. She further stated that she became aware of the stage II wound on resident 6's below the knee amputation incision at the end of August. She also stated that they discussed the weight loss and wound in the IDT (interdisciplinary) meeting with the Administrator and DON (director of nurses) and they worked through any nutritional needs, therefore she didn't call the dietitian. In an interview with the Administrator on 9/11/02 at 2:50 PM, she stated that the dietitian doesn't need to be notified of weight loss because they (referring to the facility staff) can add supplements and that is all	F 325		

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F 325	Continued From page 26 the dietitian would do. The Administrator further stated that they (referring to the facility staff) do not calculate protein needs. She also stated that resident 6 has been ill and vomiting for three weeks so they could not provide her with medication like Zinc or vitamin C. The Administrator stated she felt they had done all they could do for this resident by providing her with a normal saline IV because the BUN (blood, urea, nitrogen) lab value was increased. The Administrator did state that resident 6 has been feeling better the past few weeks and no longer vomiting. In a nursing progress note dated 8/16/02 at 1:30 PM, a facility nurse documented, "...Abnormal labs received, new order .9NS (normal saline) 150cc/hr X 10 hrs (150 cc per hour times ten hours) leave heplock in place after infusion..." In a nursing progress note dated 8/20/02 at 4:00 PM, a facility nurse documented, "...Has new orders to hold Lasix til further notice. Is to have 1 liter of 0.9NS (normal saline) @ (at) 83cc/hr (83 cc per hour) per pump then 2 liters of 1/2NS (1/2 strength normal saline) at 41cc/hr (41cc per hour)..." In a nursing progress note dated 8/30/02 at 10:00 PM, a facility nurse documented, "...had lg (large) green thin emesis [with] white sm (small) particles..." In a nursing progress note dated 8/31/02 at 3:00 PM, a facility nurse documented, "...Emesis X1 (times one) this morning..." There was no other documentation in the nursing progress notes that indicated resident 6 had a problem with nausea and/or vomiting. There was a physician's order written on 8/16/02 for Phenergan (an anti nausea medication) to be given every 6 hours	F 325		

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F 325	Continued From page 27 as needed for nausea and vomiting times 7 days. There was no documentation on the MAR that Phenergan had been given to resident 6. In a nursing progress note dated 8/20/02 at 9:00 PM, a facility nurse documented, "...[changed] drsg (dressing) to stump small open area appearing aprox (approximately) 1/4 [inch] long [no] drainage noted at this time..." In a nursing progress note dated 8/21/02 at 2:00 PM, a facility nurse documented, "...Dsg (dressing) [changed] to rt (right) stump has sm (small) 1 cm (centimeter) open area in center of incision..." In a nursing progress note dated 8/25/02 at 6:55 PM, a facility nurse documented, "... [right] BKA (below the knee amputation) dsg (dressing) [changed] [no] drainage or breakdown noted..." In a nursing progress note dated 8/26/02 at 2:30 PM, a facility nurse documented, "...wet -dry drsg (dressing) to BKA (below the knee amputation) BID (twice a day)..." The facility wound nurse and two nurse surveyors did a wound check on resident 6's right BKA on 9/11/02 at 1:50 PM. The facility wound nurse stated the dehisced incision was discovered after the first week of resident 6's admit date. She stated at that time the wound was 1 cm in length by 0.2 cm in diameter and 0.2 cm deep. When the wound nurse and two nurse surveyors looked at the wound the facility wound nurse first staged the wound at a stage II, while looking closer at the wound it was discovered the wound was down to the cartilage. At the point the facility wound nurse staged the wound at a stage IV and gave the dimensions of 3 cm in length by 2 cm in diameter and 0.3 cm deep. The wound nurse stated	F 325		

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F 325	Continued From page 28 that she did the dressing change two weeks ago and there was no cartilage showing at that time. The RD did not calculate fluid or caloric requirements to ensure resident 6 was receiving adequate nutritional requirements as needed. The RD did not calculate protein requirements for resident 6 to address the mild visceral protein depletion or wound to ensure that her diet met her protein needs and to ensure wound healing. The facility did not notify the physician or RD about resident 6's significant weight loss. The facility failed to notify the RD about resident 6's mild visceral protein deficit and dehisced stage II wound. 3. Resident 17, a 96 year- old male, was admitted to the facility on 6/3/02 with diagnoses of status post fractured hip, dementia, Parkinson's, arthritis, hernia, psycho stress, constipation, and aneurysm. Review of resident 17's weight revealed the following: August 2002 122 lbs. September 2002 115 lbs. Between the month of August 2002 and September 2002 resident 17 lost 7 lbs (5.5%) , which is significant. A lab value taken at the facility and dated 6/7/02 showed an albumin (protein) level of 1.9 g/dl. The albumin of 1.9 g/dl dated 6/7/02 was the most current lab value in resident 17's medical record, and there was no documentation to provide evidence that the RD was aware of the severe visceral protein deficit. A review of resident 17's active medical record dietary notes revealed that no RD had seen the resident since 6/6/02, and no assessment addressing	F 325		

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F 325	Continued From page 29 the weight loss had been completed for resident 17. There was no documentation that resident 17 was on any desired weight loss program. Resident 17 had a nutritional assessment on 6/6/02 and care plan completed on 6/17/02. The dietitian documented resident 17 was on a general diet with one can of NuBasic juice with each meal, to address a post operative wound (which would require an increase of 1.2 g/dl of protein per kilograms of weight) and the resident being at risk due to low weight. The dietitian had not calculated an estimation of protein, calories or fluid requirements for resident 17. There was no documentation of dietary intervention after weight loss was identified. Without a calculation of protein requirements, it would not be possible for facility staff to know whether or not the diet would meet the protein needs of this resident. In resident 17's Nursing Monthly Summary, dated 8/23/02, documented , "Eating Habits usually good, feeds self, dining room" Under comments staff documented ,"...wt. (weight) stable at this time appetite fair. Drinks all supplements without problems..." Review of resident 17's care plan documented the following, "At risk for altered nutritional R/T (related to) poor appetite and oral/dental condition. Leaves 25% or more of most meals. Is on mechanically altered diet D/T (due to) few natural teeth". An admission MDS assessment was completed on resident 17 on 6/3/02. The MDS documented that resident 17 had not had any significant weight loss or gain in the past 30 or 180 days. The MDS also	F 325		

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F 325	Continued From page 30 documented that resident 50 is independent with his eating, requiring no assistance. On 9/11/02, resident 17's breakfast was observed. For breakfast resident 17 recieved cereal, french toast , ground meat, orange wedge, 163 cc NuBasic, 240 cc milk, 120 cc juice, and 120 cc water. Resident 17 was observed to consume 100% of the cereal, 50% of the french toast, 0% of the meat, 100% of the orange wedge, 100% of NuBaic, 100% of the milk, 100% of the water. On 9/12/02, resident 17's dinner was observed. For dinner resident 17 recieved puree meat, puree corn, apple sauce, 120cc juice, and 120 cc water. Resident 17 was observed to consume 100% of the meat, 100% of the corn, 0% of the apple sauce, 100% of the juice and 100% of the water. During both meal observations resident 17 was observed to feed himself with his left hand with no assistance from staff. Review of resident 17's ADL sheet from 9/1/02-9/11/02 revealed resident 17 consumed less than 50% for 19 of 33 meals. On 6/3/02 the FSS documented the admission of resident 17, no other documentation was found in the active medical record by the FSS. The facility did not notify the RD of resident 17's severe visceral protein deficit and weight loss. 4. Resident 50, an 81 year old female, was admitted to the facility on 8/13/02 with the diagnoses of biliary cirrhosis, dyspepsia, hypothyroidism, psychological stress, constipation, edema, arthritis and anxious	F 325		

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F 325	Continued From page 31 features. A review of resident 50's weights revealed the following: August 13, 2002 185.7 lbs. September 2002 168.2 lbs. Between August 13, 2002 and September 2002 resident 50 lost 17.5 lbs. (9.5%) which is significant. A lab value taken at the facility and dated 8/17/02 showed an albumin level of 2.0 g/dl. The albumin of 2.0 g/dl dated 8/17/02 was the most current in resident 50's medical record and there was no documentation to provide evidence that the RD was aware of the severe visceral protein deficit. A review of resident 50's medical record dietary notes revealed that no RD nutritional assessment had been completed for resident 50. Without an estimated calculation of fluid requirements, caloric requirements and protein requirements it would not be possible for the facility staff to know whether or not the diet the physician ordered would meet the needs of this resident. A review of resident 50's medical record dietary notes provided no documentation to provide evidence that the RD was aware of the significant weight loss for resident 50. A care plan could not be found in resident 50's clinical record addressing a desired weight loss program. Review of resident 50's diet card on 9/10/02, revealed she was on a general diet with ensure/nubasic supplement BID (twice a day) at 10:00 AM and 3:00	F 325		

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F 325	Continued From page 32 PM. It did not indicate that resident 2 was on a desired weight loss program. Review of resident 50's care plans revealed a care plan dated 8/27/02, documenting the following problem, "Potential for impaired nutritional status/weight loss D/T (due to) poor appetite and DX (diagnoses) of biliary cirrhosis, dyspepsia, hypothyroidism. Has occasional C/O (complaint of) nausea." The care plan also documented the following approach, "...3. Monitor/record wt (weight) Q (every) month and PRN (as needed). Notify physician of 5% wt (weight) loss/gain in one month or 10% in 180 days." In an interview with the ADON on 9/10/02, she stated, the monthly weights on the residents were done the first week of September. A review of resident 50's "Resident Weight Record" form on 9/10/02, documented the above weights it did not document that the physician caring for resident 50 had been notified of the recent significant weight loss. An admission MDS assessment was completed on resident 50 on 8/20/02. The MDS documented that resident 50 had not had any significant weight loss or gain in the past 30 or 180 days. The MDS also documented that resident 50 is independent with her eating, requiring no assistance. On 9/10/02, resident 50's dinner was observed. For dinner resident 50 was served tomato soup, peanut butter sandwich, yogurt, a pickle, fries, sugar cookie, 120 cc of water, 120 cc of milk, 120 cc of juice and 60 cc of 2.0 med passsupplement. Resident 50 was observed to eat 100% of the tomato soup, 100% of the yogurt, 50% of the sugar cookie, 120 cc of the milk,	F 325		

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F 325	Continued From page 33 120 cc of the juice, 120 cc of the water and 60 cc of the 2.0 med passsupplement. On 9/11/02, resident 50's breakfast was observed. For breakfast resident 50 was served oatmeal, sausage, french toast with butter and syrup, 240 cc of hot chocolate, 240 cc of milk, 120 cc of juice and 120 cc of water. Resident 50 was observed to eat 100% of the oatmeal, 100% of the sausage, 100% of the french toast with butter and syrup, 240 cc of the hot chocolate, 240 cc of the milk, 120 cc of the juice, and 120 cc of the water. During both meal observations resident 2 was observed to feed herself with no encouragement or assistance from the facility staff. A review of resident 50's admission "Nursing History and Assessment", dated 8/13/02, provided no documentation to evidence that resident 50 was admitted with any pitting edema. In a nursing progress admit note dated 8/13/02 at 1:45 PM, a facility nurse documented, "...[lower] extremities [with] edema..." Another nursing progress noted the same day and time documented, "...Has 1-2 [plus] edema both feet and [lower] legs..." In a nursing progress note dated 8/19/02 at 1:00 PM, a facility nurse documented, "...Legs remain edematous..." In a nursing progress noted dated 8/20/02 at 4:00 PM, a facility nurse documented "...See per [physician] this afternoon for edema and UTI. Returned [with] new orders for Lasix 40 mg [one] po (by mouth) BID (twice a day)..." In a physician progress note dated 8/20/02, resident	F 325		

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F 325	Continued From page 34 50's physician documented, "...3+ +(plus) edema extends to above knee..." In a nursing progress note dated 8/21/02 at 2:00 PM a facility nurse documented, "...Wt (weight) before breakfast = 181..." In a nursing progress note dated 8/23/02 at 1:10 PM, a facility nurse documented, "...Edema +(plus) 3-feet, [lower] legs..." In a nursing progress note dated 8/24/02 at 1:20 AM, a facility nurse documented, "...Edema +(plus) 3 in bilat (bilateral) [lower] ext.(extremities)..." In a nursing progress note dated 8/26/02 at 8:00 PM, a facility nurse documented, "...3+ (plus) pitting edema bilat (bilateral) [lower] ext. (extremities)..." In a nursing progress not dated 8/27/02 at 1:15 PM, a facility nurse documented, "...Wt (weight) [decreased] to 168.5 lbs (pounds). today..." There was no documentation in the nursing progress note that the physician or RD were notified of the significant weight loss. In a nursing progress note dated 8/27/02 at 8:00 PM, a facility nurse documented, "...3+ (plus) pitting edema bilat (bilateral) [lower] ext (extremities)..." In a nursing progress note dated 8/29/02 at 2:30 PM, a facility nurse documented, "...Cont (continues) to have 3+ (plus) edema in [lower] extremities..." In a nursing progress note dated 9/1/02 at 7:10 PM, a facility nurse documented, "...+ (plus) 3 pitting edema, cont (continues) in bilat (bilateral) [lower] ext (extremities)..."	F 325		

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F 325	Continued From page 35 In a nursing progress note dated 9/2/02 at 6:40 PM, a facility nurse documented, "...Cont (continues) 3+ (plus) pitting edema bilat (bilateral) [lower] ext (extremities)..." In a nursing progress note dated 9/4/02 at 8:10 PM, a facility nurse documented, "...+ (plus) 3 pitting edema bilat (bilateral) [lower] ext (extremities)..." A review of the August 2002 MAR did not document any pitting edema for resident 50. A review of the September 2002 MAR documented resident 50's pitting edema as plus two, 11 out of 11 days. In an interview with a facility nurse on 9/11/02, she stated that resident 50's edema has been at least a plus 2 since admit. Review of the MAR from August 2002 through September 2002 revealed resident 50 was started on Lasix, a diuretic, on 8/20/02. Documentation on the MAR, nursing progress notes and interview provide evidence that resident 50's pitting edema was between a plus two to a plus three during the month of August 2002 and September 2002, even after the diuretic was started on 8/20/02. The nursing progress notes from 8/13/02 through 9/7/02, documented that resident 50's appetite was fair 1 time and good 17 times. A review of resident 50' ADL sheets from 8/13/02-9/11/02 revealed resident 50 consumed less than 75% of her meal 22 times out of 88 meals. In an interview with resident 50 on 9/11/02 at 2:15 PM, she stated she has had a hard time eating due to	F 325		

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	465084	A. BUILDING _____ B. WING _____	9/12/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTS CARE AND REHAB.	187 WEST LAGOON STREET ROOSEVELT, UT 84066

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F 325	Continued From page 36 "no appetite" she further stated she has talked to the physician concerning her lack of appetite. Resident 50 did state the food is good and she is served what she likes to eat. Review of resident 50's medical chart did not provide any documented evidence that an appetite stimulant had been suggested to tried with resident 50 to increase her appetite. The RD did not do an initial assessment on resident 50, therefore her fluid, caloric and protein requirements were not calculated to ensure resident 2 was receiving adequate nutritional requirements as needed. The facility did not notify the physician or RD about resident 50's significant weight loss. The facility did not notify the RD about resident 50's severe visceral protein depletion, which reflected malnutrition. Without a calculation of protein requirements it would not be possible for facility staff to know whether or not the diet would meet the protein needs of this resident. The facility's policy and procedures for Residents at Nutritional Risk was reviewed on 9/11/02 at 3:00 PM. It was documented in the policy that "Any resident identified at nutritional risk will have a problem of 'Alteration in Nutrition' identified on the care plan and the physician will be informed and a Dietary consultation requested." "The following criteria will be used to help identify nutritionally at risk residents...2. Has a pressure sore or wound...4. Abnormal Hemoglobin (below 12 mg/dl) Hematocrit (below 37 gm/dl) Serum Albumin (below 3.5 g/dl) Serum Transferrin (below 170 mg/dl). 5. Consistently refuses 25% or more of meals. 6. Undesirable weight loss or gain of 3 lbs	F 325		

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F 325	Continued From page 37 (under 100 lbs) and 5 lbs (over 100 lbs) or more in one month...8. On diuretics with abnormal Potassium (K)...14. Non-compliance with diet order...19. Prolonged nausea, vomiting, diarrhea not relieved by treatment given according to accepted standards of practice..." It was documented in the procedures that: "1. Once a problem has been identified and the Dietitian has been consulted, the primary nurse should work with the Dietitian and resident in setting realistic goals and identify approaches to be used...3. Nursing notes should reflect progress	F 325		
F 354 SS=E	483.30(b)(1)-(3) NURSING SERVICES Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of the staffing schedule from April 2002 to September 2002, and an interview with the Administrator, it was determined the facility did not provide the services of a registered nurse seven days a week for eight consecutive hours a day. There was no week-end coverage from April 27, 2002 to September	F 354	The facility has employed an RN for week-end coverage since 9-3-02. She will be working every weekend. If the RN hired is not capable of working, the DON or the RN Administrator will work the RN shifts for the weekend to meet compliance.	9/12/02

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F 354	Continued From page 38 1, 2002.	F 354	All rooms cited in deficiency were reassessed by plant supervisor. Curtains required plant supervisor to readjust hooks in curtains and ceiling guides to ensure proper closing. Additional wall closures (with straps attached to walls with snaps) were installed to ensure complete privacy. The plant supervisor will continue to monitor on a weekly basis. Quality Assurance will review this deficiency in QA meeting, and will continue to monitor X 6 months.	10/12/02 10-12-02
F 460 SS=B	483.70(c)(1)(iv&v) PHYSICAL ENVIRONMENT Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation, on 9/11/02 at 1:00 PM, it was determined the facility did not ensure that 23 of 59 certified beds were equipped with a means of full visual privacy. -North Hall, Room 1 bed B had a 55 inch gap in the curtain, Room 2 bed A had a 52 inch gap in the curtain, Room 3 bed A had a 47 inch gap and bed B had a 49 inch gap in the curtains, Room 4 bed A had a 20 inch gap and bed B had a 57 inch gap in the curtains, Room 8 bed B had a 58 inch gap in the curtain, Room 9 bed B had 47 in gap in the curtain, South Hall, Room 1 bed A had a 48 inch gap in the curtain,	F 460		

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F 460	Continued From page 39 Room 2 bed A had 27 inch gap in the curtain, Room 3 bed B had a 57 inch gap in the curtain, Room 4 bed A had a 20 inch gap and bed B had a 60 inch gap in the curtains, Room 5 bed B had a 47 inch gap in the curtain, Room 6 bed A had a 60 inch gap and bed B had a 47 inch gap in the curtains, Room 7 bed A had a 47 inch gap in the curtain, Room 8 bed B had a 60 inch gap in the curtain, West Hall, Room 1 bed B had a 20 inch gap in the curtain, Room 4 bed B had a 50 inch gap in the curtain, Room 5 bed A had a 60 inch gap in the curtain, Room 9 bed A and bed B both had a 60 inch gap in the curtains.	F 460		
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	F 490		10/12/02

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F 490	Continued From page 40 residents medical records, and facility policies and procedures during the annual survey from 9/9/02 through 9/12/02, 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 6 areas, not including this deficiency. Findings include: 1. On September 12, 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 adequate dietary assessment and intervention for 4 residents who had significant weight loss and 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 4 residents (2, 6, 17, 50) who experienced significant weight loss and whose laboratory values reflected nutritional deficits but did not receive adequate nutritional assessment or intervention. Resident 2 experienced a 10.9% unplanned weight loss from June 2002 to September 2002. A review of resident 2's medical record dietary notes revealed that no assessment addressing the weight loss had been completed for resident 2. The facility's RD had not	F 490	The policies and procedures will be revised to address the following: 1. The dietician will perform protein/calorie and hydration need calculations on all residents (prior was only required on tube fed residents according to facility policy) 2. The dietician will continue to be notified of significant weight changes according to facility policy. 3. The residents Physician will continue to be notified of gross weight changes according to facility policy. 4. The recommendation of vitamin/mineral use will be made to MD to further aide with nutritional status in residents with impaired skin integrity. New policy was made to address recommendations for skin impairments stage I - IV. 5. The facility will continue to employ a licensed dietician on a contract basis, working 16-24 hours in the facility per month. 6. Dietitian implemented additional QA tools to assist RD and FSS with dietary management of all residents. 7. Dietitian wrote policy to address weekly weights on all new admits. All new admits will be weighed weekly X 1 month.	

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F 490	Continued From page 41 calculated an estimation of protein required by resident 2 although she experienced significant weight loss. Without a calculation of protein requirements it would not be possible for the facility staff to know whether or not the diet would meet the protein needs of this resident. Resident 6 experienced a 8.0% unplanned weight loss from August 6, 2002 to September 2002. A review of resident 6's medical record dietary notes revealed that no assessment addressing the weight loss had been completed for resident 6. The facility's RD had not calculated an estimation of protein required by resident 6 although she experienced significant weight loss, her albumin level was below normal and also require increased protein needs due to wound healing of her recent below the knee amputation. Without a calculation of protein requirements it would not be possible for facility staff to know whether or not the diet would meet the protein needs of this resident. Resident 17 experienced a 5.5% unplanned weight loss from August 2992 to September 2002. A lab value taken at the facility and dated 6/7/02 showed an albumin (protein) level of 1.9 g/dl. A review of resident 17's active medical record dietary notes revealed that no RD had seen the resident since 6/6/02, and no assessment addressing the weight loss had been completed for resident 17. The facility's RD had not calculated an estimation of protein required by resident 17 although his most recent albumin level reflected malnutrition and the fact he had experienced significant weight loss. Without an estimated calculation of fluid requirements, caloric requirements and protein requirements it would not be possible for the facility staff to know whether or not the diet the physician ordered would meet the needs of this resident.	F 490	All new admits will have a re-weight the next day following the admit date. If new admit weights are stable after 1 month, they will be changed to a monthly weight. 8. Enclosed is a copy of our new dietary policy and procedures. 9. The dietitian will continue to have monthly conference with FSS, DON, & Administrator to discuss resident nutritional concerns. 10. Dietitian will continue to have monthly inservices with dietary department and administrator.	

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F 490	Continued From page 42 Resident 50 experienced a 9.5% unplanned weight loss from August 13, 2002 to September 2002. A review of resident 50's medical record dietary notes revealed that no RD nutritional assessment had been completed. A lab value taken at the facility and dated 8/17/02 showed an albumin level of 2.0 g/dl. for resident 50. The normal reference range, according to the lab used by the facility, was 3.2-5.0 g/dl. An albumin level less than 2.4 g/dl is considered a severe visceral protein deficit and an albumin level of 2.4-2.9 g/dl is considered moderate visceral protein deficit and an albumin level of 3.0-3.5 g/dl is considered a mild visceral protein deficit. (Reference guidance; Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000, page 22). The facility RD (Registered Dietitian) had not calculated an estimation of protein required by the resident 50 although he had experienced significant weight loss, the albumin level was below normal. Without an estimated calculation of fluid requirements, caloric requirements and protein requirements it would not be possible for the facility staff to know whether or not the diet the physician ordered would meet the needs of this resident. The facility's policy and procedures for Residents at Nutritional Risk was reviewed on 9/11/02 at 3:00 PM. It was documented in the policy that "Any resident identified at nutritional risk will have a problem of 'Alteration in Nutrition' identified on the care plan and the physician will be informed and a Dietary consultation requested." "The following criteria will be used to help identify nutritionally at risk residents...2. Has a pressure sore or wound...4. Abnormal Hemoglobin (below 12 mg/dl) Hematocrit (below 37 gm/dl) Serum Albumin	F 490	**The facility administration will monitor to ensure that the revised policies are upheld. (See copy of nutritional policies & procedures)** 1. The Administrator will be given a copy of all resident weight records to notify her of any significant weight changes. 2. The Administrator will continue to be given a copy of all Albumin levels drawn on all residents with nutritional concerns. 3. The Administrator will continue to meet with the Dietitian on a monthly basis. 4. The Administrator will be given a copy of all new completed QA tools. 5. The Administrator will continue to meet with the DON and FSS after monthly and weekly weights are completed, to determine the need for Dietitian consult and physician notification.	10-12-02

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F 490	Continued From page 43 (below 3.5 g/dl) Serum Transferrin (below 170 mg/dl). 5. Consistently refuses 25% or more of meals. 6. Undesirable weight loss or gain of 3 lbs (under 100 lbs) and 5 lbs (over 100 lbs) or more in one month...8. On diuretics with abnormal Potassium (K)...14. Non-compliance with diet order...19. Prolonged nausea, vomiting, diarrhea not relieved by treatment given according to accepted standards of practice..." It was documented in the procedures that: "1. Once a problem has been identified and the Dietitian has been consulted, the primary nurse should work with the Dietitian and resident in setting realistic goals and identify approaches to be used...3. Nursing notes should reflect progress made on a weekly basis." The facility's Policy and Procedure for Residents at Nutritional Risk also documented the following essential point, "Timely assessment and implementation of a plan is crucial in proper care of this resident at risk. Elderly residents are quick to experience a change in condition with negative outcomes, but very slow to recover." The facility's policy and procedure for Weight was reviewed on 9/11/02 at 3:00 PM. It was documented in the policy that "All resident weights will be monitored monthly or more often as indicated by the resident's condition, physician orders, etc." It was documented under the procedure that "...7. Gross weight gains or losses will prompt an immediate reweighing of resident, and if confirmed, immediate notification of the physician...9. Before recording each weight in the medical record. a. Any	F 490		

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F 490	Continued From page 44 gross weight variation has been reweighed. b. If gross gain or loss had indeed occurred, a dietary consult has been requested and the physician has been notified. The facility's policy and procedure for Nutritional Assessment was reviewed on 9/11/02 at 3:00 PM. It was documented in the policy that "The Dietitian will complete a nutritional assessment on all residents upon admission. Additionally a nutritional assessment will be completed at least annually and anytime a change in condition occurs impacting significantly on the resident's ability to maintain current nutritional status." In was documented under the purpose that "Such evaluation will provide a timely and uniform evaluation of the resident's nutritional status and adequacy of the resident's current diet." In an interview with the Administrator on 9/11/02 at 2:50 PM, she stated that the dietitian doesn't need to be notified of weight loss because they (referring to the facility staff) can add supplements and that is all the dietitian would do. The Administrator further stated that they (referring to the facility staff) do not calculate protein needs.	F 490		
F 494 SS=B	483.75(e)(2)-(3) ADMINISTRATION A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency	F 494		9/24/02

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F 494	Continued From page 45 evaluation program approved by the State as meeting the requirements of ss483.151-483.154 of this part; that individual has been deemed or determined competent as provided in s483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the facility personnel files, it was determined that one of four selected nursing aides on the facility's current employee list had been working longer than four months and was not certified. Employee identifier: A Findings include: On 9/10/02, during review of personnel files, the following aide was found to have worked longer than four months without becoming certified. Employee A was hired 3/14/02 and had been working five months, 3 weeks and 6 days. During review of the facility's August 2002 and September 2002 nurse aide schedule, it was revealed that employee A was currently providing hands on care to residents. During interview with the Director of Nurses (DON) on 9/10/02, she stated employee A had been working as a nurse aide providing hands on care to residents.	F 494	The nurses aide identified (Employee A) in this deficiency was removed from nursing schedule before survey was completed. The nurse aide was not working at the facility at all during or after the survey. The nurse aide received her certification on 9-24-02 and therefore has been reinstated. The nursing staff was re-inserviced on 9-20-02 regarding the 4 month from hire date requirement. This requirement will continue to be monitored by DON and Personnel office. The Personnel officer continued to audit Nurse Aides employee files. She reviewed findings with D.O.N. to ensure Nurse Aides were not scheduled for direct patient care after their 4 month hire date has expired without certification completed. The QA committee reviewed deficiency and plan of correction. They will continue to monitor x 6 months.	9-24-02