		(XI) PROVIDER/SUPPLIER/CLIA IF TFICATION NUMBER: 465084	(X2) MU A. BUILI B. WINC	 -	(X3) DATE SURVEY COMPLETED 9/12/2002	
	ROVIDER OR SUPPLIER	_ original approv	on s DR ed	TREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET ROOSEVELT, UT 84066	<u> </u>	72002
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (O) F6 (C) MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(NS) COMPLETE DATE
	physical restraints im or convenience, and nor convenience, and nor resident's medical synthetic resident's medical synthetic resident's medical synthetic resident's medical synthetic resident that the factor of 14 sampled residents with proper assessment and Identifier: 6, 37, and 5 Findings include: 1. Resident 6 was admitted that the diagnoses of a knee amputation, deprepoblem, hypokalemia anemia, yeast infection insufficiency, hypertencandidiasis of skin/nai pressure ulcer, peptic to bone involvement in or Observation of resident 9:00 PM, revealed resident of the side rails up times.	right to be free from any posed for purposes of discipline not required to treat the optoms. It is not met as evidenced by: and record review, it was cility was using side rails on 2 ts and geri-chairs on 1 of 14 mout a current physicians order, I care planning. Resident 50. Initted to the facility on 8/6/02 a recent right leg below the essive features due to health, cellulitis, peptic ulcer disease, it, diabetes, chronic vascular ision, congestive heart failure, is, osteomyelitis, constipation, ilcer, insomnia, gangrene and ther disease. It 6 on 9/9/02 at 8:25 PM until ident 6 was laying in bed with	F 221	The facility reviewed restrain policies (especially side rail gerichair use) with nursing sursing inservice on 9-20-00 monitoring log was designed Licensed nurses to sign for monitoring side rails accord M.D.'s orders - every shift. nurse meeting was held to a log requirement. DON will weekly night rounds unannounce staff X 6 weeks to ecompliance. Resident 37 recieved an ord M.D. for geri-chair and 2 side while in bed to prevent self Restraint information & asswere completed at that time requirements were complete resident 37 before the survey left the building. Resident 6 and 50 both had for one side rail to assist with bed mobility. Both resident care planned for one side rail. The other side rail was secular to the side rail w	s and staff per 2. A d for ling to Licensed address perform ounced to ensure ler per de rails injury. essments a All ed on by team orders th in ts were il use.	10/12/02
1	up times two.	medical record was reviewed		the bed to prevent usage.	100.10	

LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

112000

and revealed the following documentation:

for restraints only after alternative

All residents will continue to be

assessed on admission. Orders

(X6) DATE

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.

Event ID: UZUY11 Facility ID:

Ndaninistrator

1000720002441795135 | MAY 1 5 2003 | 05 62-63 CI2

CMS-2567L

UT0084

PRINTED: 4/15/2003

	RS FOR MEDICARE	& MF AID SERVICES				FORI	M APPROVE -2567
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	IULTIPLE CONST	RUCTION	(X3) DATE S COMPL	URVEY
		465084	B. WI	NG		9/1	2/2002
	ROVIDER OR SUPPLIER	B.		187 WEST LA	ss, city, state, zip coe agoon street LT, UT 84066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EA	PROVIDER'S PLAN OF CO ACH CORRECTIVE ACTION SS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
F 221	"one side rail up while An "Evaluation of Restraints", form date rail." A "Risk for Bed 18/28/02 gave resident An admission Massessment for resider staff on 8/20/02. being independent in decision making. Resassessed as needing exrequired extensive assassessed resident 6 as (e.g. half rails, one side.g. half rails, no signed for 2 side rails, no restraide rails, and no care side rails. Further review of resident for mobility.	der, dated 8/6/02, documented, e in bed to assist." of need for Side Rails as ed 8/6/02, documented "one side Entrapment" form, dated 6 a score of 3- low risk. DS (minimum data set) et 6 was completed by facility. The staff assessed resident 6 as cognitive skills for daily sident 6's bed mobility was extensive assistance and she esistance with transfers. The staff needing other types of side rails de) as restraints. In medical record on 9/9/02, ensyician order for the use of 2 amily consent form for the use raint evaluation for the use of 2 aplan that addressed the use of 2 dent 6's care plans on 9/9/02, ation that side rails were used	F 221	docum on all r resider care pl Reside bed mo rail sec side ra change conditi rail wil Reside both si All nur be inse The Qu continu	ued res have been triesentation continueresidents using restrance for restrainents' using one side oblity will have usured to the bed. if will be re-assested according to restrain the use of or the use of or the using no side restrainents secured to the using no side restrainents secured to the using staff will contribute to monitor restraints, and assure first are followed.	e to be done straints. All aints will be nt usage. de rail for inmused side Use for one sed and sidents ne side nned. rails will have to the bed. The traints used in facility	
	9/6/02 with the diagnorpersonality disorder, of	-admitted to the facility on oses of schizoaffective disorder, liabetes, obesity, osteoarthritis, ation, urinary incontinence and				10-12-02	

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

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

PRINTED: 4/15/2003 FORM APPROVED 2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
	465084	B. WIN	IG	9/1	2/2002	
NAME OF PROVIDER OR SUPPLIER STEWARTS CARE AND REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET ROOSEVELT, UT 84066			
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE	
pointed resident 37 of and stated that reside but today threw herse floor, so they placed? Observation of reside revealed resident 37 of bed was up against the from the wall was put the from the wall was not dated nor complete. A "Risk for Bed I medical record, it was a physician's order in the wall was not in the from the wall was put the from the from the from the from the from the wall was put the from the fr	geri chair. A facility nurse's aide but to the surveyor at 8:20 PM ant 37 is usually in a wheelchair, alf out of her wheelchair onto the her in the geri chair. Int 37 on 9/10/02 at 8:32 AM, was laying in bed. Resident 37's he wall and the 3/4 side rail away alled up. 37's medical record, on 9/10/02 the following: of need for Side Rails as an in the medical record, it was hed. Entrapment" form, was in the senot dated nor completed. Her for the use of side rails or a side medical record. In the medical record. It is not dated nor completed. In the medical record. In the facility staff member who cal records came and placed a sident 37's medical record, AM, that documented "1 (one) ite in bed for bed mobility" Int 37 on 9/10/02 at 1:10 PM, was laying in bed. Resident 37's wall and the 3/4 side rail away wall and the 3/4 side rail away	F 221				

UT0084

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		_	(X3) DATE SURVEY COMPLETED	
L		465084	B. WIN	NG		9/1:	2/2002
i	PROVIDER OR SUPPLIER RTS CARE AND REHA			STREET ADDRESS, CITY, STATE, ZIP 187 WEST LAGOON STREET ROOSEVELT, UT 84066	CODE		<u> 12002</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES (MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF	TION SHOUTHE APPRO	ULD BE	(X5) COMPLETE DATE
F 221	Observation of resider revealed resident 37 vbed was up against the from the wall was pull. Observation of resider revealed resident 37 vbed was up against the from the wall was pull. Review of resident 37 revealed no current place in a side rail away from the form for the use of sider restraint evaluation for the wall, and no care side rail away from the wall, and no care side rail away from the wall, and no care side rail away from the review of the medical current physician's order no signed family cons no restraint evaluation no care plan that addrestraint to protect the Observation of resident revealed resident 37 or room. There were two facility nurse with the the resident into the gestated that resident 37 wheelchair, she did not The facility nurse also (referring to resident 3 does this (referring to wheelchair). The facility nurse facility nurse also (referring to resident).	ent 37 on 9/10/02 at 4:00 PM, was laying in bed. Resident 37's he wall and the 3/4 side rail away alled up. ent 37 on 9/10/02 at 8:23 PM, was laying in bed. Resident 37's he wall and the 3/4 side rail away alled up. 7's medical record on 9/10/02, whysician's order for the use of a he wall, no signed family consent de rail away from the wall, no or the use of side rail away from plan that addressed the use of he wall. 1 record on 9/10/02, revealed no order for the use of a geri chair, sent for the use of a geri chair, no for the use of a geri chair and ressed the use of a geri chair as a resident from self harm. 1 and 37 on 9/11/02 at 9:45 AM, on the floor in the front day to facility nurse aides and one resident. The nurse aides lifted geri chair. The facility nurse of fall out of the wheelchair. The stated they have to put her stated they have to put he	F 221				

DEPARTMENT OF HEALTH AND F LAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

<u> </u>	REFORMEDICARE	& MEDICAID SERVICES	_,				2567-L
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465084	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
NAME OF P	ROVIDER OR SUPPLIER	400004				9/1	2/2002
	RTS CARE AND REHA			13	REET ADDRESS, CITY, STATE, ZIP CODE 87 WEST LAGOON STREET ROOSEVELT, UT 84066		
(X4) ID PREFIX TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	TE ACTION SHOULD BE COME TO THE APPROPRIATE	
F 221	revealed resident 37 i room. Observation of resider revealed resident 37 i Observation of resider	nt 37 on 9/11/02 at 10:00 AM, in the geri chair in the front day int 37 on 9/11/02 at 10:30 AM, in the geri chair in the TV room.	F 221				
	On 9/12/02 at 10:00 A medical record was cothe following: A "Restraint App form was revealed in a	AM a second review of the ompleted. The review revealed roval by Resident or Surrogate resident 37's medical chart. If a geri chair was recommended ons, "will not stay in					
	form also documented in the following benef The facility documen "cognitively unable to member was "unavaila	that the restraint may result its, "to prevent self injury." ited that the resident was sign for self" and the family able/out of state."					
	PM documented, "Pi undressed clothes @ (at) bedside 0 (zero discomfort, small oper No other progress	notes could be found in the ent 37 falling out of her					

DEPARTMENT OF HEALTH AND I 1AN SERVICES

PRINTED: 4/15/2003 FORM APPROVED

CLIVIE	RO FOR MEDICARE	& MEDICAID SERVICES					2567-I
	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465084		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 9/12/2002	
	PROVIDER OR SUPPLIER RTS CARE AND REHA	AB.	·- !	18	EET ADDRESS, CITY, STATE, ZIP CODE 87 WEST LAGOON STREET COOSEVELT, UT 84066	71	<i>LI LUUL</i>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE	
F 221	revealed no document for mobility or the usto protect the resident. 3. Resident 50 was a with the diagnoses of hypothyroidism, psycedema, arthritis and a cobservation of resider revealed resident 50 lup times two. Observation of resider revealed resident 50 lup times two. Observation of resider revealed resident 50 lup times two. Observation of resider revealed resident 50 laide. The side rail or and the facility aide with side rail up after place. Observation of resider revealed resident 50 lup times two. On 9/11/02, resident reviewed and revealed. A physician's ord "one side rail up while and "Evaluation of the side rail up while and revealed."	ident 37's care plans on 9/12/02, station that side rails were used to of the geri chair as a restraint of the geri chair as a restr	F 221				

A "Risk for Bed Entrapment" form, dated

DEPARTMENT OF HEALTH AND I 1AN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTER	S FOR MEDICARE	<u>& MEDICAID SERVICES</u>				2567-L	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMPL	(X3) DATE SURVEY COMPLETED	
NAME OF D	DOMESTIC OF CLIENT HER	465084			9/1	2/2002	
	ROVIDER OR SUPPLIER RTS CARE AND REHA	AB.		STREET ADDRESS, CITY, STATE, ZIP CO 187 WEST LAGOON STREET ROOSEVELT, UT 84066	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
F 221	An admission M was completed by factor The staff assessed resimpaired in cognitive making. Resident 50 needing extensive assistance resident 50 as needing half rails, one side) at Review of resident 50 revealed no current drails, no signed familiside rails, no restrain rails, and no care platrails.	DS assessment for resident 50 callity staff on 8/20/02. Sident 50 as being moderately exhills for daily decision by bed mobility was assessed as sistance and he required with transfers. The staff assessed g other types of side rails (e.g.	F 221				
F 279 SS=C	for each resident that and timetables to mee and mental and psych in the comprehensive The care plan must de The services that are maintain the resident	elop a comprehensive care plan includes measurable objectives a resident's medical, nursing, associal needs that are identified assessment.	F 279			9/15/02	

CENTERS FOR MEDICARE & MEDICAID SERVICES 2567-L STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 465084 9/12/2002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET STEWARTS CARE AND REHAB. **ROOSEVELT, UT 84066** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) The ADON was educated to the need F 279 Continued From page 7 F 279 Any services that would otherwise be required under to address 1 side rail in patients care s483.25 but are not provided due to the resident's plans for the use of in-bed mobility. exercise of rights under s483.10, including the right The ADON made necessary changes to refuse treatment under s483,10(b)(4). in care plans of residents addressed by survey team. Documentation This REQUIREMENT is not met as evidenced by: included the use of 1 SR while in bed Based on observation, interview and record review, it was determined that the facility did not develop to assist with in bed mobility in the comprehensive care plans that met the medical, care plans for resident #2, #6, nursing, mental and psychosocial needs for 7 of 14 #11,50. The side rail for #17 was sample residents. Resident identifiers: 2, 6, 11, 17, discontinued due to resident 37, 38, and 50. currently not using. The side rail for resident #38 was discontinued, due Findings include: to the use of a low bed. 1. Resident 2 was admitted to the facility on 9/1/95 with the diagnosis arthropathy, hypertension, gout, Resident #37 recieved orders for 2 diabetes and mild mental retardation. side-rails and geri-chair while survey team remained in the building, and Observation of resident 2 on 9/10/02 at 4:05 PM until restraint documentation completed. 5:00 PM, revealed resident 2 laying in bed with one 3/4 side rail up. Resident #37 us of geri-chair and 2 side-rails was addressed in her care Observation of resident 2 on 9/11/02 at 10:00 AM, plan. revealed resident 2 laying in bed with one 3/4 side 9-15-02 rail up. All future residents that are assessed Observation of resident 2 on 9/11/02 at 1:30 PM, for the need for 1 side rail for in bed revealed resident 2 laying in bed with one 3/4 side mobility (per M.D. order) will have rail up. intervention addressed on current care plan, and will be reassessed On 9/11/02, resident 6's medical record was reviewed quarterly and prn. and revealed the following documentation: A physician's order, dated 3/22/01, documented.

An "Evaluation of need for Side Rails as

"one side rail up while in bed to assist."

DEPARTMENT OF HEALTH AND I IAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES 2567-L STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465084 9/12/2002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET STEWARTS CARE AND REHAB. ROOSEVELT, UT 84066 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 279 Continued From page 8 F 279 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 continued... completed by facility staff on 8/20/02. The staff assessed resident 2 as being moderately impaired in All future residents requiring the use cognitive skills for daily decision making. Resident of a geri-chair (per M.D. order), will 2's bed mobility was assessed as needing no assistance have intervention addressed on and she required no assistance with her transfers. The staff assessed resident 2 as needing other types of resident care plan. The use of the side rails (e.g. half rails, one side) as restraints. geri-chair will be reassessed quarterly and prn. A review of resident 2's comprehensive care plan revealed there was no documented care plan problem The medical records department and for resident 2's use of one side rail while in hed for the D.O.N. will audit residents assistance. records to assure the care planning 2. Resident 6 was admitted to the facility on 8/6/02 process is completed. with the diagnoses of a recent right leg below the knee amputee, depressive features due to health The Quality Assurance team will 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,

review this deficiency and continue to monitor on a quarterly basis X 6 months.

09-15-02

CMS-2567L

UZUY11

Event ID:

Facility ID:

If continuation sheet 9 of 46

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				2567-L
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465084	(X2) MUL1 A. BUILDII B. WING _		(X3) DATE S COMPL	SURVEY LETED
	ROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET ROOSEVELT, UT 84066		12/2002
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
	revealed resident 6 la up times two. Observation of reside revealed resident 6 la rail up. Observation of reside revealed resident 6 la rail up. Observation of reside revealed resident 6 la rail up. Observation of reside revealed resident 6 la rail up. On 9/9/02, resident 6 and revealed the followant of th	lent 6 on 9/11/02 at 10:00 AM, aying in bed with one 3/4 side lent 6 on 9/11/02 at 1:30 PM, aying in bed with one 3/4 side lent 6 on 9/11/02 at 1:30 PM, aying in bed with one 3/4 side ent 6 on 9/11/02 at 2:30 PM aying in bed with one 3/4 side of smedical record was reviewed owing documentation: der, dated 8/6/02, documented, ite in bed to assist." of need for Side Rails as ated 8/6/02, documented "one side Entrapment" form, dated at 6 a score of 3- low risk. IDS assessment for resident 6 cility staff on 8/20/02. The staff is being independent in cognitive	F 279			
	A review of resident /	6's comprehensive care plan	ļ	1		

revealed there was no documented care plan problem

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		465084	B. WI	NG	_	9/1	2/2002
	ROVIDER OR SUPPLIER RTS CARE AND REHA			STREET ADDRESS, CITY, STATE 187 WEST LAGOON STREE ROOSEVELT, UT 8406	ET		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL.			X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTIVE ACTION SHOUD TO THE APPRO	LD BE	(X5) COMPLETE DATE
F 279	assistance. 3. Resident 11 was a diagnoses of congeste hypertension, convuls accident with cognitive gout. Resident 11 was obserbed with one side rail. Physician's order, data when in bed for assist. Review of resident 11 9/9/02, revealed no caside rails. A quarterly MDS assecompleted by facility assessed resident 6 as skills for daily decision mobility was assessed and she required exter The staff assessed resident for side rails (e.g. half restraints. 4. Resident 17 was readiagnoses of status po Parkinson's, arthritis, constipation, and anexpectation.	dmitted on 6/1/98 with a heart failure, diabetes, sive disorder, cerebral vascular we deficits, constipation, and rved, on 9/9/02 at 8:20 PM, in up. ed 9/02, was for on side rail up 's active medical record, on are plan that addressed the use of essment for resident 11 was staff on 9/5/02. The staff being independent in cognitive in making. Resident 11's bed as needing extensive assistance insive assistance with transfers. dent 11 as needing other types rails, one side) as	F 279				
	with one side rail up. 1	vation, on 9/10/02 at 8:00 PM, Physician's order, dated 9/02, p when in bed to assist.		į			

FORM APPROVED

PRINTED: 4/15/2003 DEPARTMENT OF HEALTH AND F **AN SERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES 2567-L STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 465084 9/12/2002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET STEWARTS CARE AND REHAB. **ROOSEVELT, UT 84066** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID D (X5)(EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 279 Continued From page 11 F 279 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

CMS-2567L

112000

An "Evaluation of need for Side Rails as Restraints" form, was in the medical record, it was

at 8:45 AM, revealed the following:

not dated nor completed.

Event ID: UZUY11 Facility ID:

If continuation sheet 12 of 46

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BU.	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		465084	B. WI	NG _		9/1:	2/2002
STEWAR	PROVIDER OR SUPPLIER RTS CARE AND REHA			1	REET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET ROOSEVELT, UT 84066		·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT: (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
F 279		Entrapment" form, was in the as not dated nor completed.	F 279	_			
	A physician's oro geri chair was not in	der for the use of side rails or a the medical record.	ı				
		cursing notes in the medical cumentation of the need for a side					
	takes care of the med physician's order in r dated 9/10/02 at 8:00	AM, the facility staff member who dical records came and placed a resident 37's medical record, AM, that documented "1 (one) hile in bed for bed mobility"		İ			
	revealed resident 37 v	ent 37 on 9/10/02 at 1:10 PM, was laying in bed. Resident 37's ne wall and the 3/4 side rail away alled up.					
	revealed resident 37 v	ent 37 on 9/10/02 at 4:00 PM, was laying in bed. Resident 37's ne wall and the 3/4 side rail away alled up.					
	revealed resident 37 v	ent 37 on 9/10/02 at 8:23 PM, was laying in bed. Resident 37's ne wall and the 3/4 side rail away illed up.					
	revealed resident 37 or room. There were two facility nurse with the the resident into the g stated that resident 37	ent 37 on 9/11/02 at 9:45 AM, on the floor in the front day to facility nurse aides and one e resident. The nurse aides lifted geri chair. The facility nurse 7 was on the floor out of her not fall out of the wheelchair.		780.			

The facility nurse also stated they have to put her

DEPARTMENT OF HEALTH AND H AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI	MULTIPLE CONSTRUCTION ULDING		(X3) DATE SURVEY COMPLETED	
		465084	B. WI	NG	9/1	2/2002	
STEWAI	PROVIDER OR SUPPLIER RTS CARE AND REHA			STREET ADDRESS, CITY, STATE, ZIP CO 187 WEST LAGOON STREET ROOSEVELT, UT 84066	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	,	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
F 279	(referring to resident does this (referring to wheelchair). The fact summer she (referring geri chair a few days.) Observation of reside revealed resident 37 iroom. Observation of reside revealed resident 37 iroom. Observation of reside until 2:30 PM, reveal in the front day room. On 9/12/02 at 10:00 medical record was conthe following: A "Restraint Approrm was revealed in form documented a gethe following reasons keeps throwing self or documented that the refollowing benefits, "to facility documented that the refollowing benefits," to facility documented that the refollowing benefits, "to facility documented that the refollowing benefits, "to facility documented that the refollowing benefits," to facility documented that the refollowing benefits, "to facility documented that the refollowing benefits, "to facility documented that the refollowing benefits," to facility documented that the refollowing benefits, "to facility documented that the refollowing benefits, "to facility docum	t 37) in the geri chair when she to being on the floor out of her cility nurse further stated, lasting to resident 37) had to be in the state of the	F 279				

CENTE	S FOR MEDICARE	& MEDICAID SERVICES					2567-L
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		DING	(X3) DATE SURVEY COMPLETED	
NAME OF P	ROVIDER OR SUPPLIER	40004	l	т		9/3	12/2002
	RTS CARE AND REHA				STREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET ROOSEVELT, UT 84066		
(X4) ID PREFIX TAG	EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
	chart concerning resist wheelchair or causing wheelchair or causing A review of resident 39/10/02 and 9/12/02 and	en area bleeding." s notes could be found in the dent 37 falling out of her g self harm. 37's comprehensive care plan on revealed there was no a problem for resident 37's use of nobility or the use of a geri chair of the from self harm. dmitted on 6/3/02 with ementia, lower extremity cosis, hypertension, cardiac con. reved, on 9/10/02 at 8:10 PM, in up. Physician's order, dated a rail up when in bed to assist. Is active medical record, on care plan that addressed the use dmitted to the facility on 8/13/02 biliary cirrhosis, dyspepsia, nological stress, constipation,	F 279				
	revealed resident 50 la up times two.	at 50 on 9/10/02 at 8:10 PM, sying in bed with 1/2 side rails at 50 on 9/11/02 at 1:30 PM,					

DEPARTMENT OF HEALTH AND F. AN SERVICES
CENTERS FOR MEDICARE & MEDICARE SERVICES

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FOR	M APPROVE: 2567-
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1		ULTIPLE CONSTRUCTION DING	(X3) DATE : COMPL	SURVEY
		465084	B. WI	NG	3	0/1	2/2002
NAME OF F	PROVIDER OR SUPPLIER			T _s	STREET ADDRESS, CITY, STATE, ZIP CODE	9/1	2/2002
STEWAI	RTS CARE AND REHA	D			187 WEST LAGOON STREET		
		XD.		l	ROOSEVELT, UT 84066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAC	TΧ	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
F 279	revealed resident 50 aide. The side rail or and the facility aide with transfers. The side rail or and the facility aide wide rail up after place. Observation of reside revealed resident 50 lup times two. On 9/11/02, resident reviewed and revealed. A physician's ord "one side rail up while An "Evaluation of Restraints, form dated rail." A "Risk for Bed I 8/28/02 gave resident An admission MI was completed by faci assessed resident 50 a cognitive skills for dat 50's bed mobility was assistance and she with transfers. The st	being put into bed by a facility of one side was already placed up was observed to place the other ing the resident into bed. Int 50 on 9/11/02 at 2:30 PM, aying in bed with 1/2 side rails 50's medical record was do the following documentation: Iler, dated 8/13/02, documented	F 279				
	revealed there was no	O's comprehensive care plan documented care plan problem fone side rail while in bed for					

STATEMEN	NT OF DEFICIENCIES						2 <u>5</u> 67
AND PLAN	OF CORRECTION	(X1) PLOVIDER/SUPPLIER/CLIA ITFICATION NUMBER:	İ	MULTIPL VILDING	E CON' ICTION	(X3) DATE COMPI	
		465084	B. WI	NG			
NAME OF F	PROVIDER OR SUPPLIER			STREET	T ADDUCTOR COMMISSION		2/2002
STEWAI	RTS CARE AND REHA	B		187 '	I ADDRESS. CITY, STATE. ZIP COI WEST LAGOON STREET OSEVELT, UT 84066	DE	
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CO	DECTION	-,
TAG	REGULATORY OR LO	MUST BE PRECEEDED BY FULL C IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETE DATE
F 325	Continued From page 16		F 325				
F 325 SS=H	483.25(i)(1) QUALIT		F 325				10/12/02
	acceptable parameters body weight and prote	comprehensive assessment, the at a resident maintains of nutritional status, such as in levels, unless the resident's onstrates that this is not		i i	A plan of correction fo dentifiers 2, 6, 17 & 50 Residents weight ord	ers have	
1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Based on clinical recor was determined that the each resident maintain nutritional status as evi residents who experien These four residents als	d review and staff interview it e facility did not ensure that ed an acceptable parameter of denced by 4 of 14 sampled ced significant weight loss. so had laboratory values and were not adequately s dietitian. Resident 50.		a id id 2 c c d le n 3 n	the changed to every we fiter September weight I dentified. Resident will continue the hecks on Albumin level one prior to survey. More evels will assess results utritional interventions. Residents will continue the tritional supplements and redered prior to survey.	e to have re- ls as was conitoring with current in place. ue to receive as were	
a a 1	ubtracting the current veight, dividing the dift and multiplying by 100, as follows: 5% in one multiply in 6 months. (Reference of the current of the curren	percentages is done by weight from the previous ference by the previous weight Significant weight losses are bonth, 7.5% in 3 months and erence guidance: Manual of rican Dietetic Association, 6th		di po su bo D 4.	rdered prior to survey. ietary personnel and nur ersonnel will assess resp upplements ordered. Ch e made per recommenda ietician and Physician of Additional vitamin/mi upplements will be recom-	rsing conse to nanges will ations of orders. ineral mmended to	
	indings include:			M ch	ID and administered if I nooses to implement.	Physician	
h:	Resident 2, a 75 year ne facility on 9/1/95 with the facility on gout, diabetardation.	old female, was admitted to the diagnosis arthropathy, etes and mild mental		5. re	Advance Directives of sidents will continue to garding aggressive nutreatments (such as feeding)	be upheld itional	
_:;	review of resident 2 w	eights revealed the following		6. co	Dietician & Physician ontinue to be notified of gnificant weight change	will any	
-2567L	1120	DO Event ID: UZUY11 F	acility ID:	UT0084		If continuation	

2567-L

CENTERS FOR MEDICARE & MEDICAID SERVICES 2567-L STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465084 9/12/2002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET STEWARTS CARE AND REHAB. ROOSEVELT, UT 84066 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 325 Continued From page 17 F 325 7. Nutritional status of all residents June 2002 179.1 lbs. (Pounds) will continue to be strictly monitored July 2002 173.4 lbs. August 2002 172 lbs. by facility dietician, dietary September 2002 159.6 lbs. supervisor, and nursing supervisors per facility policy. Between the months of June 2002 and September 8. Residents will be assessed by 2002 resident 2 lost 19.5 lbs. (10.9%) which is physician to determine if the use of significant. pharmaceuticals could improve the Between the month of August and September resident intake of these residents (e.g. 2 lost 12.4 lbs. (7.2%) which is significant. Remeron use). 9. The QA team will continue to A review of resident 2's medical record dietary notes monitor the residents addressed by revealed that no RD assessment addressing the weight the survey team X 3 months. loss had been completed for resident 2. 10. Resident #6 will continue to Resident 2 had a nutritional assessment completed by have Restorative feeding program the RD on 6/24/02. The dietitian continues with the per Restorative Aide. no added salt, no concentrated sweets and diabetic 11. All residents addressed have had snack TID(three times a day) that was originally protein/calorie & hydration needs ordered for resident 2 on 5/29/98. The dietitian had assessed per dietician. not calculated an estimation of fluid requirements, caloric requirements and/or protein requirements for resident 2. Without a calculation of the fluid, caloric All residents and future admits will or protein requirements it would not be possible for continue to have nutritional status facility staff to know whether or not the diet would monitored closely per facility meet the needs of this resident. policies. (Enclosed is a copy of our new policies) A care plan could not be found in resident 2's clinical record addressing a desired weight loss program. If residents are at risk they will Review of resident 2's diet card on 9/10/02, revealed continue to be care planned for this she was on a no added salt, no concentrated sweets risk. All nutritional interventions

diet with diabetic snacks TID. It did not indicate that

Review of resident 2's care plans revealed a care plan

dated 5/30/02, documenting the following problem,

resident 2 was on any desired weight loss program.

will continue to be addressed on

residents' care plans.

10-12-02

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 465084 9/12/2002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET STEWARTS CARE AND REHAB. ROOSEVELT, UT 84066 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 18 F 325 F 325 "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.

		I DERVICES					<u>∠JU/-L</u>	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	ILDI			3) DATE SURVEY COMPLETED	
		465084	B. WI	NG _		9/1	2/2002	
	ROVIDER OR SUPPLIER	AB.]	REET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET ROOSEVELT, UT 84066		 	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
F 325	Continued From page 1	9	F 325					
	breakfast resident 2 v sausage, french toast juice, 240 cc of milk was observed to eat 1 the sausage, 50% of t syrup, 240 cc of the j cc of the water. During both meal obsobserved to feed herse	2's breakfast was observed. For was served Special K cold cereal, with butter and syrup, 240 cc of and 120 cc of water. Resident 2 00% of the Special K, 50% of the french toast with butter and uice, 240 cc of the milk and 60 servations resident 2 was elf with no encouragement or						
	dated 7/31/02, docum Feeds self/ Dining Ro they documented, "R/ Appetite poor; 6# (po encouragement to eat	2's Nursing Monthly Summary, mented, "Eating Habits- Poortoom." Under problem number 6 T (related to) alter nutrition. aund) wt (weight) loss; needs more." There was no edema in this monthly						
	dated 8/6/02, docume good- Feeds self/ Din they documented, "! declined a total of 2.1 remain with edema, to daily to reduce swelling Under problem numb "Encouragement gir	note dated 8/23/02 at 7:00 PM, nented "Edema noted in						
		ss notes dated 7/1/02 through es documented that resident 2's						

DEPARTMENT OF HEALTH AND L IAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES 2567-L STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465084 9/12/2002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET STEWARTS CARE AND REHAB. ROOSEVELT, UT 84066 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL). PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 325 Continued From page 20 F 325 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

2. Resident 6, a 90 year old female, was admitted to the facility on 8/6/02 with the diagnoses of a recent

protein depletion.

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

DEPARTMENT OF HEALTH AND I IAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	MULTIPLE CONSTRUCTION UILDING		(X3) DATE S COMPLI	
	!	465084	B. WI	ING		0/1	* / ******
	PROVIDER OR SUPPLIER RTS CARE AND REHA			STREET ADDRESS, CITY, STATE, ZIP 187 WEST LAGOON STREET ROOSEVELT, UT 84066	CODE	<u> 9/1.</u>	2/2002
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF EACH CORRECTIVE ACT	TION SHOU THE APPRO	ILD BE	(X5) COMPLETE DATE
	right leg below the kn features due to health cellulitis, peptic ulcer infection, diabetes, ch hypertension, congest skin/nails, osteomyeli peptic ulcer, insomnia involvement in other of A review of resident 6. August 6, 2002 September 2002 Between the months of September 2002 reside is significant. A review of resident 6 revealed that no assess loss had been complete. Resident 6 had a nutrithe RD on 8/9/02. The being a no added salt, with a diabetic snack Tounces TID and 4 ounces TID at snack time that resident 6 on 8/6/02. In an estimation of fluid requirements without caloric requirements it facility staff to know with meet the needs of this document resident 6's a amputation. The RD he estimation of protein realthough her most received.	nee amputation, depressive in problem, hypokalemia, in disease, anemia, yeast intronic vascular insufficiency, tive heart failure, candidiasis of itis, constipation, pressure ulcer, a, gangrene and bone disease. 6 weights revealed the following: 123.4 lbs 113.5 lbs of August 6, 2002 and dent 6 lost 9.9 lbs. (8.0%) which 6's medical record dietary notes issment addressing the weight ted for resident 6. itional assessment completed by the dietitian records the diet as an oconcentrated sweets diet. TID, two cal supplement 2 three instant breakfast at was originally ordered for. The dietitian had not calculated requirements or caloric but a calculation of the fluid or the would not be possible for whether or not the diet would resident. The RD did recent below the knee	F 325				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU B. WI	ILDI		(X3) DATE S COMPLI	ETED
		465084				9/1:	2/2002
STEWAF	ROVIDER OR SUPPLIER RTS CARE AND REHA			1	REET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET ROOSEVELT, UT 84066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPRO DEFICIENCY)	лд ве	(X5) COMPLETE DATE
F 325	recent below the kneed calculation of protein possible for facility stated diet would meet the processible for facility stated would meet the processible for facility stated would meet the processible for facility stated would meet the processible for facility stated would meet the processible for facility stated would meet a facility stated would meet a facility stated would be facility stated would be for facility stated would be facility s	eds due to wound healing of her e amputation. Without a requirements it would not be taff to know whether or not the protein needs of this resident. In 8/16/02 was written to include B TID with meals to resident 6's to be found in resident 6's clinical lesired weight loss program. Is diet card on 9/10/02, revealed d salt, no concentrated sweet cks TID and 8 ounces of diabetic. It did not indicate that resident	F 325				
	done the first week of						

		June 101112 Dank (1023					
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BU	LDI		(X3) DATE SURVEY COMPLETED	
		465084	B. WI	NG _		9/1	2/2002
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET ROOSEVELT, UT 84066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
F 325	form on 9/10/02 docu weights, it did not do for resident 6 had bee significant weight los	6's "Resident Weight Record" mented the above mentioned ocument that the physician caring on notified of the recent ss.	F 325				
	resident 6 on 8/13/02 resident 6 had not ha gain in the past 30 or	assessment was completed on The MDS documented that d any significant weight loss or 180 days. The MDS also dent 6 required limited ag.					
		of record on 9/10/02 revealed that exive restorative nursing for the times a week.					į
	6 was not in the restoresident 6 was served vegetables, cherry pie of diabetic instant bre supplement. Residenthe chicken and dump vegetables, less than the yogurt, 20 cc of thinstant breakfast and Resident 6 was assiste encouraged to eat her continually have an a	6's lunch was observed, resident rative dining room. For lunch chicken and dumplings, mixed a, yogurt, 120 cc of water, 240 cc takfast and 60 cc of two cal to 6 was observed to eat 10% of polings, 50% of the mixed 10% of the cherry pie, 50% of the water, 40 cc of the diabetic 45 cc of the two cal supplement. The deby the staff with her meal and meal. Resident 6 did not ide sitting down with her during rent aides assisted resident 6					
	6 was not in the restoresident 6 was served 240 cc of diabetic instruction. Resident 6 was	6's dinner was observed, resident rative dining room. For dinner sloppy joe, corn, applesauce, cant breakfast and 120 cc of s observed to eat less than 10% % of the corn, 100% of the					3

DEPARTMENT OF HEALTH AND HEALTH H

1		MEDICAID SERVICES					2567-L
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) 1 A. BU		LTIPLE CONSTRUCTION DING	(X3) DATE COMPI	SURVEY
		465084	B. WI	NG		0.0	12/2004
	PROVIDER OR SUPPLIER RTS CARE AND REHA	ъВ.	<u> </u>		TREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET ROOSEVELT, UT 84066	<u>1 9/1</u>	12/2002
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPRODEFICIENCY)	ULD BE	(X5) COMPLETE DATE
F 325	diabetic instant break the staff with her mea meal.	he water and 200 cc of the fast. Resident 6 was assisted by all and encouraged to eat her	F 325				
	resident 6 was not in breakfast resident 6 w watermelon, 240 cc of cc of milk, 120 cc of wo f two cal supplement eat 100% of the yogur cc of the diabetic insta and 45 cc of the two c not assisted by facility	6's breakfast was observed, the restorative dining room. For vas served hot cereal, yogurt, f diabetic instant breakfast, 120 water, 120 cc of juice and 60 cc. Resident 6 was observed to ot, 50% of the watermelon, 100 ant breakfast, 50 cc of the water all supplement. Resident 6 was a staff with her meal. The esident 6 four times to eat her					
	and Assessment, " dat	's admission "Nursing History ed 8/6/02, provided no ride evidence that resident 6 pitting edema.					
	A review of the Augus any pitting edema for	st 2002 MAR did not document resident 6.					
	A review of resident 6 documented resident 6 out of 10 days.	's September 2002 MAR 's pitting edema as plus one, 10					
	September 2002 reveal Lasix, a diuretic. The notice on 8/20/02. The that the Lasix had been On 9/4/02 the Lasix we Documentation on the resident 6's pitting ede	r August 2002 through led resident 6 was admitted on Lasix was held until further e September MAR documented in given 9/1/02 through 9/4/02. as discontinued. MAR provided evidence that ma on admit was a zero and itting edema on September 1,					

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

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					2567-L
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465084	(X2) M A. BU B. WI	ILDI	TIPLE CONSTRUCTION NG	(X3) DATE S COMPL	SURVEY
	ROVIDER OR SUPPLIER	AB.	•	1	REET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET ROOSEVELT, UT 84066	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETE DATE
F 325	In the nursing progrey 9/5/02, facility nurse appetite was good 1 times. A review of resident 9/11/02 revealed resion of her meal 83 times. In an interview with on 9/10/02, she stated 6's recent weight loss recent weight loss recent weight loss be The FSS further state concerning the weight twelve years" and amproblems. The FSS a lots of pain and that it eating well. In an interview with she stated that the did vitamin C but the phythem. She further stated that they discuin the IDT (interdiscing Administrator and Doworked through any it didn't call the dietitian an interview with the she stated that they discuin the IDT (interdiscing Administrator and Doworked through any it didn't call the dietitian an interview with the she shaded that they discuin the IDT (interdiscing Administrator and Doworked through any it didn't call the dietitian an interview with the she she she she she she she she she s	dema remained a plus one 0, 2002. The sess notes from 8/6/02 though is documented that resident 6's time, fair 12 times and poor 6 The sess of the sess from 8/6/02-dent 6 consumed less than 75% out of 103 meals. The FSS (food service supervisor) of that she was aware of resident is. The RD was not aware of the cause she is in one time a month. It is because "I've been here for a comfortable with dietary also stated that resident 6 has had is why she [resident 6] is not the FSS on 9/11/02 at 2:05 PM, estitian does recommend Zinc and systems will not always order atted that she became aware of the sident 6's below the knee at the end of August. She also seed the weight loss and wound plinary) meeting with the ON (director of nurses) and they nutritional needs, therefore she	F 325				
	be notified of weight the facility staff) can	loss because they (referring to add supplements and that is all					

<u> 25</u>67-L STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465084 9/12/2002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET STEWARTS CARE AND REHAB. ROOSEVELT, UT 84066 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 325 Continued From page 26 F 325 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

2567-L STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465084 9/12/2002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET STEWARTS CARE AND REHAB. ROOSEVELT, UT 84066 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 325 Continued From page 27 F 325 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 that 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

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTIO	N	(X3) DATE S COMPL	
		465084	- 1	ILDING		0.4	0.000
	ROVIDER OR SUPPLIER		.	STREET ADDRESS, CITY 187 WEST LAGOON ROOSEVELT, UT	STREET	<u> 9/1</u>	2/2002
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH COR	ER'S PLAN OF CORRECT RECTIVE ACTION SHOU RENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
F 325	there was no cartilag. The RD did not calculate requirements to ensurate adequate nutritional add not calculate proto address the mild vivound to ensure that and to ensure wound notify the physician of significant weight lost the RD about resident and dehisced stage II. 3. Resident 17, a 96 the facility on 6/3/02 fractured hip, dement psycho stress, constip. Review of resident 17. August 2002 September 2002 Between the month of 2002 resident 17 lost significant. A lab value taken at the showed an albumin (jud lab value in resident and documentation RD was aware of the	sing change two weeks ago and e showing at that time. Ilate fluid or caloric re resident 6 was receiving requirements as needed. The RD tein requirements for resident 6 isceral protein depletion or her diet met her protein needs healing. The facility did not or RD about resident 6's ss. The facility failed to notify to smild visceral protein deficit.	F 325				
	dietary notes revealed	I that no RD had seen the and no assessment addressing		<u> </u>			

DEPARTMENT OF HEALTH AND HUN I SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					2567-L
1	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465084	(X2) M A. BU B. WII	LDIN		(X3) DATE S COMPLI	SURVEY ETED
NAME OF P	ROVIDER OR SUPPLIER			c.T.D	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	2/2002
STEWAI	RTS CARE AND REHA	AB.		1	87 WEST LAGOON STREET ROOSEVELT, UT 84066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
F 325	the weight loss had be There was no docume any desired weight loss had a nu and care plan comple documented resident one can of NuBasic jupost operative wound increase of 1.2 g/dl of weight) and the resid weight. The dietitian estimation of protein, for resident 17. Ther dietary intervention a Without a calculation would not be possible whether or not the die of this resident. In resident 17's Nursi 8/23/02, documented feeds self, dining roof documented,"wt. (appetite fair. Drinks problems"	een completed for resident 17. entation that resident 17 was on	F 325		DEFICIENCY)		
	Leaves 25% or more of mechanically altered of teeth". An admission MDS a resident 17 on 6/3/02.			- 1007		7	

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	MULTIPLE CONSTRUCTION ILDING	(X3) DATE S COMPLI	
2.5		465084	B. WI	NG	9/1	2/2002
	ROVIDER OR SUPPLIER RTS CARE AND REHA	.B.		STREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET ROOSEVELT, UT 84066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL. SC IDENTIFYING INFORMATION)	ID PREFI TAG	1 2 2	HOULD BE	(X5) COMPLETE DATE
F 325	on 9/11/02, resident breakfast resident 17 ground meat, orange milk, 120 cc juice, an was observed to const the french toast, 0% of wedge, 100% of NuB the water. On 9/12/02, resident dinner resident 17 recapple sauce, 120cc ju 17 was observed to co of the corn, 0% of the and 100% of the water. During both meal obsobserved to feed hims assistance from staff. Review of resident 17 9/1/02-9/11/02 reveal than 50% for 19 of 33 on 6/3/02 the FSS do resident 17, no other active medical record.	dent 50 is independent with his assistance. 17's breakfast was observed. For recieved cereal, french toast, wedge, 163 cc NuBasic, 240 cc ad 120 cc water. Resident 17 time 100% of the cereal, 50% of of the meat, 100% of the orange aic, 100% of the milk, 100% of 17's dinner was observed. For cieved puree meat, puree corn, ice, and 120 cc water. Resident tonsume 100% of the meat, 100% et apple sauce, 100% of the juice er. servations resident 17 was self with his left hand with no 18's ADL sheet from the ed resident 17 consumed less a meals.	F 325			
	to the facility on 8/13 cirrhosis, dyspepsia, h	year old female, was admitted /02 with the diagnoses of biliary hypothyroidism, psychological dema, arthritis and anxious				

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION NG	(X3) DATE S COMPLE	
		465084	B. WI	NG_		0/1	2/2002
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STI	REET ADDRESS, CITY, STATE, ZIP CODE	3/1.4	2/ 200 <i>2</i>
STEWAI	RTS CARE AND REHA	AB.		1	187 WEST LAGOON STREET ROOSEVELT, UT 84066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
F 325	Continued From page 3 features.	1	F 325				
	A review of resident following:	50's weights revealed the					
	August 13, 2002 September 2002	185.7 lbs. 168.2 lbs.					
		2002 and September 2002 lbs. (9.5%) which is significant.					
	showed an albumin le 2.0 g/dl dated 8/17/02 resident 50's medical	the facility and dated 8/17/02 evel of 2.0 g/dl. The albumin of 2 was the most current in record and there was no wide evidence that the RD was isceral protein deficit.					
	revealed that no RD r completed for resident calculation of fluid re- requirements and pro- be possible for the fac-	tein requirements it would not cility staff to know whether or cian ordered would meet the					
·	provided no documen	50's medical record dietary notes tation to provide evidence that the significant weight loss for					
		be found in resident 50's sing a desired weight loss					
	she was on a general	o's diet card on 9/10/02, revealed diet with ensure/nubasic ce a day) at 10:00 AM and 3:00					

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

PRINTED: 4/15/2003 FORM APPROVED

2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	MULTIPLE CONSTRUCTION ILDING	(X3) DATE COMPI	SURVEY LETED		
		465084	B. WI	NG	- _{0/} -	9/12/2002		
STEWAI	NAME OF PROVIDER OR SUPPLIER STEWARTS CARE AND REHAB.			STREET ADDRESS, CITY, STATE, 187 WEST LAGOON STREE ROOSEVELT, UT 84066	, ZIP CODE T	12/2002		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETE DATE		
1	PM. It did not indicate desired weight loss processive of resident 50 plan dated 8/27/02, desired weight loss Dr. (diagnoses) of biliary hypothyroidism. Has nausea." The care plate following approach, "Q (every) month and physician of 5% wt (voor 10% in 180 days." In an interview with the stated, the monthly we done the first week of A review of resident 50 form on 9/10/02, document document that the 50 had been notified of loss. An admission MDS are sident 50 on 8/20/02 resident 50 had not has gain in the past 30 or documented that reside eating, requiring no as On 9/10/02, resident 50 was butter sandwich, yogu can coordinate of 20 med passsupposerved to eat 100% of 20 plants.	the that resident 2 was on a rogram. It's care plans revealed a care occumenting the following or impaired nutritional (due to) poor appetite and DX cirrhosis, dyspepsia, occasional C/O (complaint of) an also documented the3. Monitor/record wt (weight) PRN (as needed). Notify weight) loss/gain in one month the ADON on 9/10/02, she eights on the residents were September. It's "Resident Weight Record" the above weights it did physician caring for resident of the recent significant weight research that and any significant weight loss or 180 days. The MDS also ent 50 is independent with her	F 325					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		465084	B. WING	9/12/20		2/2002
NAME OF PROVIDER OR SUPPLIER STEWARTS CARE AND REHAB.			:	REET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET ROOSEVELT, UT 84066		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
F 325	120 cc of the juice, 1: the 2.0 med passsupp On 9/11/02, resident breakfast resident 50 french toast with butt chocolate, 240 cc of r of water. Resident 50 the oatmeal, 100% of toast with butter and chocolate, 240 cc of r 120 cc of the water. During both meal obs observed to feed herse assistance from the fa A review of resident: and Assessment", dat documentation to evic admitted with any pit In a nursing progress 1:45 PM, a facility ru extremities [with] ede progress noted the sar "Has 1-2 [plus] ede In a nursing progress a facility nurse docum edematous" In a nursing progress a facility nurse docum this afternoon for ede new orders for Lasix (twice a day)"	20 cc of the water and 60 cc of olement. 50's breakfast was observed. For was served oatmeal, sausage, ter and syrup, 240 cc of hot milk, 120 cc of juice and 120 cc of was observed to eat 100% of the sausage, 100% of the french syrup, 240 cc of the hot he milk, 120 cc of the juice, and servations resident 2 was elf with no encouragement or acility staff. 50's admission "Nursing History and 8/13/02, provided no dence that resident 50 was	F 325			

				(X3) DATE SURVEY COMPLETED	
	465084	B. WING _		9/12	2/2002
NAME OF PROVIDER OR SUPPLIER STEWARTS CARE AND REHAB.		. 1	187 WEST LAGOON STREET		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE
50's physician documented to above knew the steady to above knew the steady to above knew the steady to a nursing progress a facility nurse documented feet, [lower] legs" In a nursing progress a facility nurse documented (bilateral) [lower] to a nursing progress a facility nurse documented bilat (bilateral) [lower] to 168.5 lbs (pounds) documentation in the physician or RD were weight loss. In a nursing progress a facility nurse documented bilat (bilateral) In a nursing progress a facility nurse documented bilat (bilateral) In a nursing progress a facility nurse documented bilat (bilateral) In a nursing progress a facility nurse documented bilat (bilateral) In a nursing progress a facility nurse documented bilat (plus) edema	nented, "3+ +(plus) edema e" In note dated 8/21/02 at 2:00 PM a ented, "Wt (weight) before In note dated 8/23/02 at 1:10 PM, mented, "Edema +(plus) 3- In note dated 8/24/02 at 1:20 AM, mented, "Edema +(plus) 3 in r] ext.(extremities)" In note dated 8/26/02 at 8:00 PM, mented, "3+ (plus) pitting) [lower] ext. (extremities)" In not dated 8/27/02 at 1:15 PM, a ented, "Wt (weight) [decreased] I today" There was no enursing progress note that the enotified of the significant In note dated 8/27/02 at 8:00 PM, mented, "3+ (plus) pitting) [lower] ext (extremities)" In note dated 8/29/02 at 2:30 PM, mented, "Cont (continues) to a in [lower] extremities" In note dated 9/1/02 at 7:10 PM, a ented, "+ (plus) 3 pitting	F 325			
(extremities)"					
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page 3 50's physician docume extends to above knee In a nursing progress facility nurse docume breakfast = 181" In a nursing progress a facility nurse docume feet, [lower] legs" In a nursing progress a facility nurse docume bilat (bilateral) [lowe In a nursing progress a facility nurse docume bilat (bilateral) [lowe In a nursing progress a facility nurse docume dema bilat (bilateral In a nursing progress facility nurse docume to 168.5 lbs (pounds) documentation in the physician or RD were weight loss. In a nursing progress a facility nurse docume edema bilat (bilateral In a nursing progress a facility nurse docume edema bilat (bilateral In a nursing progress a facility nurse docume edema bilat (bilateral In a nursing progress a facility nurse docume edema bilat (continue edema, cont (continue	IDENTIFICATION NUMBER: 465084 ROVIDER OR SUPPLIER RTS CARE AND REHAB. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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, "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, "4+ (plus) 3 pitting edema, cont (continues) in bilat (bilateral) [lower] ext	A BUILDI B. WING. B. WING. A BUILDI B. WING. A BUILDI B. WING. B. WING. A BUILDI B. WING. B. WING. A BUILDI B. WING. B. WING. A BUILDI B. WING. B. WING. A BUILDI B. WING. ID PREFIX. TAG F 325 F 326 F 326 F 327 In a nursing progress note dated 8/23/02 at 1:10 PM, 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, "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, "4 (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	A SULLING BENTHERATION NUMBER 465084 ROVIDER OR SUPPLIER TIS CARE AND REHAB. SUMMARY STATISHENT OF DESCRIPCING (REACH DEPTITIVE OF DESCRIPCING) (REACH CORRECTIVE ACTION SHOOL CROSS-REPERRICED TO THE APPRO DEPTITIVE CHONG STREET ROOSEVELT, UT \$4066 FROOSEVELT, UT \$4066 CROSS-REPERRICED TO THE APPRO DEPTITIVE CHONG STREET ROOSEVELT, UT \$4066 FROOSEVELT, UT \$4066 FROOSEVELT, UT \$4066 FROOSEVELT OF DEPTITIVE CHONG STREET ROOSEVELT, UT \$4066 FROOSEVELT, UT \$4066 FROOSEVELT OF DEPTITIVE CHONG STREET ROOSEVELT, UT \$4066 FROOSEVELT OF DEPTITIVE CHONG STREET ROOSEVELT, UT \$4066 FROOSEVELT OF DEPTITIVE CHONG STREET ROOSEVELT, UT \$4066 FROOSEVELT OF DEPTITIVE CHONG STREET ROOSEVELT OF THE APPRO CROSS-REPERRICED TO THE APPRO DEPTITIVE CHONG STREET ROOSEVELT, UT \$4066 FROOSEVELT OF THE APPRO CROSS-REPERRICED TO THE APPRO DEPTITIVE CHONG STREET ROOSEVELT, UT \$4066 FROOSEVELT, UT \$4066 FROOSEVELT, UT \$4066 FROOSEVELT, UT \$4066 FROOSEVELT OF THE APPRO CROSS-REPERRICED TO THE APPRO CROSS-REPERRICED TO THE APPRO CROSS-REPERRICED TO THE APPRO THE APPROVE THE	ASONDER OR SUPPLIER ASSOCIATION NUMBER STREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET ROOSEVELT, UT NAM66 PROVIDER SPLAN OF CORRECTION GRACH CORRECTION OF INCOMPATION IN A DISTRICT ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET ROOSEVELT, UT NAM66 FROUTHERS PLAN OF CORRECTION GRACH CORRECTION OF INCOMPATION IN A DISTRICT NUMBER ASSOCIATION OF INCOMPATION IN A DISTRICT NUMBER ASSOCIATION OF INCOMPATION IN A DISTRICT NUMBER ASSOCIATION OF CORRECTION PROVIDER SPLAN OF CORRECTION GRACH CORRECTION GRACH CORRECTION ASSOCIATION IN A DISTRICT NUMBER IN PREFIX TAGO PROVIDERS PLAN OF CORRECTION GRACH CORRECTION ASSOCIATION FROM THIS WEST LAGOON STREET ROOSEVELT, UT NAM66 PROVIDER SPLAN OF CORRECTION GRACH CORRECTION FROM THE WEST LAGOON SCORES. IN A DISTRICT NUMBER IN PROVIDER SPLAN OF CORRECTION FROM THE WEST LAGOON SCORES. IN A DISTRICT NUMBER IN PROVIDER SPLAN OF CORRECTION FROM THE WEST LAGOON SCORES. IN A DISTRICT NUMBER IN ASSOCIATION IN PREFIX TAGO FROM THE WEST LAGOON SCORES. IN A DISTRICT NUMBER IN PROVIDER SPLAN OF CORRECTION FROM THE WEST LAGOON SCORES. IN A DISTRICT NUMBER IN PREFIX TAGO FROM THE WEST LAGOON SCORES. IN A DISTRICT NUMBER IN PREFIX TAGO FROM THE WEST LAGOON SCORES. IN A DISTRICT NUMBER IN PREFIX TAGO FROM THE WEST LAGOON SCORES. IN A DISTRICT NUMBER IN PREFIX TAGO FROM THE WEST LAGOON SCORES. IN A DISTRICT NUMBER IN PREFIX TAGO FROM THE WEST LAGOON SCORES. IN A DISTRICT NUMBER IN PREFIX TAGO FROM THE WEST LAGOON SCORES. IN A DISTRICT NUMBER IN ASSOCIATION OF CORRECTION FROM THE WEST LAGOON SCORES. IN A DISTRICT NUMBER IN PREFIX TAGO FROM THE WEST LAGOON SCORES. IN A DISTRICT NUMBER IN ASSOCIATION OF CORRECTION FROM THE WEST LAGOON SCORES. IN A DISTRICT NUMBER IN ASSOCIATION OF CORRECTION OF CROSS TREET ROOSEVELT UNITED TOOR SCORES. IN A DISTRI

CENTERS FOR MEDICARE & MEDICAID SERVICES 2567-L STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 465084 9/12/2002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET STEWARTS CARE AND REHAB. ROOSEVELT, UT 84066 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 325 Continued From page 35 F 325 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

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

AND DIAN OF CODDECTION ('		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	465084		B. WING		9/1	2/2002	
NAME OF PROVIDER OR SUPPLIER STEWARTS CARE AND REHAB.			STREET ADDRESS, CITY, STATE, ZII 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 PREFI TAG	· ·	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
F 325	physician concerning 50 did state the food she likes to eat. Review of resident 50 any documented evid had been suggested to increase her appetite. The RD did not do ar 50, therefore her fluid requirements were now as receiving adequal needed. The facility RD about resident 50 facility did not notify severe visceral protein malnutrition. Without requirements it would to know whether or in protein needs of this in the facility's policy and Nutritional Risk was. It was documented in identified at nutrition 'Alteration in Nutrition and the physician will consultation requested." The following criterin nutritionally at risk reor wound4. Abnorming/dl) Hematocrit (below 3.5 g/dl) Serumg/dl). 5. Consistential of the protein service of the service	ther stated she has talked to the her lack of appetite. Resident is good and she is served what is good and she is goo	F 325				

DEPARTMENT OF HEALTH AND HUM CENTERS FOR MEDICARE & MEDICAID SERVICES 2567-L STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A RUILDING B. WING 465084 9/12/2002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET STEWARTS CARE AND REHAB. ROOSEVELT, UT 84066 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID TD (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 325 Continued From page 37 F 325 (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 354 483.30(b)(1)-(3) NURSING SERVICES F 354 9/12/02 SS=E 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 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.

CMS-2567L

112000

The director of nursing may serve as a charge nurse

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

only when the facility has an average daily occupancy of 60 or fewer residents.

> Event ID: UZUY11

Facility ID: UT0084 If continuation sheet 38 of 46

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465084 9/12/2002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET STEWARTS CARE AND REHAB. **ROOSEVELT, UT 84066** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ŒACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 354 Continued From page 38 F 354 1, 2002. All rooms cited in deficiency were reassessed by plant supervisor. Curtains required plant supervisor to F 460 483.70(c)(1)(iv&v) PHYSICAL ENVIRONMENT F 460 10/12/02 readjust hooks in curtains and ceiling SS=B guides to ensure proper closing. Bedrooms must be designed or equipped to assure Additional wall closures (with straps full visual privacy for each resident. attached to walls with snaps) were In facilities initially certified after March 31, 1992, installed to ensure complete privacy. except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to The plant supervisor will continue to provide total visual privacy in combination with monitor on a weekly basis. adjacent walls and curtains. 10-12-02 This REQUIREMENT is not met as evidenced by: Quality Assurance will review this Based on observation, on 9/11/02 at 1:00 PM, it was deficiency in QA meeting, and will determined the facility did not ensure that 23 of 59 continue to monitor X 6 months. 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.

DEPAR7	TMENT OF HEALTH	AND HUN SERVICES					ED: 4/15/2003
		& MEDICAID SERVICES				rukiv.	APPROVED 2567-L
STATEMEN'	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	ILDIN	TIPLE CONSTRUCTION NG	(X3) DATE SI COMPLE	URVEY
		465084	B. WIN	NG		9/12	2/2002
NAME OF P	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
STEWAR	RTS CARE AND REHA	AB.			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)		1			JLD BE	(X5) COMPLETE DATE
F 460			F 460				
		d A had 27 inch gap in the	l	-			
	curtain,	d B had a 57 inch gap in the	1				
	curtain,	1 B had a 37 men gap in the	İ				
	Room 4 bed	d A had a 20 inch gap and bed B	ĺ				
	had a		İ	1			
		in the curtains,	l				
	curtain,	d B had a 47 inch gap in the	i				
	1 '	d A had a 60 inch gap and bed B					
	47 inch gap	in the curtains, I A had a 47 inch gap in the					
	curtain,	A nad a 47 men gap in me	1			ļ	
!		d B had a 60 inch gap in the	1			ļ	
	curtain,		1			ļ	
	West Hall,	Dhada 20 insh gan in the	ł			ļ	
	curtain,	d B had a 20 inch gap in the				,	
	•	B had a 50 inch gap in the					
	1	1 A had a 60 inch gap in the					
	1	A and bed B both had a 60 inch					

CMS-2567L

gap

F 490

SS=H

Based on observation, interviews and review of 112000

This REQUIREMENT is not met as evidenced by:

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

in the curtains.

483.75 ADMINISTRATION

well-being of each resident.

Event ID: UZUY11 Facility ID:

UT0084

F 490

10/12/02

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 465084 9/12/2002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET STEWARTS CARE AND REHAB. **ROOSEVELT, UT 84066** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION TD (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 490 Continued From page 40 F 490 residents medical records, and facility policies and The policies and procedures will be procedures during the annual survey from 9/9/02 revised to address the following: through 9/12/02, it was determined that the facility was not administered in a manner that enabled it to 1. The dietician will perform use its resources effectively and efficiently to attain or maintain the highest practicable physical well-being protein/calorie and hydration need for each resident in the area of weight loss with calculations on all residents (prior nutritional assessment and intervention. The facility was only required on tube fed was found to be providing Sub-Standard Quality of residents according to facility policy) Care (a pattern of actual harm) in this area. The 2. The dietician will continue to be facility was cited in a total of 6 areas, not including this deficiency. notified of significant weight changes according to facility policy. Findings include: 3. The residents Physician will continue to be notified of gross 1. On September 12, 2002, a Standard Extended weight changes according to facility survey was completed which resulted in the policy. determination of Sub-Standard Quality of Care. The 4. The recommendation of determination of Sub- Standard Quality of Care was based on the lack of adequate dietary assessment and vitamin/mineral use will be made to intervention for 4 residents who had significant MD to further aide with nutritional weight loss and laboratory values reflecting status in residents with impaired skin malnutrition. [CFR 483.25 (i) Tag F - 325] integrity. New policy was made to address recommendations for skin Weight loss/ Nutritional Assessment and Intervention: impairments stage I - IV. Please refer to F- 325. 5. The facility will continue to employ a licensed dietician on a A pattern of actual harm was identified for 4 residents contract basis, working 16-24 hours (2, 6, 17, 50) who experienced significant weight loss in the facility per month. and whose laboratory values reflected nutritional 6. Dietitian implemented additional deficits but did not receive adequate nutritional assessment or intervention. QA tools to assist RD and FSS with dietary management of all residents. Resident 2 experienced a 10.9% unplanned weight 7. Dietitian wrote policy to address loss from June 2002 to September 2002. A review of weekly weights on all new admits. resident 2's medical record dietary notes revealed that All new admits will be weighed no assessment addressing the weight loss had been completed for resident 2. The facility's RD had not weekly X 1 month.

CENTERS FOR MEDICARE & MEDICAID SERVICES 2567-L STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465084 9/12/2002

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

STEWAR	RTS CARE AND REHAB.		STREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET	
	SUMMARY STATEMENT OF DEFICIENCIES	<u> </u>	ROOSEVELT, UT 84066	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ETE
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	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.	
	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.			
MS-2567L	112000 Event ID: UZUY11	Facility ID:	UT0084 If continuation sheet 42 c	oF 46

DEPARTMENT OF HEALTH AND HUM SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** 2567-L STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465084 9/12/2002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET STEWARTS CARE AND REHAB. ROOSEVELT, UT 84066 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X.5)PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 490 Continued From page 42 F 490 The facility administration will Resident 50 experienced a 9.5% unplanned weight monitor to ensure that the revised loss from August 13, 2002 to September 2002. A policies are upheld. (See copy of review of resident 50's medical record dietary notes nutritional policies & procedures) 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 1. The Administrator will be given a resident 50. The normal reference range, according copy of all resident weight records to to the lab used by the facility, was 3.2-5.0 g/dl. An notify her of any significant weight albumin level less than 2.4 g/dl is considered a severe changes. visceral protein deficit and an albumin level of 2.4-2.9 g/dl is considered moderate visceral protein 2. The Administrator will continue deficit and an albumin level of 3.0-3.5 g/dl is to be given a copy of all Albumin considered a mild visceral protein deficit. (Reference levels drawn on all residents with guidance; Manual of Clinical Dietetics, American nutritional concerns. Dietetic Association, 6th edition, 2000, page 22). 3. The Administrator will continue The facility RD (Registered Dietitian) had not to meet with the Dietitian on a calculated an estimation of protein required by the resident 50 although he had experienced significant monthly basis. weight loss, the albumin level was below normal. 4. The Administrator will be given a Without an estimated calculation of fluid copy of all new completed QA tools. requirements, caloric requirements and protein 5. The Administrator will continue requirements it would not be possible for the facility to meet with the DON and FSS after staff to know whether or not the diet the physician ordered would meet the needs of this resident. monthly and weekly weights are completed, to determine the need for The facility's policy and procedures for Residents at Dietitian consult and physician Nutritional Risk was reviewed on 9/11/02 at 3:00 PM notification. 10-12-02 It was documented in the policy that "Any resident identified at nutritional risk will have a problem of

CMS-2567L

112000

'Alteration in Nutrition' identified on the care plan and the physician will be informed and a Dietary

"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

consultation requested."

Event ID: UZUY11 Facility ID: UT0084 If continuation sheet 43 of 46

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

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BU	TULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		465084	B. WI	NG	9/12/2		
NAME OF PROVIDER OR SUPPLIER STEWARTS CARE AND REHAB.			STREET ADDRESS, CITY, STATE, ZIP C 187 WEST LAGOON STREET ROOSEVELT, UT 84066	CODE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		ION SHOULD BE HE APPROPRIAT		
F 490	(below 3.5 g/dl) Serumg/dl). 5. Consister meals. 6. Undesirab (under 100 lbs) and 5 one month8. On di (K)14. Non-compl Prolonged nausea, vo treatment given accorpractice" It was documented in "1. Once a problem h Dietitian has been conshould work with the realistic goals and ide Nursing notes should weekly basis." The facility's Policy a Nutritional Risk also essential point, "Time implementation of a public resident at risk. I experience a change i outcomes, but very slow that the resident at risk. It was documented in weights will be monitindicated by the residenter orders, etc." It was documented under the residenter of	m Transferrin (below 170 titly refuses 25% or more of le weight loss or gain of 3 lbs lbs (over 100 lbs) or more in uretics with abnormal Potassium tance with diet order19. miting, diarrhea not relieved by rding to accepted standards of the procedures that: has been identified and the hasulted, the primary nurse Dietitian and resident in setting entify approaches to be used3. reflect progress made on a and Procedure for Residents at documented the following ely assessment and blan is crucial in proper care of Elderly residents are quick to an condition with negative bow to recover."	F 490				

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

NAME OF PROVIDER OR SUPPLIER STEWARTS CARE AND REHAB. STREET ADDRESS, CITY, STATE, 2P CODE IN WEST LAGOON STREET ROOSEVELT, UT \$4066 SUMMAY STATEMENT OF INFIDENCES. FACTOR BECAUTOPREUNCES.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER STEWARTS CARE AND REHAB. SUMMARY STATEMENT OF DEPICIENCES (EXALI PERCINCY MUST BE PERCENED BY FULL TAG PREPRY TAG 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 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 current diet." In an interview with the Administrator or 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) and addition of the facility staff) and only provide a timely and another they or the facility and provide a timely and uniform evaluation of the resident's current diet." In an interview with the Administrator further stated that 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) can add supplements and that is all the dietitian would do. The Administrator further stated that they (referring to the facility as a nurse aide for more than 4 months, on a full-time basis, unless that 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 related services, and	· · · · · · · · · · · · · · · · · · ·	JI COMMISSION	IDENTIFICATION NUMBER:	1			COMPL	ETED	
STEWARTS CARE AND REHAB. STEWARTS CARE AND REHAB. SITUATION OF THE PROVIDENCE STATE AND RESEARCH AND REHAB. STEWARTS CARE AND REHAB. STEWARTS CARE AND REHAB. SANDHARY STATEMENT OF DEFICIENCES. (SACID PRICEINCY MIST BE PRICEIBED BY YILL REGULATORY OR LISC IDENTIFYING REFORMATION) PREPRY TAGO SEVELT, UT \$4066 PROSE VERT, UT \$4066 FOOSEVELT, UT \$406 FOOSEVELT, UT \$406 FOOSEVE			465084	B. WI	NG.		9/1	2/2002	
STEWARTS CARE AND REHAB. NAME SUMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST REPRESENTED IN FRACE DEFICIENCY MUST REPRESENTED IN FRACE DEFICIENCY MUST REPRESENTED IN FRACE DEFICIENCY MUST REPRESENTED IN FRACE DEFICIENCY MUST REPRESENTED IN FRACE DEFICIENCY MUST REPRESENTED IN FRACE DEFICIENCY MUST REPRESENTED IN FRACE DEFICIENCY	NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	<u> </u>	
ROOSEVELT, UT 340	STEWAF	RTS CARE AND REH/	A R	!		187 WEST LAGOON STREET			
FREITY TAO REGULATORY OR LISC IDENTIFYING INFORMATION) F490 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 of the resident's autritional status and adequacy of the resident's current det." 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 494 48.7.5(e)(2)-(3) ADMINISTRATION F 494 F 494 F 494 F 495 F 494 F 495 F 494 F 496 F 499 F 499 F 499 F 499 F 490	011	TID OTTEL THE TOTAL	.D.			ROOSEVELT, UT 84066			
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 rutritional 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 494 483.75(e)(2)-(3) ADMINISTRATION F 494 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									
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 sublity 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 494 483.75(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				1		CROSS-REFERENCED TO THE APPRO			
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 will provide a timely and uniform evaluation 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 494 483.75(e)(2)-(3) ADMINISTRATION F 494 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					·	DEFICIENCY)	_		
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 494 483.75(e)(2)-(3) ADMINISTRATION F 494 F 484 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	F 490			F 490	,				
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) 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 494 483.75(e)(2)-(3) ADMINISTRATION F 494 9/24/02									
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 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 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 494 483.75(e)(2)-(3) ADMINISTRATION F 494 9/24/02				l					
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 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 494 483.75(e)(2)-(3) ADMINISTRATION F 494 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		consult has been requ	lested and the physician has been	1					
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 494 483.75(e)(2)-(3) ADMINISTRATION F 494 P 494 SS=B 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		Hourica.		1					
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 494 483.75(e)(2)-(3) ADMINISTRATION F 494 P 494 SS=B 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		The facility's policy &	and procedure for Nutritional	1					
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 494 SS=B 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		Assessment was review	ewed on 9/11/02 at 3:00 PM.	t					
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 494 SS=B 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	}	Tr dammented in	of the of American state	1					
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 494 SS=B 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		It was documented in	the policy that "The Dietitian and assessment on all residents	1					
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 494 483.75(e)(2)-(3) ADMINISTRATION F 494 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				ĺ					
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 494 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		assessment will be co	ompleted at least annually and	ĺ					
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 494 483.75(e)(2)-(3) ADMINISTRATION F 494 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		anytime a change in o	condition occurs impacting	Í					
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 494 483.75(e)(2)-(3) ADMINISTRATION F 494 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				ĺ					
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 494 SS=B 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		current nutritional sta	atus."	ļ					
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 494 SS=B 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		In was documented u	inder the purpose that "Such	l					
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 494 483.75(e)(2)-(3) ADMINISTRATION F 494 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		evaluation will provid	de a timely and uniform	İ					
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 494 483.75(e)(2)-(3) ADMINISTRATION F 494 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		evaluation of the resid	dent's nutritional status and	İ					
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 494 483.75(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		adequacy of the reside	ent's current diet."	l				!	
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 494 483.75(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		In an interview with	the Administrator on 9/11/02 at	ı					
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 494 483.75(e)(2)-(3) ADMINISTRATION F 494 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				i					
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 494 483.75(e)(2)-(3) ADMINISTRATION SS=B 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		be notified of weight l	loss because they (referring to	i					
stated that they (referring to the facility staff) do not calculate protein needs. F 494 SS=B 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		the facility staff) can a	add supplements and that is all	i					
calculate protein needs. F 494 SS=B 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									
F 494 SS=B 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									
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		calculate protein need	15.						
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		l							
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		483.75(e)(2)-(3) ADN	MINISTRATION	F 494				9/24/02	
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	SS=B	l , <u> </u>							
full-time basis, unless that individual is competent to provide nursing and nursing related services; and								lj	
provide nursing and nursing related services; and									
provide nationing and nationing rotated but vices, and									
that individual has completed a training and		that individual has co	ompleted a training and						
competency evaluation program, or a competency		competency evaluatio	n program, or a competency						

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 465084 9/12/2002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 187 WEST LAGOON STREET STEWARTS CARE AND REHAB. ROOSEVELT, UT 84066 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 494 Continued From page 45 F 494 evaluation program approved by the State as meeting the requirements of ss483.151-483.154 of The nurses aide identified this part; that individual has been deemed or (Employee A) in this deficiency was determined competent as provided in s483.150(a) removed from nursing schedule and (b). before survey was completed. A facility must not use on a temporary, per diem. leased, or any basis other than a permanent employee The nurse aide was not working at any individual who does not meet the requirements the facility at all during or after the in paragraphs (e)(2)(i) and (ii) of this section. survey. The nurse aide received her This REQUIREMENT is not met as evidenced by: certification on 9-24-02 and therefore has been reinstated. 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 The nursing staff was re-inserviced employee list had been working longer than four on 9-20-02 regarding the 4 month months and was not certified. Employee identifier: A from hire date requirement. This requirement will continue to be Findings include: monitored by DON and Personnel On 9/10/02, during review of personnel files, the office. following aide was found to have worked longer than 9-24-02 four months without becoming certified. The Personnel officer continued to audit Nurse Aides employee files. Employee A was hired 3/14/02 and had been working She reviewed findings with D.O.N. five months, 3 weeks and 6 days. to ensure Nurse Aides were not scheduled During review of the facility's August 2002 and for direct patient care after their 4 month September 2002 nurse aide schedule, it was revealed hire date has expired without that employee A was currently providing hands on certification completed. care to residents. The QA committee reviewed deficiency During interview with the Director of Nurses (DON) and plan of correction. They will on 9/10/02, she stated employee A had been working as a nurse aide providing hands on care to residents. continue to monitor x 6 months.

Event ID: