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

PRINTED: 08/04/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465092	A. BUILDING _____ B. WING _____	07/20/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UINTAH CARE CENTER	510 SOUTH 500 WEST VERNAL, UT 84078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on on observation, interview and record review, it was determined the facility did not notify the resident's physician of a significant weight loss for 1 of 18 sample residents. A resident had	F 157	The physician and responsible party for resident 2 were informed of the weight loss, but this was not documented properly. This documentation will be done on the new Investigative Protocol for Weight Loss (IPWL) form for resident 2 and all other residents identified as having a significant weight loss/gain. The IPWL form tracks significant weight loss/gain and has a location on the form to document notifications of physician and responsible party. The IPWL form will be kept in the medical record. The dietary manager will create the IPWL form and track that the form is completed correctly and timely. The Director of Nursing (DON) will train the licensed staff to complete the notifications and document it on the IPWL form. The DON will monitor that the documentation is completed on a monthly basis. The Quarterly Quality Assurance Committee will be notified of the progress of making sure that the notification is being completed and documented.	9-4-06

8/15/06 POC acceptable Completion date 9/4/06 Buisenbark RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 8-15-06

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

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F 157	Continued From page 1	F 157		

lost 22% (percent) of her body weight her first 4 months at the facility and continued to lose weight. Resident 2.

Findings included:

Resident 2 was admitted to the facility 3/23/06 following a hospitalization for a fractured hip. Resident 2's admitting diagnoses included dementia with psychosis and with anxious and depressive features.

Resident 2's medical record was reviewed on 7/18/06.

The Interdisciplinary Team (IDT) completed resident 2's initial Minimum Data Set assessment 3/30/06. The IDT documented resident 2's weight was 110 pounds when she was admitted to the facility. On 4/4/06, the dietary manager (DM) documented resident 2's weight to be 96 pounds. The IDT documented resident 2's body weight as 93 pounds on the resident's quarterly MDS assessment, dated 6/29/06. Resident 2's weight was 86.6 pounds when documented by dietary on 7/11/06. On the resident's bath/weight sheet dated 7/18/06, the facility nursing staff had documented that resident 2's most current weight was 85.7 pounds.

Resident 2's medical record revealed the resident had a continual weight loss which equaled 24 pounds or 22% of her body weight from her admit date of 3/23/06 until 7/18/06.

The registered dietician's (RD) documented, on 4/20/06, that resident 2 was at high risk for malnutrition/weight loss and dehydration. There

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F 157	Continued From page 2 was no documentation that resident 2's physician had received the RD's recommendation for an appetite stimulant. On 6/20/06, the RD documented resident 2's weight was 93.8 pounds. The RD recommended that resident 2 be offered Health Shakes for 3 days to see if the resident would accept them to help with weight gain. There was no documentation to evidence the recommendation had been followed. On 7/12/06, the DM documented, "Rec (recommend) Health Shake TID (3 times daily) snack cart will try for 3 days to see how pt (patient - resident 2) accepts no other Rec's at this time." There was no documentation to evident the recommendation had been followed. Resident 2' physicians' progress notes dated 3/24/06, 4/4/06, 4/24/06, and 6/23/06, made no mention of resident 2's weight concerns. A physician's progress note, dated 5/12/06, revealed "I do not see a graft (sic) of her weight." (The facility put weight graphs in the residents' charts. The surveyor was unable to locate a weight graph in resident 2's chart until 7/20/06.) Nurses' progress notes and monthly summaries were reviewed. There was no documentation that resident 2's physician had been notified of the resident's significant and continued weight loss. Based on record review and interview it was determined the facility did not ensure that resident's physician was informed when there was a significiant change in the resident's weight for 1 of 18 sample resident's. Resident 2.	F 157		

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F 157	Continued From page 3 Findings include:	F 157		
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility did not implement policies and procedures to identify, investigate and report potential abuse occurrences for 1 of 18 sample residents. Resident 7 was found to have her pain patch missing the morning after it had been placed. Findings included: Resident 7 was admitted to the facility 6/9/03 with diagnoses that included dementia and diabetes. Review of resident 7's comprehensive Minimum Data Set (MDS) assessment, dated 3/22/06, and her quarterly MDS assessment, dated 6/21/06, revealed the resident had severely impaired cognitive skills. The MDS assessments revealed resident 7 had a communication deficit. The resident had slurred/unclear speech and was sometimes understood and sometimes able to understand others. The MDS assessments revealed that resident 7 experienced moderate pain less than daily, but daily episodes of	F 226	A Narcotic Discrepancy Record (NDR) will be filled out on the incident for resident 7 missing the Duragesic patch. A NDR will be done for any narcotic that is unaccounted for. The NDR will be filled out by the licensed nurse at the time the narcotic is discovered missing and delivered to the DON. An investigation will be completed by the DON and the final resolution will be noted on the NDR and reported to the Administrator. Quarterly the NDRs will be reviewed by the DON to search for trends. The licensed nurses will be trained by the DON no later than 9-1-06. The Quarterly Quality Assurance Committee will be notified of the procedure and of any negative trends found.	9-4-06

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F 226	Continued From page 4 screaming and calling out. The medication administration record, dated July 2007, for resident 7 revealed the resident was treated with Duragesic, Lortab and Tylenol. On 7/19/06 at 8:10 AM, the medication nurse was heard to discuss with the nurse aides that resident 7's Duragesic patch was missing. The nurse stated that she had put the medicated patch on resident 7's back the afternoon before, following the resident's bath. The medication nurse stated that the medicated patch was tightly adhered to the resident's back after her skin was completely dry. The medication nurse stated that the missing Duragesic patch was the probable cause of resident 7's increased agitation that morning. The nurse aides did not know what had happened to resident 7's pain medication. On 7/20/06 at 8:45 AM, the charge nurse for resident 7's unit was interviewed. The charge nurse stated she had been advised by the medication nurse, on 7/19/06, that resident 7's Duragesic patch was missing. The charge nurse stated that she did not notify the Director of Nursing (DON) or create an incident report regarding the missing opioid analgesic. The charge nurse stated that resident 7's pain patch had been missing before and that it was usually found in her bed. The charge nurse stated that the patch which had been applied to resident 7, on 7/18/06, was not located in the resident's bed or in her room. The charge nurse stated she did not feel that anyone in the facility would deliberately take a resident's pain medication. The charge nurse	F 226		

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F 226	Continued From page 5 stated there had been no tracking record kept to determine if there was any pattern regarding the missing medication and that she had not reported the incidents to the DON. The charge nurse said they would just put a new patch on the resident whenever one turned up missing. On 7/20/06 at 9:00 AM, the DON was interviewed. The DON stated she had not been advised that resident 7's Duragesic patch was missing or that it had happened before. Facility nursing staff did not identify or report to administration the possible abuse of resident 7 regarding the resident's missing pain mediation. There was no investigation to confirm or rule out the possibility of abuse.	F 226		

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F 272 SS=B	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Resident 14 was admitted to the facility 3/1/04 with diagnoses that included dementia and hip replacement.	F 272	The assessment review timeframes for residents 14 and 15 will be done correctly on their next assessment using the Resident Assessment Instrument (RAI) Resident Assessment Protocols. Each section of the Minimum Data Set (MDS) has it's own review timeframe that the look back would be done for. The timeframes have been copied out of the RAI and typed onto paper for the Registered Nurse (RN) Coordinator and each MDS Coordinator to use when documenting an assessment of the resident. The dates for each timeframe will be documented within the MDS documentation for the above noted residents and all other residents. The DON will train the coordinators on the process. The DON will monitor each MDS to insure that the timeframes are documented and cover the proper timeframes for each section of the MDS. The DON will report to the Quarterly Quality Assurance Committee about their progress.	9-4-06

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F 272	Continued From page 7 Resident 14's medical record was reviewed on 4/19/06. Resident 14's comprehensive MDS assessment, dated 6/13/06, did not include RAP documentation for the time periods of the assessment. The MDS assessment should have included information regarding the resident's condition for the seven day period prior to 6/13/06 (for the majority of the information.) Section V A, included information that the RAP assessments had been documented" from 5/15/06 to 5/16/06 for the resident's cognitive condition, from 5/13/06 to 6/13/06 for the resident's activities of daily living, from 5/15/06 to 5/16/06 for information regarding the resident's continence status (the assessment period should have included the fourteen days prior to the assessment date). Based record review and interview it was determined the facility did not make a comprehensive assessment of resident's needs. Specifically 2 of 18 sample residents did not have complete comprehensive minimum data set (MDS) assessments. Resident identifier 14 and 15. Findings include: Resident 15 was admitted on 12/9/04 with diagnose that included right hemiparesis, dementia with psychotic features, head injury with depressive features,seizures, aphasia, dysphagia and hypertension.	F 272		

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F 272	Continued From page 8 Resident 15's medical record was reviewed on 1/12/06. Section V under location and date of RAP assessment documentation for the 3/23/06 significant change MDS was not completed. The Resident Assessment Protocols (RAP) for 2. Cognitive Loss documented Nrsg. (nursing) Nts. (notes) 2/23/06-3/23/06, 6. Urinary Incontinence documented Nrsg. (nursing) Staff Nts. (notes) 2/23/06-3/23/06, and 17. Psychotropic Drug use documented MAR (medication administration record) 2/23/06-3/23/06. Reference was made to an entire month for the assessment. Section V under location and date of RAP assessment documentation for the 6/22/06 annual MDS was not completed. The Resident Assessment Protocols (RAP) for 1. Delirium documented "See Cognitive Loss", 5. ADL (activities of daily living) functional/Rehabilitation Potential documented ADL Doc (document) Sheets 5/22/06-6/22/06, 17. Psychotropic Drug use documented MAR (medication administration record) 5/22/06-6/22/06. Reference was made to an entire month for the assessment.	F 272		

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F 325 SS=D	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on on observation, interview and record review, it was determined the facility did not ensure that a resident maintained acceptable parameters of nutritional status as evidenced by 1 of 18 sample residents lost 21 percent of her body weight over 4 months. Resident 2. Findings included: Resident 2 was admitted to the facility 3/23/06 following a hospitalization for a fractured hip. Resident 2's admitting diagnoses included surgical repair of a fractured hip and dementia. Resident 2's medical record was reviewed on 7/18/06. The nursing assessment, dated 3/23/06, revealed resident 2's usual bed time was 6:00 AM and usual rising time was 10:00 PM. The facility Interdisciplinary Team (IDT) completed resident 2's initial Minimum Data Set assessment 3/30/06. The IDT documented resident 2's weight was 110 pounds when she was admitted to the facility. The IDT documented resident 2's body weight as 93 pounds on the resident's quarterly MDS	F 325	Resident 2 will be reviewed and an Investigative Protocol for Weight Loss form filled out using all disciplines for input and a plan developed, to include a nighttime nutritional solution. Any resident having nutritional needs at night will be accommodated in the same way. An inventory list for the West Dining Room (WDR) refrigerator will be developed and posted on the refrigerator by the dietary manager. The list will be reviewed and approved by the nursing and dietary supervisors. The dietary department evening shift will ensure that the listed items are stocked either in the WDR refrigerator or in the WDR beverage station before they leave work. The Dietary Manager (DM) will monitor the WDR weekly to ensure that the inventory is stocked. The DM will train the dietary staff about this procedure and Director of Nursing (DON) will train the nursing staff so they will be aware of the food available for resident nutritional needs after normal dietary hours. The DON will report progress of this program to the Quarterly Quality Assurance Committee.	9-4-06

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F 325	Continued From page 10 assessment, dated 6/29/06. Resident 2 had experienced a 15% weight loss within three months of being admitted to the facility. Resident 2's weight was 86.6 pounds when documented by dietary on 7/11/06. Resident 2 had lost 21% of her total body weight in less than four months. On the bath/weight sheet dated 7/18/06, resident 2's weight was documented as 85.7 pounds. The dietary manager's (DM) initial assessment of resident 2, dated 3/28/06, documented resident 2's intake was 60% of her mechanical soft diet. The DM documented resident 2's diet was regular with puree or texture as tolerated. The DM documented that resident 2 was tolerating a mechanical soft diet. On the 4/4/06 nutritional assessment, the DM documented resident 2's admit weight had been 110 pounds. The DM documented resident 2's height as 64 inches and her ideal weight range was 108 to 132 pounds. The DM had documented resident 2 was 88% of her ideal weight. At the time of the assessment, the DM documented resident 2's weight was 96 pounds, a loss of "13%" since admit. The registered dietician's (RD) documented review of resident 2 was dated 4/20/06. The RD documented that resident 2 was at high risk for malnutrition/weight loss and dehydration. The RD documented resident 2 needed to eat 77% to 98% of the offered foods to maintain adequate nutrition. The RD documented the resident's intake was 36%. The RD recommended resident 2 receive an appetite stimulant due to her poor	F 325		

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F 325	Continued From page 11 intake. On 6/20/06, the RD documented resident 2's weight was 93.8 pounds which was 91% of the resident's ideal weight range. The RD recommended to offer Health Shakes to resident 2 for 3 days to see if the resident would accept them to help with weight gain. On 7/12/06, the DM documented, "Rec (recommend) Health Shake TID (3 times daily) snack cart will try for 3 days to see how pt (resident 2) accepts no other Rec's at this time." The DM documented resident 2's weight was 90.4 which equaled 87% of the resident's ideal weight range. The DM documented that resident 2's intake was 30% but 100% of 2.0 enriched supplement. The DM documented, further, that resident 2 was awake at night and slept during the day. The DM documented that resident 2 would eat sandwiches. Resident 2's other food preferences were not documented in the dietary assessments or progress notes. Review of resident 2's social service history, dated 4/5/06, revealed the residents food preferences included bananas, oranges, homemade sweets and soups. Review of resident 2's nursing notes, dietary notes and intake records did not reveal 3-day tracking of Health Shakes being offered to the resident in June or July. There was no documentation that resident 2's physician had received the RD's recommendation for an appetite stimulant. There was no documentation to evidence that the RD's and DM's recommendations for Health Shakes had been	F 325		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UINTAH CARE CENTER	510 SOUTH 500 WEST VERNAL, UT 84078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 12 addressed. A telephone order dated 5/23/06 revealed the resident's diet should be pureed with regular bread and cottage cheese alternating with high protein ice cream. Resident 2 was observed at 3:30 AM on 7/19/06. Resident 2 was in her wheelchair at the nurses' station repeatedly calling out for help. The night nurse stated that resident 2 did not sleep much. At 3:50 AM, resident 2 asked for "a slice of something to eat." A CNA helped the resident to a table in the darkened day room. The CNA unwrapped a cookie and gave it to resident 2. The CNA stated that resident 2 stayed up at night. At 4:05 AM, resident 2 stated "my candy wrapper is empty" and the nurse offered the resident another cookie. Resident 2 continued to sit in the darkened room, but ate the other cookie. At 4:15 AM, the night nurse was interviewed. The night nurse stated that resident 2 ate better during nights. The night nurse was not aware of resident 2's diet orders and did not have cottage cheese or high protein ice cream available for the resident. The nurse stated she did not receive extra meals for resident 2 to eat at night. The nurse stated resident 2 was given cookies. The surveyor asked if resident 2 was given protein at night. The nurse stated resident 2 sometimes ate pudding or yogurt that were available. At 4:50 AM, resident 2 asked for bread and butter. The nurse suggested to try peanut butter for increased nutrition. A CNA found some peanut butter in the kitchen and made resident 2	F 325		

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

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F 325	Continued From page 13 a sandwich. Resident 2 ate the sandwich. Resident 2 was observed at breakfast on 7/19/06. Although bananas were served to the other residents at breakfast, resident 2 was not given a banana, cottage cheese or ice cream. On 7/20/06 at 7:10 AM, two CNAs who worked night shifts were interviewed. The CNAs stated that resident 2 routinely wanted to eat and sip water all night. They stated she would eat much more at night than during the day. The RD reviewed resident 2's records on 7/19/06. The RD again recommended considering an appetite stimulant, offering fruit drinks, and to make a reasonable effort to offer foods. to the resident. On 7/20/06, the DON, the DM and the RD were interviewed. The DON and RD stated they were not aware resident 2 wanted to eat at night. Facility staff had identified resident 2: was at high risk for nutritional deficit, she had poor nutritional intake during the day, she had abnormal sleeping habits, she liked to eat at night, she was below ideal body weight, she had continued to lose weight. The facility had not incorporated their assessment information or the dietician's recommendations to ensure resident 2 maintained an acceptable body weight.	F 325		

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F 364 SS=E	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility did not ensure residents were served meals that were warm; thus affecting the palatability and placing residents at risk of diminished dining experience. Findings include: During a confidential group meeting, held on 7/19/06 at 9:00 AM, 7 of 12 residents actively participating in the group discussion stated that they were served cold food and the food was not palatable because of this. On 7/19/06 at 7:30 AM, a confidential resident interview with a formal resident was conducted. The resident stated that the food "was cold and did not taste good". On 7/20/06, a test tray was obtained during the breakfast meal. The test tray was prepared as the last tray of the breakfast meal. This tray was delivered to the surveyor at 8:30 AM. At 8:30 AM, the test tray was received and the temperatures were taken. The hot cereal was 124.9 degrees, the poached egg was 99.7 degrees, the ground sausage was 103.1 degrees, the sausage patty was 95.9 degrees, the toast was cold and dry and the milk was 43.3 degrees.	F 364	The dietary staff will take and record the temperatures of the foods in the steamtables at the beginning and middle of each meal to ensure that hot foods are above 139 degrees Fahrenheit and below 41 degrees Fahrenheit for cold foods. If they are not at the appropriate temperatures, the dietary staff will make the corrections before serving the food. The dietary and nursing staff will work on ensuring that the food gets to the residents quickly so the food is palatable. The Dietary Manager (DM) will monitor the temperature to ensure the temperatures are correct and that the food is getting quickly to the residents on a weekly basis. The DM will train the staff to take the temperatures as outlined and to make sure food is delivered timely to the residents. The DM will report to the Quarterly Quality Assurance Committee the progress in this area.	9-4-06

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