INTOEL 8-30-01

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 8/10/01
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

POC accepted 9/10/01 ETR

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 157 SS=E	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on review of resident medical records, it was determined that for 2 of 7 diabetic residents on the sample and 2 additional diabetic residents, the facility did not notify the physician of a significant change in the resident's physical status. Specifically, the physician was not notified when resident blood sugars	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10/05/01

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 157	Continued From page 1 were out of accepted ranges. Resident blood sugars which were not reported to the physician ranged from 55 to 510mg/dL. Resident identifiers: 28, 41, 42, 73. Findings include: 1. Resident 28 was an 83 year old male who was admitted to the facility on 7/10/01 with the diagnosis of insulin dependent diabetes mellitus. The facility had orders from the physician to call him if the blood sugar of resident 28 went below 70 or above 400mg/dL. The July 2001 "Patient Diabetic Record" for resident 28 was reviewed on 8/6/01. During the review, it was noted that during July 2001, the blood sugars of resident 28 had been found by facility nurses to be out of the accepted ranges, as set by the physician, on 6 occasions. The out of range blood sugars were as follows: 7/16/01 - 69mg/dL 7/20/01 - 55mg/dL 7/21/01 - 65mg/dL 7/22/01 - 68mg/dL 7/27/01 - 63mg/dL 7/28/01 - 466mg/dL There was no documentation in the medical record of resident 28 to evidence that the physician had been called and notified of these out of range blood sugars. It was also noted that the sliding scale insulin orders from the physician for resident 28 did not cover blood sugars above 400. Facility nurses gave insulin to resident 28 on the evening of 7/28/01 based on the orders for a blood sugar of 351 to 400mg/dL. There was no documentation to evidence that facility staff called the physician to report and/or obtain orders to	F 157	Resident #28: The physician will be notified of any blood sugar levels of <70 or >400 per facility policy. The sliding scale insulin has been adjusted to cover >400. Resident #41: The physician will be notified of any blood sugar levels of <70 or >450 per facility policy. Resident #42: The physician will be notified of any blood sugar levels of <70 or >400 per facility policy. Resident #73: the physician will be notified of any blood sugar levels of <70 or >450 per facility policy. The blood sugar levels >450 will be dealt with on an individual basis. In speaking with the physician about this resident, since his blood sugars have only been out of his individual parameters twice since the 17th of May, he does not want to make any changes to this resident's sliding scale at this time. All diabetic residents admitted to the facility from 08-01-01 forward, will have orders per facility policy to notify the physician is blood sugar levels are <70 or >400 unless otherwise indicated. Anytime a diabetic resident has a blood sugar out of their ordered blood sugar parameter range, the physician will be notified per facility policy. (Please see the attached copy of the Physician Notification of Blood Sugar Readings Policy and Procedure.)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 157	Continued From page 2 address the blood sugar of 466mg/dL. 2. Resident 41 was an 82 year old male who was admitted to the facility on 2/26/99 with the diagnosis of diabetes. The facility had orders from the physician to call the physician if the blood sugar of resident 41 went below 80 or above 450mg/dL. The July 2001 "Patient Diabetic Record" for resident 41 was reviewed on 8/6/01. During this review, it was noted that during July 2001, the blood sugars of resident 41 had been found by facility nurses to be out of the accepted ranges, as set by the physician, on 4 occasions. The out of range blood sugars were as follows: 7/14/01 - 77mg/dL. 7/16/01 - 60mg/dL. 7/20/01 - 75mg/dL. 7/21/01 - 72mg/dL. There was no documentation in the medical record of resident 41 to evidence that the physician had been called and notified of these out of range blood sugars. 3. Resident 42 was a 68 year old male who was admitted to the facility on 6/5/01 with the diagnosis of insulin dependent diabetes mellitus. The facility had orders from the physician to call the physician if the blood sugars of resident 42 went below 70 or above 400mg/dL. The July 2001 "Patient Diabetic Record" for resident 42 was reviewed on 7/30/01. During this review, it was noted that during July 2001, the blood sugars of resident 42 had been found by facility nurses to be out of the accepted ranges, as set by the physician, on 2 occasions. The out of range blood sugars were as	F 157	Any diabetic resident who has more than two high or two low readings on different days during the week, will be placed on "alert" charting until the blood sugar levels have stabilized. On the September MAR's we will have a separate treatment sheet for tracking of everything having to do with a diabetic resident. This will help the staff be more consistent in their documentation, and to see at a glance everything about the diabetic resident. A nursing inservice will be held on 09-10-01 to educate all nurses on how to handle physician notification of blood sugars that are out of the parameter range. Specific inservice materials pertaining to policy and procedures used in our facility, will be kept in a binder, and this material will be given to any new nurse that hires on. All diabetic residents blood sugars will be audited on a weekly basis by the day shift unit nurse. The nurse will audit for blood sugars drawn and documented, and to make sure that residents who are consistently out of range is reported to the D.O.N.. This will be part of the tracking for trends that the D.O.N. is responsible to report on in our monthly Q.A. meeting. Lead Person: Director of Nursing	10-01-01

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 426	Continued From page 20 June 2001 Between 6/1/01 and 6/30/01, the morning blood sugar of resident 41 was recorded as being below 110 on 18 days. The nurse signed as giving the Glucotrol, in contradiction with physician orders, on all 18 days. July 2001 Between 7/1/01 and 7/31/01, the morning blood sugar of resident 41 was recorded a being below 110 on 27 days. The nurse signed as giving the Glucotrol, in contradiction with physician orders, on 26 of those 27 days. 2. Resident 42 was a 68 year old male who was re-admitted to the facility on 6/5/01 with the diagnosis of insulin dependent diabetes mellitus. During review of the medical record for resident 42 on 7/30/01, it was noted that current physician's orders for insulin included the following: Insulin NPH 18 units SQ Q AM Insulin Regular 8 units SQ Q AM Insulin sliding scale - Regular Q (every) AC (before meals) and HS (at bedtime) Call MD for BS (blood sugar) < (less than) 70, 201 - 250 = 2 u (units) 251 - 300 = 4 u 301 - 350 = 6 u 351 - 400 = 8 u > (more than) 400 = Call MD On 7/30/01, the June 2001 and July 2001 "Patient Diabetic Record" for resident 42 were reviewed. It	F 426	doing the monthly 4-way check at the beginning of each month. This will also be added to the MAR audit the D.O.N. or designee will do at the end of each month. The MAR's will be checked for documentation accuracy and omissions. Any issues or patterns that are identified will be reviewed and followed through the Q.A. process at our monthly meeting. Random audits to review for accuracy will be done at least monthly by the D.O.N. or designee. Telephone orders, admission orders, and monthly physician orders will be checked to ensure that the nurses understand the systems. The D.O.N. will bring these audits for tracking purposes to the monthly Q.A. meeting. All resident's medical records will be reviewed on a monthly basis by the consulting pharmacist to ensure that all residents have had their drug regimen reviewed. Lead Person: Director of Nursing	10-01-01

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 8/10/01
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 371	Continued From page 16 directly to the residents. During this same meal preparation, the cook was observed to be preparing french toast for the residents. In his preparation of the french toast, he would dip the toast into a large bowl of eggs, milk, and cinnamon, by placing the french toast into the bowl with gloved hands. He was observed to leave the stove area and rinse his gloves in the hand sink. The cook removed a paper towel and dried his gloves. He was not observed to wash his hands and reglove. He dropped the paper towel on a small table next to the stove and returned to prepare the french toast. The cook placed bread into the bowl of eggs, milk, and cinnamon with the same gloves. He was observed to lift the paper towel from the table top and walk into the food preparation area, adjacent to the walk-in refrigerator. He lifted the lid of the garbage can with the same gloved hands to throw the paper towel away. The cook, then, returned to the food preparation area and placed french toast into the bowl of eggs, milk, and cinnamon, with the same contaminated gloves. The cook was observed to leave the meal preparation area and place the food processor on the food preparation table, with the same contaminated gloves. He returned to the container of cooked french toast, and placed several slices into the food processor. The cook did not remove the gloves or wash his hands before he placed the french toast into the food processor, contaminating the french toast. The cook was observed to enter the walk-in refrigerator by opening the door, contaminating the gloves. He removed a gallon of milk, poured milk into the food processor with the same gloves; and returned the milk to the walk-in refrigerator. The cook removed a metal container from the dish shelf and poured the pureed french toast into the container. He was not	F 371	The Dietary Manager will monitor her staff daily during different meal preparation times, to make sure they are understanding cross contamination issues, and hand washing. The Dietician will also observe this when she is in during meal preparation. This will be written up on a Q.A. problem log, and the Dietary Manager will address how she is going to track her staff with regards to cross contamination, and hand washing. (Please see attached log). She will address this issue during the monthly Q.A. meeting as part of her report. Lead Person: Dietary Manager	10-01-01

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 157	Continued From page 2 address the blood sugar of 466mg/dL. 2. Resident 41 was an 82 year old male who was admitted to the facility on 2/26/99 with the diagnosis of diabetes. The facility had orders from the physician to call the physician if the blood sugar of resident 41 went below 80 or above 450mg/dL. The July 2001 "Patient Diabetic Record" for resident 41 was reviewed on 8/6/01. During this review, it was noted that during July 2001, the blood sugars of resident 41 had been found by facility nurses to be out of the accepted ranges, as set by the physician, on 4 occasions. The out of range blood sugars were as follows: 7/14/01 - 77mg/dL 7/16/01 - 60mg/dL 7/20/01 - 75mg/dL 7/21/01 - 72mg/dL There was no documentation in the medical record of resident 41 to evidence that the physician had been called and notified of these out of range blood sugars. 3. Resident 42 was a 68 year old male who was admitted to the facility on 6/5/01 with the diagnosis of insulin dependent diabetes mellitus. The facility had orders from the physician to call the physician if the blood sugars of resident 42 went below 70 or above 400mg/dL. The July 2001 "Patient Diabetic Record" for resident 42 was reviewed on 7/30/01. During this review, it was noted that during July 2001, the blood sugars of resident 42 had been found by facility nurses to be out of the accepted ranges, as set by the physician, on 2 occasions. The out of range blood sugars were as	F 157	Any diabetic resident who has more than two high or two low readings on different days during the week, will be placed on "alert" charting until the blood sugar levels have stabilized. On the September MAR's we will have a separate treatment sheet for tracking of everything having to do with a diabetic resident. This will help the staff be more consistent in their documentation, and to see at a glance everything about the diabetic resident. A nursing inservice will be held on 09-10-01 to educate all nurses on how to handle physician notification of blood sugars that are out of the parameter range. Specific inservice materials pertaining to policy and procedures used in our facility, will be kept in a binder, and this material will be given to any new nurse that hires on. All diabetic residents blood sugars will be audited on a weekly basis by the day shift unit nurse. Any resident who is consistently out of range will be reported to the D.O.N. so this can be part of the tracking for trends that the D.O.N. is responsible to report on in our monthly Q.A. meeting. Lead Person: Director of Nursing	10-01-01

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 157	Continued From page 3 follows: 7/7/01 - 66mg/dL 7/23/01 - 60mg/dL There was no documentation in the medical record of resident 42 to evidence that the physician had been called and notified of these out of range blood sugars. 4. Resident 73 was a 68 year old male who was admitted to the facility on 9/13/99 with the diagnosis of insulin dependent diabetes mellitus. The facility had orders from the physician to call the physician if the blood sugars of resident 73 went below 80 or above 450mg/dL. The July 2001 "Patient Diabetic Record" for resident 73 was reviewed on 8/2/01. During this review, it was noted that during July 2001, the blood sugars of resident 73 had been found by facility nurses to be out of the accepted ranges, as set by the physician, on 6 occasions. The out of range blood sugars were as follows: 7/5/01 - 510mg/dL 7/6/01 - 65mg/dL 7/13/01 - 72mg/dL 7/14/01 - 66mg/dL 7/23/01 - 73mg/dL 7/31/01 - 79mg/dL There was no documentation in the medical record of resident 73 to evidence that the physician had been called and notified of these out of range blood sugars. It was also noted that the sliding scale insulin orders from the physician, for resident 73, did not cover blood sugars above 400mg/dL. Facility nurses gave insulin to resident 73 on the morning of 7/5/01 based	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 157	Continued From page 4 on the orders for a blood sugar ranging from 351 to 400mg/dL. There was no documentation to evidence that facility staff had called the physician to report and/or obtain orders to address the blood sugar of 510mg/dL.	F 157		
F 281 SS=E	483.20(k)(3)(i) RESIDENT ASSESSMENT The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based upon interviews and review of the medical records of three insulin dependent residents, the facility did not ensure that professional standards of quality were met in following physician's orders, checking of blood glucose levels and/or administering of inulin and sliding scale regular insulin for 3 of 3 insulin dependent diabetics who were reviewed. Resident identifiers: 73, 28 and 42. Findings include: 1. Resident 73 was a 68 year old male who was admitted to the facility on 9/13/99 with the diagnosis of insulin dependent diabetes mellitus. Resident 73 was alert and oriented to person, place and time. The physician's orders for resident 73 include instructions for the administration of insulin. The insulin orders were as follows: Insulin NPH 22 units SQ (subcutaneous) Q (every) AM (morning) Insulin Regular 10 units SQ Q AM Insulin Regular 10 units SQ Q PM	F 281	8/30/01 Resident #73: Glucoscan will be done AC and HS as ordered at 0630-0700, 1115-1145, 1615-1645, and at 2100. The insulin will be administered promptly following the glucoscan. If for any reason the meal is delayed for longer than 45 minuets from the time of administering the insulin, the resident will be given orange juice or an appropriate snack. Blood sugars will be audited on a weekly basis by the day shift unit nurse, and any omissions other than the resident being LOA will be reported to the D.O.N.. Resident #42: Glucoscan will be done as ordered twice a day at 0630-0700, and 1615-1645. The insulin will be administered promptly following the glucoscan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 281	Continued From page 5 Insulin NPH 10 units SQ Q HS (at bedtime) The physician also ordered blood sugars to be taken four times a day, before each meal and then at bedtime, and then to administer sliding scale insulin based on the results of the blood sugar. The sliding scale orders for insulin are as follows: For a blood sugar of: 180 - 250, give 2 units of Regular insulin 251 - 300, give 4 units of Regular insulin 301 - 350, give 8 units of Regular insulin 351 - 400, give 12 units of Regular insulin At 6:50 AM on 8/1/01, the night nurse was interviewed. She stated that she starts taking blood sugars at "about 5:30 AM" and that "everyone has their pills and insulin by 6:00 (AM)". During further interview, she stated that the blood sugar for resident 73 that morning (8/1/01) had been 338. The nurse stated that she had given him 22 units of NPH insulin with 10 units of Regular insulin and an additional 8 units of Regular insulin, based on the sliding scale, to cover the blood sugar of 338mg/dL. During interview with resident 73 on 8/1/01 at 7:30 AM, he was asked what time he had received his insulin that morning. He replied that he had been given his insulin at "a quarter to six (AM)". Resident 73 was then asked if he had eaten yet that morning or had anything to drink besides water. Resident 73 replied that he had not. When asked how he was feeling that morning, resident 73 stated that he had felt "a bit shaky on the way down here" (to the dining area). The Assistant Director of Nurses (ADON) was told this information and asked to assess the blood sugar of resident 73. At 7:35 AM on 8/1/01, the ADON obtained a blood sugar of resident 73 and	F 281	If for any reason the meal is delayed for longer than 45 minuets from the time of administering the insulin, the resident will be given orange juice or an appropriate snack. This resident's glucoscan and sliding scale insulin order was corrected on 08-01-01 when this was brought to our attention by the surveyor. In speaking to Dr. Grange on 08-01-01, he thought the order for glucoscan all along was twice a day, and he had been following residents glucoscan on the resident diabetic record as such. In explaining to him that this was a change for this resident when he was readmitted from a hospitalization, he said to monitor AC, HS and he would review the record on 08-03-01when he was in to do facility rounds. On 08-03-01 the glucoscan order was changed to twice a day. Resident #28: Glucoscan will be done as ordered AC and HS at the following times; 0630-0700, 1115-1145, 1615-1645, and at 2100. Insulin will be administered promptly following the glucoscan. If for any reason the meal is delayed for longer than 45 minuets, the resident will be given orange juice or an appropriate snack. All diabetic residents will have their glucometer tracking sheets/diabetic flow sheets audited on a weekly basis by the day shift unit nurse. If any irregularities or omissions are found, the nurse will report these to the D.O.N.. This will assure that all diabetic residents will be monitored to make sure that the Dr's. Orders are being followed, and the policy and procedure for Gulcometer/Glucoscan checks and Insulin Administration is being followed for each diabetic resident.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 281	Continued From page 6 found it to be 203mg/dL. During further interview with resident 73 on 8/1/01, later in the afternoon, he stated that he had received his breakfast a minute or so after the ADON had taken his blood sugar. This was approximately 1 hour and 50 minutes after the resident received 40 units of insulin (22 NPH, 18 Regular). Reference: Brunner and Suddarth's Textbook of Medical Surgical Nursing, Eighth Edition, 1996, Pg 1031: "The onset of regular human insulin action is ½ hour; peak, 2 to 3 hours; duration, 4 to 6 hours....Regular insulin is clear in appearance and is administered 20 –30 minutes before a meal, either alone or in combination with longer-acting insulin." Reference: Brunner and Suddarth's Textbook of Medical Surgical Nursing, Eighth Edition, 1996, Pg 1045: "Hypoglycemia (abnormally low blood glucose level) occurs when the blood glucose falls below 50 to 60 mg/dl (2.7 to 3.3 mmol/L). It can be caused by too much insulin or oral hypoglycemic agents, too little food, or excessive physical activity. Hypoglycemia may occur at any time of the day or night. It often occurs before meals, especially if meals are delayed or snacks omitted." In addition, there was no documentation to evidence that blood sugars were obtained, from resident 73, four times a day and sliding scale insulin administered, if necessary, as ordered by the physician, on the following days: 7/1/01 7/6/01 7/18/01 7/23/01	F 281	On 08-02-01 a new policy and procedure was written for Glucometer/Glucoscan Checks and Insulin Administration. Please see attached document which outlines the policy and procedures that have been utilized in the answers for the three residents identified on the 2567 form. An inservice was held on 08-10-01 to discuss how the new changes in our policy and procedures regarding Glcometer/Glucoscan Checks and Insulin Administration was working. This will be re-inserviced along with physician notification of blood sugars when they are out of the residents parameter range. Also, how to document on MAR and Gucometer Tracking Sheet when the resident is out of the facility at the time this is to be done. This inservice will be held on 08-25-0l. Specific inservice material pertaining to policy and procedures used in our facility, will be kept in a binder, and this material will be given to any new nurse that hires on. The audit addressed in this plan of correction, will be added as part of the tracking for trends that the D.O.N. is responsible to report on in our monthly Q.A. meeting. Lead Person: Director of Nursing	10-01-01

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 281	Continued From page 7 7/25/01 2. Resident 42 was a 68 year old male who was re-admitted to the facility on 6/5/01 with the diagnosis of insulin dependent diabetes mellitus. During review of the medical record for resident 42, it was noted that current physician's orders for insulin included the following: Insulin NPH 18 units SQ Q AM Insulin Regular 8 units SQ Q AM Insulin sliding scale - Regular Q (every) AC (before meals) and HS (at bedtime) Call MD for BS (blood sugar) < (less than) 70, 201 - 250 = 2 u (units) 251 - 300 = 4 u 301 - 350 = 6 u 351 - 400 = 8 u > (more than) 400 = Call MD On 7/30/01, the June 2001 and July 2001 "Patient Diabetic Record" for resident 42 were reviewed. It was determined that facility staff were not following the physician's orders for obtaining blood sugars or providing sliding scale insulin. The physician ordered blood sugars to be performed four times a day, before each meal and again at bedtime. Review of the Patient Diabetic Record for June 2001 revealed that from dinner on 6/5/01 through bedtime on 6/30/01, facility staff should have obtained a blood sugar from resident 42 one hundred and two times. Facility staff obtained only 53 of those 102 ordered blood sugars. There were 49 times that resident 42 was not evaluated for his need for additional insulin as provided by the sliding scale.	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 281	Continued From page 8 Review of the Patient Diabetic Record for July 2001 revealed that from breakfast on 7/1/01 through bedtime on 7/31/01, facility staff should have obtained a blood sugar from resident 42 one hundred and twenty-four times. Facility staff obtained only 62 of those 124 ordered blood sugars. There were 62 times that resident 42 was not evaluated for his need for additional insulin as provided by the sliding scale. During further review of the June and July 2001 Patient Diabetic Records, it was noted that facility nurses were not using the sliding scale that was ordered by the physician upon the resident's readmission to the facility on 6/5/01. Facility nurses were using the following incorrect sliding scale for Regular insulin: > (more than) 160 = 2 u (units) Regular insulin > 200 = 4 u > 250 = 6 u > 300 = 8 u > 350 = 10 u > 400 = 15 u Resident 42 received insulin based on this incorrect sliding scale 8 times in June 2001 and 13 times in July 2001. For specific medication errors regarding the insulin administration for resident 42, please refer to tag F- 426. 3. Resident 28 was an 83 year old male who was admitted to the facility on 7/10/01 with the diagnosis of insulin dependent diabetes mellitus. During interview with a facility nurse at 6:45 AM on 8/1/01, it was confirmed that resident 28 had received his routine insulin, 50 units of NPH, and an	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 281	Continued From page 9 additional 2 units of Regular insulin, based on sliding scale orders, "about 6:00 (AM)." Breakfast did not begin to be served in the facility on 8/1/01 until approximately 7:25 AM. Resident 28 was not provided food after being given his insulin for approximately one hour and twenty-five minutes. In addition, there was no documentation to evidence that facility staff had obtained all blood sugars as ordered or provided sliding scale insulin, if required, on 7/14/01 and 7/31/01.	F 281		
F 314 SS=G	483.25(c) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility did not ensure that a resident who entered the facility without a pressure sore did not develop a pressure sore; and the facility did not ensure that necessary treatment and services to promote healing and prevent infection was maintained as evidenced by: One of seventeen sampled residents did not receive preventive measures to protect skin; and once the pressure sore was identified, the facility did not provide timely and routine dressing changes. Resident identifier 58	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 314	Continued From page 10 Findings include: Resident 58 was an 81 year old male admitted to this facility with diagnoses of Parkinsonism, diabetes, glaucoma, and malignant neoplasm of the prostate. Resident 58 was identified on his MDS (minimum data set), dated 5/23/01, as using his wheelchair for his primary mode of locomotion. A physician's progress note, dated 6/1/01, and a nursing progress note, dated 1/28/01, identified that resident 58 required two hours or more to consume his meals while up in his wheelchair and one hour on the toilet to have a bowel movement. Resident 58, also, had a history of pressure sores. One pressure sore was documented, on the weekly skin assessment, in February, 2000 as "breakdown beginning" on the buttocks and the second documentation, on the weekly skin assessment, stated that the resident had bilateral inner ankle pressure sores in October, 2000. Review of resident 58's medical records, revealed that on 6/1/01, a nurses note identified a wound to the right posterior thigh which was to be "cleaned and dressed" every day until healed. In that same note the nurse documented that nursing /therapy would try a wheelchair seat cushion to decrease pressure, especially under the distal thighs, and would try a softer toilet seat. Continued review revealed that a physician's telephone order, written on 6/1/01, at 6:30 AM, for this same treatment and pressure relieving device in the wheelchair and on the toilet, was signed by the physician. Review of resident 58's treatment record, for the month of June, 2001, documented that there was a	F 314 8/30/01	Resident #58: We will continue to do weekly skin assessments on this resident, and will follow through with any interventions as needed. The wound on his buttocks has resolved, and we will continue to monitor for skin integrity. This resident will have a Braden High Risk Assessment done on a quarterly basis in conjunction with his care plan review. This resident will continue to work with restorative therapies for ambulation, wheel chair mobility, self repositioning and energy conservation. He will be followed by the Nutritional Intervention Team to make sure his needs are being met. The Skin Care Policy and Procedure that is in place for our facility addresses our Plan of Correction for F314, and is as follows: All residents upon admission to our facility will have a full body assessment done, and the Braden High Risk Assessment filled out. This assessment will be updated on a quarterly basis with their care plan review. If the resident triggers at a moderate to high risk, pre-ventative measures will be put into place. If the resident triggers at a high risk, they will be evaluated by the Nutritional Intervention Team. This will assure that all nutritional requirements for the healing process are being met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 314	Continued From page 11 treatment of the right posterior thigh sore to be done every day until healed. This treatment was documented by nursing, to be started on 6/2/01. There was a column, on the treatment sheet, that was documented, 6/2/01, 6/3/01, 6/4/01,by nursing, that a wheelchair seat cushion to decrease pressure, especially, under the distal thighs, and a softer toilet seat was being used. This column was changed to FYI (for your information), on 6/4/01, which no longer required nursing initials to document that the pressure relieving devices were present. There was no order and no documentation, on resident 58's treatment record, for dressing changes to a stage II pressure sore on resident 58's left buttock, for the month of June, 2001. Review of resident 58's medical records, revealed that on 6/6/01, a weekly skin assessment, documented by a facility nurse, identified that resident 58 had no skin breakdown present. The skin assessment, also, documented risk factors as being diabetes, incontinence and mobility. Continued review of resident 58's medical records, revealed that a stage II pressure sore had been identified on his left buttock, on 6/14/01, during the weekly skin assessment, documented by a facility nurse. The pressure sore measured 1/8 cm (centimeter) by 1/8 cm with no odor and no drainage, according to the documentation. On 6/26/01, a weekly skin assessment, documented by nursing, identified that the pressure sore on resident 58's left buttock had increased in size from 1/8 cm by 1/8 cm to .3 cm by .3 cm with a depth of .1 cm. There was documentation in the 6/26/01 weekly nursing note, of another stage II pressure sore which measured 1 cm by 1 cm with a depth of .1 cm but had no location documented. There was no further documentation of	F 314	Nursing will do weekly skin assessments on all residents. Any resident that is reported to the R.N. Supervisor to have a change in skin condition, will have a Braden High Risk Assessment filled out, the area of concern photographed, and a nurses note documented. The resident will be added to the high risk group and followed weekly by the skin team, and added to the list for the nutritional intervention team. The physician, designated family member, and the D.O.N. will be notified immediately. The D.O.N. will review any residents with new breakdown with the management team at daily update meeting. The Dietary Manager will also review any residents with significant weight loss with the management team at daily update meeting. To monitor this skin care policy and procedure the afternoon R.N. Supervisor will be assigned to monitor all skin issues in the facility. These duties will include: checking all weekly skin assessments for content and completion. The skin assessments will ensure care planning is initiated, treatments are ordered and followed through, and that alert charting is initiated and followed through. The R.N. will consult with the physician for any non-healing or slow to heal wounds, and note any changes to treatment orders. The R.N. will check all Braden High Risk Skin Assessments for completion and follow through of protocols as indicated for moderate to high risk residents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 314	Continued From page 12 the second pressure sore through 8/6/01, in the nursing notes or on the skin assessments. On 7/4/01, a weekly skin assessment, documented by nursing, identified that the pressure sore on resident 58's left buttock was 1 cm by 1 cm and had a greenish/white drainage noted. The nurse surveyor was unable to determine which stage II pressure sore was being referenced in relation to the drainage. Review of resident 58's physician's telephone orders, revealed that on 6/25/01, a physician's order was written, for a dressing change to a stage II pressure sore to resident 58's left buttock, to clean with normal saline, apply hydrogel and cover with non-adherent dressing until healed. Facility staff did not obtain orders for how often the dressing was to be changed. However, according to the Agency for Health Care Policy Research, the manufacturers recommendation for dressing changes using hydrogel with a non-adhesive dressing cover, is to change the dressing daily. Review of resident 58's nurses notes and treatment sheets for the months of June and July, 2001, revealed there was no documentation of dressing changes done for nine (9) days after the identification, on 6/14/01, of the pressure sore on resident 58's left buttock. Continued review revealed that starting with 6/25/01, neither the nurses notes nor the treatment sheet documented dressing changes on 6/25/01, 7/1/01, 7/3/01, 7/7/01, and 7/14/01. There was no documentation of dressing changes or any other treatment to a second stage II pressure sore for June, 2001, July, 2001, or through August 6, 2001. Review of resident 58's dietary evaluations, revealed that dietary involvement occured on 7/11/01; and there was no change to resident 58's diet orders until	F 314	All telephone orders for cushions, positioning devices, and restraints will have a copy placed in the box on the door of the Physical Therapist. The therapy group will call the designated family member for approval (financial). If approval is obtained, they will order the equipment. While waiting for the equipment, the facility will adapt in-house alternatives as appropriate. If approval is not obtained, the therapist will try to educate the family on the need for the recommended equipment, and the potential outcome if not used. If the family continues to refuse to authorize the purchase, the facility will use in-house alternatives as appropriate. These identified high risk residents, and residents with actual breakdown will be followed in our Q.A. monthly meeting. The D.O.N. will discuss the weekly audits, as part of the tracking for trends that she follows for quality assurance. Lead Persons: The D.O.N. and R.N. Supervisor.	10-01-01

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 314	Continued From page 13 7/31/01. Resident 58's diet was changed from a mechanical soft with no concentrated sweets to mechanical soft with no concentrated sweets with pureed meats and enriched; add five grams of protein powder to pureed meat three times a day; resident needs ninety five grams of protein daily, high protein milk three times a day. Review of resident 58's care plan revealed that there was no care plan problem addressing preventive measures for pressure sores or actual loss in skin integrity until July, 2001. Review of resident 58's medical chart revealed that there was no skin risk assessment present in the chart that was done at the time of resident 58's admit to this facility. There was no skin risk assessment present in the chart that was done in the month of February, 2000, when resident 58 had the "beginning breakdown." There was no skin risk assessment present in the chart that was done in the month of October, 2000, when resident 58 had the bilateral ankle pressure sores. The first noted skin risk assessment, on resident 58, was on 7/19/01, thirty four (34) days after the facility identified the stage II pressure sore, and documented him to be at moderate risk for skin breakdown. During continuous observation on 7/31/01, from 1:00 PM until 3:55 PM, and on 8/2/01, from 12:15 PM until 3:15 PM, while resident 58 was observed in his wheelchair, in the dining room or in the common area, no pressure relieving device was observed in his wheelchair. Resident 58 was observed to be sitting in an upright position in the center of the seat of the wheelchair. At no time during observation, was staff observed to assist resident 58 to reposition himself in the wheelchair; nor was resident 58 observed to reposition himself, on his own, in the wheelchair.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 314	Continued From page 14 Resident 58 remained in the same position, in his wheelchair, without repositioning to relieve pressure, on 7/31/01, for two hours and fifty five minutes and three hours on, 8/2/01. On 8/2/01, at 6:45 AM, observation of resident 58, revealed that he was in the resident bathroom, seated on the toilet. Resident 58 remained on the toilet until 7:35 AM. Observation of the toilet seat, after resident 58 left the bathroom, revealed that the toilet seat was the original hard surface and the facility staff had not obtained the softer toilet seat as ordered by the physician. Resident 58 remained on the hard surface of the toilet seat for fifty minutes with no relief in pressure to those areas in contact with the surface of the toilet seat. On 8/2/01, a telephone interview was conducted with the medical director of this facility, who was responsible for resident 58's medical care. When asked concerning a pressure relieving device in resident 58's wheelchair, he stated that if resident 58 had redness to his skin, he (resident 58) should certainly have a pressure relieving device in his wheelchair, since he is up in his wheelchair so much. On 8/6/01, during the exit interview with the director of nursing, administrator, and regional administrator present, the director of nursing stated that when the wound on the thigh of resident 58 had healed, the cushion to relieve pressure in the wheelchair had been discontinued. The director of nursing was unable to find a physician's order to discontinue the pressure relieving device for the wheelchair in resident 58's medical record. She also stated that it was the practice of the facility to document a skin risk assessment on each resident when they were admitted to the facility. She was unable to obtain a skin risk	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 314	Continued From page 15 assessment in resident 58's medical record, dated before 7/19/01. The regional administrator stated that resident 58 was able to reposition himself in the wheelchair by lifting himself with his arms using the arms of the wheelchair. During observation of resident 58, on 7/31/01 and 8/2/01, the nurse surveyor did not witness resident 58 repositioning himself in the wheelchair on his own.	F 314		
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation the facility did not store, prepare, distribute, and serve food under sanitary conditions, as evidenced by: During observation of two meals, the dietary assistant did not wash his hands after potential contamination and did not wear gloves; and the cook moved from a dirty to clean area in preparation of the meals, with contaminated gloves, without removing the gloves or washing his hands. Findings include: On 8/1/01, during the breakfast preparation, at 6:35 AM, the dietary assistant was observed to place the knives, forks, and spoons on the resident trays. He touched the service end of several utensils before placing them on the resident napkins. The dietary assistant was observed to move from a dirty area to a clean area of tray preparation, on several occasions. He was not observed to wash his hands or glove at any time during the tray preparation being served	F 371	There will be an in service scheduled on Sept. 10th 2001, with our Dietician, Dietary Manager, and all of the dietary staff. The issues of cross contamination, and hand washing will be throughly discussed. The Dietary Manager will make sure that when she hires on a new staff member, she uses the in service material to educate and train them on cross contamination and hand washing. The surveyor who observed the dietary dept. on 08-01-01 was made aware of an emergency situation that occurred on that morning. The cook that was scheduled in at 5:00am took his wife to the hospital to deliver. He had called in someone to cover, but his replacement hadn't shown up when breakfast needed to be prepared. A housekeeping aide who used to work as a tray line aide in dietary, was ask by the D.O.N. to pitch-hit in the kitchen until the cook arrived. We were appreciative of his help even though he made some errors in cross contamination and hand washing,, the residents received a hot breakfast timely.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 371	Continued From page 16 directly to the residents. During this same meal preparation, the cook was observed to be preparing french toast for the residents. In his preparation of the french toast, he would dip the toast into a large bowl of eggs, milk, and cinnamon, by placing the french toast into the bowl with gloved hands. He was observed to leave the stove area and rinse his gloves in the hand sink. The cook removed a paper towel and dried his gloves. He was not observed to wash his hands and reglove. He dropped the paper towel on a small table next to the stove and returned to prepare the french toast. The cook placed bread into the bowl of eggs, milk, and cinnamon with the same gloves. He was observed to lift the paper towel from the table top and walk into the food preparation area, adjacent to the walk-in refrigerator. He lifted the lid of the garbage can with the same gloved hands to throw the paper towel away. The cook, then, returned to the food preparation area and placed french toast into the bowl of eggs, milk, and cinnamon, with the same contaminated gloves. The cook was observed to leave the meal preparation area and place the food processor on the food preparation table, with the same contaminated gloves. He returned to the container of cooked french toast, and placed several slices into the food processor. The cook did not remove the gloves or wash his hands before he placed the french toast into the food processor, contaminating the french toast. The cook was observed to enter the walk-in refrigerator by opening the door, contaminating the gloves. He removed a gallon of milk, poured milk into the food processor with the same gloves; and returned the milk to the walk-in refrigerator. The cook removed a metal container from the dish shelf and poured the pureed french toast into the container. He was not	F 371	The Dietary Manager will monitor her staff during meal preparation times, to make sure they are understanding cross contamination issues, and hand-washing. The Dietician will also observe this when she is in during meal preparation. This will be written up on a Q.A. problem log, and the Dietary Manager will address how she is going to track her staff with regards to cross contamination, and hand-washing. (Please see attached log). She will address this issue during the monthly Q.A. meeting as part of her report. Lead Person: Dietary Manager	10-01-01

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 371	Continued From page 17 observed to remove his gloves or wash his hands before removing the clean container and placing it in the steam table. The cook removed his gloves, washed his hands, and regloved. The cook was, then, observed to use both gloved hands to lift his pants at the waist. He, immediately, went to a stack of small glass bowls and lifted them from the shelf. He counted each bowl by touching the rim and inside edge of each bowl. He was not observed to remove his gloves or wash his hands after lifting his pants at the waist and obtaining the bowls from the shelf. The cook took the bowls to the preparation table and placed the bowls, individually, on a serving tray. He opened the walk-in refrigerator and removed a container of eggs. He was not observed to remove his gloves or wash his hands. The cook cracked ten eggs on the side of the food preparation table and emptied the contents into the individual bowls. He was not observed to remove his gloves or wash his hands before contact with the egg surface after cracking them. On 8/2/01, during the breakfast preparation, at 6:40 AM, the dietary assistant was observed to place the knives, forks, and spoons on the resident trays. He touched the service end of the utensils before placing them on the resident napkins. The dietary assistant was observed to move from a dirty area to a clean area on several occasions. He was not observed to wash his hands or glove during the tray preparation that would be served directly to the residents. During this same meal preparation, the cook was observed to remove a piece of saran wrap from a box with ungloved hands and place it over a bowl of pancake batter. He returned to the food preparation table and picked up a bacon container with the same ungloved hands. He placed his thumb and finger over	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 371	Continued From page 18 the edge of the rim of the container. The cook was not observed to wash his hands before contact with the food surfaces. He washed his hands and put on clean gloves. The cook, then, picked up the menu book and turned the pages, contaminating his gloves. He removed a scoop from a container under the steam table and placed it in the eggs, with the same contaminated gloves. The cook was observed to touch six measured scoops and placed two of the scoops on the side of the steam table, contaminating the two scoops. He washed his hands and regloved. The cook picked up the temperature clipboard and placed it on the table beside the steam table, contaminating his gloves. He, then, placed the thermometer into the eggs after touching the metal point, with the same contaminated gloves. The cook picked up a pen and documented the temperature of the eggs on the clipboard. He removed a glass plate from a stack touching the edge and rim of the plate, with the same contaminated gloves. The cook lifted the two scoops from the edge of the steam table and placed them on the plate, contaminating the plate. He was observed to measure the temperature on two more containers of food, with the same contaminated gloves. The cook, then, leaned on the steam table with his right, gloved hand, and used the same contaminated glove to clean the thermometer.	F 371		
F 426 SS=E	483.60(a) PHARMACY SERVICES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	This REQUIREMENT is not met as evidenced by: Based on interview and review of resident medical records, it was determined that the facility did not provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of 3 of 17 sample residents. Specifically, drugs were not administered as ordered by the physician. Resident identifiers: 41, 42 and 58. Findings include: 1. Resident 41 was an 82 year old male who was admitted to the facility on 2/26/99 with the diagnosis of non-insulin dependent diabetes mellitus. On 5/18/01, the physician wrote an order for resident 41 to receive "Glucotrol XL 10 mg po (by mouth) QD (every day) - DM (diabetes mellitus). Hold if FS (fasting blood sugar) < (less than) 110." Facility staff also had physician's orders to check the blood sugar of resident 41 twice a day. The medication records and patient diabetic records for resident 41 for May 2001, June 2001 and July 2001 were reviewed on 8/6/01. The Glucotrol was scheduled to be given everyday at 8:00 AM. The morning blood sugar was also scheduled, per the medication record, to be obtained at 8:00 AM. The following results were revealed: May 2001 Between 5/19/01 and 5/31/01, the morning blood sugar of resident 41 was recorded as being below 110 on 12 days. The nurse signed as giving the Glucotrol, in contradiction with physician orders, on 9 of those 12 days.		Resident #41: The problem identified with this resident's Glucotrol XL order was corrected on 08-01-01. The order as the physician wrote it was being followed up until the Glucotrol XL was discontinued on 08-17-01. Resident #42: The sliding scale insulin administration record was corrected to reflect the current order on 08-01-01. Resident #58: The MAR was corrected for August 2001. The order is being followed with all appropriate days for the Aspirin to be held crossed off on the MAR. An in service will be held on 09-10-01 to address the policy and procedure on the administration of medication, the 4-way monthly physician order check process, and transcription of physician orders so that all nursing staff understand the necessity of documentation and accuracy with order transcription. All medications that are not given everyday will have the date that the drug is not to be given crossed off or if it is a once a month dose the area on the MAR will be blocked off to help prevent medication errors. This will be done by the nurses	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 426	Continued From page 20 June 2001 Between 6/1/01 and 6/30/01, the morning blood sugar of resident 41 was recorded as being below 110 on 18 days. The nurse signed as giving the Glucotrol, in contradiction with physician orders, on all 18 days. July 2001 Between 7/1/01 and 7/31/01, the morning blood sugar of resident 41 was recorded a being below 110 on 27 days. The nurse signed as giving the Glucotrol, in contradiction with physician orders, on 26 of those 27 days. 2. Resident 42 was a 68 year old male who was re-admitted to the facility on 6/5/01 with the diagnosis of insulin dependent diabetes mellitus. During review of the medical record for resident 42 on 7/30/01, it was noted that current physician's orders for insulin included the following: Insulin NPH 18 units SQ Q AM Insulin Regular 8 units SQ Q AM Insulin sliding scale - Regular Q (every) AC (before meals) and HS (at bedtime) Call MD for BS (blood sugar) < (less than) 70, 201 - 250 = 2 u (units) 251 - 300 = 4 u 301 - 350 = 6 u 351 - 400 = 8 u > (more than) 400 = Call MD On 7/30/01, the June 2001 and July 2001 "Patient Diabetic Record" for resident 42 were reviewed. It	F 426	doing the monthly 4-way check at the beginning of each month. This will also be added to the MAR audit the D.O.N. or designee will do at the end of each month. The MAR's will be checked for documentation accuracy and omissions. Any issues or patterns that are identified will be reviewed and followed through the Q.A. process at our monthly meeting. Random audits to review for accuracy will be done by the D.O.N. or designee. Telephone orders, admission orders, and monthly physician orders will be checked to ensure that the nurses understand the systems. The D.O.N. will bring these audits for tracking purposes to the monthly Q.A. meeting. All resident's medical records will be reviewed on a monthly basis by the consulting pharmacist to ensure that all residents have had their drug regimen reviewed. Lead Person: Director of Nursing	10-01-01

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 426	Continued From page 21 was determined that facility staff were not following the physician's orders for obtaining blood sugars or in providing sliding scale insulin. During further review of the June and July 2001 Patient Diabetic Records, it was noted that facility nurses were not using the sliding scale that was ordered by the physician upon the resident's readmission to the facility on 6/5/01. Facility nurses were using the following incorrect sliding scale for Regular insulin: > (more than) 160 = 2 u (units) Regular insulin > 200 = 4 u > 250 = 6 u > 300 = 8 u > 350 = 10 u > 400 = 15 u Resident 42 received insulin based on this incorrect sliding scale 8 times in June 2001 and 13 times in July 2001. June 2001 The blood sugar at dinner on 6/6/01 was recorded as 248. Based on the physician's orders dated 6/5/01, the nurses should have given 2 units of regular insulin, but gave 4 units instead. The blood sugar at dinner on 6/14/01 was recorded as 252. Based on the physician's orders dated 6/5/01, the nurses should have given 4 units of regular insulin, but gave 6 units instead. The blood sugar at dinner on 6/15/01 was recorded as 198. Based on the physician's orders dated 6/5/01, the nurses should have given no regular insulin, but	F 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 426	Continued From page 22 instead gave 2 units. The blood sugar at bedtime on 6/18/01 was recorded as 239. Based on the physician's orders dated 6/5/01, the nurses should have given 2 units of regular insulin, but instead gave 5 units. The blood sugar at dinner on 6/19/01 was recorded as 211. Based on the physician's orders dated 6/5/01, the nurses should have given 2 units of regular insulin, but instead gave 4 units. The blood sugar at dinner on 6/20/01 was recorded as 244. Based on the physician's orders dated 6/5/01, the nurses should have given 2 units of regular insulin, but instead gave 4 units. The blood sugar at dinner on 6/22/01 was recorded as 345. Based on the physician's orders dated 6/5/01, the nurses should have given 6 units of regular insulin, but instead gave 8 units. The blood sugar at dinner on 6/24/01 was recorded as 293. Based on the physician's orders dated 6/5/01, the nurses should have given 4 units of regular insulin, but instead gave 6 units. July 2001 The blood sugar at dinner on 7/5/01 was recorded as 215. Based on the physician's orders dated 6/5/01, the nurses should have given 2 units of regular insulin, but instead gave 4 units. The blood sugar at dinner on 7/6/01 was recorded as 176. Based on the physician's orders dated 6/5/01, the nurses should have given no regular insulin, but instead gave 2 units.	F 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 426	Continued From page 23 The blood sugar at breakfast on 7/10/01 was recorded as 188. Based on the physician's orders dated 6/5/01, the nurses should have given no regular insulin, but instead gave 2 units. The blood sugar at dinner on 7/10/01 was recorded as 304. Based on the physician's orders dated 6/5/01, the nurses should have given 6 units of regular insulin, but instead gave 8 units. The blood sugar at dinner on 7/11/01 was recorded as 187. Based on the physician's orders dated 6/5/01, the nurses should have given no regular insulin, but instead gave 2 units. The blood sugar at dinner on 7/14/01 was recorded as 193. Based on the physician's orders dated 6/5/01, the nurses should have given no regular insulin, but instead gave 2 units. The blood sugar at dinner on 7/16/01 was recorded as 230. Based on the physician's orders dated 6/5/01, the nurses should have given 2 units of regular insulin, but instead gave 4 units. The blood sugar at dinner on 7/17/01 was recorded as 214. Based on the physician's orders dated 6/5/01, the nurses should have given 2 units of regular insulin, but instead gave 4 units. The blood sugar at dinner on 7/18/01 was recorded as 184. Based on the physician's orders dated 6/5/01, the nurses should have given no regular insulin, but instead gave 2 units. The blood sugar at dinner on 7/21/01 was recorded as 179. Based on the physician's orders dated 6/5/01,	F 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 426	Continued From page 24 the nurses should have given no regular insulin, but instead gave 2 units. The blood sugar at dinner on 7/24/01 was recorded as 249. Based on the physician's orders dated 6/5/01, the nurses should have given 2 units of regular insulin, but instead gave 4 units. The blood sugar at dinner on 7/26/01 was recorded as 180. Based on the physician's orders dated 6/5/01, the nurses should have given no regular insulin, but instead gave 2 units. The blood sugar at dinner on 7/30/01 was recorded as 200. Based on the physician's orders dated 6/5/01, the nurses should have given no regular insulin, but instead gave 2 units. Resident 42 also had orders to receive Lopressor 50 mg by mouth twice a day, but to hold it for a systolic blood pressure below 100, a diastolic blood pressure below 50 or a heart rate below 60. On 7/26/01, at noon, the nurse recorded the blood pressure of resident 42 to be 118/48. The Lopressor, an antihypertensive, was not held as ordered for that day. 3. Resident 58 was an 81 year old male admitted to this facility with diagnoses of Parkinsonism, diabetes, glaucoma and malignant neoplasm of the prostate. Resident 58 had physician's orders, written 2/18/01, for Fosamax 70 milligrams, every thursday, thirty minutes before his morning meal, for osteoporosis. Resident 58, also, had physician's orders, written 9/28/00, for aspirin 325 milligrams every day for pain. The resident had a physician's order, written 2/6/01, for a mechanical soft diet related to dysphagia	F 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 426	Continued From page 25 (difficulty swallowing) and ill fitting dentures. Findings include: Review of resident 58's medical record, revealed that when the physician's order for Fosamax was written on 2/18/01, the order stated to give Fosamax 70 milligrams, every thursday, thirty minutes before his meal, and that the aspirin, 325 milligrams, should be held the day the Fosamax was given and the day after. Review of resident 58's medication administration records revealed that the facility had scheduled the Fosamax for 6:00 AM on the days it was administered. The facility had scheduled the aspirin for 8:00 AM each morning. Continued review revealed that the medication administration records documented that, on several occasions, the Fosamax and the aspirin were administered on the same day. The medication administration record documented that, on several occasions, the aspirin was not consistently held the day after the Fosamax was administered. April, 2001--aspirin was administered 8 of 8 days that it should have been held May, 2001--aspirin was administered 4 of 8 days that it should have been held June, 2001--aspirin was administered 9 of 9 days that it should have been held July, 2001--aspirin was administered 6 of 8 days that it should have been held On 8/2/01, a telephone interview was conducted with the medical director of the facility, the physician responsible for resident 58's medical care. He was questioned concerning the reason for the order written for aspirin to be held the day of and the day	F 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 426	Continued From page 26 after the Fosamax was administered. The physician stated that if resident 58 received the Fosamax and aspirin simultaneously, he (resident 58) would be at risk for esophageal inflammation. The physician also stated that because resident 58 had dysphagia, he would be at a higher risk for complications.	F 426		
F 514 SS=E	483.75(l)(1) ADMINISTRATION The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. This REQUIREMENT is not met as evidenced by: Based on record review, the facility did not maintain clinical records on each resident in accordance with accepted professional standards and practices that were complete or accurately documented as evidenced by the lack of documentation of bowel movements or implementation of the bowel protocol. 2 of 17 sample records and 2 of 16 randomly selected supplemental [ADL] activity of daily sheets were reviewed. Each of these residents had documentation in the [CNA] certified nurse aide ADL sheets which reflected that they did not have a [BM] bowel movement for 10 or more days. A review of the medication sheets, nurses notes and doctor orders revealed that there was no documentation of intervention or implementation of the bowel protocol which was in accordance with professional standards and set up by the facility. Residents: 20, 42, 45, 54. Findings include:	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 514	Continued From page 27 A review of the facility's policy and procedures for the bowel program stated that if a resident had no bowel movement for three days the nurse was to: 1. Start by giving the resident 30 cc's of Milk of Magnesia (unless the resident was on dialysis). If there were no results: 2. Give a dulcolax suppository. If there were no results: 3. Give a ready to use cleansing enema. If there were no results: 4. Ask the physician for further orders. 5. Document the results in the nursing notes and place the resident on alert charting to follow up on constipation and effectiveness of their individual bowel program. 6. Notify the physician of the bowel program that was the best for this resident. If constipation was frequent the nurse was to ask for a regular medication which would be indicated (i.e. Colace 100 milligrams every day for constipation). Addendum (added during this survey process)- If the resident was independent with toileting, an appropriate assessment was to be done every third day of bowel sounds, abdominal distention etc.. Resident 20 was an 80 year old male with the diagnoses of Bell's Palsy, cerebral vascular accident, dementia with delusional features, aphasia and diabetes. A record review of the CNA ADL sheet dated July of 2001 was done on 8/6/01. Starting from the 15th to the 26th there were no bowel movements documented. This accounted for 11 days. There was no documentation by the nurse that this had been addressed.	F 514	Resident #20: This resident was assessed by nursing for any concerns related to constipation. Documentation on CNA flow sheet is checked every shift by the R.N. Supervisor or designee to ensure that the residents bowel movements are being documented accurately. The bowel policy and procedure is being initiated and followed when indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 514	Continued From page 28 A record review was done on 8/6/01 of the medication record, physician orders, nurses notes and care plan which revealed that the bowel program policy and procedures were not documented as being implemented by the facility staff. Resident 42 was a 68 year old male with the diagnoses of cerebrovascular disease, diabetes, malignant neoplasm of prostate, coronary artery disease, post stroke hemiparalysis and hypertension. A record review of the CNA ADL sheet dated July 2001 was done on 8/6/01. Starting from the 13th to the 25th there were no bowel movements documented. This accounted for 12 days. There was no documentation by the nurse that this had been addressed. A record review was done on 8/6/01 of the medication record, physician orders and nurses notes which revealed that the bowel program policy and procedures were not documented as being implemented by the facility staff. Resident 45 was a 74 year old male with the diagnoses of spinal muscular atrophy and aphasia. A record review of the CNA ADL sheet dated July of 2001 was done. Starting from the 11th to the 23rd there were no bowel movements documented. This accounted for 12 days. There was no documentation by the nurse that this had been addressed. A record review was done on 8/6/01 of the medication record, physician orders and nurses notes which revealed that the bowel program policy and procedures were not documented as being	F 514	Resident #42: This resident was assessed by nursing for any concerns related to constipation. Documentation on CNA flow sheet is checked every shift by the R.N. Supervisor or designee to ensure that the residents bowel movements are being documented accurately. The bowel policy and procedure is being initiated and followed when indicated. Resident #45: This resident was assessed by nursing for any concerns related to constipation. Documentation on CNA flow sheet is checked every shift by the R.N. Supervisor or designee to ensure that the residents bowel movements are being documented accurately. The bowel policy and procedure is being initiated and followed when indicated. Resident # 54: This resident was assessed by nursing for any concerns related to constipation. Documentation on CNA flow sheet is checked every shift by the R.N. Supervisor or designee to ensure that the residents bowel movements are being documented accurately. The bowel policy and procedure is being initiated and followed when indicated.	

8/30/01

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. BUILDING _____ B. WING _____	8/6/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTAH STATE VETERANS NURSING	700 FOOTHILL BLVD SALT LAKE CITY, UT 84113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 514	Continued From page 29 implemented by the facility staff. Resident 54 was an 84 year old female with the diagnoses of coronary artery disease, congestive heart failure, depression, generalized weakness, insomnia and anxiety. A record review of the CNA ADL sheet dated July 2001 was done on 8/6/01. Starting from the 12th to the 23rd there were no bowel movements documented. This accounted for 11 days. There was no documentation by the nurse that this had been addressed. A record review was done on 8/6/01 of the medication record, physician orders and nurses notes which revealed that the bowel program policy and procedures were not documented as being implemented by the facility staff.	F 514	All residents CNA flow sheets are being check at the end of each shift by the R.N. Supervisor to ensure accuracy and completion especially in the area of elimination to ensure that the bowel policy and procedure is initiated and followed if indicated. If prior to the documentation check, the CNA notes this will be the third day in a row that the resident has not had a bowel movement, the CNA will bring this to the attention of the unit nurse and the bowel policy and procedure will be initiated and followed is indicated. When the R.N. Supervisor checks the CNA flow sheet for elimination at the end of each shift, he/she will make a list of the residents who have not had a bowel movement in three days. He/she will then give this list to the unit nurse as a cross check to make sure the bowel policy and procedure has been initiated and followed if indicated. The night shift R.N. Supervisor is auditing all ADL's on the CNA flow sheet on a nightly basis especially in the area of elimination. Any concerns are communicated through report to day shift unit nurses. This will be monitored at least monthly by the A.D.O.N., to ensure that the CNA flow sheets are complete and accurate, and that the bowel policy and procedure was initiated and followed when indicated. The A.D.O.N. will monitor this system for any trends or concerns, and will bring this as part of her report in the monthly Q.A. Meeting. Lead Person: A.D.O.N. and R.N. Supervisor.	10-01-01