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

PRINTED: 08/17/2006
FORM APPROVED
OMB NO. 0938-0391

Tammy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465115	A. BUILDING ______ B. WING ______	08/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON TERRACE HEALTH SVS	400 EAST 5350 SOUTH OGDEN, UT 84405

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F 252 SS=B	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview with the facility maintenance supervisor, it was determined that the facility did not provide a safe, functional, sanitary and comfortable environment for residents. Findings Include: 1. The rocking chair in room 212 had many large and small stains on the seat and arms. 2. The wall in room 212 (beside bed A) had 15 chips and scratches in the paint. 3. The wall just inside the door, in room 233 had a hole in the sheet rock that was 3 inches long and ½ inch wide and a section that was 1-2 inches wide by 8 inches long that was missing paint. 4. The wall just inside the door in room 225 had various areas of chipped paint. 5. The facility had 8 bent screens located in the following areas: 1- Front courtyard 1- Back courtyard 2- South side of building 4- North side of building 6. The facility had 6 missing screens located in the following areas: 2- Front conference room 2- Assistive dining room 2- Front courtyard	F 252	F252 The "rocking chair" in room 212 was replaced on 8/29/06. The wall in room 212 was patched on 8/30/06 and will be painted on 8/31/06. The wall in room 233 was patched on 8/25/06 and will be painted on 8/31/06. The wall in room 225 was patched on 8/25/06 and will be painted on 8/31/06. The 8 bent screens located in the front courtyard, back courtyard, south side of the building and north side of the building were replaced on 8/21/06. The 6 missing screens located at the front conference room, assistive dining room, and front courtyard were replaced on 8/11/06. All residents have the potential to be affected by this practice. The director of plant operations checked all windows for missing or bent screens on 8/21/06. Any other bent or missing screens were replaced at this time. The Director of Plant Operations will conduct monthly environmental rounds to ensure the residents are in a comfortable and homelike environment. During these rounds, the Director of Plant Operations will check interior walls as well as screens and rocking chairs/recliners. There will be an all staff inservice on 9/8/06. At this inservice the Director of Plant Operations will review the location and appropriate use of the maintenance log for reporting bent or missing screens, stained chairs, chipped paint, and holes in sheet rock as well as other maintenance related issues.	

9/6/06 POC acceptable completion date 9/22/06 Bowman RD

Utah Department of Health
receipt 761364
AUG 31 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	8/31/06

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

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F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations of four facility nurses during medication administration, interviews and record review, it was determined the facility had a medication error rate of 10%. Five medication errors were observed out of 48 opportunities for error. Errors included wrong dose, wrong medication, missed medication, and wrong time. Resident identifier's 18, 19, 20. Findings included: Nurse 1 was observed on 8/7/05 at 8:05 AM, as she administered medications to resident 18. 1. Resident 18 had a physician's order to receive a multivitamin with minerals every day. Nurse 1 administered resident 18's scheduled 8:00 AM medications except the multivitamin with minerals. At 2:30 PM, nurse 1 was asked about the vitamins with minerals. The nurse had not been able to locate the medication in the medication cart. The nurse then obtained a new bottle of vitamins and a new bottle of vitamins with minerals from the nurse's station to put in the cart. 2. Resident 18 had a physician's order to receive	F 332	F252 (cont) The maintenance log and the results of the environmental rounds will be reviewed monthly at quality assurance meetings. Responsible Party: Director of Plant Operations F332 Nurses 1, 2, and 4 were educated on the importance of providing all medications as ordered. The "5 rights" (right resident, medication, dose, route, and time) were reviewed with nurses 1, 2 and 4. All residents have the potential to be affected by this deficient practice. The Director of Nursing or a designated nurse will review all residents medications monthly to ensure medications such as Reglan and Nexium are scheduled 30 minutes before meals. Nurses were inserviced on the "5 rights" (right resident, medication, route, dose, and time) on 8/25/06. The nurses also reviewed a video titled: Preventing Medications Errors. The Director of Nursing or another designated nurse will monitor 2 random medication passes per week for 2 weeks, and then 1 random medication pass per week for 1 month. Results of the medication review and medication pass observations will be reported and discussed at monthly quality assurance meetings.	9/23/06

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F 332	Continued From page 2 Phenergan 12.5 mg (milligrams) every 4 to 6 hours when needed for nausea. Resident 18 asked for Phenergan. Nurse 1 was unable to locate the medication in the medication cart. The nurse obtained Phenergan 25 mg from the PIXUS machine (dispenses some medications) and administered the entire dose to resident 18. Nurse 2 was observed on 8/7/05 at 9:10 AM, as she administered medications to resident 19. 3. Resident 19 had a physician's order to receive a multivitamin with minerals every day. Nurse 2 was observed to administer a vitamin without minerals to resident 19. 4. Resident 19 had a physician's order to receive Nexium 40 mg every day half an hour before breakfast. Breakfast was served at 7:30 AM. Resident 19 received the Nexium at 9:10 AM, more than an hour after he had finished his breakfast. Nurse 4 was observed on 8/8/06 at 8:10 AM as she administered medications to resident 20. 5. Resident 20 had a physician's order for Reglan 10 mg to be given before meals for gastroesophageal reflux. Nurse 4 administered the Reglan to resident 20 while the resident was eating breakfast. The PharMerican 2006 Drug Handbook was located at the nurses' station. The handbook revealed Reglan needed to be administered half an hour before meals.	F 332	F332 (cont) Responsible Party: Director of Nursing Services	9/23/06

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F 367 SS=E	483.35(e) THERAPEUTIC DIETS Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on meal observation, record reviews, and interview, it was determined that the facility did not provide therapeutic diets as prescribed by the attending physician, for one of 17 sampled residents, with a gluten free diet, and for all facility residents with a pureed diet. Resident identifier 17. Findings include: Resident 17 was admitted to the facility on 7/26/06 with diagnoses which included, post operative exploratory laparotomy, thrombocytopenia, and cystadenoma. A review of resident 17's medical record was completed on 8/8/06. Dietary progress notes revealed that on 8/7/06, resident 17 told the dietitian about her gluten intolerance. It was documented on a diet order dated 8/7/06 that resident 17 was to receive a "gluten free diet, and no milk products." It was documented on 8/8/06 on a change of diet form that resident 17 was to receive a "gluten free diet, and no milk products." On 8/9/06 at 8:15 AM resident 17 was observed with her breakfast tray, in her room. The tray contained oatmeal and pancakes.	F 367	F367 The Administrator and Food Services Manager reviewed the meal menu with resident 17 at breakfast time on 8/19/06 and discussed appropriate meals for a gluten and lactose free diet. The Food Services Manager replaced resident's breakfast with fresh fruits per resident's request. Any resident on a therapeutic diet has the possibility of being affected by this deficient practice. On 8/29/06 an inservice was given by the Registered Dietician to the dietary staff. This inservice included the elements of a gluten free diet and giving properly pureed fruit to those residents on a pureed diet. Written information was also provided. There will be an all staff inservice on 9/8/06 to educate staff about the importance of checking resident tray cards prior to serving residents their meals. This practice will help to ensure residents receive their appropriate therapeutic diet. The Food Services Manager will observe 3 meals per week for eight weeks to ensure that the dietary staff adheres to the gluten free diet and properly pureed desserts. The food services manager will report his findings to the Administrator. The Registered Dietician will observe 1 meal per month to ensure that the gluten free diet and pureed desserts are served properly. The Registered Dietician will report finding to the Administrator. Findings will also be reviewed in monthly quality assurance meetings.	

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F 367	Continued From page 4 On 8/9/06 resident 17 was interviewed. She stated that she wasn't supposed to receive the oatmeal and pancakes because she is allergic to gluten. She went on to say the facility knew she had this allergy, but they continue to bring her food that contains gluten. Review of the facility tray card revealed that resident 17 was to receive a gluten free diet. Observation at the lunch meal on 8/8/06 revealed fruit cocktail was served for dessert. It was observed that each of the residents who had puree diets received the fruit cocktail in solid form. The Food Service Manager (FSM) was interviewed on 8/9/06 at 12:30 PM. The FSM stated the fruit cocktail should have been pureed and the solid fruit was served in error.	F 367	F367 (cont) Responsible Party: Food Services Manager	9/23/06
F 371 SS=B	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not store and prepare food under sanitary conditions.	F 371	F371 All open and undated items were discarded by the end of the day on 8/9/06. The dietary manager conducted a review of all food items on 8/9/06, ensuring all food containers were sealed and properly dated. All residents have the potential to be affected by this deficient practice. On 8/9/06 an inservice was given by the Registered Dietician to the dietary staff on proper storage and dating of food items. Written information was also provided.	

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F 371	Continued From page 5 Findings included: Observations in the kitchen on 8/7/06 at 6:16 AM revealed the following: In the Reach in four door refrigerator: 1. A stainless steel container covered with plastic wrap, on the top shelf, that contained a lunch meat, had no date or label. 2. An open can of diet coke on top shelf. 3. 4 sandwiches in plastic, not labeled or dated. 4. An 8 pound carton of potato salad, opened but not dated. In the Walk in freezer: 5. A bag of rib shaped pork wide open, exposing meat to freezer burn. Above the sink: 6. An open bag of brown sugar, not labeled or dated. Observation in the kitchen on 8/8/06 at 7:35 AM revealed: In the Reach in four door refrigerator: 7. An 8 pound carton of potato salad, opened but not dated. 8. An open can of coke on the middle shelf.	F 371	F371 (cont) The Food Services Manager will conduct a review of the kitchen for properly stored and labeled food on a daily basis. Findings will be reported to the Administrator daily in the Department Head Meeting. The Administrator will complete weekly audits of the kitchen checking for appropriate dating and storage of food products. The Registered Dietician will conduct monthly reviews to ensure all food items are dated and stored properly. Findings will be reported to the Administrator. All findings will be discussed in the monthly quality assurance meeting. Responsible Party: Food Services Manager	9/23/06

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F 426 SS=D	483.60(a) PHARMACY SERVICES - PROCEDURES 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. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined the facility did not assure the accurate dispensing of medications for 1 of 7 residents observed during medication administration. Nurses were administering a medication dosage different than the dosage they were documenting. Resident 16. Findings included: Nurse 4 was observed on 8/8/06 at 8:10 AM as she administered medications to resident 16. Nurse 4 administered calcium 500 mg to resident 16, but documented the resident received 600 mg. Resident 16 had been admitted to the facility 1/24/06. Resident 16's medical record was reviewed on 8/8/06. The Medication Administration Records (MARs) for resident 16, dated June 2006 and July 2006, had been documented as calcium 600 mg to be given three times daily. Further review of the MARs revealed the facility nurse's had been documenting that resident 16 had been receiving	F 426	F426 The Calcium order in resident 16's medication record was corrected on 8/18/06 to show the actual ordered dose of Calcium (500 mg). All residents have the potential to be affected by this deficient practice. The Director of Nursing Services conducted an inservice on 8/25/06 reviewing the "5 Rights" (right resident, medication, dose, route, and time). Nurses were instructed to carefully check medication orders before administering medications. A video titled Preventing Medication Errors was also reviewed with the nurses on 8/25/06. The Director of Nursing Services or an appointed nurse will monitor 2 random medication passes per week for 2 weeks followed by 1 random medication pass per week for 1 month. Results will be reviewed monthly in the quality assurance meeting. Responsible Party: Director of Nursing	9/23/06

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F 426	Continued From page 7 600 mg of calcium three times daily. Resident 16's medications were observed to be in 500 mg doses. Further review revealed the medication did not come in 600 mg doses. Resident 16's initial physician's order for the resident's medications included calcium 500 mg three times daily. The physician's recertification of orders, dated July 2006 revealed the initial order had been transcribed as 600 mg of calcium. Nursing obtained a clarification order during survey to reveal resident 16 was to get 500 mg calcium three times daily.	F 426		
F 454 SS=E	483.70 PHYSICAL ENVIRONMENT The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review it was determined that the facility did not maintain the physical environment of the facility to protect the safety of residents and the public. Specifically, 19 of 58 resident bedroom doors were very difficult to open from the inside creating a safety hazard in an emergency situation. The following room doors were found to be very difficult to open from the inside: 119, 115, 123, 129, 128, 126, 124, 225, 229, 235, 239, 228, 216, 212, 208, 201, 203, 209, and 217.	F 454	F454 On 8/8/06 a life safety surveyor determined that the listed doors except 208 did not present a safety problem. On 8/10/06 during a life safety survey, another surveyor also did not find there was a problem with the resident's doors. The door for room 208 was replaced 8/28/06. New doors have been ordered for rooms 201, 203, 209, 212, 216, 228, 229, 235, 231, 239, 119, 123, and 128, as these rooms were determined to be slightly more difficult to open than the others. These doors will be installed upon arrival to the facility. Doors will be replaced while placing a priority on residents with physically limiting medical conditions. Appropriate adjustments were made to the other doors listed under this deficiency.	

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F 454	Continued From page 8 Findings include: On 8/8/06 at 8:10 AM room 208 was observed to have a washcloth placed in between the door frame and the door, preventing it from closing. Staff Member 1 was asked why the washcloth was placed there. Staff Member 1 stated that if you shut the door without the rag in the door then you cannot open the door without pounding on the handle and that the residents cannot open it at all. Staff Member 1 stated that since the residents in room 208 are a married couple they want the door shut. An interview was held with the Maintenance Supervisor on 8/8/06 at 10:15 AM in room 208. He stated that the door was warped from the air conditioner and that a new one had been ordered. A copy of the order form was requested and the Maintenance Supervisor stated that it had not been ordered but had been submitted to the corporate office for approval to purchase and had not yet been approved. An interview was held with the Maintenance Supervisor on 8/8/06 at 10:40 AM and he stated that about 2 weeks ago the handle on the door for room 208 was broken and that he had fixed it. The Maintenance Supervisor said he had not heard any complaints about the door on 208 since then. On 8/8/06 at 12:00 PM a review of the facilities maintenance work orders was completed. A maintenance work order for room 208 was completed on 5/24/06, the section labeled " DESCRIPTION OF REPAIRS NEEDED " was completed and read as follows " resident	F 454	F454 (cont) All residents have the possibility for being affected by this practice. The Administrator met with the resident council on 8/29/06 to discuss possible issues with the facility doors as well as to discuss the proposed plan of corrections. All members in attendance at resident council meeting denied having difficulties opening doors. The Administrator encouraged residents to report any problems with doors to the Administrator or to have the staff write maintenance issues in the "maintenance log". The Director of Plant Operations will conduct monthly environmental rounds checking each resident room door and take appropriate actions. The Director of Plant Operations will report finings monthly to the quality assurance team. Responsible Party: Director of Plant Operations	9/23/06

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F 454	Continued From page 9 expressing need for new latch on door, states it is to difficult to open at times. " The section labeled " TYPE OF REPAIRS MADE " was completed and read " adjusted handle " . The Maintenance Supervisor, Staff Member 1 and a surveyor entered room 128 on 8/8/06 at 1:25 PM. The door to room 128 was closed, neither the Staff Member nor the Surveyor could open the door to exit. The Maintenance Supervisor stated he had been unaware of a problem with room 128 ' s door. An interview was held with Staff Member 1 at 1:30 PM on 8/8/06. Staff Member 1 stated that she was unaware of the problem with the door on room 128 because that door is never shut. Staff Member 1 stated that the door on room 208 had been that way for 1-2 months and that she had not completed a maintenance work order because everyone knew about it, including her supervisor and the maintenance supervisor. On 8/8/06 at 4:40 PM a loud pounding noise could be heard in the 100 hall. A Certified Nurses Aide (CNA) was inside room 117 and could not open the door to get out. On 8/9/06 beginning at 8:45 AM, a tour of the facility was made to determine which doors were difficult to open. The following comments and observations were made: A. Resident in room 119 stated " I can't get my door open if not forced. " B. Resident in room 124 stated " People have a hard time with it. " (Referring to her door) C. Asked resident in room 225 to open his door	F 454		

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F 454	Continued From page 10 from inside, he tried several times and could not open it. D. Resident in room 229 stated " DON'T " CLOSE IT TIGHT OR YOU WON'T BE ABLE TO OPEN IT " (Referring to her door) E. Resident in room 231 sated " It's pretty hard to open. " (referring to his door) F. Asked resident in room 228 to open her door from the inside, she tried but could not do it on her own. G. Resident in room 224 stated " Can't open the door very well. "	F 454		