acceptable POC 7116/02 =

PRINTED: 6/28/

|                          | IMENT OF HEALTH<br><u>H CARE FINANCING</u>   |  | ICES 0   | adende  | um datio  | SSLINDE A  | 20 FORM   | I APPROVE<br>2567        |
|--------------------------|--|--|--|---|---|--|---|--------------------------|
| STATEMEN                 | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER<br>IDENTIFICATION NUM   |  | (X2) MUL<br>A. BUILDI   | TIPLE CONSTRUCTIO   |  | (X3) DATE SI<br>COMPLE  |                          |
|                          |  | 46A064   |  | B. WING_  |   |  | 6/2   | 20/02                    |
| NAME OF P                | ROVIDER OR SUPPLIER  |  | STREET AD  | DRESS, CITY, S  | TATE, ZIP CODE  |  |   |                          |
| FAIRVIE                  | EW CARE CENTER - V   | VEST   |  | T 700 SOUT<br>KE CITY, U  |   |  |   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEEDED BY<br>SC IDENTIFYING INFORMA  | FULL   | ID<br>PREFIX<br>TAG   | (EACH CO  | DER'S PLAN OF CORRECTI<br>RRECTIVE ACTION SHOU<br>ERENCED TO THE APPRO<br>DEFICIENCY)  | LD BE   | (X5)<br>COMPLETE<br>DATE |
| F 164<br>SS=D            | The resident has the reconfidentiality of his records.  Personal privacy inclustreatment, written and personal care, visits, a resident groups, but it to provide a private in Except as provided in the resident may appropersonal and clinical the facility.  The resident's right to clinical records does transferred to another release is required by  This REQUIREMEN Based on observation that the facility did not treatment, insulin admits and privace in the resident was a second control of th | right to personal privace or her personal and climate and climate and accommodations, it telephone communicate and meetings of family his does not require the room for each resident. In paragraph (e)(3) of the overor refuse the release records to any individual or refuse release of personot apply when the resident health care institutions law.  This not met as evident and interview, it was controlled to provide privacy during ininistration, for 1 of 10 | medical medical ations, and e facility is section, se of all outside onal and ident is correcord ced by: | F 164 OK June Addition Notice | This facility we that each residence personal privations or her personal records. Including All Residents and 19, will be and treatment was provided on 6-21-02. Indirectly by the and by Departing Resident Rolling issues or trending that the same of the same | 0(d)(3) FREE CH<br>vill continue to as<br>dent has the right<br>acy and confident<br>sonal and clinical<br>ding Medical Tre<br>, including reside<br>the provided their it<br>is in privacy. Inse<br>to all Licensed N<br>his will be monited to all Licensed N<br>this will be monited to all Licensed Nurse<br>the Director of Nurse<br>the Director of Nurse<br>the Director of Nurse<br>the Quality Assura | sure to iality of atment.  nts 3 nsulin ervice furses ored sing, ng the Any d and | 4/21/02                  |
|                          | Findings include: On 6/18/02, during th from 9:13 AM to 9:50   | e medication pass obsect insulin to 9 residents  | ervation<br>e was  |   | Ut  | 508 00 5<br>ah Dept. of He<br>JUL 1 1 2002   | w <sup>®</sup><br>alth  |                          |

LABORATORY DIBLOTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Resident 3 was in the day room. At 9:25 AM, the

facility/nurse informed resident 3 he was going to give

Bur. of Medicare/Medicaid Prog.

Certification and Res. Assessment

(X6) DATE

7-11-2002

If continuation sheet 1 of

Administratar Any deliciency 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 aft such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

|                          |  |   |                               |                          |   | 1                      | 2307                     |
|--------------------------|--|---|-------------------------------|--------------------------|---|------------------------|--------------------------|
|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER<br>IDENTIFICATION NUM                                  |                               | (X2) MUL<br>A. BUILDI    | TIPLE CONSTRUCTION  NG  | (X3) DATE SU<br>COMPLE |                          |
|                          |  | 46A064  |                               | B. WING                  |   | 60                     | 20/02                    |
| NAME OF P                | ROVIDER OR SUPPLIER  | 1   | STREET ADI                    | DRESS, CITY, S           | STATE, ZIP CODE   | 014                    | .0/02                    |
| FAIRVIE                  | EW CARE CENTER - V   | WEST  | 876 WEST                      | F 700 SOUT<br>KE CITY, U | Н   |                        |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEEDED BY<br>LSC IDENTIFYING INFORMA  | FULL                          | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)   | ULD BE                 | (X5)<br>COMPLETE<br>DATE |
| F 164                    | her insulin. The facil<br>3's blouse, exposing hadminister the insulin   | lity nurse then lifted up<br>her abdomen and proce<br>n. At the time there we | eeded to<br>re 9 other        | F 164                    | F-223 - 483.13(b) ABUSE   |                        |                          |
|                          | Residents in the day room, 3 men and 6 women.  Resident 19 was in the hallway by the nursing stat.  At 9:30 AM, the facility purse was observed to |   | ien.                          | į                        | This facility will continue to a  |                        | į                        |
|                          |  |   | -4-43                         |                          | that each resident is free from   |                        | İ                        |
|                          |  |   |                               | ļ                        | sexual, physical, and mental a  |                        | i<br>I                   |
|                          |  | !   | corporal punishment, and invo |                          | I   |                        |                          |
|                          |  |   | İ                             |                          |   |                        |                          |
|                          | observed in the hallw  | vay at the time the facili  |                               |                          | A new abuse policy an   | ıd                     |                          |
|                          | administered resident 19's insulin.  During a resident group interview on 6/18/02 at 2:00  |   |                               |                          | procedure was put into place of   | on 7-01-               |                          |
|                          |  |   |                               | !                        | 02. Stated in the policy and p  | rocedure               |                          |
|                          |  | that it bothered her to   |                               | [                        | is "After investigation is comp   | plete, the             | l<br>I                   |
|                          | insulin given to her in the day room. She stated, "How   |   |                               |                          | administration will document  |                        |                          |
|                          | would you like it?"  | ,   | · /                           |                          | summary of its findings as to   | whether                |                          |
|                          | <br> -   |   | 1                             |                          | the alleged abuse was verified  |                        |                          |
| !                        | i<br>i   |   | !                             | į<br>i                   |   |                        |                          |
| F 223                    | 483.13(b) ABUSE  |   |                               | F 223                    | which were notified at the beg  | ginning                |                          |
| SS=D                     |  |   |                               | OK THUM                  | report its findings to the agend<br>which were notified at the beg<br>of the investigation. The facil<br>in the case of all substantiated<br>involving a staff member, im | lity will,             |                          |
|                          |  | right to be free from ver<br>mental abuse, corporal                           | rbal,                         | ad Winling               | in the case of all substantiated  | abuse                  |                          |
| !                        | punishment, and invol  |   | i                             | domin                    | involving a staff member, imr   | mediately              |                          |
|                          | punionini, and in, o   | iuitui y seciusion.   |                               | 300                      | terminate that employee and r   |                        |                          |
|                          | This REQUIREMEN  | T is not met as evidence  | ced by:                       |                          | appropriate law enforcement   |                        |                          |
|                          | Based on interview w   | rith the facility administ  | trator and                    | 1                        | regulatory agencies."   |                        |                          |
|                          | review of a facility "R  | Resident Abuse Investig   | gation                        |                          | Regular and ongoing inservice   | e has                  |                          |
| Ì                        |  | nined that the facility a   |                               |                          | been scheduled for all staff.   | • 11                   |                          |
|                          |  | (a) to continue employments   |                               |                          | The facility will maintain an   | ongoing                |                          |
|                          |  | to provide direct resider<br>determined that the NA                           |                               |                          | log of all reported incidents the   |                        |                          |
|                          | physically abused a re   |   | liau                          |                          | potentially abusive. This log   |                        |                          |
|                          | • •  | ,   | i                             |                          | include date, type of incident,   |                        |                          |
|                          | Findings include:  |   |                               |                          | of those involved, injuries, an   | nd agency              |                          |
|                          | An interview was held  | d with the facility admir   | nistrator                     |                          | reported to. A separate section   | i                      |                          |
|                          |  | M. During the interview   |                               |                          | include copies of incident rep  | ort,                   |                          |
|                          |  | hat the facility had inve<br>ed abuse between an NA                           |                               |                          |   |                        |                          |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (XI) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |  |  | (2) MULTIPLE CONSTRUCTION  BUILDING  WING  |   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|--|--|--|---|-------------------------------|--|
|   |  | 46A064   |  |  |  | 6/  | 20/02                         |  |
|   | ROVIDER OR SUPPLIER  EW CARE CENTER - V  | VEST   | 876 WEST   | ADDRESS, CITY, STATE, ZIP CODE ST 700 SOUTH AKE CITY, UT 84104     |  |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            |  |  |  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  |   |                               |  |
| F 223   | had investigated the a that the alleged abuse further stated that the by Adult Protective S substantiated.  During the same interthat the NA had been months prior to the inthe training to obtain administrator further sinvestigation the NA stated that when the in NA was allowed to recare for resident 18. NA worked in the fact | ninistrator stated that the lileged abuse and had do had occurred. The adrincident had been investigated and had been wiew, the administrator employed in the facility cident, and had just conhist certification. The | etermined ministrator estigated stated y for 3 mpleted ork. She eted, the eted, the et provide d that the est then | F 223  | investigative reports of those in and witnesses, notification agen and any other information.  Any trends or issues will be add in staff, group, and individual trand reviewed at the Quality Assurance Meeting.   | cies,<br>Iressed                              | 7/01/02                       |  |
|   | Report", dated 3/5/02, AM. The report docu assistant was changing 18 swore at the NA are hit him back in the short A review of an "Emp. Behavior/Action Notic on 6/17/02 at 10:35 A the NA, "admitted to   | ce" form dated 3/5/02 v.M. The form document of Administrator the heart Stated he did it without   | at 10:30 ursing I resident IA. NA t."  was done uted that had  |  | F-248 - 483.15(f)(1) QUALITY LIFE  This facility will continue to profor an ongoing program of activ designed to meet, in accordance the comprehensive assessment, interests and the physical, mental psycho-social well-being of each resident  There will be a monthly calendary | ovide<br>ities<br>with<br>the<br>al, and<br>h |                               |  |
| F 248<br>SS=E                                       | 483.15(f)(1) QUALIT The facility must provactivities designed to r   | Y OF LIFE  ide for an ongoing progneet, in accordance wit  | gram of th the   | F 248<br>Ox Jandum<br>Ox Jalum<br>Ox Jalum<br>Ox Jalum<br>Ox Jalum | contains at least 4 group activitiday on Monday through Friday   |   | 8 Per                         |  |

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | I(AI) FROVIDENSUFFLIENC  |   |  | LTIPLE CONSTRUCTION<br>DING  | (X3) DATE S<br>COMPLI                         |                          |  |
|--------------------------|---|--|---|--|--|---|--------------------------|--|
|                          |   | 46A064   |   | B. WING  |  | 6/  | 20/02                    |  |
| NAME OF P                | ROVIDER OR SUPPLIER   |  | STREET ADD  | RESS, CITY,  | STATE, ZIP CODE  |   | ZU/UZ                    |  |
| FAIRVIE                  | W CARE CENTER -   | WEST   |   | 876 WEST 700 SOUTH<br>FALT LAKE CITY, UT 84104       |  |   |                          |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEEDED BY<br>LSC IDENTIFYING INFORMA | FULL  | ID<br>PREFIX<br>TAG                                  | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIECT OF THE APPROPRIE | OULD BE                                       | (X5)<br>COMPLETE<br>DATE |  |
| F 248                    | comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observations, a resident group interview, and interview with the facility recreation employee, it was determined that the facility did not provide an activity program that met the interests of the residents. This had the potential to affect all residents in the facility.  Findings include:  1. A review of the facility activity calender for June 2002, was done on 6/17/02. The calender included activities such as glamour, snack social, grocery orders, reading, stretch/walk, religious services, current events, and bingo. During the week, there were no activities schedule included Snack Social at 10:00 AM, Relaxation at 3:00 PM, and a television program at 7:00 PM. On Sunday the schedule included Word Search at 9:30 AM, Music at 12:00 PM, religious services at 2:30 PM, and resident choice at 7:00 PM.  Deservation of the glamour activity was scheduled at 10:00 AM. Observation of the glamour activity was done on 6/17/02, and 6/18/02. The activity involved the recreation employee combing and curling residents hair and applying cologne.  The glamour activity was scheduled at 10:00 AM. Observation of the snack social was done on 6/17/02, 6/18/02, and 6/19/02. The activity involved the residents being provided with a snack in the dining room. Snacks were also distributed to the residents in the rest of the facility who were not in the dining room. In the dining room. In the thing room. |  | dar for vill be in ties on ies on ery list of the   | 8/01/0   |  |   |                          |  |
|                          |   |  | cluded<br>cery<br>ices,   |  | scheduled after the 3:00 time  | ams<br>weekly                                 | 8/01/02                  |  |
| :                        |   |  | committee of recreation plant<br>committee implemented mon<br>this meeting the residents hel<br>elements of the calendar acco | cil sub-<br>ning<br>athly. In<br>p plan<br>ording to | 7/29/0   |   |                          |  |
|                          |   |  | oo AM. e on the sidents 10:00 one on involved the dining sidents in   |  | and placed with the resident of notes. As long as programs a realistic, they will be added to calendar the next month.  The grooming activity will be protocol. Will be for a self-est emphasis of "looking pretty", not be an ADL orientation, but geared towards self-esteem is related to ow one presents the   | council are to the teem It will at more ssues | 7/15/02                  |  |
| İ                        | c. The grocery order  | activity was scheduled   | on  | Facility ID:   | In this there will be separate   |   | ion sheet 4 of           |  |

|    |                        | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER<br>IDENTIFICATION NUM  |  | A. BUILDI                                |  | (X3) DATE S<br>COMPLE   |   |
|----|------------------------|--|---|--|--|--|---|---|
|    |                        |  | 46A064  |  | B. WING                                  |  | 6/:   | 20/02   |
|    |                        | ROVIDER OR SUPPLIER  W CARE CENTER - V   | VEST .  | 876 WEST   | PRESS, CITY, S<br>700 SOUT<br>KE CITY, U |  |   |   |
| ΡI | (4) ID<br>REFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEEDED BY<br>SC IDENTIFYING INFORMA   | FULL   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | JLD BE  | (X5)<br>COMPLETE<br>DATE  |
|    | F 248                  | recreation employee the residents.  d. The reading activity involved providing residents the e. The stretch/walk at 10:55 AM in the days the dayroom. Four of participating. The officipating is closed and appeared activity beginning, the around the facility to the employee stated, you say exercise."  f. The current events at 1:30 PM in the day was reading the news were eight residents the dayroom shortly a began reading the new g. The bingo activity PM in the dining room in the activity.  2. A resident group in 2:00 PM. Twelve resinterview. The reside program. Eight of the enough to do. The rethe evening and on the would like more out do.  3. Through out the second in the second i | ty was scheduled on 6/11 the recreation employed the residents were activity was observed on the residents were activity was observed on the residents were activity was observed on the residents were activity was observed on the residents were activity residents to the a "No one wants to compare to the recreation employee winvite residents to the a "No one wants to compare to the recreation employee to the recreation employee to the residents. In attendance. Two residents to them.  was observed on 6/17/m. Nine residents were involved in the residents stated they were every weekend. They stated they were every weekend. They stated | 17/02. ee laterial. 6/19/02 at esidents in lively heir eyes the went citivity. e when on 6/19/02 mployee There idents left loyee 01 at 2:35 involved (18/02 at the group he activity he was not bored in it they | F 248                                    | combs/brushes, make-up applied etc. for each individual packag separate bag. Combs and brushe cleaned after each use.  The social is restructured into a getting treats, but also stimulat activities as part of the social (trivia, discussion group, social and ice-breaker activities.)  The TR staff is currently involcourse geared towards program and obtaining the TRT license, will be completed July 14th. Stathen be on a structured experie per identified student training protocol, where the consultant work with her on providing a sprogram to meet the needs and interests of the residents. This include motivational technique both staff assistance and reside involvement, programming gethe different cognitive levels, understanding of the needs and interests regarding different diconditions and activity modified meet their needs and interests. The TR staff will be able to encomore residents out to activities activities will better meet their and interests. This should increase the treatment of the residents. This should increase activities will better meet their and interests. This should increase activities will better meet their and interests. This should increase activities will better meet their and interests. This should increase activities will better meet their and interests. This should increase activities will better meet their and interests. This should increase activities will be the meet their and interests. This should increase activities will be the meet their and interests. | ed in a hes will not only ting ie: tickler ved in a aming. This he will ence as will stronger less will es for ent ared to desabling cation to In this courage is and a needs | 7/20/02<br>Chaes<br>7/14/12-<br>7/14/12-<br>7/14/12-<br>0/30/02 |

involvement in the group programs.

The consultant will review the program monthly for variety and quarterly for cognitive level activity offerings.

8/1/02

Aides will have an in-service on the importance of having residents up and to activities, talking up the importance of the activities to the residents so that the number of residents in a program will increase.

8/15/02

Not every program is for every individual - but every individual should have a program that is geared for them. Therefore, each resident will be involved in at least 2 activities weekly either a group or 1 x 1 interventions of at least 20 minutes each. This will be documented in attendance logs and in 1 x 1 logs.

8/1/02

There will be a quarterly audit done by the Activities Director, to assure that the activity plan meets the needs and interests of the residents. The audit findings and activities calendars will be reviewed by the Quality Assurance Committee.

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |  | A. BUILDIN                    | IPLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED                                      |                          |  |
|---|--|--|--|-------------------------------|---|--|--------------------------|--|
|   |  | 46A064   |  | B. WING _                     |   | 6/2  | 0/02                     |  |
| NAME OF P   | ROVIDER OR SUPPLIER  |  |  |                               | TATE, ZIP CODE  |  |                          |  |
| FAIRVIE   | W CARE CENTER - V  | VEST   |  | T 700 SOUTH KE CITY, UT 84104 |   |  |                          |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEEDED BY SC IDENTIFYING INFORMA   | FULL   | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | JLD BE   | (X5)<br>COMPLETE<br>DATE |  |
|   | day room, sitting on to rooms, or wandering  4. An interview with member was done on she had only worked stated that she meets about the residents ar She stated that she had a individual basis. She group for men and had less cognitive individual basis are cognitive individual basis of a resident not less.  A facility must conduct of a resident not less. This REQUIREMEN Based on record revidual basis of the familian based on record revidual ba | in the facility recreation so the facility recreation so the facility recreation so the facility recreation so the facility for 2 moonce a week with her could the activities in the facility for 2 moonce a week with her could the activities in the facility to meet with respect to the stated she had not deals had difficulty working the stated she had not deals had difficulty working the stated she had not deals had difficulty working the stated she had not deals had difficulty working the stated she had not deals had difficulty working the stated she had not deals had difficulty working the stated she had not deals had difficulty working the stated she had not deals had difficulty working the stated she had not deals had difficulty working the stated she had not deals had difficulty working the stated she had not deals had difficulty working the stated she had not deals had difficulty working the stated she had not deals had difficulty working the stated she had not deals had difficulty working the stated she had not deals had difficulty working the stated she had not deals had difficulty working the stated she had not deals had difficulty working the stated she had not deals had difficulty working the stated she had not deals had difficulty working the stated she had not deal sh | in their  staff She stated inths. She consultant facility. sidents on veloped a ag with the  IT  sessment inths.  aced by: a an annual ast every  1/7/97 with avascular  iewed on juarterly juarterl | F 275  SIL TO DUM             | C-275 483.20(b)(2)(iii) RESIDE ASSESSMENT  This facility will continue condomprehensive assessment of a esident not less than once ever months.  A Significant Correction Annual Assessment was completed to a complete the Medical Records possible the Yearly and quarte MDS schedule for timely compand notify the Interdisciplinary The Director of Nursing and Dof Social Services will be respector assuring timely and accurate completion of the MDS.  All MDS audits and completion issues will be reviet the Quality Assurance Commit | y 12  n, and eted on erson erly oletion, Team. irrector onsible te | 7/9/2002                 |  |

CMS-2567L

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER<br>IDENTIFICATION NUM   |  | (X2) MUL<br>A. BUILD<br>B. WING | TIPLE CONSTRUCTION   | (X3) DATE SU<br>COMPLE   | <b>TED</b>               |
|--------------------------|--|--|--|---------------------------------|--|--|--------------------------|
|                          |  | 46A064   |  |                                 |  | 6/2  | 0/02                     |
|                          | PROVIDER OR SUPPLIER  EW CARE CENTER - 1   | WEST   | 876 WES  | T 700 SOUT<br>KE CITY, U        |  |  |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEEDED BY<br>LSC IDENTIFYING INFORMA   | FULL   | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY  | ON SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLETE<br>DATE |
| F 275                    | at approximately 10: had completed a qua should have completed 483.20(k) RESIDEN. The facility must dev for each resident that and timetables to me and mental and psychin the comprehensive. The care plan must derive the services that are maintain the resident mental, and psychos under s483.25; and Any services that wo s483.25 but are not pexercise of rights under to refuse treatment under the services that wo s483.25 but are not pexercise of rights under s483.25 but are not pexercise of rights under s483.25 but are not pexercise of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are not perfectly did not ensure the services of rights under s483.25 but are | rator was interviewed of 00 AM. She stated the reterly assessment on 9/ed an annual assessment.  IT ASSESSMENT  Velop a comprehensive tincludes measurable of et a resident's medical, hosocial needs that are et assessment.  Rescribe the following: to be furnished to attain's highest practicable procial well-being as required to the resident state.  It is not met as evidence, it was determined to et that residents' comprehensive to be the residents' highest process that were to be the residents' highest process of 10 sample residence. | facility 13/01 and at.  care plan bjectives nursing, identified  n or hysical, uired  ed under dent's the right  aced by: that the chensive furnished ractible |                                 | F279 - 483.20(k) RESIDE ASSESSMENT  This facility will continue comprehensive care plan fresident that includes mean objectives and timetables resident's medical, nursing mental and pychosocial nursing dentified in the compreheassessment.  1. Resident #21 has working with the Physical three times per week since When discontinued from Therapy, resident will be the Restorative Nursing lexercise program with go have been written by the Therapist with weekly do by the Restorative Aide.  2. Resident #1's #8b Addressed Impaired Actual. The Physical The working with resident (see 6/3/2002) interrupted by hospital stay. When disfrom Physical Therapy, be placed in the Restoration. | to develop a for each surable to meet a g, and eeds that are ensive  as been as been as the following the followin |                          |
|                          | <u>-</u>   | desired to the Control   | 1 <i>/7/</i> 07  |                                 | Program.( See response   | to F-311)  |                          |
|                          | •  | dmitted to the facility on the contract of the depression, cerebra   |  |                                 | :<br>:<br>:  |  | i<br>!                   |

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 279 Continued From page 7 F 279 accident, right-sided hemi paresis, expressive aphasia, All residents functional status will be seizure disorder and incontinence. evaluated on a monthly basis as part of An observation of resident 21 was made of 6/17/02 at the monthly nursing summary 9:15AM. Resident 21 was observed to have a contracture of his right hand. The Restorative Nursing Program will be evaluated and reported on at the Review of resident 21's medical record was done on 7.01-2002 Quality Assurance Committee, by the 6/18/02 at 10:00 AM. Director of Nursing.. A quarter Minimum Data Set (MDS) assessment for Restorative Nursing Program was established with full policies and procedures on July & 2002. resident 21 was completed by facility staff on 5/24/02. The facility staff documented that resident 21 had limitation of range of motion in his arm, hand, leg and foot on 1 side, partial loss of voluntary movement in his arm, leg and foot on one side and full loss of voluntaary movement in his hand on one side. Facility staff also documented that resident 21 was receiving passive and active range of motion from nursing staff on a daily basis. An Interdisiplinary Team Care Plan for resident 21 dated 6/7/02, did not address residnt 21's contractures or that range of motion was to be provided by nursing staff. 2. Resident 1 was originally admitted to the facility on 11/1/99. Resident 1 was readmitted to the facility on 8/17/01 with diagnoses of pneumonia, diabetes mellitus, cerebral vascular accident (1998) with right hemiparesis, osteoarthritis and congestive heart failure. Resident 1 had contractures of the right hand and right elbow on admission. On 6/17/02, resident 1 was observed to have a dressing over his right elbow. Review of resident 1's medical record was done on 6/18/02 at 9:00 AM.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH FAIRVIEW CARE CENTER - WEST** SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 279 Continued From page 8 F 279 A quarterly MDS assessment for resident 1, completed by facility staff on 5/14/02, documented that resident 1 had limitation of range of motion in his arm, hand, leg and foot on one side, and full loss of voluntary movement in his arm and hand on one side. Facility staff also documented that resident 1 was receiving passive and active range of motion from nursing staff on a daily basis. An Interdisciplinary Team Care Plan for resident 1 dated 5/9/02, did not address resident 1's contractures, or that range of motion was to be provided by nursing staff. A nurses' note for resident 1, dated 5/21/02 at 8:00 PM, documented the following: "Found resident [with] hand and upper arm on rt [right] side swollen and discolored. Had coban [elastic type bandage] dsg [dressing] around elbow. Found deep wound on inside of rt elbow, foul odor [with] greenish drainage. Cleaned and wrapped [with] non-adhering dsg and conform. Called [physician]. V/O [verbal order] culture for C & S [culture and sensitivity], start on Tequin 400 mg qd [daily] x [ times] 10 days and make appt [ appointment][ [with] wound clinic at [hospital]...." A nurses note dated 5/22/02 at 10:00 AM documented. "[changed] dressing on R [right] elbow. Two wound site-one is inside axis area of elbow. It is about the size of a silver dollar. There had been purulent drainage...." Resident 1 was seen in a hospital wound clinic on 5/22/02. A wound specialist documented in a progress note, "[Resident 1] was evaluated by myself and [physician]. There is some concern in regards to the exposed tendon...."

#### DEPARTMENT OF HEALTH AND HUM. SERVICES

| HEALTI                   | H CARE FINANCING   | ADMINISTRATION  |           |                                    |   | 1 Oldy  | 2567                     |
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|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM   |           | (X2) MULT<br>A. BUILDIN<br>B. WING | TIPLE CONSTRUCTION  | (X3) DATE S<br>COMPLE   | ETED                     |
| NAME OF B                | DOLUBER OF GUIDALIES   | 46A064  | CTREET AD | DDEGG OFFI                         | TATE ZID CODE   | 6/2   | 20/02                    |
| NAME OF P                | ROVIDER OR SUPPLIER  |   |           |                                    | TATE, ZIP CODE  |   |                          |
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| F 279                    | Continued From page 9  |   |           | F 279                              |   |   |                          |
|                          | the physician on 5/21 5/24/02, was reviewe documented that resid resistant staph aureus was contacted and the cephalothin.  An Interdisciplinary dated 4/18/02, documented for impaired documented, "Will have approach documented when bathing, not been updated to a | An Interdisciplinary Team Care Plan for resident 1 dated 4/18/02, documented that resident 1 had a potential for impaired skin integrity. The goal documented, "Will have no loss of skin integrity." The approach documented to monitor entire skin surface when bathing/showering. The care plan had not been updated to address the wound on the inside of resident 1's right elbow and did not address the MRSA infection.  A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, it was determined that the facility did not provide treatment and services for 1 of 10 sample esidents to achieve and maintain maximum abilities for transfers and ambulation. (Resident 20) |           |                                    | F-311 - 483.25(a)(2) QUALIT CARE  This facility will continue to a that each resident is given the appropriate treatment and serve maintain or improve his or he abilities.  Resident #20 was evaluated the Physical Therapist on 7-2 and was placed in the Restoral Nursing Program which was and implemented on 7 26-200. | ussure<br>vices to<br>r<br>luated by<br>-2002,<br>ative<br>written        |                          |
| SS=G                     | A resident is given the services to maintain of specified in paragraph. This REQUIREMEN Based on observation staff interview, it was not provide treatment residents to achieve as for transfers and ambiguitation.  |   |           |                                    | All Residents discharged Physical Therapy will be placed Restorative Nursing and Dinit Program, which has goals detained written by the Physical Tand Speech Therapist.  The Restorative Nurside evaluated and reported to Quality Assurance Committee Director of Nursing.   | ged from<br>sed in the<br>ing<br>termined<br>Therapist<br>ing will<br>the | 7/2/2002                 |
|                          | with diagnoses of Parl   | tted to the facility on 1<br>kinson disease, hyperte<br>phagia, osteoporosis ar   | nsion,    |                                    |   |   | 1                        |

arthritis.

DEPARTMENT OF HEALTH AND HUM. SERVICES

HEALTH CARE FINANCING ADMINISTRATION

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2567 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH FAIRVIEW CARE CENTER - WEST** SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 311 | Continued From page 10 F 311 A review of resident 20's medical record was done on 6/17/02. A quarterly Minimum Data Set (MDS) assessment for resident 20, completed by facility staff on 5/7/02, documented that resident 20 required extensive assistance of two persons for transfers. The facility staff documented that resident 20 had no limitations in range of motion or loss of voluntary movement in any extremities. The facility staff also documented that nursing was providing passive range of motion and transfer training. An Interdisciplinary Team Care Plan for resident 20 completed by facility staff, dated 4/10/02, documented a problem of impaired physical mobility. The goal documented that resident 20 would maintain current level of function. The approach documented that the [CNAs] certified nursing assistants would perform passive range of motion (PROM) when assisting resident 20 with hygiene, transfer and dressing tasks daily. A note in the physical therapy section of the medical record dated 11/28/01 at 12:30 documented, "[Resident 20] has experienced decline in function more dependent in transfers. PT [physical therapy] to increase independence and function in transfers. balance and strength." A physical therapy screen dated 11/28/01 documented that resident 20, "Isn't bearing weight. CNAs-can help 'a little' in transfers but feel she can do more." The physical therapy notes dated from 11/30/01 through 3/8/02 documented that resident 20 improved with the physical therapy.

PRINTED: 6/28/ DEPARTMENT OF HEALTH AND HUM. SERVICES FORM APPROVE **HEALTH CARE FINANCING ADMINISTRATION** STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH FAIRVIEW CARE CENTER - WEST** SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL). PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 311 Continued From page 11 F 311 A progress note by the physical therapist on 3/8/02 documented, "Pt [patient] reports cont. [continued] improved transfers/stand. Pt stand improved @ [at] FWW [front wheel walker] [with] CGA [contact guard assist] min [minimum] A [assist]." A review of resident 20's "Flow Sheet Record"s for the months of March 2002 through June 19, 2002 was done on 6/19/02 at 10:00 AM. On the back of the record an area was provided to document any restorative cares given to resident 20. Resident 20's record had no documentation on the record that restorative services had been provided. On 6/19/02 at 11:15 AM, two nurse surveyors requested to observe resident 20's ability to stand. Three nursing assistants (NAs) were present to assist resident 20 with incontinence care. Two of the facility NAs assisted resident 20 to a standing position from a wheelchair. Resident 20 held on to the siderails of her bed. The facility NA's had difficulty standing resident 20 and holding resident 20 in a standing position. Resident 20 had difficulty holding on to the siderails. The third facility NA provided incontinence care to resident 20 while the other two CNAs held resident 20 up in a standing position. An interview with the two facility NA's who assisted resident 20 up from the wheelchair was done on 6/19/02 at 11:30 AM. They both stated that they did not provide resident 20 with any PROM or strengthening exercises at any time while providing cares for resident 20 on a daily basis.

During a mini exit interview on 6/18/02 at 4:30 PM, the director of nursing (DON) was present. The DON stated that the facility did not have a restorative nursing or maintenance program in place.

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|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (XI) PROVIDER/SUPPLIER IDENTIFICATION NUM   |   | (X2) MUL<br>A. BUILD<br>B. WING   |   | (X3) DATE SURVEY<br>COMPLETED  |     |
|                          |  | 46A064  |   |   |   | 6/20/02  |     |
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| F 314<br>SS=G            | Based on the compreishe facility must ensure facility without pressure sores unless condition demonstrate and a resident having necessary treatment a prevent infection and developing.  This REQUIREMEN Based on observation interview, it was deterensure that a resident develop pressure sore  Findings include:  Resident 1 was origin 11/1/99. Resident 1 v8/17/01 with diagnose mellitus, cerebral vaschemiparesis, osteoarth failure. Resident 1 ha and right elbow on ad  On 6/17/02, resident 1 over his right elbow.  Review of resident 1's 6/18/02 at 9:00 AM.  An Interdisciplinary T dated 4/18/02, documpotential for impaired   | thensive assessment of a re that a resident who care sores does not dever the individual's clinical test that they were unaway pressure sores received and services to promote prevent new sores from T is not met as evident, record review, and standard that the facility without pressure sores s. (Resident 1)  ally admitted to the factors of pneumonia, diabeted accident (1998) waritis and congestive hed contractures of the ries. | looidable; shealing, m  ced by: aff did not did not did not add not a dressing one on  dent 1 d a l | F 314 OV THE PORT OF THE PORT | This facility will continue to en that a resident who enters the fawithout pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident have pressure sores receives necessat treatment and services to promine healing, prevent infection and pressure sores from developing. But the comprehensive assessment resident.  Resident's #1's Plan of Care#8b, Addressed Impaired Integrity: Actual. Initiated on IDT reviewed on 5-9-02 and ure on 5-22-02.  An inservice is schedulated on IDT reviewed on 5-9-02 and ure for licensed nurses. It will be president by the Pharmacy Consultant Regarding bandage and dressin application.  A Monthly Inservice of Care is also scheduled for All (see Inservice Calendar)  A skin inspection will | he ving cry ote prevent ased on of the Skin 5-6-02 apdated led on all sented RN, ng on Skin CNA's. |     |
|                          |  | ive no loss of skin integ<br>nted to monitor entire   |   |   | -   |  |     |

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 314 Continued From page 13 F 314 surface when bathing/showering. weekly by the Assistant Director of Nursing on ALL residents and A nurses' note dated 5/21/02 at 8:00 PM, documented documented on the Weekly Skin the following: "Found resident [with] hand and upper arm on rt [right] side swollen and discolored. Had Condition Progress Report. coban [elastic type bandage] dsg [dressing] around All Skin Reports will be elbow. Found deep wound on inside of rt elbow, foul reviewed by the Director of Nursing, odor [with] greenish drainage. Cleaned and wrapped and issues and trends will be reported [with] non-adhering dsg and conform. Called 1/22/02 on at the Quarterly Quality Assurance [physician]. V/O [verbal order] culture for C & S [culture and sensitivity], start on Tequin 400 mg qd Committee Meeting. [daily] x [ times] 10 days and make appt [ appointment][ [with] wound clinic at [hospital]...." A nurses note dated 5/22/02 at 10:00 AM documented. "[changed] dressing on R [right] elbow. Two wound site-one is inside axis area of elbow. It is about the size of a silver dollar. There had been purulent drainage...." Resident 1 was seen in a hospital wound clinic on 5/22/02. A wound specialist documented in a progress note, "[Resident 1] was evaluated by myself and [physician]. There is some concern in regards to the exposed tendon...." The C & S of resident 1's right arm wound, ordered by the physician on 5/21/02, reported to the facility on 5/24/02, was reviewed on 6/18/02. The report documented that resident 1 had MRSA (methicillin resistant staph aureus) in the wound. The physician was contacted and the antibiotic was changed to cephalothin. A physician progress note dated 5/30/02 documented that resident 1 had a DQ (decubitus) on his right arm and was to continue the cephalothin. During an interview with a facility staff nurse on

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| NAME OF P                | ROVIDER OR SUPPLIER   | 40/1004   | STREET AL  | DRESS CITY                      | STATE, ZIP CODE  | 6/20/02   | <u> </u>                |
|                          | EW CARE CENTER - V  | VEST  | 876 WES  | T 700 SOUT<br>LKE CITY, U       | Н  |   |                         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEEDED BY<br>SC IDENTIFYING INFORMA   | FULL   | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | ILD BE CO   | (X5)<br>OMPLETE<br>DATE |
|                          | resident 1 frequently skin tears to the outsiderssings were placed 1's right elbow but he sleeves. The facility mapproximately 2 monicellulitis in the right of cellulitis had been treataff continued to place securing them with an facility nurse stated the area of resident 1's right he elastic stretch drestresident 1's elbow area.  483.25(d)(2) QUALITY A resident who is incompanion to the function as possible.  This REQUIREMENT Based on observation was determined that the residents received appropriate treatment tract infections. Residents 3 2 hours as assessed an urinary tract infections. | the facility staff nurse is bumped his right elbow. He open areas or refused to wear protectures further stated that this ago, resident 1 had outer elbow. He stated that the attendance with antibiotics and the desired with antibiotics and the desired with antibiotics and the desired with antibiotics and the desired with antibiotics and the breakdown on the state of the desired with a state of the desired with a state of the state | v, causing He stated In resident Itive  developed the Id nursing Itin tears The Ite inside Ite aused by Ite ght around  developed Ite de inside Ite inside |                                 | F-316 483.25(d)(2) QUALITY (CARE  This facility will continue to ensith at a resident who is incontinent bladder receives appropriate treat and services to prevent urinary to infections and to restore as much normal bladder function as possional bladder function as possional function as possional function as possional function as possional function as a functional function as possional function as possional functional function as possional functional functio | sure at of atment ract h iible. s #3 ssessed and as ol and 2, tants. oilet toileted. oplied |                         |
|                          | Findings include:  1. Resident 3 was admitted diagnoses of congmellitus, osteoarthritis.  | nitted to the facility on<br>gestive heart failure, dia<br>, hypertension and bipo  | abetes   |                                 | the Director of Nursing. Any is<br>trends will be tracked using the<br>infection control tracking police   | ssues or  |                         |

disease.

PRINTED: 6/28/ DEPARTMENT OF HEALTH AND HUM. SERVICES FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION 2567 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 46A064 6/20/02 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) F 316 Continued From page 15 F 316 procedures and tracking sheet and then Resident 3's medical record was reviewed on 6/18/02 reported at the Quality Assurance at 10:00 AM. Meeting. A quarterly Minimum Data Set (MDS) assessment completed by facility staff for resident 3, dated Rounds checklist will 3/27/02, documented that resident 3 required limited be used as a tool to assist in monitoring frequency of touting and brief change. assistance of one person for toileting. The facility staff documented that resident 3 was frequently incontinent of bowel and bladder and was to be toileted. The facility staff also documented that resident 3 had a urinary tract infection in the last 30 days. An Interdisciplinary Team Care Plan for resident 3, completed by facility staff, documented that resident 3 had episodes of urinary incontinence and required toileting every 2 hours and whenever necessary. The Care Plan also documented that resident 3 had a urinary tract infection and to observe for burning or painful urination. A review of resident 3's nursing notes dated from 1/8/02 through 6/15/02, revealed that facility nurses documented that resident 3 was incontinent of bowel and bladder and required assistance with toileting. Further review of resident 3's nursing notes and laboratory results revealed the following: A nurses note dated 2/10/02 at 12:30 PM, documented, "C/O [complaining of] pain and burning when she voids. Order obtained for UA [urinalysis] in UA results dated 2/13/02, documented that resident 3

had a UTI involving the organism klebsiella oxytoca.

A nurses note dated 4/13/02, documented, "Res [resident] C/O burning on urination. Will get a UA." UA results dated 4/17/02, documented that resident 3

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 316 Continued From page 16 F 316 had a UTI involving the organisms streptococci, group D and klebsiella pneumoniae. A nurses note dated 5/22/02 at 2:00 PM, documented, "Pt [patient] C/O burning upon urination. Will get UA." UA results dated 5/25/02 documented that resident 3 had a UTI involving the organism klebsiella oxytoca. Review of the physician orders for resident 3 from 2/10/02 through 5/25/02, revealed that resident 3 was treated with antibiotics for all of the above infections. On 6/17/02, continuous observation of resident 3 was done from 6:30 AM to 11:00 AM. Resident 3 was observed to leave her room at 6:30 AM and sit in a recliner in the day room. At 7:35 AM, resident 3 was assisted by a facility nursing assistant (NA) to stand up from the recliner and ambulate with a walker to the dining room. At 8:20 AM, resident 3 was observed to ambulate from the dining room back to the day room and sit in a recliner. At 9:10 AM, resident 3 was assisted by the recreation staff person to go to the opposite end of the day room and have her hair fixed. Resident 3 then returned to the recliner in the day room. At 10:00 AM, resident 3 was assisted by a NA to get up out of the recliner and ambulate to the dining room for a snack. At 10:25 AM, resident 3 was observed to ambulate back to the day room and sit in the recliner chair until 11:00 AM. Resident 3 was not observed to be toileted or changed from 6:30 AM to 11:00 AM, a period of 4 1/2 hours. On 6/18/02, continuous observation of resident 3 was done from 6:20 AM to 11:30 AM and 12:30 PM to 4:00 PM.

#### DEPARTMENT OF HEALTH AND HUM. **SERVICES**

FORM APPROVE **HEALTH CARE FINANCING ADMINISTRATION** 2567 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH FAIRVIEW CARE CENTER - WEST SALT LAKE CITY, UT 84104** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 316 | Continued From page 17 F 316 Resident 3 was observed to leave her room at 6:20 AM and sit in a recliner in the day room. At 7:40 AM, resident 3 was assisted by a facility NA to stand up from the recliner and ambulate with a walker to the dining room. At 8:25 AM, resident 3 was observed to ambulate from the dining room back to the day room and sit in a recliner. At 9:30 AM, resident 3 was assisted by the recreation staff person to go to the opposite end of the day room and have her hair fixed. Resident 3 then returned to the recliner in the day room. At 10:10 AM, resident 3 was assisted by an NA to get up out of the recliner and ambulate to the dining room for a snack. At 10:25, resident 3 was observed to ambulate back to the day room and sit in the recliner chair. Resident 3 remained in the recliner during an activity until 11:30 AM. Resident 3 was not observed to be toileted or changed from 6:20 AM to 11:30 AM, a period of 5 hours. On 6/18/02, resident 3 was observed to be sitting in a recliner in the day room at 12:30 PM. At 12:40 PM, resident 3 was assisted to stand up from the recliner and ambulate to the dining room. At 1:15 resident 3 ambulated back to the day room and sat in a recliner. At 1:50 PM, resident 3 was assisted from the recliner to the dining room for a resident meeting. At 3:00 PM, after the meeting resident 3 returned to the day room and sat in a recliner chair until 4:00 PM. Resident 3 was not observed to be toileted or changed from 12:30 PM to 4:00 PM, a period of 3 1/2 hours.

On 6/19/02, resident 3 was observed in a recliner in

At 7:40 AM, resident 3 was assisted to stand up from

the day room from 6:50 AM to 7:40 AM.

the recliner and ambulate to the dining room.

PRINTED: 6/28/ DEPARTMENT OF HEALTH AND HUM **SERVICES** FORM APPROVE **HEALTH CARE FINANCING ADMINISTRATION** 2567 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST **SALT LAKE CITY, UT 84104** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 316 Continued From page 18 F 316 At 8:15 AM, resident 3 ambulated from the dining room back to the day room and sat in a recliner. From 8:15 AM to 10:20 AM resident 3 was observed to be sitting in a recliner in the day room. At 10:20 AM, resident 3 was observed to be assisted by an NA to get out of the recliner and resident 3 ambulated to the dining room for a snack. At 10:40 AM, resident 3 ambulated back to a recliner in the day room and sat down. From 10:40 AM to 11:15 AM, resident 3 was observed to sit in the recliner in the day room. Resident 3 was not observed to be toileted or changed from 6:50 AM to 11:15 AM, a period of 3 1/2 hours. 2. Resident 20 was admitted to the facility on 1/26/00 with diagnoses of Parkinson disease, hypertension, diabetes mellitus, dysphagia, osteoporosis and arthritis. A review of resident 20's medical record was done on 6/17/02. A quarterly MDS assessment for resident 20, completed by facility staff on 5/7/02, documented that resident 20 required extensive assistance of two persons for toileting. The facility staff documented that resident 20 was frequently incontinent and would be toileted. The facility staff also documented that resident 20 had a urinary tract infection in the last 30 days.

An Interdisciplinary Team Care Plan for resident 20, completed by facility staff, documented that resident 20 was incontinent and incontinence would be

managed by staff. The care plan documented to assist resident 20 to the bathroom every two hours if able and change briefs every two hours. The plan also documented to report any complaints of burning or painful urination by resident 20 to the charge nurse.

2567 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) F 316 F 316 | Continued From page 19 A review of resident 20's nursing notes dated from 11/1/01 through 6/18/02, revealed that facility nurses documented that resident 20 was incontinent of bladder and occasionally incontinent of bowel. A review of resident 20's Flow Sheet Records. completed by facility nursing assistants, dated from November 2001 through May, 2002, documented that resident 20 was incontinent of bladder. Further review of resident 20's nursing notes and laboratory results revealed the following: A nurses note dated 11/8/01, documented, "res C/O pain when urinating. Will send UA to lab." UA results dated 11/11/01 documented that resident 20 had a UTI involving the organisms Klebsiella pneumoniae, proteus mirabilis and streptococci group В. A nurses note dated 12/9/01, documented, "Res C/O burning on urination. Will send UA." UA results dated 12/13/01 documented that resident 20 had a UTI involving the organisms proteus mirabilis, escherichia coli and streptococci group D. A nurses note dated 2/26/02, documented, "Seen by [regular physician]. C/O dysuria. UA to be done 2/28/02. Results to [urologist]." UA results dated 3/1/02 documented that resident 20 had a UTI involving the organisms escherichia coli, proteus mirabilis and methicillin resistant staphylococcus aureus (MRSA). A nurses note dated 5/28/02 at 8:00 AM documented. "C/O pain and discomfort when voiding. d/t [due to] pts Hx [history) of UTI's order obtained for UA with C&S if indicated."

| HEALTI                             | H CARE FINANCING  | ADMINISTRATION   |   |                          |   | 2567   |
|------------------------------------|---|--|---|--------------------------|---|--|
| AND PLAN OF CORRECTION IDENTIFICAT | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM   |  | (X2) MULTIP<br>A. BUILDING<br>B. WING   | LE CONSTRUCTION          | (X3) DATE SURVEY COMPLETED 6/20/02  |  |
| NAME OF P                          | ROVIDER OR SUPPLIER   |  | STREET ADI  | RESS, CITY, STA          | TE. ZIP CODE  | 0/20/02                                      |
|                                    | EW CARE CENTER - V  | WEST   | 876 WEST  | 700 SOUTH<br>KE CITY, UT |   |  |
| (X4) ID<br>PREFIX<br>TAG           | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY SC IDENTIFYING INFORMA  | FULL  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENCE | TION SHOULD BE COMPLETE THE APPROPRIATE DATE |
| F 316                              | had a UTI involving pseudomonas aerugin streptococci group D A follow up UA date resident 20 had a UT methicillin resistant s and streptococci group D Review of the physic 11/11/01 through 5/3 was treated with antilinfections.  Review of the urolog dated 11/19/01 docur toileted routinely. Vol. Review of the urolog dated 2/21/02 docum Hx recurrent UTIs"  On 6/17/02, continuo done from 7:15 AM tobserved to be taken at 7:15 AM. At 9:20 AM resident dining room.  At 9:35 AM, resident and placed in front of remained until 11:00 observed to be toilete 11:00 AM, a period of Con 6/18/02, continuo done from 6:20 AM total control of the | o/02 documented that refine organisms proteus in the organisms proteus in the organisms proteus in the organisms proteus in the organisms of t | mirabilis, oniae and that ms MRSA)  20 from dent 20 ove  resident 20 seldom d"  resident 20 times] 24.  ent 20 was an her room the mer room the not so AM to ent 20 was o PM to | F 316                    |   |  |
|                                    | wheelchair in the dini  | 0 was observed to be up<br>ng room at 6:20 AM.<br>20 was served breakfa:   |   |                          |   | •<br>•                                       |

PRINTED: 6/28/ DEPARTMENT OF HEALTH AND HUM. SERVICES FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH FAIRVIEW CARE CENTER - WEST** SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Continued From page 21 F 316 dining room. At 10:10 AM resident 20 was observed to still be in the dining room in a wheelchair, leaning to her left side with her eyes closed. At 10.25 AM, resident 20 was taken back to her room and placed in front of her television. At 11:00 AM, resident 20 was observed to still be in her room, in a wheelchair, in front of her television. Resident 20 was not observed to be toileted or changed from 6:20 AM to 11:00 AM, a period of 4 1/2 hours. On 6/18/02, resident 20 was observed to be in the dining room sitting in a wheel chair at 12:30 PM. At 1:30 PM, resident 20 was observed to be taken into the day room in a wheelchair. At 2:00 PM, resident 20 was taken back into the dining room. From 2:00 PM to 3:00 PM, resident 20 attended a meeting for the residents. At 3:10 PM, resident 20 was taken to her room and placed in front of her television where she remained until 4:30 PM. Resident 20 was not observed to be toileted or changed from 12:30 PM to 4:30 PM, a period of 4 hours. On 6/19/02, resident 20 was observed to be in a wheelchair, in the dining room, from 7:50 AM to 8:55 AM. At 8:55 AM, resident 20 was taken back to her room and placed in front of her television. Resident 20 was observed to be in her room, in the wheelchair, in front of her television until 11:15 AM.

CMS-2567L

At 11:15 AM, two nurse surveyors requested to observe resident 20's ability to stand and to observe resident 20's skin. Three NAs were present to assist resident 20 with incontinence care. Two of the facility NAs assisted resident 20 to a standing position from a wheelchair. The wheelchair pad was observed to be wet. The brief the facility NAs removed from resident

If continuation sheet 22 of

PRINTED: 6/28/ DEPARTMENT OF HEALTH AND HU. .N SERVICES FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 22 F 316 20 was wet. Resident 20 was not observed to be F-318 - 483.25(e)(2)QUALITY OF toileted or changed from 7:50 AM to 11:15 AM, a period of 3 1/2 hours. Based on the comprehensive assessment of a resident, this facility F 318 483.25(e)(2) QUALITY OF CARE will continue to ensure that a resident F 318 with a limited range of motion SS=G Based on the comprehensive assessment of a resident. receives appropriate treatment and the facility must ensure that a resident with a limited services to increase range of motion range of motion receives appropriate treatment and and/or to prevent further decrease in services to increase range of motion and/or to prevent further decrease in range of motion. range of motion. Residents #1 and #21, are currently This REQUIREMENT is not met as evidenced by: being treated by Physical Therapy. All Based on observation, record review, resident and staff residents with contractures, when interviews, it was determined the facility did not identified through the function status provide treatment and services to 2 of 10 sample part of the monthly nursing summary, residents to increase range of motion or to prevent will be evaluated and treated by further decrease in range of motion. (Residents 1 and 21) Physical Therapy. When residents are discontinued by the Physical Findings include: Therapist, they will be placed on the Restorative Nursing Program initiated 1. Resident 1 was originally admitted to the facility on on July 8, 2002, with goals and plan 11/1/99. Resident 1 was readmitted to the facility on 8/17/01 with diagnoses of pneumonia, diabetes written by the Physical Therapist, and mellitus, cerebral vascular accident (1998) with right performed by the Restorative Aide. hemiparesis, osteoarthritis and congestive heart The Restorative Aide will document failure. Resident 1 had contractures of the right hand resident status through weekly notes. and right elbow on admission. The Restorative will be monitored on

Review of resident 1's medical record was done on 6/18/02 at 9:00 AM.

A quarterly Minimum Data Set (MDS) assessment for resident 1, completed by facility staff on 5/14/02, documented that resident 1 had limitation of range of motion in his arm, hand, leg and foot on one side, and full loss of voluntary movement in his arm and hand

7/08/2002

Meeting.

an ongoing basis by the Director of

Nursing. Documentation and issues will be reviewed and reported at the

**Quality Assurance Committee** 

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |   | A. BUILDIN                 | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |           | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|---|----------------------------|---|-----------|-------------------------------|--|
|   | ·  | 46A064   |   | B. WING                    |   | 6         | /20/02                        |  |
| NAME OF P   | PROVIDER OR SUPPLIER   |  | STREET ADI  | DRESS, CITY, ST            | ATE, ZIP CODE   |           |                               |  |
| FAIRVIE   | EW CARE CENTER - V   | VEST   |   | T 700 SOUTH<br>KE CITY, UT |   |           |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>( MUST BE PRECEEDED BY<br>.SC IDENTIFYING INFORMA   | FULL  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETE<br>DATE      |  |
|   | resident 1 was received motion from nursing staff.  An Interdisciplinary To dated 5/9/02, did not so or that range of motion staff.  A physician progress documented that reside and the plan was to provide the plan was to provide the plan was to provide the plan was to provide the plan was to provide the plan was to provide the plan was to provide the plan was to provide the plan was to provide the plan was to provide the plan was to provide the plan was to provide the plan was to decrease the plan was to provide the plan was to provide the plan was to provide the plan was to provide the plan was to provide the plan was to provide the plan was to provide the plan was to decrease the plan was to decrease the plan was to decrease the plan was to decrease the plan was to decrease the plan was to decrease the plan was to decrease the plan was to plan was to decrease the plan was to decrease the plan was to plan was to decrease the plan was to plan was to decrease the plan was to decreas | staff also documented ing passive and active to staff on a daily basis.  Team Care Plan for rest address resident 1's coron was to be provided by the provided by the provided range of motion for the provide range of motion for the provide range of motion for the provide range of motion for the provide range of motion for the provide range of motion for the provide range of motion for the provide range of motion for the provide range of the provided by the provided to the provided to document and the prov | range of sident 1 intractures, by nursing ed 5/30/02, intractures i. cumented, t] hand mail [resident by a d that the i. d''s for the 202 was of the ey int 1's that been | F 318                      |   |           |                               |  |
|   | An interview was held with resident 1 on 6/19/02 at 7:00 AM. Resident 1 was aphasic and directive questions had to be asked. Resident 1 was asked if he could move his right hand and elbow. Resident 1 noded his head and said "no." Resident 1 was asked if facility staff provided range of motion exercises to his right hand and elbow. Resident 1 again noded his  |  |   |                            |   |           |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |   |   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|--|--|---|---|-------------------------------|--|
| 46A06   |  | 46A064   | <del></del>  | B. WING  |   | 6 | /20/02                        |  |
| NAME OF P   | ROVIDER OR SUPPLIER  |  | 1  |  | TATE, ZIP CODE  |   |                               |  |
| FAIRVIE   | EW CARE CENTER - V   | WEST   |  | 700 SOUTH<br>KE CITY, UT                         |   |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | FULL ;   | ID<br>PREFIX<br>TAG                              | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |   | (X5)<br>COMPLETE<br>DATE      |  |
| F318  | head and said "no". I receiving physical the Resident 1 noded his left hand and held up asked if he meant for head and said "yes".  An interview was held (NA) on 6/19/02 at 7 did not do anything specific process. | Resident 1 was asked if erapy to his right hand a head and said "yes" and two fingers. Resident 1 r 2 weeks. Resident 1 r dd with a facility nursing 2:10 AM. The NA state special while providing | and elbow.  Indused his  was  noded his  g assistant  ed that she  daily ADL | F 318  |   |   |                               |  |
|   | An interview was held 6/19/02 at 7:30 AM. got resident 1 up in the   | ving) to resident 1. Whoved resident 1's arm an ated, "no."  Id with a second facility The NA stated that she he morning and did not and hand anymore than   | y NA on frequently   |  |   |   |                               |  |
|   | the director of nursing  | terview on 6/18/02 at 4: g (DON) was present. did not have a restorat ce program in place.   | The DON  |  |   |   | :                             |  |
|   | 2. Resident 21 was admitted to the facility on 1/7/97 with diagnoses of major depression, cerebral vascular accident, right-sided hemi paresis, expressive aphasia, seizure disorder and incontinence.               |  |  |  |   |   |                               |  |
| :   | An observation of resident 21 was made of 6/17/02 at 9:15 AM. Resident 21 was observed to have a contracture of his right hand.  |  |  |  |   |   |                               |  |
|   | Review of resident 21 6/18/02 at 10:00 AM.   | l's medical record was o   | done on  | İ  |   |   |                               |  |
| A quarterly Minimum Data Set (MDS) assessment for   |  |  |  |  |   |   |                               |  |

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST **SALT LAKE CITY, UT 84104** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 318 : Continued From page 25 F 318 resident 21 was completed by facility staff on 5/24/02. The facility staff documented that resident 21 had limitation of range of motion in his arm, hand, leg and foot on 1 side, partial loss of voluntary movement in his arm, leg, and foot on one side and full loss of voluntary movement in his hand on one side. Facility staff also documented that resident 21 was receiving passive and active range of motion from nursing staff on a daily basis. A review of the "Interdisciplinary Team Care Plan" updated on 6/7/02, did not address resident 21's contracture or range of motion was to be provided by nursing staff. A nursing admission note dated 1/7/97, did not document that resident 21 had any contractures with his right-sided hemia paresis. A nurses' note dated 1/19/02, documented resident 21 had contractures to his right hand. Resident 21's morning cares were observed on 6/19/02 at 7:40 AM. The NA was observed to assist resident 21 with getting his clothing on and combing his hair. The NA did not provide resident 21 range of motion to his right hand. The charge nurse and Director of Nursing (DON) were interviewed on 6/19/02 at 1:30 PM. The facility nurse stated that the only place that range of motion was documented was the NA flow sheets. The DON stated there was no tracking form or documentation for the range of motion but there was a brief explanation in the NA flow sheet. A review of the NA flow sheets dated January 2002, February 2002, April 2002, and May 2002 was don. The NA flow sheets did not document any range of

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH FAIRVIEW CARE CENTER - WEST SALT LAKE CITY, UT 84104** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 318 Continued From page 26 F 318 motion being provided to resident 21. For the month F-332 - 483.25(m)(1) QUALITY OF of March 2002, the NAs had documented an "N "on 5 of the 31 days in March. This facility will continue to ensure that it is free of medication error rates Resident 21 was interviewed on 6/19/02 at approximately 1:45 PM. Resident 21 stated that the of five percent or greater facility staff did not provide him with range of motion by exercising his fingers or his right hand. At that On June 21, 2002 and inservice and time, resident 21's face was observed to grimace as he meeting was held for all licensed tried to uncurl his fingers on his right hand by using nurses. At the meeting, it was agreed his left hand. that the night and morning shifts would overlap by thirty minutes to assure that all insulins are given in a F 332 483.25(m)(1) QUALITY OF CARE F 332 imely manner. SS=E The facility must ensure that it is free of medication An inservice is scheduled on July 22, error rates of five percent or greater. 2002 for all licensed nurses. It will be presented by the Pharmacy Consulting This REQUIREMENT is not met as evidenced by: R.N., and will address the nursing Based on observations, interviews and review of basic concept of the 5 R's - 1. Right resident medical records, it was determined that the facility did not ensure that it was free of medication patient, 2. Right time, 3. Right error rates of five percent or greater. Specifically, the medication, 4. Right dose. 5. Right registered nurse surveyor observed two facility nurses route (of administration), Ascertain administer medications to 12 residents. One facility and repeat aloud. The Pharmacy nurse made one omission error and one dosage error. Consulting R.N. has scheduled un-A second facility nurse gave insulin to 7 residents after 9:15 AM and the scheduled times for the insulin to be announced medication pass given were at 7:00 AM or 8:00 AM. Out of 67 monitoring on a monthly basis for the opportunities for error, 9 errors were made the next six months. facility's medication error rate 13.4%. Resident On all residents identified as having identifiers: 3, 4, 8, 16, 19, 27, 30, 32 Type I or II Diabetes Mellitus, the Findings include: Blood Sugar and insulin records will be audited weekly for one year by the 1. Resident 32 Medical Records Director. The audits The registered nurse surveyor observed a facility medication pass on 6/18/02 at 6:00 AM. The surveyor

PRINTED: 6/28/ FORM APPROVE

#### DEPARTMENT OF HEALTH AND HU IN SERVICES

HEALTH CARE FINANCING ADMINISTRATION 2567 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 332 F 332 Continued From page 27 observed the nurse to pour one tablet of Cogentin 0.5 will be reviewed by the Director of mg (milligrams) for resident 32. The prescription Nursing, and all issues or trends will bottle read to give 0.25 mg of Cogentin which was 1/2 be reported to the Quality Assurance of the tablet of 0.5 milligrams. The nurse continued to pour other medications for resident 32. The surveyor Committee asked the nurse to show her resident 32's tablet of Cogentin. The facility nurse was observed to place a whole tablet of Cogentin in a separate medication cup. The surveyor pointed out to the nurse that she had poured 0.5 mg and not 0.25 mg. A review of resident 32's Medication Administration Record (MAR) and physicians orders dated June 2002 documented to give 0.25 mg of Cogentin. The nurse was then observed to finish pouring the medications for resident 32. The nurse could not find one medication, Vitamin E, to give to resident 32. She had circled the medication on the MAR and documented that it was missing in the comment section of the MAR. The prescription bottle of Vitamin E for resident 32 was observed between the three rings of the binder of the MAR. The surveyor pointed out to the nurse where the vitamin E medication was located. 2. Resident 8 was admitted to the facility on 1/6/01 with the diagnoses of ulcerative colitis, diabetes mellitus ketoacidosis type I and vertigo A second facility nurse was asked to get the surveyor when the nurse started to give residents their insulin. The nurse told the surveyor at 9:10 AM that he/she was going to start giving residents with diabetes their insulin. By that time, all but one resident finished eating breakfast. The following insulin administration observations

were made on 6/18/02:

#### DEPARTMENT OF HEALTH AND HU ... N SERVICES

HEALTH CARE FINANCING ADMINISTRATION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST **SALT LAKE CITY, UT 84104** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL). PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE. REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 28 F 332: F 332 The nurse was observed to give resident 8 NPH insulin at 9:10 AM. The nurse was observed to initial the MAR for the insulin and did not change the time to the actual time it was given. A review of the MAR documented that resident 8 was to receive her insulin administration at 8:00 AM. Resident 8's blood sugar (BS) was documented as being 116 which according to the sliding scale (SS) required no regular insulin. A review of the physician recertification orders dated June 2002, documented that resident 8 was to have her blood sugar taken three times per day and receive sliding scale three times a day. The sliding scale for regular insulin was ordered to start from a blood sugar above 200. Resident 8 had orders to receive 2 U of NPH insulin every AM and 5 U every PM. 3. Resident 3 was admitted to the facility on 1/6/00 with diagnoses of congestive heart failure, low tension glaucoma and diabetes mellitus ketoacidosis type I. The nurse was observed to give resident 3 her insulin in the day room at 9:20 AM. The nurse gave the resident 12 units (U) of NPH insulin and 2 units of regular sliding scale insulin. The nurse documented giving her regular insulin at 8:00 AM. A review of the MAR documented that resident 3 was to receive her NPH insulin administration at 7:00 AM. Resident 3's blood sugar was documented as being done at 6:00 AM and was 221. A review of the physician recertification orders dated April 2002 documented that resident 3 was to have her

blood sugar checked twice a day. The SS for regular insulin was ordered to start from a blood sugar above 180. Resident 3 had orders to receive 12 U of NPH

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  46A064  |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |  | (X3) DATE SURVEY COMPLETED 6/20/02 |                          |
|---|--|---|--|--|--|------------------------------------|--------------------------|
| NAME OF PROVIDER OR SUPPLIER                        |  |   | STREET ADI   | ORESS, CITY, STA                                 | ATE, ZIP CODE  |                                    | 120/02                   |
| FAIRVIEW CARE CENTER - WEST                         |  | 876 WEST 700 SOUTH SALT LAKE CITY, UT 84104   |  |  |  |                                    |                          |
| (X4) ID<br>PREFIX<br>TAG                            | X (EACH DEFICIENCY MUST BE PRECEEDED BY FULL   |   |  | ID<br>PREFIX<br>TAG                              | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE  | (X5)<br>COMPLETE<br>DATE |
| F 332   | with the diagnoses of multi-infarct dementionsteoporosis, and hys The nurse was observat 9:30 AM. The nurse was give A review of MAR do receive her NPH insuractual time it was give A review of the physical decoration of the SS of A review of the physical decoration of the SS for regular in BS above 200. Resident 19's BS was according to the SS for regular in BS above 200. Resident BS checked before The SS for regular in BS above 200. Resident 30 was according to the SS for regular in BS above 200. Resident 30 was according to the significant of the diagnoses of aspiration risk, hyperturosepsis, gastroesop type I and closed fractions. The nurse was observat 9:35 AM. The nur MAR for the insuling actual time it was given A review of MAR do receive his NPH insuland his BS twice a data. | dmitted to the facility of diabetes hyperosmolaria, urinary incontinence pertension.  Wed to give resident 19 are was observed to initiate and did not change the ren.  Commented that resident alin administration at 7: a documented as being equired no regular insuration are remained that resident 19 was remeals and hour before sulin was ordered to statent 19 had orders to remorning.  Imitted to the facility of cerebral vascular accidence to the | type II,  ther insulin ial the time to the  19 was to 00 AM. 130 which lin.  lers dated to have re sleep.  art from a ceive 12 U  n 2/19/02 lent, dder, diabetes  his insulin ial the time to the  30 was to 00 AM. as | F 332  |  |                                    |                          |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING B. WING   | (X3) DATE SURVEY<br>COMPLETED |                          |  |  |  |
|--|-------------------------------|--------------------------|--|--|--|
| 46A064   | 6/                            | 20/02                    |  |  |  |
| NAME OF PROVIDER OR SUPPLIER  FAIRVIEW CARE CENTER - WEST  STREET ADDRESS, CITY, STATE, ZIP CODE  876 WEST 700 SOUTH  SALT LAKE CITY, UT 84104   | VEST 700 SOUTH                |                          |  |  |  |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COLORRECTIVE ACTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COLORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)  | N SHOULD BE                   | (X5)<br>COMPLETE<br>DATE |  |  |  |
| F 332 Continued From page 30 required no regular insulin.  A review of the physician recertification orders dated June 2002, documented that resident 30 had orders to receive 7 U of NPH insulin every morning at 8:00 AM. The SS for regular insulin was ordered to start from a BS above 201.  6. Resident 16 was admitted to the facility on 2/6/02 with the diagnoses of non insulin diabetes, osteoarthritis, cataract, and hypertension  The nurse was observed to give resident 16 her insulin at 9:40 AM. The nurse was observed to initial the MAR for the insulin and did not change the time to the actual time it was given.  A review of MAR documented that resident 19 was to receive her NPH insulin administration at 7:00 AM. Resident 16's BS was documented as being 140 which according to the SS required no regular insulin.  A review of the physician recertification orders dated April 2002, documented that resident 16 was to receive BS at meals and at 9:00 PM. The SS for regular insulin was ordered to start from a BS above 251. Resident 16 had orders to receive 12 U of NPH insulin twice a day.  7. Resident 27 was admitted to the facility on 12/14/01 with the diagnoses of diabetes, hypertension and osteoarthritis.  The nurse was observed to give the resident 27 her insulin at 9:45 AM. The nurse was observed to initial the MAR for the insulin and did not change the time to the actual time it was given.  A review of MAR documented that resident 27 was to |                               |                          |  |  |  |

| AND BLANCE CORRECTION    |  | (X1) PROVIDER/SUPPLIER<br>IDENTIFICATION NUM  | 1 1 2  |                          |  | (X3) DATE SURVEY<br>COMPLETED                |        |
|--------------------------|--|---|--|--------------------------|--|--|--------|
| 46A064                   |  |   |  | B. WING_                 |  | 6  | /20/02 |
| NAME OF P                | ROVIDER OR SUPPLIER  |   | STREET ADD   | RESS, CITY, ST           | FATE, ZIP CODE   |  |        |
| FAIRVIE                  | W CARE CENTER - V  | VEST  |  | 700 SOUTH<br>KE CITY, UT |  |  |        |
| (X4) ID<br>PREFIX<br>TAG |  |   | FULL   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC'<br>CROSS-REFERENCED TO T<br>DEFICIENC | CTION SHOULD BE COMP OF THE APPROPRIATE DATE |        |
| F 332                    | receive her NPH insulation in the receive her NPH insulation. A review of physician April 2002, document have her BS taken two insulin was ordered to Resident 27 had orderevery day 42 U every 8. Resident 4 was admitted in the receive her NPH in the rec | lin administration at 27's BS was documented or regular insulin.  In recertification orders ted that resident 27 had ice a day. The SS for resident 27 had ice a day. The SS for resident 27 had ice a day. The SS above its to receive 84 U of Nov PM.  Initted to the facility on betes type I, degenerate tinence, and chronic browned to give resident 4 had so a decident at the sulin at a catual time it was given a documented that resident at the sulin administration at the sulin administration at the sulin and that resident 4 had contained a day. The SS for receive 60 U of New rening.  In administered the insulin a sulin was a time sensitive further stated that he in until after the resident. | dated of orders to regular 250. PH insulin 6/21/02 ave joint onchitis. There insuling her insuli | F 332                    |  |  |        |
|                          | The facility Director of Nursing (DON) was   |   |  |                          |  |  | i.     |

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH FAIRVIEW CARE CENTER - WEST SALT LAKE CITY, UT 84104** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) **PREFIX** (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 332 F 332 Continued From page 32 interviewed on 6/18/02 at 4:00 PM. The DON stated that there had been some problems in the past with residents who had received their insulin before meals. She stated that she had instructed the nursing staff to wait to administer the residents insulin until after breakfast, to make sure the residents had eaten. The DON also stated she had not changed the administration times on the MAR and had not consulted with the residents physicians about the change. 483.25(m)(2) QUALITY OF CARE F-333 483.25(m)(2) QUALITY OF SS=E The facility must ensure that residents are free of any significant medication errors. This facility will continue to ensure This REQUIREMENT is not met as evidenced by: that residents are free of any significant medication errors. Based on observation, interview, and review of the Medication Administration Record (MAR), it was determined that the facility did not ensure that See F-332 residents were free of any significant medication errors. Specifically by the timing of the administration of insulin, and it's relationship to when residents were scheduled for blood glucose testing and when the residents received breakfast. Standards of practice addresses the synergistic relationship between the timing of obtaining blood glucose levels, administering insulin, and when meals are served to provide optimum treatment of diabetes. Residents 3, 4, 8, 16, 19, 27 and 30 were noted to be diabetics who were observed during the medication pass to have recieve insulin after breakfast. Finding include: A medication pass was observed on 6/18/02. A facility nurse was asked to get the surveyor when the CEXSII UT0026

| AND PLAN OF CORRECTION IDENTIFICATION N   |   | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM  |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |  | (X3) DATE SURVEY COMPLETED        |                          |
|---|---|--|--|--|--|-----------------------------------|--------------------------|
| NAME OF P   | ROVIDER OR SUPPLIER   | 46A064   | STREET ADD   | RESS CITY STAT                                   | TE ZIP CODE  |                                   | /20/02                   |
| FAIDVIEW CADE CENTED WEST 876 WEST  |   |  | DRESS, CITY, STATE, ZIP CODE  F 700 SOUTH  KE CITY, UT 84104 |  |  |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |  |  | ID<br>PREFIX<br>TAG                              | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO '<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| F 333 Continued From page 33 nurse started to give residents their insulin. The told the surveyor at 9:10 AM that he/she was go start giving residents with diabetes their insulin. that time, all but one resident finished eating bre  The following insulin administration observation |   |  | s going to lin. By greakfast.                                | F 333  |  |                                   |                          |
|   | were made on 6/18/0   | 02:<br>dmitted to the facility or<br>f ulcerative colitis, diab  | n 1/6/01   | :  |  |                                   |                          |
|   | at 9:10 AM. The nu  | ved to give resident 8 N<br>rse was observed to init<br>and did not change the<br>ven.   | ial the  |  |  |                                   |                          |
|   | to receive her insuling Resident 8's blood so   | R documented that residual administration at 8:00 agar (BS) was document ording to the sliding scansulin.  | AM.<br>ted as  |  |  |                                   |                          |
|   | June 2002, document<br>blood sugar taken the<br>sliding scale three tiregular insulin was of<br>above 200. Resider      | tician recertification ord<br>ted that resident 8 was to<br>ree times per day and re<br>mes a day. The sliding so<br>redered to start from a blat 8 had orders to receive<br>M and 5 U every PM. | o have her ceive scale for ood sugar                         |  |  |                                   |                          |
| , i   | with diagnoses of co  | mitted to the facility on<br>ngestive heart failure, lo<br>es mellitus ketoacidosis  | w tension  | !  |  |                                   |                          |
| İ   | in the day room at 9: resident 12 units (U)   | ved to give resident 3 he<br>20 AM. The nurse gave<br>of NPH insulin and 2<br>insulin. The nurse docu  | the<br>units of  | ;<br>;<br>;                                      |  |                                   |                          |

#### DEPARTMENT OF HEALTH AND HU N SERVICES

HEALTH CARE FINANCING ADMINISTRATION 2567 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST **SALT LAKE CITY, UT 84104** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 333 Continued From page 34 F 333 giving her regular insulin at 8:00 AM. A review of the MAR documented that resident 3 was to receive her NPH insulin administration at 7:00 AM. Resident 3's blood sugar was documented as being done at 6:00 AM and was 221. A review of the physician recertification orders dated April 2002 documented that resident 3 was to have her blood sugar checked twice a day. The SS for regular insulin was ordered to start from a blood sugar above 180. Resident 3 had orders to receive 12 U of NPH every morning. 3. Resident 19 was admitted to the facility on 9/9/00 with the diagnoses of diabetes hyperosmolar type II. multi-infarct dementia, urinary incontinence, osteoporosis, and hypertension. The nurse was observed to give resident 19 her insulin at 9:30 AM. The nurse was observed to initial the MAR for the insulin and did not change the time to the actual time it was given. A review of MAR documented that resident 19 was to receive her NPH insulin administration at 7:00 AM. Resident 19's BS was documented as being 130 which according to the SS required no regular insulin. A review of the physician recertification orders dated June 2002, documented that resident 19 was to have her BS checked before meals and hour before sleep. The SS for regular insulin was ordered to start from a BS above 200. Resident 19 had orders to receive 12 U of NPH insulin every morning. 4. Resident 30 was admitted to the facility on 2/19/02

with the diagnoses of cerebral vascular accident, aspiration risk, hypertension, neurogenic bladder,

Event I

UT0026

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |   |   | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION   | 1 ' '                         | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|---|--------------------------|--|-------------------------------|-------------------------------|--|
|  | 46A064  |   | B. WING                  |  | 6,                            | 20/02                         |  |
| NAME OF PROVIDER OR SUPPLIER   |   | STREET ADD  | RESS, CITY, ST           | ATE, ZIP CODE  |                               |                               |  |
| FAIRVIEW CARE CENTER -   | WEST  |   | 700 SOUTH<br>KE CITY, UT |  |                               |                               |  |
| PREFIX (EACH DEFICIENCY  | EFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL   |   |                          | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY) | ON SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETE<br>DATE      |  |
| The nurse was obser at 9:35 AM. The nur MAR for the insulin actual time it was given and his BS twice a decumented as being required no regular in the A review of the physology June 2002, documented as being from a BS above 2015. Resident 16 was a with the diagnoses of osteoarthritis, cataracter The nurse was obser at 9:40 AM. The nur MAR for the insulin actual time it was given a review of MAR deceive her NPH instruction Resident 16's BS was according to the SS in the receive BS at meals a regular insulin was of the sum of the physology. | phageal reflux disease, cture of humeral shaft.  ved to give resident 30 rse was observed to init and did not change the ven.  commented that resident alin administration at 7: ay. Resident 30's BS was 187 which according to insulin.  dician recertification orded that resident 30 had insulin every morning a alar insulin was ordered to the facility of non insulin diabetes, et, and hypertension ved to give resident 16 rse was observed to init and did not change the | his insulingial the time to the 30 was to 00 AM. as to the SS ders dated to orders to at 8:00 to start an 2/6/02 to start an 19 was to 00 AM. 140 which alin. ders dated to start at 5 to 5 for 5 above | F 333                    |  |                               |                               |  |

PRINTED: 6/28/ DEPARTMENT OF HEALTH AND HU .N SERVICES FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES m PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 333 F 333 i Continued From page 36 insulin twice a day. 6. Resident 27 was admitted to the facility on 12/14/01 with the diagnoses of diabetes, hypertension and osteoarthritis. The nurse was observed to give the resident 27 her insulin at 9:45 AM. The nurse was observed to initial the MAR for the insulin and did not change the time to the actual time it was given. A review of MAR documented that resident 27 was to receive her NPH insulin administration at 7:00 AM. Resident 27's BS was documented as being 246 which required no regular insulin. A review of physician recertification orders dated April 2002, documented that resident 27 had orders to have her BS taken twice a day. The SS for regular insulin was ordered to start from a BS above 250. Resident 27 had orders to receive 84 U of NPH insulin every day 42 U every PM. 7. Resident 4 was admitted to the facility on 6/21/02 with diagnoses of diabetes type I, degenerative joint diease, urinary incontinence, and chronic bronchitis. The nurse was observed to give resident 4 her insulin at 9:50 PM. Resident BS was observed to have been taken at 6:00 AM and was 90. The nurse was observed to initial the MAR for the insulin and not change the time to the actual time it was given.

A review of the MAR documented that resident 4 was to receive her NPH insulin administration at 7:00 AM.

A review of the physician recertification orders dated June 2002, documented that resident 4 had orders to have her BS taken twice a day. The SS for regular

PRINTED: 6/28/ DEPARTMENT OF HEALTH AND HU. N SERVICES FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION 2567 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH FAIRVIEW CARE CENTER - WEST SALT LAKE CITY, UT 84104** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ΙD PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 333 Continued From page 37 F 333 insulin was order to start from a BS above 150. Resident 4 had orders to receive 60 U of NPH insulin every morning and evening. The facility nurse who administered the insulin was interviewed on 6/18/02 at 10:00 AM. The nurse acknowledged that insulin was a time sensitive medication. The nurse further stated that he/she did not like to give insulin until after the residents had eaten breakfast. The facility Director of Nursing (DON) was interviewed on 6/18/02 at 4:00 PM. The DON stated that there had been some problems in the past with residents who had received their insulin before meals. She stated that she had instructed the nursing staff to wait to administer the residents insulin until after breakfast, to make sure the residents had eaten. The DON also stated she had not changed the administration times on the MAR and had not consulted with the residents physicians about the change. In the Textbook of Basic Nursing, sixth edition, Caroline Bunker Rosdahl, RN-C, BSN, MA, copyright 1995, page 1067, stated "Regular insulin and semilente insulin are quick acting and are given 15 to 30 minutes before a meal so they will reach the bloodstream at about the same time as the glucose from the meal....Intermediate-acting insulins are usually given 30 minutes before breakfast...Their action will handle the glucose from meals during the day. Regular insulin is often combined with intermediate and long

acting insulin for the best glucose management." Page 1069 stated "Nursing Skill Guidelines: Giving Insulin - Test the patient's blood glucose each time before giving any insulin. Insulin is usually given before meals. (Rationale: To make sure the patient is not getting too much or too little insulin.) Give the

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |            | A. BUILD  |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|--|------------|---|--|-------------------------------|--------------------------|
| _   |  | 46A064   |            | B. WING   |  | 6/20                          | 1/02                     |
| NAME OF P   | ROVIDER OR SUPPLIER  |  | STREET ADI | DRESS, CITY,  | STATE, ZIP CODE  | 0/20                          | 11 U Z                   |
| FAIRVII   | EW CARE CENTER - V   | VEST   |            | T 700 SOUT<br>KE CITY, I  |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEEDED BY<br>SC IDENTIFYING INFORMA  | FULL       | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)                                       | JLD BE                        | (X5)<br>COMPLETE<br>DATE |
| F 333   | Continued From page 3 insulin on time. (Rat the schedule. Alterat patient.)"   | alin on time. (Rationale: The dosage depends on schedule. Alteration in the time is dangerous to the                       |            |   | F-371 483.35 DIETARY SERV  | !                             |                          |
| F 371<br>SS=E                                       | 483.35(h)(2) DIETAI  The facility must stord food under sanitary contains the second s | store, prepare, distribute, and serve  |            | F 371   | prepare, distribute, and serve food under sanitary conditions.  A. General Sanitation: All areas were thoroughly cleaned on 6/25/2002.           |                               |                          |
|   | This REQUIREMEN  | Γ is not met as eviden   | ced by:    |   | Beginning on 6/25/2002 a full shour shift was added to dietary   |                               |                          |
|   | determined the facility  | d on observations and interviews it was mined the facility did not prepare, serve and bute food under sanitary conditions: |            |   | specifically for cleaning.  B. Kitchen Refrigerator: All items in refrigerator will be dated and secured.  The mighty shakes will be charted on, |                               |                          |
| ;<br>;  | 1. An observation of t<br>AM revealed the follo  | he kitchen on 6/17/02 a<br>owing:  | at 5:55    |   | by listing the number taken out will be dated on the container.  C. Resident Refrigerator: Effective (25,1000)                                   | tive                          |                          |
|   | a. General Sanitation All of the cupboards in the kitchen had a layer of dried food debris. The kitchen aide mixer had a yellow dried substance near the neck of where the mixer turns. The meat slicer had pieces of dry brown substances near the blade which slices the meat. The floor in the kitchen was sticky especially by the table in the center of the kitchen and in the dry storage room. The microwave had several crumbs, splatter marks on the inside. A layer of dried food substance was present on the outside of the microwave. On the dish table there was a cleaning cloth that was stored out of the sanitary bucket. On the shelf below the microwave and coffee server was a open bag of plastic silverware.  |  |            | of/25/2002, no resident of staff will be stored in the kitchen. Of sodas will be kept in this refrig D. Kitchen Freezer: All items freezer will be secured using so bags or rubber bands, and will dated. Daily temperatures are taken for freezers and refrigera E. Dry storage: Scoops for sugflour, rice, and dry milk are key scoop holders mounted in the property swatter has been disposed as sauce has been thrown away. Items have been properly stored Everything is stored off the flo | Only erator. in ealing be being tors. gar, pt in cantry. of. Hot   |                               |                          |
| :   |  | eiling were observed to  | have a     |   | 12 tory uning is stored our the field  |                               | :                        |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   |   | A. BUILDIN   | TIPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED  |   |
|---|---|---|--|---------------------|--|---|
|   |   | 46A064  |  | B. WING_            |  | 6/20/02   |
| NAME OF F   | ROVIDER OR SUPPLIER   |   | STREET ADDI  | RESS, CITY, S       | TATE, ZIP CODE   |   |
| FAIRVII   | EW CARE CENTER - V  | VEST  | 876 WEST<br>SALT LAK   |                     |  |   |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEEDED BY<br>SC IDENTIFYING INFORMA   | FULL   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | JLD BE COMPLETE                                     |
| F 371   | The hood above the greasy film. Six bowls that cereal outside. The drawer filled wit debris in them.  b. Kitchen Refrigerat A case of thawed Mig indicating when they manufacturer expiration thawing There were containers  c. Resident Refrigerat   | were served in were be the cutting knifes had drawere taken out to thaw on date was 14 days after filled with juices with the or f the resident refrigera at 7:30 AM. There was   | ed . The ter no date.  | ]                   | F. Meal Preparation: Inservice presented on July 8, 2002 on prhand washing and usage of glow The food service supervisor will monitor and inservice as needengs will have cooked yolks who served to residents, Inservice who presented on June 24, 2002 and additionally on July 8, 2002. Except in oven while serving, are 140 degrees.  G. Dish Washing: Inservice who presented on July 8, 2002 on how washing and sanitizing of hand putting away clean dishes. | oper ves.  Il d. All nen vas d Eggs dept at vas and |
|   | sack. The bag could n were exposed to the or A bag of cut up red unlabeled and had a sp outside of the bag. A bag of mixed vege with no date on the ite There was no thermore e. Dry storage A green fly swatter sugar bins. The bins filled with inside of them. A bottle of hot sauce sauce on the outside or | atside elements of the atsorbided substance stuck to etables and peas that warm.  The properties of the atsorbided substance stuck to etables and peas that warm.  The properties of the atsorbided substance in the freezer.  The properties of the atsorbided substance is sugar and flour had so the had no lid and had decreased. | rn dogs freezer. r that was o the as open  flour and coops rips of |                     | <ol> <li>Observation of kitchen on 6/18/2002:</li> <li>A. All areas have been thorous cleaned. Cereal bowls have be disposed of.</li> <li>B. All items in refrigerator we dated.</li> <li>C. Resident Refrigerator: On will be kept in the resident refrigerator.</li> <li>D. Kitchen Freezer - All item freezer will be stored in sealing or with rubber bands and date.</li> <li>E. Dry storage: Green fly sweet been disposed of. Scoops have</li> </ol>          | rill be ly soda's  ns in ng bags ed. vatter has     |

#### DEPARTMENT OF HEALTH AND HUM. **SERVICES**

FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID m (X5)(EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 371 | Continued From page 40 F 371 them with their handles laying down. place in wall mounts. Everything is A package of graham crackers was observed to be stored off of the floor of the store open and undated. One of the bottom shelves contained approximately room. F. Meal Preparation. Inservice was a loaf of dried bread that was not bagged. presented on July 8, 2002 on proper A six packs of coke and diet coke were laying on the floor of the dry storage room with spilled water hand washing and use of gloves. FSS will monitor and inservice as needed. A resident's package of fig newtons was open with G. Interviews: A cleaning schedule no date. was written and implemented on June 25, 2002. All cooks will initial when f. Meal preparation The facility cook was observed at 7:30 AM wearing assignments are completed. gloves while preparing breakfast for the residents. The cook was observed touching the ladle that was in the The food service supervisor will pan cooking the oatmeal. Then she touched the oven monitor kitchen cleanliness, safety and controls, without washing her hands and changing her sanitation, using the "Kitchen Safety gloves she picked up a sliced of bread with her right gloved hand. She got a knife from the cupboard to & Sanitation Monitoring Form", on a butter the slices of bread. She continued to handle weekly basis, and will report findings slices of bread. to the Quality Assurance Committee 7/08/2012 The cook was cooking fried eggs for breakfast. She placed them in the oven until ready to start tray line. Before tray line begun, the cook was asked to take temperatures. The fried egg temperature was 124 degrees F. During breakfast residents were observed in the dining room being served fried eggs with yolks that were not congealed. g. Dish Washing The dish washer was observed at 2:00 PM to be washing dishes from lunch. The dishwasher was observed three times loading dirty dishes into the dishwasher and without changing her gloves or washing her hands she was observed to be putting away clean dishes.

DEPARTMENT OF HEALTH AND HUM. SERVICES

HEALTH CARE FINANCING ADMINISTRATION 2567 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 46A064 6/20/02 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER

| AIRVIE                 |  | 76 WEST 70<br>ALT LAKE |                     |   |                         |
|------------------------|--|------------------------|---------------------|---|-------------------------|
| X4) ID<br>REFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION |                        | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5)<br>COMPLET<br>DATE |
| F 371                  | Continued From page 41   | I                      | F 371               |   |                         |
|                        | 2. An observation of the kitchen on 6/18/02 at 7 AM and 3:00 PM revealed the following:                                | 7:30                   |                     |   |                         |
|                        | a. General Sanitation  | i                      |                     |   |                         |
|                        | The microwave had several crumbs, splatter ma  |                        |                     | !   |                         |
|                        | the inside. A layer of dried food substance was  | present                |                     | !   | İ                       |
|                        | on the outside of the microwave.   | 210.0                  |                     |   | 1                       |
|                        | The air vents on the ceiling were observed to ha layer of dust build up.   | ave a                  |                     |   | :                       |
|                        | The hood above the oven was observed to have   | e a                    |                     |   | ž<br>V                  |
|                        | greasy film.   |                        |                     |   | !                       |
|                        | Six bowls that cereal were served in were burnt outside.   | on the                 |                     |   |                         |
|                        | b. Kitchen Refrigerator  | i<br>:<br>:            |                     |   |                         |
|                        | A container of chocolate milk was observed a   | it 3:00                |                     |   |                         |
|                        | PM open and not dated.   |                        |                     |   |                         |
|                        | c. Resident Refrigerator   |                        |                     |   |                         |
|                        | The temperature of the resident refrigerator was   | s 50 F                 |                     |   |                         |
|                        | at 7:30 AM. There was a container of rice and  |                        |                     |   |                         |
|                        | container of fish in the refrigerator.   |                        |                     |   |                         |
|                        | The temperature of the refrigerator was 65 F at  |                        |                     |   |                         |
|                        | PM. There was a container of rice and a contain fish in the refrigerator.  | ner oi                 |                     |   |                         |
|                        | d. Kitchen Freezer   |                        |                     |   |                         |
|                        | Several corn dogs were observed in a plastic great   |                        |                     |   |                         |
|                        | sack. The bag could not be sealed and the corn   | -                      |                     |   |                         |
|                        | were exposed to the outside elements of the free   | ezer.                  |                     |   |                         |
|                        | e. Dry storage   |                        |                     |   |                         |
|                        | A green fly swatter was hanging over the flour a   | and                    |                     |   |                         |
|                        | sugar bins.  |                        |                     |   |                         |
|                        | The bins filled with sugar and flour had scoops  | ınside                 |                     |   |                         |
|                        | of the bin.  The bins filled with rice and beans had the scoo  | on in                  |                     |   |                         |
|                        | them with their handles laying down.   | ър ш                   |                     |   |                         |
|                        | A six pack of coke and diet coke was laying on   | the                    |                     |   |                         |

6/20/02

DEPARTMENT OF HEALTH AND HUM. **SERVICES** HEALTH CARE FINANCING ADMINISTRATION

NAME OF PROVIDER OR SUPPLIER

2567

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING

(X3) DATE SURVEY COMPLETED

46A064

STREET ADDRESS, CITY, STATE, ZIP CODE

| FAIRVIEW CARE CENTER - WEST                                     |  | 876 WEST 700 SOUTH SALT LAKE CITY, UT 84104 |                    |   |                         |  |  |
|---|--|---|--------------------|---|-------------------------|--|--|
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION  |   | ID<br>REFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5)<br>COMPLET<br>DATE |  |  |
| F 371   | Continued From page 42   | F3  | 71                 |   |                         |  |  |
|   | floor of the dry store room.   |   |                    |   |                         |  |  |
|   | f. Meal Preparation  |   |                    |   |                         |  |  |
|   | The facility cook was observed at 7:30 AM pre  | eparing                                     |                    |   |                         |  |  |
|   | breakfast for the residents. She poured cereal i   | into  |                    |   |                         |  |  |
|   | several bowls that was sitting directly on the tal   |   |                    |   |                         |  |  |
|   | stacked it onto the other bowl containing cereal   |   |                    |   |                         |  |  |
|   | was later observed handling slices of bread after<br>touching the cupboard, bowls and spatula with   |   |                    | ,   |                         |  |  |
|   | washing her hands or changing gloves.  | out   |                    |   |                         |  |  |
|   | The dining room was observed during breakfas   | st and                                      |                    |   |                         |  |  |
| residents were served fried eggs which had a was not congealed. |  | olk that                                    |                    |   | !                       |  |  |
|   | g. Interviews  |   |                    |   | •                       |  |  |
|   | The cook was interviewed on 6/18/02 at 3:00 P stated that there was no set cleaning schedule. She stated that the dietary supervisor tells her we clean things.  |   |                    |   |                         |  |  |
|   | The dietary manager was interviewed on 6/18/0 7:30 AM. She stated that there were certain resi who liked their eggs over easy /not congealed. Smention three residents names and stated that she consent forms signed for them. She stated the f | ident<br>She<br>he had                      |                    | •   |                         |  |  |
|   | policy was to give the residents what they want order to make them happy.  |   |                    |   | !<br>!                  |  |  |
|   | On 6/18/02 at 2:00 PM a confidential group into  | erview                                      |                    |   | İ                       |  |  |
| 1   | was held. A resident stated that she did not like  | 1   |                    |   | i<br>•                  |  |  |
| 1   | eggs over easy.  |   |                    | ••  | :                       |  |  |
| F 441   | 483.65(a)(1)-(3) INFECTION CONTROL   | F 44  | <b>1</b> 1         |   | ;<br>;<br>;             |  |  |
| SS=E  | The facility must establish an infection control   |   |                    |   |                         |  |  |
|   | program under which it investigates, controls, a   | nd  |                    |   |                         |  |  |
| 2567L   | ATG112000 Event I CFX51  | 1 Facili                                    | v ID:              | JT0026 If continua  | tion sheet 43 o         |  |  |

FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING - 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 441 : Continued From page 43 F 441 prevents infections in the facility; decides what F 441 - 483.65(a)(1)-(3) INFECTION procedures, such as isolation should be applied to an individual resident; and maintains a record of CONTROL incidents and corrective actions related to infections. This facility will continue to assure This REQUIREMENT is not met as evidenced by: that an established infection control Based on observation, record review and staff program under which it investigates, interview, it was determined that the facility did not controls, and prevents infections in the effectively investigate, control and prevent infections facility is in place; decides what in the facility as evidenced by: procedures, such as isolation should be 1. Observation of facility staff not adhering to good infection control practices applied to an individual resident; and 2. Lack of toileting residents and providing maintains a record of incidents and incontinence care to prevent infections (Residents 3 corrective actions related to infections. and 20) 3. Lack of follow through when trends were identified. An inservice training regarding infection control is scheduled on July Findings include: 22, 2002, and again on a monthly basis throughout the year, for all nursing 1. a. On 6/17/02 and 6/18/02, from 9:00 AM to 10:00 assistants and housekeeping staff. AM, the facility recreation employee was observed to Items to be presented will include the be combing residents hair during a grooming activity. following: Hand washing, Sanitizing The employee was observed to use the same comb on each of the residents hair without sanitizing the comb. of combs, the checking of nasal The employee was also observed not to wash her cannula placement, proper placement hands or sanitize her hands between residents. The of urinary down drain bags, proper employee stated that she used to be a nursing assistant usage of gloves, the bagging of soiled and knew that her practice was not acceptable. linens, the placing of soiled linens in b. On 6/17/02 at 12:15 PM, in room 106, a nasal bags, and the bagging of wet briefs. oxygen cannula was observed to be lying on the edge An inservice training is scheduled on of a garbage can. July 22, 2002, and again on a monthly On 6/18/02 at 8:00 AM, in room 113, a nasal oxygen basis for all Nursing Assistants cannula was observed to be lying on the edge of a regarding skin care, and the changing garbage can. The nasal canula was brown with brown

On 6/19/02 at 7:00 AM, in room 108, a nasal oxygen cannula was observed to be lying on the floor.

debris in the ends of the canula.

of briefs and toileting. (See F-316)

# DEPARTMENT OF HEALTH AND HUMAN .RVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

46A064

B. WING

6/20/02

NAME OF PROVIDER OR SUPPLIER

FAIRVIEW CARE CENTER - WEST

STREET ADDRESS, CITY, STATE, ZIP CODE

876 WEST 700 SOUTH

SALT LAKE CITY, UT 84104

| (X4) ID |   |
|---------|---|
| PREFIX  |   |
| TAG     | ! |

SUMMARY STATEMENT OF DEFICIENCIES (ÉACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

F 441

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5) COMPLETE DATE

F 441 Continued From page 44

At 8:10 AM, in room 113, a nasal oxygen cannula was observed to be on the floor.

- c. On 6/18/02 from 6:00 AM to 8:00 AM, a resident in room 114 had a urinary down drain bag that was observed to be hanging from a walker at the residents bedside. The urinary down drain bag was above the level of the residents bladder, not allowing for proper drainage.
- d. On 6/17/02 from 12:30 PM to 12:55 PM, a facility housekeeping employee was observed emptying garbage, without gloves on, or washing hands, and was opening facility doors with contaminated hands. On 6/18/02 at 6:30 AM, a facility nursing assistant (NA) was observed to come out of a resident room carrying dirty linen in her right hand. The NA was wearing gloves. She opened the door with her left hand. The NA then proceeded to assist a resident in a wheel chair to the hall touching the handle of the wheelchair with her contaminated hand. On 6/19/02 from 6:45 AM to 7:20 AM, two facility housekeeping employees were observed to be emptying garbage and stripping resident beds. Neither employee was wearing gloves. Both employees were observed to enter several resident rooms touching door knobs with contaminated hands. The dirty linen barrels were located outside of the facility just off the main hall. The housekeeping employees were observed to take the dirty linen out to the barrels and return to the hall without washing hands in between. On 6/19/02, at 8:15 AM, a facility housekeeper was observed to carry dirty linen in ungloved hands to the linen barrels outside. She was then observed to start dusting in the day room. The employee was not observed to wash her hands. On 6/20/02 at 7:00 AM, a facility NA was observed to

Facility practice and reviews of trends and issues will be monitored by the Administrator. Inservice will be presented on a monthly basis based on the trends or absence thereof, and documented. The trends, inservice, comments and issues will be reviewed at the Quality Assurance Committee Meeting.

to the trash can. The NA opened the door to the

carry a bag filled with soiled incontinence pads outside

## DEPARTMENT OF HEALTH AND HUM. SERVICES HEALTH CARE FINANCING ADMINISTRATION

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER<br>IDENTIFICATION NUM  |  | (X2) MULTIPL<br>A. BUILDING<br>B. WING     | LE CONSTRUCTION   | (X3) DATE<br>COMPL                | ETED                     |
|---|---|--|--|---|-----------------------------------|--------------------------|
|   | 46A064  | CEREET ARRIVE                              | DEGG CHELL CELL                            | TE TIN CORE   | 6                                 | /20/02                   |
| NAME OF PROVIDER OR SUPPLIER  FAIRVIEW CARE CENTER -  | WEST  | 876 WEST                                   | RESS, CITY, STA<br>700 SOUTH<br>E CITY, UT |   |                                   |                          |
| PREFIX (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEEDED BY<br>LSC IDENTIFYING INFORMA  | FULL                                       | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC'<br>CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| the incontinence page e. On 6/18/02 at 12:  | ved hands and placed the ds into the trash can outs 40 PM to 1:05 PM, soile on the floor in room 105  | ide.<br>ed linen                           | F 441                                      |   |                                   |                          |
| AM to be passing me hands and without usersidents. She admit different residents we hand sanitizer.  g. On 6/19/02 at 11 observed changing the resident's wet brief to the sanitizer. | as observed on 6/18/02 andication without washing a hand sanitizer bettinistered medication to so without washing her hand :15 AM, facility NA's was resident's briefs. On was placed on the carpet. The other resident's well nt's made bed. | ng her ween even s or using ere e e        |  |   |                                   |                          |
| 's dressing on his ga<br>6/19/02 at 7:00 AM<br>resident 30's old gua<br>changing her gloves<br>saline solution. She   | was observed to change restroenteral feeding tube; The nurse was observed aze dressing off. Without, she cleansed the site withen placed a new guaze feeding tub site without   | site on d to take ut ith normal e dressing |  |   |                                   |                          |
| with diagnoses of co  | dmitted to the facility on ongestive heart failure, ditis, hypertension and bip   | iabetes                                    |  |   |                                   |                          |
| Resident 3's medica at 10:00 AM.  | l record was reviewed or  | ı 6/18/02                                  |  |   |                                   |                          |
|   | m Data Set (MDS) asses<br>y staff for resident 3, dat   |  | !  |   |                                   | :                        |

DEPARTMENT OF HEALTH AND HUM. SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 46A064 6/20/02 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **876 WEST 700 SOUTH FAIRVIEW CARE CENTER - WEST** SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5)(EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 441 Continued From page 46 F 441 3/27/02, documented that resident 3 required limited assistance of one person for toileting. The facility staff documented that resident 3 was frequently incontinent of bowel and bladder and was to be toileted. The facility staff also documented that resident 3 had a urinary tract infection in the last 30 days. An Interdisciplinary Team Care Plan for resident 3, completed by facility staff, documented that resident 3 had episodes of urinary incontinence and required toileting every 2 hours and whenever necessary. The Care Plan also documented that resident 3 had a urinary tract infection and to observe for burning or painful urination. A review of resident 3's nursing notes dated from 1/8/02 through 6/15/02, revealed that facility nurses documented that resident 3 was incontinent of bowel and bladder and required assistance with toileting. Further review of resident 3's nursing notes and laboratory results revealed the following: A nurses note dated 2/10/02 at 12:30 PM, documented, "C/O [complaining of] pain and burning when she voids. Order obtained for UA [urinalysis] in the am." UA results dated 2/13/02, documented that resident 3 had a UTI involving the organism klebsiella oxytoca. A nurses note dated 4/13/02, documented, "Res [resident] C/O burning on urination. Will get a UA." UA results dated 4/17/02, documented that resident 3 had a UTI involving the organisms streptococci, group D and klebsiella pneumoniae. A nurses note dated 5/22/02 at 2:00 PM, documented, "Pt [patient] C/O burning upon urination. Will get UA."

LIT0026

#### DEPARTMENT OF HEALTH AND HUM **SERVICES**

HEALTH CARE FINANCING ADMINISTRATION 2567 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

| FAIRVIEW CARE CENTER - WEST |  | 876 WEST 700 SOUTH     |                     |  |                          |  |  |  |
|-----------------------------|--|------------------------|---------------------|--|--------------------------|--|--|--|
| FAIKVIE                     | W CARE CENTER - WEST   | SALT LAKE              | CITY, UT            | 84104  |                          |  |  |  |
| (X4) ID<br>PREFIX<br>TAG    |  |                        | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |  |  |  |
| F 441                       | F 441 Continued From page 47 UA results dated 5/25/02 documented that had a UTI involving the organism klebsiell:  |                        | F 441               |  |                          |  |  |  |
|                             | Review of the physician orders for resident 3 2/10/02 through 5/25/02, revealed that reside treated with antibiotics for all of the above in   | ent 3 was              | :                   |  | :                        |  |  |  |
|                             | On 6/17/02, continuous observation of reside done from 6:30 AM to 11:00 AM.  Resident 3 was observed to leave her room a AM and sit in a recliner in the day room.   | at 6:30                |                     |  |                          |  |  |  |
| ,                           | At 7:35 AM, resident 3 was assisted by a facility nursing assistant (NA) to stand up from the recline and ambulate with a walker to the dining room. At 8:20 AM, resident 3 was observed to ambulate       | ecliner<br>m.<br>ulate | <br> -<br> -<br> -  |  |                          |  |  |  |
|                             | from the dining room back to the day room at recliner.  At 9:10 AM, resident 3 was assisted by the restaff person to go to the opposite end of the d   | ecreation<br>lay room  |                     |  |                          |  |  |  |
|                             | and have her hair fixed. Resident 3 then return the recliner in the day room.  At 10:00 AM, resident 3 was assisted by a Naup out of the recliner and ambulate to the dimensional transfer.                | A to get               |                     |  |                          |  |  |  |
|                             | for a snack.  At 10:25 AM, resident 3 was observed to amb back to the day room and sit in the recliner ch 11:00 AM. Resident 3 was not observed to b   | hair until             |                     |  |                          |  |  |  |
|                             | or changed from 6:30 AM to 11:00 AM, a pe 1/2 hours.   | i i                    | !<br>               |  |                          |  |  |  |
|                             | On $6/18/02$ , continuous observation of reside done from $6:20$ AM to $11:30$ AM and $12:30$ $4:00$ PM .  |                        |                     |  |                          |  |  |  |
|                             | Resident 3 was observed to leave her room at and sit in a recliner in the day room.  At 7:40 AM, resident 3 was assisted by a fac to stand up from the recliner and ambulate wi walker to the dining room. | ility NA               |                     |  |                          |  |  |  |
| 1S-2567L                    | At 8:25 AM, resident 3 was observed to amb   |                        | acility ID: U       | TT0026   | ation sheet 48 of        |  |  |  |

|                             | FATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER   |  |  |                            |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|-----------------------------|--|--|--|----------------------------|---|-------------------------------|--------------------------|
|                             |  | 46A064   |  | B. WING                    |   | 6/                            | /20/02                   |
| NAME OF P                   | PROVIDER OR SUPPLIER   |  | STREET ADI   | DRESS, CITY, STA           | TE, ZIP CODE  |                               |                          |
| FAIRVIEW CARE CENTER - WEST |  | WEST   |  | T 700 SOUTH<br>KE CITY, UT | 84104   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG    |  |  |  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | ON SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| F 441                       | from the dining room recliner.  At 9:30 AM, resident staff person to go to tand have her hair fixe the recliner in the day At 10:10 AM, resident up out of the recliner for a snack.  At 10:25, resident 3 with the day room and sit is remained in the recline AM. Resident 3 was changed from 6:20 Althours.  On 6/18/02, resident recliner in the day room At 12:40 PM, resident the recliner and ambut resident 3 ambulated recliner.  At 1:50 PM, resident to the dining room for At 3:00 PM, after the the day room and sat Resident 3 was not obtained from 12:30 PM to 4:00 Cm 6/19/02, resident the day room from 6:4 At 7:40 AM, resident the recliner and ambut At 8:15 AM, resident room back to the day 8:15 AM to 10:20 AM, resident in At 10:20 AM, resident in At 10:20 AM, resident in At 10:20 AM, resident room back to the day resident in At 10:20 AM, re | t 3 was assisted by the rest the opposite end of the ed. Resident 3 then rest y room.  In the assisted by an and ambulate to the direct was observed to ambulate in the recliner chair. Rest and ambulate to the direct during an activity us not observed to be toiled. Moreover, as a sassisted to standate to the dining room at 12:30 PM.  In the assisted to standate to the dining room back to the day room at 3 was assisted from the or a resident meeting. In the energy are meeting resident 3 returns a recliner chair until between the control of 3 1/2 and 3 was observed in a recommendate to the dining room at 3 was assisted to standal at the dining room at 3 was assisted to standal at the dining room and sat in a recliner room and sat in a recliner resident 3 was observed in a recommendate to the dining room at 3 ambulated from the commendate to the dining room and sat in a recliner resident 3 was observed in a recliner resident 3 was observed and as a sobserved in a recliner resident 3 was observed and a recliner resident 3 | recreation day room furned to  NA to get ining room  ate back to resident 3 antil 11:30 leted or iod of 5  atting in a find up from an At 1:15 and sat in a find e recliner furned to 14:00 PM. For changed 2 hours.  Cliner in dining finer. From execution we assisted | F 441                      |   |                               |                          |

|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER  (X1) PROVIDER/SUPPLIER/C   |  |   | A. BUILDING                | IPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|--|---|----------------------------|--|-------------------------------|
|                          |  | 46A064                                       |   | B. WING                    |  | 6/20/02                       |
| NAME OF P                | PROVIDER OR SUPPLIER   |  | STREET ADI  | DRESS, CITY, ST            | TATE, ZIP CODE   | <u> </u>                      |
| FAIRVIE                  | EW CARE CENTER - V   | VEST   |   | Г 700 SOUTH<br>KE CITY, UT |  |                               |
| (X4) ID<br>PREFIX<br>TAG |  |  | FULL  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | JLD BE COMPLETE               |
| F 441                    | ambulated to the dinin At 10:40 AM, resident in the day room and s From 10:40 AM to 11 observed to sit in the Resident 3 was not observed to sit in the Resident 3 was not observed to sit in the Resident 20 was adwith diagnoses of Part diabetes mellitus, dystarthritis.  A review of resident 26/17/02.  A quarterly MDS assecompleted by facility resident 20 required e persons for toileting. resident 20 was freque toileted. The facility resident 20 had a urina days.  An Interdisciplinary T completed by facility 20 was incontinent and managed by staff. The resident 20 to the bath and change briefs ever documented to report painful urination by resident 2 11/1/01 through 6/18/6 documented that resident 2 days are sident 2 11/1/01 through 6/18/6 documented that resident 2 days are sident 2 days. | ng room for a snack.  nt 3 ambulated back to | as m. or changed /2 hours. n 1/26/00 ension, and s done on , tented that two mented that two mented that e last 30 defent 20, resident of the done on the mented that if able also hing or enurse.  I from ty nurses of | F 441                      |  |                               |
| i                        | i  |  |   |                            |  | :                             |

DEPARTMENT OF HEALTH AND HUM. SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST **SALT LAKE CITY, UT 84104** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 441 Continued From page 50 F 441 A review of resident 20's Flow Sheet Records, completed by facility nursing assistants, dated from November 2001 through May, 2002, documented that resident 20 was incontinent of bladder. Further review of resident 20's nursing notes and laboratory results revealed the following: A nurses note dated 11/8/01, documented, "res C/O pain when urinating. Will send UA to lab.' UA results dated 11/11/01 documented that resident 20 had a UTI involving the organisms Klebsiella pneumoniae, proteus mirabilis and streptococci group R A nurses note dated 12/9/01, documented, "Res C/O burning on urination. Will send UA." UA results dated 12/13/01 documented that resident 20 had a UTI involving the organisms proteus mirabilis, escherichia coli and streptococci group D. A nurses note dated 2/26/02, documented, "Seen by [regular physician]. C/O dysuria. UA to be done 2/28/02. Results to [urologist]." UA results dated 3/1/02 documented that resident 20 had a UTI involving the organisms escherichia coli, proteus mirabilis and methicillin resistant staphylococcus aureus (MRSA). A nurses note dated 5/28/02 at 8:00 AM documented, "C/O pain and discomfort when voiding. d/t [due to] pts Hx [history) of UTI's order obtained for UA with C&S if indicated." UA results dated 5/30/02 documented that resident 20 had a UTI involving the organisms proteus mirabilis. pseudomonas aeruginosa, klebsiella pneumoniae and streptococci group D. A follow up UA dated 6/13/02 documented that resident 20 had a UTI involving the organisms

PRINTED: 6/28/ DEPARTMENT OF HEALTH AND HUM. SERVICES FORM APPROVE **HEALTH CARE FINANCING ADMINISTRATION** 2567 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 441 Continued From page 51 F 441 methicillin resistant staphylococcus aureus (MRSA) and streptococci group D. Review of the physician orders for resident 20 from 11/11/01 through 5/30/02, revealed that resident 20 was treated with antibiotics for all of the above infections. Review of the urologists progress notes for resident 20 dated 11/19/01 documented, "Pt in diapers - seldom toileted routinely. Voluntary voids if toileted ... " Review of the urologists progress notes for resident 20 dated 2/21/02 documented, "Pt wears pads [times] 24. Hx recurrent UTIs..." On 6/17/02, continuous observation of resident 20 was done from 7:15 AM to 11:00 AM. Resident 20 was observed to be taken to the dining room from her room at 7:15 AM. At 9:20 AM resident 20 was observed to still be in the dining room. At 9:35 AM, resident 20 was taken back to her room and placed in front of her television, where she remained until 11:00 AM. Resident 20 was not observed to be toileted or changed form 7:15 AM to 11:00 AM, a period of 3 3/4 hours. On 6/18/02, continuous observation of resident 20 was done from 6:20 AM to 11:30 AM, and 12:30 PM to

ATG112000

4:00 PM. Resident 20 was observed to be up in a wheelchair in the dining room at 6:20 AM.

At 7:55 AM, resident 20 was served breakfast in the

At 10:10 AM resident 20 was observed to still be in the dining room in a wheelchair, leaning to her left

At 10:25 AM, resident 20 was taken back to her room

Event I CFX511 Facility ID: UT0026

dining room.

CMS-25671

side with her eyes closed.

## DEPARTMENT OF HEALTH AND HUM. SERVICES

HEALTH CARE FINANCING ADMINISTRATION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 46A064 6/20/02 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 441 Continued From page 52 F 441 and placed in front of her television. At 11:00 AM, resident 20 was observed to still be in her room, in a wheelchair, in front of her television. Resident 20 was not observed to be toileted or changed from 6:20 AM to 11:00 AM, a period of 4 1/2 hours. On 6/18/02, resident 20 was observed to be in the dining room sitting in a wheel chair at 12:30 PM. At 1:30 PM, resident 20 was observed to be taken into the day room in a wheelchair. At 2:00 PM, resident 20 was taken back into the dining room. From 2:00 PM to 3:00 PM, resident 20 attended a meeting for the residents. At 3:10 PM, resident 20 was taken to her room and placed in front of her television where she remained until 4:30 PM. Resident 20 was not observed to be toileted or changed from 12:30 PM to 4:30 PM, a period of 4 hours. On 6/19/02, resident 20 was observed to be in a wheelchair, in the dining room, from 7:50 AM to 8:55 AM. At 8:55 AM, resident 20 was taken back to her room and placed in front of her television. Resident 20 was observed to be in her room, in the wheelchair, in front of her television until 11:15 AM. At 11:15 AM, two nurse surveyors requested to observe resident 20's ability to stand and to observe resident 20's skin. Three NAs were present to assist resident 20 with incontinence care. Two of the facility NAs assisted resident 20 to a standing position from a wheelchair. The wheelchair pad was observed to be wet. The brief the facility NAs removed from resident 20 was wet. Resident 20 was not observed to be toileted or changed from 7:50 AM to 11:15 AM, a period of 3 1/2 hours.

3. An interview was held with the Director of Nursing

|   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |  |   | (X3) DATE<br>COMPI  |   |
|---|--|--|--|---|---|---|
|   | 46A064   |  | B. WING  | ·   | 6   | /20/02  |
| ROVIDER OR SUPPLIER   | **   | STREET ADI   | ORESS, CITY, ST  | ATE, ZIP CODE   |   |   |
| EW CARE CENTER - V  | WEST   |  |  |   |   |   |
| SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |  | ID<br>PREFIX<br>TAG  | (EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO TI   | ION SHOULD BE<br>HE APPROPRIATE   | (X5)<br>COMPLETE<br>DATE  |
| (DON) on 6/17/02 at every month she revirecords and completes sheet. The DON state completes a monthly infection rate.  A review of the mont sheets and monthly re May 2002, was compfollowing:  January 2002-4 reside infection rate.  February 2002 - 5 resinfection rate.  March 2002- 9 reside infection rate.  April 2002-7 resident rate.  May 2002-13 resident rate.  May 2002-13 resident rate.  Five residents were infection rate.  Five residents were infections, specifically a second interview we 6/20/01 at 9:00 AM. facility practice was we through the tracking swould try to identify the staff. The DON states increase in urinary trainserviced staff on prefor incontinence care. had not kept written dactions she had taken. | ews the medication adress an infection control ted she takes the tracking report and calculates the thly infection control traceports for January 2002 pleted on 6/19/02 and resembled to the infections and a 2.2 pleted on 6/19/02 and resembled to the infections and a 3.5% and infections and a 3.5% and infections and a 11.4 plentified as having reperty urinary tract infections in the DON was doned that the DON was asked when trends were identified. The DON stated the cause, monitor and in the cause, monitor and in the cause of the cau | ninistration racking ag sheet, he monthly acking through evealed the wealed the wealed the sheet on the that sheet enoted an sheet cocedure end that sheet the that sheet the wealed that sheet enoted an sheet cocedure end that sheet the wealed that sheet the wealed that sheet the wealed that sheet the wealed that sheet the wealed that sheet the wealed that sheet the wealed that sheet the wealed that sheet the wealed that sheet the wealed that sheet the wealed that sheet the wealed that sheet the wealed that sheet the wealed that sheet the wealed that sheet the wealed the wealed that sheet the wealed that sheet the wealed the wealed that sheet the wealed | F 441  |   |   |   |
| A review of the facilit   | y Inservice Training fro   | om   |  |   |   |   |
|   | Continued From page 5 (EACH DEFICIENCY REGULATORY OR I  Continued From page 5 (DON) on 6/17/02 at every month she revirecords and completes sheet. The DON state completes a monthly infection rate.  A review of the month sheets and monthly remained for the month sheets and monthly remained for the month sheets and monthly remained for the month sheets and monthly remained for the month sheets and monthly remained for the month sheets and monthly remained for the month sheets and monthly remained for the month sheets and monthly remained for the month sheets and monthly remained for the month sheets and monthly remained for the month sheets and monthly remained for the month sheets and monthly remained for the month sheets and monthly remained for the month sheets and month sheets were in the month sheet for the month sheets and month sheets are in the month sheets and month sheets and month sheets are in urinary trainserviced staff on prefor incontinence care. The month sheets are incontinence care. The month sheets are incontinence care. The month sheets are incontinence care. The month sheets are incontinence care. The month sheets are incontinence care. The month sheets are incontinence care. The month sheets are incontinence care. The month sheets are incontinence care. The month sheets are incontinence care. The month sheets are incontinence care. The month sheets are incontinence care. The month sheets are incontinence care. The month sheets are incontinence care. The month sheets are incontinence care. The month sheets are incontinent sheets are incontinent sheets are incontinent sheets. The month sheets are incontinent sheets are incontinent sheets are incontinent sheets. The month sheets are incontinent sheets are incontinent sheets are incontinent sheets are incontinent sheets are incontinent sheets are incontinent sheets are incontinent sheets are incontinent sheets are incontinent sheets are incontinent sheets are incontinent sheets are incontinent sheets are incontinent sheets are incontinent sheets | A review of the monthly infection control trasheets and monthly report and calculates the infection rate.  A review of the monthly infections and a 2.2 infection rate.  February 2002 - 4 resident infections and a 2.2 infection rate.  February 2002 - 5 resident infections and a 3.5% rate.  May 2002- 9 resident infections and a 3.5% rate.  May 2002- 13 resident infections and a 11.4 infection rate.  Five residents were identified as having repe infections, specifically urinary tract infection rate.  Five residents were identified as having repe infections, specifically urinary tract infection and a 2.1 infection rate.  Five residents were identified as having repe infections, specifically urinary tract infection at 3.5% rate.  A second interview with the DON was asked we facility practice was when trends were identified would try to identify the cause, monitor and staff. The DON stated that in May 2002, she increase in urinary tract infections and correct profor incontinence care. The DON further state had not kept written documentation to support actions she had taken.   | A review of the monthly infection control tracking sheets and monthly report and calculates the monthly infection rate.  A review of the monthly infections and a 2.2% infection rate.  A review of the monthly infections and a 9.6% infection rate.  March 2002- 9 resident infections and a 8.6% infection rate.  March 2002- 7 resident infections and a 11.4% infection rate.  May 2002- 13 resident infections and a 11.4% infection rate.  Five residents were identified as having repeat infections, specifically urinary tract infections.  A second interview with the DON was asked what the facility practice was when trends were identified through the tracking sheet. The DON stated that rough the tracking sheets and monthly reports for January 2002 through May 2002, was completed on 6/19/02 and revealed the following:  January 2002-4 resident infections and a 9.6% infection rate.  March 2002- 9 resident infections and a 8.6% infection rate.  May 2002- 13 resident infections and a 11.4% infection rate.  Five residents were identified as having repeat infections, specifically urinary tract infections.  A second interview with the DON was asked what the facility practice was when trends were identified through the tracking sheet. The DON stated that she would try to identify the cause, monitor and inservice staff. The DON stated that in May 2002, she noted an increase in urinary tract infections and stated she inserviced staff on precautions and correct procedure for incontinence care. The DON further stated that she had not kept written documentation to support the | ROVIDER OR SUPPLIER  **ROVIDER OR SUPPLIER**  **ROVIDER OR SUPPLIER**  **ROVIDER OR SUPPLIER**  **SUMMARY STATEMENT OF DEFICIENCIES** (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  **COntinued From page 53** (DON) on 6/17/02 at 12:30 PM. The DON stated that every month she reviews the medication administration records and completes an infection control tracking sheet. The DON stated she takes the tracking sheet, completes a monthly report and calculates the monthly infection rate.  A review of the monthly infection control tracking sheets and monthly reports for January 2002 through May 2002, was completed on 6/19/02 and revealed the following:  January 2002-4 resident infections and a 2.2% infection rate.  March 2002- 9 resident infections and a 9.6% infection rate.  May 2002- 13 resident infections and a 3.6% infection rate.  A pril 2002-7 resident infections and a 11.4% infection rate.  Five residents were identified as having repeat infections, specifically urinary tract infections.  A second interview with the DON was asked what the facility practice was when trends were identified through the tracking sheet. The DON stated that she would try to identify the cause, monitor and inservice staff. The DON stated that in May 2002, she noted an increase in urinary tract infections and stated she inserviced staff on precautions and correct procedure for incontinence care. The DON further stated that she had not kept written documentation to support the actions she had taken. | A BULLING  46A064  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEEDED BY PULL REQUILATORY OR ISC IDENTIFYING INFORMATION)  Continued From page 53  (DON) on 6/17/02 at 12:30 PM. The DON stated that every month she reviews the medication administration records and completes an infection control tracking sheet, the DON stated be takes the tracking sheet, completes a monthly report and calculates the monthly infection rate.  A review of the monthly infection control tracking sheets and monthly reports for January 2002 through May 2002, was completed on 6/19/02 and revealed the following:  January 2002-4 resident infections and a 2.2% infection rate.  March 2002-9 resident infections and a 9.6% infection rate.  March 2002-9 resident infections and a 11.4% infection rate.  Five residents were identified as having repeat infections, specifically urinary tract infections.  A second interview with the DON was asked what the facility practice was when trends were identified through the tracking sheet. The DON stated that she would try to identify the cause, monitor and inservice staff. The DON stated that she ad not kept written documentation to support the actions she had taken. | A BRILDING B. WIND  46A064  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCY  (EACH DEFICIENCY MUST BE PRECEDEDED BY HULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (ACTION OF 1/20 at 12:30 PM. The DON stated that every month she reviews the medication administration records and completes an infection control tracking sheet, completes an infection rate. A review of the monthly infection and a 2.2% infection rate.  A review of the monthly reports for January 2002 through May 2002, was completed on 6/19/02 and revealed the following:  January 2002-4 resident infections and a 9.6% infection rate.  Are second interview with the DON was asked what the facility practice was when trends were identified through the tracking sheet. The DON stated that the facility practice was when trends were identified through the tracking sheet. The DON stated that the facility practice was when trends were identified through the tracking sheet. The DON stated that the facility practice was when trends were identified through the tracking sheet. The DON stated that she would by to identify the cause, monitor and inservice staff. The DON stated that in May 2002, she noted an increase in univary tract infections and inservice staff. The DON stated that in May 2002, she noted an increase in univary tract infections and stated she inserviced staff on precautions and correct procedure for incontinence care. The DON further stated that she had not kept written documentation to support the actions she had taken. |

DEPARTMENT OF HEALTH AND HUM SERVICES FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION 2567 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST **SALT LAKE CITY, UT 84104** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 441 Continued From page 54 F 441 11/7/01 through 5/7/02 was completed on 6/20/02. The documented inservice training did not include basic universal precautions or interventions to prevent urinary tract infections. An interview was held with two facility nurses on 6/20/02 at 7:30 AM. The nurses were asked if they had received any inservice training on infection control in the past two months. The both stated they had not. An interview was held with two facility housekeeping employees on 6/20/02 at 7:40 AM. The employees were asked if they had received any inservice training on infection control in the past two months. They both stated they had not. An interview was held with two facility nursing assistants on 6/20/02 at 7:50 AM. The nursing assistants were asked if they had received any inservice training on infection control in the past two months. They both stated they had not. An interview was held with the facility recreation employee on 6/20/02 at 7:55 AM. The employee was asked if she had received any inservice training on infection control in the past two months. She stated she had not. F 502 <sup>1</sup> 483.75(j) ADMINISTRATION F 502 SS=D The facility must provide or obtain laboratory services

CMS-2567L

services.

ATG112000

This REQUIREMENT is not met as evidenced by:

to meet the needs of its residents. The facility is responsible for the quality and timeliness of the

> Event I CFX511

Facility ID: UT0026

If continuation sheet 55 of

#### DEPARTMENT OF HEALTH AND HUMA **SERVICES**

FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST SALT LAKE CITY, UT 84104 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 502 Continued From page 55 F 502 Based on review of resident's medical records and F-502 483.75(j) ADMINISTRATION facility staff interviews, it was determined that the facility did not provide timely laboratory services as ordered by the physician. Specifically, the facility did This facility will continue to lprovide not obtain a valproic acid level and liver functional or obtain laboratory services to meet test (LFT) for resident 21. The facility did not obtain a the needs of its residents. The facility LFT, lithium level, tegretol level and dilantin level is responsible for the quality and until 1 month after the levels were ordered by the timeliness of the services physician for resident 5. Findings include: 1. Resident #21 had a LFT and\_ Valproic acid drawn on 6-4-2002 with 1. Resident 21 was admitted to the facility on 1/7/97 results of 57.49 in range 50-100. LFT schedule with the diagnoses of major depression, cerebral 40 pr quar 2. Resident #5 had multiple attempts vascular accident, dysphagia and seizure disorder. 7-11-03 at Lab draws which were refused by A review of resident 21's recertification of physician's resident adamantly. Resident has orders was done on 6/17/02. The recertification Doctor appointment on 7-12-2002 orders dated June 2002, documented that the facility with Laura Blair APRN for follow-up was to obtain an LFT and a valproic acid level in and bloodwork. March 2002 for resident 21 7/12/2012 There was no documentation that could be found in A new policy and procedure for resident 21's medical record that the LFT and valproic Laboratory Services has been acid had been done in March 2002. implemented. A complete Laboratory Audit has been completed by Medical A review of the laboratory request form documented that the facility had requested an LFT and valproic Records and will continue on a acid level to been done on 3/5/02. monthly basis. Any issues or trends will be reported to the Administrator A review of the facility laboratory log documented that and Director of Nursing, and will be the resident 21 had a blood specimen collected on presented and discussed at the Quality 3/5/02 and the date of return was not documented. Assurance Committee Meeting. The Director of Nursing (DON) was interviewed on 6/19/02 at approximately 1:00 PM. She stated a note had been left for her that a facility staff member had

called the laboratory service for the missing laboratory results for resident 21. She stated that the note stated

## DEPARTMENT OF HEALTH AND HUM SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH** FAIRVIEW CARE CENTER - WEST SALT LAKE CITY, UT 84104 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 502 i Continued From page 56 F 502 that the laboratory service could not find the LFT and valproic acid level results. She further stated the laboratory service had performed a valproic acid level on 6/4/02 but had no record of the LFT. 2. Resident 5 was admitted to the facility on 8/29/96 with the diagnoses of dermatitis, constipation, deaf mute, pain, osteoarthritis, bipolar disorder, organic brain disease, cerebral palsy, and seizures. A review of resident 5's recertification of physician's orders was done on 6/17/02. The recertification orders dated April 2002, documented that the facility was to obtain an LFT, lithium level, tegretol level in March 2002. A review of laboratory results dated 4/16/02 documented that resident 5 did have the LFT, lithium level, tegretol level one month after the laboratory tests were ordered. A review of the laboratory requisition form documented that the the facility had requested an LFT, lithium level, tegretol level was to be done on 3/5/02. On the laboratory requisition form a nurse had noted that "This was signed off by [laboratory service person] [The laboratory service person] never had drawn the blood and had a history of this kind of problem with laboratory service. [The laboratory service person] no longer works there. This had been reordered for 4/16/02. It is possible the resident refused." During an interview with the DON (Director of Nursing) on 6/18/02 at 4:00 PM, it was stated that the facility did not have a tracking system to ensure that all laboratory results were obtained. She stated that she was notified by one of the facility staff members that the laboratory service person had been taking the

DEPARTMENT OF HEALTH AND HUM. SERVICES

**HEALTH CARE FINANCING ADMINISTRATION** 2567 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 46A064 6/20/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **876 WEST 700 SOUTH FAIRVIEW CARE CENTER - WEST SALT LAKE CITY, UT 84104** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 502 : Continued From page 57 F 502 laboratory requisition forms and had not collected any specimens for the necessary laboratory tests. She stated she had filled out a requisition form for a resident to receive a laboratory test and had it come up missing. She had called laboratory service and they had fired one of their laboratory service persons for not doing his/her job.

The following is an addendum to the 2567 for the recertification survey of Fairview Care Center West completed on June 20,2002.

#### F 164-483,10(d)(3) FREE CHOICE

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This will be monitored directly by the Director of Nursing an by the Department Heads(SS,Rec,Diet, Hskg) using a Resident Rounds Checklist that will be completed 2x/day at least 5 days per week. The administrator will oversee this process and track data on trends on a weekly basis. (See copy Rounds Checklist Policy)

#### F 223-483.13(b) ABUSE

The Social Services staff will maintain the log of reported incidents and supporting documentation. The log will be reviewed by the administrator for completeness an accuracy manthly This will also be reviewed on a quarterly basis in the Quality Assurance Meeting.

#### F 248483.15(f)(1) QUALITY OF LIFE

Completion date for the plan of correction is August 19,2002.

#### F 275-483.20(b)(2)(iii) RESIDENT ASSESSMENT

The Medical Records Staff will audit the yearly an quarterly MDS schedule for timely completion on a weekly basis.

#### F 279-483.20(k) RESIDENT ASSESSMENT

All residents functional status will be evaluated on a monthly basis as part of the monthly summary complete by the charge nurse.

The Restorative Nursing Program will be evaluate monthly by the Director of Nursing and reported to the Quality Assurance Committee quarterly by the Director of Nursing.

#### F 311-483.25(a)(2) QUALITY OF CARE

The Restorative Nursing Program will by evaluated monthly by the Director of Nursing and reported to the Quality Assurance Committee Meeting quarterly by the Director of Nursing.

#### F 314-483.25(c) QUALITY OF CARE

All weekly skin reports completed by the Assistant Director of Nursing will be reviewed by the Director of Nursing on a monthly basis an issues an trends will be reported at the quarterly Quality Assurance Committee Meeting.

#### F 316-483.25(d)(2) QUALITY OF CARE

All bowel and bladder assessments will be reviewed quarterly with the MDS by the Director of Nursing and PRN with any UTI diagnosis, change in level of continence, etc. Any issues or trends will be tracked using the infection control tracking policies and procedures an tracking sheets by the Nursing Administration and then reported at the quarterly Quality Assurance Committee Meeting.

#### F 318-483.25(e)(2) QUALITY OF CARE

The Restorative Program will be monitored on a monthly basis by the Director of Nursing.

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Documentation and issues will be reviewed by the Director of Nursing and reported at the quarterly Quality Assurance Committee Meeting.

### F 332.483.25(m)(1) QUALITY OF CARE

Residents 3,4,8,16,19,27,30, and 32 have had their blood sugar and insulin administration orders reviewed an verified by the nursing staff.

On all residents identified as having Type I or II Diabetes Mellitus; including residents 3,4,8,16,19,27,30, and 32; the blood sugar and insulin records will be audited weekly for one year by the Medical Records Director. The audits will be reviewed monthly by the Director of Nursing an all issues an trends will be reported to the Quality Assurance Committee on a quarterly basis.

## F 333-483.25(m)(2) QUALITY OF CARE

This facility will continue to ensure that residents are free of any significant medication errors. On June 21,2002 an inservice and meeting was held for all licensed nurses. At the meeting, it was agreed that the night and morning shifts would overlap by thirty minutes to assure that all insulins are given in a timely manner.

An inservice is scheduled on July 22, 2002 for all licensed nurses. It will be presented by the Pharmacy Consulting R.N., an will address the nursing basic concept of the 5 R's: 1. Right patient 2. Right time 3. Right medication 4. Right dose 5. Right route of administration. The Pharmacy Consulting R.N. has scheduled unannounced medication pass monitoring on a monthly basis for the next six months.

On all residents identified as having Type I or II Diabetes Mellitus; including residents 3,4,8,16,19,27,30, an 32; the blood sugar and insulin records will be audited weekly for one year by the Medical Records Director. The audits will be reviewed monthly by the Director of Nursing an all issues or trends will be reported to the Quality Assurance Committee on a quarterly basis.

## F 441-483.65(a)(1)-(3) INFECTION CONTROL

Facility practice and review of the trends and issues will be monitored monthly by the Administrator. Inservices will be presented of a monthly basis based on the trens or absence thereof, and documented. The trends, inservices, comments and issues will be reviewed at the Quality Assurance Committee Meeting held each quarter.

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