DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

acceptable PoC 7/16/02 c addendum dated 7/16/02 S. Slinde RN

PRINTED: 6/28/
FORM APPROVE
2567

STATEMENT OF DEFICIENCIES 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 ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER - WEST	876 WEST 700 SOUTH SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 164 SS=D	483.10(d)(3) FREE CHOICE The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not provide privacy during medical treatment, insulin administration, for 1 of 10 sample residents and 1 additional resident. (Residents 3 and 19) Findings include: On 6/18/02, during the medication pass observation from 9:13 AM to 9:50 AM, the facility nurse was observed to administer insulin to 9 residents. Resident 3 was in the day room. At 9:25 AM, the facility nurse informed resident 3 he was going to give	F 164 ok c addendum received 7/16/02 SS	F-164 - 483.10(d)(3) FREE CHOICE This facility will continue to assure that each resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Including Medical Treatment. All Residents, including residents 3 and 19, will be provided their insulin and treatments in privacy. Inservice was provided to all Licensed Nurses on 6-21-02. This will be monitored directly by the Director of Nursing, and by Department Heads, using the "Resident Rounds Checklist" Any issues or trends will be reported and addressed at the Quality Assurance Meeting. 508 045 wp Utah Dept. of Health JUL 1 1 2002 Bur. of Medicare/Medicaid Prog. Certification and Res. Assessment	6/21/02

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7-11-2002

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days aft such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 her insulin. The facility nurse then lifted up resident 3's blouse, exposing her abdomen and proceeded to administer the insulin. At the time there were 9 other residents in the day room, 3 men and 6 women. Resident 19 was in the hallway by the nursing station. At 9:30 AM, the facility nurse was observed to administer resident 19's insulin to her, in her arm, in the hallway. Other facility staff and residents were observed in the hallway at the time the facility nurse administered resident 19's insulin. During a resident group interview on 6/18/02 at 2:00 PM, resident 3 stated that it bothered her to have her insulin given to her in the day room. She stated, "How would you like it?"	F 164	F-223 - 483.13(b) ABUSE This facility will continue to assure that each resident is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. A new abuse policy and procedure was put into place on 7-01-02. Stated in the policy and procedure is "After investigation is complete, the administration will document a summary of its findings as to whether the alleged abuse was verified and report its findings to the agencies which were notified at the beginning of the investigation. The facility will, in the case of all substantiated abuse involving a staff member, immediately terminate that employee and notify the appropriate law enforcement and regulatory agencies." Regular and ongoing inservice has been scheduled for all staff. The facility will maintain an ongoing log of all reported incidents that are potentially abusive. This log will include date, type of incident, names of those involved, injuries, and agency reported to. A separate section will include copies of incident report,	
F 223 SS=D	483.13(b) ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on interview with the facility administrator and review of a facility "Resident Abuse Investigation Report", it was determined that the facility allowed a nursing assistant (NA) to continue employment in the facility and continue to provide direct resident care after the facility had determined that the NA had physically abused a resident. (Resident 18) Findings include: An interview was held with the facility administrator on 6/17/02 at 10:00 AM. During the interview the administrator stated that the facility had investigated one incident of alleged abuse between an NA and	F 223 ok c addendum dated 7/16/02 [initials]		

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F 223	Continued From page 2 resident 18. The administrator stated that the facility had investigated the alleged abuse and had determined that the alleged abuse had occurred. The administrator further stated that the incident had been investigated by Adult Protective Services and had been substantiated. During the same interview, the administrator stated that the NA had been employed in the facility for 3 months prior to the incident, and had just completed the training to obtain his certification. The administrator further stated that during the investigation the NA was suspended from work. She stated that when the investigation was completed, the NA was allowed to return to work but did not provide care for resident 18. The administrator stated that the NA worked in the facility for two more weeks then decided to quit. The facility had not terminated the NA. A review of a facility "Resident Abuse Investigation Report", dated 3/5/02, was done on 6/17/02 at 10:30 AM. The report documented that a facility nursing assistant was changing resident 18's brief and resident 18 swore at the NA and then, "punched the NA. NA hit him back in the shoulder with a closed fist." A review of an "Employee Concerning Behavior/Action Notice" form dated 3/5/02 was done on 6/17/02 at 10:35 AM. The form documented that the NA , "...admitted to Administrator the he had 'slapped' resident back. Stated he did it without thought - simply responding to being hit."	F 223	investigative reports of those involved and witnesses, notification agencies, and any other information. Any trends or issues will be addressed in staff, group, and individual training. And reviewed at the Quality Assurance Meeting. F-248 - 483.15(f)(1) QUALITY OF LIFE This facility will continue to provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psycho-social well-being of each resident	7/01/02
F 248 SS=E	483.15(f)(1) QUALITY OF LIFE The facility must provide for an ongoing program of activities designed to meet, in accordance with the	F 248 ok c̄ addendum dated 7/16/02 [illegible]	There will be a monthly calendar that contains at least 4 group activities per day on Monday through Friday and	8/ [illegible]

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F 248	Continued From page 3 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 scheduled past 3:00 PM. On Saturdays the 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. a. The glamour activity was scheduled at 9:00 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. b. The snack social 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. c. The grocery order activity was scheduled on	F 248	two group activities per day on Saturday and Sunday. Individual activities such as providing reading material, special TV programming is on the calendar for residents desired reference, will be in addition to the 4 group activities on weekdays and 2 group activities on each weekend day. The grocery list will be posted and not a part of the calendar. There will be at least 2 programs scheduled after the 3:00 time weekly on the calendar. There will be a resident council sub-committee of recreation planning committee implemented monthly. In this meeting the residents help plan elements of the calendar according to their interests. Minutes will be kept and placed with the resident council notes. As long as programs are realistic, they will be added to the calendar the next month. The grooming activity will be protocol. Will be for a self-esteem emphasis of "looking pretty". It will not be an ADL orientation, but more geared towards self-esteem issues related to ow one presents themselves. In this there will be separate	8/01/02 8/01/02 7/29/02 7/15/02

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F 248	Continued From page 4 6/17/02 at 11:00 AM. This activity involved the recreation employee obtaining shopping requests from the residents. d. The reading activity was scheduled on 6/17/02. This activity involved the recreation employee providing residents that wanted it, reading material. e. The stretch/walk activity was observed on 6/19/02 at 10:55 AM in the dayroom. There were six residents in the dayroom. Four of the residents were actively participating. The other two residents had their eyes closed and appeared to be sleeping. Prior to the activity beginning, the recreation employee went around the facility to invite residents to the activity. The employee stated, "No one wants to come when you say exercise." f. The current events activity was observed on 6/19/02 at 1:30 PM in the dayroom. The recreation employee was reading the newspaper to the residents. There were eight residents in attendance. Two residents left the dayroom shortly after the recreation employee began reading the newspaper to them. g. The bingo activity was observed on 6/17/01 at 2:35 PM in the dining room. Nine residents were involved in the activity. 2. A resident group interview was held on 6/18/02 at 2:00 PM. Twelve residents were involved in the group interview. The residents were asked about the activity program. Eight of the 12 residents stated there was not enough to do. The residents stated they were bored in the evening and on the weekend. They stated they would like more out door activities. 3. Through out the survey from 6/17/02 to 6/20/02, the majority of the residents were observed to be	F 248	combs/brushes, make-up applicators, etc. for each individual packaged in a separate bag. Combs and brushes will be cleaned after each use. The social is restructured into not only getting treats, but also stimulating activities as part of the social (ie: trivia, discussion group, social tickler and ice-breaker activities.) The TR staff is currently involved in a course geared towards programming and obtaining the TRT license. This will be completed July 14th. She will then be on a structured experience as per identified student training protocol, where the consultant will work with her on providing a stronger program to meet the needs and interests of the residents. This will include motivational techniques for both staff assistance and resident involvement, programming geared to the different cognitive levels, understanding of the needs and interests regarding different disabling conditions and activity modification to meet their needs and interests. In this the TR staff will be able to encourage more residents out to activities - and activities will better meet their needs and interests. This should increase the	7/20/02 Class 7/14/02 Training 8/30/02

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.

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F 248	Continued From page 5 sleeping in their rooms or in the recliner chairs in the day room, sitting on the front porch, sitting in their rooms, or wandering in the hallway. 4. An interview with the facility recreation staff member was done on 6/19/02 at 9:00 AM. She stated she had only worked in the facility for 2 months. She stated that she meets once a week with her consultant about the residents and the activities in the facility. She stated that she had tried to meet with residents on a individual basis. She stated she had not developed a group for men and has had difficulty working with the less cognitive individuals.	F 248	F-275 483.20(b)(2)(iii) RESIDENT ASSESSMENT This facility will continue conduct a comprehensive assessment of a resident not less than once every 12 months. A Significant Correction, and Annual Assessment was completed on Resident #21 on 7-9-2002. The Medical Records person will audit the Yearly and quarterly MDS schedule for timely completion, and notify the Interdisciplinary Team. The Director of Nursing and Director of Social Services will be responsible for assuring timely and accurate completion of the MDS. All MDS audits and completion issues will be reviewed by the Quality Assurance Committee.	7/9/2002
F 275 SS=D	483.20(b)(2)(iii) RESIDENT ASSESSMENT A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility did not complete an annual Minimum Data Set (MDS) assessment at least every 12 months for 1 of 10 sample residents. Findings include: Resident 21 was admitted to the facility on 1/7/97 with the diagnoses of major depression, cerebral vascular accident, dysphagia and seizure disorder. Resident 21's active medical record was reviewed on 6/17/02. The medical record contained six quarterly assessments dated 6/6/02, 3/31/02,12/13/01, 9/13/01, 6/12/01, 3/22/01 and one annual assessment dated 9/25/00. An annual MDS assessment should have been completed on or about 9/13/01. There were no other annual MDS assessments in resident 21's active	F 275 ok c addendum dated 7/16/02		

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F 275	Continued From page 6 medical record. The facility administrator was interviewed on 6/19/02 at approximately 10:00 AM. She stated the facility had completed a quarterly assessment on 9/13/01 and should have completed an annual assessment.	F 275	F279 - 483.20(k) RESIDENT ASSESSMENT This facility will continue to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and pychosocial needs that are identified in the comprehensive assessment.	
F 279 SS=D	483.20(k) RESIDENT ASSESSMENT The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under s483.25; and Any services that would otherwise be required under s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility did not ensure that residents' comprehensive care plans included services that were to be furnished to attain or maintain the residents' highest practible physical well being for 2 of 10 sample residents. (Residents 1 and 21) Finding include: 1. Resident 21 was admitted to the facility on 1/7/97 with diagnoses of major depression, cerebral vascular	F 279 OK c addendum dated 7/10/02 [initials]	1. Resident #21 has been working with the Physical Therapist, three times per week since 6-7-2002. When discontinued from Physical Therapy, resident will be placed into the Restorative Nursing Program. The exercise program with goals and plan have been written by the Physical Therapist with weekly documentation by the Restorative Aide. 2. Resident #1's Plan of Care #8b Addressed Impaired Skin Integrity Actual. The Physical Therapist is working with resident (see T.O. dated 6/3/2002) interrupted by resident's hospital stay. When discontinued from Physical Therapy, resident will be placed in the Restorative Nursing Program.(See response to F-311)	

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F 279	Continued From page 7 accident, right-sided hemi paresis, expressive aphasia, seizure disorder and incontinence. An observation of resident 21 was made of 6/17/02 at 9:15AM . Resident 21 was observed to have a contracture of his right hand. Review of resident 21's medical record was done on 6/18/02 at 10:00 AM. A quarter Minimum Data Set (MDS) assessment for 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.	F 279	All residents functional status will be evaluated on a monthly basis as part of the monthly nursing summary The Restorative Nursing Program will be evaluated and reported on at the Quality Assurance Committee, by the Director of Nursing.. Restorative Nursing Program was established with full policies and procedures on July 8, 2002.	7-01-2002

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F 279	Continued From page 8 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...."	F 279		

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F 279 — Continued From page 9

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.

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.

F 311 SS=G — 483.25(a)(2) QUALITY OF CARE

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 residents to achieve and maintain maximum abilities for transfers and ambulation. (Resident 20)

Findings include:

Resident 20 was admitted to the facility on 1/26/00 with diagnoses of Parkinson disease, hypertension, diabetes mellitus, dysphagia, osteoporosis and arthritis.

Provider's Plan of Correction

F 279

F 311 — OK c̄ addendum dated 7/16/02 [initials]

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

This facility will continue to assure that each resident is given the appropriate treatment and services to maintain or improve his or her abilities.

Resident #20 was evaluated by the Physical Therapist on 7-2-2002, and was placed in the Restorative Nursing Program which was written and implemented on 7-2[illegible]-2002.

All Residents discharged from Physical Therapy will be placed in the Restorative Nursing and Dining Program, which has goals determined and written by the Physical Therapist and Speech Therapist.

The Restorative Nursing will be evaluated and reported to the Quality Assurance Committee, by the Director of Nursing.

Complete date: 7/2/2002

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FAIRVIEW CARE CENTER - WEST	876 WEST 700 SOUTH SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 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.

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F 311	Continued From page 11 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.	F 311		

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F 314 SS=G	483.25(c) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined that the facility did not ensure that a resident without pressure sores did not develop pressure sores. (Resident 1) Findings include: 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. 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	F 314 ok c addendum dated 7/16/02 [initials]	F-314 - 483.25(c)QUALITY OF CARE This facility will continue to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.. Based on the comprehensive assessment of the resident. Resident's #1's Plan of Care#8b, Addressed Impaired Skin Integrity: Actual. Initiated on 5-6-02 IDT reviewed on 5-9-02 and updated on 5-22-02. An inservice is scheduled on July 22, 2002 at 2:00 p.m. for all licensed nurses. It will be presented by the Pharmacy Consultant RN, regarding bandage and dressing application. A Monthly Inservice on Skin Care is also scheduled for All CNA's. (see Inservice Calendar) A skin inspection will be done	

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F 314	Continued From page 13 surface when bathing/showering. A nurses' note 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...." 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	F 314	weekly by the Assistant Director of Nursing on ALL residents and documented on the Weekly Skin Condition Progress Report. All Skin Reports will be reviewed by the Director of Nursing, and issues and trends will be reported on at the Quarterly Quality Assurance Committee Meeting.	7/22/02

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F 314	Continued From page 14 6/19/02 at 7:15 AM, the facility staff nurse stated that resident 1 frequently bumped his right elbow, causing skin tears to the outside of his right elbow. He stated dressings were placed over the open areas on resident 1's right elbow but he refused to wear protective sleeves. The facility nurse further stated that approximately 2 months ago, resident 1 had developed cellulitis in the right outer elbow. He stated the cellulitis had been treated with antibiotics and nursing staff continued to place dressings over the skin tears securing them with an elastic type bandage. The facility nurse stated that the breakdown on the inside area of resident 1's right arm was probably caused by the elastic stretch dressing being placed to tight around resident 1's elbow area.	F 314		
F 316 SS=E	483.25(d)(2) QUALITY OF CARE A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and resident record review, it was determined that the facility did not ensure that residents received appropriate treatment and services to prevent urinary tract infections for 2 of 10 sample residents. Residents 3 and 29 were not toileted every 2 hours as assessed and care planned and acquired urinary tract infections (UTIs). Findings include: 1. Resident 3 was admitted to the facility on 1/16/00 with diagnoses of congestive heart failure, diabetes mellitus, osteoarthritis, hypertension and bipolar disease.	F 316 ok c addendum 7/16/02 [initials]	F-316 483.25(d)(2) QUALITY OF CARE This facility will continue to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All residents, including residents #3 and #20 will be identified and assessed Through a bowel and bladder assessment on a quarterly basis and as needed with a noted change of condition. An inservice on infection control and toileting is scheduled for July 22, 2002, and on a monthly basis thereafter for all Nursing Assistants. All Nursing Assistants will be instructed again, to change or toilet residents every two hours and document the time changed or toileted. Also to initial and write time applied on incontinent brief. All assessments will be reviewed by the Director of Nursing. Any issues or trends will be tracked using the infection control tracking policies and	

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F 316	Continued From page 15 Resident 3's medical record was reviewed on 6/18/02 at 10:00 AM. A quarterly Minimum Data Set (MDS) assessment completed by facility staff for resident 3, dated 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	F 316	procedures and tracking sheet and then reported at the Quality Assurance Meeting. Rounds checklist will be used as a tool to assist in monitoring frequency of toileting and brief changes.	7/22/02

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NAME OF PROVIDER OR SUPPLIER FAIRVIEW CARE CENTER - WEST	STREET ADDRESS, CITY, STATE, ZIP CODE 876 WEST 700 SOUTH SALT LAKE CITY, UT 84104		

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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 .

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NAME OF PROVIDER OR SUPPLIER: FAIRVIEW CARE CENTER - WEST	STREET ADDRESS, CITY, STATE, ZIP CODE: 876 WEST 700 SOUTH, SALT LAKE CITY, UT 84104		

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F 316	Continued From page 17 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 the day room from 6:50 AM to 7:40 AM. At 7:40 AM, resident 3 was assisted to stand up from the recliner and ambulate to the dining room.	F 316		

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NAME OF PROVIDER OR SUPPLIER: **FAIRVIEW CARE CENTER - WEST**	STREET ADDRESS, CITY, STATE, ZIP CODE: **876 WEST 700 SOUTH SALT LAKE CITY, UT 84104**		

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F 316	Continued From page 18 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.	F 316		

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F 316	Continued From page 19	F 316		

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 B.

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."

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F 316	Continued From page 20 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 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 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	F 316		

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F 316	Continued From page 21 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. 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	F 316		

STATEMENT OF DEFICIENCIES 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 ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER - WEST	876 WEST 700 SOUTH SALT LAKE CITY, UT 84104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 316	Continued From page 22 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.	F 316		
F 318 SS=G	483.25(e)(2) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, it was determined the facility did not provide treatment and services to 2 of 10 sample residents to increase range of motion or to prevent further decrease in range of motion. (Residents 1 and 21) Findings include: 1. 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. 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	F 318 ok c addendum dated 7/16/02 SIS	F-318 - 483.25(e)(2)QUALITY OF CARE Based on the comprehensive assessment of a resident, this facility will continue to ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Residents #1 and #21, are currently being treated by Physical Therapy. All residents with contractures, when identified through the function status part of the monthly nursing summary, will be evaluated and treated by Physical Therapy. When residents are discontinued by the Physical Therapist, they will be placed on the Restorative Nursing Program initiated on July 01, 2002, with goals and plan written by the Physical Therapist, and performed by the Restorative Aide. The Restorative Aide will document resident status through weekly notes. The Restorative will be monitored on an ongoing basis by the Director of Nursing. Documentation and issues will be reviewed and reported at the Quality Assurance Committee Meeting.	7/08/2002

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. BUILDING ____ B. WING ____	6/20/02

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F 318	Continued From page 23 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 physician progress note for resident 1 dated 5/30/02, documented that resident 1 had right arm contractures and the plan was to provide range of motion. A nurses note dated 6/3/02 for resident 1 documented, "Despite surgery for tendon release, R [right] hand contractures appear worsening [with] thumbnail pressing into palm. Order obtained to have [resident 1] evaluated and treated if feasible." A physicial therapy plan of care completed by a physical therapist, dated 6/4/02, documented that the goal was to decrease right hand contractures. A review of resident 1's "Flow Sheet Record"s for the months of January 2002 through June 18, 2002 was done on 6/18/02 at 10:00 AM. On the back of the record an area was provided to document any restorative cares given to resident 1. Resident 1's record had no documentation on the record that restorative services or range of motion had been provided. 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	F 318		

STATEMENT OF DEFICIENCIES 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

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F 318	Continued From page 24 head and said "no". Resident 1 was asked if he was receiving physical therapy to his right hand and elbow. Resident 1 noded his head and said "yes" and used his left hand and held up two fingers. Resident 1 was asked if he meant for 2 weeks. Resident 1 noded his head and said "yes". An interview was held with a facility nursing assistant (NA) on 6/19/02 at 7:10 AM. The NA stated that she did not do anything special while providing daily ADL (activities of daily living) to resident 1. When asked specifically if she moved resident 1's arm and hand to exercise them she stated, "no." An interview was held with a second facility NA on 6/19/02 at 7:30 AM. The NA stated that she frequently got resident 1 up in the morning and did not move resident 1's right arm and hand anymore than to get his shirt on. 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. 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's medical record was done on 6/18/02 at 10:00 AM. A quarterly Minimum Data Set (MDS) assessment for	F 318		

STATEMENT OF DEFICIENCIES 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: FAIRVIEW CARE CENTER - WEST	STREET ADDRESS, CITY, STATE, ZIP CODE: 876 WEST 700 SOUTH SALT LAKE CITY, UT 84104		

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F 318	Continued From page 25 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	F 318		

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	46A064	A. BUILDING ___ B. WING ___	6/20/02

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F 318	Continued From page 26 motion being provided to resident 21. For the month of March 2002, the NAs had documented an "N "on 5 of the 31 days in March. Resident 21 was interviewed on 6/19/02 at approximately 1:45 PM. Resident 21 stated that the facility staff did not provide him with range of motion by exercising his fingers or his right hand. At that time, resident 21's face was observed to grimace as he tried to uncurl his fingers on his right hand by using his left hand.	F 318	F-332 - 483.25(m)(1) QUALITY OF CARE This facility will continue to ensure that it is free of medication error rates of five percent or greater On June 21, 2002 and 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., and 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), Ascertain and repeat aloud. The Pharmacy Consulting R.N. has scheduled un-announced medication pass monitoring on a monthly basis for the next six months. On all residents identified as having Type I or II Diabetes Mellitus, the Blood Sugar and insulin records will be audited weekly for one year by the Medical Records Director. The audits	
F 332 SS=E	483.25(m)(1) QUALITY OF CARE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of resident medical records, it was determined that the facility did not ensure that it was free of medication error rates of five percent or greater. Specifically, the registered nurse surveyor observed two facility nurses administer medications to 12 residents. One facility nurse made one omission error and one dosage error. A second facility nurse gave insulin to 7 residents after 9:15 AM and the scheduled times for the insulin to be given were at 7:00 AM or 8:00 AM. Out of 67 opportunities for error, 9 errors were made the facility's medication error rate 13.4%. Resident identifiers: 3, 4, 8, 16, 19, 27, 30, 32 Findings include: 1. Resident 32 The registered nurse surveyor observed a facility medication pass on 6/18/02 at 6:00 AM. The surveyor	F 332 ok c addendum dated 7/16/02 SG		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. BUILDING ____ B. WING ____	6/20/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER - WEST	**876 WEST 700 SOUTH** **SALT LAKE CITY, UT 84104**

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F 332	Continued From page 27 observed the nurse to pour one tablet of Cogentin 0.5 mg (milligrams) for resident 32. The prescription bottle read to give 0.25 mg of Cogentin which was 1/2 of the tablet of 0.5 milligrams. The nurse continued to pour other medications for resident 32. The surveyor 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:	F 332	will be reviewed by the Director of Nursing, and all issues or trends will be reported to the Quality Assurance Committee	7/22/2002

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. BUILDING ______ B. WING ______	6/20/02

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F 332	Continued From page 28 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	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. BUILDING ______ B. WING ______	6/20/02

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F 332	Continued From page 29 every morning. 4. 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. 5. Resident 30 was admitted to the facility on 2/19/02 with the diagnoses of cerebral vascular accident, aspiration risk, hypertension, neurogenic bladder, urosepsis, gastroesophageal reflux disease, diabetes type I and closed fracture of humeral shaft. The nurse was observed to give resident 30 his insulin at 9:35 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 30 was to receive his NPH insulin administration at 7:00 AM. and his BS twice a day. Resident 30's BS was documented as being 187 which according to the SS	F 332		

DEPARTMENT OF HEALTH AND HU N SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES 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: **FAIRVIEW CARE CENTER - WEST**	STREET ADDRESS, CITY, STATE, ZIP CODE: **876 WEST 700 SOUTH SALT LAKE CITY, UT 84104**		

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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	F 332		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW CARE CENTER - WEST	**876 WEST 700 SOUTH SALT LAKE CITY, UT 84104**

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F 332	Continued From page 31	F 332		

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 .

8. 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 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

STATEMENT OF DEFICIENCIES 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
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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.	F 332		
F 333 SS=E	483.25(m)(2) QUALITY OF CARE The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the Medication Administration Record (MAR), it was determined that the facility did not ensure that 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	F 333 ok c̄ addendum dated 7/16/02 [illegible]	F-333 483.25(m)(2) QUALITY OF CARE This facility will continue to ensure that residents are free of any significant medication errors. See F-332	7/22/2002

STATEMENT OF DEFICIENCIES 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
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F 333	Continued From page 33	F 333		

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:

1. Resident 8 was admitted to the facility on 1/6/01 with the diagnoses of ulcerative colitis, diabetes mellitus ketoacidosis type I and vertigo

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.

2. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. BUILDING ____ B. WING ____	6/20/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 333	Continued From page 34 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,	F 333		

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F 333	Continued From page 35 urosepsis, gastroesophageal reflux disease, diabetes type I and closed fracture of humeral shaft. The nurse was observed to give resident 30 his insulin at 9:35 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 30 was to receive his NPH insulin administration at 7:00 AM. and his BS twice a day. Resident 30's BS was documented as being 187 which according to the SS 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. 5. 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	F 333		

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F 333	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	F 333		

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F 333	Continued From page 37 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	F 333		

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F 333	Continued From page 38 insulin on time. (Rationale: The dosage depends on the schedule. Alteration in the time is dangerous to the patient.)"	F 333		
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined the facility did not prepare, serve and distribute food under sanitary conditions: Finding include: 1. An observation of the kitchen on 6/17/02 at 5:55 AM revealed the following: 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. The air vents on the ceiling were observed to have a layer of dust build up.	F 371 OK 7/16/02 SD	F-371 483.35 DIETARY SERVICES This facility will continue to store, prepare, distribute, and serve food under sanitary conditions. A. General Sanitation: All areas were thoroughly cleaned on 6/25/2002. Beginning on 6/25/2002 a full seven hour shift was added to dietary hours specifically for cleaning. B. Kitchen Refrigerator: All items in refrigerator will be dated and secured. The mighty shakes will be charted on, by listing the number taken out, and will be dated on the container. C. Resident Refrigerator: Effective 6/25/2002, no resident ~~of~~ or staff foods will be stored in the kitchen. Only sodas will be kept in this refrigerator. D. Kitchen Freezer: All items in freezer will be secured using sealing bags or rubber bands, and will be dated. Daily temperatures are being taken for freezers and refrigerators. E. Dry storage: Scoops for sugar, flour, rice, and dry milk are kept in scoop holders mounted in the pantry. Fly swatter has been disposed of. Hot sauce has been thrown away. All items ~~hve~~ have been properly stored. Everything is stored off the floor.	

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F 371	Continued From page 39 The hood above the oven was observed to have a greasy film. Six bowls that cereal were served in were burnt on the outside. The drawer filled with cutting knifes had dried food debris in them. b. Kitchen Refrigerator A case of thawed Mighty shakes was not dated indicating when they were taken out to thaw. The manufacturer expiration date was 14 days after thawing There were containers filled with juices with no date. c. Resident Refrigerator The temperature of the resident refrigerator was 45 degrees Farenheit (F) at 7:30 AM. There was a container of rice and a container of fish in the refrigerator. d. Kitchen Freezer Several corn dogs were observed in a plastic grocery sack. The bag could not be sealed and the corn dogs were exposed to the outside elements of the freezer. A bag of cut up red food item in the freezer that was unlabeled and had a spilled substance stuck to the outside of the bag. A bag of mixed vegetables and peas that was open with no date on the item. There was no thermometer in the freezer. e. Dry storage A green fly swatter was hanging over the flour and sugar bins. The bins filled with sugar and flour had scoops inside of them. A bottle of hot sauce had no lid and had drips of sauce on the outside of the bottle. The bins filled with rice and beans had the scoop in	F 371	F. Meal Preparation: Inservice was presented on July 8, 2002 on proper hand washing and usage of gloves. The food service supervisor will monitor and inservice as needed. All eggs will have cooked yolks when served to residents, Inservice was presented on June 24, 2002 and additionally on July 8, 2002. Eggs kept in oven while serving, are ~~dept~~ kept at 140 degrees. G. Dish Washing: Inservice was presented on July 8, 2002 on hand washing and sanitizing of hands when putting away clean dishes. 2. Observation of kitchen on 6/18/2002: A. All areas have been thoroughly cleaned. Cereal bowls have been disposed of. B. All items in refrigerator will be dated. C. Resident Refrigerator: Only soda's will be kept in the resident refrigerator. D. Kitchen Freezer - All items in freezer will be stored in sealing bags or with rubber bands and dated. E. Dry storage: Green fly swatter has been disposed of. Scoops have been	

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F 371	Continued From page 40 them with their handles laying down. A package of graham crackers was observed to be open and undated. One of the bottom shelves contained approximately a loaf of dried bread that was not bagged. A six packs of coke and diet coke were laying on the floor of the dry storage room with spilled water near by. A resident's package of fig newtons was open with no date. f. Meal preparation The facility cook was observed at 7:30 AM wearing gloves while preparing breakfast for the residents. The cook was observed touching the ladle that was in the pan cooking the oatmeal. Then she touched the oven controls. without washing her hands and changing her gloves she picked up a sliced of bread with her right gloved hand. She got a knife from the cupboard to butter the slices of bread. She continued to handle slices of bread. 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.	F 371	place in wall mounts. Everything is stored off of the floor of the store room. F. Meal Preparation. Inservice was presented on July 8, 2002 on proper hand washing and use of gloves. FSS will monitor and inservice as needed. G. Interviews: A cleaning schedule was written and implemented on June 25, 2002. All cooks will initial when assignments are completed. The food service supervisor will monitor kitchen cleanliness, safety and sanitation, using the "Kitchen Safety & Sanitation Monitoring Form", on a weekly basis, and will report findings to the Quality Assurance Committee	7/08/2002

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F 371	Continued From page 41 2. An observation of the kitchen on 6/18/02 at 7:30 AM and 3:00 PM revealed the following: a. General Sanitation The microwave had several crumbs, splatter marks on the inside. A layer of dried food substance was present on the outside of the microwave. The air vents on the ceiling were observed to have a layer of dust build up. The hood above the oven was observed to have a greasy film. Six bowls that cereal were served in were burnt on the outside. b. Kitchen Refrigerator A container of chocolate milk was observed at 3:00 PM open and not dated. c. Resident Refrigerator The temperature of the resident refrigerator was 50 F at 7:30 AM. There was a container of rice and a container of fish in the refrigerator. The temperature of the refrigerator was 65 F at 3:00 PM. There was a container of rice and a container of fish in the refrigerator. d. Kitchen Freezer Several corn dogs were observed in a plastic grocery sack. The bag could not be sealed and the corn dogs were exposed to the outside elements of the freezer. e. Dry storage A green fly swatter was hanging over the flour and sugar bins. The bins filled with sugar and flour had scoops inside of the bin. The bins filled with rice and beans had the scoop in them with their handles laying down. A six pack of coke and diet coke was laying on the	F 371		

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F 371	Continued From page 42 floor of the dry store room . f. Meal Preparation The facility cook was observed at 7:30 AM preparing breakfast for the residents. She poured cereal into several bowls that was sitting directly on the table and stacked it onto the other bowl containing cereal. She was later observed handling slices of bread after touching the cupboard, bowls and spatula without washing her hands or changing gloves. The dining room was observed during breakfast and residents were served fried eggs which had a yolk that was not congealed. g. Interviews The cook was interviewed on 6/18/02 at 3:00 PM. She stated that there was no set cleaning schedule. She stated that the dietary supervisor tells her when to clean things. The dietary manager was interviewed on 6/18/02 at 7:30 AM. She stated that there were certain resident who liked their eggs over easy /not congealed. She mention three residents names and stated that she had consent forms signed for them. She stated the facility policy was to give the residents what they want in order to make them happy. On 6/18/02 at 2:00 PM a confidential group interview was held. A resident stated that she did not like her eggs over easy.	F 371		
F 441 SS=E	483.65(a)(1)-(3) INFECTION CONTROL The facility must establish an infection control program under which it investigates, controls, and	F 441		

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F 441	Continued From page 43 prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined that the facility did not effectively investigate, control and prevent infections in the facility as evidenced by: 1. Observation of facility staff not adhering to good infection control practices 2. Lack of toileting residents and providing incontinence care to prevent infections (Residents 3 and 20) 3. Lack of follow through when trends were identified. Findings include: 1. a. On 6/17/02 and 6/18/02, from 9:00 AM to 10:00 AM, the facility recreation employee was observed to be combing residents hair during a grooming activity. The employee was observed to use the same comb on each of the residents hair without sanitizing the comb. The employee was also observed not to wash her hands or sanitize her hands between residents. The employee stated that she used to be a nursing assistant and knew that her practice was not acceptable. b. On 6/17/02 at 12:15 PM, in room 106, a nasal oxygen cannula was observed to be lying on the edge of a garbage can. On 6/18/02 at 8:00 AM, in room 113, a nasal oxygen cannula was observed to be lying on the edge of a garbage can. The nasal canula was brown with brown debris in the ends of the canula. On 6/19/02 at 7:00 AM, in room 108, a nasal oxygen cannula was observed to be lying on the floor.	F 441 ok c addendum dated 7/16/02 SD	F 441 - 483.65(a)(1)-(3) INFECTION CONTROL This facility will continue to assure that an established infection control program under which it investigates, controls, and prevents infections in the facility is in place; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. An inservice training regarding infection control is scheduled on July 22, 2002, and again on a monthly basis throughout the year, for all nursing assistants and housekeeping staff. Items to be presented will include the following: Hand washing, Sanitizing of combs, the checking of nasal cannula placement, proper placement of urinary down drain bags, proper usage of gloves, the bagging of soiled linens, the placing of soiled linens in bags, and the bagging of wet briefs. An inservice training is scheduled on July 22, 2002, and again on a monthly basis for all Nursing Assistants regarding skin care, and the changing of briefs and toileting. (See F-316)	

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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 carry a bag filled with soiled incontinence pads outside to the trash can. The NA opened the door to the	F 441	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.	7/22/2002

STATEMENT OF DEFICIENCIES 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

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F 441	Continued From page 45 outside with her gloved hands and placed the bag with the incontinence pads into the trash can outside. e. On 6/18/02 at 12:40 PM to 1:05 PM, soiled linen was observed to be on the floor in room 105 by the door. f. A facility nurse was observed on 6/18/02 at 6:00 AM to be passing medication without washing her hands and without using a hand sanitizer between residents. She administered medication to seven different residents without washing her hands or using hand sanitizer. g. On 6/19/02 at 11:15 AM, facility NA's were observed changing two resident's briefs. One resident's wet brief was placed on the carpeted floor in the resident's room. The other resident's wet brief was placed on the resident's made bed. h. A facility nurse was observed to change resident 30 's dressing on his gastroenteral feeding tube site on 6/19/02 at 7:00 AM. The nurse was observed to take resident 30's old guaze dressing off. Without changing her gloves, she cleansed the site with normal saline solution. She then placed a new guaze dressing on the gastroenteral feeding tub site without changing her gloves. 2. Resident 3 was admitted to the facility on 1/16/00 with diagnoses of congestive heart failure, diabetes mellitus, osteoarthritis, hypertension and bipolar disease. Resident 3's medical record was reviewed on 6/18/02 at 10:00 AM. A quarterly Minimum Data Set (MDS) assessment completed by facility staff for resident 3, dated	F 441		

STATEMENT OF DEFICIENCIES 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: **FAIRVIEW CARE CENTER - WEST**	STREET ADDRESS, CITY, STATE, ZIP CODE: **876 WEST 700 SOUTH SALT LAKE CITY, UT 84104**		

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F 441	Continued From page 46 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."	F 441		

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	46A064	A. BUILDING ______ B. WING ______	6/20/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 47 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 . 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	F 441		

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F 441	Continued From page 48 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 the day room from 6:50 AM to 7:40 AM. At 7:40 AM, resident 3 was assisted to stand up from the recliner and ambulate to the dining room. 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	F 441		

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	46A064	A. BUILDING ________ B. WING ________	6/20/02

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F 441	Continued From page 49 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. b. 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. 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.	F 441		

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	46A064	A. BUILDING ______ B. WING ______	6/20/02

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F 441	Continued From page 50 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 B. 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	F 441		

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F 441	Continued From page 51 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 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 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	F 441		

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F 441	Continued From page 52 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	F 441		

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FAIRVIEW CARE CENTER - WEST	**876 WEST 700 SOUTH SALT LAKE CITY, UT 84104**

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F 441	Continued From page 53	F 441		

(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.
February 2002 - 5 resident infections and a 9.6% infection rate.
March 2002- 9 resident infections and a 8.6% infection rate.
April 2002-7 resident infections and a 5.5% 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 done on 6/20/01 at 9:00 AM. 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 review of the facility Inservice Training from

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	46A064	A. BUILDING ______ B. WING ______	6/20/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 54 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 441		
F 502 SS=D	483.75(j) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by:	F 502		

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	46A064	A. BUILDING ______ B. WING ______	6/20/02

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F 502	Continued From page 55 Based on review of resident's medical records and facility staff interviews, it was determined that the facility did not provide timely laboratory services as ordered by the physician. Specifically, the facility did not obtain a valproic acid level and liver functional test (LFT) for resident 21. The facility did not obtain a LFT, lithium level, tegretol level and dilantin level until 1 month after the levels were ordered by the physician for resident 5. Findings include: 1. Resident 21 was admitted to the facility on 1/7/97 with the diagnoses of major depression, cerebral vascular accident, dysphagia and seizure disorder. A review of resident 21 's recertification of physician's orders was done on 6/17/02. The recertification orders dated June 2002, documented that the facility was to obtain an LFT and a valproic acid level in March 2002 for resident 21. There was no documentation that could be found in resident 21's medical record that the LFT and valproic acid had been done in March 2002. A review of the laboratory request form documented that the facility had requested an LFT and valproic acid level to been done on 3/5/02. A review of the facility laboratory log documented that the resident 21 had a blood specimen collected on 3/5/02 and the date of return was not documented. 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	F 502	F-502 483.75(j) ADMINISTRATION This facility will continue to lprovide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services 1. Resident #21 had a ~~LFT and~~ Valproic acid drawn on 6-4-2002 with results of 57.49 in range 50-100. LFT scheduled to be drawn 7-11-02. 2. Resident #5 had multiple attempts at Lab draws which were refused by resident adamantly. Resident has Doctor appointment on 7-12-2002 with Laura Blair APRN for follow-up and bloodwork. A new policy and procedure for Laboratory Services has been implemented. A complete Laboratory Audit has been completed by Medical Records and will continue on a monthly basis. Any issues or trends will be reported to the Administrator and Director of Nursing, and will be presented and discussed at the Quality Assurance Committee Meeting.	7/12/2002

STATEMENT OF DEFICIENCIES 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
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F 502	Continued From page 56 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	F 502		

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	46A064	A. BUILDING ______ B. WING ______	6/20/02

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FAIRVIEW CARE CENTER - WEST	**876 WEST 700 SOUTH SALT LAKE CITY, UT 84104**

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F 502	Continued From page 57 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.	F 502		

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

This will be monitored directly by the Director of Nursing and 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 and accuracy monthly. This will also be reviewed on a quarterly basis in the Quality Assurance Meeting.

F 24[illegible]483.15(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 and issues and 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 and 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.

5080107
Utah Dept. of Health
JUL 16 2002
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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~~ sixty 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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JUL 16 2002

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