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 _____	04/20/2006

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WEST SIDE COMMUNITY NURSING CENTER	876 WEST 700 SOUTH SALT LAKE CITY, UT 84104

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F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined, that the facility did not ensure that the Minimum Data Set (MDS) assessments accurately reflected residents' status for 2 of 10 sample residents. Resident identifier 6 and 7. Findings included:	F 278	483.20(g) – (j) RESIDENT ASSESSMENT This facility will continue to assure that each assessment accurately reflects the resident's status The MDS assessment of residents 6 and 7 will be updated appropriately on 5/11/2006 to reflect the current status. In order to assure the accuracy of each assessment, a review of each and every assessment will be done by the Interdisciplinary team at each meeting prior to the certification of the assessment. This will begin at the meeting of May 11, 2006 and continue each weekly meeting thereafter. Any issues or trends will be noted at each weekly meeting by the Director of Nurses, and discussed at the quarterly Quality Assurance Meeing.	5/11/06

5/10/06 POC acceptable Compliance date 5/26/06 Rosenberg RN

Utah Department of Health
755859
MAY 10 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/10/06

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

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F 278	Continued From page 1 Resident 6 was admitted on 2/1/04 with diagnoses that included diabetes mellitus type II, hypertension, dementia with depressive features, congestive heart failure, and Alzheimer's dementia with combative behaviors. Resident 6's clinical record was reviewed on 4/19/06. The annual MDS, dated 2/9/06, documented under Section M. Skin Condition. History of resolved ulcers, last 90 days was 0. (No). Resident 6 had triggered for pressure ulcers on the Resident Assessment Protocol and had a pressure ulcer risk assessment score of 18 (high risk), dated 2/8/06. Under the section for skin treatments section j. was marked "None Of The Above". Resident 6's clinical record documented a telephone order, dated 1/2/06, for treatment of a stage II pressure sore on the left inner buttocks. The Monthly Summary, dated 2/1/06, stated "skin was impaired, recent stage II buttocks resolved". In an interview with the acting Director of Nursing (DON), on 4/19/06 at 1:00 AM, she confirmed that resident 6 had been treated for a pressure ulcer that had resolved and did not know why it was not documented on the MDS. Resident 7 was admitted on 2/13/06 with diagnoses that included mentally retarded, seizures, hypothyroidism, and pain.	F 278		

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F 278	Continued From page 2 On 04/20/06 a review of resident 7's medical record was completed. In section G(1) c and d the MDS resident 7 was coded as needing extensive assistance, as well as, one person physical assist while walking between location in the bedroom and in the unit. On 4/18/06 at 8:30 AM resident 7 was observed wandering the kitchen and living-room of the facility independently. On 4/18/06 at 2:55 PM resident 7 was observed wandering the halls of the facility independently. On 4/19/06 at 10:30 AM resident 7 was observed wandering in and out of the resident council meeting independently.	F 278		
F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility did not ensure that a medication that had been discontinued was not given for 1 of 10 sample residents. Resident	F 329	F 329 483.25(l((1) UNNECESSARY DRUGS This facility will continue to ensure that each resident's drug regimen is free from unnecessary drugs. As stated, resident #1's Cymbalta was ultimately discontinued on 2/27/06. Any new medication orders will be immediately documented in the MAR, and medication will be removed from the medication cart. Pharmacy will be notified. The Nurse taking the order will be responsible for this action. This will be monitored by the Director of Nurses through MAR review, on a weekly basis, to begin on May 11, 2006. Any issues or trends will be reviewed at the Quarterly Quality Assurance Meeting.	5/11/06

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F 329	Continued From page 3 identifier 1. Findings included: Resident 1 was admitted on 4/26/05 with diagnoses that included anoxic brain syndrome, insulin dependent diabetes mellitus, Grand mal seizure disorder, esophageal reflux and aphasia. Resident 1's clinical record was reviewed on 4/18/06. Psychotropic drug review was done on 2/7/06, it documented the recommendation that Cymbalta 30 mg (milligram) qd (every day) be discontinued. The order was signed by resident 1's primary care physician and dated 2/7/06. The February 2006 medication administration record (MAR) documented that Cymbalta 30 mg qd was given through 2/27/06. A telephone order, dated 2/28/06, stated "DC (discontinue) Cymbalta". Resident 1 received the psychotropic drug Cymbalta for 20 days after it was discontinued.	F 329		
F 371 SS=B	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by:	F 371	F-371 483.35(i)(2) SANITARY CONDITIONS – FOOD PREP & SERVICE This facility will continue to store, prepare, distribute, and serve food under sanitary conditions.	

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F 371	Continued From page 4 Based on observation, it was determined that the facility did not prepare, distribute and serve food under sanitary conditions. Finding included: On 4/18/06 at 7:30 AM, observations were made in the facility kitchen. The freezer in the dry supply storage room had the following food items. Two zip lock bags with 10 bread sticks, one zip lock bag with 4 bread sticks, dated but not labeled, Large plastic bag of pepperoni with a tear in the bag and evidence of freezer burn, dated but not label, Three large plastic bags of red meat, dated but not labeled, The freezer located next to the back door had the following food items. Large plastic bag of white meat with no label or date, Large plastic bag of brown meat with no label or date.	F 371	All Zip lock bags were labeled and dated on 4/18/06. The pepperoni was thrown away on 4/18/2006. The bag with white meat (chicken) was labeled and dated, and the Large plastic bag of brown meat was thrown out on 4/18/2006. Effective 5/08/2006, all food will be dated when it is received. All items placed in zip lock bags will be dated and marked before storage. The storage of the freezer and refrigerator will be double checked every Monday for proper storage. Any items found in ripped bags will be discarded. Daily monitoring is assigned to the afternoon cook, Dietary Cleaning Assignment, and will be monitored by the Dietary Manager. Any issues or trends will be reported in the Quarterly Quality Assurance Meeting.	5/8/06

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F 496 SS=D	483.75(e)(5)-(7) REQUIRED TRAINING OF NURSING AIDES Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility did not check with the state registry before allowing an individual to work as a CNA (certified nursing assistant).	F 496	F 496 483.75(e)(5)-(7) REQUIRED TRAINING OF NURSING AIDES This facility will continue to ensure that nurses aides have registry verification that the individual has bet competency evaluation requirements. CNA #1 was immediately placed under Nursing Assistant status and under the direct supervision of Certified and Licensed staff. Documentation was provided that competency evaluation program was completed on 3/16/2005. The Director of Nurses will attach an electronic verification copy of each individual's certification or licensure to each nursing employee's application upon hiring. Each new employee's file will be reviewed by the Administrator for completeness. Any issues or trends will be presented and discussed at the Quarterly Quality Assurance Meeting.	4/20/06

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F 496	Continued From page 6 Findings included: On 04/19/06 a review of the employee records revealed that CNA1's file did not contain verification from the state registry. On 4/19/06 at 9:03 AM the facility administrator was interviewed. When asked if she was able to locate the CNA's registry verification she stated that she had forgotten to check with the registry. During the interview the administrator was unable to locate the employee on the state registry registry. Refer to F499	F 496		
F 499 SS=D	483.75(g) STAFF QUALIFICATIONS The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility did not hire a CNA (certified nursing assistant) who was licensed in accordance with applicable state laws. Findings included:	F 499	F 499 483.75(g) This facility will continue to employ individuals who are licensed, certified, or registered in accordance with applicable State laws. CNA #1 was immediately placed under Nursing Assistant status and under the direct supervision of Certified and Licensed staff. Documentation was provided that competency evaluation program was completed on 3/16/2005. The Director of Nurses will attach an electronic verification copy of each individual's certification or licensure to each nursing employee's application upon hiring. Each new employee's file will be reviewed by the Administrator for completeness. Any issues or trends will be presented and discussed at the Quarterly Quality Assurance Meeting.	4/20/06

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F 499	Continued From page 7 On 04/19/06 a review of the employee records revealed that CNA1's file did not contain verification from the state registry. On 4/19/06 at 9:03 AM the facility administrator was interviewed. When asked if she was able to locate the CNA's registry verification she stated that she had forgotten to check with the registry. During the interview the administrator was unable to locate the employee on the state registry. On 04/19/06 at 9:15 AM the facility administrator stated that she had called CNA1 and was told that the CNA1 had let her CNA license expire, and was waiting for the form to arrive to register again. Refer to F496	F 499		
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514	F 514 483.75(l)(1) CLINICAL RECORDS This facility will continue to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized Re-certification orders will reflect all current medications. The Director of Nurses will review all medication changes with the charge nurses. As psychotropic are reviewed each month, any changes or new orders will be recorded in the chart. Any new medication orders or D/C orders will be immediately documented in the MAR, and medication will be removed from the medication cart as necessary. The nurse taking the order will be responsible for this action. This will be monitored on a weekly basis by the Director of Nurses, to begin on May 11, 2006. Any issues or trends will be reviewed at the Quarterly Quality Assurance Meeting.	

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F 514	Continued From page 8 Based on record reviews and interviews, it was determined that the facility did not ensure current clinical records were complete and accurate for 3 of 10 sample residents. Resident identifiers 1, 3, 6. Findings included: 1. Resident 1 was admitted on 4/26/05 with diagnoses that included anoxic brain syndrome, insulin dependent diabetes mellitus, Grand mal seizure disorder, esophageal reflux and aphasia. Resident 1's clinical record was reviewed on 4/18/06. Psychotropic drug review was done on 2/7/06, it documented the recommendation that Cymbalta 30 mg (milligram) qd (every day) be discontinued (DC). The order to DC Cymbalta was signed by resident 1's primary care physician and dated 2/7/06. The recertification orders for March 2006, which were signed by the physician on 2/28/06, documented that Cymbalta 30 mg was to be given QHS (every day at bed time). 2. Resident 3 was admitted to the facility on 10/7/03 with diagnoses that included post polio syndrome, esophageal reflux, and gastroenteritis. Resident 3's clinical record was reviewed on 4/18/06. Laboratory (lab) report documented that a blood test for Lipid panel and TSH (thyroid test) was completed on 3/17/06. There was no order on	F 514	A Lab calendar was established on 5/6/2006 to reflect all standing and new orders. Prior to blood draws, RN/LPN will verify MD orders. A one-to-one in-service with each Licensed Nurse will be completed by the Director of Nurses by 5/26/2006.	5/26/06

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F 514	Continued From page 9 the clinical record for the two lab test. In an interview with nurse 1, on 4/17/06 at 7:30 AM, she confirmed there was no order for the lab. 3. Resident 6 was admitted on 2/1/04 with diagnoses that included osteoarthritis, diabetes mellitus type II, dysphagia, hypertension, cerebral vascular accident, dementia with depressive features, and congestive heart failure. Resident 6's medical record was reviewed on 4/18/06. Monthly summary, dated 4/9/06, documents the following: Resident 6 is not depressed, has no language/communication problems, walks with a walker and has his/her own natural teeth. The annual MDS, dated 2/9/06, documents that resident 6, does not ambulate, uses a wheel-chair for locomotion, has some/or all natural teeth lost, has language/communication problems and is treated with psychotropic drugs for moods and behaviors. Resident 6 was observed on 4/18/06 at 9:00 AM to be in a wheelchair in resident's room, not responding to conversation. Resident was yelling at other resident's and staff. Observation was also done on 4/19/06 at 7:30 AM, resident 6 was sitting in wheel-chair in the TV room, resident was observed to have few if any teeth present and was not responding to conversation with staff or other residents. In an interview, on 4/19/06 at 11:00 AM, with the	F 514		

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F 514	Continued From page 10 acting Director of Nursing, she said resident 6 never walks, always uses a wheel-chair, has practically no teeth, and has problems understanding communications.	F 514		