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	465074	A. BUILDING _____ B. WING _____	02/28/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW WOOD CARE CENTER	1205 EAST 4725 SOUTH SALT LAKE CITY, UT 84117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and records review, it was determined the facility did not promote care in a manner to maintain or enhance each resident's dignity for 3 of 15 sample residents and 3 of 4 alert and oriented residents in a confidential group interview. Specifically 1 resident had her breakfast interrupted to be taken to her room for medication administration that was due prior to the meal, 1 alert and oriented resident felt she could not get nurses to address her concerns, and call lights were not answered promptly for 4 residents. Resident identifiers: 4, 10 and 12. Findings included: 1. On 2/27/07 at 9:00 AM, call lights were being observed. At 9:11 AM, resident 12's call light was activated. The light was on in the hallway above resident 12's door. The call light alert appeared visually and audibly on a monitoring board at the nurses' station. At 9:30 AM, after 19 minutes of continuous observation, a nursing assistant answered resident 12's call light. Resident 12 requested pain medication. Continuous observations were made by the survey team from 9:11 AM until 9:50 AM when a registered nurse entered resident 12's room to administer medications.	F 241		4/14/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Resident 12 was interviewed on 2/27/07 at 10:45 AM. Resident 12 stated that she had originally activated her call light to request pain medication at 7:00 AM. Resident 12 stated a nursing assistant answered her call light saying the nurse would be notified. Resident 12 stated that she waited for the nurse but no one came. Resident 12 stated that, after awhile, she activated her call light again. Resident 12 stated the nursing assistant answered her call light and stated the nurse would be notified that she needed pain medication. Resident 12 stated that the surveyors observed the third time she had activated the call light in order to get pain medication. Resident 12 stated the nurse brought her pain medication around 10:00 AM.

2. A confidential group interview was held on 2/26/07 at 2:00 PM with four alert and oriented residents. Three of the four residents stated that call lights were not answered in a timely manner. The residents stated they had waited twenty minutes up to an hour for staff assistance.

3. Resident 4 was admitted to the facility on 8/18/06 and readmitted on 10/25/06 with diagnoses that include: dementia, hypertension, arthritis and urinary tract infections.

Resident 4 was observed, on 2/25/07, in the dining room and as she was assisted to her room after lunch. Resident 4 was observed in her room from 1:00 PM to 1:10 PM. Resident 4 was taken from the dining room and was left in her wheelchair, just inside the door of her bedroom. The surveyor observed resident 4 as she attempted to wheel herself to her bed (Resident 4 shared her bedroom with one other resident, Resident 4's bed was farthest away from the

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F 241	Continued From page 2 door.) Resident 4 continually got her wheelchair wheels stuck between her roommate's bed and a nightstand in the bedroom. Resident 4 tried, unsuccessfully, to get to her side of the room for 10 minutes. At 1:10 PM, resident 4 was assisted by a nursing assistant to her side of the room and into bed. Resident 4 was observed on 2/26/07 from 8:46 AM to 9:00 AM. Resident 4 was observed to be in her bedroom. The surveyor observed resident 4 as she attempted to wheel herself to her bed. Resident 4 continually got her wheelchair wheels stuck between her roommate's bed and a nightstand in the bedroom. Resident 4 tried for 14 minutes but was unable to get to her side of the bedroom. At 9:00 AM resident 4 was taken out of her room by the activities director. 4. On 2/26/07 at 8:10 AM, during a medication pass, resident 17 was observed in the dining room. Resident 17 was eating her breakfast. Registered Nurse (RN) 1 told resident 17 that she needed to be returned to her room to receive her insulin injection. Resident 17 responded, "Do you have to do it now?" Resident 17 was taken to her room where the injection was given in the left arm. Resident 17 asked the RN, " Why do I have to get my shot in my room today?" The RN 1 told her that her room was where she was supposed to get injections. On 2/27/07 at 7:57 AM, resident 17 was observed in the dining room. Resident 17 was eating her breakfast. RN 1 took resident 17 from the dining room to her room to receive her insulin injection. At 8:04 she was returned to the dining room to finish her meal.	F 241		
F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT	F 278		4/14/07

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F 278	Continued From page 3 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 observation, record review and interview, it was determined the facility did not ensure that the Minimum Data Set (MDS) assessments accurately reflected residents' status for 4 of 15 sample residents. Resident identifiers: 3, 7, 11, 13. Findings include:	F 278		

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F 278	Continued From page 4 1. Resident 7 was admitted on 12/15/06 with diagnoses that included fracture of humerus and sacrum/coccyx, diabetes mellitus, and congestive heart failure. Resident 7's medical record was reviewed on 2/25/07. Resident 7's initial MDS, dated 12/22/06, Section G-4 Physical Functioning and Structural Problems, Functional Limitation In Range of Motion, listed that there was no problem with any extremity in range of motion or voluntary movement. Resident 7's admission orders dated 12/15/06 revealed the resident was to be "NWB (not weight bearing) right upper ext (extremity), shoulder immobilizer at all times." In an interview with resident 7's physical therapist on 2/28/07 at 9:50 AM, he stated that he did passive range of motion (ROM) on resident 7. He stated that resident 7 was getting better at transferring to the wheelchair with help. The Plan of Treatment For Outpatient Rehabilitation form for resident 7, dated 12/2006, included ROM/contracture management as part of the plan. The Occupational Therapy Progress Summary dated 12/25/06 to 12/31/06 for resident 7 revealed the resident required skilled services for ROM/contracture management. 2. Resident 11 was admitted to the facility on 2/7/04 and readmitted on 3/18/06 with diagnoses	F 278		

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that included anoxic brain injury, degenerative joint disease, back pain, hypertension, and arthritis.

Resident 11's medical record was reviewed on 2/28/07.

Resident 11's annual MDS dated 2/12/07, section G -4, Functional limitation in Range of Motion revealed resident 11 had a partial loss of voluntary movement in all extremities. In section I-1, Disease Diagnoses, quadriplegia is checked as one of resident 11's diagnoses.

The physician's progress notes for 11/30/06 and 1/25/07, under neurosensory, was documented that resident 11 had impaired motor skills. There was no documentation that resident 11 had quadriplegia.

The nursing assistants' notes for January 2007, on the Dressing or Grooming Program for Nursing Rehabilitation, revealed that resident 11 was to brush or comb her hair own twice a day with assistance.

An interview was conducted with Licensed Practical Nurse (LPN) 1 on 2/28/07 at 12:50 PM. LPN 1 stated that resident 11 feeds herself.

On 2/28/07 at 12:42, resident 11 was observed in the dining hall feeding herself.

3. Resident 13 was admitted to the facility on 12/29/06 with diagnoses that included Parkinson's disease, Multiple Sclerosis, and depressive disorder.

Resident 16's MDS dated 1/10/07 section J-2,

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F 278	Continued From page 6 revealed the resident did not complain of or exhibit evidence of pain. The nurses notes for resident 16, dated 12/29/06, revealed that resident 16 called out in pain all night and pain medications were given. The social services note for resident 16 dated 12/29/06 revealed that the daughter said that that the resident yelled when she was in severe pain or when she had infection. 4. Resident 3 was admitted to the facility on 12/29/06 with diagnoses that included: depression, diabetes, arthritidis, colon cancer and deep vein thrombosis. A review of resident 3's medical record was completed on 2/26/07. Resident 3's initial MDS, dated 1/10/07, was reviewed. Under section M (Skin Condition), it was documented that resident 3 had two stage IV pressure ulcers. A review of resident 3's weekly pressure sore record, dated 12/29/06, revealed that resident 3 had one stage IV pressure ulcer on her right buttocks and one stage III pressure ulcer on her right buttocks. An interview was conducted with the DON (Director of Nursing) on 2/27/07 at 10:00 AM. She was asked about staging resident 3's pressure ulcers. She stated that resident 3 was admitted with one stage IV pressure ulcer and one stage III pressure ulcer.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS	F 279		4/14/07

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F 279	Continued From page 7 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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 services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility did not implement their care plan to provide needed services for 1 of 15 sample residents. Resident identifier: 4. Findings included: Resident 4 was admitted to the facility on 8/18/06 and readmitted on 10/25/06 with diagnoses that included: dementia, decubitus ulcer, arthritis and hypertension. Resident 4's medical record was reviewed on	F 279		

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2/26/07. There was a physicians order dated 8/18/06 for resident 4 to have a "pressure reducing device to wheelchair, check every shift." This order appeared on the September, 2006, October, 2006, November, 2006, January, 2007 and February, 2007 physician recertification orders.

Resident 4's care plan " Potential for Impaired Skin Integrity" revealed. under approaches to be implemented by the nursing staff, that resident 4 was to have a "pressure reducing device to bed and wheelchair."

According to the resident 4's "Weekly Pressure Sore Record" resident 4 had a stage III pressure ulcer on her right heel at time of survey. Resident 4 was assessed by the facility as being at "moderate risk" for skin breakdown.

Observations of resident 4 were made at various times on 2/25/07 and 2/26/07. Observations of resident 4 included:

On 2/25/07 at 12:40 PM, resident 4 was observed in the dining room, during lunchtime, in her wheelchair. There was not a pressure reliving device in her wheelchair.

On 2/26/07 at 7:45 AM resident 4 was observed in the dining room, during breakfast, in her wheelchair. There was not a pressure reliving device in her wheelchair.

On 2/26/07 at 9:50 AM resident 4 was observed in her wheelchair in her bedroom. There was not a pressure reliving device in her wheelchair.

On 2/26/07 at 1:05 PM resident 4 was observed

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F 279	Continued From page 9 in her wheelchair in her bedroom. There was not a pressure reliving device in her wheelchair. An interview was conducted with RN (Registered Nurse) 1 on 2/26/07 at 1:45 PM. RN 1 was asked if resident 4 had a pressure reliving device in her wheelchair. RN stated that "I am not sure" if resident 4 has a pressure reliving device in her wheelchair.	F 279		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, it was determined the facility did not provide services to maintain the highest practicable physical well-being for 1of 15 sample residents who did not receive timely assessment and intervention for comfort / pain relief. Resident identifiers: 10. Findings included: Resident 10 was admitted to the facility 10/3/06, and readmitted 1/2/07, after a temporary hospitalization. Resident 10's diagnoses included multiple sclerosis (MS), sepsis, constipation, neurogenic bladder and urine retention. Resident 10's medical record was reviewed on	F 309		4/14/07

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2/28/07. The comprehensive Minimum Data Set (MDS) assessments, dated 10/15/06 and 1/6/07, revealed the resident was independent in her decision making, had no memory deficit, and could communicate verbally without problem. The MDS assessments revealed resident 10 had no behavior problems. The MDS assessment, dated 10/15/06, revealed resident 10 had no mood issues. The MDS assessment, dated 1/6/07, revealed resident 10 exhibited repetitive anxious concerns and repetitive health complaints that were easily resolved.

A physician's admitting order, dated 10/3/06, revealed resident 10 was to have a suprapubic catheter, size 18 French, with a 10 cubic centimeter (cc) balloon, and that the catheter was to be changed monthly.

Resident 10 was interviewed on 2/26/07 at 2:40 PM. Resident 10 stated that some of the nursing staff had not been responsive when she tried to communicate concerns about the nursing cares she had received. She stated the staff wound not believe her when she tried to tell them there was a problem with her suprapubic catheter.

Resident 10 stated that on Friday, 12/29/06, she had a clinic appointment for a specialized multiple sclerosis treatment. Resident 10 stated she had repeatedly requested, from the nursing staff, that her monthly suprapubic catheter change be done Tuesday or Wednesday, before her appointment. The resident stated the nurses would not respond to her request until Thursday, 12/28/06. Resident 10 stated she was informed that someone would do it Thursday night, 12/28/06.

Resident 10 stated that when nurse 4 changed

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her suprapubic catheter, the night of 12/28/06, the nurse attempted to deflate the catheter balloon. Resident 10 stated that the catheter's balloon was not completely deflated before the nurse began to pull the catheter out. Resident 10 stated that she told nurse 4 that it was hurting, but that nurse 4 continued to pull the catheter. Resident 10 stated that she screamed when the catheter was removed. Resident 10 stated that she had "never had that much pain all at once." Resident 10 stated nurse 4 told the her that it "shouldn't hurt" and asked "Why are you screaming?" Resident 10 stated after the procedure, she repeatedly told nurse 4 that she was in pain. Resident 10 stated nurse 4 repeatedly replied that the resident's pain was probably from bladder spasms due to the procedure and that the pain would stop.

Resident 10 stated that the next day, 12/29/06, she began to have leakage from her urethra and from around the suprapubic catheter. Resident 10 stated she complained of pain but RN 5 told her it was just bladder spasms.

Resident 10 stated she continued to have urinary leakage from her urethra as well as from around the suprapubic catheter. Resident 10 stated the amount of urinary output, through the catheter, was minimal. She stated she continued to express to the nurses, on 12/29/06 and 12/30/06, that she was wet from urinary leakage and that she continued to have abdominal pain.

On 12/30/07, a physician telephone order was obtained to change the size of the suprapubic catheter to the next larger size.

Resident 10 stated that on Saturday, 12/30/06, RN 3 replaced the resident's suprapubic catheter.

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Resident 10 stated that RN 3 pushed the new catheter into her abdomen far beyond the point where it should have stopped. Resident 10 stated she tried to tell RN 3 that the catheter should not go in so far, but that RN 3 replied she was trying to get urine return. The resident stated the procedure was witnessed by two of her family members.

Resident 10 stated that following the procedure, she was given a shower. Resident 10 stated there was blood in her urine collection bag and that she was feeling bloated. Resident 10 stated she had vomited in the shower, but that could have been secondary to a procedure she had at a clinic the previous day.

Resident 10 stated she went to dinner and began to experience numbness in her hand and increased abdominal pain. Resident 10 stated she reported the numbness and pain to RN 3. Resident 10 stated she began to have sharp chest pains after dinner which she reported to RN 3. Resident 10 stated she advised RN 3 that she was not anxious to go to the hospital, but that she thought she needed to.

Resident 10's family members were interviewed by telephone on 3/5/07 at 2:30 PM. The family members stated they had attended a meeting with the social services advocate (SSA) on 12/30/06 at approximately 1:30 PM. Resident 10's family members stated that the meeting focused on resident 10's acute complaints of pain and bloating and concerns regarding nursing care. The family members stated that resident 10 was complaining of feeling bloated and all swollen up and of abdominal pain.

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The family members stated that following the meeting, they accompanied resident 10 and RN 3 to the resident's room to check for urine leakage and to observe the catheter change. Resident 10 requested a suppository before the catheter change. The family members stated they had observed the blanket in resident 10's wheel chair to be wet with urine. The family members stated that, after the suppository produced results and resident 3's brief was changed, they witnessed that the brief was soggy as well as soiled. A family member stated there was blood and a thick, light colored substance in resident 10's catheter tubing, but there was nothing flowing yet. The family members stated that, after the procedure, resident 10 was taken to the shower and they returned home.

The family members stated that at 7:00 PM, they received a telephone call at home from RN 3. The family members stated that RN 3 told them resident 10 "was crying and in a lot of pain." The family members stated they requested that vital signs be checked for resident 10. They stated they waited a minute and then were told that resident 10's vital signs were normal.

The family members stated that they arrived at the facility 15 minutes later to find resident 10 had a fever (by touch) and had also complained of chest pain. They stated they asked that she be taken to the emergency room. The family members stated that RN 3 told them the hospital would just check the resident and send her back, but the RN agreed to call for transport. The family members stated that RN 3 called an ambulance but told the dispatch it was just a transport, not an emergency, and that lights and sirens were not necessary.

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WILLOW WOOD CARE CENTER	1205 EAST 4725 SOUTH SALT LAKE CITY, UT 84117

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F 309	Continued From page 14 The surveyors obtained the ambulance transport report from the ambulance company on 3/6/07 at 9:30 AM. As documented in the report, the ambulance arrived at the facility at 8:15 PM on 12/30/07. The ambulance report revealed the medics had been been advised that resident 10 had a procedure the previous day which caused side effects. The ambulance report revealed resident 10 had complaints of lower abdominal pain, right upper quadrant pain, right lower quadrant pain, low oxygen saturation of 85% (percent), and nausea and vomiting "upon arrival". Resident 10 received oxygen at 15 liters via a nonbreather mask, an intravenous line was started at 8:20 PM, the hospital was contacted and the resident was transported at the family's request. Resident 10 was assessed in the Emergency Room (ER) on 12/30/06 and admitted to the hospital on 12/31/06 at 12:33 AM. As documented by the ER physician, resident 10's chief complaint was abdominal pain since a suprapubic catheter change on Thursday (12/28/06). The physician documented that resident 10 "also has had some chest discomfort." The Emergency Center Report revealed that resident 10 had: . Been "positive for fever yesterday," . Nausea and vomiting "today" and that the resident "sometimes gets nausea after her MS treatment." The latest MS treatment had been on 12/29/06, . Abdominal pain, mostly in the area of her suprapubic catheter, . Distended abdomen, mildly diffusely tender to	F 309		

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palpation.
. "A little bit of purulent discharge noted at the opening" of the suprapubic site,
. "CT [computerized tomography] scan of the abdomen without contrast showed misplaced suprapubic catheter sitting over the top of the dome of the bladder",
. And "quite severe constipation."

Treatment in the ER for resident 10 included oxygen, pulse oximetry, intravenous (IV) bolus of 500 cc (cubic centimeters) normal saline, plus morphine and Zofran for pain and nausea. In addition, "She was given a gram of Rocephin IV after seeing her urine." Resident 10's urinalysis at the hospital ER "showed too numerous to count red cells, 50 to 100 white cells, and 1+ bacteria."

On 12/30/06 at 9:10 PM, resident 10's urine appearance was "bloody". Additional hospital information, provided by the facility on 3/5/07, revealed resident 10's urine, from the new Foley catheter that had been placed at the hospital, was "Clear, Yellow to Amber in Color" on 1/2/07.

Documentation in the facility's nurses notes revealed:

a. A late entry by nurse 4, dated 12/29/06 for 12/28/06 at 10:00 PM, regarding the procedure to change resident 10's suprapubic catheter. Nurse 4 documented that she had removed 10-15 cc of fluid from the balloon before removing the catheter. Nurse 4 documented that she had felt a small resistance but the catheter eased out. Nurse 4 documented that resident 10 stated, "It hurts". Nurse 4's note documented further, "this nurse reassured resident that it could be bladder

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spasms - was not satisfied et [and] continued to complain again this nurse reassured resident that it could be bladder spasms." Nurse 4 documented that the catheter changing materials were removed from the room and a nursing assistant "readied resident for bed."

b. A late entry by RN 5, dated 12/29/06 at 6:00 AM to 2:00 PM for 12/28/06. RN 5 documented that resident 10 had approached her saying, 'It's my catheter change day and [another staff nurse] says you have to do it.' Resident 10 was additionally quoted, 'Yes, but you have to do it before 2:00 PM.' The resident was reassured that the catheter would be changed, "regardless of the hour on the clock or shift time limits." RN 5 documented that resident 10 expressed opinions "that no one does it correctly."

RN 5 continued to document that "This AM res [resident 10] has constantly C/O [complained of] last HS [bedtime] catheter change: 'She hurt me!', 'She does not know what she's doing!', 'It's not working!' etc." RN 5 documented that the night shift had reported that resident 10 had made the same complaints all night and that the catheter had been functioning. RN 5 documented that resident 10 sent her a note saying she would prefer 'to stay in bed [with] a leaking catheter than go to her AM appointment in misery'. RN 5 documented that she sent the message back that, "If this is what res chooses to do, we will allow it."

RN 3 documented, on 12/30/06 at 11:05 AM, resident 10 complained of a leaking catheter. RN 3 documented she checked for leakage but found none. In response to resident 10's complaints and the family's concerns, RN 3 called the physician

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F 309	Continued From page 17 and received an order to replace the catheter with the next larger size. The new order was for a 20 French catheter with a 30 cc balloon. RN 3 documented that when she prepared to change the suprapubic catheter, she found that the previous catheter had been too small. Resident 10's suprapubic catheter had been changed to a 16 French 5 cc balloon. RN 3 documented that, at 3:10 PM, she replaced it with the correct size that had originally been ordered; an 18 French with a 10 cc balloon. RN 3 documented that resident 10 was medicated for pain and numbness in her hands at 6:00 PM On 1/2/07 (documented "06" but note followed a 12/31/06 note) RN 3 documented a late entry to her 12/30/06 nurse's note. The entry revealed that when she had replaced resident 10's suprapubic catheter, she got "Urine out 50 cc Color clear yellow, no odor. [no] C/O of pain." On 1/3/07 (documented "06") RN 4 documented a "Late entry Addendum to 12/30/06". RN 4 documented that she had checked drainage to resident 10's leg bag when she returned from her appointment because the resident was complaining of leaking urine. RN 4 documented that resident 10's leg bag was approximately 50 % full at that time.	F 309		
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	F 496		4/14/07

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F 496	Continued From page 18 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 interview and review of facility personnel files, it was determined that the facility did not seek information from the nurse aide registry in another state prior to allowing 1 of 5 nursing assistants to perform direct cares for facility residents. The nurse aide registry provides information on whether or not a current aide has been certified and whether or not an aide has had a history of abuse. Findings included:	F 496		

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F 496	Continued From page 19 Employee 3 was hired on 10/30/06, and was permitted to work in the facility as a nursing assistant providing direct patient contact. On the application for employment, dated 10/6/06, employee 3 documented that she had worked in the health care field since 1999. On the applicant release section, employee 3 documented that she had lived in Minnesota from 2000 to 2006. On 2/27/07 the Human Resource assistant was asked for documentation that the Minnesota registry had been checked. There was no documentation that the Minnesota nurse aide registry had been checked to determine if they had any information regarding employee 3. On 2/28/07 the Corporate Social Services informed the surveyors that the Minnesota registry was not available on the Internet and had to be telephoned. They had not been telephoned prior to the survey.	F 496		
F 514 SS=E	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		4/14/07

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Resident 10 and documentation / interview regarding constipation, catheter, chest pain.
Based on observation, record review and interview, it was determined the facility did not maintain medical records that were complete, readily accessible and accurately documented for 2 of 15 sample residents. Resident identifiers: 4 and 12.

Findings included:

1. Resident 12 was admitted to the facility on 1/19/07 with diagnoses that included: depression, streptococcal pneumonia, seizure disorder and bipolar disorder.

On 2/27/07 continuous observations were made of resident 12's room from 9:11 AM until 9:50 AM. At 9:50 AM, Registered Nurse (RN) 1 entered resident 12's bedroom to administer medications.

An interview was conducted with resident 12 on 2/27/07 at 10:45 AM. Resident 12 stated that she did receive pain medication around 10:00 AM from RN 1 whom the surveyors observed going into the resident's room at 9:50 AM.

Resident 12's medication administration record (MAR) was reviewed on 2/28/07. The MAR revealed nurses' documentation the following PRN (as needed) medication had been given around the time of continuous surveyor observation.
Oxycodone 10/650 signed out at 9:26 AM by RN 6.
Carisoprodol 350 milligrams signed out at 10:47 AM by RN 6.
No medications were documented as having been given by RN 1.

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F 514	Continued From page 21 An interview was conducted on 2/28/07 at 10:50 AM with RN 1, RN 6 and a corporate RN. The surveyor asked RN 1 one if he remembered which medications were given to resident 12 during the observed time period. RN 1 stated that he could not remember because he gives a lot of pills in a day. RN 6 was asked if she gave resident 12 any medications during the observed time period. RN 6 stated that she did not give any medications to resident 12 on 2/27/07. RN 6 was asked to clarify the MAR documentation that medications had been administered by her. RN 6 stated that she logged into the computer in the morning and stayed logged in all day. A corporate RN was asked why the times documented in the computer for resident 12's Oxycodone did not match what was observed by the survey team. The corporate RN stated that it was probably the Carisoprodol that was given because pain medications are to be given as soon as they are signed out. Neither RN 1, RN 6 nor the corporate RN were able to tell the survey team what exactly had been administered to resident 12 at 9:50 AM on 2/27/07. A letter was faxed to the state survey agency on 3/5/07 by the facility's corporation. The letter revealed that "Resident 12 takes a Klonopin at 12:00, which was probably the medication that was given as reported by the state surveyors." Resident 12's MAR had been documented that resident 12 received oxycodone at 3:55 PM on 2/27/07, but no oxycodone had been signed out from the narcotic sign-out record. As documented in the narcotic sign-out record, resident 12 received oxycodone on 2/27/07 at 2:30 AM and 9:25 AM. The next documented	F 514		

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F 514	Continued From page 22 dose that oxycodone had been given was on 2/28/07 at 1:30 AM. 2. Resident 4 was admitted to the facility on 8/18/06 and readmitted after a brief hospitalization on 10/25/06 with diagnoses that include: decubitus ulcer, dementia, urinary tract infections, hypertension and arthritis. Resident 4's medical record was reviewed on 2/26/07. Resident 4's "Weight/Skin Condition Review," dated 10/18/06, had been documented by nursing that the resident had a right heel stage II pressure ulcer from popped blister covered with skin from popped blister with .5 centimeter opening at lower edge that was .2 centimeters deep, no drainage or odor or signs and symptoms of infection. Surrounding tissue was intact without erythema. Resident 4's History and Physical from the hospital, dated 10/18/06, revealed the following: Physical Exam Extremities- Resident 4 has erythema of her right lower leg that extends above the knee. It is tender to touch. Resident 4 does have black eschar on her right heel.	F 514		