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	465111	A. BUILDING ______ B. WING ______	11/29/2007

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SANDY REGIONAL HEALTH CENTER	**50 EAST 9000 SOUTH** **SANDY, UT 84070**

(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 observations and interviews, the facility did not promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of each resident's individuality, for 3 of 21 sampled residents and 3 supplemental sampled residents. Resident identifiers 2, 14, 16, 26, 27 and 28 Findings include: 1. Resident 16 was admitted to the facility on 10/6/06 with diagnoses which included anemia, joint contractures, congestive heart failure, insomnia and general osteoarthritis. Resident 16 minimum data set assessment (MDS) dated 10/24/07 was reviewed on 11/28/07. On resident 16's MDS the facility staff had documented that resident 16 had physical limitation (full and partial loss) on both sides. Resident 16 was observed on 11/28/07 in the south dining room. Staff wheeled resident 16 from the dining room at 1:45 PM. At 2:00 PM resident 16 was observed in her room behind the privacy curtain and beside her bed facing south. Resident 16's call light pad was on her pillow at the head of her bed which was behind her and out of reach.	F 241		1/23/08

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

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 241	Continued From page 1 Resident 16 was interviewed and stated she was sad and that she had gotten a pain pill from licensed practical nurse (LPN 2) and that now she needed her drops from LPN 2. When resident 16 was asked how she lets the nurse know when she needs something resident 16 looked into her lap and said "I cannot see my call light". Resident 16 began to cry. LPN 2 was notified by the surveyor that resident 16 needed something. LPN 2 entered resident 16's room and stated "Let's put your call light within reach." 2. Resident 2 was admitted to the facility on 6/29/07 with diagnoses that included congestive heart failure, two stage II pressure ulcers, joint pain, osteoarthrosis, esophageal reflux, anxiety disorder, stroke and chronic obstructive pulmonary disease. On 11/27/07 at 2:05 PM personal cares for resident 2 were observed. The call button, bed control and resident 2's water were moved out of the way. On 11/27/07 at 2:35 PM (thirty minutes later) the surveyor was interviewing resident 2 about her pain level. Resident 2 did not have a call button within her reach, the bed control, or her water. Resident 2 was very anxious and asked for the things to be given her. When resident 2 received the call button, the bed control, and her water resident 2 sighed and stated, "there that's better. I can put my head down now". 3. Resident 14 was admitted to the facility on 8/21/98 and readmitted on 8/1/05 with diagnoses that included hypertension, hypothyroidism, atherosclerosis, constipation, insomnia,	F 241		

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osteoporosis, and senile delusions.

On 11/27/07 at 3:15 PM resident 14 was heard from the west nursing station which was, across from resident 14's room, yelling, "Take me to the bathroom, You better hurry". This was repeated several times.

At 3:18 PM resident 14 was taken to the bathroom by an aide.

At 3: 24 PM resident 14 was again yelling, "Take me to the bathroom, You better hurry." Resident 14 repeated this again several times.

At 3:27 PM an aid yelled into resident 14's room from the door way, "I already took you to the bathroom". Resident 14 yelled, "No you didn't". The aid yelled again from the door way, "Yes I did."

At 3:37 PM resident 14 was still repeating, "take me to the bathroom."

At 4:00 PM after 45 minutes of continuous observation, the surveyor went into resident 14's room. Resident 14 was behind the privacy curtain, in the wheel chair with a lap buddy on, beside the bed, facing the north wall. The only thing resident 14 could look at was the wall.

4. On 11/27/07 at 4:08 PM resident 26 was observed calling out, "Help me, help me repeatedly. Resident 26 was parked beside the bed in the wheel chair with a restraint belt on, facing towards the hall door. There was no call button within reach of resident 26.

Resident 26 was observed for six minutes. One

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F 241	Continued From page 3 aide walked by, but did not respond to resident 26's calls. 5. On 11/28/07 at 1:00 PM residents were observed in the south dining room. Resident 27 was brought to table 7. Resident 27 stated to CNA 1 that she would like to eat with her husband, resident 28. Resident 28 was seated at table 6, directly behind resident 27. CNA 1 stated, "Maybe we can work that out another time". At 1:16 PM resident 27 was not eating. CNA 1 stated, "Maybe you will eat better if we sit you by your husband". Resident 28 was moved next to resident 27. Both residents smiled at each other and held hands. Resident 27 began crying.	F 241		
F 252 SS=D	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility did not provide a safe, clean and comfortable environment for one of 24 sampled residents. Resident identifier 9. Findings included: Resident 9 was readmitted to the facility on 10/04/04 with diagnoses which included Chronic Obstructive Pulmonary Disease, morbid obesity, glaucoma, macular degeneration, peripheral vision disorder and chronic depression.	F 252		1/23/08

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F 252	Continued From page 4 During the annual recertification survey conducted at the facility on 11/26/07, the room occupied by resident 9's was routinely observed for safe, clean and comfortable conditions. The bathroom attached to resident 9's room was observed to have dark, discolored seams along the tiled flooring near the toilet. One tile bordering the toilet and the adjacent wall was observed to be lifted approximately 1/4" from the floor surface. Approximately 9 additional tiles showed dark discoloration around their perimeter. On 11/28/07, resident 9 was interviewed regarding the condition of the tile. Resident 9 stated that he was unable to see the tiled floor in his bathroom clearly. Resident 9 stated that he expected that the bathroom floor would be in good condition. Resident 9 stated that the facility was now his home and he would not tolerate broken or loose flooring in his bathroom. On 11/29/07, the facility maintenance supervisor was interviewed. The facility maintenance supervisor stated that no maintenance or repair was scheduled for the flooring in resident 9's bathroom. After the facility maintenance supervisor had inspected the bathroom floor in resident 9's bathroom, the maintenance supervisor stated that the flooring needed to be replaced and that the work was scheduled.	F 252		
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		1/23/08

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Based on observation, interview, and record review it was determined that the facility did not provide services to meet professional standards of quality for 2 of 25 sample residents. Specifically, medications were left on a residents bedside table and medications were documented as being given to a resident when they had not been administered to that resident. Resident identifiers: 9 and 25.

Findings include:

Reference: Professional Standards of Practice in medication administration

a. Lippincott, Seventh Edition, Textbook of Basic Nursing, Caroline Bunker Rosdahl, Chapter 63, Pg. 749, Administration of Medications. "An important part of medication administration is documentation or charting. . . Proper documentation communicates to other members of the healthcare team which medications you administered and when. If a medication is PRN (as needed) or a first-time administration, your documentation will further relay the medication's effect".

b. Mosby Year Book, Second Edition, Basic Nursing Theory and Practice , Patricia A. Potter, RN, MSN, Anne G. Perry, RN, MSN, ANP, EdD (cand), Chapter 24, pg. 558 and 559, Recording drug administration. "After administering a drug, the nurse records it immediately on the appropriate record form. . . The nurse never charts a drug before administering it. Recording immediately after administration prevents errors. The recording of a drug includes the name of the drug, dose, route, and exact time of administration . . . If a client refuses a drug or is

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undergoing tests or procedures that result in a missed dose, the nurse explains the reason the drug was not given in the nurse's notes. Some agencies require the nurse to circle the prescribed administration time on the drug record when a dose is missed."

1. Resident 25 was admitted to the facility on 9/27/07 with diagnoses that included debility, senile delusion, depression, congestive heart failure, hypertension and atrial fibrillation.

Resident 25's medication orders for November listed ten medications which included:

a. Multivitamin Tablet PO (by mouth) QD (every day) supplement
b. Calcium +D 600 MG (milligrams) tablet PO QD supplement
c. Zinc 50 MG caplet PO QD supplement
d. KCL (potassium chloride) 10 MEQ (milliequivalents) liquid 1 tablespoon QAM (every morning)
e. Benazepril HCL (hydrochloride) 40 MG tablet PO QAM
f. Atenolol 100 MG tablet PO BID (two times a day).

On 11/26/07 at 8:52 AM a medication pass was observed for resident 25. Licensed Practical Nurse (LPN) 1 stated that the facility was out of KCL for resident 25. LPN 1 stated that the medications came from a wholesale pharmacy and that resident 25's family member would have to get it.

LPN 1 also stated that resident 25 would always refuse to take the multi-vitamin (MV), the Zinc and the Calcium. LPN 1 stated that resident 25

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had refused to take them every morning that LPN 1 had offered them.

The medications were taken to resident 25 in the physical therapy room. Resident 25 was told by LPN 1 that they would have to get the KCL from her family member. Resident 25 was offered the MV, the Zinc, and the Calcium. Resident 25 stated "I'm not going to take the vitamins, they're too big."

On 11/26/07 at 1;00 PM resident 25's medication administration record (MAR) was reviewed and copied. The following medications were initialed by facility nurses as having been administered to resident 25, but had not been administered:

a. KCL 20 MEQ (this medication still had not been supplied by the family member) was initialed as having been administered on the 26th as well as the 27th, which would have been the next day.

b. Benazepril HCL 40 MG was initialed as having been administered on the 26th as well as the 27th, which would have been the next day.

c. Atenolol 100 MG was initialed as having been administered on the 26th as well as the 27th, which would have been the next day.

d. Multivitamin was initialed as having been administered daily from November 1 to the 27th, which would have been the next day. There was no documentation on the MAR to indicate that resident 25 had refused the MV.

e. Calcium +D 600 MG was initialed as having been administered daily from November 1 to the 27th, which would have been the next day. There

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F 281	Continued From page 8 was no documentation on the MAR to indicate that resident 25 had refused the Calcium+D. f. Zinc 50 MG was initialed as having been administered daily from November 1 to the 27th, which would have been the next day. There was no documentation on the MAR to indicate that resident 25 had refused the Zinc. On 11/27/07 at 7:00 AM an interview was held with LPN 1. LPN 1 stated resident 25's family member had been called on 11/26/07 in the evening and that the KCL had not arrived yet, but would be available by noon. LPN 1 stated that resident 25 had not received the MV, calcium, or the Zinc, but facility staff had convinced resident 25 to take those medications at 12:00 PM instead of at 8:00 AM. On 11/27/07 at 10:11 AM the MAR for resident 25 was reviewed and copied. The following medications were initialed by facility nurses as having been administered to resident 25. a. KCL 20 MEQ (this medication still had not been supplied by the family member) This medication was initialed as having been administered on the 26th, 27th as well as the 28th, which would have been the next day. b. Benazepril HCL 40 MG was initialed as having been administered on the 28th, which which would have been the next day. c. Atenolol 100 MG was initialed as having been administered on the 28th, which would have been the next day.	F 281		

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F 281	Continued From page 9 d. Multivitamin was still initialed daily as having been administered from November 1 to the 27th. No refusals were documented. No initials were circled. The administration time was changed to 12:00 PM. e. Calcium +D 600 MG was initialed daily as having been administered November 1 to the 27th. No refusals were documented. No initials were circled. The administration time was changed to 12:00 PM. f. Zinc 50 MG was initialed as having been administered daily November 1 to the 27th. No refusals were documented. No initials were circled. The administer time was changed to 12:00 PM. On 11/27/07 at 10:17 AM an interview was held with LPN 1. LPN 1 stated that she should have circled the initials on the MAR to indicate that the vitamins, Zinc and Calcium had been refused. LPN 1 stated that these medications had not been given that day, but would be given at 12:00 PM.	F 281		

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F 281	Continued From page 10 Reference: Lippincott, Seventh Edition, Textbook of Basic Nursing, Caroline Bunker Rosdahl. Chapter 63, Pg. 746, Administration Of Medications. "Although each facility's routine for administering medications varies, you must conscientiously observe universal rules for safe administration. Remember that these safety rules protect not only clients but also healthcare facility personnel from mistakes with very serious consequences. See the Nursing Skill Guidelines for more information. Nursing Skill Guidelines. . .Do not leave medications at the clients's bedside." Resident 9 was readmitted to the facility on 10/04/07 with diagnoses which included chronic obstructive pulmonary disease, morbid obesity, glaucoma, macular degeneration, peripheral vision disorder and chronic depression. Resident 9 was observed in his bed on 11/27/07 at 9:00 AM with a cup of medications on his over-bed tray. Resident 9's television was on and he had head phones on his ears. Resident 9 did not know anyone had entered the room until the surveyor passed the end of his bed and waved a hand to get resident 9's attention. Resident 9 stated the nurse had left the cup of medication for him to take when he was ready. Resident 9's LPN 3 was interviewed on 11/27/07 at 9:05 AM. LPN 3 stated that no one in that hall was participating in a self medication program. LPN 3 also stated that it is against the rules and regulations to set up medications and leave them with the resident without watching them swallow the medications. LPN 3 stated he did not leave medications at residents bedside today.	F 281		

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F 281	Continued From page 11 On 11/27/07 at 1:10 PM LPN 3 contacted the surveyor and stated that resident 9 had told LPN 3 about the medications that had been left at his bedside. LPN 3 stated that resident 9 had told LPN 3 the resident would take the medications and that resident 9 always takes them but sometimes the resident eats a little first.	F 281		
F 309 SS=D	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 that for 1 of 25 sampled residents, the facility did not ensure each resident received the necessary assessment and treatment to achieve pain relief. (Resident identifier: 2) Findings included: Resident 2 was admitted to the facility on 6/29/07, with diagnoses that included congestive heart failure, two stage II pressure ulcers, joint pain, osteoarthrosis, esophageal reflux, anxiety disorder, stroke and chronic obstructive pulmonary disease. Resident 2 was also receiving hospice services. Observations of resident 2 were made at various times on 11/26/07, 11/27/07, 11/28/07, and	F 309		1/23/08

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F 309	Continued From page 12 11/29/07. The following observations were made: 11/26/07 at 12:36 PM - Resident 2 was observed sitting up in bed with her lunch on an overbed table. Resident 2 was grimacing and stated, "I always hurt. It's hard to move." 11/27/07 at 8:01 AM - Resident 2 was observed sitting up in bed with her breakfast on an overbed table. Resident 2 was yelling out, "I hurt so bad, Oh, Oh." At the time of this observation, licensed practical nurse (LPN) 2 was in the hallway, near resident 2's room. LPN 2 was passing medications to other residents. 11/27/07 at 2:05 PM - Resident 2 was observed as a facility nurse, with the assistance of two nurse aides, completed a dressing change pressure ulcers on the resident's coccyx and right heal. As staff provided cares to resident 2, she called out, "Oh, it hurts so much, be careful. It always hurts." Note: At 2:35 PM, resident 2 was observed in her bed, with her call light out of reach. The surveyor asked the resident to rate her level of pain from 0 to 10, with 0 being no pain. The resident responded that her level of pain was at 8. 11/27/07 at 2:42 PM - Resident 2 was observed to be crying out, stating she was in pain. Her call light was observed to be signaling. LPN 2 entered the resident's room, the call signal was turned off, then LPN 2 left the resident's room. 11/27/07 at 2:46 PM - Resident 2's call light was again signaling. A nurse aide entered resident 2's room and the call light was turned off. Note: Resident 2's room was observed until 3:06 PM. (two hours from the beginning of the dressing change) No pain medication was administered to resident 2. 11/27/07 at 4:03 PM - Resident 2 was observed to be in bed awake. Resident 2 stated, "I hurt all the time."	F 309		

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On 11/28/07 at 7:58 AM, Resident 2 was observed sitting up in bed, with the overbed table in front of her, eating breakfast. Resident 2 stated, "I hurt all over."

An interview was held with resident 2 on 11/27/07 at 8:20 AM. Resident 2 expressed that she was in pain. The surveyor asked resident 2 to rate her pain on a scale of 0 to 10, 0 being no pain. Resident 2 responded that her pain level was at 8. During the interview, resident 2 began to moan stating, "Oh, I'm having a pain."

An interview was held with certified nurse aide (CNA) 2 on 11/28/07 at 1:38 PM. CNA 2 stated that resident 2 had been in a lot of pain for the last 3 or 4 days.

An interview was held with registered nurse (RN) 1On 11/28/07 at 2:10 PM. The surveyor asked RN 1 about resident 2's level of pain. RN 1 replied that resident 2, "has been okay with pain". RN 1 stated that resident 2 had said that she was not hurting. RN 1 stated that resident 2 was usually stoic and that she did not like receiving Roxanol.

An interview was held with CNA 1 on 11/28/07 at 2:12 PM. CNA 1 stated, "to even touch her (resident 2), she hurts. When we changed her a little bit ago it really hurt her. She is real sensitive to touch and real sore."

A second interview was held with RN 1 on 11/28/07 at 2:18 PM. RN 1 stated she had just gone in to assess resident 2 for pain. RN 1 stated the resident did express that she was in pain, but that the resident was refusing the Roxanol because she did not like the way in

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made her feel. RN 1 stated she would contact the hospice agency to obtain an order for something stronger than Ultram for resident 2.

A third interview was held with RN 1 on 11/29/07 at 8:56 AM. RN 1 stated that resident 2 had been in a lot of pain this morning and that resident 2 had been given the Methadone and Clonazepam. RN 1 stated that she had talked with staff of the hospice agency last night and the the hospice agency had called resident 2's physician, but that had not received a call back. RN 1 stated that the Nurse Practitioner, who works with resident 2's physician, was currently in the facility and that she would ask for an order for something stronger than Ultram for resident 2.

Resident 2's medical record was reviewed on 11/26/07.

a. Per documentation, facility staff completed an admission Minimum Data Set (MDS) assessment and a quarterly MDS for resident 2 on 7/9/07 and 10/1/07, respectively. Facility staff assessed that resident 2 experienced pain on a daily basis and that, at times, the pain was horrible or excruciating. Facility staff assessed that resident 2 experienced pain in her back, hip and joints.

b. A review of the resident 2's Care Plan, dated 6/29/07, and updated 10/10/07, revealed the following:
Needs and Problems:
Alteration in comfort related to: chronic obstructive pulmonary disease, shortness of breath, anxiety, degenerative joint disease, Left hip pain, gastric esophageal reflux disease, and constipation.

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F 309	Continued From page 15 Measurable Goals: Resident will be at comfort goal and relieved from pain 30 minutes after medication administration. Approach: Assess intensity of pain based upon 0-10 scale based upon the following: present pain, worst pain, best the pain gets, acceptable level of pain Assess the following: quality of pain, onset, duration, variation etc., manner of expressing pain, what relieves pain, what causes pain Asses effects of pain based on the following: Accompanying symptoms, sleep, appetite, physical activity, relationships with others, emotions, concentration Diversional activities Assess for nonverbal signs and symptoms of pain Reposition for comfort Give supportive meds as ordered c. Resident 2's medical record included a "Pain Assessment" form. This form was incomplete, had no signature of assessor, and was not dated.	F 309		

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F 309	Continued From page 16 Per documentation on this form, resident 2 verbalized having pain and described the pain as aching, being chronic and generalized. On a scale of 0 to 10 (0 being no pain), 2 to 3 was documented. This form included a note that resident 2 was on hospice. Although included on the assessment form, the assessor did not document the following: Pain location, type and frequency; level of pain after receiving medication; nonverbal signs of pain, and how the pain was relieved. d. Review of resident 2's physician recertification orders, for November 2007, revealed the following orders for pain, anti-inflammatory, and anti-anxiety medications: Roxanol 0.25 - 1 MG (milligram) by mouth, every hour, as needed. The clinician was to "Document level of pain intensity before & after MED (medication) Admin. (administration) using 0-10 pain scale" The order date for this medication was documented to be 10/24/07. Methadone 10 MG by mouth, two times a day, for pain. The clinician was to "Document level of pain intensity before & after MED Admin. using 0-10 pain scale" The order date for this medication was documented to be 6/30/07. Ultram 50 MG by mouth, every six hours, as needed for pain. The clinician was to "Doc level of pain intensity before and after med admin on back of MAR (medication administration record) using 0-10 pain scale". The order date for this medication was documented to be 6/29/07. Lorazepam 1 MG by mouth, every four hours as needed. The order date for this medication was documented to be 10/24/07. Clonazepam 0.5 MG my mouth, two times a day. The order date for this medication was 6/29/07. Dexamethasone 4 MG by mouth, every day, for	F 309		

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inflamation to right neck and shoulder. The order date for this medication was documented to be 8/26/07.

On 12/4/07, the facility provided surveyors a physician's order, dated 11/29/07, to increase Methadone from 10 to 15 mg, two times a day and to add Hydrocodone 7.5/5 MG, every four hours, as needed, for pain.

e. A review of facility Nursing Notes, for resident 2, between 10/10/07 and 11/28/07 was completed on 11/29/07. On 10/10/07 at 4:00 PM, a facility nurse documented, "Res (Resident) c/o (complaint of) severe pain to L (left) groin. . . ." No other documentation of pain was found in the facility nursing notes.

f. A review of hospice agency documentation for resident 2, between 11/26/07 and 11/29/07, was completed on 11/29/07 at 2:00 PM. The hospice agency staff documentation included the following entries:

11/26/07, between 9:00 AM and 10:00 AM, the hospice nurse documented resident 2 was experiencing pain at the level of 4 on a scale of 0 to 10. The pain was documented to be arthritic in both shoulders and back. Per documentation, the resident's level of pain, within the previous 24 hours had ranged from a low of 3 to a high of 6. The hospice nurse documented that resident 2 had received a dose of Roxanol one time in the previous 24 hours for breakthrough pain. However, per documentation on resident 2's MAR, no Roxanol had been administered to resident 2. Even though the hospice nurse documented resident 2 was never pain free, she documented the current medications were

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effective to manage the resident's pain.

On 12/4/07, the facility provided surveyors a hospice nursing note that was dated 11/29/07. The documented time of the hospice nursing visit was from 9:00 AM through 10:00 AM. The hospice nurse documented, "She [resident 2] is having (increased) pain. States 'all over'. Refusing Roxinal (sic) d/t (due to) side effects i.e. way it makes her feel. [Name of resident 2's attending physician] notified for new order. Methadone (increased) 15 mg bid (two times a day) et (and) Hydrocodone 7.5/5 mg (every four hours) PRN ordered for breakthrough px (pain)."

f. A review of resident 2's Medication Administration Record (MAR) was completed on 11/29/07 at 2:00 PM. Per documentation, resident 2 had not received any, as needed, medication to address break through pain on 11/26/07, 11/27/07, 11/28/07, and 11/29/07.

Further review of resident 2's MAR, for November 2007 revealed the following:
Resident had received Methadone 10 mg, twice a day, at 8 AM and 8 PM. Resident 2's level of pain was documented to be 4-6 prior to receiving the medication and 0-2 after receiving the medication.
Dexamethasone 4 MG PO had been given everyday at 8 AM.
Roxanol 0.25- 1 MG had been given 2 times on 11/15/07 and one time on 11/16, 11/17, 11/18, 11/19, 11/20 and 11/21 and 11/22.
Ultram 50 MG had not been given in November.
Clonazepam 0.5 MG had been given twice a day at 8 AM and 8 PM. Anxious behaviors had been documented as no behaviors or sedation.

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F 309	Continued From page 19 On 12/4/07 the facility provided a MAR which revealed that Roxanol was offered to resident 2 on 11/29/07, and that the resident refused the medication. The MAR also included documentation that Ultram had been administered to resident 2 on 11/12/07 at 2:00 PM, on 11/28/07 at 2:30 PM, and on 11/29/07 at 10:30 AM. These medications were not documented as being administered on the MAR as of the review 11/29/07 at 1:58 PM.	F 309		
F 334 SS=C	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 334		1/23/08

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The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

This REQUIREMENT is not met as evidenced by:

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Based on interview and record review, it was determined that the facility did not document in the resident's medical record that the resident received the pneumococcal immunization either while residing at the facility, or prior to admission, or did not receive the pneumococcal immunization due to medical contraindication, and the facility did not document that the resident or the resident's legal representative had received education on the pneumococcal vaccine for 5 of 5 sample residents, selected for the Immunization Protocol sample.
Resident identifiers: 4, 8, 11, 13 and 14.

Findings include:

1. Resident 4's clinical record review was completed on 11/29/07.
Resident 4's record did not include documentation that the resident had been educated on the benefits with pneumococcal immunization or given the opportunity to refuse the pneumococcal immunization. Resident 4's record revealed no documentation that the pneumococcal vaccine had been offered or administered to resident 4.

2. Resident 8's clinical record review was completed on 11/29/07.
Resident 8's record did not include documentation that the resident had been educated on the benefits with pneumococcal immunization or given the opportunity to refuse the pneumococcal immunization. Resident 8's record revealed no documentation that the pneumococcal vaccine had been offered or administered to resident 8.

3. Resident 11's clinical record review was

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F 334	Continued From page 22 completed on 11/29/07. Resident 11's record did not include documentation that the resident had been educated on the benefits with pneumococcal immunization or given the opportunity to refuse the pneumococcal immunization. Resident 11's record revealed no documentation that the pneumococcal vaccine had been offered or administered to resident 11. 4. Resident 13's clinical record review was completed on 11/29/07. Resident 13's record did not include documentation that the resident had been educated on the benefits with pneumococcal immunization or given the opportunity to refuse the pneumococcal immunization. Resident 13's record revealed no documentation that the pneumococcal vaccine had been offered or administered to resident 13. 5. Resident 14's clinical record review was completed on 11/29/07. Resident 14's record did not include documentation that the resident had been educated on the benefits with pneumococcal immunization or given the opportunity to refuse the pneumococcal immunization. Resident 14's record revealed no documentation that the pneumococcal vaccine had been offered or administered to resident 14. The facility Immunization Policy was reviewed on 11/28/07. The policy did not include provisions for the education of each resident before offering the influenza vaccine or the pneumococcal vaccine. The policy did not include provisions ensuring that each resident's medical record would include documentation that the resident	F 334		

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F 334	Continued From page 23 was educated on the influenza vaccine and the pneumococcal vaccine. The policy did not include how the facility would determine if the administration of vaccines would either be covered by physician order for each individual resident or by medical director approved facility wide protocol. The policy did not include the location of documentation of education and administration of the vaccines. On 11/28/07 an interview was done with the director of nursing (DON). The DON stated that the facility did not have documentation on which residents had received pneumococcal immunizations in the past. The DON stated that facility staff were in the process of determining which residents had already had the pneumococcal vaccine and who still needed it. The DON also provided a partial list of residents in the facility and their pneumococcal immunization status. Sample residents 4, 8, 11, 13 and 14 had no documentation that they had received pneumococcal vaccine.	F 334		
F 371 SS=D	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility did not store, prepare or distribute food under sanitary conditions. Findings include:	F 371		1/23/08

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F 371	Continued From page 24 1. On 11/26/07 at 8:00 AM the facility kitchen was observed. In the dry storage area of the kitchen, nine white packages were located which had "cut or tear here" printed on them. The packages were not labeled as to what the product was or any other information such as an expiration date, date received, etc. 2. On 11/26/07 at 3:00 PM a facility refrigerator in the restorative dining room was observed. A temperature log was posted on the front of the refrigerator. The log did not show that temperatures had been checked since September of 2007. The following items were located inside of the restorative dining room refrigerator: a. A blue liquid inside of a water bottle with no label or date. b. An open container of yogurt dated 8/11/07. c. An open container of sour cream dated 6/11/07. d. Two open jugs of apple cider with a label that read "From mtg (meeting) 9/19/7". e. One open container of cranberry/raspberry juice with no date as to when it was opened. f. One container of leftovers labeled "[Name deleted] 8/23/7". g. Six yogurts dated 9/27/07. h. A partially eaten sandwich with no date or label. i. An open package of cheese dated 5/7/07. j. A bowl of cooked ground beef with several areas of mold growing in it with no label or date. On 11/26/07 at 3:05 PM an interview was held with an activities staff member. The staff member stated that the refrigerator was used by residents as well as facility staff members.	F 371		

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F 371	Continued From page 25 3. On 11/27/07 at 12:54 PM CNA (certified nurses aide) 3 was observed while in the south dining room. CNA 3 removed a resident's tray from the tray cart in the dining room, walked out of the dining room, and delivered the resident's tray to his room. However, CNA 3 did not cover the drinks or dessert on the resident's tray. 4. On 11/29/07 at 9:35 AM observations were made in the facility dishroom. The following observations were made: a. An employee purse was set directly on a rack of clean dishes, which was also directly over another rack of clean dishes. b. An employee cell phone and water bottle were set directly on a rack of clean dishes.	F 371		