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	465006	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH VALLEY REHABILITATION	2200 EAST 3300 SOUTH SALT LAKE CITY, UT 84109

(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 250 SS=E	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review and observation it was determined that the facility did not provide medically-related social services to attain or maintain the highest practicable mental and psychosocial well-being of each resident for 3 of 16 sample residents. Residents 2, 7, and 10. Findings include: 1. Resident 2 was admitted on 6/17/07 with diagnoses that included depression, hip fracture, hypertension, gastroesophageal reflux, vitamin B-12 deficiency, restless leg syndrome, anemia, iron deficiency, neurogenic bladder, and Parkinson's disease. Resident 2's medical record was reviewed on 12/10/07. Based on an initial Minimum Data Set (MDS) assessment, with an assessment reference dated 6/24/07, resident 2 triggered in the area of "Behavior" of section V, Resident Assessment Protocols. In a review of resident 2's interdisciplinary progress notes, the following notes were located (and who documented the incident): a. 6/25/07 resistant to cares, confused (RCA - Resident Care Advocate)	F 250		2/4/08

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

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F 250	Continued From page 1 b. 7/15/07 using vulgar language with staff (nursing) c. 7/29/07 sometimes behavior is demanding (nursing) d. 8/17/07 patient is "very focused on getting his catheter out" (nursing) e. 8/17/07 patient "yelling about getting catheter out" (nursing) f. 8/26/07 "obsessed" with catheter removal (nursing) g. 8/27/07 increased "sexually aggressive behavior toward female pt (patient) at westside et (and) verbally abusive to staff and other residents." (nursing) h. 8/28/07 resident reported as having sexual behaviors toward female staff and female residents. Resident became verbally abusive toward facility staff when approached about his aggression. (RCA) i. 8/28/07 resident chose to eat in room due to adverse behavior (nursing) j. 10/4/07 resident needs to be monitored in group activities due to inappropriate behaviors (activities staff) k. 10/31/07 resident became verbally abusive toward another resident in the dining room (nursing). In a review of resident 2's comprehensive care plan, no documentation could be found that the facility developed a care plan addressing resident 2's inappropriate behaviors. An interview was held on 12/13/07 at 3:48 PM with RCA 1 and RCA 2. RCA 1 stated that resident 2 can be sexually inappropriate at times with staff and residents. RCA 1 described past incidents where resident 2 has tried to chew through his catheter in an effort to have sexual	F 250		

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relations with other residents in the facility. RCA 1 also stated that resident 2 is easily agitated, gets loud and belligerent sometimes, and can become physically abusive. RCA 1 also related an incident that occurred in August in which resident 2 was "ramming" another resident's wheelchair (with another resident in it) into the wall. RCA 1 stated that as recently as 12/10/07 resident 2 was "harassing" another resident. When asked about how the facility tracked resident behaviors, RCA 1 stated that tracking is not being done on resident behaviors. RCA 1 further remarked that "the thought before was if it's in the nursing notes that was sufficient enough." When asked how much time she has to look through the nursing notes prior to meetings regarding residents, RCA 1 stated "Not a lot." RCA 1 stated that the "behavior program" was "in full force" with the previous RCA, and indicated that currently there is no behavior program for resident 2. RCA 1 also verified that no RCA notes have been written since 8/28/07.

2. Resident 10 was admitted to the facility on 6/8/07 and readmitted on 7/3/07 with diagnoses that included coronary artery disease, pickwickian syndrome, diabetes mellitus, retinopathy, peripheral neuropathy, left lower extremity amputation, and gastric reflux disease.

Resident 10's medical record was reviewed on 12/12/07.

Resident 10 was observed at various times from 12/10/07 through 12/13/07. Resident 10 was always in bed, sitting or laying and watching TV.

Resident 10's Resident Assessment Protocol Summary triggered for delirium, cognitive loss,

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communication, ADL functional/rehabilitation potential, urinary incontinency and indwelling catheter, psychosocial well-being, mood state, behavioral symptoms, activities, falls nutritional status, pressure ulcers, and psychotropic drug use.

Resident 10's care plan was reviewed. Resident 10's care plan included a psychosocial - initial adjustment care plan, dated 7/6/07, initiated by Social Services and a mood/psycho-social care plan, dated 7/19/07, that was initiated by the recreation department.
No further notes were located from social services.

Nurses notes dated 11/21/07 for resident 10 revealed that resident 10 was non-compliant with positioning, required extensive assist with ADL's (activities of daily living), and required validation and encouragement to participate in care.

A Care Plan Conference Summary discussion dated 7/18/07 read:
"Goal to be able to transfer self bed to chair and back and to toilet then go home. Prothesis possible with adequate wt (weight bearing) and strength. still need to work on toileting ability. . . ."
The social service note stated: " (does not) see LCSW (licensed clinical social worker) for surplus (decreased) soc (social) needs - PRN"

Another Care Plan Summary was dated 11/26/07. Dietary listed the resident's weight. Activities wrote: "encourage our group act (activities). Social Service wrote: "try to increase activity outside of room."

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The summary of care plan conference discussion read: "dietary will give built-up spoon and fork with hi (sic) wall plate Pt (patient) and family discussed the decrease in strength, which has effected (sic) the goals. The decrease in strength has inabled (sic) the pt. to use a prostetic (sic). Pt. is advised to join more activities."

On 12/13/07 at 9:36 AM the assistant director of nursing (ADON) was interviewed concerning the care for resident 10. The ADON reported that he did not know much about resident 10. The ADON did not know about a prosthesis having been ordered or what the future plans were for the care of resident 10.

The ADON stated that RN (registered nurse) 1 had been caring for resident 10 and that RN 1 would know about resident 10.

On 12/13/07 at 10:08 AM the Director of Nursing (DON) was interviewed. She knew about resident 10's trip to the ER on 11/10/07 with a high INR (International Normalized Ratio) and blood in his urine.

The DON said to ask RN 1 about resident 10.

On 12/13/07 at 10:10 AM RN 1 was interviewed. RN 1 reported that he had not cared for the "residents over there", including resident 10 since RN 1 had gotten the new position of Clinical Nurse Manager about 7/30/07. RN 1 stated that resident 10 only wanted to stay in bed and was not motivated to participate in cares. RN 1 stated that resident 10's wife had told resident 10, in November, that he had to start helping himself get better.

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F 250	Continued From page 5 3. Resident 7 was admitted to the facility on 9/22/07 with diagnoses that included diabetes mellitus, neuropathy, depression, anxiety, rheumatoid arthritis, chronic pain and lower extremity cellulitis. Resident 7's medical record was reviewed on 12/10/07. Resident 10's initial Minimum Data Set for 10/6/07 listed resident 7 in Mood and Behavior Patterns as follows: Indicators of depression, anxiety, sad mood almost daily: resident made negative statements-e.g.; "Nothing matters, Would rather be dead; What's the use . . . repetitive anxious complaint/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues. sad, pained, worried facial expressions. . . Indicators of depression, anxiety, sad mood; insomnia/change in usual sleep pattern up to five days a week. Mood persistence: Not easily altered. No behavioral symptoms were flagged. Nurses notes for resident 7 revealed behaviors including: hoarding of pain medications and frequent self-mutilation. The care plan for anxious features dated 12/4/07 listed an approach as " referral to (LCSW) (psychologist) (psychiatrist) for (evaluation) (treatment) (medication management)" for resident 7.	F 250		

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F 250	Continued From page 6 The care plan for psycho-social-initial adjustment dated 12/4/07 listed an approach as "assess leisure patterns and as feasible continue involvement with needed modifications for success and other: 1:1 PRN (meaning person to person visiting as needed)" Resident 7's care plan did not include a plan for correcting specific behaviors i.e. self mutilation and drug dependency. On 11/5/07 a physicians order was written for a "psych (psychiatric) consult" for resident 7 for destructive behavior. The Initial Psychological Consultation was dated 11/14/07. The Diagnostic Summary/Impressions revealed: " (Resident 7) is a 43 year old . . . who was referred to psychology due to altered consciousness and her refusal of medical recommendations. Unfortunately, (resident 7) was unable to engage in the evaluation due to lethargy and significant disruption of her cognitive ability. She was referred back for further evaluation of possible infection/medical condition that may have caused a delirium state." The Treatment Recommendations revealed: "1) Refer for evaluation of further medical issues affecting cognition and orientation." On 12/11/07 an interview was held with the resident care advocate 1. Resident care advocate 1 stated that she had not been available for about 11 weeks. Resident care advocate 1 stated that another psych evaluation had not been scheduled for resident 7.	F 250		

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F 250	Continued From page 7 On 12/12/07 at 9:45 AM and interview was conducted with the DON. The DON was asked what the plan of care for resident 7 was. The DON stated that behaviors for resident 7 were tracked for refusing cares, but not for self-mutilation or drug seeking.	F 250		
F 252 SS=B	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 observation and interview, it was determined that the facility did not provide a safe and clean environment. Findings include: The environment was inspected on 12/10/07-12/13/07. 1. The following observations were made in the east dining room: a. The floor in the doorway had black dirt and grime around the coving. b. A pat of butter had slid down the window by the outside doorway and was there on 12/11/07 through 12/13/07. c. The curtains hanging on the windows were soiled on the bottom. d. The front of the cabinets were soiled and chipped. 2. Two intake vents by the windows in rooms 27,	F 252		2/4/08

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F 252	Continued From page 8 29, and 40 were soiled and had lint and grime sticking to them. 3. There was a red stain on the carpet by the bed in room 38. 4. There were rust colored stains on the floor in room 48. 5. The physical therapy room floor was visibly soiled. 6. The floors in rooms 10 and 11 and the floor near the vending machines had black dirt and grime around the edges. 7. Wheel chair arms were broken for residents 4 and 5. 8. The transport van had a soiled carpet with many loose papers and wrappers around the floor of the van. On 12/11/07 at 2:00 PM a resident group interview was held. One resident complained about the untidy van.	F 252		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility did not maintain the area in good repair. Findings included:	F 253		2/4/08

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F 253	Continued From page 9 1. The door to room 11 had a bent metal plate on the right side on the bottom. 2. The west wall in room 15 was damaged. There were 2 broken floor tiles in room 15. 3. The south wall in room 14 had multiple torn areas on the wallpaper. 4. There were cracked and missing tiles by the window in room 29. 5. There were broken tiles in the east dining room north of the desk, behind the desk, and by the cabinets. 6. There were broken vents under the windows in rooms 39 and 46. 7. The bathroom in room 34 had an approximately 3 foot gouge in the wall opposite the sink. 8. There was peeling wallpaper over the drinking fountain on the west side, and next to the west dining room. 9. The corner molding and trim was missing by the drinking fountain, and east of the Medicare nursing station. 10. The shower by room 26 had 11 cracked tiles and a broken shower hose holder. The shower floor was not completely caulked around the bottom edge. 11. The shower in the west hall had a cracked tile by the drain, and it was not completely	F 253		

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F 253	Continued From page 10 caulked around the edge. 12. The physical therapy room had several cracked tiles. One cracked area was approximately 5 feet long and another cracked area was approximately 44 inches long. 13. In room 42 the carpet was soiled, the west wall was patched, but not painted. The north wall by the bed was patched and repatched, but not painted. The wall paper was peeling outside the door. The bathroom south wall was patched, but not painted.	F 253		
F 279 SS=E	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS 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	F 279		2/4/08

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by:
Based on observation, interview and record review it was determined that for 4 of 16 sample residents the facility did not develop, review and revise the comprehensive plans of care. The facility did not include measurable objectives and timetables to meet the residents medical, nursing, and mental and psychosocial needs. Residents 2, 7, 10 and 11.

Findings included:

1. Resident 7 was admitted to the facility on 9/22/07 with diagnoses that included diabetes mellitus, neuropathy, depression, anxiety, rheumatoid arthritis, chronic pain and lower extremity cellulitis.

Resident 7's medical record was reviewed on 12/10/07.

Resident 7's initial Minimum Data Set (MDS) assessment, dated 10/6/07, listed the resident's Mood and Behavior Patterns as follows:

Indicators of depression, anxiety, sad mood almost daily:

Resident made negative statements-e.g.; "Nothing matters, Would rather be dead; What's the use . . .

Repetitive anxious complaint/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues.

Sad, pained, worried facial expressions. . .

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Indicators of depression, anxiety, sad mood; insomnia/change in usual sleep pattern up to five days a week.

Mood persistence: Behaviors were not easily altered

No behavioral symptoms were flagged.

Nurses notes for resident 7 revealed:

9/30/07 ". . . frequent request for pain meds.(medications)"

10/1/07 "pt. up most of noc (night). request frequent for soma lortab. etc."

10/1/07 ". . . resident very demanding concerning cares ADL's (Activities of Daily Living)"

10/3/07 "pt. expressing numerous needs - will repeat request especially for narcotic use."

10/3/07 2300 (11:00 PM) "pt found with picc line (central intravenous line) out and exposed. . . . Will call for IV nurse to replace pic-line"

". . . pt refused PICC line after IV nurse was in to replace it."

10/5/07 "pt continues to refuse PICC line placement . . . send pt to (hospital) ER for eval (evaluation) and PICC line placement"

10/5/07 (7:00 PM) ". . . picc line noted to R upper arm - drsg (dressing) intact. . ."

10/6/07 ". . . pt found touching PICC line drsg (dressing) - enc (encouraged) pt to leave alone -

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F 279	Continued From page 13 reapplied dressing. . ." 10/12/07 ". . . drsg to wound changed pt still continues to request pain meds despite being delirious.". . . 10/13/07 "Caught the pt pulling on and messing with her picc line Line dc'd (discontinued) to prevent Sepis (sic) pt also got the scissors and cut on her drsg." 10/13/07 ". . . pt found unwrapping dressing to LE (lower extremity)." 10/18/07 "pt now has gotten out her scissors to cut into the bandage because it is out of reach of her fingernails. And she has started new and larger holes in her legs to start infection again." 10/19/07 "pts VS (vital signs) are afebrile. still despite all her efforts to infect her legs again. Will monitor. Pt always looking for more meds. Pt requires a lot of assistance to prevent harm and also to keep her area clean." 10/23/07 "pt keeps on asking for pain meds all times, appears very lethargic all times, refuses any kind of activity but sit. . . Encouraged to participate in care but refuses. Monitor for changes." 10/29/07 ". . . takes some meds (medications) crushed" 11/3/07 "(name of doctor) called concerning pts destructive behavior 1) spilling coffee on self 2)cutting bandage off with scissor's and digging wounds with fingernails 3) cellulitis 3)(sic) crashing drawers on her foot."	F 279		

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F 279	Continued From page 14 11/4/07 ". . . she is still destructive to her sores with her fingernails, . . . hopefully she will rest and leave her sores alone. She cuts her bandges (sic) with scissors to be able to get to her sores." 11/5/07 "pt found hoarding pills. . ." 11/11/07 ". . . scratched her ear, bleeding freely, drsg changed. . ." 11/6/07 "concern- R/T (related to) razor blade found in rm (room) concern of safety to pt. et (and) other residents. concern R/T pt removing dsg's BLE (both lower extremities) causing self inflicted wounds. Pt. denied all above although all above observed by nsg staff." 11/8/07 " pt so far has kept her bandages on her legs, but her neck is now being scratched and dug with her nails" 11/16/07 ". . . today she scratched a larger hole on her ears and managed also to cut a hole in her toe and neck. We are giving her all her PRNs (as needed psychoactive and pain medications) to try to calm her down and prevent this destructive behavior." 11/17/07 ". . . ear's especially the R (right) one has become very injured by her fingernails. . . Aware of the destruction she is causing. . . We are trying to keep her tired so she won't injure herself so much" 11/21/07 . . . toenails are a bleeding mess, (because she can get to them). . .Pt also still trying to scratch the scabs in her ears and it looks quite sore"	F 279		

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11/22/07 "pt continues to pull off her toenails down to the quick so her toes are a mess only a few toenails remain. Also she continues to scratch larger wounds in her ears."

11/23/07 "pt continues to be self destructive 4 toenails are ripped off with no nail showing on these toes pt continues to scratch holes and scabs in her ears, but most of the day she slept."

12/6/07 " legs wrapped again. pt has been digging R leg before the nurse rushed in to wrap it again."

Resident 7's care plan did not include a plan for correcting specific behaviors i.e. self mutilation and drug dependency. The care plan did not address the crushing of resident 7's medications.

On 12/12/07 at 9:45 AM and interview was conducted with the DON. The DON was asked what the plan of care for resident 7 was. The DON stated that behaviors for resident 7 were tracked for refusing cares, but not for self-mutilation or drug seeking.

On 12/11/07 at 11:10 AM and interview was conducted with LPN 2. LPN 2 stated that resident 7 had been having the medications crushed for one week.

On 12/12/07 at 9:30 AM an interview was conducted with RN 2. RN 2 stated that she had been crushing all of resident 7's meds for about a month. RN 2 stated that they suspected resident 7 cheeked them(hid them in the cheeks) and gave them to resident 7's boyfriend.

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On 12/12/07 at 1:20 PM an interview was conducted with the ADON. The ADON stated that resident 7 had been hoarding the medications since admit. The ADON stated that resident 7 takes all narcotics crushed with yogurt. The ADON stated that they tried to redirect resident 7 from the destructive behaviors and "watch her."

2. Resident 10 was admitted to the facility on 6/8/07 and readmitted on 7/3/07 with diagnoses that included coronary artery disease, pickwickian syndrome, diabetes mellitus, retinopathy, peripheral neuropathy, left lower extremity amputation, and gastric reflux disease.

Resident 10's medical record was reviewed on 12/12/07.

Resident 10's initial Minimum Data Set (MDS) for 5/18/07 and quarterly MDS dated 11/23/07 listed resident 10 as follows:
Cognitive Patterns
Short term memory was ok
Mental function varied over the course of the day

Communication: Usually understood others

Mood and Behavior:
Up to 5 days a week had repetitive health complaints
Up to 5 days a week had repetitive physical movements
Mood persistence was not easily altered
For 1-3 days in the last 7 days resident 10 resisted care and the behavior was not easily altered.
Behavioral symptoms had deteriorated

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Physical Functioning and structural problem: For locomotion on and off the unit resident 10 needed extensive assistance by one person in the initial MDS. In the quarterly MDS resident 10 was totally dependent.

For eating resident 10 needed supervision with set up only in the initial MDS. In the quarterly MDS resident 10 needed limited assistance with eating.

For functional limitation in range of motion (ROM) resident 10 had a limitation on one side of his leg and a full loss in the initial MDS. In the quarterly MDS resident 10 had limited ROM and partial loss of voluntary movement in both arms and both hands.

On the initial MDS resident 10's ADL (activities of daily living) had deteriorated.

Continence in the last 14 days, resident 10 was listed as having an indwelling catheter. Resident 10 was continent of bowel in the initial MDS. In the quarterly MDS resident 10 was incontinent of bowel all (or almost all) of the time.

Skin condition: resident 10 was listed as having a history of resolved ulcers in the initial MDS. In the quarterly MDS resident 10 had 1 stage 1 pressure ulcer.

Medications: resident 10 received antianxiety and antidepressant medications in the initial MDS. In the quarterly MDS resident 10 received only antidepressant medications.

Resident 10's Resident Assessment Protocol

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Summary triggered for delirium, cognitive loss, communication, ADL functional/rehabilitation potential, urinary incontinency and indwelling catheter, psychosocial well-being, mood state, behavioral symptoms, activities, falls nutritional status, pressure ulcers, and psychotropic drug use.

Resident 10's care plan was reviewed. Resident 10's care plan included:
1. A physical therapy admission care plan dated 9/4/07.
2. A skin integrity impaired: actual that was undated that addressed the Left medial stump wound.
3. A mood/psycho-social care plan dated 7/19/07 that was followed by the recreation department.
4. A new admission care plan with a date on the bottom of the page of 11/27/07. that addressed activities. This was followed by the recreation department.
5. A communication/cognitive care plan dated 7/19/07 and 11/27/07 related to activities. This was followed by the recreation department.
6. A hearing/vision loss care plan dated 7/19/07 and 11/27/07 related to activities. This was followed by the recreation department.
7. A psycho-social-initial adjustment care plan dated 7/6/07 initiated by Social Services.
8. A Fall Prevention Care Plan dated 8/24/07.

Nurses notes for resident 10 revealed:
8/29/07 ". . . pt. (patient) cont (continues on PO (by mouth) abx. (antibiotics) d/t (due to) UTI (urinary tract infection)"

9/7/07 "pt. discussed in Fall committee for fall on 8/24/07 Plan to educate staff in correct transfer technique."

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F 279	Continued From page 19 9/10/07 "Continues on abx for UTI. . ." 9/28/07 ". . .frequent visits from family pt seldom initiates leaving his bed. PT (physical therapy as ordered)" 10/8/07 ". . . pt has a blister to R (right) lower leg. . . " 10/9/07 ". . . pt has a blister to R (right) lower (leg) which is infected." 10/16/07 ". . . foley cath has been (changed) this afternoon. was collected urine for UA (urine analysis), C&S (culture and sensitivity) . . . will follow." 11/10/07 "pt returned from (name of hospital) ER (emergency room) with a dx (diagnoses) of UTI and an INR (International normalized ratio) of 5.18. Coumadin will be held for 2 days. . ." 11/13/07 ". . . pt is also on Levaquin for UTI. . ." 11/21/07 ". . a pressure area noted on R heel. . . ." 11/26/07 "Res (resident) up in bed, required extensive assist with ADL's (activities of daily living) incont (incontinent). required validation and encouragement to participate in care, BS (blood sugar check as order Care Plans addressing the following areas for resident 10 could not be found: Psychoactive medications Indwelling catheter use and frequent UTI's Pressure ulcers	F 279		

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An updated psycho-social care plan
Coumadin administration or the monitoring of the PT/INR was not addressed.
Diabetes mellitus

A Care Plan Conference Summary discussion dated 7/18/07 stated:
"Goal to be able to transfer self bed to chair and back and to toilet then go home. Prothesis possible with adequate wb (weight bearing) and strength. still need to work on toileting ability. . . ."

Another Care Plan Summary was dated 11/26/07. Dietary listed the weight. Activities wrote: "encourage our group act (activities) and Social Service wrote: "try to increase activity outside of room."

The summary of care plan conference discussion read: "dietary will give built-up spoon and fork with hi wall plate Pt (patient) and family discussed the decrease in strength, which has effected the goals. The decrease in strength has inabled (sic) the pt. to use a prostetic (sic). Pt. is advised to join more activities."

On 12/13/07 at 9:36 AM the assistant director of nursing (ADON) who was the facility wound treatment nurse, was interviewed concerning the care for resident 10. The ADON reported that he did not know much about resident 10. The ADON stated that he thought resident 10's stump had healed. The ADON did not know about a pressure ulcer for resident 10. The ADON did not know about a prosthesis having been ordered or what the future plans were for the care of resident 10.

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The ADON stated that RN (registered nurse) 1 had been caring for resident 10 and that RN 1 would know about resident 10.

On 12/13/07 at 10:08 AM the Director of Nursing (DON) was interviewed. She knew about resident 10's trip to the ER on 11/10/07 with a high INR and with blood in his urine.

The DON said to ask RN 1 about resident 10.

On 12/13/07 at 10:10 AM RN 1 was interviewed. RN 1 reported that he had not cared for the "residents over there", including resident 10 since RN 1 had gotten the new position of Clinical Nurse Manager about July 30. RN 1 stated that resident 10's wife had told resident 10 in November that he had to start helping himself get better.

3. Resident 2 was admitted on 6/17/07 with diagnoses that included depression, hip fracture, hypertension, gastroesophageal reflux, vitamin B-12 deficiency, restless leg syndrome, anemia, iron deficiency, neurogenic bladder, and Parkinson's disease.

Resident 2's medical record was reviewed on 12/10/07. Based on an initial Minimum Data Set (MDS) assessment, with an assessment reference dated 6/24/07, resident 2 triggered in the area of "Behavior" of section V, Resident Assessment Protocols.

An interview was held on 12/13/07 at 3:48 PM with Resident Care Advocates (RCAs) 1 and 2. RCA 1 stated that resident 2 can be sexually inappropriate at times with staff and residents.

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RCA 1 also stated that resident 2 is easily agitated, gets loud and belligerent sometimes, and can become physically abusive.

In a review of resident 2's comprehensive care plan, no documentation could be found that the facility developed a care plan addressing resident 2's inappropriate behaviors as described by the social worker.

4. Resident 11 was admitted to the facility 10/19/06 with diagnoses that included Alzheimer's disease with psychosis and aggression, Meniere's disease and coronary artery disease.

On 12/10/07 at 8:30 AM, the surveyor and the Assistant Director of Nursing, (ADON) were standing at the East nurses' station. A nurse (LPN 3) in the East hall was heard to call out , "No, I'm the boss." The nurse called out that she would call the police to come for the resident if she needed to.

LPN 3 was interviewed on 12/10/07 at 1:30 PM. The nurse stated that two certified nursing assistants (CNAs) had asked her to intervene with resident 11. LPN 3 stated that resident 11 had shoved a female resident in her wheelchair and kicked another resident's wheelchair tires. LPN 3 stated one of the residents makes continuous noises and resident 11 does not like noise. The nurse stated that when she told him to sit down, resident 11 shouted that he was the boss.

LPN 3 stated that resident 11 had many problem behaviors. LPN 3 stated resident 11 refused

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showers; stated he would take them on his own; then would wet his hair and say he had showered. LPN 3 stated it was necessary to be firm with resident 11 because he had a power problem.

On 12/10/07 at 2:00 PM, an interview was conducted with the two CNAs who had called for LPN 3 to assist them in the dining room. The CNAs stated that resident 11 was displeased with the way they had set out his meal on the table. The CNAs stated that resident 11 had become verbally abusive toward them and when he stood up, they called LPN 3 to assist them.

The Activities Director (AD) was interviewed on 12/12/07. The AD stated that resident 11 did not exhibit problem behaviors during activities with other residents or with her. The AD stated that she interacted with resident 11 frequently and that he responded to her appropriately. The AD stated that she understood that nursing had problems working with resident 11 because he refused cares. The AD stated that her interactions were on a different level. The AD stated that resident 11 could not be forced to do anything.

Resident 11's medical record was reviewed 12/12/07.

Resident 11's Lifestyle History, dated 10/26/06, revealed the resident did not like "pushy people". Resident 11's Lifestyle History, dated 10/30/07, revealed the resident did not like noise. Both histories revealed resident 11's "primary strength" was that he was social and he liked to talk.

Social services had a care plan for resident 11, most recently updated October, 2007. One

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concern was that resident 11 had altered behavioral patterns secondary to a thought disorder. The care plan reveled resident 11 was verbally abusive - cursed and screamed at others and got upset when people didn't close his door. The goal was that resident 11 would not be verbally abusive or rude. The approaches to alter resident 11's behaviors were for social services to remind the resident of appropriate actions as needed, to avoid confrontation and power struggles with the resident, and to use a validation therapy approach for resident 11. Nursing was not integrated as one of the disciplines to assist with the social services care plan. Nursing did have a separate care plan page for impaired thought processes, but no specific goal or approach was identified.

Another concern for resident 11's care plan was ineffective individual coping secondary to a decline in health and anxiety. The care plan revealed resident 11 had persistent anger towards himself and others, had an unpleasant mood, and had anxious behaviors and complaints. The care plan goal was for resident 11 to find and use outlets for anger and frustration that did not infringe on others or would not be self defeating. The approaches to alter resident 11's behaviors were for social services to avoid power struggles, use a calm and supportive approach on all contacts, praise accomplishments as they occur, support areas of independence, use positive humor, to reframe negatives into positives as possible, and to refer for psych services as needed. The activity department identified the same concern and had their own care plan. The activity department's care plan included to monitor for, and attempt to avoid, triggers that upset resident 11. Nursing

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F 279	Continued From page 25 was not listed as one of the disciplines to assist with their care plans. Nursing did have a care plan page for resident 11, dated 10/1/07, regarding resident self cares of bathing, hygiene, dressing and toileting. No specific goals or approaches were identified. Through documentation in nursing notes and through staff interviews, it was determined that most of resident 11's behavioral problems involved nursing staff and the resident's activities of daily living. There was no documentation that the information gleaned through interdisciplinary assessments and the most effective interventions that had been identified for working with resident 11 were shared with nor implemented by nursing. Nursing did not have a plan to effectively provide cares for resident 11 while maintaining his dignity and individuality.	F 279		
F 281 SS=D	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: 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 16 sample residents and 1 supplemental resident. Resident identifiers: 7, 13 and 17. Findings include: Reference: Lippincott, Seventh Edition, Textbook of Basic Nursing, Caroline Bunker Rosdahl.	F 281		2/4/08

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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' bedside."

1. Resident 7 was admitted to the facility on 9/22/07 with diagnoses that included diabetes mellitus, neuropathy, depression, anxiety, rheumatoid arthritis, chronic pain and lower extremity cellulitis.

a. On 12/10/07 at 8:20 AM resident 7 was observed in her room. Resident 7 was eating a creamy substance with streaks of red in it that was in a medication cup. Resident 7 stated that it was her crushed medications mixed in yogurt. A facility nurse was observed to be five doors down the hall at the medication cart. There was no facility staff observing resident 7 take the medications.

b. On 12/10/07 at 2:04 PM a medication cup was observed at resident 7's bedside. Resident 7 stated that the medication cup contained her medications. No facility staff were in resident 7's room to observe resident 7 take the medications.

c. On 12/10/07 at 4:00 PM an interview was conducted with resident 7. Resident 7 stated that facility staff had previously been leaving the medications for her to take on her own. Resident 7 stated that she did not always take the medication and would leave them on the night

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F 281	Continued From page 27 stand. d. An Assessment for Self-Administration of Medications dated 9/29/07 revealed that resident 7 was not granted approval to self-administer her medications. e. The nursing notes dated 11/5/07 revealed: Pt (patient) pills: 2 med cups with crushed whitetabs, 1 whole lortab, . . . 2 Oxycont (oxycontin) 80 mg (milligrams). Pt. stated "I have problems swallowing my pills, that's when I have to save my pills for later" . . . "today I gave all pills spoon feed 1 by 1 with yogurt et (and) stayed with her till swallow all meds. but she said one of the pill oxyc. (oxycontin) 80 mg is what she had at 1600 (4:00 PM) and was unable to swallow, but that pill is dry et doesn't look that was in her mouth at all. reported this incident to the noc (night) nurse will report to DON (Director of Nurses) tomorrow." f. The nursing notes dated 12/3/07 revealed: . . . found pt hoarding pills Oxycontin 7 tabs. (pt stated) "I have problems swallowing this pill et don't help me with my pain." 2. On 12/11/07 at 2:00 PM a resident group interview was held. Resident 17 stated that facility staff left his medications on his bedside table or by his breakfast for him to take with his food. On 12/15/07 at 8:15 AM resident 17 stated, "yes, they leave my medications with me to take with my breakfast."	F 281		

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Reference: Lippincott, Eighth Edition, Textbook of Basic Nursing, Caroline Bunker Rosdahl and Mary T. Kowalski. Chapter 83, Pg. 1352, Allergic, Immune, and Autoimmune Disorders. "Give no medications without first making sure the client is not allergic to it." Chapter 63, Pg. 861, Pharmacology and Administration of Medications, Nursing Care Guidelines 63-2. "Check very carefully for medication allergies, including checking the MAR, the client's chart and the physicians's order... Rationale: Checking for allergies is essential to prevent client injuries."

3. Resident 13 was admitted to the facility on 3/17/05 with diagnoses that included depression, failure to thrive, chronic pancreatitis, and hypothyroidism.

Resident 13's facility medical record review was completed on 12/13/07.

Resident 13's record contained a red "ALLERGIC" sticker on the inside of the front cover. Hydrocodone was listed as an allergy on the sticker.

Resident 13's current physician recertification orders listed hydrocodone in the allergy section on each page. Resident 13's current physician recertification orders contained an order for "Lortab (hydrocodone w/ (with) acetaminophen 5/500, 1 tablet PO (by mouth) Q (every) 6hrs (hours)".

Resident 13's December 2007 medication administration record (MAR) was reviewed. The front page was a "Resident Information" page which listed hydrocodone as an allergy. Resident

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F 281	Continued From page 29 13's December 2007 MAR's was 3 pages long, all 3 pages listed hydrocodone in the allergies section. On page one the facility nurses had documented administering 1 5/500 milligram tablet of hydrocodone routinely every 6 hours. Which was 45 doses from 11/01/07 until 11/13/07. An interview was conducted with licensed practical nurse (LPN) 1 on 12/13/07 at 9:50 AM. LPN 1 stated that she reviews the residents MAR for listed allergies. LPN 1 also stated that if a resident had a prescribed medication listed as an allergy she would talk with the resident and the physician regarding the medication allergy. LPN 1 reviewed resident 13's December 2007 MAR and the allergies section and said "(Resident 13's) is allergic to hydrocodone and she is on it routinely, I will call the doctor to clarify and talk to (Resident 13)".	F 281		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not ensure the environment remained as free of accident hazards as possible. Findings include:	F 323		2/4/08

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F 323	Continued From page 30 On 12/10/07 to 12/13/07 the environment of the facility was inspected. 1. An approximately 6 foot high, free standing closet, in the west dining room was not level with the floor. It tipped easily. The doors were not well hinged and hung slightly away from the closet, making it tip more when bumped. 2. The laminate flooring in the west hall was rippled in some places and coming up in others making it easy to trip. Particularly, the floor between dietary and the dietary storage area was coming up. On 12/13/07 at 9:45 AM the maintenance supervisor said, yes the floors are "a tripping hazard." I've almost "tripped myself." 3. The phone jack in the restorative dining room was not covered. Only the open wires were visibile. 4. Observation on 6 different heating vents found that the front panels were protruding approximately 3 inches out. There was a pin at each end of the protruding panel. One vent in the east dining room Two vents in the west dining room Two vents in the main dining room One vent in the north hallway. On 12/11/07 a tour of the facility was taken with the maintenance supervisor. The heating vent panel in the north hallway was easily pushed in flush with the vent by the supervisor. The maintenance supervisor stated that the protruding panel could be a tripping hazard.	F 323		

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F 323	Continued From page 31 5. The floor in the physical therapy room about midway where the additions are connected was uneven with the rest of the floor. On 12/11/07 a resident was observed tripping over the raised floor with his walker. 6. Deep gouges and slivers of wood were found in the handrails outside rooms 24, 30, and near the central supply door.	F 323		
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility did not provide appropriate respiratory care for 1 of 16 residents who did not receive oxygen as had been ordered. Resident 6. Findings included: Resident 6 was admitted to the facility 6/8/02 with diagnosis which included congestive heart failure, atrial fibrillation, dementia with psychosis, depression and anxiety, hypotension,	F 328		2/4/08

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osteoporosis, arthritis, obesity, reflux, neurogenic bladder and hypercholesterolemia.

Resident 6's medical record was reviewed on 12/11/07.

A physician's order dated 11/27/07 revealed resident 6 was to have her oxygen saturation monitored. Resident 6 was to receive oxygen via nasal cannula at a rate titrated to maintain her oxygen saturation at 90 percent or greater.

The vital sign flow sheet for resident 6 included three saturation check results. There was no date documented for the first result, but it had been documented that resident 6's oxygen saturation was 86 percent. On 11/11/07 "PM", it had been documented that resident 6's oxygen saturation was 87 percent. On 12/9/07 "AM" it had been documented that resident 6's oxygen saturation was 87 percent on room air. No interventions were noted on the vital sign flow sheet or the nurses' notes.

A nurse's weekly summary dated 11/30/07 at 6:00 PM revealed resident 6's oxygen saturation was 90 percent on room air. The other nurses' notes dated from 10/3/07 through 12/10/07 did not include information regarding oxygen saturation checks for resident 6.

A physician's progress note dated 12/6/07 revealed resident 6 had a chest X-ray on 12/2/07 that revealed left lower lobe interstitial pneumonia. On 12/6/07, the physician ordered a repeat chest X-ray for resident 6.

A nurse's note dated 12/6/07 revealed resident 6's X-rays had been compared and the physician

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ordered the resident to receive an antibiotic for pneumonia. A physician's order dated 12/6/07 revealed resident 6 was to have her oxygen saturation monitored daily and as needed. Resident 6 was to receive oxygen via nasal cannula at a rate titrated to maintain oxygen saturation of 92 percent or greater.

Resident 6's plan of care, dated 10/7/07, included four concerns that required oxygen intervention. The four care plan concerns were, (2) Activity Intolerance, (4) Impaired Airway Clearance, (8) Impaired Breathing Patterns, and (9) Altered Cardiac Output. Documented nursing interventions included: provide resident 6 with oxygen titrated as ordered, measure the resident's oxygen saturation as ordered, and report blue lips or nails.

Resident 6 was observed to be lying in bed on 12/10/07 at 8:45 AM. Resident 6 was awake and was not receiving supplemental oxygen. At 1:30 PM, resident 6 was slumped down in bed and awake. Resident 6 was not receiving supplemental oxygen. Resident 6's nail beds appeared to be blue/gray in color. An oxygen concentrator was at resident 6's bedside. The oxygen tubing was coiled and tucked under the handle of the concentrator and not within reach of resident 6. At 4:30 PM, resident 6 was sitting up in bed. Resident 6 was not receiving supplemental oxygen.

Resident 6 was observed on 12/11/07, intermittently from 7:50 AM until 4:00 PM. Resident 6 was observed to be without supplemental oxygen at each observation. Resident 6's nail beds appeared to be blue/gray in color. The oxygen concentrator remained at

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F 328	Continued From page 34 resident 6's bedside. The oxygen tubing remained coiled and tucked under the handle of the concentrator and not within reach of resident 6. At 10:00 AM on 12/12/07, resident 6 was observed to be in bed with no oxygen supplement and the resident's nail beds appeared blue/gray. The oxygen concentrator was at the resident's bedside. The oxygen tubing remained coiled and tucked under the handle of the concentrator and not within reach of resident 6. Resident 6 was asked why she wasn't using her oxygen. Resident 6 stated that no one had given it to her and that she couldn't reach it by herself. Resident 6's nurse was asked to check the resident's oxygen saturation. The nurse did not have a saturation monitor at the East nurse's station. The nurse was able to locate the West nurse's saturation monitor at the Medicare nursing station. When the surveyor and the nurse returned to resident 6's room at 10:15 AM, the resident had been given her nasal cannula. Resident 6's nail beds were pink. Resident 6's oxygen saturation was checked to be 96 percent while the resident was receiving 4 liters per minute of supplemental oxygen. The resident was observed intermittently until 3:00 PM. Resident 6 did not remove her nasal cannula during that time.	F 328		
F 329 SS=G	483.25(l) 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	F 329		2/4/08

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F 329	Continued From page 35 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for 2 of 16 sampled residents, the facility did not ensure the residents' drug regimen was free from unnecessary drugs. Specifically, 1) a Depakote level was not drawn as ordered and 2) Coumadin was administered without proper monitoring. A Prothrombin time (PT) and an international normalized ratio (INR) were not drawn as ordered and not monitored for over 10 weeks. PT and INR are the laboratory tests used to monitor the anti-coagulation effects of Coumadin or Warfarin. Resident identifiers: 9 and 10. Findings include: 1. Resident 10 was admitted to the facility on	F 329		

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6/8/07 and readmitted on 7/3/07 with diagnoses that included coronary artery disease, pickwickian syndrome, diabetes mellitus, retinopathy, peripheral neuropathy, left lower extremity amputation, and gastric reflux disease.

Resident 10's medical record was reviewed on 12/12/07.

The nurses notes dated 11/10/07 revealed: "As soon as I got here this AM, night shift CNA's (certified nursing assistants) inf (informed) that pt. (patient) had dark emesis x1 (one time). I went in to see pt. and noted a moderate amount of dark emesis with noted hematuria (blood in urine). T.O. (telephone order) to transfer pt. to (hospital) ER (emergency room) for eval (evaluation) and tx (treatment). . ."

Emergency Department Nurses notes dated 11/10/07 revealed:
"7:08 (AM) . . . History
Chief Complaint: VOMITING.
This started last night. . . . Vomiting this AM turned brownish, causing RN (registered nurse) at facility to be concerned about possible GI (gastrointestinal) Bleed. . . .
7:15 (AM) . . . gross hematuria in foley catheter bag. . .
08:55 (AM) 16 fr (french) (size of catheter) catheter placed using sterile technique . . . , with return of 50 ml (milliliters) red-colored urine. . . (Old Foley Discontinued, new one placed.)."

Emergency Department Physician notes dated 11/10/07 for resident 10 revealed:
History of present illness. . . vomited a clear liquid x2 and then brown liquid, the nurse thought she saw blood in the emesis so called 911.. . . Patient

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has not had similar symptoms previously.

Review of systems: The patient has had hematuria (noted today in foley).

Laboratory Tests
UA (urinalysis) color red
UA blood dipstick 250
UA RBC (red blood cells) too numerous to cnt (count)

Laboratory Tests
prothrombin time patient 51.5
international normal ratio 5.18

Clinical Impression
vomiting (resolved)
Acute urinary tract infection
elevated INR on coumadin

Instructions
STOP COUMADIN ! ! !
Recheck INR on Monday

On 8/22/07 the PT and INR results and laboratory reference parameters were as follows:
PT 26.5 High Normal range would be 11.5-13.5
INR 3.09 High Normal range would be 2.00-3.00
Orders were written to recheck in one week, which would have been on or around 8/29/07.

There was no PT/INR from 8/22/07 through 11/10/07 in resident 10's medical record.

On 12/13/07 at 11:00 AM an interview was held with the Director of Nursing (DON). The DON reported that resident 10 did not have a PT/INR drawn on 8/29/07 and as far as she knew it didn't

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get ordered with the laboratory. The DON also reported that there were no PT/INRs drawn between 8/22/07 and 11/12/07. The DON stated that the Medical Director was changed in June and July and new systems were not in place.

Resident 10's care plan was reviewed. Coumadin administration or the monitoring of the PT/INR was not addressed.

References:
Brunner & Suddarth's Textbook of Medical-Surgical Nursing -10th Edition, Suzanne C. Smeltzer, RN, EdD. FAAN and Brenda G. Bare, RN, MSN, 2004, pg 921 and 922. "When the INR reaches the desired therapeutic range, the (coumadin) is stopped. The dosage required to maintain the therapeutic range. . .varies widely among patients and even within the same patient. Frequent monitoring of the INR is extremely important so that the dosage of (coumadin) can be adjusted as needed. "

Nursing 2007 Drug Handbook, Lippincott Williams & Wilkins, pg. 1361. "Warfarin: . . . continue checking (INR) until therapeutic goal is achieved, and monitor it periodically thereafter. . . " (Warfarin is the same as coumadin.)

2. Resident 9 was admitted to the facility on 8/1/07 with diagnoses that included obstructive sleep apnea, chronic headache, hypercholesteremia, hypertension, stroke, coronary artery disease, depression, brain cyst, and hydrocephalus.

Resident 9's medical record was reviewed on 12/10/07.

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F 329	Continued From page 39 A physician's order dated 8/14/07 requested a Depakote level to be drawn in three weeks, which would have been on or about 9/4/07. There was not a result for a Depakote level in resident 9's medical record. On 12/11/07 at 3:52 PM an interview with the DON was conducted. The DON reported that the Depakote level was missed and that it was drawn that day.	F 329		
F 334 SS=E	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		2/4/08

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F 334	Continued From page 40 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:	F 334		

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WASATCH VALLEY REHABILITATION	2200 EAST 3300 SOUTH SALT LAKE CITY, UT 84109

(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
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Based on record review and interview it was determined that the facility did not ensure that all residents were offered the pneumococcal and influenza immunizations unless the immunizations were medically contraindicated or the residents had already been immunized. This occurred for 4 of 16 sampled residents. Resident identifiers 6, 7, 8, and 12.

Findings include:

1. Resident 6 was admitted to the facility on 6/8/02 with diagnoses that included diabetes, congestive heart failure, obesity, Alzheimer's disease with psychosis, depression, and anxiety.

On 12/10/07 resident 6's medical record was reviewed. Documentation of administration of the pneumococcal immunization could not be located.

2. Resident 7 was originally admitted to the facility on 10/05/07 with diagnoses that included diabetes mellitus, neuropathy, depression, anxiety, rheumatoid arthritis, chronic pain and lower extremity cellulitis.

On 12/10/07 resident 7's medical record was reviewed. Documentation of administration of the influenza and/or pneumococcal immunization could not be located.

3. Resident 8 was originally admitted to the facility on 7/2/07 and readmitted to the facility on 12/7/07 with diagnoses that included diabetes, hypertension, hypothyroidism, anemia, chronic pain, chronic thrombocytopenia, leukopenia, and osteoporosis.

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F 334	Continued From page 42 On 12/10/07 resident 8's medical record was reviewed. Documentation of administration of the influenza and/or pneumococcal immunization could not be located. 4. Resident 12 was admitted to the facility on 3/18/06 with diagnoses that included cerebral vascular accident, hypertension, hyperlipidemia, arthritis, and depression. On 12/10/07 resident 12's medical record was reviewed. Documentation of administration of the pneumococcal immunization could not be located. 5. On 12/11/07 a document entitled "Resident Vaccination Log" was provided to surveyors by the facility staff developer. Documentation of the missing immunizations listed above for residents 6, 7, 8 or 12 could not be located. In addition, the "Resident Vaccination Log" documented that 25 of the current 77 residents living in the facility had not been offered the pneumococcal vaccine. It also documented that 12 of the 77 residents had not been offered the influenza vaccine. On 12/12/07 at 3:00 PM the facility staff developer was interviewed. The staff developer stated that he was unsure of why so many residents were missing the pneumococcal and influenza vaccine. He stated the pneumococcal vaccines may have just been "missed" and that he was doing the influenza vaccines when he had time.	F 334		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE	F 371		2/4/08

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F 371	Continued From page 43 The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility did not store, prepare, distribute, or serve food under sanitary conditions. Findings include: 1. On 12/10/07 at 8:15 AM the following observations were made in the facility reach-in refrigerator: a. Three green salads with no date. b. Four individual portions of salad dressing dated 11/27/07. c. A pitcher of apple juice dated 10/8/07. d. A pitcher of apple juice dated 11/1/07. e. A pitcher of apple juice dated 11/26/07. f. A pitcher of cranberry juice dated 10/8/07. g. A pitcher of cranberry juice dated 10/11/07. h. A pitcher of cranberry juice dated 11/26/07. i. A pitcher of orange juice dated 10/12/07. j. A pitcher of orange juice dated 11/8/07. k. Thirty-six fortified shakes dated 11/20/07. 2. On 12/10/07 at 8:25 AM in the dry storage area of the facility kitchen the container labeled "powdered milk" was observed to be uncovered. 3. On 12/11/07 at 8:15 AM the popcorn machine in the facility activities room was observed. The machine was placed on top of a cart. The top shelf of the cart was covered with oil, dust and popcorn particles. The two bottom shelves had oil	F 371		

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and dust particles on them. The top of the popcorn machine was covered in oil and dust particles.

When the popcorn machine was opened, a smell of rancid oil was observed by the surveyor. A thick layer of oil was noted to be built up on all areas inside of the machine, where the popcorn is held until served to the residents. The bottom inside of the popcorn machine had several burnt particles of popcorn. Multiple globules of oil approximately 1/2 inch in size were hanging down from the ceiling of the machine. The globules were dark brown in color. A kettle hanging down from the ceiling of the machine had multiple globules of oil approximately 1/4 inch in size hanging on the bottom of it that were dark brown in color. The wires connected to the kettle were covered in very dark brown oil globules and dust particles. The light bulb and wire light bulb cage inside the machine had smaller oil globules and oil buildup.

On 12/13/07 at 2:30 PM the facility Activities Director stated that the popcorn machine "needs to be cleaned."

On 12/13/07 at 2:30 PM the facility Dietary Manager stated that the popcorn machine was used the previous Wednesday to pop popcorn which was served to the residents.

4. The following observations were made in the facility dishroom on 12/11/07:

a. At 9:15 AM dietary staff member (DSM) 1 was observed while she was loading soiled dishes into dish racks and placing them into the dish machine. DSM 1 was observed to open the door of the dishmachine and use her soiled

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F 371	Continued From page 45 hands to pick up a clean plate that had fallen out of the dishrack. DSM 1 was then observed to place the clean plate back into the dish rack of clean dishes and move the rack through the dishmachine so that the clean dishes could be put away by DSM 2. b. At 9:20 AM a certified nurses aide (CNA) entered the facility kitchen and asked DSM 2 to refill her coffee mug. DSM 2 refilled the coffee mug and then washed his hands. DSM 2 then walked over to the clean dish area, wiped his nose on his hand, and started to put clean dishes away. 5. On 12/11/07 at 12:36 PM CNA 1 was observed to retreive a meal tray from the facility kitchen. The tray left the kitchen and was delivered to a resident. The kitchen did not cover the resident's juice, milk, dessert or roll before these items left the kitchen on the resident's meal tray. 6. On 12/13/07 at 11:00 AM the facility's refrigerator in the activities room was observed. The following items were found: a. One half orange, peeled with no label or date. b. One sandwich with no label or date.	F 371		
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and	F 441		2/4/08

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corrective actions related to infections.

This REQUIREMENT is not met as evidenced by:
Based on observation it was determined that the facility did not provide a sanitary environment to prevent the transmission of disease and infection. Specifically, catheter collection bags were observed on the floor, ice scoops were observed in ice chests, and contamination was noted during two residents' dressing changes.

Findings include:

1. Resident 4 was admitted to the facility on 8/5/06 with diagnoses that included hyperkalemia, rhabdomyolysis, acute renal failure, urinary tract infection, failure to thrive, urinary retention, dysphagia, pneumonia, and wound infection.

On 12/11/07 resident 4's medical record was reviewed. Physician's recertification orders for the month of December 2007 were located. The recertification orders document that resident 4 has had a suprapubic catheter since May of 2007.

On 12/11/07 at 1:00 PM , 1:30 PM, and 2:00 PM resident 4's catheter collection bag was observed to be lying directly on the floor on the right side of resident 4's bed.

On 12/12/07 at 8:15 AM, 8:35 AM, and 9:55 AM resident 4's catheter collection bag was observed to be lying directly on the floor on the right side of resident 4's bed.

On 12/12/07 at 5:00 PM the facility was informed

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of the observations made of resident 4's catheter collection bag on 12/10/07 and 12/11/07.

On 12/13/07 at 8:20 AM resident 4's catheter collection bag was again observed to be directly on the floor on the right side of resident 4's bed.

2. During the facility's annual recertification survey from 12/10/07 to 12/13/07 a concern with possible contamination of ice scoops in the facility ice chests was noted. With each observation, the handle of the ice scoop was found to be touching the ice in the ice chest. Observations were as follows:

a. On 12/10/07 at 10:45 AM, 2:46 PM, and 3:56 PM an ice scoop was observed lying in the ice inside the ice chest located near the west nursing station.

b. On 12/10/07 at 11:05 AM and 2:18 PM an ice scoop was observed lying in the ice inside the ice chest located near the medicare nursing station.

c. On 12/11/07 at 10:10 AM and 3:45 PM an ice scoop was observed lying in the ice inside the ice chest located near the west nursing station.

d. On 12/12/07 at 8:14 AM an ice scoop was observed lying in the ice inside the ice chest located near the west nursing station.

3. Resident 7 was admitted to the facility on 9/22/07 with diagnoses that included diabetes mellitus, neuropathy, depression, anxiety, rheumatoid arthritis, chronic pain and lower extremity cellulitis.

On 12/12/07 at 10:10 AM a dressing change was observed for resident 7. An overbed table with

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F 441	Continued From page 48 dried food and grime was beside resident 7's bed. Laying on the bedside table was a butter knife with butter on it. The assistant director of nursing (ADON) placed the dressing supplies on the soiled overbed table. A clean wash cloth was placed on the overbed table. The wash cloth fell onto the butter knife. The ADON used this wash cloth to cleanse resident 7's wounds on the left leg.	F 441		
F 504 SS=D	483.75(j)(2)(i) LABORATORY SERVICES The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility continued to provide laboratory tests after the physician had ordered them discontinued and after the medication for which the tests were related had been discontinued for 1 of 16 sample residents. Resident 5. Findings include: Resident 5 was admitted to the facility 6/13/07 with diagnoses which included coronary atherosclerosis, atrial flutter, dementia, hypertension, anemia and depression. Resident 5's medical record was reviewed on 12/11/07. On 11/9/07, resident 5 had been transported to an emergency room secondary to a head laceration received during a fall. The emergency	F 504		2/4/08

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physician recommended that Coumadin be discontinued due to the resident's frequent falls.

Laboratory test results revealed that PT/INR tests were completed for resident 5 on 11/11/07 and the results were faxed to the facility 11/12/07. Resident 5's physician documented the laboratory report that resident 5 was to have the next PT/INR test in four weeks. Four weeks would have made the next test due 12/10/07.

Resident 5's medication regimen had included Coumadin for anti-coagulation until 11/14/07. On 11/14/07 resident 5's physician had ordered the resident's Coumadin be discontinued. The change in medication was documented by a facility nurse in the Resident Progress Notes on 11/14/07.

On 11/18/07 Prothrombin time and International Normalized Ratio (PT/INR) laboratory tests were completed for resident 5. A facility nurse documented on the laboratory report that the physician was notified of the test results on 11/19/07. The nurse documented, on the same report, that the physician ordered the PT/INR tests be discontinued because resident 5 was no longer receiving Coumadin.

Laboratory test results revealed that PT/INR tests were completed for resident 5 on 11/25/07 and the results were faxed to the facility 11/2607.

Laboratory test results revealed that PT/INR tests were completed for resident 5 on 12/2/07 and the results were faxed to the facility 12/3/07. Resident 5's physician documented the laboratory report that resident 5 was to have "no more" (underlined by the physician) PT/INRs.

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F 504	Continued From page 50 On 12/14/07, the facility director of nursing (DON) stated that it was found the nurses had routine PT/INRs scheduled for resident 5. The DON stated that no new orders were taken for the laboratory tests, but that the previously scheduled tests had not been stopped until the physician's second order to cancel, on 12/3/07.	F 504		