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F 167 SS=B	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined that the facility did not have the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility available for examination and readily accessible to the residents. During review of the binder where the state survey results are designated to be posted, it was determined that the 6/15/06 certification survey results were not present. During an interview with the Administrator on 6/19/07, he stated that the state survey agency (SA) did not send him a copy of the approved plan of correction after he submitted it to the SA.	F 167		8/21/07
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225		8/21/07

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 225	Continued From page 1 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, incident report review and interview it was determined that for 1 of 12 sampled residents the facility did not ensure that all alleged violations involving injuries of unknown origin were reported immediately to the	F 225		

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F 225	Continued From page 2	F 225		

State survey and certification agency. Specifically, resident 12 acquired a fracture of unknown origin to her right upper arm.

Findings include:

1. Resident 12 was originally admitted to the facility on 8/10/05 with diagnosis which included: rheumatoid arthritis, contractures and weakness.

Resident 12's medical record was reviewed on 6/20/06.

The following entry was documented in the nurse's notes by facility staff:

"6/13/07 2:00 PM (late entry) some bruises noted on upper R (right) arm"

"6/16/07 4:00 PM went in to check resident found Rt (right) arm that bruised earlier in the week, the arm looked misshapen (sic) and increased around Rt shoulder looked twice it's normal size and she cried when I touched it."

An incident report dated 6/13/07 was filled out by facility staff regarding resident 12. It was documented, by a facility nurse, in the description of the incident was "bruising on R upper arm, transfer versus telephone cause."

An interview was conducted with the DON (Director of Nursing) on 6/20/07 at 2:45 PM. The DON was asked if she knew how resident 12's arm was fractured the DON stated that resident 12's right arm was broken and that it either happened from a transfer or from rolling over the phone in bed but was not sure between the two

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F 225	Continued From page 3 options. Review of state agency documentation revealed that the injury of unknown origin was not reported to the State survey and certification agency nor did the agency receive a final investigation report.	F 225		
F 324 SS=D	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility did not provide adequate supervision to prevent accidents. This occured for 2 of 12 residents on the survey sample. 1. On 6/21/07 at 8:40 AM, it was observed that CNA (Certified Nurses Aide) 1 was pushing the north hall dining cart down the hallway. CNA 1 was pushing the cart from the back so the she did not have a full view of what was in front of her. It was observed that CNA 1 pushed the dining cart into resident 4 hitting resident 4 in the knee. Resident 4 then yelled "ouch". 2. On 6/20/07 at 8:10 AM, medication pass was being conducted with LPN (Licensed Practical Nurse) 1. LPN 1 had his medication cart outside the dining room and was passing medications to residents that were inside the dining room. LPN 1 drew up 4 units of Novalog insulin per physicians order for resident 8. LPN 1 then went to look in the dining room for the resident 8, the cap had not been replaced on the insulin syringe leaving the	F 324		8/21/07

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F 324	Continued From page 4 needle exposed. Resident 8 was not in the dining room. LPN 1 then walked down the hallway to resident 8's bedroom with the insulin needle exposed. LPN 1 gave resident 8 his insulin injection in his left upper arm. LPN 1 then left resident 8's room with the contaminated insulin needle exposed. LPN 1 walked down the hallway with the contaminated needle to the nurses station where a sharps container was located.	F 324		
F 329 SS=D	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 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 staff interviews and record review, it	F 329		8/21/07

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F 329	Continued From page 5 was determined that facility staff did not ensure that each resident's drug regimen is free from unnecessary drugs. This occurred for 1 of 12 residents in the survey sample in that a resident received a prn (as needed) hypnotic medication for 171 consecutive days. Resident identifier 9. Findings included: 1. Resident 9 was admitted to the facility on 12/27/06 and had the diagnoses which included hypertension, insomnia, reflux disease and chronic obstructive pulmonary disease. Resident 9 had a physician's telephone order dated 12/28/06 for "Restoril (a hypnotic) 15 mg po (by mouth) (at) hs (hour of sleep) prn" signed by the director of nursing (DON) and stamped with the physician's signature. During an interview with the DON on 6/20/07 at 2:45 PM, when asked why resident 9 received a daily dose of Restoril the DON stated, "She asks for it." A review of resident 9's care plan goal for the Restoril dated 1/5/07 and with review dates of 3/25/07 and 4/10/07 documented that resident 9 "will have 6-8 hrs (hours) of uninterrupted sleep q (every) night pnr (sic). A review of the medication administration record (MAR) for resident 9 documented in 2/07 that she slept between 6 and 7 hours every night except on 2/19 and 2/26/07 where she slept 5 hours with daily naps of 1 to 4 hours. During 3/07, resident 9's MAR documented that she slept between 6 and 7 hours every night except on 3/21 where she slept 1 hour and on 3/25/07 where she slept 5	F 329		

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F 329	Continued From page 6 hours with daily naps of 1 to 3 hours. During 4/07, resident 9's MAR documented that she slept between 6 and 7 hours every night except on 4/1 and on 4/29/07 where she slept 4 hours with daily naps of 1 to 4 hours. A review of Psychotropic Drug Review form dated 4/10/07 documented that the target behaviors (hours of sleep) has "stabilized" and the drug committee recommends the dose to be "Maintained."	F 329		
F 371 SS=E	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, interview, and kitchen document review it was determined that the facility did not store, prepare, distribute or serve food under sanitary conditions. Findings include: 1. On 6/18/07 at 8:30 AM, the following observations were made in the facility kitchen: a. One box of fruit cocktail stored directly on the floor in the dry storage area. b. One box of corn oil stored directly on the floor in the dry storage area. 2. On 6/18/07 at 12:30 PM, a CNA (certified nurses aide) was observed while passing out clothing protectors to the residents in the south	F 371		8/21/07

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F 371	Continued From page 7 unit dining room. The CNA was observed to drop a clothing protector on the floor, pick it up, and place it on a resident to use during the lunch meal. 3. On 6/20/07 at 9:30 AM, dietary staff member 1 (DSM 1) was observed while washing the soiled breakfast dishes. DSM 1 was observed to touch several soiled dishes with her gloved hands, put the soiled dishes in the dishwasher, and then put clean dishes away. At no time was DSM 1 observed to wash her hands or change her gloves. This observation was made multiple times. 4. On 6/20/07 at 9:45 AM, the facility dishwasher temperature was checked after observation of several loads of dishes were put through the dishwasher to be washed. The dishwasher temperature was observed to be 102 degrees Farenheit for the wash cycle and 105 degrees Farenheit for the rinse cycle. The manufacturer's recommendations posted on the facility dishwasher state that the temperature for both the wash and rinse cycle should be at least 120 degrees Farenheit. Temperature logs for the facility dishwasher for the month of June were reviewed. All temperatures recorded were within normal limits. On 6/20/07 at 9:50 AM, an interview was held with DSM 1 regarding the dishwasher temperature. DSM 1 stated that the dishwasher "only gets warm for a little bit and then it gets cold." DSM 1 also stated that she only checks the dishwasher temperature at the beginning of her shift.	F 371		

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F 371	Continued From page 8 5. On 6/20/07 at 12:00 PM, DSM 2 was observed while serving the lunchtime meal. DSM 2 was slicing pizza and was observed to hold one end of the pizza slices down with his left hand which had a soiled oven mitt on it. 6. On 6/20/07 at 2:30 PM, an observation was made of the medication refrigerator in the south unit. A container of orange juice was found which was not dated as to when it was opened.	F 371		
F 460 SS=B	483.70(d)(1)(iv)-(v) RESIDENT ROOMS Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation of facility rooms, it was determined that the facility did not ensure that all bedrooms were equipped to assure full visual privacy for each resident. Findings include: 1. During an observation of Resident 3 in his bedroom on 6/19/07, it was observed that he had to walk through the area of his roommate's living area to access his bed. The privacy curtain rod was designed to close at the extended doorway of his roommate's living area and did not leave enough space for his roommate's full visual	F 460		8/21/07

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privacy when resident 3 walked to his living area. Also, the rod did not have a curtain on it at this observation.

2. During an observation of room 213, it was determined that the bed to the left of the door did not have full visual privacy. The resident was observed in bed without having full visual privacy. The curtain rod was designed to cross over the bed resulting in the curtain resting on the bed instead of clearing it at the foot of the bed.

3. During an observation of room 109, it was determined that the bed to the left side of the entrance door did not have full visual privacy. The curtain rod was designed to cross over the bed in the center resulting in the curtain resting on the bed instead of clearing it at the foot of the bed.

4. During an observation of room 112, it was determined that the bed to the right of the door did not have full visual privacy. The resident was observed in bed without having full visual privacy. The curtain rod was designed to end in the middle of the doorway entrance. When the bedroom door is open the resident does not have privacy from the hallway because the curtain will not wrap around the bed.

5. During an observation of room 105, it was determined that the bed to the left of the door did not have full visual privacy. The curtain rod was designed to cross over the bed resulting in the curtain resting on the bed instead of clearing it at the foot of the bed.

6. During an observation of room 102, it was determined that the bed near the door did not have full visual privacy. The resident was

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F 460	Continued From page 10 observed in bed without having full visual privacy. The curtain rod was designed to cross over the bed resulting in the curtain resting on the bed instead of clearing it at the foot of the bed.	F 460		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and resident interview, it was determined that the nurses' station did not have a functioning call system for all resident rooms; and toilet and bathing facilities. Findings include: 1. Resident 9 was admitted to the facility on 12/27/06 and had diagnoses which included hypertension, insomnia, reflux disease and chronic obstructive pulmonary disease and had a physician's order for coumadin 5 mg. (milligrams) everyday. During an interview with resident 9 on 6/20/07 at 9:30 AM, it was stated that the call system at her bed does not work. Resident 9's call light was tested and it did not activate a light nor have an audio indicator at the nurses' station. 2. On 6/19/07, the call system was tested in the bathroom of room 201. The nurses' station call light system activated the lights for rooms 203,	F 463		8/21/07

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F 463	Continued From page 11 204 and 212 when the bathroom call light in room 201 was activated. 3. On 6/19/07, the call system was tested in room 215. The nurses' station call light system activated the lights for rooms 203, 204, 212 and 215 when resident 1's call light was activated at her bed. 4. On 6/19/07, the call system was tested in the bathroom of room 215. The nurses' station call light system did not activate a light nor have an audio indicator at the nurses' station. 5. On 6/19/07, the call system was tested in the bathroom and at the two beds that had the call light switch in room 216. The nurses' station call light system did not activate a light nor have an audio indicator when the call light was activated. The bed at the right of the entrance to room 216 did not have a call system to activate. 6. On 6/19/07 at 8:20 AM, resident 3 was observed in bed in his room and he did not have access to a call light. The mechanism for the call system was missing from the wall connection and the wall connection was on the opposite side of the room from the bed.	F 463		
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, it	F 502		8/21/07

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was determined that facility staff did not obtain laboratory services to meet the needs of its residents by not obtaining ordered labs. This occurred for 2 of 12 residents in the survey sample. Resident identifiers 9 and 1.

Findings included:

1. Resident 9 was admitted to the facility on 12/27/06 and had diagnoses which included hypertension, insomnia, reflux disease and chronic obstructive pulmonary disease.

Resident 9 had a physician's order for coumadin 5 mg. everyday.

Resident 9 had a physician's telephone order dated 3/27/07 that documented to have a "PT (Protime) and INR Q (every) month" lab completed to monitor the coumadin therapy. According to the facility's laboratory purveyor the normal range for PT was 11.5 to 13.5 and for INR it was 2.0 to 3.0. On 3/28/07, a PT and INR lab was completed and the results for the PT was 21.6 and the INR was 2.35.

On 6/20/07 the director of nursing (DON) was asked to provide resident 9's labs for April, May and June '07. During an interview with the DON on 6/21/07, she stated that the PT INR labs for April and May '07 could not be found. The DON completed the June lab on 6/21/07 and the results for the PT was 35.2 and the INR was 4.44 with both being in the high range.

The physician's recertification order dated May 2007 and stamped by the physician documented "PT and INR Q month".

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F 502	Continued From page 13 2. Resident 1 was admitted on 1/28/05 with diagnoses that included coronary artery disease, thyroid disease, bi-polar disorder, seizure disorder, gait abnormality, weakness, diabetes, dyslipidemia, hemiplegia, osteoporosis, hypertension, and schizophrenia. On 6/18/07 resident 1's clinical record was reviewed. A laboratory result for resident 1's lithium level dated 3/07/07 was located. A handwritten statement on the laboratory results read, "Handed to nurse 5/29 - 2200 (10:00 PM)." On 6/20/07 at 2:00 PM the Director of Nursing (DON) was interviewed regarding the handwritten statement on the lithium level results for resident 1. The DON stated that it "may have been a missed lab and we caught it in our QA (quality assurance) process."	F 502		
F 514 SS=B	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514		8/21/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465122	A. BUILDING _____ B. WING _____	06/21/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN CARE CENTER	2325 MADISON AVENUE OGDEN, UT 84401

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F 514	Continued From page 14	F 514		

Based on interview and record review it was determined that the facility did not maintain accurately documented clinical records for one of twelve sampled residents. Resident identifier 1.

Findings include:

1. Resident 1 was admitted on 1/28/05 with diagnoses that included coronary artery disease, thyroid disease, bi-polar disorder, seizure disorder, gait abnormality, weakness, diabetes, dyslipidemia, hemiplegia, osteoporosis, hypertension, and schizophrenia.

On 6/18/07 resident 1's clinical record was reviewed. A physician's order for "PT (physical therapy) to eval (evaluate) and treat" resident 1 was located on the May 2007 physician recertification orders. Physical therapy notes for resident 1 were obtained from the facility physical therapist, including a document entitled "Discharge Summary" dated "11/25/07."

On 6/21/07 at 9:45 AM, the facility physical therapist was interviewed. When asked about the date of 11/25/07 on resident 1's physical therapy discharge summary, the facility physical therapist stated "I wrote this today." She also stated that resident 1 had been discharged from physical therapy 11/25/06. The physical therapy discharge order written by the physician could not be located.

2. On 6/19/07 resident 1's physical therapy notes were provided to surveyors. Resident 1 had physical therapy notes dated 11/15/06 that read: "Plan: Recommend continue with current plan 4 more wks (weeks)." However, resident 1 was discharged 11/25/06 according to an interview

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F 514	Continued From page 15 held with the facility physical therapist on 6/21/07 at 9:45 AM. On 6/26/07 at 2:30 PM, an additional interview was held with the facility physical therapist regarding the discrepancy in the physical therapy notes. The facility physical therapist stated that the computer program she uses automatically writes that the plan for every resident in physical therapy is to continue for four more weeks.	F 514		