STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465156	A. BUILDING _____ B. WING _____	10/19/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER	523 NORTH MAIN STREET BOUNTIFUL, UT 84010

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and review of resident council minutes, it was determined the facility did not always answer residents' call lights in a timely manner. Findings included: On 10/17/06 from 8:45 AM until 9:50 AM, continuous observation was made of the residents' activated call lights on the 200 hall. Residents activated their call lights 14 times during the observations. The light was activated in room 215 at 8:51. The call light was answered after two minutes and the resident was advised someone would be back to help shortly. After waiting 10 minutes, at 9:03 AM, the resident in room 215 reactivated the light. The call light for room 215 was answered at 9:11 AM, 8 minutes later. The call light in room 226 was activated at 8:51 AM. and was answered at 8:58 AM, 7 minutes later. The call light in room 203 was activated at 9:05 AM. and was answered at 9:11 AM, 6 minutes later. The call light in room 213 was activated at 9:42	F 241	F241- A staff in-service was conducted on October 20, 2006 for the 200 hall nurses and CNA's on call light protocol. Additional huddles will be given to staff monthly and as needed to address call light protocol compliance. Beginning November 6, 2006, DON / designee will conduct focus rounds during random times and in random halls to assess for compliancy to call light response. These audits will be conducted weekly, or as needed, to identify trends in times of day, specific residents with increase needs, and to identify needed staff inservices that will assure timeliness of answering call lights and assuring ongoing compliance. Identified trends and any concerns expressed in Resident council will be reviewed monthly in the Quality Assurance meeting and as needed until a lesser frequency is deemed appropriate. Completion date: 12/05/06	

POC acceptable compliance date 12/5/06

Utah Department of Health
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Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David Bland	Administrator	11-03-06

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

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F 241	Continued From page 1 AM and was answered at 9:48 AM, 6 minutes later. The call light in room 221 was activated at 9:43 AM and was answered at 9:49 AM, 6 minutes later. The Resident Council Meeting minutes for August 2006 were reviewed on 8/17/06 at 12:30 PM, after observations had been made of the call lights. It had been documented that residents stated, on 8/4/06, that call lights were taking longer than 5 minutes to be answered. It was documented the residents stated that at times the staff would answer the call lights and say they would return to help, then not return for an hour. The Resident Council Meeting minutes revealed the residents had stated that the nurse's on the 200 hall had not been responding fast enough to residents' needs. Inservice records, dated 8/4/06, revealed that 16 nursing staff had been inserviced regarding answering call lights promptly and considerately.	F 241		

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F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility did not ensure that the Minimum Data Set (MDS) assessments accurately reflected residents' status for 3 of 17 sample residents. Resident identifiers 3, 4 and 9. 1. Resident 4 was admitted to the facility on	F 278	F278- The MDS's for Res 3, 4 and 9 were corrected and the appropriate corrections were submitted to the state on 10/18/06 and 10/19/06. An in-service will be conducted on 11/7/06 for all staff involved in the MDS process. A complete audit for accuracy and compliance of MDS's will be completed by the DON / designee by 12/05/06. DON /designee will review MDS's for accuracy and compliancy prior to submission to state. This review will focus on accurate diagnoses and signatures of required staff. Identified trends will be reviewed in the Quality Assurance meeting monthly and as needed until a lesser frequency is deemed appropriate. Completion date: 12/05/06	

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F 278	Continued From page 3	F 278		

7/27/06 with diagnoses that included osteoporosis, anemia, constipation, cardiomyopathy, and gastro esophageal reflux disease.

A review of resident 4's medical record was completed on 10/18/06. A bowel continence risk assessment was completed for resident 4 on 8/9/06. It stated that resident 4 was continent of bowel and no change in bowel score was noted. On 8/9/06 an initial MDS assessment was completed by the facility for resident 4. Section H2 triggered for fecal impaction.

An interview was held with the ADON on 10/18/06 at 2:30 PM. The ADON was shown resident 4's MDS, where it triggered for fecal impaction. The ADON stated that the fecal impaction marked was a mistake and that resident 4 had not had a fecal impaction.

2. Resident 9 was admitted to the facility on 2/16/06 with diagnoses that included: hypertension and hypothyroidism.

The 8/14/06, quarterly MDS assessment completed by facility staff, had not been signed

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F 278	Continued From page 4 under section R2a; Signature of Person Coordinating the Assessment, Signature of RN (registered nurse) Assessment Coordinator. 3. Resident 3 was admitted to the facility 4/20/06 with diagnoses that included peripheral vascular disease and rheumatoid arthritis. Resident 3's medical record was reviewed on 10/17/06. Resident 3's initial MDS assessment was dated 4/27/06. The first quarterly MDS assessment for resident 3 should have been dated July 2006. There was no MDS assessment in the resident's medical record that had been documented as a quarterly assessment. Four full MDS assessments had been completed by the facility for Medicare reimbursement. The assessments were dated 7/5/06, 7/11/06, 7/18/06 and 7/27/06. One of the Medicare assessments should also have been coded as a quarterly MDS assessment.	F 278		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 309	F309- On 9/15/06, Resident 10 was assessed by Physical Therapy and had achieved his goals. This resident was appropriately referred to a Restorative Nursing program. By November 3, 2006, the Rehabilitation Team Lead/designee will review current resident caseload to ensure that residents are receiving the physician-	

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F 309	Continued From page 5 review, it was determined that the facility did not provide care and services to attain or maintain the highest practicable well-being for 2 of 17 sampled residents. Specifically, one resident did not receive Physical Therapy (PT) treatments as ordered by the physician and one resident did not get Range of Motion (ROM) therapy in accordance with their comprehensive assessments and plans of care. Resident identifiers: 10 and 13. Findings included: 1. Resident 10 was an 87 year old male who was admitted 2/16/04 with diagnoses that included blindness, deafness, and a right medial malleolus (inner ankle) pressure sore. Resident 10 ' s medical record was reviewed 10/17/06. A nurse's note, dated 8/30/06, revealed resident 10 was found sitting on the floor between his bed and bathroom. A nurse's note, dated 9/5/06, revealed resident 10 was found sitting on the floor between his toilet and laundry barrels. Nurses' notes dated 9/1/06 and 9/5/06 revealed resident 10 was receiving pain medication secondary to his complaints of back pain. A physician's order, dated 9/15/06, revealed resident 10 was to be seen by PT for 3-5 treatments a week for 4-6 weeks for bed mobility, transfer, gait training, balance, and safety skills. On 10/13/06 a second physician's order was documented that resident 10 was to "continue P.T. daily up to 5x/wk (5 times a week)" for 5 weeks. Both orders were documented in the nurse's notes.	F 309	ordered frequency physical therapy treatment. Beginning November 6, 2006, the Rehabilitation Team Lead/designee will have physician orders recorded and tracked to compare ordered treatments to actual treatments on a weekly basis. On November 3, 2006, the Rehabilitation Team Lead/designee will train rehabilitation staff to properly record refused treatments in the medical record. The Rehabilitation Team Lead/designee will prepare a report to be addressed in the facility monthly QA meeting. Identified trends will be reviewed every month and as needed to ensure that satisfactory compliance is achieved and maintained. Completion date: 12/05/06 Resident 13 was screened by physical therapy on 10/23/06 and skilled therapy or	

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F 309	Continued From page 6 Physical therapy's plan of treatment for resident 10, dated 9/15/06, revealed the resident was to be seen 3 to 5 times a week for 5 weeks. The PT progress summary records for the weeks from 9/15/06 to 10/12/06 revealed resident 10 was treated 7 times. As ordered by the physician, resident 10 should have been treated 12 to 20 times during that four week period. The physical therapist documented resident 10's progress summary, dated 9/15/06 to 9/21/06, that the resident had "not been seen since evaluation 2' (secondary) to time constraint from skilled PT services to address fall, safety, immobility risks & (and) achieve functional PT goals outlined above." On 10/17/06 at 2:20 PM and at 3:45 PM, an interview was conducted with the physical therapist. The therapist stated that resident 10 had been given physical therapy 2 times a week. The therapist stated resident 10 had "made great strides" and his back pain had improved. The physical therapist stated that he would like to be able to see the resident 3 times a week. The therapist stated resident 10 "sometimes refuses", but that with encouragement, the resident would get up for therapy. There was no documentation of resident 10's refusals. The therapist stated he had just returned, on 10/17/06, from a 10-day vacation. On 10/17/06 at 12:20 PM, an interview was conducted with an occupation therapist (OT) at the facility. The OT stated the facility had not had PT "for awhile". The facility had used an agency "for awhile" during the time the facility physical therapist had been on vacation.	F 309	Restorative nursing deemed not appropriate. Resident referred to a Functional Maintenance Program. DON / designee to review Residents by 12/05/06 for provision of skilled therapy, Restorative nursing program or FMP based on current need. All residents will be re-evaluated quarterly and as needed for needed changes to current plan of care. DON / designee to review all patient charts by 12/05/06 for appropriate documentation required for provided treatment. Focus review findings/trends will be reviewed in Quality Assurance meeting monthly and as needed until a lesser frequency is deemed appropriate. Completion date: 12/05/06	

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An interview was conducted, on 10/17/06 1:50 PM, with a licensed practical nurse who worked with resident 10 and with the Assistant Director of Nursing (ADON)/Case Manager for resident 10. Each nurse stated that there had been no problem getting resident 10 up for physical therapy.

On 10/18/06, an interview was conducted with the recreation therapist (TRT). The TRT stated that resident 10 did not routinely participate in group or independent activities due to his vision and hearing deficits. The TRT stated that resident 10 liked to eat and sleep and was pretty much solitary. The TRT stated, further, that resident 10 had been very physically active in the past, liked sports, and liked to run 10 miles a day. The TRT had documented that her attempts to include resident 10 in activity pursuits were mostly unsuccessful. Other than outings with his family, physical therapy sessions were the main documented source of resident 10's activities.

On 10/17/06 at 12:50 PM, a telephone interview was conducted with resident 10's family member. The family member stated that he wished the facility had more help so they could get him (resident 10) up a little more. The family member stated further, "If they did more physical therapy, he would fall less."

2. Resident 13 is an 84 year old female who was admitted to the facility with diagnoses that included arthritis, stroke, and a history of polio.

Resident 13's medical record was reviewed on 10/18/2006.

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Resident 13's interdisciplinary care plan, originally dated 5/26/06 and updated 8/29/06, revealed the resident had a problem of altered ability to perform activities of daily living (ADLs) secondary to impaired memory and impaired physical mobility. The care plan revealed approaches (10 and 19) for restorative nursing to provide resident 13 with a functional maintenance program to improve her range of motion (ROM) for morning and evening ADL's. It was documented in the care plan that the goal and modalities for the functional maintenance program could be located in the program flow sheets.

On 10/18/2006 at 1:05 PM, an interview was conducted with a certified nursing assistant (CNA) who provided cares for resident 13. The CNA stated that she assisted resident 13 with ADL tasks and that the resident was cooperative with cares. The CNA stated that she did not provide ROM therapy for resident 10.

There was no documentation located that would indicate resident 13 had worked with restorative nursing.

On 10/18/06 at 1:40 PM, the ADON was interviewed. The ADON was asked to assist in locating documentation of the functional maintenance program for resident 13. The ADON provided documentation dated July 2006 for a range of motion program for resident 13. The July documentation was documented by the CNAs who provided ADL assistance for resident 13. No additional documentation for a functional maintenance program or a range of motion program was provided. The ADON stated they

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F 309	Continued From page 9 must have been missed and that she would alert the right person to get a documentation sheet started for October.	F 309		