DEPARTMENT OF HEALTH AND HUMA ΞRVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 465146	MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	DATE SURVEY COMPLETE: 9/12/2005
NAME OF PROVIDER OR SUPPLIER **AVALON VALLEY REHABILITATION CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **2472 SOUTH 300 EAST** **SALT LAKE CITY, UT**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 279	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).

Utah Department of Health
2660739
OCT 07 2005
Bureau of Health Facility Licensing, Certification and Resident Assessment

This REQUIREMENT is not met as evidenced by:
Based on observation, interviews and record review, it was determined that the facility did not develop a comprehensive care plan for 1 of 23 sampled residents that included measurable objectives and timetables to meet the residents' medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Resident identifier is 9.

Findings include:

1. Resident 9 was admitted to the facility on 6/8/04 with diagnoses that included anxiety, Chronic Obstructive Pulmonary Disease, venous insufficiency, Diaphragmatic hernia, rectal prolapse, dermatitis, Arthrosclerotic Heart Disease, Congestive Heart, Pulmonary Embolism, Diabetes Mellitus, and Paranoid Schizophrenia, and incontinence.

Record review revealed that resident 9's annual MDS (minimum data set) assessment triggered the following RAPs (resident assessment protocols) concerns: Cognitive loss, Communication, Urinary Incontinence, Psychosocial well-being, Behavioral symptoms, Pressure ulcers, ADL (activities of daily living)/rehab program, Mood state, Dehydration risk, and Psychotropic drug use. All of the triggered RAPs were checked by the facility (IDT) interdisciplinary team to be care planned.

Resident 9's medical record contained the following care plans: Alteration in Activity Patterns, Potential for

ny 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 otection 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. r 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

'he above isolated deficiencies pose no actual harm to the residents

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Falls, Alteration in ADL's, Alteration in Comfort, Potential for infection, Impaired Skin Integrity, Alteration in Mood/Behavior, and Nutritional risk. There were several Psychotropic medicine reviews documented in the residents medical record; however, a care plan related to the use of psychotropic medications was not located.

Several facility staff members, including the Director of Nursing, Administrator, Medical Records were informed that this information was unable to be located; however, no further documentation was provided to the surveyors.

There was no documentation in resident 9's clinical record that the RAP's triggered for communication, cognitive loss, or Urinary incontinence had been care planned. The care plan for resident 9 was incomplete.

F279

Resident #9 records were reviewed on September 30, 2005. All triggered raps were care planned and updated on the appropriate care plans.

An audit will be completed by medical records for all patients related to triggered raps and care plans by November 11, 2005

The Director of Nursing/Designee completed inservice training on October 4, 2005 for all staff involved with the MDS process in regards to the care planning process.

Inservice training will be provided annually and as needed for this process.

Identified trends will be reviewed/reported monthly to facility Quality Assurance team until a lesser frequency is deemed appropriate

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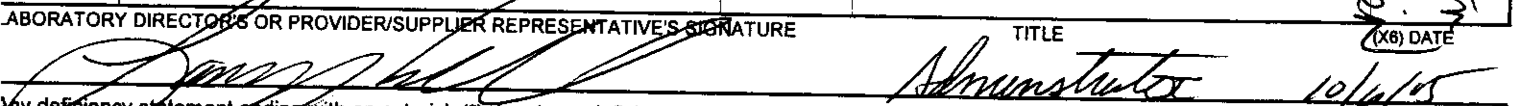
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) 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 interview, it was determined that the facility did not promote care for residents in a manner and in a environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality. Specifically, the facility did not maintain dignity for 1 out of 23 sampled residents and 1 supplemental resident, by making sure their call lights were within reach and answered within an appropriate time frame, and that the privacy of their bodies was maintained. Findings included: Resident 10 was admitted on 7/1/05 with diagnosis including: hypokalemia, rhabdomyolysis, anorexia, protein-calorie malnutrition, agoraphobia, hypothyroidism, depressive disorder, deep vein thrombosis, decubitus ulcer, anemia and esophageal reflux. During observation on 9/07/05 at 8:01 AM, it was observed that Resident 10 was lying in bed asleep. Resident 10's breakfast tray was sitting on the bedside table, the silverware was clean and wrapped in the napkin, and the food was untouched. At 9/7/05 at 8:40 AM, Resident 10 was observed	F 241 10/11/05 POC acceptable completion date 10/25/05 [illegible]	F241 Resident #10 was assessed for ability to use call light. Resident has the ability to use her call light. Registered Dietician assessed patient for her likes and dislikes. The Director of Nursing/Designee completed in-service training on October 4, 2005 for all direct care staff regarding patients' right to privacy and dignity. Facility policy reviewed regarding meal intake and alternative choices available. In-service training will be provided to new employees as part of general orientation and completed annually and as needed there after. Director of Nursing/Designee will perform dignity focused rounds 3 times per week to ensure that all residents are afforded the highest respect. Identified trends will be reviewed/reported monthly to facility Quality Assurance team until a lesser frequency is deemed appropriate	11/05/05 added c̄ permission 10/11/05 - Per telephone call c̄ administrator stated completion date for all tags is 10/25/05. [illegible]



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/4/05

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 laying in bed, having difficulty grasping the call light. Resident 10 stated that she was "waiting for someone to help me with my breakfast". At 9/7/05 at 9:00 AM, it was observed that there were two Certified Nursing Assistant's (CNA's) in room 306. One CNA was filling Resident 10's and room mate's mug with ice. The other CNA was getting Resident 10 up in his/her wheelchair. It was observed that Resident 10's breakfast tray was still sitting on the bedside table with about two bites gone from the eggs. On 9/7/05 at 10:35 AM, it was observed that Resident 10 was laying in bed, with the call light at the foot of the bed (not within reach of Resident 10). During an interview with Resident 10 she stated, "Im waiting for help so I can get a drink". Further on during the interview Resident 10 stated that he/she did not eat any breakfast because he/she "didn't like eggs". Resident 10 also said that she was not offered an alternative, and that they did not offer to warm up her breakfast. During observation on 9/7/05 at 11:48 AM, Resident 10 was observed laying in bed with the bed sheet pulled down at her feet, and the call light was at the foot of her bed. Resident 10 only had an adult brief on, and was in direct view of room mate, who was sitting in a recliner, facing Resident 10's direction. Privacy curtain was not closed. On 9/08/05 at 8:20 AM, Resident 10 was observed laying in bed, call light within reach, and bed sheet pulled down to her feet, Resident 10 was only wearing a brief. The privacy curtain was closed preventing view from room mate, but not	F 241		

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F 241	Continued From page 2 to preventing view from persons entering the room. During a confidential group interview on 9/07/05 at 11:00 AM, it was determined that 1 out of 8 group members said that he/she had to wait 2-4 hours on Sunday, to have his/her call light answered.	F 241	F272 Resident #13 records were reviewed and brought current on September 9, 2005. An audit was completed by the facility on September 15, 2005 of all recent admissions to ensure proper and timely completion of initial MDS.	11/05/05
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the	F 272	The Director of Nursing/Designee will perform weekly audits to ensure that all MDS reports are completed timely. An in-service is scheduled on October 7, 2005 for all staff involved with the MDS process in regards state regulations for date of completion. In-service training will be provided annually and as needed for this process. Identified trends will be reviewed/reported monthly to facility Quality Assurance team until a lesser frequency is deemed appropriate	

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resident assessment protocols; and
Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined that for one of twenty-three sampled residents the facility did not conduct initially, a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Specifically, Resident 13 did not have a comprehensive admission assessment or Minimum Data Set completed 14 days after her admission to the facility.

Resident Identifier: 13

Findings Included:

The Centers for Medicare and Medicaid Services state, "A facility must make a comprehensive assessment of a resident's needs, using the Resident Assessment Instrument specified by the State. The assessment must include at least the following:

(i) Identification and demographic information
(ii) Customary routine
(iii) Cognitive patterns
(iv) Communication
(v) Vision
(vi) Mood and behavior patterns
(vii) Psychological well-being

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F 272	Continued From page 4 (viii) Physical functioning and structural problems (ix) Continence (x) Disease diagnosis and health conditions (xi) Dental and nutritional status (xii) Skin Conditions (xiii) Activity pursuit (xiv) Medications (xv) Special treatments and procedures (xvi) Discharge potential (xvii) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols (xviii) Documentation of participation in assessment" Resident 13 was readmitted to the facility on 8/18/05 with diagnosis including, hypertension, gastroesophageal reflux disease, urinary incontinence, seizure disorder, syncope, obesity, and Schizoaffective disorder. On 9/8/05 Resident 13's medical record was reviewed. The Minimum Data Set for Nursing Home Resident Assessment and Care Screening form was reviewed. The form found in the chart was blank except for the nutritional status section. According to State and Federal guidelines the Minimum Data Set should have been completed on 9/01/05. Review of the medical record on 9/8/05 showed this was not completed on 9/1/05. On 9/8/05 at 10:30 AM, the Director of Nursing was interviewed as to why the Minimum Data Set was not completed for Resident 13. The Director of Nursing responded, "I don't know much about the MDS (Minimum Data Set) since I'm not the	F 272		

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F 272	Continued From page 5 MDS guru, so I can't tell you why it was not done." No other information was provided to the survey team during the coarse of the survey to explain or justify why the Comprehensive Assessment was not completed.	F 272		
F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that for 1 out of 23 sampled residents the facility did not complete a comprehensive assessment of a resident within 14 days after the facility determined that there had been a significant	F 274	F274 Resident #10 records were reviewed and brought current on September 9, 2005. The Director of Nursing/Designee will perform weekly audits to ensure that all MDS reports are completed timely. An in-service is scheduled on October 7, 2005 for all staff involved with the MDS process in regards to purpose and state regulations for significant change MDS assessments. In-service training will be provided annually and as needed for this process. Identified trends will be reviewed/reported monthly to facility Quality Assurance team until a lesser frequency is deemed appropriate	11/05/05

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F 274	Continued From page 6 change in the resident's physical or mental condition. Specifically, Resident 10 did not have a completed comprehensive assessment after the facility had documented Resident 10 had a significant change. Findings included: Resident 10 was admitted to the facility on 7/1/05 with the following diagnosis including: hypokalemia, rhabdomyolysis, anorexia, protein-calorie malnutrition, agoraphobia, hypothyroidism, depressive disorder, deep vein thrombosis, decubitus ulcer, anemia, and esophageal reflux. Resident 10's medical record was reviewed on 9/6/05-9/08/05. The significant change Minimum Data Set found in Resident 10's medical record was incomplete. In section A3 the assessment reference date was documented as 08/05/05. In section R2a and b there was no registered nurse signature, and there was no completion date documented. On 9/7/05 at 10:00 AM, a telephone interview was conducted with the Minimum Data Set (MDS) clinical coordinator for the Utah State Department of Health. The MDS Clinical Coordinator confirmed that the MDS was to be done and signed by a registered nurse no later than 14 days following the assessment reference date, but no later than the end of the 14th calendar day following the determination that a significant change had occurred. No other information was provided to the survey team as to why the significant change MDS was	F 274		

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F 274	Continued From page 7 not completed.	F 274		
F 276 SS=E	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two of twenty-three sampled residents the facility did not assess a resident using the quarterly review instrument specified by the State and approved by the Centers for Medicare and Medicaid Services not less frequently than once every 3 months. Specifically, Resident 4 and 9 did not have a completed quarterly assessment in their chart. Resident Identifiers: 4 and 9 Findings included: Resident 4 was admitted to the facility on 5/6/05 with diagnosis including Chronic Obstructive Pulmonary Disease, Glaucoma, Osteoporosis, hypoxia, hypertension, deep vein thrombosis, hypolipidemia, Bi-Polar Disorder, and gastroesophageal reflux disease. Resident 4's medical record was reviewed on 9/6/05. The Minimum Data Set quarterly assessment	F 276	F276 Residents' #4 and #9 records were reviewed and brought current September 9, 2005. The Director of Nursing/Designee will perform weekly audits to ensure that all MDS reports are completed timely. An in-service is scheduled on October 7, 2005 for all staff involved with the MDS process in regards to state regulations for quarterly MDS assessments In-service training will be provided annually and as needed for this process. Identified trends will be reviewed/reported monthly to facility Quality Assurance team until a lesser frequency is deemed appropriate	11/05/05

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F 276	Continued From page 8 found in Resident 4's chart was incomplete. Resident 4 should have had the Quarterly Assessment completed by 8/17/05. Review of the Quarterly Assessment form showed that the form had no Assessment Reference Date completed and no Registered Nurse signature. The Registered Nurse Signature is needed on each Minimum Data Set. The Registered Nurse signature signifies that the assessment is complete. On 9/7/05 at 10:00 AM, a telephone interview was conducted with the Minimum Data Set Clinical Coordinator for the Utah State Department of Health. The Minimum Data Set Clinical Coordinator confirmed that the quarterly Minimum Data Set is to be done and signed by the Registered Nurse no later than 92 days after the Admission assessment or last quarterly assessment. On 9/8/05 at 10:30 AM, the Director of Nursing was interviewed as to why the Minimum Data Set was not completed for Resident 4. The Director of Nursing responded, "I don't know much about the MDS (Minimum Data Set) since I'm not the MDS guru, so I can't tell you why it was not done." No other information was provided to the survey team during the coarse of the survey to explain or justify why the Quarterly assessment was not completed. Resident 9 was admitted to the facility on 6/8/04 with diagnoses that included anxiety, Chronic Obstructive Pulmonary Disease, venous insufficiency, Diaphragmatic hernia, rectal prolapse, dermatitis, Arthrosclerotic Heart Disease, Congestive Heart, Pulmonary	F 276		

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Embolism, Diabetes Mellitus, and Paranoid Schizophrenia, and incontinence.

Clinical record review on 9/6/05 through 9/8/05 demonstrated that resident 9 had the following MDS (minimum data sheets) completed:
On 6/14/04 an admission MDS assessment was performed
On 6/22/04 a 14 day Medicare MDS assessment was performed
On 7/7/04 a 30 day Medicare MDS assessment was performed
On 8/15/04 a 60 day Medicare MDS assessment was performed
On 7/31/04 an Other Medicare required assessment was performed
On 8/26/04 a Quarterly review assessment was performed
On 11/27/04 a Quarterly review assessment was performed
On 2/26/05 a Quarterly review assessment was performed
On 5/28/05 an Annual assessment was performed

According to CMS (Centers for Medicare/Medicaid), the RAI (resident assessment instrument) assessment schedule summary dated July 2002, the quarterly MDS assessment is to be done no later than 92 days from R2b to R2b (Date RN Assessment Coordinator signed as complete).

An interview was conducted on 9/7/05 at 10:00 AM with the MDS Coordinator for the Utah State Department of Health. The information regarding the RAI schedule was verified that the quarterly MDS must be completed within 92 days following the previous MDS assessment.

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F 276	Continued From page 10 In accordance with these national guidelines, a quarterly MDS must have been completed for resident 9 by 8/28/05. Review of resident 9's medical record did not document that a quarterly MDS assessment was completed for resident 9 by 8/28/05. On 9/8/05 at 10:30 AM, the Director of Nursing was interviewed as to why the Minimum Data Set was not completed for Resident 9. The Director of Nursing responded, "I don't know much about the MDS (Minimum Data Set) since I'm not the MDS guru, so I can't tell you why it was not done." A group interview was conducted with facility staff on 9/8/05 at 4:00 PM. At this time, it was explained to the staff that this information was missing from resident 9's clinical record. No information was provided to the survey team by the exit conference on 9/12/05 to document that resident 9's quarterly MDS had been performed.	F 276		
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 interview and medical record review, it was determined that for one of twenty-three	F 309	F309 Resident 2 records were reviewed. Social Services evaluated for suicidal ideation finding none. Social Servied Director/designee will conduct on going social service assestment and intervention as well as identification of psycho social issues upon admission and updated quaterly, annually and as circumstances require. An in-service was provided on October 4, 2005 to all direct care staff regarding appropriate interventions for residents who are having psychiatric crisis.	11/1/05

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F 309	Continued From page 11 sampled residents the facility did not 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. Specifically, Resident 2 had complaints of suicidal ideation and the facility did not implement the interventions specified by three facility staff members. Resident Identifier: 2 Findings Included: Resident 2 was admitted to the facility on 4/21/05 with diagnosis including Schizoaffective disorder, sleep apnea, hyperlipidemia, seizure disorder, chronic airway obstruction, hypertension, hypothyroidism, diabetes, and Bi-polar disorder. Resident 2's medical record was reviewed on 9/8/05. On 6/11/05 at 3:20 PM a facility nurse documented in the nursing notes, "Resident came to me complaining of increased depression, crying uncontrollably, and complaints of suicidal ideation. New orders for Cymbalta 30 mg (milligrams) po (by mouth) QD (every day) times four days. Then increase to 60 mg po QD." No other documentation could be found in the nurses' notes regarding the suicidal ideation. No documentation could be found in the Social Services notes regarding the suicidal ideation. No documentation could be found in the CNA flow sheets regarding increased monitoring. No documentation could be found on the alert charting forms regarding the suicidal ideation.	F 309	In-service training will be provided annually and as needed for this process. Identified trends will be reviewed/reported monthly to facility Quality Assurance team until a lesser frequency is deemed appropriate	

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F 309	Continued From page 12 No documentation could be found in the Valley Mental Health Section of the chart regarding the suicidal ideation. On 9/8/05 at 2:30 PM an interview was conducted with the Regional Licensed Clinical Social Worker(LCSW). The LCSW stated that if a resident complained of suicidal ideation it was standard practice for the facility SW (Social Worker) or the nurse to go and assess the patient and determine if they had a plan or if the resident could contract for safety. The LCSW further stated that if the resident could contract for safety the facility staff would increase their monitoring and interactions with the resident. The LCSW stated, "it is a serious issue when someone has suicidal ideation." On 9/8/05 at 2:40 PM an interview was conducted with the facility Director of Nursing (DON). The DON stated that if a resident complained of suicidal ideation the staff would perform more frequent checks of the resident with suicidal ideation, do alert charting and notify the family and Doctor, and call the crisis line through Valley Mental Health. On 9/8/05 at 2:50 PM an interview was conducted with the facility Licensed Practical Nurse (LPN) who documented the complaint of suicidal ideation on 6/11/05. The LPN stated that if a resident complained of suicidal ideation she would pull the resident aside and question the resident about the ideation, call Valley Mental Health or the Social Worker regarding the ideation, keep an aide with the resident, check the resident every 15 minutes and monitor the resident's room. When asked where the surveyor could find this information, the LPN stated, "In the	F 309		

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F 309	Continued From page 13 nurses' notes and on the alert charting. The 15 minute checks may be found in the aide flow sheets." On 9/8/05 at 4:00 PM an exit conference was conducted with the facility staff. During the conference the staff were made aware of the missing documentation to support the interventions that the staff specified they would do with a complaint of suicidal ideation. No other information was provided to the survey team over the course of the survey to show the specified interventions were performed.	F 309		
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observations of unsecured chemicals being stored on an unattended housekeeping cart, it was determined that the facility did not always ensure that the residents' environment remained as free of accident hazards as was possible. Findings included: Observations of the unattended housekeeping cart were made at various times between 7:15 AM and 10:00 AM on 9/12/05. It was documented that several residents walked by the unattended housekeeping cart during that time.	F 323	F323 Housekeeping Carts have been rekeyed and chemicals will be locked on housekeeping carts while in resident areas. Supervisor will perform daily rounds on the floor. An in-service was provided on Sept 19, 2005 to all housekeeping staff regarding containment of chemicals while cleaning in resident areas. In-service training will be provided annually and as needed for this process. Identified trends will be reviewed/reported monthly to facility Quality Assurance team until a lesser frequency is deemed appropriate	9/19/05

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F 323	Continued From page 14 During these observations, the housekeeping cart had a spray bottle on top of it labeled RE-JUV-NAL disinfectant. The label had several warnings mentioned, such as: Caution: keep out of reach of children, harmful if swallowed, keep out of eyes.	F 323		
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 interview, observation, and medical record review, it was determined that for one of twenty-three sampled residents the facility did not provide adequate supervision and assistance devices to prevent accidents. Specifically, Resident 19 had orders for a self-releasing seat belt and tab alarm which were not instituted resulting in Resident 19 sustaining numerous falls. Resident Identifier: 19 Findings Included: Resident 19 was admitted to the facility on 6/5/05 with diagnosis including urinary tract infection, sepsis, anorexia, urinary obstruction, urinary incontinence, renal failure, generalized pain, dysphagia, and difficulty in walking. On 9/12/05 Resident 19's medical record was reviewed.	F 324	F324 Resident #19 records were reviewed and updated. Director of Nurse/Designee will conduct weekly fall meetings to review and add intervention for any patient with >1 fall in 30 days. An in-service was provided on October 4, 2005 to all direct care staff regarding interventions for residents who are a fall risk. In-service training will be provided annually and as needed for this process. Identified trends will be reviewed/reported monthly to facility Quality Assurance team until a lesser frequency is deemed appropriate	11/05/05

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F 324	Continued From page 15	F 324		

A physician's order dated 6/9/05 stated, "Lap buddy to wheelchair for safety prevention of falls.

On 7/11/05 it was documented on an alert charting form, "Pt. found on floor next to bed. Patient has skin tear to left elbow. Wound dressed after cleaning. Patient assisted into wheelchair. Lap buddy in place Call light within reach......"

On 8/2/05 it was documented on an alert charting form that Resident 19 sustained a fall at 8:00 PM. No information could be found in the medical record to show that the facility implemented different procedures to prevent further falls.

On 8/8/05 it was documented on an alert charting form that Resident 19 sustained a fall at 10:20 AM. A facility nurse documented on the alert charting form on 8/8/05, "Therapy notification made out to eval (evaluate) for more app (appropriate) device to prevent pt. (patient) from injuring himself et. or falling."

No documentation could be found in Resident 19's medical record that therapy or any other ancillary service evaluated Resident 19 for a more appropriate device.

On 8/19/05 it was documented on an alert charting form that Resident 19 sustained a fall at 9:45 AM. No documentation could be found that the lap buddy or other device was in place to prevent the fall.

On 8/20/05 it was documented on an alert charting form that Resident 19 was found on the floor. Resident 19 admitted to removing "The

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F 324	Continued From page 16 blue thing" or lap buddy. No documentation could be found that the facility implemented different procedures to prevent further falls. A physician's order dated 8/22/05 stated, "Pt. (patient) to use self-releasing seat belt and tab alarm to prevent falls. D/C (discontinue) lap buddy." On 8/24/05 at 9:50 PM, it was documented on an alert charting form that Resident 19 was found on the floor with a bump on his forehead and a 1 centimeter skin tear to his left elbow. No documentation could be found that the facility had the self-releasing seat belt or tab alarm in place prior to or after Resident 19 was found on the floor. A physician's order dated 8/28/05 stated, "Self-releasing seat belt to w/c (wheelchair) check Q (every) 30 minutes, release Q 2 hours for repositioning and cares. Tab alarm while in w/c and in bed. Check placement Q shift." On 9/11/05 at 10:15 AM, it was documented on an alert charting form that Resident 19 was found on the floor. It was documented by a facility nurse, "No lap buddy on wheelchair or around bed or wheelchair....." On 9/11/05 at 6:36 PM, it was documented on an alert charting form that Resident 19 was found on the floor. It was documented by a facility nurse, "....Left in room without lap buddy. No lap buddy on floor or bed..." Review of resident 19's medical record revealed a care plan for Potential for Fall/Injury. The only assistance device implemented in the care plan	F 324		

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F 324	Continued From page 17 was the lap buddy. On 9/12/05 at 11:10 AM, Resident 19 was observed by two surveyors to have the lap buddy in place over the wheelchair. No tab alarm could be found attached to Resident 19. No self-releasing seat belt could be visualized to be in use on Resident 19. On 9/12/05 at 1:25 PM, Resident 19 was observed by two surveyors to be lying in bed with the tab alarm behind the mattress of Resident 19's bed and hanging on the light fixture string. The tab alarm was not connected to the resident nor was a tab alarm visualized on Resident 19's wheelchair. On 9/12/05 at 1:30 PM, an interview was conducted with 300 Hall unit manager. The unit manager stated that Resident 19 used a lap buddy and tab alert for safety. On 9/12/05 at 1:31 PM, an interview was conducted with a facility nurse who had been assigned to deliver care for Resident 19 . The nurse stated that Resident 19 had a lap buddy for safety. On 9/12/05 at 1:33 PM, an interview was conducted with a facility Certified Nursing Assistant (CNA) assigned to the 300 Hall. The CNA stated that Resident 19 only used a lap buddy for safety and nothing for safety while in bed. On 9/12/05 at 1:35 PM, an interview was conducted with a different facility CNA assigned to the 300 Hall. The CNA stated that Resident 19 used a lap buddy for safety.	F 324		

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F 324	Continued From page 18 On 9/12/05 at 1:40 PM, an interview was conducted with a facility nurse who had been assigned to care for Residents on the hall in which Resident 19 resided. The nurse stated that Resident 19 used a lap buddy and possibly a tab alert.	F 324		
F 371 SS=E	483.35(h)(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 it was determined that the facility did not store, prepare, distribute, and serve food under sanitary conditions. Findings included: Observations were made in the kitchen on 9/6/05 and 9/7/05. 1. On 9/6/05 at 9:45 AM, there was a 1 gallon jar of dill relish in the walk-in refrigerator with no open date and the lid would not seal. There was a lid over plastic wrap on top of the jar. The bin of powdered milk had a scoop laying with the handle down in the bin on a plastic bag. 2. On 9/6/05 at 9:50 AM, observations were done in the dish room of a male worker loading dirty dishes while wearing gloves. He then went directly to the clean dishes to pull them out and touched clean silverware without washing his hands and changing gloves. He was observed to	F 371	Dietary Manager/designee is doing daily monitoring that proper safety and sanitation measures are in place. 1. Dill relish was dated on 9/6/5 2. Cup/scoop removed from bin of sugar on 9/6/5 3. Large Hobart mixer cleaned and sanitized on 9/7/5 4. Crate of shell eggs was placed on bottom shelf on 9/6/5 All appropriate consumables will be dated and stored in the proper areas and refrigerated if required. Dates will be visible and checked on a daily basis by the dietary manager or designee. Dietary manager will complete focus rounds to insure there is no cross contamination in the dish room..	11/05/05

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F 371	Continued From page 19 cross-contaminate for approximately 7 minutes, going from dirty dishes to clean dishes, and dirty to clean again without washing hands and changing gloves. 3. On 9/6/05 at 3:00 PM, there was a cup scoop laying in the bin of sugar. The large Hobart mixer had dried food on the neck and shield, which could flake off and contaminate a new batch of food. 4. On 9/6/05 at 3:00 PM, there was a 4 oz. carton of strawberry Health Shake with no thaw date in the microwave oven. It was room temperature to the touch. 5. On 9/6/05 at 3:05 PM, there was a crate of shell eggs on the top shelf in the walk-in refrigerator stored over a plastic gallon container of mixed whole fortified milk that was covered with plastic wrap. 6. On 9/7/05 at 9:30 AM, observations were done in the dish room of a female worker loading dirty dishes while wearing gloves. She then went directly to the clean dishes, putting away clean trays, dishes and plate covers without washing her hands and changing her gloves. She was observed to cross-contaminate for approximately 5 minutes, going from dirty dishes to clean dishes, not washing her hands and not changing her gloves. 7. On 9/7/05 at 9:35 AM, the dietary worker handwashing the pans was observed to dip clean trays into sanitizer solution and stack the trays wet. The trays nested inside one another and stayed wet. Dishes and trays need to be dry before stacking.	F 371	On 9/6/5, an in-service was conducted to the Dietary staff regarding proper kitchen sanitation and cleaning procedures and cross contamination. All identfied trends will be reported/reviewed in the QA monthly meetings until a lesser frequency is deemed appropriate. The dietary manager will be responsible for assuring appropriate compliance is maintained	

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F 372 SS=C	483.35(h)(3) SANITARY CONDITIONS - GARBAGE DISPOSAL The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the dumpster did not have the lid closed to cover garbage as required. Findings included: On 09/08/05 at 5:00 PM, it was observed that the dumpster lid was left open. On 09/12/05 at 7:30, 8:30, and 9:30 AM, it was observed that the dumpster lid was open. The dumpster had boxes and garbage piled up inside, which was higher than the sides of the outer edge of the dumpster. Dumpsters must have a lid or be otherwise covered to maintain a sanitary condition, and so it will not provide harborage and feeding of pests.	F 372	F372 Garbage lid will be closed at all times. Supervisor will perform rounds to ensure garbage can lid is closed and refuse disposed of properly. An in-service was provided on Sept 19, 2005 to all Maintenance and housekeeping regarding containment of garbage and keeping the garbage lid closed. Maintenance Director will enusure garbage is disposed of properly and the garbage lid closed all times and will report to the QA committee any identified to be reviewed/reported monthly to facility Quality Assurance team until a lesser frequency is deemed	9/19/05
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;	F 514	F514 Residents' #8 and #14 records were reviewed and updated. Medical records will perform an audit of all current resident charts to ensure proper documentation of phycian progress notes are completed timely.	10/11/05

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F 514	Continued From page 21 and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility did not maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented. Residents: 8, 14. Findings included: Resident 8 was readmitted to the facility on 1/16/01 with diagnoses which included: Senile depressive disorder, Catatonia, reflux, Diabetes Mellitus, hypertension, Major depression recurrent with psychotic features, and introverted personality. A review of resident 8's clinical record was performed on 9/7/05. Documentation of physician's progress notes were found for the following dates: 12/20/04 2/24/05 3/31/05 4/12/05 No documentation could be found in the clinical record that resident 8 was seen by, or that the physician had reviewed her progress, in May,	F 514	Medical Records Department will perform audits of current resident records for appropriate documentation and keep an updated list of physician visits two times weekly to ensure that each patient is visited in accordance with state regulations. An in-service was provided on October 4, 2005 to all medical records staff regarding complete and accurate charts. In-service training will be provided annually and as needed for this process. Identified trends will be reviewed/reported monthly to facility Quality Assurance team until a lesser frequency is deemed appropriate	

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F 514	Continued From page 22 June, July, August, or September, 2005. An interview was conducted with the medical records staff on 9/8/05. The staff member was asked to provide the surveyor with any documentation of the aforementioned progress notes. The medical record staff stated "I know he/she has notes for June and August...I will get you the paperwork..." . The medical record staff brought the August 2005 progress note to the surveyor and stated "I will keep looking for the rest." There was no documentation provided of a June 2005 physician visit. Frequency of physician visits must be every 60 days, after the resident has been in a facility for 90 days. A period of four months passed without a documented physician visit or progress note (April to August). No further documentation was provided to the survey team prior to exit on 9/12/05; therefore, resident 8's medical record was incomplete. Resident 14 was admitted to the facility on 10/25/04 and readmitted on 9/3/05 with diagnoses including: leukopenia, thrombocytopenia, hypokalemia, seizure disorder and chronic pain. Record review of resident 14's clinical record was done on 9/7/05 at the facility. The Quarterly MDS (Minimum Data Set) due August 6, 2005 was missing. The discharge and re-entry tracking forms were not in the chart. Interviews of facility staff DON and MDS coordinator were conducted on 9/7/05. They	F 514		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON VALLEY REHABILITATION CENTER	2472 SOUTH 300 EAST SALT LAKE CITY, UT 84115

(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 514	Continued From page 23 were unable to provide the missing documents for resident 14.	F 514		