DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. BUILDING _____ B. WING _____	10/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE COUNTRY CARE CENTER	1340 EAST 300 NORTH PRICE, UT 84501

(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 221 SS=K	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This Requirement is not met as evidenced by: Based on observation, resident record review, facility policy review and facility staff interviews, it was determined that the facility failed to assess residents medical symptoms that would necessitate the implementation and use of physical restraints for 6 of 13 sample residents (residents CL1, 4, 8, 9, 10 and 11) and 0 supplemental residents, (residents 14, 15, CL2, CL4 and CL6). One resident (resident CL1) sustained a serious injury requiring hospital treatment, five of the residents (resident 9, 10, 14, 15 and CL6) sustained actual harm and five of the residents (resident 4, 8, 11, CL2 and CL4) had a potential for experiencing harm as a result of being physically restrained without adequate assessment of the need. Due to the lack of assessment and subsequent harm, the facility was found to be in Immediate Jeopardy. Findings include: Facility Policy A review of the facility "Physical Restraint Management" program was done on 9/23/04. The policy stated," Purpose/Objective: To provide an environment for residents which allows for zero usage of restraints or, when restraints are required--the least restrictive type possible...A restraint will be used only after less restrictive methods have been used and after the appropriate inter-disciplinary team has reached	F 221	11/3/04 POC Acceptable Completion date 11/15/04 CRwennbank RN Utah Department of Health NOV 03 2004 Long Term Care and Residential Assessment F 221 1. All other residents as well as those mentioned in this document have also been re-evaluated for the least restrictive restraints or reduction/elimination of present restraints according to new fall/restraint protocol and policies utilizing present assessment tools. 2. All new admits will be assessed the same manner. 3. Quality Assurance meetings will be held every week. To review Restraints, Falls, Injuries and Infections and to establish a plan of action for residents identified. Once substantial compliance is established Quality Assurance meeting will be held monthly. 4.The D.O.N. will keep a QA Incident Report Summary Log. This log will be reviewed every month in QA meeting to look for trends. 5. The Timber program was implemented that identifies residents that are high risk for falls. These Trees are placed on the resident's door. The staff was inserviced on this program on 10/11/04. D.O.N. will monitor.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ronald R. Deeter	Administrator	10/22/04

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 221	Continued From page 1 an agreement that the restraint is necessary. The recommendations will be presented to the physician who will authorize appropriate orders. Informed choice will be obtained from the resident and/or surrogate/representative...All restraints will be ordered by a physician. The order must specify type, reason for use, and times to be used..." Observations On 9/21/04 at approximately 3:10 AM, 4:10 AM, 5:10 AM and 6:10 AM, the following observations were made throughout the facility: 1. The special needs unit had 7 of the 14 residents in bed with full length side rails up on both sides, or the side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. 2. The 100 hall had 7 of the 13 residents in bed with full length side rails up on both sides, or the side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. 3. The 300 hall had 8 of the 24 residents in bed with full length side rails up on both sides, or the side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. Based on these observations, it was determined that 22 of 51 residents (43%) were physically restrained. Resident who experienced serious injury as a result of being physically restrained without assessment of the need included the following: 1. Resident CL1 was admitted to the facility on 11/1/01 and re-admitted on 10/22/02 with diagnoses which included diabetes mellitus,	F 221	6. A Nurse Consultant was hired to comply with the directed plan of correction. Inservices were held 10/05/04, 10/06/04 on fall and incident policies, protocols, and assessment tools by RN Consultant and D.O.N. A Knowledge test was given to staff in conjunction with inservices on restraint and incident/accident. She has participated in QA meetings. 7.D.O.N. to monitor tracking and logs weekly. 8. Medical records to monitor forms in charts monthly via chart audits. 9.The Above was integrated into QA system on 10/14/04. 10.The above to be in effect 11/15/04. Resident CL1 was discharged	

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F 221	Continued From page 2 cystitis, congestive heart failure, candidiasis and prostate cancer. A review of resident CL1's medical record was completed on 9/23/04. A significant change Minimum Data Set (MDS) assessment completed by facility staff on 7/5/04, documented that resident CL1 had short and long term memory problems and his cognitive skills for daily decision making were severely impaired. The facility staff also documented that resident CL1 resisted cares. The facility staff documented that resident CL1 was able to transfer with extensive assistance and was able to ambulate with extensive assistance. The facility staff documented that resident CL1 used full bed rails daily. On 7/9/04, the interdisciplinary team (IDT) performed a "Restraint Evaluation and Quarterly Review for Elimination" assessment. The IDT documented that resident CL1 had side rails, a bed alarm and a soft waist restraint. There was no documentation that the IDT had attempted alternatives or determined the need for the restraint. The IDT documented that the side rails and soft waist restraint were the least restrictive measures. There was no documentation to indicate which restraint alternatives were previously used. Review of the medical record revealed that resident CL1 had been residing in the facility SCU (Special Care Unit), a secured unit, until 7/17/04. On 7/2/04 at 5:45 AM, a nurse's note in resident CL1's medical record documented the following entry: "Nurse found pt (patient) lying under bed when entering room... [no] s/s (signs and	F 221		

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F 221	Continued From page 3 symptoms) injury..." On 7/2/04, a facility nurse documented the following on a fax to resident CL1's physician, "Your pt (patient)...was found under his bed [at] 0545 (5:45 AM)... [no] s/s (signs and symptoms) injury..." On 7/2/04, a facility nurse documented the following on an "Incident/Accident Report": "...Was restraint in use? Yes bed alarm...Nurse found pt (patient) lying under neath bed...string was so long on alarm that it was still attached..." On 7/3/04 at 2:30 AM, a nurse's note in resident CL1's medical record documented the following entry: "Pt (patient) found sitting on floor beside bed, alarm did not sound, no injuries noted. Pt bed exchanged for bed [with] side rails to discourage pt from getting out of bed..." On 7/3/04, a facility nurse documented the following on an "Incident/Accident Report": "...Was restraint in use? Yes bed alarm...Pt (patient) attempted to get out of bed, bed alarm failed to sound, pt slipped to floor. No injuries, Bed exchanged for one [with] side rails...Have bed alarm [checked]..." On 7/3/04 at 8:00 PM, a nurse's note in resident CL1's medical record documented the following entry: "...Not responding to questions too confused...More confused than usual tonight..." On 7/4/04 at 1:30 PM, a nurse's note in resident CL1's medical record documented the following entry: "...c/ (complains) when moved from bed to WC (wheelchair)..." On 7/5/04 at 4:30 AM, a nurse's note in resident	F 221		

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F 221	Continued From page 4 CL1's medical record documented the following entry: " Pt (patient) yelling continuously, comfort measure provided [with] poor effect, very restless climbing out of bed..." On 7/17/04 at 7:00 PM, a nurse's note in resident CL1's medical record documented the following entry: "...Pt (patient) found on floor by his bed on [left] side. Pt turned on back, slightly lifted [left] leg..." On 7/17/04, a facility nurse documented the following on an "Incident/Accident Report": "...Were bed rails ordered? Yes...Were bed rails present? yes...Pt (patient) found on floor next to bed...Found out [after] sent to ER (emergency room) [left] hip fx'd (fractured)..." There was no documentation of a physician's order for side rails in resident CL1's medical record. A phone interview was held with a facility staff nurse on 9/21/04 at 2:15 PM. She stated that resident CL1 resided on the special needs unit. She stated that resident CL1 had constantly climbed out of bed. She stated that prior to 7/3/04, he had a bed with side rails but he broke the left side rail, so on 7/3/04, she got a new bed with working side rails on both sides. She further stated that resident CL1 was a high fall risk and that anytime resident CL1 was in bed he had side rails up times two. An interview was held with a second facility nurse on 9/22/04 at 3:15 AM. She stated that resident CL1 was able to stand but not walk. She further stated that resident CL1 had side rails up when ever he was in bed, as well as a bed alarm. She further stated that by the time facility staff could	F 221		

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F 221	Continued From page 5 respond to the bed alarm he usually had already fallen. The facility nurse further stated that resident CL1 had many falls from his bed. Residents who experienced actual harm as a result of being physically restrained without assessment of the need included the following: 2. Resident 9 was admitted to the facility on 4/27/04 and then re-admitted to the facility on 5/19/04 with diagnoses which included psychotic disorder, chronic edema, hypothyroidism, dementia, anxiety, hypertension and a cognitive disorder. Resident 9 resided on the facility's SCU. A review of resident 9's medical record was completed on 9/23/04. On 5/3/04, the IDT performed an "Admission Restraint/Side Rail Evaluation & Bed Entrapment Hazard Risk Assessment" for resident 9. The IDT documented the following, "...Pt (patient) will require a lap belt when in the w/c (wheelchair) and 2 side rails up when in bed..." There was no documentation that the IDT had attempted alternatives or determined the need for the restraint. The IDT did not document that the side rails and lap buddy were the least restrictive measures. There was no documentation to indicate which restraint alternatives were previously used. An admission MDS assessment completed by facility staff on 6/1/04, documented that resident 9 had short and long term memory problems and her cognitive skills for daily decision making were moderately impaired. The facility staff documented that resident 9 required supervision	F 221		

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F 221	Continued From page 6 with transfers and was able to ambulate with limited assistance. The facility staff documented that resident 9 did not use any restraints. On 6/1/04, a "Physical Restraint Consent" form was signed by resident 9's husband which documented, "...I defer judgment regarding restraints until the appropriate healthcare professionals have assessed the need..." There was no documented evidence that the IDT performed a re-admit "Admission Restraint/Side Rail Evaluation & Bed Entrapment Hazard Risk Assessment" on 5/19/04, for resident 9. On 5/5/04 at 6:00 AM, a nurse's note in resident 9's medical record documented the following entry: "Woke-up at 0400 (4:00 AM) in morning [and] climbing OOB (out of bed) [and] over SR (side rails)..." On 5/27/04 at 1:45 AM, a nurse's note in resident 9's medical record documented the following entry: "Found pt (patient) on buttocks between bed and wall, states she was climbing OOB (out of bed) on that side when the bed shifted, c/o (complains of) [left] knee pain..." On 5/27/04, a facility nurse documented the following on an "Incident/Accident Report": "...Were bed rails ordered? No...Were bed rails present? Yes...Pt (patient) found sitting on buttocks between bed and wall...Pt c/o (complains of) [left] knee pain..." On 7/9/04, a facility nurse documented the following on an "Incident/Accident Report": "...Were bed rails ordered? Yes no...Were bed rails present? Yes...Fell out of bed at 9:30 PM..."	F 221	Resident 9 had consent form updated with signatures 10/7/04; new choice documented. A. Bed entrapment updated 9/29/04. B. New physical therapy evaluation for restraint reduction 9/29/04 C. Removed side rails and applied bed alarm. Bed moved away from wall. D. Physician orders obtained 10/6/04.	

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F 221	Continued From page 7 On 7/10/04 at 12:00 PM, a nurse's note in resident 9's medical record documented the following entry: "Documented in CNA (certified nursing assistant) charting 7/9/04 that pt (patient) fell out of bed at 9:30 PM...been sitting herself on the floor frequently the last few days." On 7/19/04 at 5:30 AM, a nurse's note in resident 9's medical record documented the following entry: "Pt (patient) found sitting cross legged on floor next to bed... [At] 0630 (6:30 AM) pt found on floor below recliner..." On 7/19/04, a facility nurse documented the following on a fax to resident 9's physician, "...[at] 0530 (5:30 AM) your pt (patient), [resident 9] was found sitting cross legged on floor below rails on her bed...[at] 0630 (6:30 AM) found on floor below recliner..." On 7/19/04, a facility nurse documented the following on an "Incident/Accident Report": "...Were bed rails ordered? No...Were bed rails present? Yes...aide found pt (patient) sitting cross legged on floor [at] bedside... [Left] great toe nail area had a few gtts (drops) of blood..." On 7/28/04 at 3:00 AM, a nurse's note in resident 9's medical record documented the following entry: "Aide found pt (patient) sitting cross legged on floor beside bed, pt states she does not know how she got there, later she states she was tired of being in bed [and] climbed out. Pt does have 2 cm (centimeter) swelling area under old senile purpura on [right] antecubital..." On 7/28/04, a facility nurse documented the following on a fax to resident 9's physician, "...Your pt (patient), [resident 9] was found sitting cross legged on floor, SRX2 (side rails times	F 221		

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F 221	Continued From page 8 2)...Pt has 2 cm (centimeter) bump under old senile purpura on [right] antecubital..." On 7/28/04, a facility nurse documented the following on an "Incident/Accident Report": "...Were bed rails ordered? No...Were bed rails present? yes...Pt (patient) states she was tired of being in the bed so she climbed out, pt was sitting cross legged on floor when found by aide 2 cm (centimeter) swelling under senile purpura [right] antecubital..." On 9/21/04 at 6:30 AM, resident 9 was observed to be in her room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/22/04 at 3:10 AM, resident 9 was observed to be in her room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/22/04 at 4:12 AM, resident 9 was observed to be in her room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/22/04 at 5:25 AM, resident 9 was observed to be in her room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/22/04 at 6:05 AM, resident 9 was observed to be in her room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/23/04 at 8:30 PM, resident 9 was observed to be in her room lying in bed. The side rail used was on the side of the bed opposite the wall, with	F 221		

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F 221	Continued From page 9 the bed positioned against the wall. There was no documentation of a physician's order for side rails in resident 9's medical record. On 9/23/04, the ADON (assistant director of nurses) was interviewed. After reviewing resident 9's medical record she stated that she could not find a physician's order for the usage of side rails. She further stated that resident 9 tries to roll herself out of bed and that was why resident 9's bed was up against the wall, with the other side rail used. She further stated that a low bed would not be an option for resident 9 because of resident 9's weight and that resident 9's knees were not strong enough to hold her up. 3. Resident 10 was re-admitted to the facility on 9/19/04 as a respite resident, with diagnoses which included seizures, urinary tract infections, neurogenic bladder, cancer of the prostate, hypothyroidism, cerebral vascular accident (stroke) with psychotic and agitated features, and arthritis. A review of resident 10's medical record was completed on 9/23/04. Resident 10 had multiple stays in the facility for Respite Care. During one of these stays from 6/7/04 to 7/14/04, an admission MDS assessment was completed by facility staff on 6/7/04. The MDS documented that resident 10 had short and long term memory problems and his cognitive skills for daily decision making were moderately impaired. The facility staff documented that resident 10 was able to transfer and ambulate with extensive assistance. The facility staff also documented that resident 10 used full bed rails daily.	F 221	Resident 10 was discharged. 9/24/04	

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F 221	Continued From page 10	F 221		

On 6/7/04, a "Physical Restraint Consent" form was signed by resident 10's daughter which documented, "I defer judgment regarding restraints until the appropriate healthcare professionals have assessed the need."

On 6/20/04, the IDT performed a "Restraint Evaluation and Quarterly Review for Elimination" assessment. The IDT documented that resident 10 had a soft restraint - lap buddy. There was no documentation that the IDT had attempted alternatives or determined the need for restraints. The IDT did not document that the soft restraint - lap buddy were the least restrictive measures. There was no documentation to indicate which restraints were previously used.

On 6/8/04 at 3:30 AM, a nurse's note in resident 10's medical record documented the following entry: "pt (patient) assisted to WC (wheel chair) [secondary to] restlessness [and] multiple attempts to climb OOB (out of bed)..."

On 6/18/04 at 8:45 PM, a nurse's note in resident 10's medical record documented the following entry: "pt (patient) crawled under seat belt restraint [and] fell on floor. [no] apparent injury..."

On 6/18/04, a facility nurse documented the following on a fax to resident 10's physician, "Your Pt (patient) slid under soft waist restraint in w/c (wheelchair) [and] fell. [No] injury. Can we have something to help his agitation [and] for sleep. Risperdol [sic], Remeron, Haldol nothing still tries to climb out of bed frequently at nocl (night)."

On 6/18/04, a facility nurse documented the following on an "Incident/Accident Report": "...Pt

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F 221	Continued From page 11 (patient) slid under seatbelt restraint in w/c (wheelchair) [and] fell.... [Check] into lap buddy for this res. (resident)....." On 6/21/04, a nurse's note in resident 10's medical record documented the following entry: "...doesn't want soft restraint on...SR (side rails) [up] X 2 (times two). Bed alarm on." On 6/21/04 at 8:50 PM, a nurse's note in resident 10's medical record documented the following entry: "pt (patient) pulled restraint over head, tried to stand [up] [and] fell - lying (?) bed, alert [and] responsive - family notified - [no] injury [at] this time." On 6/21/04, a facility nurse documented the following on a fax to resident 10's physician, "[resident 10] climbed under seat belt restraint [and] fell on floor - [no] apparent injury. Will monitor 72 [hour]. FYI (for your information) again; Risperdol [sic], Remeron, Haldol not working. but [sic] about a sleeper? or something. Constantly crawling out of bed at night (night) - uses bed alarm too [and] SR X 2 (side rails times two)." On 6/21/04, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) pulled waist restraint over head in w/c (wheel chair) [and] fell by bed....." On 6/22/04 at 9:00 PM, a nurse's note in resident 10's medical record documented the following entry: "...sat in front of nurses station in w/c (wheel chair) [with] restraint. Got out of restraint and stood up - was walking holding onto chair - aide got by him and held him and eased him to floor as he started to fall. Order from Dr. (doctor) Ativan 0.5 g mg po (by mouth) qhs (every night)."	F 221		

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	465098	A. BUILDING _____ B. WING _____	9/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE COUNTRY CARE CENTER	1340 EAST 300 NORTH PRICE, UT 84501

(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 221	Continued From page 12 There was no documentation that an "Incident/Accident Report" was completed regarding this fall. On 6/22/04 at 4:00 AM, a nurse's note in resident 10's medical record documented the following entry: "Pt (patient) very restless struggling to climb under soft waist restraint reaching door [and] floor, rocking wc (wheelchair), placed in shoulder restraint to prevent injury by tipping over wc." On 6/23/04 facility staff obtained a physician's order which documented the following, "PT (physical therapy) to eval (evaluate) res (resident) for Lap buddy [and] [change] of W/C (wheel chair) [with] foot rests." On 7/6/04, the physical therapist performed an "Admission Restraint/Side Rail Evaluation and Bed Entrapment Hazard Risk Assessment." It should be noted that this evaluation did not occur until 13 days after a physician's order was obtained. The physical therapist documented that resident 10, "leans to [right] needs lap buddy [with] w/c (wheelchair) and side rails while in bed." There was no documentation that the IDT had attempted alternatives or determined the need for the restraints. The IDT did not document that the side rails and lap buddy were the least restrictive measures. There was no documentation to indicate which restraint alternatives were previously used. There was no documentation of a physician's order for a waist restraint in resident 10's medical record. On 7/5/04 at 3:00 AM, a nurse's note in resident	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. BUILDING _____ B. WING _____	8/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE COUNTRY CARE CENTER	1340 EAST 300 NORTH PRICE, UT 84501

(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 221	Continued From page 13 10's medical record documented the following entry: "Aide responded to yelling found pt (patient) lying on R (right) side below left side of bed, small superficial abrasion R (right) knee...Pt bed alarm secure, removed by pt." On 7/5/04, a facility nurse documented the following on a fax to resident 10's physician, "your pt. (patient) [resident 10] was found lying on R (right) side on floor below raised bed rails, standard ROM (range of motion), superficial 1 cm (centimeter) abrasion R (right) knee.. pt had unclipped bed alarm..." On 7/5/04, a facility nurse documented the following on an "Incident/Accident Report": "...Were bed rails ordered? Yes...Were bed rails present? Yes...Was a restraint in use? Yes bed alarm...Aide responded to yelling found pt (patient) lying on R (right) side on L (left) side of bed on floor, superficial (1 cm) abrasion R (right) knee...bed alarm in place but pt had removed..." On 7/6/04 at 5:30 AM, a nurse's note in resident 10's medical record documented the following entry: "Pt (patient) climbing OOB (out of bed) X (times) 1...." There was no documentation of a physician's order for side rails in resident 10's medical record. Resident 10 had another Respite stay from 9/19/04 to 9/23/04. Review of resident 10's current respite stay's medical record was completed on 9/23/04. On 9/20/04 at 8:00 AM, a nurse's note in resident 10's medical record documented the following entry: "...Was a restraint in use? No...Found in	F 221		

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	465098	A. BUILDING _____ B. WING _____	9/28/2004

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F 221	Continued From page 14 room in front of W/C (wheel chair)." At 10:50 AM, the same facility nurse documented, "Told son when he came it [sic] that he hit the back of his head. Small (?) noted on back of head. Will contin. (continue) to monitor for problems." On 9/20/04 at 10:15 AM, a facility nurse documented the following on an "Incident/Accident Report": "Found pt (patient) on floor in front of W/C (wheel chair). Said he was looking for son. No apparent injury. Told son at 10:50 AM he hit back of head..." On 9/21/04 at 9:00 PM, a nurse's note in resident 10's medical record documented the following entry: "... soft waist restraint for safety." On 9/21/04 at approximately 4:00 PM, a nurse surveyor observed resident 10 in his bed with the bed against the wall and a side rail up on the open side of the bed. Resident 10 was pulling himself to a sitting position with both of his legs over the side rail. Resident 10 appeared to be getting ready to climb over the side rail. His bed alarm cord was observed to be approximately 18 inches long. The bed alarm did not sound until he was at the edge of the bed, close to the bottom of the bed, with his legs over the side rail and his upper body was leaning forward. At that time the surveyor told an aide, who was in another room, to help resident 10 so he would not fall. The aide came into the room and asked resident 10 what he was doing. Resident 10 stated that he wanted to get up. He also stated "This is hurting my leg. (pointing to the side rail that his legs were over). The aide stated "It's the side rail, let me put it down." The aide the helped him into his wheel chair and put his soft waist restraint on and affixed it to the back of the wheel chair. Resident 10 then stated, "Do I need that	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 221	Continued From page 15 there.".(pointing to the soft waist restraint) The aide stated "Yes, so you will be safe." On 9/22/04 at 3:10 AM, resident 10 was observed to be in his room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/22/04 at 4:08 AM, resident 10 was observed to be in his room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/22/04 at 5:20 AM, resident 10 was observed to be in his room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/22/04 at 6:30 AM, resident 10 was observed to be in his room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/22/04 at 7:10 AM, resident 10 was observed to be in the dinning room in a wheel chair with a soft waist restraint on. On 9/22/04 at 10:20 AM, resident 10 was observed to be in the 100 hallway in a wheel chair with a soft waist restraint on. On 9/22/04 at 8:00 PM, resident 10 was observed to be in his room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/22/04 at 8:20 PM, a facility nurse was interviewed. The nurse stated that the "respite gentlemen" (resident 10), fell over this weekend while in a wheel chair. She stated he was a fall	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 221	Continued From page 16 risk. The nurse stated that he crawled out of bed, had an alarm on and side rails. She stated that facility staff usually would catch him before going over the side rails. There was no documentation of a physician's order for side rails in resident 10's medical record. There was no documentation to evidence that an "Admission Restraint /Side Rail Evaluation Assessment" was completed. On 9/23/04, the ADON was interviewed. After reviewing resident 10's medical record she stated that she could not find a physician's order for the usage of side rails. 4. Resident 14 was admitted to the facility on 12/2/03 with diagnoses which included left hip fracture, insomnia, neurogenic bladder, iron deficiency anemia and Alzheimers. Resident 14 resided on the facility's SCU. A review of resident 14's medical record was completed on 9/23/04. Two quarterly MDS assessments were completed by facility staff on 5/27/04 and 8/3/04. Both assessments documented that resident 14 had problems with his short term memory and his cognitive skills for daily decision making were modified independence. The facility staff also documented that resident 14 wandered (moved with no rational purpose, seemingly oblivious to needs or safety). The facility staff documented that resident 14 was able to transfer and ambulate with limited assistance. The facility staff documented that resident 14 used full bed	F 221		

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	465098	A. _____ B. _____	9/28/2004

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CASTLE COUNTRY CARE CENTER	1340 EAST 300 NORTH PRICE, UT 84501

(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 221	Continued From page 17 rails daily. On 5/27/04, the IDT performed a "Restraint Evaluation and Quarterly Review for Elimination" assessment for resident 14. The IDT documented that resident 14 had side rails and a merry walker. There was no documentation that the IDT had attempted alternatives or determined the need for the restraints. The IDT documented that the side rails and merry walker restraint were the least restrictive measures. There was no documentation to indicate which alternatives were previously used. On 8/23/04, the IDT performed a "Restraint Evaluation and Quarterly Review for Elimination" assessment for resident 14. The IDT documented that resident 14 had side rails and a merry walker. There was no documentation that the IDT had attempted alternatives or determined the need for the restraints. The IDT did not document that the side rails and merry walker restraint were the least restrictive measures. There was no documentation to indicate which alternatives were previously used. On 12/3/03, a "Physical Restraint Consent" form was signed by resident 14. There was no documentation to provide evidence that resident 14 consented to the use of any restraints. A physician's order dated 1/26/04, documented the following, "...Crisscross restraint while in w/c (wheel chair)/unaware of safety r/t (related to) Alzhiemers [sic]..." There was no documentation in resident 14's medical record to provide evidence that he had been evaluated by the IDT for the use of a crisscross restraint while in his wheelchair.	F 221	Resident 14 new physical therapy evaluation on 9/29/04 whereas SR's x1 were De'd. A. Low bed and bed alarm and wheel chair alarm ordered. B. Physician order obtained 10/06/04 C. Physical restraint consent updated on 10/12/04. IDT meeting 10/21/04 W/C alarm not effective, resident removes clip @ times and continually get up without assistance. Gait unsteady. Lap Buddy while in W/C now applied.	

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	465098	A. BUILDING _____ B. WING _____	3/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 221	Continued From page 18	F 221		

On 3/17/04, a facility nurse documented the following on an "Incident/Accident Report": "...Were bed rails ordered? Yes...Were bed rails present? Yes...Pt (patient) climbed out of foot of bed; SR (side rail) present X2 (times 2) fell on floor..."

On 3/31/04, a facility nurse documented the following on a fax to resident 14's physician, "...Pt (patient) climbed out of foot of bed. SRX2 (side rails times 2) present. Found on floor..."

On 4/24/04 at 9:00 PM, a nurse's note in resident 14's medical record documented the following entry: "[At] 1630 (4:30 PM) res (resident) FOF (found on floor) in hallway outside his room- SR (side rails) were both up- Res had swelling [and] bruising [with] scrapes above [right] eye [and] scratches to sm (small) finger on (right) hand, eyes unequal, unreactive to light..."

On 4/24/04, a facility nurse documented the following on an "Incident/Accident Report": "...Were bed rails ordered? Yes...Were bed rails present? yes...Res (resident) climbed over [and] around SR (side rail) [and] fell into hall- res found on [right] side [with] bruise [and] swelling forming above [right] eye [with] dime sized scratch- eye unequal, unreactive to light..."

On 4/25/04, a nurse documented the following on a "Referral Physician/Clinics", "...Resident climbed over side rail walked into hall [and] fell hit head 4/24/04 (1630) (4:30 PM)...Pupils are unequal [right] side not reactive to light..."

On 7/404, a nurse's note in resident 14's medical record documented the following entry: "Pt (patient) found on floor crawling out from PVC

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	465093	A. BUILDING _____ B. WING _____	9/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 221	Continued From page 19 (merry walker) chair..." On 7/4/04 at 6:00 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Was a restraint in use? PVC (merry walker) chair with belt...Found on floor crawling out of PVC chair..." On 8/3/04 at 3:00 PM, a nurse's note in resident 14's medical record documented the following entry: "Pt (patient) found on floor in next room from his, lying against bed in merri [sic] - walker tipped over..." On 8/3/04, a facility nurse documented the following on an "Incident/Accident Report": "...Was a restraint in use? Merri [sic] walker...Pt (patient) found on floor in next room over, lying against bed, inside merry walker tipped over..." On 8/3/04, a facility nurse documented the following on a fax to resident 14's physician, "...Your pt'(patient) [resident 14] was found on floor in merri [sic] - walker..." On 8/24/04 at 9:00 PM, a nurse's note in resident 14's medical record documented the following entry: "[At] 1915 (7:15 PM) res (resident) was found lying on back in his room next to window, stated hit his head..." On 8/24/04, a facility nurse documented the following on an "Incident/Accident Report": "...Was a restraint in use? Lap belt...Res (resident) found lying on back in rm (room) next to window, stated hit head..." On 9/14/04 at 5:00 PM, a nurse's note in resident 14's medical record documented the following entry: "Pt (patient) found on floor [with] a	F 221		

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	465098	A. BUILDING _____ B. WING _____	9/28/2004

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F 221	Continued From page 20 fall...One small bump on top of head noted, bump on [right] temple..." On 9/14/04, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) tipped over to [right] side in merry walker in room. 1. 2 x 4 cm (centimeter) abrasion 2. Reddened area [at right] temple. 3. Abrasion (1 x 2 cm) [at right] wrist..." On 9/14/04, a facility nurse documented the following on a fax to resident 14's physician, "...[resident 14] took a fall in his geri-chair in his room- fell on [right] side, hit his head [and] pinned [right] wrist under chair...Lump on top of head [and at right] temple..." On 9/21/04 at 6:35 AM, resident 14 was observed to be in his room lying in bed with full length side rails up on both sides. On 9/22/04 at 3:10 AM, resident 14 was observed to be in his room lying in bed with full length side rails up on both sides. On 9/22/04 at 4:12 AM, resident 14 was observed to be in his room lying in bed with full length side rails up on both sides. On 9/22/04 at 5:25 AM, resident 14 was observed to be in his room lying in bed with full length side rails up on both sides. On 9/22/04 at 6:05 AM, resident 14 was observed to be in his room lying in bed with full length side rails up on both sides. On 9/22/04 at 12:00 PM, resident 14 was observed in the hallway up in a wheel chair with a soft waist restraint.	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465036	A. BUILDING _____ B. WING _____	09/28/2004

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(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 221	Continued From page 21 On 9/22/04 at 1:45 PM, resident 14 was observed in the hallway up in a wheel chair with a soft waist restraint. On 9/22/04 at 7:45 PM, resident 14 was observed to be in his room lying in bed with full length side rails up on both sides. There was no documentation of a physician's order for side rails, a merry walker, a lap belt or a geri chair in resident 14's medical record. On 9/22/04 at 8:00 PM, a facility nurse stated that resident 14 tipped over his merry walker a week ago and resident 14's wrist was sore afterwards. On 9/23/04 at 9:45 AM, the ADON was interviewed. After reviewing resident 14's medical record the ADON stated that the crisscross restraint was discontinued on 9/22/04 at 5:00 PM, and that a physician's order was obtained for the merry walker and wheelchair with soft waist restraint as needed. She stated that resident 14 required the merry walker and wheelchair with soft waist restraint because resident 14 has had a decline and requires them for safety. The ADON was not able to find a physician's order for side rails while resident 14 was in bed. She stated that resident 14 uses the full length side rails for mobility. 5. Resident 15 was admitted to the facility on 5/8/01 with diagnoses which included Alzheimers, dyspnea, angina, anxiety and arrhythmias. Resident 15 resided on the facility's SCU. A review of resident 15's medical record was completed on 9/23/04.	F 221		

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F 221	Continued From page 22 Two quarterly MDS assessments were completed by facility staff on 4/21/04 and 7/8/04. Both assessments documented that resident 15 had problems with her short and long term memory and her cognitive skills for daily decision making were moderately impaired. The facility staff documented that resident 15 was able to transfer with supervision and ambulate with limited assistance. The facility staff documented that resident 15 used full bed rails daily. On 5/18/01, a "Physical Restraint Consent" form was signed by resident 15's son. The consent documented that restraints could be used if the appropriate healthcare professionals had assessed the need for such and a restraining device was indicated as part of the recommended plan of care. A physician's order dated 8/20/02, documented the following, "...Side rails up X (times) 2 safety r/t (related to) alzheimers unaware to physical limitations..." On 5/5/04, the IDT performed a "Restraint Evaluation and Quarterly Review for Elimination" assessment for resident 15. The IDT documented that resident 15 had side rails on both sides of the bed. There was no documentation that the IDT had attempted alternatives or determined the need for the restraints. The IDT documented that the side rails were the least restrictive measure. There was no documentation to indicate which alternatives were previously used. On 7/20/04, the IDT performed a "Restraint Evaluation and Quarterly Review for Elimination" assessment for resident 15. The IDT	F 221	Resident 15 Physical restraint consent updated 10/12/04. A. Orders obtained for physical therapy to re-evaluate on 9/29/04 B. Orders obtained to Dc SR's on 10/05/04 and apply low bed with bed alarm and lap buddy when up in wheel chair.	

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	465090	A. BUILDING _____ B. WING _____	9/23/2004

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(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 221	Continued From page 23 documented that resident 15 had side rails on both sides of the bed. There was no documentation that the IDT had attempted alternatives or determined the need for the restraints. The IDT documented that the side rails were the least restrictive measure. There was no documentation to indicate which alternatives were previously used. On 4/22/04 at 8:30 PM, a nurse's note in resident 15's medical record documented the following entry: "Found on floor next to bed. Side rails [up] sm (small) red area on back [at] center waistline..." On 4/22/04, a facility nurse documented the following on a fax to resident 15's physician, "... [Resident 15] found on floor [at] bedside..." On 4/22/04, a facility nurse documented the following on an "Incident/Accident Report": "...Were bed rails ordered? Yes...Were bed rails present? Yes...Found on floor beside bed. Sm (small) reddened area on back [at] waist line..." On 9/21/04 at 6:35 AM, resident 15 was observed to be in her room lying in bed with full length side rails up on both sides. On 9/22/04 at 3:10 AM, resident 15 was observed to be in her room lying in bed with full length side rails up on both sides. On 9/22/04 at 4:12 AM, resident 15 was observed to be in her room lying in bed with full length side rails up on both sides. On 9/22/04 at 5:25 AM, resident 15 was observed to be in her room lying in bed with full length side rails up on both sides.	F 221		

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	465098	A. BUILDING _____ B. WING _____	9/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE COUNTRY CARE CENTER	1340 EAST 300 NORTH PRICE, UT 84501

(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 221	Continued From page 24 On 9/22/04 at 8:25 PM, resident 15 was observed to be in her room lying in bed with full length side rails up on both sides. On 9/22/04 at 6:05 AM, resident 15 was observed to be in her room lying in bed with full length side rails up on both sides. On 9/22/04 at 12:00 PM, a facility nurse stated that resident 15 "frequently tries to climb out of bed." On 9/22/04 at 8:20 PM, a facility nursing assistant stated that resident 15 tries often to get out of her bed by going to the bottom of the bed. She further stated that she did not know why resident 15 had side rails, "probably because she gets out of bed and is unsteady." On 9/22/04 at 8:32 PM, a facility nursing assistant stated that resident 15 works her way down to the end of the bed. She stated that resident 15 does not walk well and the "side rails slow her down from getting out of bed." 6. Resident CL6 was admitted to the facility on 5/17/04 with diagnoses which included pneumonia, CVA (cardiovascular accident or "stroke") with depressive features, intracranial hemorrhage, and progressive Alzheimer's disease. A review of resident CL6's medical record was completed on 9/23/04. An admission MDS assessment completed by facility staff on 5/17/04 documented that resident CL6 had short and long term memory problems and that her cognitive skills for daily decision	F 221	Resident CL6 was discharged.	

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F 221	Continued From page 25 making were moderately impaired. The facility staff documented that resident CL6 required extensive assistance with transfers, ambulation, eating, toilet use and personal hygiene. Facility staff documented that resident CL6 used full rails daily and a trunk restraint daily. On 7/8/04, the interdisciplinary team (IDT) performed a "Restraint Evaluation and Quarterly Review for Elimination" assessment. The IDT documented that resident CL6 had side rails. There was no documentation that the IDT had attempted alternatives or determined the need for the restraint. The IDT documented that the side rails were the least restrictive measure. There was no documentation to indicate which restraint alternatives were previously used. On 5/17/04, a "Physical Restraint Consent" form was signed by resident CL6's son. The consent documented that restraints could be used if the appropriate healthcare professionals had assessed the need for such and a restraining device was indicated as part of the recommended plan of care. On 6/8/04 at 11:00 AM, a nurse's note in resident CL6's medical record documented the following entry: "...Continue to assist [with] walking [and] keep rails up [and] alarm attached." On 6/20/04 at 3:00 AM, a nurse's note in resident CL6's medical record documented the following entry: "[Resident CL6] has gotten herself OOBX2 (out of bed times two) this shift. Apparently climbs over the rail or out of the bottom..." On 6/21/04 at 2:00 AM, a nurse's note in resident CL6's medical record documented the following entry: "...Ambulating [without] assist having climbed over rails..."	F 221		

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F 221	Continued From page 26 On 6/26/04, a nurse's note in resident CL6's medical record documented the following entry: "Had anew [sic] incident. [Facility aide] went into her room and found her sitting on floor next to bed..." There was no documentation that an "Incident/Accident Report" was completed regarding this fall. On 6/28/04 at 12:00 PM, a nurse's note in resident CL6's medical record documented the following entry, "Pt (patient) found sitting on floor in front of w/c (wheelchair). Said 'I slid out of chair..." There was no documentation that an "Incident/Accident Report" was completed regarding this fall. On 7/7/04 at 10:30 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) slipped out of restraint, walked to door of room [and] slid down wall to floor..." On 7/25/04 at 2:00 PM, a nurse's note in resident CL6's medical record documented the following entry, "Found pt (patient) lying on floor..." On 7/25/04, a facility nurse documented the following on an "Incident/Accident Report": "...Found patient lying on floor. Chest restraint still attached to chair..." On 7/29/04 at 5:30 PM, a nurse's note in resident CL6's medical record documented the following entry: "Pt (patient) untied restraint stood [up] nurse catched [sic] pt to break fall, w/c (wheel chair) landed on pt sm (small) skin tear [right] elbow..." On 7/29/04 at 5:30 PM, a facility nurse	F 221		

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F 221	Continued From page 27 documented the following on an "Incident/Accident Report": "...pt unified restraint from w/c (wheel chair) stood [up] - nurse caught pt to break fall, w/c fell on pt caused sm (small) skin tear [right] elbow..." On 8/22/04 at 11:30 AM, a nurse's note in resident CL6's medical record documented the following entry: "Pt (patient) found with wheel chair tip over on her. Restraints were still on..." On 8/22/04 at 11:30 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Found pt (patient) in room tipped over in wheel chair restraints were still on..." There was no documentation of a physician's order for side rail or a chest restraint in resident CL6's medical record. Residents who had potential for experiencing harm as a result of being physically restrained without assessment of the need included the following: 7) Resident 4 was admitted to the facility on 11/28/04 with the diagnoses of pre-senile dementia, Alzheimers, falls, and hypothyroidism. A review of resident 4's medical record was completed on 9/23/04. A quarterly MDS assessment dated 8/21/04 and a significant change MDS assessment dated 5/25/04 were completed by facility staff. Both assessments documented that resident 4 had short and long term memory problems and her cognitive skills for daily decision making were moderately impaired. The facility staff	F 221		

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F 221	Continued From page 28 documented that resident 4 was able to transfer with limited assistance and ambulate with limited to extensive assistance. The facility staff documented that resident 4 was usually continent of bowel and occasionally incontinent of bladder. It was also documented that resident 4 used full bed rails and a trunk restraint daily. On 12/3/03, the IDT performed an "Admission Restraint/Side Rail Evaluation [and] Bed entrapment Hazard Risk Assessment." The IDT documented, "Pt. (patient) attempts to get up frequently unassisted and is not safe in doing so [independently]. She would benefit from having a seat belt restraint while in w/c (wheel chair)." There was no documentation that the IDT had attempted alternatives or determined the need for the restraint. The IDT documented that the side rails and criss cross restraint were to be used and that they were the least restrictive measures. There was no documentation to indicate which restraint alternatives were previously used. On 5/25/04, The IDT performed a "Restraint Evaluation and Quarterly Review for Elimination." The IDT documented, "SR's (side rails) [up], SB (seat belt) [up] in w/c (wheel chair) [and] bed alarm." There was no documentation that the IDT had attempted alternatives or determined the need for the restraint. The IDT documented that the side rails and seat belt restraint were the least restrictive measures. There was no documentation to indicate which restraint alternatives were previously used. On 6/9/04, the IDT performed a "Restraint Evaluation and Quarterly Review for Elimination." The IDT documented, "Evaluate SR's (side rails) [up] when in bed seat belt when in w/c (wheel chair), cont (continue) [with] SR's and seat belt in	F 221	Resident 4 Bed entrapment updated on 9/22/04. A. Order for physical therapy re-evaluation for restraints 9/29/04 update. B. Dc seat belt while up in wheel chair. C. Ordered low bed, with bed alarm and wheel chair alarm on 10/06/04 D. Physical restraint consent updated 10/07/04. E. Monthly Summary... D.O.N. to inservice all nursing staff 10/28/04 on documenting skills. F. Order obtained 10/06/04 to Dc SR's.	

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F 221	Continued From page 29 w/c." There was no documentation that the IDT had attempted alternatives or determined the need for the restraint. There was no documentation that the restraint and/or side rails were recommended. There was no documentation that the side rails and soft belt restraint were the least restrictive measures. There was no documentation to indicate which restraint alternatives were previously used. On 6/7/04, a "Physical Restraint Consent" form was signed by resident 4's daughter which documented, "I defer judgment regarding restraints until the appropriate healthcare professionals have assessed the need." On 11/29/03 at 10:00 PM, a nurse's note in resident 4's medical record documented the following entry: "...Pt (patient) up in geri[sic] chair for dinner meal...Anxious [sic] [and] Restless..." On 11/30/03 at 10:00 PM, a nurse's note in resident 4's medical record documented the following entry: "...up in geri - chair for dinner meal..." There was no documentation of a physician's order for a geri chair in resident 4's medical record. On 12/12/03 at 10:00 PM, a nurse's note in resident 4's medical record documented the following entry: "CNA (certified nurse's assistant) reported finding Pt (patient) on floor next to w/c (wheel chair). Daughter was observed removing lap belt prior to Pt falling...pt denies any pain." On 12/12/04, a facility nurse documented the following on an "Incident/Accident Report":	F 221		

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F 221	Continued From page 30 "...Was a restraint in use? No (has lap belt ordered)...CNA (certified nurses assistant) reported finding pt (patient) on floor sitting below w/c (wheel chair) on her buttocks. Daughter was observed removing safety belt. Pt denies pain to bottom...." On 12/12/03, a facility nurse documented on a fax to resident 4's physician, "[resident 4] was observed by a CNA to be found on floor sitting by w/c (wheel chair). Daughter was observed removing safety belt prior to pt falling. Pt (patient) denies any pain to bottom. No injury." On 12/31/03 at 2:30 AM, a nurse's note in resident 4's medical record documented the following entry: "pt (patient) found kneeling on floor beside bed states 'I don't know how I got here' no injuries noted..." On 12/31/03, a facility nurse documented the following on an "Incident/Accident Report": "...Were bed rails ordered? Yes...Were bed rails present? Yes...Was a restraint in use? Yes...pt (patient) found on floor beside bed. No injuries noted pt states "I don't know how I got here," bed alarm had been removed." On 12/31/03 at 9:20 AM, a nurse's note in resident 4's medical record documented the following entry: "...w/c (wheel chair) [with] cris [sic] - cross restraint on ..." In January 2004, a "Nursing Monthly Summary" documented, "...side rail X (times) 2, lap restraint..." On 1/3/04 at 10:10 AM, a nurse's note in resident 4's medical record documented the following entry: "pt (patient) found on floor of ER	F 221		

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F 221	Continued From page 31 (bathroom) Belt restraint removed by pt. Pt stated she was going to BR and lost her balance sliding down the door to the floor. Red area noted [left] upper back from door knob..." On 1/3/04 at 10:10 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Physical restraint type Belt - pt (patient) removed...Pt stated she was going to the BR (bathroom) and lost her balance sliding down the floor, red spot (marked on diagram of body on the left upper back)..." On 1/3/04 at 6:00 PM, a nurse's note in resident 4's medical record documented the following entry: "...some c/o (complains of) back upper discomfort." On 1/15/04 at 5:40 AM, a nurse's note in resident 4's medical record documented the following entry: "found sitting on floor below bed, bed rails up X (times) 2 ..." On 1/15/04 at 5:40 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Were bed rails ordered? Yes...Were bed rails present? Yes...Was a restraint in use? Yes bed alarm pt (patient) removes... pt found sitting on buttocks below left bed corner, states she doesn't know how she got there...[no] s/s (signs and symptoms) injury...pt confused crawled out [at] end of bed." On 1/15/04, a facility nurse documented on a fax to resident 4's physician, "pt (patient) was found sitting on floor at bottom of bed, [no] s/s (signs and symptoms) injury ...pt had removed bed alarm..." In February 2004, a "Nursing Monthly Summary"	F 221		

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F 221	Continued From page 32 documented, "...side rail X (times) 2, lap restraint..." On 2/2/04 at 8:10 PM, a nurse's note in resident 4's medical record documented the following entry: "...said w/c (wheel chair) restraint was too tight. Checked and there was 2 finger space slack in but adjusted it a little looser..." In March 2004, a "Nursing Monthly Summary" documented, "...side rail X (times) 2, lap restraint..." On 3/3/04 at 4:15 AM, a nurse's note in resident 4's medical record documented the following entry: "...found pt (patient) on floor laying on [right] side, pt c/o (complains of) bump on [right] side of head above ear, slight swelling noted, [no] abrasion...will monitor for 72 [hours] [with] neuro ck (check) [secondary] head bump." On 3/3/04, a facility nurse documented the following on an "Incident/Accident Report": "...Were bed rails ordered? Yes...Were bed rails present? Yes...Was a restraint in use? Yes bed alarm...aide responded to light found pt (patient) on floor on right side, pt stated she climbed over bottom of bed [and] fell striking right side of head...Type of injury Hematoma..." On 3/3/04, a facility nurse documented on a fax to resident 4's physician, "Your pt, [resident 4] was found on [right] side on floor below bed...pt stated she climbed over bottom of bed. Pt sustained small bump on [right] side of head above ear..." On 3/8/04 at 3:30 PM, a nurse's note in resident 4's medical record documented the following entry: "...bed rail and bed alarm for safety..."	F 221		

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F 221	Continued From page 33 On 3/15/04 at 7:00 PM, a nurse's note in resident 4's medical record documented the following entry: "...can you take this belt off, so I can get out of chair...SR (side rail), bed alarm..." In April 2004, a "Nursing Monthly Summary" documented, "...bed rails, bed alarm, seat belt (fall precautions)..." On 4/5/04, a nurse's note in resident 4's medical record documented the following entry: "...w/c (wheel chair) [with] soft waist..." On 4/18/04 at 7:00 AM, a nurse's note in resident 4's medical record documented the following entry: "Pt (patient) climbed over side rail [and] in chair...." On 4/19/04, a nurse's note in resident 4's medical record documented the following entry: "SR (side rails) while in bed - bed alarm - soft waist restraint when [up] in w/c (wheel chair)..." In May 2004, a "Nursing Monthly Summary" documented, "...side rail X (times) 2, bed alarm..." On 5/22/04, a nurse's note in resident 4's medical record documented the following entry: "Pt (patient) found sitting on floor, no injuries...." On 5/22/04, a facility nurse documented the following on an "Incident/Accident Report": "...Were bed rails ordered? Yes...Were bed rails present? Yes...Was a restraint in use? Yes soft belt restraint...Found on floor by member of kitchen staff member, no injuries...assisted back to w/c (wheel chair) soft belt restraint placed back on...." On 5/22/04, a nurse's note in resident 4's medical	F 221		

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F 221	Continued From page 34 record documented the following entry: "Pt (patient) found sitting on floor in bedroom, no injuries, no complaints of pain, fell on knees...." On 5/23/04, a nurse's note in resident 4's medical record documented the following entry: "Pt (patient) in w/c (wheel chair) [with] soft belt restraint on...." On 5/24/04, a nurse's note in resident 4's medical record documented the following entry: "...soft waist lap belt on...." On 5/25/04 at 6:30 PM, a nurse's note in resident 4's medical record documented the following entry: "...Has a bruise on [left] leg. Did not want to be resting earlier and was trying to get out of bed herself. Assisted to w/c (wheel chair)...wears lap restraint in w/c tries to get up alone and is prone to falls...." On 5/31/04 at 3:00 PM, a nurse's note in resident 4's medical record documented the following entry: "pt (patient) found on floor by bed, pt states she slid out under w/c (wheel chair) restraint, tried to put self to bed....[no] apparent injury." On 5/31/04, a facility nurse documented the following on an "Incident/Accident Report": "...pt (patient) found on floor by bed - states she slid out of chair restraint [and] was trying to put self to bed...." On 6/11/04, 12 days after resident 4's fall occurred, a facility nurse documented on a fax to resident 4's physician, "pt (patient) found on floor by bed, states she slid under w/c (wheel chair) restraint [and] tried to put self to bed.."	F 221		

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F 221	Continued From page 35 On 6/1/04 at 10:30 PM, a nurse's note in resident 4's medical record documented the following entry: "...she does hate lap belt..." On 6/22/04 at 6:30 PM, a nurse's note in resident 4's medical record documented the following entry: "...pt (patient) in w/c (wheel chair) pulling at lap belt..." On 6/30/04 at 6:00 AM, a nurse's note in resident 4's medical record documented the following entry: "during routine end of shift bed checks aide found pt (patient) sitting cross legged sitting on the floor..." On 6/30/04, a facility nurse documented the following on an "Incident/Accident Report": "...Were bed rails ordered? Yes...Were bed rails present? Yes...Was a restraint in use? Yes bed alarm/pt removed...aide found pt (patient) sitting cross legged below open side of bed below bed rail...pt removed bed alarm...." On 6/30/04, a facility nurse documented on a fax to resident 4's physician, "pt (patient) [resident 4] was found [with] am bed checks sitting on floor next to bed, [no] injury...Pt SR (side rails) were both up, pt had removed bed alarm per self." On 7/27/04 at 6:30 PM, a nurse's note in resident 4's medical record documented the following entry: "...can toilet self with assistance taking off belt...." On 8/9/04, a nurse's note in resident 4's medical record documented the following entry: "...w/c (wheel chair) mobility when [up] [with] soft waist restraint...." On 8/17/04, a nurse's note in resident 4's medical	F 221		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 221	Continued From page 36 record documented the following entry: "...take this belt off..." On 8/30/04, a nurse's note in resident 4's medical record documented the following entry: "... [up] in w/c (wheel chair) soft belt restraint in place...waist restraint w/c mobility." On 9/13/04, a nurse's note in resident 4's medical record documented the following entry: "...soft waist restraint while in w/c (wheel chair) [and] SR (side rails) in bed." On 9/21/04 at 8:30 PM, a nurse's note in resident 4's medical record documented the following entry: "...soft waist restraint on while in w/c (wheel chair) [and] SR (side rails) in bed ..." On 9/21/04 at 6:15 AM, resident 4 was observed to be in her room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/21/04 at 10:15 AM, resident 4 was observed to be by the nurse's station in a wheel chair with a soft waist restraint on. On 9/21/04 at 3:30 PM, resident 4 was interviewed. She stated, "Whenever I am in bed, this rail is up (pointing to the side rail)." She also stated, "I don't like the side rails up. If I want to get out of bed I can scoot to the bottom of the bed to get out." On 9/21/04 at 4:05 PM, resident 4 was observed to be in her room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/22/04 at 3:10 AM, resident 4 was observed	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. BUILDING _____ B. WING _____	9/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE COUNTRY CARE CENTER	1340 EAST 300 NORTH PRICE, UT 84501

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F 221	Continued From page 36 record documented the following entry: "...take this belt off'..." On 8/30/04, a nurse's note in resident 4's medical record documented the following entry: "... [up] in w/c (wheel chair) soft belt restraint in place ..waist restraint w/c mobility." On 9/13/04, a nurse's note in resident 4's medical record documented the following entry: "...soft waist restraint while in w/c (wheel chair) [and] SR (side rails) in bed." On 9/21/04 at 8:30 PM, a nurse's note in resident 4's medical record documented the following entry: "...soft waist restraint on while in w/c (wheel chair) [and] SR (side rails) in bed...." On 9/21/04 at 6:15 AM, resident 4 was observed to be in her room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/21/04 at 10:15 AM, resident 4 was observed to be by the nurse's station in a wheel chair with a soft waist restraint on. On 9/21/04 at 3:30 PM, resident 4 was interviewed. She stated, "Whenever I am in bed, this rail is up (pointing to the side rail)." She also stated, "I don't like the side rails up. If I want to get out of bed I can scoot to the bottom of the bed to get out." On 9/21/04 at 4:05 PM, resident 4 was observed to be in her room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/22/04 at 3:10 AM, resident 4 was observed	F 221		

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	465099	A. BUILDING _____ B. WING _____	9/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 221	Continued From page 37 to be in her room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/22/04 at 4:08 AM, resident 4 was observed to be in her room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/22/04 at 5:20 AM, resident 4 was observed to be in her room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/22/04 at 6:30 AM, resident 4 was observed to be in her room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/22/04 at 8:00 PM, resident 4 was observed to be in her room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/23/04 at 10:30 AM, resident 4 was observed to be in a wheel chair by the nurse's station with a soft waist restraint on. There was no documentation of a physician's order for side rails or a soft waist restraint in resident 4's medical record. On 9/23/04, the ADON was interviewed. After reviewing resident 4's medical record she stated that she could not find a physician's order for the usage of side rails or the soft waist restraint. 8. Resident 8 was admitted to the facility on 5/8/03 with diagnoses which included congestive heart failure, hypertension, pneumonia and	F 221	Resident 8 was discharged 9/28/04.	

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F 221	Continued From page 38 Alzheimers. Resident 8 resided on the facility's SCU. A review of resident 8's medical record was completed on 9/23/04. An annual MDS assessment dated 4/27/04, and a quarterly MDS assessment dated 7/24/04, was completed by facility staff. Both assessments documented that resident 8 had short and long term memory problems and his cognitive skills for daily decision making were moderately impaired. The facility staff also documented that resident 8 wandered (moved with no rational purpose, seemingly oblivious to needs or safety). The facility staff documented that resident 8 was able to transfer and ambulate with independence. The facility staff documented that resident 8 did not use any type of restraints. On 4/27/04 and 5/5/04, the IDT performed a "Restraint Evaluation and Quarterly Review for Elimination" assessment for resident 8. The IDT documented that resident 8 had no restraints. On 9/21/04 at 6:28 AM, resident 8 was observed to be in his room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/21/04 at 7:10 AM, resident 8 was observed to be in his room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. On 9/21/04 at 2:45 PM, resident 8 was observed to be in his room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall.	F 221		

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F 221	Continued From: page 39 On 9/22/04 at 7:45 PM, resident 8 was observed to be in his room lying in bed. The side rail used was on the side of the bed opposite the wall, with the bed positioned against the wall. There was no documentation of a physician's order for side rails in resident 8's medical record. On 9/22/04 at 12:00 PM, a facility nurse stated that resident 8 had been falling out of bed and currently had a side rail. She further stated that there was no physician order for the side rail, but when he started having falls the bed was moved up against the wall and the side rail was put up on the opposite side from the wall. On 9/23/04 at 9:45 AM, the ADON was interviewed. She stated that a physician's order for side rails and a soft waist restraint were obtained for resident 8 on 9/22/04 at 9:00 AM. She stated that the side rail physician's order was obtained because resident 8 had recent falls and a decline in function, so they will be used for his safety. After reviewing resident 8's medical record the ADON stated that she could not find a resident/family consent for the use of restraints or an evaluation for the use of side rails. 9. Resident 11 was admitted to the facility on 8/2/04 with the diagnoses of cellulitis of face, atrial fibrillation, hypertension, congestive heart failure with anxious features, and edema. A review of resident 11's medical record was completed on 9/23/04. An admission MDS assessment dated 8/15/04 was completed by facility staff. The assessment documented that resident 11 had short term	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465068	A. BUILDING _____ B. WING _____	9/28/2004

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F 221	Continued From page 40 memory problems and her cognitive skills for daily decision making were moderately impaired. The facility staff documented that resident 11 was able to transfer with extensive assistance and ambulate on the unit with supervision. It was also documented that resident 11 used full bed rails and a trunk restraint daily. On 8/6/04, the IDT performed an "Admission Restraint/Side Rail Evaluation [and] Bed Entrapment Hazard Risk Assessment." There was no documentation that the IDT had determined the need for the restraint. The IDT documented that a restraint and/or side rails were recommended. On 8/15/04, the IDT performed a "Restraint Evaluation and Quarterly Review for Elimination." The IDT documented, "Pt (patient) to have lap buddy while in w/c (wheel chair) and SR's (side rails) [up] X (times) 2 for safety." There was no documentation that the IDT had attempted alternatives or determined the need for the restraint. The IDT did not document that the side rails and lap buddy restraint were the least restrictive measures. There was no documentation to indicate which restraint alternatives were previously used. On 8/2/04, a nurse's note in resident 11's medical record documented the following entry: "...side rails X (times) 2...." On 8/7/04 at 11:50 AM, a nurse's note in resident 11's medical record documented the following entry: "...lap belt in place on patient...." On 8/19/04 at 9:00 PM, a nurse's note in resident 11's medical record documented the following entry: "I walked by pt (patient) room; [and] found	F 221	Resident 11 Entrapment risk updated 9/22/04. A. order for physical restraint evaluation per physical therapy 9/22/04. B. Evaluation completed per physical therapy 9/29/04. C. Recommended De'ing SR's apply bed alarm. Keep lap buddy due to patient request. D. Orders received 10/05/04 to De SR's. Bed alarm applied. E. Nurse to document Weekly soap notes of resident's ability to remove and replace lap buddy and also note on tx rand. F. D.O.N. to hold inservice on 10/28/04 covering documentation skills.	

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	465096	A. BUILDING _____ B. WING _____	9/28/2004

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F 221	Continued From page 41 her lying on floor... [no] s/s (signs and symptoms) of any injuries..." On 8/19/04, a facility nurse documented the following on an "Incident/Accident Report": "...Was a restraint in use? Yes Lap Belt...lap belt restraint in use...walked by room, found pt. (patient) lying on floor. [no] s/s (signs and symptoms) of any injuries. [no] pain..." On 8/27/04, a facility nurse documented on a fax to resident 11's physician, "I found pt. (patient) lying on floor when I walked by her room. She had no s/s (signs and symptoms) of injuries...Lap belt restraint was still attached to wheelchair. She stated she had [no] pain." On 8/27/04 at 8:00 PM, a physician's telephone order documented, "PT (physical therapist) to evaluate for lap buddy." On 9/1/04, the physical therapist performed a "Restraint Evaluation and Quarterly Review for Elimination." It should be noted that this evaluation did not occur until 5 days after a physician's order was obtained. The physical therapist documented, "Lap buddy + SR's (side rails) X (times) 2." There was no documentation that the IDT had attempted alternatives or determined the need for the restraint. There was no documentation that the restraint and/or side rails were recommended. The IDT did not document that the side rails and lap buddy were the least restrictive measures. There was no documentation to indicate which restraint alternatives were previously used. On 9/4/04 at 11:30 PM, a nurse's note in resident 11's medical record documented the following entry: "pt (patient) found on floor. States she	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46563G	A. BUILDING _____ B. WING _____	09/28/2004

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F 221	Continued From page 42 slipped trying to return to bed from BR (bathroom). No injury noted..." On 9/4/04, a facility nurse documented the following on an "Incident/Accident Report": "...Were bed rails ordered? Yes...Were bed rails present? Yes...Was a restraint in use? No...pt (patient) found on floor in Room states "I got up to go to the bathroom and fell when I tried to get back into bed..." On 9/22/04 at 6:50 AM, a nurse's note in resident 11's medical record documented the following entry: "...side rails X (times) 2 at nite (sic) for safety. lap buddy , bed alarm..." On 9/22/04, from 3:10 AM until 5:30 AM, resident 11 was observed to have side rails up times 2. On 9/22/04 at 10:50 AM, resident 11 was observed to be by the nurse's station in a wheel chair with a lap buddy on. On 9/22/04 at 10:00 AM, resident 11 was observed to be by the nurse's station in a wheel chair with a lap buddy on. There was no documentation of a physician's order for side rails or a lap buddy in resident 11's medical record. On 9/23/04, the ADON was interviewed. After reviewing resident 11's medical record she stated that she could not find a physician's order for the usage of side rails or the lap buddy. 10. Resident CL2 was admitted to the facility on 8/24/02 with the diagnoses of prostate cancer, congestive heart failure, asthma, insulin	F 221	Resident CL 2 was discharged.	

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F 221	Continued From page 43 dependant diabetes mellitus, and Parkinson's disease. A review of resident CL2's medical record was completed on 9/23/04. A significant change MDS assessment was completed by facility staff on 6/3/04. The assessment documented that resident CL2 had short and long term memory problems and his cognitive skills for daily decision making were moderately impaired. The facility staff documented that resident CL2 was able to transfer and ambulate with extensive assistance. It was also documented that resident CL2 used full bed rails daily. On 2/27/04, the IDT performed a "Restraint Evaluation and Quarterly Review for Elimination." The IDT documented, "No Restraints." The IDT documented that "No restraints and/or side rails were recommended." On 12/4/03, a nurse's note in resident CL2's medical record documented the following entry: "side rails [up] 2 (times two)." On 12/12/03, a nurse's note in resident CL2's medical record documented the following entry: "side rails [up] 2 (times two)." On 5/27/04 at 7:00 PM, a nurse's note in resident CL2's medical record documented the following entry: "pt (patient) found on floor by bed... [no] apparent injury..." On 5/27/04, a facility nurse documented the following on an "Incident/Accident Report": "...Were bed rails ordered? Yes...Were bed rails present? Yes...Pt (patient) found on floor by bed.	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 221	Continued From page 44 States he tried to get [up]." There was no documentation of a physician's order for side rails in resident CL2's medical record. 11. Resident CL4 was admitted to the facility on 4/30/04 with the diagnoses of intestinal obstruction, pure hypercholesterolemia, hypertension, and constipation. A review of resident CL4's medical record was completed on 9/23/04. A significant change MDS assessment was completed by facility staff on 5/13/04. The assessment documented that resident CL4 had short and long term memory problems and his cognitive skills for daily decision making were moderately impaired. The facility staff documented that resident CL4 was able to transfer and ambulate with extensive assistance. It was also documented that resident CL4 used full bed rails daily. There was no documentation to evidence that an "Admission Restraint/Side Rail Evaluation [and] Bed entrapment Hazard Risk Assessment" was completed. On 4/30/04, a "Physical Restraint Consent" documented, "I Do Not consent to the use of restraints...." Facility nurses documented on the following dates, in the "Nursing Care Records", that resident CL4 had side rails up times two: 5/3/04, 5/4/04, 5/5/04, 5/6/04, 5/8/04, 5/10/04, 5/11/04, 5/13/04, 5/15/04, 5/16/04, 5/17/04, 5/19/04, 5/18/04, 5/20/04, 5/21/04, 5/23/04,	F 221	Resident CL4 was discharged.	

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F 221	Continued From page 45 5/24/04, 5/28/04, 5/30/04, 6/1/04, 6/5/04, 6/8/04, 6/13/04, 6/18/04, 6/21/04, 6/24/04 and 6/27/04. On 6/26/04 at 11:45 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Were bed rails ordered? Yes...Were bed rails present? Yes...Was a restraint in use? Yes Bed alarm...pt (patient) removed bed alarm [and] climbed over bed rail no injury noted." There was no documentation of a physician's order for side rails in resident CL4's medical record. INTERVIEWS On 9/22/04 at 12:40 PM, the DON (director of nurses) was interviewed. She stated the restraint consent is obtained when a resident is admitted to the facility. She further stated that when family members attend the IDT meeting, consent will also be obtained then. The DON stated that a physician's order should be obtained for a physical restraint and then a physical therapist will evaluate the resident for the appropriateness.	F 221		
F 224 SS=K	483.13(c)(1)(i) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (Use F224 for deficiencies concerning mistreatment, neglect or misappropriation of resident property.)	F 224		

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	465098	A. BUILDING _____ B. WING _____	9/25/2004

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F 224	Continued From page 46 This Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop and implement policies and procedures that prohibited neglect. Seven out of 13 residents (residents CL1, 4, 8, 9, 10,11 and 12) and 6 supplemental residents (CL2, CL4, CL5, CL6, 14 and 15) experienced multiple falls. Incidence of individual falls, within this sampled and supplemental resident group, ranged from two to ten. Three of the residents (resident CL1, CL5 and 8) sustained serious injuries requiring hospital treatment. Five of the residents (resident 9, 10, 14, 15 and CL6) sustained actual harm as a result of falls and five of the residents (resident 4, 11, 12, CL2 and CL4) had a potential for experiencing harm as a result of falls. The facility neglected to develop, fully implement and re-evaluate interventions to avoid physical harm associated with falls. Due to the lack of assessment and subsequent harm, the facility was found to be in Immediate Jeopardy. Findings include: Observations: On 9/22/04 from 3:10 AM until 6:05 AM, a nurse surveyor made the following observations the SCU (Special Care Unit), a secured unit: From 3:10 AM until 4:11 AM, there was no facility staff present on the SCU. At 4:11 AM, a facility nursing assistant came onto the SCU. From 4:12 AM until 4:18 AM, there was no facility staff present on the SCU. At 4:18 AM, two facility nursing assistants came onto the SCU. From 4:20 AM until 4:30 AM, there was no facility staff present on the SCU. AT 4:30 AM, three facility nursing assistants	F 224	F 224 1. All other residents as well as those mentioned in this document have also been re-evaluated for the least restrictive restraints or redaction/elimination of present restraints according to new fall/restraint protocol and policies utilizing present assessment tools. 2. All new admits will be assessed the same manner. 3. Quality Assurance meetings will be held every week. To review Restraints, Falls, Injuries and Infections and to establish a plan of action for residents identified. Once substantial compliance is established Quality Assurance meeting will be held monthly. 4.The D.O.N. will keep a QA incident Report Summary Log. This log will be reviewed every month in QA meeting to look for trends. 5. The Tether program was implemented that identifies residents that are high risk for falls. These Trees are placed on the resident's door. The staff was inserviced on this program on 10/11/04. D.O.N. will monitor. 6. D.O.N. has inserviced the night shift and has made clear the need for a CNA on the unit at all times. The CNA's on night shift rotate working 200 hall or SCU every 2 hours throughout the shift.	

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	465093	A. BUILDING _____ B. WING _____	9/28/2004

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CASTLE COUNTRY CARE CENTER	1340 EAST 300 NORTH PRICE, UT 84501

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F 224	Continued From page 47 came onto the SCU. From 4:35 AM until 6:05 AM, there was no facility staff present on the SCU. The SCU was observed by the nurse surveyor for two hours and fifty-five minutes. During that time period the SCU was observed to be left unattended by facility staff for two hours and forty-seven minutes. Resident who experienced serious injury as a result of falls included the following. 1. Resident CL1 was admitted to the facility on 11/1/01 and re-admitted on 10/22/02 with diagnoses which included diabetes mellitus, cystitis, congestive heart failure, candidiasis and prostate cancer. A review of resident CL1's medical record was completed on 9/23/04. A significant change Minimum Data Set (MDS) assessment completed by facility staff on 7/5/04, documented that resident CL1 had short and long term memory problems and his cognitive skills for daily decision making were severely impaired. The facility staff also documented that resident CL1 resisted cares. The facility staff documented that resident CL1 was able to transfer and ambulate with extensive assistance. The facility staff documented that resident CL1 had fallen within the past 30 days and the last 31 to 180 days. On 1/3/04 and 4/6/04, facility nurses completed the "Fall Risk Assessment/Side Rail & Restraint Use" assessments for resident CL1. On both assessments, resident CL1's assessed score was "26", which indicated the resident was at a	F 224	6. A Nurse Consultant was hired to comply with the directed plan of correction. Inservices were held 10/05/04. 10/06/04 on fall and incident policies, protocols, and assessment tools by RN Consultant and D.O.N. A Knowledge test was given to staff in conjunction with inservices on restraint and incident/accident. She has participated in QA meetings. 7.D.O.N. to monitor tracking and logs weekly. 8. Medical records to monitor forms in charts monthly via chart audits. 9. The Above was integrated into QA system on 10/14/04. 10.The above to be in effect 11/15/04. Resident CL1 was discharged.	

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	465098	A. BUILDING _____ B. WING _____	9/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE COUNTRY CARE CENTER	1340 EAST 300 NORTH PRICE, UT 84501

(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 224	Continued From page 48 high risk for falls. A review of resident CL1's medical record, revealed that a comprehensive care plan, addressing resident CL1's high fall risk, could not be found in the medical record. Review of the medical record revealed that resident CL1 had been residing in the facility SCU until his transfer to an acute care hospital on 7/17/04. On 3/23/04 at 4:00 PM, a nurse's note in resident CL1's medical record documented the following entry: "Found on dining room floor..." On 3/23/04 at 2:00 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Resd (resident) was found on floor of dining room. W/C (wheel chair) sitting at table..." On 3/24/04 at 2:30 AM, a nurse's note in resident CL1's medical record documented the following entry: "...Pt (patient) found sitting on buttocks beside his bed..." On 3/24/04 at 2:30 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Aide responded to yelling [and] found pt (patient) sitting on buttocks on floor next to bed..." On 5/13/04 at 2:30 AM, a nurse's note in resident CL1's medical record documented the following entry: "Aide responded to bed alarm, found pt (patient) sitting on floor, next to bed..." On 5/13/04 at 2:30 AM, a facility nurse documented the following on an	F 224		

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	465099	A. BUILDING _____ B. WING _____	9/28/2004

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F 224	Continued From page 49 "Incident/Accident Report": "...Aide responded to bed alarm found pt (patient) sitting on floor next to bed..." On 5/19/04 at 5:15 AM, a nurse's note in resident CL1's medical record documented the following entry: "Pt (patient) found sitting on buttocks leaning against bed, crying it hurts..." On 5/19/04 at 5:15 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Aide found pt (patient) sitting on buttocks against stating 'he hurts'..." On 5/19/04, a physician documented the following on a "[Facility's name] Referral Physician/Clinic", "[left] hip contusion- no fracture seen." On 7/2/04 at 5:45 AM, a nurse's note in resident CL1's medical record documented the following entry: "Nurse found pt (patient) lying under bed when entering room...[no] s/s (signs and symptoms) injury..." On 7/2/04, a facility nurse documented the following on a fax to resident CL1's physician, "Your pt (patient)...was found under his bed [at] 0545 (5:45 AM)...[no] s/s (signs and symptoms) injury..." On 7/2/04 at 5:45 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Nurse found pt (patient) lying under neath bed...string was so long on alarm that it was still attached..." On 7/3/04 at 2:30 AM, a nurse's note in resident CL1's medical record documented the following entry: "Pt (patient) found sitting on floor beside	F 224		

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	465090	A. BUILDING _____ B. WING _____	9/28/2004

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F 224	Continued From page 50 bed, alarm did not sound, no injuries noted. Pt bed exchanged for bed [with] side rails to discourage pt from getting out of bed." On 7/3/04 at 2:30 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) attempted to get out of bed, bed alarm failed to sound, pt slipped to floor. No injuries, Bed exchanged for one [with] side rails...I have bed alarm [checked]..." On 7/17/04 at 7:00 PM, a nurse's note in resident CL1's medical record documented the following entry: "...Pt (patient) found on floor by his bed on [left] side. Pt turned on back, slightly lifted [left] leg..." On 7/17/04 at 4:00 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) found on floor next to bed...Found out [after] sent to ER (emergency room) [left] hip fx'd (fractured)..." A phone interview was held with a facility staff nurse on 9/21/04 at 2:15 PM. She stated that resident CL1 resided on the special needs unit. She stated that resident CL1 had constantly climbed out of bed. She further stated that resident CL1 was a high fall risk. An interview was held with a second facility nurse on 9/22/04 at 3:15 AM. She stated that resident CL1 was able to stand but not walk. She further stated that resident CL1 had side rails up when ever he was in bed, as well as a bed alarm. She further stated that by the time facility staff could respond to the bed alarm he usually had already fallen. The facility nurse further stated that resident CL1 had many falls from his bed.	F 224		

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	465093	A. BUILDING _____ B. WING _____	07/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 51 Based on the documentation it was determined that resident CL1 had 7 falls from 3/23/04 until 7/17/04. Two of the falls occurred on the evening shift and five of the falls occurred on the night shift. There was no documentation to provide evidence that facility staff developed interventions, individualized to resident CL1's needs to reduce his falls or to minimize potential injury. 2. Resident CL5 was admitted to the facility on 4/27/04 with diagnoses which included hypertension, retinitis pigmentosa and progressive dementia with delusions. A review of resident CL5's medical record was completed on 9/23/04. An admission MDS assessment completed by facility staff on 5/10/04, documented that resident CL5 had severely impaired vision and that his cognitive skills for daily decision making were moderately impaired. The facility staff documented that resident CL5 required extensive assistance with walking, dressing, toileting, and personal hygiene but could transfer with supervision and was independent for bed mobility. The facility staff documented that resident CL5 had no fall accidents in the past 180 days. On 4/27/04, a facility nurse had completed a "Fall Risk Assessment/Side Rail & Restraint Use" assessment. The facility nurse documented on the assessment a score of "24", which indicated that resident CL5 was a high fall risk. On 4/27/04, an admission nurse's note on resident	F 224	Resident CL5 was discharged.	

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F 224	Continued From page 52 CL5's medical record documented the following entry: "...Pt (patient) uses walking stick with ambulation. Is leagally [sic] blind. Requires 1 person SBA (stand by assist) with all ADL's (activities of daily living). Family notes that pt (patient) is a fall risk and will attempt to do activities independently..." A review of resident CL5's medical record, revealed a comprehensive care plan dated 5/19/04, addressing resident CL5's fall risk. There was no documentation to evidence that the comprehensive care plan had been updated by facility staff. On 4/29/04 at 10:30 PM, a nurse's note in resident CL5's medical record documented the following entry: "When Res (resident's) son came, he told RN (registered nurse) that he found pt (patient) on floor, sitting next to bed...Nurse stated that sometimes it is better to let pt be- the son stated that he didn't think so because he said 'My father is blind [and] can't be left alone'. Also wanted to know where bed alarm was. Res has taken it off [and] it hasn't been found..." On 4/30/04 at 9:30 PM, a facility nurse documented the following on an "Incident/Accident Report": Res (resident's) son came [and] told RN (registered nurse) that he found pt (patient) on floor, sitting next to bed..." On 5/21/04 at 2:45 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Aide found pt (patient) sitting on floor in front of closet..." On 5/21/04 at 3:00 AM, a nurse's note in resident CL5's medical record documented the following entry: "Pt (patient) found sitting on floor next to	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465998	A. BUILDING _____ B. WING _____	5/28/2004

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F 224	Continued From page 53 closet..." On 5/22/04 at 12:15 AM, a facility nurse documented the following on the "Incident/Accident Report": "...Pt (patient) yelling in room. Sitting in chair [at] bedside. 1 cm (centimeter) skin tear to [right] elbow. C/O (complains of) [right] rib pain...Pt states he fell, no one saw pt fall, or saw him on the ground..." On 5/22/04 at 12:15 AM, a nurse's note in resident CL5's medical record documented the following entry, "Pt (patient) yelling from room. Went in [and] pt sitting in chair. States he fell [No] one witnessed his fall or him on the ground. 1/2 cm (centimeter) skin tear to [right] elbow. Pt c/o (complains of) [right] rib pain..." On 5/22/04 at 4:45 AM, a nurse's note in resident CL5's medical record documented the following entry, "Pt (patient) ret (returned) from ER (emergency room)...Daughter in law [at] bedside. States he broke 3 ribs..." Based on the documentation, it was determined that resident CL5 had 3 falls from 4/30/04 until 5/21/04. One fall occurred on the evening shift and two falls occurred on the night shift. There was no documentation to provide evidence that facility staff developed interventions, individualized to resident CL5's needs to reduce his falls or to minimize potential injury. 3. Resident 8 was admitted to the facility on 5/8/03 with diagnoses which included congestive heart failure, hypertension, pneumonia and Alzheimers. Resident 8 resided on the facility's SCU.	F 224	Resident 8 was discharged 9/23/04.	

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F 224	Continued From page 54 A review of resident 8's medical record was completed on 9/23/04. On 7/24/04, a quarterly MDS assessment was completed by facility staff. Facility staff documented that resident 8 had short and long term memory problems and his cognitive skills for daily decision making were moderately impaired. The facility staff also documented that resident 8 wandered (moved with no rational purpose, seemingly oblivious to needs or safety). The facility staff documented that resident 8 was able to transfer and ambulate with independence. The facility staff documented that resident 8 had fallen within the past 30 days and the last 31 to 180 days. On 5/4/04, a facility nurse completed a "Fall Risk Assessment/Side Rail & Restraint Use" assessment for resident 8. The facility nurse documented on the assessment a score of "20", which indicated that resident 8 was a high fall risk. On 7/19/04, a facility nurse completed a "Fall Risk Assessment/Side Rail & Restraint Use" assessment for resident 8. The facility nurse documented on the assessment a score of "16", which indicated that resident 8 was a high fall risk. A review of resident 8's medical record, revealed a comprehensive care plan dated 5/4/04, addressing resident 8's fall risk. There was no documentation to evidence that the comprehensive plan of care had been updated by facility staff. On 2/29/04 at 10:00 AM, a nurse's note in	F 224		

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F 224	Continued From page 55 resident 8's medical record documented the following entry: "Pt (patient) found sitting on floor..." On 2/29/04 at 9:00 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) was found sitting on floor next to bed..." On 2/29/04, a facility nurse documented the following on a fax to resident 8's physician, "...[Resident 8] was found sitting on the floor next to his bed...He reports he just slid to the floor..." On 3/19/04 at 5:30 AM, a nurse's note in resident 8's medical record documented the following entry: "Aides found resident sitting on buttocks by bed on floor..." On 3/19/04 at 5:30 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) found sitting on floor on buttocks, stated he fell out of bed .." On 3/19/04, a facility nurse documented the following on a fax to resident 8's physician, "...Your pt (patient), [resident 8], was found sitting on floor on his buttocks..." On 3/21/04, a nurse's note in resident 8's medical record documented the following entry: "...Pt (patient) found on floor in his room by NA (nursing assistant)..." On 3/22/04 at 10:00 PM, a facility nurse documented the following on an "Incident/Accident Report": "...CNA (certified nursing assistant) reports pt (patient) found down on floor in pt's room..."	F 224		

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	465093	A. BUILDING _____ B. WING _____	9/28/2004

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F 224	Continued From page 56 On 8/25/04 at 6:40 PM, a nurse's note in resident 8's medical record documented the following entry: "...Pt (patient) fallen in room on [left] hip...Pt found lying on floor by aide on [left] hip [and] arm..." On 8/25/04 at 6:40 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) walked into room [with] [zero] assistance. Aide walked by and found pt on floor on [left] hip and arm..." On 8/25/04 at 10:24 PM, a nurse's note in resident 8's medical record documented the following entry: "Pt (patient) toileting self and stood up took step [with] pants down [and] fell against it out the door landing on floor in front of aide, pt alert, quiet, not responding to questions..." On 8/25/04 at 10:45 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) was in bathroom toileting when he stood up he never pulled up pants, walked lost balance and fell against bathroom door onto floor..." On 8/25/04, a facility nurse documented the following on a fax to resident 8's physician, "[resident 8] had his second fall this evening [at] 2245 (10:45 PM). He was toileting when he stood up, stepped [with] pants around ankles, lost balance [and] fell against and out the door onto floor..." On 9/13/04 at 6:15 AM, a nurse's note in resident 8's medical record documented the following entry: "Visitor reported pt (patient) on floor in responding nurse found pt lying flat on	F 224		

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F 224	Continued From page 57 backside..." There was no documentation that an "Incident/Accident Report" was completed regarding this fall. On 9/16/04 at 10:00 AM, a nurse's note in resident 8's medical record documented the following entry: "...Pt (patient) found on floor of room. 3 cm (centimeter) laceration to [left] eyebrow..." On 9/16/04 at 10:00 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) lying in bed, fell out the left side, struck head on dresser, 3 cm (centimeter) laceration to above eyebrow in furrow area..." On 9/16/04, a facility nurse documented the following on a fax to resident 8's physician, "...[Resident 8]- fell out of bed. 3 cm (centimeter) laceration to [right] eyebrow. Steri strips applied..." On 9/16/04 at 11:30 AM, a nurse's note in resident 8's medical record documented the following entry: "Pt (patient) standing in doorway of room. Cut top of head, 1 [inch] laceration..." On 9/16/04 at 11:30 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) standing in doorway of room, fell [and] struck top of head. 1 [inch] laceration to top of head. Pt also c/o (complains of) [right] clavicle pain..." On 9/16/04, a facility nurse documented the following on a fax to resident 8's physician, "...[[Resident 8] fell again, this [time] striking top of head- has 1 [inch] laceration. Also c/o (complains of) [right] clavicle pain. Sent to ER	F 224		

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	46509	A. BUILDING _____ B. WING _____	9/28/2004

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F 224	Continued From page 58 (emergency room) via ambulance for sutures [and] eval (evaluation)." On 9/16/04 at 2:30 PM, a nurse's note in resident 8's medical record documented the following entry: "Pt (patient) ret (returned) from ER (emergency room) via [facility] fan. 8 staples to top of head. I [changed] dreg (dressing) to [left] eyebrow..." On 9/21/04 at 11:00 PM, a nurse's note in resident 8's medical record documented the following entry: "Pt (patient) slid out of his W/C (wheel chair) this evening..." On 9/21/04 at 9:00 PM, a facility nurse documented the following on an "Incident/Accident Report": "Pt (patient) was trying to get out of his (wheelchair) [and] slid to the floor in the hall..." Based on the documentation it was determined that resident 8 had 9 falls from 2/29/04 until 9/21/04. Three of the falls occurred on the day shift, three of the falls occurred on the evening shift and three of the falls occurred on the night shift. There was no documentation to provide evidence that facility staff developed interventions, individualized to resident 8's needs to reduce his falls or to minimize potential injury. Residents who experienced actual harm as a result of falls included the following: 4. Resident 9 was admitted to the facility on 4/27/04 and then re-admitted to the facility on 5/19/04 with diagnoses which included psychotic	F 224		

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F 224	Continued From page 59 disorder, chronic edema, hypothyroidism, dementia, anxiety, hypertension and a cognitive disorder. Resident 9 resided on the facility's SCU. A review of resident 9's medical record was completed on 9/23/04. An admission MDS assessment completed by facility staff on 6/1/04, documented that resident 9 had short and long term memory problems and her cognitive skills for daily decision making were moderately impaired. The facility staff documented that resident 9 required supervision with transfers and was able to ambulate with limited assistance. The facility staff documented that resident 9 had fallen within the past 30 days. A quarterly MDS assessment completed by facility staff on 8/28/04, documented that resident 9 had fallen within the past 30 days and the last 31 to 180 days. On 6/7/04, a facility nurse completed a "Fall Risk Assessment/Side Rail & Restraint Use" assessment for resident 9. The facility nurse documented on the assessment a score of "18", which indicated that resident 9 was a high fall risk. On 8/23/04, a facility nurse charted a "Fall Risk Assessment/Side Rail & Restraint Use" assessment for resident 9. The facility nurse did not document a score to indicate resident 9's fall risk. A review of resident 9's medical record, revealed a comprehensive care plan dated 6/7/04, addressing resident 9's fall risk. There was no	F 224	Resident 9 Fall risk score added for 8/23/04 assessment completed and added to care plan. Resident has been put on the Timber program that flags residents high risk for falls. Resident 9 had consent form updated with signatures 10/7/04; new choice documented. A. Bed entrapment updated 9/29/04. B. New physical therapy evaluation for restraint reduction 9/29/04 C. Removed side rails and applied bed alarm. Bed moved away from wall. D. Physician orders obtained 10/6/04. A. D.O.N. to have in-service on documenting skills on 10/28/04	

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	465095	A. BUILDING _____ B. WING _____	06/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE COUNTRY CARE CENTER	1340 EAST 300 NORTH PRICE, UT 84501

(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 224	Continued From page 60 documentation to evidence that the comprehensive plan of care had been updated by facility staff. On 5/2/04 at 11:30 PM, a nurse's note in resident 9's medical record documented the following entry: "...Nurse found pt (patient) on floor, assisted to WC (wheel chair) and then to bed...Found pt at 2400 (12:00 AM) sitting on floor by bed..." On 5/2/04 at 11:30 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) stated she wanted to lie down on floor from WC (wheelchair) pt later found lying on floor assisted to WC [and] to bed found sitting on buttocks next to bed 1/2 hr (hour) later..." On 5/5/04 at 6:00 AM, a nurse's note in resident 9's medical record documented the following entry: "Woke-up at 0400 (4:00 AM) in morning [and] climbing OOB (out of bed) [and] over SR (side rails)..." There was no documentation that an "Incident/Accident Report" was completed regarding this fall. On 5/27/04 at 1:45 AM, a nurse's note in resident 9's medical record documented the following entry: "Found pt (patient) on buttocks between bed and wall, states she was climbing OOB (out of bed) on that side when the bed shifted, c/o (complains of) [left] knee pain..." On 5/27/04 at 1:45 AM, a facility nurse documented the following on an "Incident/Accident Report": "...(patient) found sitting on buttocks between bed and wall...Pt c/o (complains of) [left] knee pain..."	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. BUILDING _____ B. WING _____	07/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 61 On 7/9/04 at 9:30 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Fell out of bed at 9:30 PM..." On 7/10/04 at 12:00 PM, a nurse's note in resident 9's medical record documented the following entry: "Documented in CNA (certified nursing assistant) charting 7/9/04 that pt (patient) fell out of bed at 9:30 PM...been sitting herself on the floor frequently the last few days..." On 7/19/04 at 5:30 AM, a nurse's note in resident 9's medical record documented the following entry: "Pt (patient) found sitting cross legged on floor next to bed...[at] 0630 (6:30 AM) pt found on floor below recliner..." On 7/19/04, a facility nurse documented the following on a fax to resident 9's physician, "...[at] 0530 (5:30 AM) your pt (patient), [resident 9] was found sitting cross legged on floor below rails on her bed...[at] 0630 (6:30 AM) found on floor below recliner..." On 7/19/04 at 5:30 AM, a facility nurse documented the following on an "Incident/Accident Report": "...aide found pt (patient) sitting cross legged on floor [at] bedside...[left] great toe nail area had a few gtts (drops) of blood .." On 7/28/04 at 3:00 AM, a nurse's note in resident 9's medical record documented the following entry: "Aide found pt (patient) sitting cross legged on floor beside bed, pt states she does not know how she got there, later she states she was tired of being in bed [and] climbed out. Pt does have 2 cm (centimeter) swelling area under old senile purpura on [right] antecubital..."	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. BUILDING _____ B. WING _____	9/28/2004

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F 224	Continued From page 62 On 7/28/04, a facility nurse documented the following on a fax to resident 9's physician, "...Your pt (patient), [resident 9] was found sitting cross legged on floor, SRX2 (side rails times 2)...Pt has 2 cm (centimeter) bump under old senile purpura on [right] antecubital..." On 7/28/04 at 3:00 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) states she was tired of being in the bed so she climbed out, pt was sitting cross legged on floor when found by aide 2 cm (centimeter) swelling under senile purpura [right] antecubital..." Based on the documentation it was determined that resident 9 had 6 falls from 5/2/04 until 7/28/04. One of the falls occurred on the evening shift and seven of the falls occurred on the night shift. There was no documentation to provide evidence that facility staff developed interventions, individualized to resident 9's needs to reduce her falls or to minimize potential injury. 5. Resident 10 was re-admitted to the facility on 9/19/04 as a respite resident, with diagnoses which included seizures, urinary tract infections, neurogenic bladder, cancer of the prostate, hypothyroidism, cerebral vascular accident (stroke) with psychotic and agitated features, and arthritis. A review of resident 10's medical record was completed on 9/23/04. Resident 10 had multiple stays in the facility for Respite Care. During one of these stays from	F 224	Resident 10 was discharged.	

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F 224	Continued From page 63 6/7/04 to 7/14/04, an admission MDS assessment was completed by facility staff on 6/7/04. The MDS documented that resident 10 had short and long term memory problems and his cognitive skills for daily decision making were moderately impaired. The facility staff documented that resident 10 was able to transfer with extensive assistance and ambulate with extensive assistance. The facility staff documented that resident 10 had no fall accidents in the past 180 days. On 6/7/04, a facility nurse had completed a "Fall Risk Assessment/Side Rail & Restraint Use" assessment for resident 10. The facility nurse documented on the assessment a score of "21", which indicated that resident 10 was a high fall risk. A review of resident 10's medical record, revealed a comprehensive care plan dated 6/23/04, addressing resident 10's fall risk. There was no documentation to evidence that the comprehensive care plan had been updated by facility staff. On 3/24/04 at 8:30 PM, a nurse's note in resident 10's medical record documented the following entry: "In DR (dining room), Res (resident) was [with] granddaughter [and] fell, she eased him to floor..." On 3/24/04 at 6:00 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Res (resident) began to fall [and] granddaughter eased him to floor...." On 3/26/04, a facility nurse documented the following on a fax to resident 10's physician,	F 224		

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	465058	A. BUILDING _____ B. WING _____	9/28/2004

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F 224	Continued From page 64 "...Pt. (patient) had a fall 3/24/04 - no apparent injuries..." On 6/18/04 at 8:45 PM, a nurse's note in resident 10's medical record documented the following entry: "pt (patient) crawled under seat belt restraint [and] fell on floor. [no] apparent injury...." On 6/18/04, a facility nurse documented the following on a fax to resident 10's physician, "...Your Pt (patient) [resident 10] slid under soft waist restraint in w/c (wheelchair) [and] fell. [no] injury. Can we have something to help his agitation [and] for sleep. Resperdol [sic], Remeron, Haldol nothing still tries to climb out of bed frequently at noct (night)..." On 6/18/04 at 8:45 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) slid under seatbelt restraint in w/c (wheel chair) [and] fell..." On 6/21/04 at 8:50 PM, a nurse's note in resident 10's medical record documented the following entry: "pt (patient) pulled restraint over head, tried to stand [up] [and] fell - lying (?) bed..." On 6/21/04, a facility nurse documented the following on a fax to resident 10's physician, "...[resident 10] climbed under seat belt restraint [and] fell on floor - [no] apparent injury. FYI (for your information) again: Risperdal [sic], Remeron, Haldol not working. but [sic] about a sleeper? or something. Constantly crawling out of bed at noct (night) - uses bed alarm too [and] SR X 2 (side rails times two)..." On 6/21/04 at 8:50 PM, a facility nurse	F 224		

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	465098	A. BUILDING _____ B. WING _____	6/28/2004

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F 224	Continued From page 65 documented the following on an "Incident/Accident Report": "...Pt (patient) pulled waist restraint over head in w/c (wheel chair) [and] fell by bed....." On 6/22/04 at 9:00 PM, a nurse's note in resident 10's medical record documented the following entry: "...sat in front of nurses station in w/c (wheel chair) [with] restraint. Got out of restraint and stood up - was walking holding onto chair - aide got by him and held him and eased him to floor as he started to fall. Order from Dr. (doctor) Ativan 0.5 g mg po (by mouth) qhs (every night)." There was no documentation that an "Incident/Accident Report" was completed regarding this fall. On 7/5/04 at 3:00 AM, a nurse's note in resident 10's medical record documented the following entry: "Aide responded to yelling found pt (patient) lying on R (right) side below left side of bed, small superficial abrasion R (right) knee...Pt bed alarm secure, removed by pt..." On 7/5/04, a facility nurse documented the following on a fax to resident 10's physician, "your pt. (patient) [resident 10] was found lying on R (right) side on floor below raised bed rails, standard ROM (range of motion), superficial 1 cm (centimeter) abrasion R (right) knee... pt had unclipped bed alarm." On 7/5/04 at 3:00 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Aide responded to yelling found pt (patient) lying on R (right) side on L (left) side of bed on floor, superficial (1 cm) abrasion R (right) knee..." Resident 10 had another Respite stay from	F 224		

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	465093	A. BUILDING _____ B. WING _____	9/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 66 9/19/04 to 9/23/04. Review of resident 10's current respite stay's medical record was completed on 9/23/04. There was no documentation of evidence of a current Fall Risk Assessment or Fall Risk Care Plan for resident 10. On 9/20/04 at 10:15 AM, a nurse's note in resident 10's medical record documented the following entry: "Found in room in front of W/C (wheel chair)." At 10:50 AM, the same facility nurse documented, "Told son when he came it (sic) that he hit the back of his head. Small (?) noted on back of head. Will contin. (continue) to monitor for problems." On 9/20/04 at 10:15 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Found pt (patient) on floor in front of W/C (wheel chair). Said he was looking for son. No apparent injury. Told son at 10:50 AM he hit back of head..." On 9/21/04 at approximately 4:00 PM, a nurse surveyor observed resident 10 in his bed with the bed against the wall and a side rail up on the open side of the bed. Resident 10 was pulling himself to a sitting position with both of his legs over the side rail. Resident 10 appeared to be getting ready to climb over the side rail. His bed alarm cord was observed to be approximately 18 inches long. The bed alarm did not sound until he was at the edge of the bed, close to the bottom of the bed, with his legs over the side rail and his upper body was leaning forward. At that time the surveyor told an aide, who was in another room, to help resident 10 so he would not fall. The aide came into the room and asked resident 10 what he was doing. Resident 10	F 224		

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F 224	Continued From page 67 stated that he wanted to get up. He also stated "This is hurting my leg. (pointing to the side rail that his legs were over). The aide stated "It's the side rail, let me put it down." The aide the helped him into his wheel chair and put his soft waist restraint on and affixed it to the back of the wheel chair. Resident 10 then stated, "Do I need that there." (pointing to the soft waist restraint) The aide stated "Yes, so you will be safe." On 9/22/04 at 8:20 PM, a facility nurse was interviewed. The nurse stated that the "respite gentlemen" (resident 10), fell over this weekend while in a wheel chair. She stated that he was a fall risk. The nurse stated that he crawled out of bed, had an alarm on and side rails. She stated that facility staff usually would catch him before going over the side rails. Based on documentation it was determined that resident 10 had 6 falls from 3/24/04 to 9/20/04. One of the falls occurred on the day shift, four of the falls occurred on the evening shift, and one of the falls occurred on the night shift. There was no documentation of evidence that facility staff developed interventions, individualized to resident 10's needs to reduce his falls or to minimize potential injury. 6. Resident 14 was admitted to the facility on 12/2/03 with diagnoses which included left hip fracture, insomnia, neurogenic bladder, iron deficiency anemia and Alzheimers. Resident 14 resided on the facility's SCU. A review of resident 14's medical record was completed on 9/23/04.	F 224		

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F 224	Continued From page 68 A quarterly MDS assessment was completed by facility staff on 8/3/04. Facility staff documented that resident 14 had problems with his short term memory and his cognitive skills for daily decision making were modified independence. The facility staff also documented that resident 14 wandered (moved with no rational purpose, seemingly oblivious to needs or safety). The facility staff documented that resident 14 was able to transfer and ambulate with limited assistance. The facility staff documented that resident 14 had fallen with in the past 30 days and the last 31 to 180 days. On 5/25/04 and 8/23/04, facility nurses completed the "Fall Risk Assessment/Side Rail & Restraint Use" assessments for resident 14. On both assessments, resident 14's assessed score was "23", which indicated that resident 14 was a high fall risk. A review of resident 14's medical record, revealed a comprehensive care plan dated 12/3/03, addressing resident 14's fall risk. There was no documentation to evidence that the comprehensive plan of care had been updated by facility staff. On 3/17/04 at 3:45 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) climbed out of foot of bed, SR (side rail) present X2 (times 2) Fell on floor..." On 3/27/04 at 2:00 PM, a nurse's note in resident 14's medical record documented the following entry: "Pt (patient) had fall kicked self over in WC (wheel chair)..." On 3/27/04 at 11:00 AM, a facility nurse documented the following on an	F 224	Resident 14 care plan has been updated noting all listed incidences. Resident has been put on the Timber program that flags residents high risk for falls. D.O.N. to have inservice on documenting skills on 10/28/04. IDT meeting 10/21/04 W/C alarm not effective, resident removes clip @ times and continually get up without assistance. Gait unsteady. Lap Buddy while in W/C now applied.	

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F 224	Continued From page 69 "Incident/Accident Report": "...Patient in WC (wheel chair) kicked chair [and] flipped WC over falling on back side. Red mark on [left] shoulder..." On 3/31/04, a facility nurse documented the following on a fax to resident 14's physician, "...Pt (patient) climbed out of foot of bed. SRX2 (side rails times 2) present. Found on floor..." There was no documentation that an "Incident/Accident Report" was completed regarding this fall. On 4/24/04 at 9:00 PM, a nurse's note in resident 14's medical record documented the following entry: "[At] 1630 (4:30 PM) res (resident) FOF (found on floor) in hallway outside his room- SR (side rails) were both up- Res had swelling [and] bruising [with] scrapes above [right] eye [and] scratches to sm (small) finger on (right) hand, eyes unequal, unreactive to light..." On 4/24/04 at 4:30 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Res (resident) climbed over [and] around SR (side rail) [and] fell into hall- res found on [right] side [with] bruise [and] swelling forming above [right] eye [with] dime sized scratch- eye unequal, unreactive to light..." On 4/25/04, a nurse documented the following on a "Referral Physician/Clinics", "...Resident climbed over side rail walked into hall [and] fell hit head 4/24/04 (1630) (4:30 PM)...Pupils are unequal [right] side not reactive to light..." On 7/4/04, a nurse's note in resident 14's medical record documented the following entry: "Pt (patient) found on floor crawling out from PVC (merry walker) chair..."	F 224		

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F 224	Continued From page 70 On 7/4/04 at 6:00 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Found on floor crawling out of PVC chair..." On 8/3/04 at 3:00 PM, a nurse's note in resident 14's medical record documented the following entry: "Pt (patient) found on floor in next room from his, lying against bed in merri [sic]- walker tipped over..." On 8/3/04 at 3:00 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) found on floor in next room over, lying against bed, inside merry walker tipped over..." On 8/3/04, a facility nurse documented the following on a fax to resident 14's physician, "...Your pt (patient) [resident 14] was found on floor in merri [sic]- walker..." On 8/24/04 at 9:00 PM, a nurse's note in resident 14's medical record documented the following entry: "[At] 1915 (7:15 PM) res (resident) was found lying on back in his room next to window, stated hit his head..." On 8/24/04 at 7:15 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Res (resident) found lying on back in rm (room) next to window, stated hit head..." On 9/14/04 at 5:00 PM, a nurse's note in resident 14's medical record documented the following entry: "Pt (patient) found on floor [with] a fall...One small bump on top of head noted, bump on [right] temple..."	F 224		

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F 224	Continued From page 71 On 9/14/04 at 4:15 PM, a facility nurse documented the following on an "Incident/Accident Report". "...Pt (patient) tipped over to [right] side in merry walker in room. 1. 2 x 4 cm (centimeter) abrasion 2. Reddened area [at right] temple. 3. Abrasion (1 x 2 cm) [at right] wrist..." On 9/14/04, a facility nurse documented the following on a fax to resident 14's physician, "...[resident 14] took a fall in his geri-chair in his room- fell on [right] side, hit his head [and] pinned [right] wrist under chair...Lump on top of head [and at right] temple..." Based on the documentation it was determined that resident 14 had 8 falls from 3/17/04 until 9/14/04. One of the falls occurred on the day shift, six of the falls occurred on the night shift and one of the falls did not have any documentation as to what time it occurred. There was no documentation to provide evidence that facility staff developed interventions, individualized to resident 14's needs to reduce his falls or to minimize potential injury. 7. Resident 15 was admitted to the facility on 5/8/01 with diagnoses which included Alzheimers, dyspnea, angina, anxiety and arrhythmias. Resident 15 resided on the facility's SCU. A review of resident 15's medical record was completed on 9/23/04. A quarterly MDS assessment was completed by facility staff on 7/8/04, documented that resident 15 had problems with her short and long term	F 224	Resident 15 Physical restraint consent updated 10/12/04. A. Orders obtained for physical therapy to re-evaluate on 9/29/04 B. Orders obtained to De SR's on 10/05/04 and apply low bed with bed alarm and lap buddy when up in wheel chair. Resident 15 Care plan updated with all incidences and fall risk scores. Resident has been put on the Timber program that flags residents high risk for falls.	

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F 224	Continued From page 72 term memory and her cognitive skills for daily decision making were moderately impaired. The facility staff documented that resident 15 was able to transfer with supervision and ambulate with limited assistance. The facility staff documented that resident 15 had fallen within the past 30 days and the last 31 to 180 days. On 4/20/04, facility nurse completed a "Fall Risk Assessment/Side Rail & Restraint Use" assessment. The facility nurse documented on the assessment a score of "16", which indicated that resident 15 was a high fall risk On 7/19/04, a facility nurse started a "Fall Risk Assessment/Side Rail & Restraint Use" assessment. The facility nurse documented on the assessment a score of "24", which indicated that resident 15 was a high fall risk. A review of resident 15's medical record, revealed a comprehensive care plan dated 2/16/04, addressing resident 15's fall risk. There was no documentation to evidence that the comprehensive plan of care had been updated by facility staff. On 4/22/04 at 8:30 PM, a nurse's note in resident 15's medical record documented the following entry: "Found on floor next to bed. Side rails [up] sm (small) red area on back [at] center waistline..." On 4/22/04, a facility nurse documented the following on a fax to resident 15's physician, "...[resident 15] found on floor [at] bedside..." On 4/22/04 at 8:30 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Found on floor	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465096	A. BUILDING _____ B. WING _____	9/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE COUNTRY CARE CENTER	1340 EAST 300 NORTH PRICE, UT 84501

(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 224	Continued From page 73 beside bed. Sm (small) reddened area on back [at] waist line..." On 5/30/04 at 7:00 PM, a nurse's note in resident 15's medical record documented the following entry: "Res (resident) FOF (found on floor) in rm (room) next to bed..." On 5/30/04 at 6:40 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Res (resident) found on floor in rm (room) next to bed..." On 5/30/04, a facility nurse documented the following on a fax to resident 15's physician, "[Resident 15] was found on floor [at] 1840 (6:40 PM) 5/30/04, it is unclear if she fell..." On 6/3/04 at 10:00 PM, a nurse's note in resident 15's medical record documented the following entry: "...Found on floor [at] 2130 (9:30 PM). Sitting on bottom..." There was no documentation that an "Incident/Accident Report" was completed regarding this fall. On 6/21/04 at 10:00 PM, a nurse's note in resident 15's medical record documented the following entry: "Resident wanted to get out of bed, was up in wheelchair, tried to get up and fell, sliding down wall..." On 6/21/04 at 10:00 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Wanted to get out of bed- was up in W/C (wheel chair) in front of nurses station- got up and slid down wall..." On 7/9/04, a facility nurse documented the following on an "Incident/Accident Report": "...Fell in DR (dining room) at 9:15 PM. Pt	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. BUILDING _____ B. WING _____	9/28/2004

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F 224	Continued From page 74 (patient) has sat herself on floor several times nobody witnessed fall..." On 7/10/04, day shift, a nurse's note in resident 15's medical record documented the following entry: "CNA (certified nursing assistant) reported to nurse the res (resident) had fallen on 7/9 eve (evening) shift, 7/9 CNA documented following 'fell in DR (dining room) at 9:15 (9:15 PM)', eve nurse assessed pt (patient). Pt has sat herself down on the floor several times in the past, nobody witnessed fall..." On 8/3/04 at 8:30 PM, a nurse's note in resident 15's medical record documented the following entry: "Found on floor in DR (dining room)..." On 8/3/04 at 8:20 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) found sitting on floor in dining room..." On 8/3/04, a facility nurse documented the following on a fax to resident 15's physician, "[Resident 15] was found on the floor in DR (dining room)..." Based on the documentation it was determined that resident 15 had 6 falls from 4/22/04 until 8/3/04. All six of the falls occurred on the evening shift. There was no documentation to provide evidence that facility staff developed interventions, individualized to resident 15's needs to reduce her falls or to minimize potential injury. 6. Resident CL6 was admitted to the facility on 5/17/04 with diagnoses which included pneumonia, CVA (cardiovascular accident or	F 224	Resident CL 6 was discharged.	

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F 224	Continued From page 75 "stroke") with depressive features, intracranial hemorrhage, and progressive Alzheimer's disease. A review of resident CL6's medical record was completed on 9/23/04. An admission MDS assessment completed by facility staff on 5/30/04, documented that resident CL6 had short and long term memory problems and that her cognitive skills for daily decision making were moderately impaired. The facility staff documented that resident CL6 required extensive assistance with transfers, ambulation, eating, toilet use and personal hygiene. The facility staff documented that resident CL6 had no fall accidents in the past 180 days. On 5/17/04, a facility nurse completed a "Fall Risk Assessment/Side Rail & Restraint Use" assessment for resident CL6. The facility nurse documented on the assessment a score of "17", which indicated that resident CL6 was a high fall risk. A review of resident CL6's medical record, revealed a comprehensive care plan dated 6/3/04, addressing resident CL6's fall risk. There was no documentation to evidence that the comprehensive plan of care had been updated by facility staff. On 6/18/04 at 10:00 AM, a nurse's note in resident CL6's medical record documented the following entry: "Aid [sic] reported pt (patient) slid out of bath chair. Skin tere [sic] sustained to [left] arm..." There was no documentation that an "Incident/Accident Report" was completed regarding this fall.	F 224		

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F 224	Continued From page 76 On 6/18/04, a facility nurse documented the following on a fax to resident CL6's physician, "...slid out of shower chair on to bottom. Skin tear to left arm below elbow..." On 6/24/04 at 6:00 AM, a nurse's note in resident CL6's medical record documented the following entry: "Pt (patient) being toileted when sitting down she missed seat [and] sat on floor between wall [and] toilet without injury apparent,..." On 6/24/04 at 6:00 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) assisted to toilet, aide then left to get brief pt sat down [and] missed toilet seat sitting down on floor..." On 6/26/04, a nurse's note in resident CL6's medical record documented the following entry: "Had anew [sic] incident. [facility aide] went into her room and found her sitting on floor next to bed..." There was no documentation that an "Incident/Accident Report" was completed regarding this fall. On 6/28/04 at 12:00 PM, a nurse's note in resident CL6's medical record documented the following entry, "Pt (patient) found sitting on floor in front of w/c (wheelchair). Said 'I slid out of chair...'" There was no documentation that an "Incident/Accident Report" was completed regarding this fall. On 7/7/04 at 10:30 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) slipped out of restraint, walked to door of room [and] slid down wall to floor..."	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. BUILDING _____ B. WING _____	9/28/2004

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F 224	Continued From page 77 On 7/25/04 at 2:00 PM, a nurse's note in resident CL6's medical record documented the following entry, "Found pt (patient) lying on floor..." On 7/25/04, a facility nurse documented the following on an "Incident/Accident Report": "...Found patient lying on floor. Chest restraint still attached to chair..." On 7/26/04 at 8:00 PM, a nurse's note in resident CL6's medical record documented the following entry: "After shower CNA (certified nursing assistant) was getting her slippers out of closet and [resident CL6] got out of chair (shower chair) and fell on [left] buttocks..." On 7/26/04, a facility nurse documented the following on an "Incident/Accident Report": "...After shower aide turned to get slippers from closet. Pt (patient) got up and fell...Fell on [left] hip/buttocks- no bruise yet. Skin tear [left] elbow..." On 7/29/04 at 5:30 PM, a nurse's note in resident CL6's medical record documented the following entry: "Pt (patient) untied restraint stood [up] nurse caught pt to break fall, w/c (wheelchair) landed on pt (patient) sm (small) skin tear [right] elbow..." On 7/29/04 at 5:30 PM, a facility nurse documented the following on an "Incident/Accident Report": "Pt (patient) untied restraint from w/c (wheelchair) stood up- Nurse caught patient to break fall, w/c (wheelchair) fell on pt caused sm (small) skin tear [right] elbow..." On 8/22/04 at 11:30 AM, a nurse's note in resident CL6's medical record documented the following entry: "Pt (patient) found with wheel	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465093	A. BUILDING _____ B. WING _____	9/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 78 chair tip over on her. Restraints were still on..." On 8/22/04 at 11:30 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Found pt (patient) in room tipped over in wheel chair restraints were still on..." Based on the documentation, it was determined that resident CL6 had 9 falls from 6/18/04 until 8/22/04. five of the falls occurred on the day shift, two of the fall occurred on the evening shift, one of the falls occurred on the night shift and one of the falls did not have any documentation as to what time it occurred. There was no documentation to provide evidence that facility staff developed interventions, individualized to resident CL6's needs to reduce her fall's or to minimize potential injury Residents who had potential for experiencing harm as a result of falls included the following: 9. Resident 4 was admitted to the facility on 11/28/04 with the diagnoses of pre-senile dementia, Alzheimers, falls, and hypothyroidism. A review of resident 4's medical record was completed on 9/23/04. A quarterly MDS assessment dated 8/21/04 documented that resident 4 had short and long term memory problems and her cognitive skills for daily decision making were moderately impaired. The facility staff documented that resident 4 was able to transfer with limited assistance and ambulate with limited to extensive assistance. Facility staff also documented that resident 4 had a fall in the past 30 days and the	F 224	Resident 4 Bed entrapment updated on 9/22/04. A. Order for physical therapy re-evaluation for restraints 9/29/04 update. B. Dc seat belt while up in wheel chair. C. Ordered low bed, with bed alarm and wheel chair alarm on 10/06/04 D. Physical restraint consent updated 10/07/04. E. Monthly Summary... D.O.N. to inservice all nursing staff 10/28/04 on documenting skills. F. Order obtained 10/06/04 to Dc SR's. Resident 4 care plan updated with fall dates applied. Resident has been put on the Timber program that flags residents high risk for falls.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. BUILDING _____ B. WING _____	05/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 79 last 31-180 days. On 2/24/04, a facility nurse completed a "Fall Risk Assessment/Side Rail & Restraint Use" assessment for resident 4. The facility nurse documented on the assessment a score of "21", which indicated that resident 4 was a high fall risk. On 5/25/04, a facility nurse completed a "Fall Risk Assessment/Side Rail & Restraint Use" assessment for resident 4. The facility nurse documented on the assessment a score of "21", which indicated that resident 4 was a high fall risk. On 8/16/04, a facility nurse completed a "Fall Risk Assessment/Side Rail & Restraint Use" assessment for resident 4. The facility nurse documented on the assessment a score of "19", which indicated that resident 4 was a high fall risk. A review of resident 4's medical record, revealed a comprehensive care plan dated 11/23/04, addressing resident 4's fall risk. There was no documentation to evidence that the comprehensive plan of care had been updated by facility staff. On 12/12/03 at 10:00 PM, a nurse's note in resident 4's medical record documented the following entry: "CNA (certified nurses assistant) reported finding Pt (patient) on floor next to w/c (wheel chair)..." On 12/12/04, a facility nurse documented the following on an "Incident/Accident Report": "...CNA (certified nurses assistant) reported finding pt (patient) on floor sitting below w/c	F 224		

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	465090	A. BUILDING _____ B. WING _____	1/29/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 80 (wheel chair) on her buttocks ..." On 12/31/03 at 2:30 AM, a nurse's note in resident 4's medical record documented the following entry: "pt (patient) found kneeling on floor beside bed states 'I don't know how I got here' no injuries noted..." On 12/31/03, a facility nurse documented the following on an "Incident/Accident Report": "...pt. (patient) found on floor beside bed. No injuries noted pt states 'I don't know how I got here,' bed alarm had been removed..." On 1/3/04 at 10:10 AM, a nurse's note in resident 4's medical record documented the following entry: "pt (patient) found on floor of BR (bathroom) Belt restraint removed by pt. Pt stated she was going to BR and lost her balance sliding down the door to the floor. Red area noted [left] upper back from door knob ..." On 1/3/04 at 10:10 AM, a facility nurse documented the following on an "Incident/Accident Report": "...pt (patient) stated she was going to the BR (bathroom) and lost her balance sliding down the door..." On 1/3/04 at 6:00 PM, a nurse's note in resident 4's medical record documented the following entry: "...some c/o (complaints of) back upper discomfort." On 1/9/04 at 5:45 AM, a nurse's note in resident 4's medical record documented the following entry: "aides found pt (patient) on buttocks between wc (wheel chair) [and] toilet, pt states she was moving to wc when she slipped and fell to buttocks, denies pain..."	F 224		

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	465088	A. BUILDING _____ B. WING _____	03/28/2004

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F 224	Continued From page 81 On 1/9/04 at 5:45 AM, a facility nurse documented the following on an "Incident/Accident Report": "...aides found pt (patient) on buttocks between wc (wheel chair) [and] toilet, pt states she was transferring to wc when she slipped and fell to floor. Pt wc was up against sink..." On 1/15/04 at 5:40 AM, a nurse's note in resident 4's medical record documented the following entry: "found sitting on floor below bed, bed rails up X (times) 2..." On 1/15/04 at 5:40 AM, a facility nurse documented the following on an "Incident/Accident Report": "...pt (patient) found sitting on buttocks below left bed corner, states she doesn't know how she got there. [no] s/s (signs and symptoms) injury...pt confused crawled out [at] end of bed..." On 3/3/04 at 4:15 AM, a nurse's note in resident 4's medical record documented the following entry: "...found pt (patient) on floor laying on [right] side, pt c/o (complains of) bump on [right] side of head above ear, slight swelling noted, [no] abrasion...will monitor for 72 [hours] [with] neuro ck (check) [secondary] head bump." On 3/3/04, a facility nurse documented the following on an "Incident/Accident Report": "...aide responded to light found pt (patient) on floor on right side, pt stated she climbed over bottom of bed [and] fell striking right side of head...Type of injury Hematoma.. " On 3/3/04, a facility nurse documented on a fax to resident 4's physician, "Your pt (patient), [resident 4] was found on [right] side on floor below bed...pt stated she climbed over bottom of bed. Pt	F 224		

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	465098	A. BUILDING _____ B. WING _____	9/28/2004

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F 224	Continued From page 82 sustained small bump on [right] side of head above ear..." On 3/17/04 at 9:30 PM, a nurse's note in resident 4's medical record documented the following entry: "found pt (patient) on floor by bed, pt states she wanted up [and] fell..." On 3/17/04 at 9:30 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) got self oob (out of bed) [and] slid to floor - unwitn incident..." On 5/22/04, a nurse's note in resident 4's medical record documented the following entry: "Pt (patient) found sitting on floor..." On 5/22/04 at 8:00 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Found on floor by member of kitchen staff member..." On 5/31/04 at 3:00 PM, a nurse's note in resident 4's medical record documented the following entry: "pt (patient) found on floor by bed, pt states she slid out under w/c (wheel chair) restraint, tried to put self to bed..." On 5/31/04 at 3:00 PM, a facility nurse documented the following on an "Incident/Accident Report": "...pt (patient) found on floor by bed - states she slid out of chair restraint [and] was trying to put self to bed..." On 6/30/04 at 6:00 AM, a nurse's note in resident 4's medical record documented the following entry: "During routine end of shift bed checks aide found pt (patient) sitting cross legged sitting on the floor...."	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. BUILDING _____ B. WING _____	07/28/2004

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F 224	Continued From page 83 On 6/30/04 at 6:00 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Aide found pt (patient) sitting cross legged below open side of bed below bed rail...pt removed bed alarm...." Based on documentation it was determined that resident 4 had 10 falls from 12/12/03 to 6/30/04. One of the falls occurred on the day shift, four of the falls occurred on the evening shift and five of the falls occurred on the night shift. There was no documentation of evidence that facility staff developed interventions, individualized to resident 4's needs to reduce her falls or to minimize potential injury. 10. Resident 11 was admitted to the facility on 8/2/04 with the diagnoses of cellulitis of face, atrial fibrillation, hypertension, congestive heart failure with anxious features, and edema. A review of resident 11's medical record was completed on 9/23/04. An admission MDS assessment completed by facility staff on 8/15/04, documented that resident 11 had short term memory problems and her cognitive skills for daily decision making were moderately impaired. The facility staff documented that resident 11 was able to transfer with extensive assistance and ambulate on the unit with supervision. The facility staff documented that resident 11 had no fall accidents in the past 180 days. On 8/2/04, a facility nurse completed a "Fall Risk Assessment/Side Rail & Restraint Use" assessment for resident 11. The facility nurse	F 224	Resident 11 Entrapment risk updated 9/22/04. A. order for physical restraint evaluation per physical therapy 9/22/04. B. Evaluation completed per physical therapy 9/29/04. C. Recommended Dc'ing SR's appl bed alarm. Keep lap buddy due to patient request. D. Orders received 10/05/04 to Dc SR's, bed alarm applied. E. Nurse to document Weekly soap notes of resident's ability to remove and replace lab buddy and also note on ts rend. F. D.O.N. to hold inservice on 10/28/04 covering documentation skills. Resident 11 care plan updated with all' incedances. Resident has been put on the Timber program that flags residents high risk for falls.	

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	465098	A. BUILDING _____ B. WING _____	9/28/2004

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F 224	Continued From page 84 documented on the assessment a score of "23", which indicated that resident 11 was a high fall risk. A review of resident 11's medical record, revealed a comprehensive care plan dated 8/25/04, addressing resident 11's fall risk. There was no documentation to evidence that the comprehensive plan of care had been updated by facility staff. On 8/5/04 at 3:15 AM, a nurse's note in resident 11's medical record documented the following entry: "Aide was assisted pt (patient) ambulate to bathroom, as he reached to turn on bathroom light, pt lost balance [with] walker fell backwards hitting back on wall [and] slid to floor, striking [left] dorsal arm on garbage can as well as [left] rib cage causing skin tear to [left] dorsal arm and redness to rib cage...." There was no documentation that an "Incident/Accident Report" form was completed regarding this fall. On 8/19/04 at 9:00 PM, a nurse's note in resident 11's medical record documented the following entry: "I walked by pt (patient) room [and] found her lying on floor..." On 8/19/04 at 8:30 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Walked by room, found pt. (patient) laying on floor..." On 8/27/04, a facility nurse documented on a fax to resident 11 physician, "I found pt. (patient) lying on floor when I walked by her room. She had no s/s (signs and symptoms) of injuries...Lap belt restraint was still attached to wheelchair. She stated she had [no] pain."	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. BUILDING _____ B. WING _____	9/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE COUNTRY CARE CENTER	1340 EAST 300 NORTH PRICE, UT 84501

(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 224	Continued From page 85 On 9/4/04 at 11:30 PM, a nurse's note in resident 11's medical record documented the following entry: "pt (patient) found on floor. States she slipped trying to return to bed from BR (bathroom)..." On 9/4/04 at 11:15 PM, a facility nurse documented the following on an "Incident/Accident Report": "...pt (patient) found on floor in Room states 'I got up to go to the bathroom and fell when I tried to get back into bed'...." Based on documentation it was determined that resident 11 had 3 falls from 8/5/04 to 9/4/04. Two of the falls occurred on the evening shift and the other fall occurred on the night shift. There was no documentation of evidence that facility staff developed interventions, individualized to resident 11's needs to reduce her falls or to minimize potential injury. 11. Resident 12 was admitted to the facility on 1/28/04 with diagnoses which included left BKA (below-the-knee amputation), arteriosclerosis, hypertension and pre senile dementia. On 9/20/04, during the entrance tour of the facility, a facility nurse stated that resident 12 had fallen after she had her leg amputated because she would forget the leg was gone and try to stand up. On 9/22/04 at approximately 10:25 AM, resident 12 was interviewed by a nurse surveyor. Resident 12 was able to recount the recent events of her illness. Resident 12 stated that when she came back to the facility after her amputation she fell many times: "eight times in	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465090	A. BUILDING _____ B. WING _____	9/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 224	Continued From page 86 one day right over there in that corner." Resident 12 was asked what action the facility had taken after the falls to "keep you safe or help you". Resident 12 replied "they kept adjusting my medicine". A review of resident 12's medical record was completed on 9/23/04. A Medicare 5 day MDS assessment completed by facility staff on 2/4/04, documented that resident 12's cognitive skills for daily decision making were modified independent. The facility staff documented that resident 12 required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. The facility staff documented that resident 12 had fallen within the last 31 to 180 days. On 3/23/04, a facility nurse completed a "Fall Risk Assessment/Side Rail & Restraint Use" assessment for resident 12. The facility nurse documented on the assessment a score of "17", which indicated that resident 12 was a high fall risk. On 7/1/04, a facility nurse completed a "Fall Risk Assessment/Side Rail & Restraint Use" assessment for resident 12. The facility nurse documented on the assessment a score of "19", which indicated that resident 12 was a high fall risk. A review of resident 12's medical record, revealed a comprehensive care plan dated 2/17/04, addressing resident 12's fall risk. There was no documentation to evidence that the comprehensive plan of care had been updated by facility staff.	F 224	Resident 12 care plan has been updated with all incidences re-falls. A. Resident 12 was assessed for fall risk and restraints, none were needed at this time. Resident has been put on the Timber program that flags residents high risk for falls Bed moved against wall per resident request. No side rails on bed. Physical Therapy working with resident with her prosthesis to improve balance to decrease fall risk.	

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	465098	A. BUILDING _____ B. WING _____	9/28/2004

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F 224	Continued From page 87 On 3/20/04 at 9:30 AM, a facility nurse documented the following on an "Incident/Accident Report": "...CNA (certified nursing assistant) reported pt (patient) fell to floor [and] hitting stump to [left] leg while attempting to stand. Pt c/o (complains of) sharp shooting pains, to knee...". On 3/22/04 at 10:15 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Attempting to transfer to chair alone, wheelchair slid she landed on floor on knees then bottom...Sore on [right and left] knee..." On 3/29/04 at 10:30 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Patient up [without] asking for assistance opening blinds [and] fell...mild c/o (complaints of) pain..." On 4/14/04 at 9:00 PM, a nurse's note in resident 12's medical record documented the following entry: "Res (resident) tried to transfer herself from bed to W/C (wheelchair), res has been confused the last while..." There was no documentation that an "Incident/Accident Report" was completed regarding this fall. On 4/17/04 at 7:00 PM, a nurse's note in resident 12's medical record documented the following entry: "[at] 1830 (6:30 PM) res (resident) was found on floor next to bed, res states 'I flipped out of bed', appear res rolled out of bed, res states she hit her head..." On 4/17/04 at 6:30 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Res (resident) states 'I flipped out of bed', it appears res rolled	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. BUILDING _____ B. WING _____	9/28/2004

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F 224	Continued From page 88 out of bed- res very confused, disoriented- res lethargic at fall- states she hit her head..." On 4/20/04 at 11:45 AM, a nurse's note in resident 12's medical record documented the following entry: "Found pt (patient) to side of bed on knees...Noted pt had tried to transfer herself...Blanket [and] pillow were under pt knees when she was found..." There was no documentation that an "Incident/Accident Report" was completed regarding this fall. On 5/16/04 at 10:00 PM, a nurse's note in resident 12's medical record documented the following entry: "[at] 2115 (9:15 PM) res (resident) FOF (found on floor) next to closet..." There was no documentation that an "Incident/Accident Report" was completed regarding this fall. On 6/11/04 at 2:30 AM, a nurse's note in resident 12's medical record documented the following entry: "Aide responding to noc (night) noise found pt (patient) on buttocks on floor states she was transferring to WC (wheelchair) to toilet when WC overturned and dumped her on her knees and then to floor...C/O (complains of) knee pain..." On 6/11/04 at 2:30 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) found on buttocks on floor stated she was transferring to wc (wheelchair) for toileting when wc over-turned striking knees c/o (complaints of) stump pain..." Based on the documentation, it was determined that resident 12 had 8 falls from 3/20/04 until 6/11/04. Three of the falls occurred on the day	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465036	A. BUILDING _____ B. WING _____	03/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 224	Continued From page 39 shift, four of the falls occurred on the evening shift and one of the falls occurred on the night shift. There was no documentation to provide evidence that facility staff developed interventions, individualized to resident 12's needs to reduce her falls or to minimize potential injury 12. Resident CL2 was admitted to the facility on 8/24/02 with the diagnoses of prostate cancer, congestive heart failure, asthma, insulin dependant diabetes mellitus, and Parkinson's disease. A review of resident CL2's medical record was completed on 9/23/04. A significant change MDS assessment, completed by facility staff on 6/3/04, documented that resident CL2 had short and long term memory problems and his cognitive skills for daily decision making were moderately impaired. The facility staff documented that resident CL2 was able to transfer and ambulat e with extensive assistance. Facility staff documented that resident CL2 had a fall within the past 30 days and the last 31-180 days. A review of resident CL2's medical record, revealed that a "Fall Risk Assessment/Side Rail & Restraint Use" assessment, addressing resident CL2's fall risk, could not be found. A review of resident CL2's medical record, revealed that a comprehensive care plan, addressing resident CL2's fall risk, could not be found. On 3/25/04 at 2:15 PM, a facility nurse	F 224	Resident CL2 was discharged.	

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	465098	A. BUILDING _____ B. WING _____	5/28/2004

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F 224	Continued From page 90 documented the following on an "Incident/Accident Report": "...Pt (patient) leaned over in w/c(wheel chair) to pick something off the floor [and] slid out of w/c - landing on buttocks .." On 4/12/04 at 10:00 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) stated he fell onto buttocks while trying to walk back to bed from bathroom..." On 4/14/04 at 2:45 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) found lying on back in doorway to BRoom (bathroom), states going to BR (bathroom) when he slipped to his buttocks and then laid back on floor..." On 5/19/04 at 2:45 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) found lying supine in street clothes, jacket half on...states [left] arm hurts..." On 5/20/04 at 10:00 AM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) found on floor by side of bed. Said he slid out of bed..." On 5/26/04 at 5:40 AM, a nurse's note in resident CL2's medical record documented the following entry: "pt (patient) found on floor, states 'I was getting up'..." On 5/26/04 at 5:40 AM, a facility nurse documented the following on an "Incident/Accident Report": , "...Pt (patient) found on floor [at] 0540 (5:40 AM) states 'I was getting up...'	F 224		

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	465098	A. BUILDING _____ B. WING _____	9/28/2004

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F 224	Continued From page 91 On 5/27/04 at 7:00 PM, a nurse's note in resident CL2's medical record documented the following entry: "pt (patient) found on floor by bed..." On 5/27/04 at 7:00 PM, a facility nurse documented the following on an "Incident/Accident Report": "...Pt (patient) found on floor by bed. States he tried to get [up]..." Based on documentation it was determined that resident CL2 had 7 falls from 5/25/04 to 5/27/04. Three of the falls occurred on the day shift, one of the falls occurred on the evening shift and three of the falls occurred on the night shift. There was no documentation of evidence that facility staff developed interventions, individualized to resident CL 2's needs to reduce his falls or to minimize potential injury. 13. Resident CL4 was admitted to the facility on 4/30/04 with the diagnoses of intestinal obstruction, pure hypercholesterolemia, hypertension, and constipation. A review of resident CL4's medical record was completed on 9/23/04. A significant change MDS assessment, completed by facility staff on 5/13/04, documented that resident CL4 had short and long term memory problems and his cognitive skills for daily decision making were moderately impaired. The facility staff documented that resident CL4 was able to transfer and ambulate with extensive assistance. The facility staff documented that resident CL4 had fallen within the past 30 days. On 5/18/04, a facility nurse completed a "Fall Risk Assessment/Side Rail & Restraint Use"	F 224	Resident CL 4 was discharged.	

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	465093	A. BUILDING _____ B. WING _____	9/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE COUNTRY CARE CENTER	1340 EAST 300 NORTH PRICE, UT 84501

(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 224	Continued From page 92 assessment for resident CL4. The facility nurse documented on the assessment a score of "8", which indicated that resident CL4 was a low fall risk. A review of resident CL4's medical record, revealed a comprehensive care plan dated 5/18/04, addressing resident CL4's fall risk. There was no documentation to evidence that the comprehensive plan of care had been updated by facility staff. On 5/11/04, a facility nurse documented one of resident CL4's falls on an "Incident/Accident Report": "...Resident was in P/T (physical therapy) rest room got off of the toilet [and] was transferring to w/c by his (sic) self. Call light was in reach P/T (physical therapy) staff was in room...." On 6/26/04 at 11:45 PM, a nurse's note in resident CL4's medical record documented the following entry: "Pt (patient) found on floor in front of chair [with] door closed, states he slid to floor." On 6/26/04 at 11:45 PM, a facility nurse documented the following on an "Incident/Accident Report": "...pt (patient) removed bed alarm [and] climbed over bed rail..." Based on documentation it was determined that resident CL4 had 2 falls from 5/11/04 to 6/26/04. One of the falls occurred on the day shift and the other fall occurred on the evening shift. There was no documentation of evidence that facility staff developed interventions, individualized to resident CL4's needs to reduce his falls or to minimize potential injury.	F 224		

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	465098	A. BUILDING _____ B. WING _____	9/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE COUNTRY CARE CENTER	1340 EAST 300 NORTH PRICE, UT 84501

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F 224	Continued From page 93 Interviews: On 9/22/04, a facility nurse who worked the SCU was interviewed. She stated that usually when a resident had a fall a nursing assistant witnessed it. She stated that the nursing assistant would get a nurse. She stated that the nurse would then complete an assessment of the resident. The facility nurse stated that an assessment consisted of assessing for injury, mental status and vital signs. She stated that after a resident experienced a fall, it would be passed on to the next shifts and the resident would be charted on every shift for 72 hours. The facility nurse further stated that the nursing assistants see the most so they were the ones who would let the nurses know what the nurses might need to watch for. On 9/22/04 at 12:40 PM, the DON was interviewed. She stated that when a resident had a fall they were to be assessed by a nurse, the doctor and family were to be called, an incident report would be completed, and if needed, there may be a change to the resident's psychoactive medications. The DON further stated that when a resident has had a fall they were charted on every shift for 72 hours. The DON stated that she had been watching falls and had felt there had been a decline in the falls since March of 2004. The DON further stated that the SCU was staffed with a nursing assistant at all times and that the unit should not be left unattended.	F 224		
F 253 SS=E	483.15(h)(2) ENVIRONMENT The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465093	A. BUILDING _____ B. WING _____	9/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE COUNTRY CARE CENTER	1340 EAST 300 NORTH PRICE, UT 84501

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F 253	Continued From page 94 This Requirement is not met as evidenced by: Based on observation, the facility did not provide housekeeping and maintenance services necessary to maintain sanitary, orderly and comfortable interior(s) as evidenced by inadequate housekeeping and maintenance findings in fifteen of twenty-five resident rooms and resident common areas in three of three wings of the facility. Findings include: Observations of the facility's occupied resident rooms and resident common areas during the re-certification survey conducted 9/20/04 through 9/23/04, revealed the following: Rooms 201, 203, 204, 205, 206, 207, 208, 209, 210, and 212 were observed to have closet doors without pull knobs or handles and dresser drawers without drawer pulls. The bathroom between Rooms 201 and 203 was observed to have brown stains around the base of the toilet. The exhaust fan cover was observed to be covered with lint-like material. The sink faucet was observed to be dripping continuously. The common shower room between Rooms 207 and 209 was observed to have no cover over the wall thermometer. There were two small holes noted in the wall drywall where a towel bar had apparently become detached. Three 2 X 2 inch pieces of floor tile were broken. The bathroom for Room 209 was observed to have a fan cover hanging loose from the ceiling. The bathroom floor had gray and brown stains near the toilet base.	F 253	F 253 1. Maintenance to follow A calendar of cleaning schedule to clean carpets and buff floors on a monthly basis. 2. Floors, drawer handles, faucets, thermostats, windows, floor tiles, and walls to be on maintenance rounds sheet. Maintenance will monitor weekly. 3. Maintenance will address identified problems obtained though his rounds in QA committee meeting monthly. All handles on doors and drawers of closets have been removed for safety. On rooms: 201,203,204,205,206,207,208,209, 210,212 completed 10/19/04. Bathroom floor between rooms 201and 203 needs replaced Will be repaired by 11/15/04 Bathroom between rooms 201and 203 Fan cover cleaned 10/19/04 Faucet gasket replaced.10/19/04 The shower room between room 207 and 209 Thermostat cover has been replaced.10/19/04 Towel bar replaced and holes patched. 10/19/04 Need to replace broken tile pieces. Will be repaired by 11/15/04 Bathroom for room 209 Fan cover was secured. 10/19/04 Floor was replaced. 10/20/04	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465099	A. BUILDING _____ B. WING _____	2/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE COUNTRY CARE CENTER	1340 EAST 300 NORTH PRICE, UT 84501

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F 253	Continued From page 95 Near the common dining room area designated "Castle Country Cafe", two nails were observed to be protruding from the wall near the entrance door. Walls were scratched at a height of approximately two feet from the floor. A glass pane in the corner of the window had been cracked and was secured in the window pane by tape. The bathroom near the common dining room area on the 200 Hall was observed to have brown and gray stains on the floor near the base of the toilet. The bathroom near Rooms 208 and 206 was observed to have gray stains around the toilet base. The bathroom near Room 204 was observed to have brown and gray stains around the toilet base. The carpet covering the common area hallway on the 200 Hall was observed to be soiled and stained throughout the length of the hallway. 1. Near the entry to Room 212, a dark brownish colored stain approximately 15 inches in diameter was observed. This stain was observed to be seeping a faint reddish material in a 6 inch diameter area in its center. 2. Between Rooms 204 and 206, on the north side of the hallway, dark blackish stains were observed on the carpet. 3. On both sides of the hallway, in front of Room 201 and in front of the common area television room opposite Room 201, dark blackish stains were observed on the carpet. Rooms 304 and 306 were both observed to have	F 253	Near the Dinning room Nails were removed 10/19/04 Walls painted 10/20/04 Window has been repaired The dinning room bathroom Floor has been replaced 10/15/04 Bathroom near rooms 206 and 208 Floor needs replaced Will be repaired by 11/15/04. The above to be in effect 11/15/04 Bathroom near room 204 floor was replaced 10/21/04 Carpet being cleaned 10/20/04 Cleaned regularly every two weeks 200 hall carpet Stains on floor cleaned 10/19/04	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465092	A. BUILDING _____ B. WING _____	9/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE COUNTRY CARE CENTER	1340 EAST 300 NORTH PRICE, UT 84501

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F 253	Continued From page 96 black stains at tile edges the length of their entry areas and approximately eight inches into the entryway. The baseboard molding near the north side of Room 304's entry and the baseboard molding near the south side of Room 306's entry were observed to have black stains above the baseboard molding. The entry areas for these rooms border the common shower area for Hall 300.	F 253	Rooms 304 and 306 Walls above base board painted. 10/19/04 Leaks in shower have been repaired. 10/15/04 4.All Bathroom floors in the facility have been checked and a list of those that need replaced made up. Will replace over the next 3 months. 5.The above to be in effect 11/15/04	
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This Requirement is not met as evidenced by: Based on observation and interview, it was determined that the facility did not store, distribute and serve food under sanitary conditions. Findings included: The following observations were made during the initial kitchen tour completed on 9/20/04 from 3:15 PM until 3:30 PM. Refrigerator in kitchen: 1. A container of chili beans, dated 9/15/04. 2. A container of cottage cheese, with a manufacturer use by date 9/13/04, dated 9/15/04. 3. An opened package of orange cheese, dated 9/15/04. 4. An opened package of white cheese, which had no date.	F 371	F 371 1. On 9/20/04 the following finding were corrected and stored properly: The orange juice and fruit juice was labeled and dated. The can of isosource, oranges, and apples were discarded from the nursing unit fridge. The fridge was cleaned on9/20/04. The can of chili beans, cottage cheese, and cheese were all discarded on 9/20/04. The freezer items including all meat and packages were all clearly labeled with package contents. 2. On 9/22/04 Dietary employees were inserviced by registered dietitian regarding proper storage of food. The facility "left over" policy was reviewed and will remain posted for reference.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465038	A. BUILDING _____ B. WING _____	9/28/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLE COUNTRY CARE CENTER	1340 EAST 300 NORTH PRICE, UT 84501

(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 371	Continued From page 97 5. A container of ice tea, dated 9/15/04. Freezer in kitchen: 1. A brown bag, which had no label. 2. A clear package of breaded patties, which had no label. 3. Ten clear bags of meat, which had no label. 4. Four white packages of meat, which had no label. On 9/20/04 at 4:00 PM, the following observations were made of the unit refrigerator. 1. A container of orange juice, which had no label and no date. 2. A container of fruit juice, which had no label and no date. 3. A can of Isosource, which had an expiration date of July, 04. 4. Three oranges, which were bruised and discolored. 5. Two apples, which were bruised and discolored. 6. The bottom of the refrigerator had red sticky spots.	F 371	3. Additional measures in place to ensure continuing compliance include: A. Registered dietitian will complete a report monthly including sanitation check of all refrigerator/freezer units for proper food storage. B. A copy of report will be given to Administrator for continued quality assurance. C. All frozen food will be stored in original boxes or removed and clearly labeled. D. Dietary staff will check nursing and unit fridge daily, (when being restocked), for proper food storage. E. A cleaning schedule along with fridge inspection for proper food storage will be posted at nursing unit station and to be completed as posted. Dietary supervisor will oversee this. This plan of correction to be in effect OCT. 22, 2004.	
F 387 SS=E	483.40(c)(1)&(2) PHYSICIAN SERVICES The resident must be seen by a physician at least once every 30 days for the first 90 days after	F 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465093	A. BUILDING _____ B. WING _____	9/28/2004

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F 387	Continued From page 98 admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This Requirement is not met as evidenced by: Based on record review and interview, it was determined that 6 of 13 sample residents (Resident 3, 4, 5, 6, 7 and 8) were not seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days as required. Findings include: 1. Resident 3 was re-admitted to the facility on 10/1/03 with diagnoses which included sepsis, hypertension and dementia. A review of resident 3's medical record revealed that the resident had been seen by a physician on 2/9/04, 3/11/04, 3/19/04, 4/19/04, 5/17/04, 5/19/04 and 8/25/04. Resident 3 should have been seen by a physician on or around 7/19/04. There was no documentation in the medical record to provide evidence that resident 3 had been seen by a physician on or around 7/19/04. 2. Resident 4 was admitted to the facility on 11/28/03 with diagnoses of pre-senile dementia, Alzheimers, falls, and hypothyroidism. A review of resident 4's medical record revealed that the resident had been seen by a physician on 12/9/03, 1/8/04, 2/10/04, 7/13/04, and 9/13/04.	F 387	F 387 1. Medical Records will maintain a physician visit log on all residents to ensure physician visits are scheduled and done in a timely manner with in regulations. 2. All residents progress notes have been reviewed to ensure compliance. 3. This log will be reviewed in QA committee meeting by Medical Records and the Administrator every month. The above to be in effect by 11/15/04 1. Resident 3 was seen 9/22/04 will be seen again 11/17/04. 2. Resident 4 was seen 10/01/04 will be seen again 12/03/04. 3. Resident 5 was seen 8/31/04 will be seen 10/04. Dr. sees patient at Castle Country Care Center. 4. Resident 6 was seen 8/08/04 will be seen 10/04. Dr. sees patient at Castle Country Care Center. 5. Resident 7 was seen 8/31/04 will be seen again 10/04. Dr. sees patient at Castle Country Care Center. 6. Resident 8 was seen 8/31/04 seen again at ER per Dr. Potter on 9/22/04. Expired 9/28/04.	

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F 387	Continued From page 99 Resident 4 should have been seen by a physician on or around 4/10/04 and 6/10/04. There was no documentation in the medical record to provide evidence that resident 4 had been seen by a physician on or around 4/10/04 and 6/10/04. 3. Resident 5 was admitted to the facility on 9/7/01 with the diagnoses of diabetes mellitus, hemiplegia, senile dementia, congestive heart failure, hypertension, and diabetic neuropathy. A review of resident 5's medical record revealed that the resident had been seen by a physician on 10/12/03, 12/19/03, 1/30/04, 2/18/04, 5/27/04, 5/31/04 and 8/25/04. Resident 5 should have been seen by a physician on or around 4/18/04 and 7/27/04. There was no documentation in the medical record to provide evidence that resident 5 had been seen by a physician on or around 4/18/04 and 7/27/04. 4. Resident 6 was re-admitted to the facility on 11/17/02 with the diagnoses of sepsis, nausea, hypertension, chronic renal failure, constipation, diabetes mellitus, gastroesophageal reflux disease, and congestive heart failure. A review of resident 6's medical record revealed that the resident had been seen by a physician on 9/30/03, 1/28/03, 5/31/04 and 8/8/04. Resident 6 should have been seen by a physician on or around 11/30/03 and 3/28/04.	F 387		

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	465098	A. BUILDING _____ B. WING _____	7/28/2004

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F 387	Continued From page 100 There was no documentation in the medical record to provide evidence that resident 6 had been seen by a physician on or around 11/30/04 and 3/28/04. 5. Resident 7 was admitted to the facility on 5/6/04 with diagnoses which included pulmonary insufficiency, closed fracture dorsal spine, and diabetes mellitus Type I. A review of resident 7's medical record revealed that the resident had been seen by a physician on 5/14/04 and 5/31/04. Resident 7 should have been seen by a physician on or around 6/31/04 and 8/31/04. There was no documentation in the medical record to provide evidence that resident 7 had been seen by a physician after 5/31/04 6. Resident 8 was admitted to the facility on 5/8/03 with diagnoses which included congestive heart failure, hypertension, pneumonia and Alzheimers. A review of resident 8's medical record revealed that the resident had been seen by a physician on 9/30/03, 10/17/03, 12/29/03, 1/30/04 and 4/22/04. Resident 8 should have been seen by a physician on or around 6/22/04 and 8/22/04. There was no documentation in the medical record to provide evidence that resident 8 had been seen by a physician after 4/22/04 On 7/21/04, 7/22/04, and 7/23/04, the medical records person was asked by the survey team to find record of the missing physician visits for	F 387		

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F 387	Continued From page 101 residents 3, 4, 5, 6, 7 and 8. She was unable to locate documentation for any of the missing physician visits. She made phone calls to the residents' physicians and they were unable to provide any documented evidence of the missing physician visits.	F 387		
F 490 SS=K	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently 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 a re-certification survey with a subsequent extended survey, conducted 9/20/04 through 9/28/04, and resultant finding of Immediate Jeopardy and Sub-Standard Quality of Care, it was determined that the facility was not being administered in a manner that enabled it to use its resources either efficiently or effectively to ensure that residents were provided the opportunity to attain or maintain their highest practicable physical, mental, and psychosocial well-being for each resident in the areas of physical restraints and fall interventions (neglect). The facility was found to be providing Sub-Standard Quality of Care (a pattern of actual harm) in these areas. The facility was cited in a total of 6 areas, not including this deficiency Findings include: On 9/20/04, a re-certification survey was initiated. On 9/28/04, facility administration was notified of the elements of Immediate Jeopardy and Sub-Standard Quality of Care. The determination	F 490	F 490 1.We have put into place a new fall/incident policy and a new restraint policy. Note: copy of Fall/ Restraint policy. (A). Fall Policy includes: Fall Documentation procedure, Accidents/Incident/Fall Investigation, Fall Protocol, Fall Risk Assessment form, Incident/Accident Report form, Investigation Report form, Quality Assurance Incident Report Summary Tracking Log form, a monthly Incident/Accident Log form, and Individual Incident/Accident Tracking Log form. (B). Restraint Policy includes: Physical Restraint Documentation, Physical Restraint Protocol, Physical Restraint Consent form, Admission Restraint/Side Rail Evalnation form, Side Rail Rational Screen form, Bed and Side Rail Entrapment Assessment form, Physical Restraint Elimination Assessment form, Accident/Incident Audit form, and Physical Restraint Audit form. D.O.N. to monitor tracking and logs weekly, and Medical Records to monitor forms in charts monthly via chart audits.	

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F 490	Continued From page 102 of Immediate Jeopardy and Sub-Standard Quality of Care was based on the findings of significant non-compliance in the area of Resident Behavior and Facility Practices [42 Code of Federal Regulations (CFR) 483.13 (b) (c) Tag F-221 and Tag F-224]. 1. Facility administration failed to ensure that the use of restraints were evaluated, ordered and used to treat a medical symptoms. (Scope and severity "K", refer to Tag F-221) 2. Facility administration failed to ensure that policies and procedures were implemented that prohibited neglect for residents that were experiencing multiple falls. (Scope and severity "K", refer to Tag F-224) 3. In addition to the areas of Immediate Jeopardy and Sub-Standard Quality of Care stated above, the facility administration failed to effectively and efficiently use its resources to ensure that each resident attained or maintained their highest practicable, physical, mental and psychosocial well-being in the following areas of deficient practice cited during the annual and extended survey completed 9/28/04. a. Facility administration failed to ensure that housekeeping and maintenance were provided to maintain a sanitary, orderly, and comfortable interior. (Scope and severity "E", refer to Tag F-253) b. Facility administration failed to ensure the storage, preparing, distribution and the serving of food under sanitary condition. (Scope and severity "E", refer to Tag F- 371) c. Facility administration failed to ensure that	F 490	2. The side rails on all unoccupied beds have been removed to ensure that no side rails are used without proper assessments or physician's orders on new admissions. Completed on 10/5/04. 3. All residents have had an entrapment assessment completed. Completed on 9/22/04. 4. All residents in the facility have been assessed by our Physical Therapy for falls and restraints. Dr's orders have been written up following Physical Therapy's recommendations. Those residents that had side rails and Physical Therapy has recommended that they are not necessary have been removed from the bed. Completed on 10/07/04. 5. On October 5th 2004, an inservice with the Department Heads was held to discuss these new policies. On October 6th 2004, an inservice was held for all nursing staff where theses new policies were discussed and implemented. A. Maintenance will address identified problems obtained though his rounds in QA committee meeting monthly. B. Registered dietitian will complete a report monthly including sanitation check of all refrigerator/freezer units for proper food storage. A copy of the report will be given to Administrator for continued quality assurance.	

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F 490	Continued From page 103 residents were seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. (Scope and severity "E", refer to Tag F-387) d. Facility administration did not ensure that the quality assurance committee identified and implemented plans of action to correct quality issues. (Scope and severity "K", refer to Tag F-521)	F 490	C. The physician visit log will be reviewed in QA committee meeting by Medical Records and the Administrator every month. D. New QA forms have been implemented that will ensure that problems are identified and plans of action are implemented with follow ups. These include: Quality Assessment and Assurance Log, Quality Assurance Subcommittee form. Administrator will maintain these logs. 10/22/04 The above to be in effect by	
F 521 SS=K	483.75(o)(2)&(3) ADMINISTRATION The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. This Requirement is not met as evidenced by: Based on a review of the facility "Utilization Review Quarterly Meeting" (the facility Quality Assurance Committee) and interviews with the facility Administrator and DON (director of nurses), it was determined that the facility did not ensure that the quality assurance committee effectively developed and implemented appropriate plans of action to correct identified quality deficiencies. Findings include:	F 521	F521 1. Quality Assurance meetings will be held every week. To review Restraints, Falls, Injuries and Infections and to establish a plan of action for residents identified. Once substantial compliance is established Quality Assurance meeting will be held monthly. 2.The D.O.N. will keep a QA incident Report Summary Log. This log will be reviewed every month in QA meeting to look for trends. 3. The Timber program was implemented that identifies residents that are high risk for falls. These Trees are placed on the resident's door. The staff was inservieced on this program on 10/11/04. D.O.N. will monitor. 4. A Nurse Consultant was hired to comply with the directed plan of	

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F 521	Continued From page 104 1. During an interview with the DON on 9/22/04 at 12:40 PM, she stated that the facility had a quality assurance committee that met about every three months. She further stated that she identified that there was a high incident of falls in March of 2004, but since March of 2004, the falls had decreased. 2. During an interview with the administrator on 9/23/04 at 11:00 AM, he stated that the facility had a quarterly assurance committee that met quarterly and was attended by all department heads and the medical director. He stated that they identify facility problems by incidents during that time period and decided what to do in the meeting. He further stated that they follow up on the incidents by identifying a decline in the incidents. 3. A review of the facility "Utilization Review Quarterly Meeting" minutes was done on 9/23/04. The documentation indicated that the facility had identified a high percentage of resident falls. The minutes documented that they informed the physician about monitoring of the falls and a scheduled inservice for the staff. There was no documentation to evidence that they incorporated an action plan to monitor the high percentage of resident falls. There documentation did not indicate that the facility had identified any concerns with physical restraints. 4. The facility's quality assessment and assurance committee did not implement, and subsequently did not establish corrective action plans to ensure that residents were free from physical restraints not required to treat the resident's medical symptoms, resulting in harm to residents. (Refer to Tag F-221)	F 521	correction. She was approved on 10/8/04 Inservices were held 10/05/04, 10/06/04 on fall and incident policies, protocols, and assessment tools by RN Consultant and D.O.N. A Knowledge test was given to staff in conjunction with inservices on restraint and incident/accident. She has participated in QA meetings. 5. Quality Assurance was held on October 8th on Falls and Restraints. A QA meeting was held on October 14 2004. The above to be in effect by 11/15/04.	

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F 521	Continued From page 105 5. The facility's quality assurance committee did not identify, and subsequently did not establish corrective action plans that prohibited neglect for residents that were experiencing multiple falls, resulting in harm to residents. (Refer to Tag F-224)	F 521		