METHOD OF HEALTH AND HUMAN DEBYICES SHOOM APPROVED NTERS FOR MEDICARE & MEDICAID DMG 1995 0938-6391 JEMENT OF DEFICIENCIES. (X1) PROVIDER/SUPPLICE/CLIA (X2) MULTIPLE CONSTRUCTION STREETS OF SURRIVEY D PLAN OF CORRECTION IDENTIFICATION NUMBER OR COURTED BY A BURLDING B. WING 465898 1728/2004 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, OTTY, STATE ZIP COOK CASTLE COUNTRY CARE CENTER 1340 EAST 300 NORTH PRICE, UT 84561 CX41 ID CUMMARY STATEMENT OF BUILDING PROMILER'S PLAN OF CORRUCTION. PREFIX EACH DEFICIENCY MUST BE THE CITYORD CHEDIO. (EACH CORRECTIVE ACTION DISORDERS BE COMPREDE ppy no-IAG REGULATORY OR USC IDENTIFYER: INFORMATIONS CROSS REFERENCED TO THE APPROPRIATE 10630 100 DEFICIENCY F 221 483.13(a) PHYSICAL RESTRAINTS F-221 5S=K The resident has the right to be free from any physical restraints imposed for numo accor-NOV 03 200 discipline or convenience, and not required to treat the resident's medical symptoms. 11221 1. All other residents as will and Reside mentioned in this document have also This Requirement is not met as evidenced by: been re-evaluated for the least Based on observation, resident record review. restrictive restraints or facility policy review and facility staff interviews, i reduction/climination of present was determined that the facility failed to assess. restraints according to new residents medical symptoms that would fall/restraint protocol and policies. necessitate the implementation and use of utilizing present assessment tools. physical restraints for 6 of 13 sample residents 2. All new admits will be assessed the (residents CL1, 4, 8, 9, 10 and 11) and (same manner. supplemental residents, (residents 14 To, CL2, CL4 and CL6). One resident (resident CL1) 5. Quality Assurance meetings will be sustained a serious injury requiring heapital held every week. To review treatment, five of the residents (resident 9, 10, Restraints, Falls, Injuries and 14, 15 and CL6) sustained actual harm and five Infections and to establish a plan of of the residents (resident 4, 8, 11, CL2 and CL4). action for residents identified. Once had a potential for experiencing harm as a result substantial compliance is established of being physically restrained without adequate Quality Assurance meeting will be assessment of the need. Due to the lack of held monthly. assessment and subsequent harm, the facility was found to be in Immediate Jeopardy. 4.The D.O.N. will keep a QA incident Report Summary Log. This log will be Findings include: reviewed every month in OA meeting to look for trends. Facility Policy 5. The Timber program was implemented A review of the facility "Physical Restrain! that identifies residents that are high risk Management" program was done on 9/23/04. for fails. These Trees are placed on the The policy stated," Purpose/Objective: To resident's door. The staff was inserviced provide an environment for residents which on this program on 10/11/04, D.C.N. will allows for zero usage of restraints or, when monitor. 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 (26) DAT:: Any deficiency statement ending with an asteriak (1) denotes a deliciency which the instantion may be excused from correcting providing it is determined that

Any deficiency statement ending with an asterist () denotes a deliciency which the instantion 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 needing homes, the above findings and plans of correction accessed to continue 4 days following the date these documents are made available to the facility. It deliciencies are cited, an approved plan of correction is requisite to continued programs participation.

433111

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/St., PLIET IDENTIFICATION NUM	VCLIA ABER:	(X2) MULTIPE A. BUILDING	E CONSTRUCTION	(X3) DATE	D. 0 93 8-0 391 SURVEY LETED
	465098		B. WING	-	9/5	28/2004
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
CASTLE COUNTRY CARE		PRICE,	AST 300 NC UT 84501	RTH		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES OF MUST BE PRECEEDED BY RESCHOOLS INFORMATION OF THE PROPERTY OF T	FOLI	ID PREFIX TA/3	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE
physician who will Informed choice v resident and/or su restraints will be of order must specifitimes to be used. Observations On 9/21/04 at app 5:10 AM and 6:10 were made throug 1. The special neresidents in bed w both sides, or the of the bed opposit positioned against 2. The 100 hall ha with full length side side rait used was the wall, with the b 3. The 300 hall ha with full length side side rait used was the wall, with the b Based on these ob	the restraint is necessivill be presented to the authorize appropriate authorize appropriate authorize appropriate in the properties of th	10 AM, sevations I up on the side in bed copposite the wall.	F 221	6. A Nurse Consultant we comply with the directed correction. Inservices we 10/06/04 on fall and inciprotocols, and assessment Consultant and D.O.N. A was given to staff in conjunctional faction of the conjunction of the c	as bired to plan of re-held 10/05/04, dent policies, it tools by RN is Knowledge tearunction with d participated in acking and logs monitor forms hart audits.	
Resident who experiesult of being physical	ents (43%) were physic erienced serious injury sically restrained without need included the folio	as n				
1. Resident CL1 w	as admitted to the faci hitted on 10/22/02 with cluded diabetes meliti	lity on		Resident CLI was	discharged	

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

STREET ADDRUSS CITY, STATE, JP CODE TAGE CASTLE COUNTRY CARE CENTER PRICE, UT \$4301 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRICEEDED BY PULL PRETEX TAG CONTINUED From page 3 symptoms) injury	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465098		RECONSTRUCTION	(X3) DATE S COMPL	SURVCY ETED 8/2004
F221 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) ying under neath bed; style so so ong on alarm that it was still attached" On 7/2/04, a facility nurse documented the following on an "incident/Accident Report"; "Was restraint in use? Yes bed alarmNurse found pt (patient) ying under neath bedstring 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 signifes noted. Pt bed exchanged for med limit), 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 alarmPt (patient) found sitting on floor beside bed, alarm did not sound, no signifes noted. Pt bed exchanged for bed [with] sade 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 alarmPt (patient) attempted to get out of bed, bed alarm failed to sound, pt slipped to floor. No injuries, Bed exchanged for one [with] side railsHave bed alarm [checked]" On 7/3/04 at 8:00 PM, a nurse's note is resident CL1's medical record documented the following entry: "Not responding to questroms too confusedMore confused fican usual tonight" On 7/4/04 at 1:30 PM, a nurse's note is resident CL1's medical record documented the following entry: "C/ (complains) when moved from bed to		NTER 1	1340 EAST 300 N			
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CL1's medical record documented the following entry: "c/ (complains) when moved from bed to	CL1's medical record of entry: "Not respondi	focumented the following to questions too	ing			
wo (wheelchair)	CL1's medical record of entry: "c/ (complains	documented the follow	ing			
On 7/5/04 at 4:30 AM, a nurse's note in resident						

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S (X1) PROVIDERSUMPLI IDENTIFICATION IN 46509	MOER:	(X2) MULTIE A. BUILDING B. WING	LE CONSTRUCTION	(X3) DAT: 3 GOE 3 3570	
JAME OF PROVIDER OR SUP CASTLE COUNTRY C		1340 E	AST 300 N	TAIL, ZIP CODE		
PREFIX (EACH DEF	ARY STATEMENT OF DEFICITIVE CENCYMUST BE PRECEEDED BY OR USC IDENTIFYING INFOR	IF S SY FULL	UT 84501 ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(%) COMPLETION DATE
entry: "Pt (p. measure providing out of the control	I record documented the attent) yelling continuously ided [with] poor effect, virif bed" 7:00 PM, a nurse's note I record documented the patient) found on floor by turned on back, slightly li	in resident following his bed on fixed [left] dd the orth: a bed rails or next to exgency	F 221			
nurse on 9/21 resident CL1 She stated th climbed out o 7/3/04, he ha the left side ra with working s stated that re- that anytime r rails up times An interview o on 9/22/04 at	view was held with a facil /04 at 2:15 PM. She state resided on the special neat resident CL1 had consideresident CL1 had consideresident She stated that provide a had soon 7/3/04, she got side rails on both sides. Sident CL1 was a high fall esident CL1 was in bed I two. vas held with a second for 3:15 AM. She stated that to stand but not walk. S	ed that eds unit, tantly or to he broke a new bed She further I risk and he had side				
stated that re ever he was i	sident CL1 had side rails n bed, as well as a bed a that by the time facility st	up when arm. She	1			
RM CMS-2567(02-99) Previ	ous Versions Obsolete			4IB111	If continuation -	cet Page 5 of 10

THE THE T	OF CORRECTION	IDENTIFICATION NO	PVDER:	A. BUILDING		- COM: L	ETED
		465098	3	B. WING		9/2	8/2004
	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	ATE, ZIP CODE		
CASTLE	COUNTRY CARE	CENTER		AST 300 NO	ORTH		
			PRICE	, UT 84501			
(X4) ID PREFIX		ATEMENT OF DEFICION .		10	PROVIDER'S PLAN OF C		COMPLETION
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F 221	Continued From p	age 5		F 221	***************************************	***************************************	
	respond to the bed	l <mark>alarm</mark> be usualiy ba	d already				1
·		nurse further stated					
	resident CL1 had r	nany falls from his b	ed,	1			
	ei ia i			i			
		perienced actual Iran		1			
		sically restrained with		i			
1	assessment of the	need included the fo	Dirowing:				
	2. Resident 9 was	admitted to the facil	ity on	1			
	4/27/04 and then re	e-admitted to the fac	ility on	i i			
		oses which included		1			
+1		dema, hypothyroidis		i			
	dementia, anxiety,	hypertension and a	cognitive	1			1
:	disorder.			100			
	± 7'						
	Resident 9 resided	on the facility's SCL	J.				1
	A review of recider	nt &s medical record	WOC .	1			
	completed on 9/23		was	i			1
				į			
	On 5/3/04, the IDT	performed an "Adm	ission	į			
	Restraint/Side Rail	Evaluation & Bed E	ntrapment				
	Hazard Risk Asses	sment" for resident	9. The				
		ne following, "Pt (p.					
		then in the w/c (when		:			1
		when in bed" The		i			
;		t the IDT had attemp					
		ermined the need for					
		did not document the					
		were the least restri was no decumentali					
ĺ		raint alternatives we					
	previously used.	remit ditorratives, vice					
	,						1
	An admission MDS	assessment compl	eled by				į
		04, documented tha					
	had short and long	term memory proble	ems and				1
		for daily decision ma	aking were 🖟				
		ed. The facility staff		· i			
	documented that re	esident 9 required or	pervision	į			1
ORM CMS-	2567(02-99) Previous Ve	ersions Obsolcte			4IB111	If continuation st	met Page -0 of 10t

OMB NO. 0008-0301

DEPAR CENTER	IMENT OF HEALTH RS FOR MEDICARE	HAND HUMAN GERN E& MEDICAID RV	VICES ICES				MAPPROVED D. 0938-0361
	OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NO	POLIA MOER:	(X2) MULTIP A. GUILDIN	TE CONSTRUCTION	(X3) DATE COMP	SURVEY
		465098		B. WING		- 04	28/2004
l .	ROVIDER OR SUPPLIER				TATE, ZIP CODE		
CASTLE	COUNTRY CARE	CENTER		AST 300 NO , UT 84501	ORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCE Y MUST BE 1% CEEDED H LSC IDENTIFY HIS INFORM	PERUIT 1	ID PREFIX 1AG	PROVIDER'S PLAN OF C (PACH CORRECTIVE ACTIV CROSS-EIEFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	COMPLETION EAT:
F 221	with transfers and limited assistance. that resident 9 did On 6/1/04, a "Phys was signed by resid documented,"I d restraints until the a professionals have There was no docuperformed a re-adr Rail Evaluation & B Assessment" on 5/ On 5/5/04 at 6:00 A 9's imedical record entry: "Woke-up at fand] climbing OOE (side rails)" On 5/27/04 at 1:45 9's medical record entry: "Found pt (pabed and wall, states of bed) on that side (complains of) [left] On 5/27/04, a facility following on an "Inc "Were bed rails o present? YesPt (p buttocks between b (complains of) [left] On 7/9/04, a facility following on an "Inc "Were bed rails o rosent? YesPt (p buttocks between b (complains of) [left] On 7/9/04, a facility following on an "Inc "Were bed rails o	was able to embulate. The facility staff dor not use any restraints ical Restraint Consert don't see a	at the IDT mint/Side and Risk resident wing oming over SR resident wing of the retire ed rails on the retire ed ra	F 221	Resident 9 had consent with signatures 19/7/04; documented, A. Bed entrapment updr B. New physical therapy for restraint reduction 9/ C. Removed side rails at bed alarm. Bed moved a wall. D. Physician orders obta	form updated , new choice ated 9/29/04, y evaluation /29/04 and applied away from	

CENTER	RS FOR MEDICARE	& MEDICAID RV	ices Ices					0. 0938-0391		
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIFE A. BUILDING	E CONSTRUCTION		(X3) DATE S COMPLE			
	$\frac{\lambda^{\alpha}}{a} = \frac{1}{\lambda} = \frac{1}{\lambda}$	465098		B. WING			9/2	3/2004		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE					
CASTLE	COUNTRY CARE	CENTER		AST 300 NC , UT 84501	RTH					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRICEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PROCEEDED BY FULL			ID PREFIX TAG	(EACH CORRE CROSS-REFEREI	FLAN OF CORR CTIVE ACTION S NOED TO THE AF DEFICIENCY)	HOULD BE	COMPLETION DATE
F 221	21 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 PMbecn sitting herself on the floor frequently the last few days"		F 221							
	9's medical record entry: "Pt (patient)	AM, a nurse's note in documented the folio found sitting cross leg [At] 0630 (6:30 AM) p iner"	owing gged on							
	following on a fax to 0530 (5:30 AM) yo found sitting cross	ity nurse documented to resident 9's physici ur pt (patient), [reside legged on floor below (6:30 AM) found on t	an, "[at] ent 9] was v rails on							
1	following on an "In "Were bed rails of present? Yesaid legged on floor [at]	ity nurse documenter cident/Accident Repo ordered? NoWere b e found pt (patient) sit bedside [Left] grea s (drops) of blood"	ed rails tring cross					:		
	9's medical record entry: "Aide found on floor beside bed how she got there, of being in bed [an	AM, a nurse's note in documented the follout (patient) sitting crost, t, pt states she does in later she states she vid d] climbed out. Pt do welling area under old intecubital"	wing ss legged not know was tired es have 2							
	following on a fax t "Your pt (patient)	ty nurse documented o resident 9's physica ; [resident-9] was fou or; SRX2 (side rails t	en, nd sitting		eri eri					
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER	CLIA BER:	1.	IE CONSTRUCTION	. (X3) DA (
		465098		B. WING	sping to the		8/2004
	ROVIDER OR SUPPLIER COUNTRY CARE (1340 E	AST 300 NC , UT 84501	RTH	r :	
(X4) ID PREFIX TAG	, (EACH DEFICIENC)	ATEMENT OF DEFICIENCILS MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATI,	COMPLETION DATE
F-221	senile purpura on [i On 7/28/04, a facilit following on an "Ind "Were bed rails o present? yesPt (p being in the bed so cross legged on flo (centimeter) swellir antecubital" On 9/21/04 at 6:30 to be in her room ly was on the side of the bed positioned On 9/22/04 at 3:10 to be in her room ly was on the side of the bed positioned On 9/22/04 at 4:12 to be in her room ly was on the side of the bed positioned On 9/22/04 at 6:55 to be in her room ly was on the side of the bed positioned On 9/22/04 at 6:05 to be in her room ly was on the side of the bed positioned On 9/22/04 at 6:05 to be in her room ly was on the side of the bed positioned On 9/22/04 at 6:05 to be in her room ly was on the side of the bed positioned On 9/23/04 at 8:30 to be in her room ly	antimeter) Lump underight] antecubitat" by nurse documented bident/Accident Report refered? Now. Were beyontend by aidenty states she was she climbed out, pt wor when found by aideng under senile purpur. AM, resident 9 was of ing in bed. The sident he bed opposite the vagainst the wall. AM, resident 9 was of ing in bed. The sident he bed opposite the vagainst the wall. AM, resident 9 was of ing in bed. The sident he bed opposite the vagainst the wall. AM, resident 9 was of ing in bed. The sident he bed opposite the vagainst the wall. AM, resident 9 was of ing in bed. The sident he bed opposite the vagainst the wall. AM, resident 9 was of ing in bed. The sident he bed opposite the vagainst the wall. AM, resident 9 was of ing in bed. The sident he bed opposite the vagainst the wall.	ithe in: id rails is tred of ass sitting 2 cm a [right] eserved ail used vall, with	F 221	14 fr. 8		
		the bed opposite the v			 		
RM CMS-	2567(02-99) Previous Ve	rsions Obsolete			4lB111	If continuation si	neel Page 9 or 100

	OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NO 465098	NICER:	(X2) MULTIP A BUILDING B. WING	E CONSTRUCTION	(X3) DA i GOT/	30.0938-0394 L SURVEY PLETED
	ROVIDER OR SUPPLIER COUNTRY CARE		1340 E	DRESS, CHY. 6 AST 300 NO , UT 84501	ATE, ZP CODE RTH		/23/2004
(X4) ID PREFIX FAG	(EACH DEFICIENT	STATEMENT OF PEFICIENCE CY MUST BE PRECEDED OF R LSC (DENTIFYING INFORM	STEUGL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	ONDER FICAL
F 221	Continued From the bed positioned			F 221		2. P. Maddishing special processing and the	
	There was no doc order for side rails	cumentation of a physic in resident 9's medic	fcian's al record.				÷
	nurses) was interved to medical record find a physician's She further stated herself out of bed bed was up again rail used. She fur not be an option for resident 9's weigh were not strong er as Resident 10 we 9/19/04 as a respiration included se neurogenic bladde hypothyroidism, or	DON (assistant direct viewed. After reviewing a she stated that she order for the usage of that resident 9 tries the wall, with the of the stated that a low or resident 9 because at and that resident 99 nough to hold her up. as re-admitted to the for resident, with diagrizures, urinary tract in ar, cancer of the prost prebral vascular accident vascular vascula	ng resident could not side rails. e roll ident 9's ber side bed would of knees facility on noses fections, ate, lent		Resident 10 was discharged.	9,24/04	
	arthritis.	hotic and agitated fea nt 10's medical record 3/04,					: : !
	Respite Care. Du 677/04 to 7/14/04, assessment was of 677/04. The MDS had short and long his cognitive skills moderately impair documented that and ambulate with	nultiple stays in the faring one of these stay an admission MDS completed by facility s documented that resig term memory proble for daily decision maied. The facility staff resident 10 was able to extensive assistance ocumented, that residedaily.	taff on ident 10 ms and king were transfer :. The				

If continuation sheet Page, 10 of 100.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERAGOPELE IBILNELECATION DE	EALOCTS:	A. BUILDING A. BUILDING (S.2) MULUSI	E CONSTRUCTION	(X3) DATE: COLST	
	465090	3	D. 178903		9/2	8/2004
NAME OF PROVIDER OR SUPPLIER		1	ORESC, CITY, 61			
CASTLE COUNTRY CARE	CENTER		AST 300 NO	DRTH		
		PRICE	, UT 84501			
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENC ICY MUST BE PRECEEDED I IR LSC IDENTIFYING INFORM	of PULL	ID PREFIX T/AG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIATE JENCY)	DVIE COMMETERIA (5.2)
F 221 Continued From	page 10		F 221			
was signed by re documented, "I d restraints until the	ysical Restraint Conse sident 10's daughter w efer judgment regardi e appropriate healthca ve assessed the need.	vhich ng ire			a. a.	
Evaluation and Q assessment. The 10 had a soft res documentation the alternatives or do The IDT did not of lap buddy were ti	DT performed a "Rest marterly Review for EL e IDT documented tha traint - lap buildy. The nat the IDT had attempted fine need for locument that the soft ne least restrictive mes cumentation to indicat reviously used.	imination" at resident are was-no aled restraints, restraint - asures,				
10's medical reco , entry: "pt (patien [secondary to] re	2 AM, a non-o's note is and documented the for t) assisted to WC (who stlessness [-and] multip OOB (out of bed)"	liowing cel chair)				
10's medical reco entry: "pt (patien	ISPM, a nurse's note of documented the fo t) crawled under seat Fon floor. [no] appare	flowing belt				
following on a fax "Your Pt (patient) w/c (wheelchair) have something t sleep. Risperdol	cility nurse documente to resident 10's phys slid under soft weist r [and] fell. [No] injury, to help his agitation [a [sic], Remeron, Halde out of bed frequently a	ician, restraint in Can we nd] fer of nothing				
	cility nurse documente Incident/Accident Rep					
ORM CMS-2567(02-99) Previous	Varriana Obselata			4IB111	If continuation th	net Page 11 of 10s

DELITARTIVIDATI OF FICALTH AND FROM AS SERVICES

PERMITAL PROVED

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPERS IDENTIFIED AREA PO		(X2) MULTIPI A. BOLDING	E CONSTRUCTION	(X3) DA-1.	<u>0.0938-0291</u> survey taten
		465 957		B Mitter		:11	28/2004
	ROVIDER OR SUPPLIER COUNTRY CARE	CENTER	1340 E	PERG, CITY, ST AST 300 NO , UY 84501		The second secon	THE RESIDENCE I SHAPE IN A PARTY OF THE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DELICITIES AND ATEMENT OF DELICITIES AND A MUST BE PRECEDED AS A MUST BE AND A MUST BE A MUST B	OV FULL	PRÉFIX TAG	PROVIDER'S PLAN OF GOR (EACH CORRECTIVE ACTION CROSS-RUPERENCED TO THE / DELICALVELY)	SHOULD BE	COMPLETION DATE
F 221	(patient) slid under	seatbelt restraint in fell, [Check] into la		F 221	AMALICAN MENT OF STATE OF STAT	TO THE PART OF THE	
	medical record doc	e's note in resident i umented the followin t restraint onSR (s). Bed allarm on."	ng entry:				:
	10's medical record entry: "pt (patient) tried to stand [up] [PM, a nurse's note if documented the fo pulled restraint over and] feil - lying (?) be family notified - [no] if	llowing head, ed, alert				
	following on a tax t "[resident 10] climb [and] felf on floor - monitor 72 [hour]. again: Risperdol [s working. but [sic] a Constantly crawling	ly nurse documento- o resident 10's physi- ded under boat belt re [no] apparent injury. FYI (for your informatic); Remozon, Haldot about a sleeper? or s y out of bed at noct () [and] SR X 2 (side)	cian, estraint Will eition) eat esmething, eight) -				
	following on an "In-	ty nurse documented cident/Accident Repo st restraint over hoe fell by bed"	at": "Pt				
	10's medical recon entry: "sat in froi (wheel chair) [with] and stood up - was aide got by him an floor as he started	PM, a nurse's note in documented the formers station in restraint. Got out or walking holding out of held him and ease to fall. Order from E. (by mouth) ghs (ey)	llowing n w/c f restraint o chair - d him to or. (doctor)				

	S FOR MEDICARE TOF DEFICIENCIES	(X1) PROVIDER/SUP	RVICES	LOND MIN 3 2 3	L CONSTRUCTION		O. 0938-0391
AND PLAN (OF CORRECTION	IDENTIFICATION		A. BUILDING			ELETED
		4650	198	B. WING			/20/2004
WE OF B	ROVIDER OR SUPPLIER			NUCCE ON E	FATE, ZIP CODE		/28/2004
	COUNTRY CARE	CENTER	1	AST 300 NO			
			1	UT 84501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIE Y MUST BE PRECEED LSG IDENTIFYING INF	BO BY FULL	1D PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(89) COMPLETION DASH
F 221	Continued From p There was no docu "Incident/Accident regarding this fall.	<mark>imentati</mark> en Shat ar		F 221			
	On 6/22/04 at 4:00 10's medical record entry: "Pt (patient) climb under soft wa [and] floor, rocking shoulder restraint t wc."	d documented the very restless stri aist restraint react wc (wheelchair),	e following iggling to hing door placed in				
	On 6/23/04 facility order which docum (physical therapy) for Lap buddy [and [with] foot rests."	nented the followir to eval (evaluate)	rg, "FT res (resident)		V.		-
	On 7/6/04, the phy- "Admission Restra Bed Entrapment H should be noted th until 13 days after obtained. The phy that resident 10, "It [with] w/c (wheelch bed." There was n had attempted after need for the restra document that the the least restrictive	int/Side Nat/Evali azard Rick Asses at this evaluation a physician's orde sical therapist do- pair) and side rails to documentation matives or determints. The IDT did side rails and lap e measures. Ther	Jatien and sment." It and not occur it was samented dis lap buddy while in that the IDT niced the not buddy were e was no				
	documentation to i alternatives were purely the second order for a waist reference. On 7/5/04 at 3:00 /	previously ased, umentation of a plestraint in resident	iysidian's 10's medical	:			

FURM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROZOFROJUPPRE BZSCIA. (32) MULTIPLE CONSTRUCTION OXBEDA - SURVEY AND PLAN OF CORRECTION IDENTIFICATION BY STATE COMPLETED A. BUILDING 465698 9/28/2004 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CASTLE COUNTRY CARE CENTER 1340 EAST 360 NORTH PRICE, UT 84501 SUMMARY STATEMENT OF DEFICIENCES. PROVIDER'S PLAN OF CORRECTION (X4) ID In COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX TAG REGULATORY OR USC IDENTIFYING INFORMATIONS TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 221: Continued From page 13 F 221 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 at (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 of had removed..." Ori 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

FORM APPROVED OMB FIO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION LIDENTIFICATION BUMBER: A BUILDING LIDENTIFICATION BUMBER: A BUILDING LIDENTIFICATION BUMBER: B. WING LIDENTI

	100000		. !		9/28	8/2004
NAME OF P	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	ATE, ZIP CODE		
CASTLE	COUNTRY CARE CENTER	l .	AST 300 NO			
*		1	UT 84501			
(X4) ID	CUMMADY OTATOLOGY					
PREFIX	SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEIPED B	S !	ID !	FROVIDER'S PLAN OF CORRECT		(85)
TAG	REGULATORY OR LSC IDENTIFYING INFORM	AHON	PREFIX	(EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR	JUD BE	COMPLETION DATE
				DEFICIENCY)	SHAME	
E 224	to the second se					
F 221	Continued From page 14		F 221			
	room in front of W/C (wheel chair)." At	10:50 AM, j				
	the same facility nurse documented, To		i			
	when he came it [sic] that he bit the bac	k of his				
	head. Small (?) noted on been of head.	Will				
	contin. (continue) to monitor for problem	r5."				
	!					i
	On 9/20/04 at 10:15 AM, a facility nurse			T.		
	documented the following on an					
	"Incident/Accident Report": "Found pt (;	patient) on :				
	floor in front of W/C (wheel chair). Said	he was	1			;
	looking for son. No apparent injury. Tol	ld son at				
	10.50 AM he hit back of head"					
	l	1	!			
	On 9/21/04 at 9:00 PM, a nui∍e's note ir	resident :	1			;
	10's medical record documented the foll	owing				
i	entry: " soft waist restraint for safety."	9				1
:		:				
İ	On 9/21/04 at approximately 4:00 PM, a	nurse				
.	surveyor observed resident 10 in his ben	with the	ļ			
	bed against the wall and a slue rail up or) the	- :			
	open side of the bed. Resident 10 was ;	oullina	:			
	himself to a sitting position with both of I	is leas	i			1
	over the side rail. Resident 10 appeared		:			i
i	getting ready to climb over the side mil.					
	alarm cord was observed to be approxin	utely 18	1			
¥	inches long. The bed alarm did not sour	ad until				
i	he was at the edge of the bed, close to the	he				
	bottom of the bed, with his legs over the	side rail				
	and his upper body was leaning forward.	At that				
ĺ	time the surveyor told an aide, who was	in	1			1
. 1	another room, to help resident 10 so he	ton bluow				
	fall. The aide came into the room and as	sked				- i
	resident 10 what he was doing. Residen					i
	stated that he wanted to get up. He also	stated				!
İ	"This is hurting my leg. (pointing to the si	ide rail				į į
	that his legs were over). The aide stated	l "It's the				!
'	side rail, let me put it down." The aide the	ne helped	İ			
- 1	him into his wheel chair and put his soft	waist				
	restraint on and affixed it to the back of t		. ;			
	chair. Resident 10 then stated, "Do I need		1			
	The state of the s	Jo mai				1 (

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAR TERVICES. CENTERS FOR MEDICARE & MEDICAIL RVICES OMP NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 465098 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 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID сомет пом (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE. REGULATORY OR LSC IDENTIFYING INFORMATION) ľAG TAG DEFICIENCY) F 221 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

FORM CMS-2567(02-99) Previous Versions Obsolete

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	S FOR MEDICARE	HAND HUMAN SER E & MÉDICAID — R	AVICES VICES				RM APPROVE 10, 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPER IDENTIFICATION N	UMBLR:	(X2) MULTIPI A. DUILDING B. WING	LE CONSTRUCTION	(X3) DA-1	: SURVEY PLETED
		46503	8	B. WING		9	/28/2004
	OVIDER OR SUPPLIER		i	ORESS, CITY, S			
CASILE	COUNTRY CARE	CENTER		EAST 300 NK I, UT 84501	жтн		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENT CY MUST BE PRECEEDED RESC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPULER DATE
F 221	Continued From p	nage 16		F 221			
		ated that he crawled	out of bed.	i i			
		ind side rails. She a					
		y would cotch him b	clore going				
	over the side rails.	·		·			
11	: There was no doc	umentation of a phy	edelan's				
		in resident 10's me					
	record.	W					1
	* · · · · · · · · · · · · · · · · · · ·	in the second	d				
		umentation to evide aint /Side Rail Evalu					
	Assessment" was		(31)(4)				
		,					
		DON was interview		.			
		t 10's me dical record . find a physician's o					ı
	usage of side rails		THE TOT LIE				
	4. Resident 14 w	as admitted to the f	acility on				
		ioses which include					
		, neurogeric bladd:	r, iron				:
	deficiency anemia	and Alzne mas.					
	Resident 14 reside	ed on the facility's S	CU.				
	A review of reside	nt 14's medical rece	ad was				
	completed on 9/23						
i	Trees are made who MAD	C					:
		S assessments wer 5/27/04 and 8/3/04.					
		umented that reside					
		short term memory					
		daily decision maki dence. The facility s					
		cence. The facility s resident 14 wanders					:
ŀ	with no rational pu	irpose, seemingly of	blivious to				
		The facility staff do					
		as able to transfer a					
٠.		ited assistance. The that resident 14 use					:

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIF (DENTIFICATION FIL		A. BURUDING B. WING	E CONSTRUCTION	(X3) DA1. COM.:/	SURVEY LETED			
		465098		19, 371132		9/3	28/2004			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	DIRESS, CITY, STATE, ZIP CODE						
CASTLE	COUNTRY CARE	CENTER	1340 E	AST 300 NO	DRTH		}			
			PRICE,	UT 84501						
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCE Y MUST BE PRECEEDED L LSC IDENTIFYING INFORM	Y FULL	ID PPEFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE			
	Continued From prails daily.	age 17		F 221			:			
	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 roils and a merry wriker. 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 toxed.			Resident 1-i new physics evaluation on 9/29/04 w SR's x1 were De'd. A. Low bed and bed alachair alarm ordered. B. Physician order obtain C. Physical restraint coron 10/12/04. IDT meeting 10/21/04 weffective, resident removes and continually geas-sistance. Gait mustead while in W/C now applied.	hereas rm and wheel ned 10/06/03 isent updated //C alarm not cs clip (i) t up without y, Lap Buddy					
į	was signed by res documentation to	ysical Restraint Cons ident 14. There was provide evidence tha ne use of any restrain	no t resident	: : : !						
	the following, "C	er dated 1/26/04, doct risscross restraint wi ware of safety r/t (rela "	ગીe in w/c							
	medical record to been evaluated by	cumentation in reside provide evidence the y the IDT for the use nt while in his wheeld	it be had of a							
		/ersions Obsolide			4iB111	& continuation :	heet Page 10 of 10			

STATEMEN AND PLAN (T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUF IDENTIFICATION 465		(X2) MULTIP A. BUILDING B. WING		(X3) DATE COMPT	
	ROVIDER OR SUPPLIER COUNTRY CARE	CENTER	1340 E	DRESS, CITY, S AST 300 NO UT 84501	TATE, ZIP CODE DRTH		
(X4) ID PREFIX 1AG	(EACH DEFICIENC	ATEMENT OF DEFICI Y MUST BE PRECEED LSC IDENTIFYING INF	DED BY FULL	CI XIFINA DAT	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE (1) DATE
F 221	Continued From p On 3/17/04, a facili following on an "Inc"Were bed rails of present? YesPt (bed; SR (side rail) floor" On 3/31/04, a facili following on a fax to (patient) climbed or rails times 2) present? "[At] 1630 (4 (found on floor) in I (side rails) were boruising [with] scra	ity nurse docume cident/Accident R ordered? YesW patient) climbed a present X2 (times to resident 14's plut of foot of bed. ent. Found on flo PM, a nurse's not d documented the 130 PM) res (ros hallway outside In oth up- Res had s	teport": ere bed rails out of foot of s 2) fell on nted the hysician, "Pt SRX2 (side or" ote in resident e following ident) FOF is room- SR welling [and]	F 221			
	scratches to sm (si eyes unequal, unre On 4/24/04, a facili following on an "Ind "Were bed rails of present? yesRes around SR (side ra on [right] side [with above [right] eye [v unequal, unreactive On 4/25/04, a nurs a "Referral Physical climbed over side r head 4/24/04 (1630 unequal [right] side On 7/404, a nurset record documented (patient) found on t	mall) finger on (ri- pactive to light" ty nurse docume- cident/Accident R ordered? YesW (resident) climbre ii) [and] fell into h] bruise [and] swe vith] dime sized s e to light" e documented the an/Clinics", "Re all walked into ha b) (4:30 PM)Pu e not reactive to light s note in resident d the following en	glit) hand, nted the teport"; ere bed rails adleres found elling forming cratch- eye e following on sident all [and] felt hit pils are ght"				

	IMENT OF HEALTH RS FOR MEDICARE		KVICES KVICES				MAPPROVED O. 0938-03 91
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPI IDENSIFICATION I		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION ,	(X3) DA (1	
		4650	93	B. WING		1.57	28/2004
	PROVIDER OR SUPPLIER COUNTRY CARE	CENTER	1340 E	AST 300 NC UT 84501			E-skill E-s & war-skiller
(X4) ID FREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIE! Y MUST BL. PERCEPTOR LSC IDENTIFYING INFO	DIOY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AT DEFICIENCY)	TOULD BE	COMBIEST DATE
F 221	(merry walker) cha On 7/4/04 at 6:60 l documented the fo "Incident/Accident	iir" PM, a facility nurse sllowing on ⊲n Report": "Was ⊲ walker) chair with t	restraint in	F 221			
	entry: "Pt (patient)	d documented the	following rext room				
÷	following on an "In "Was a restraint (patient) found on	y nurse documento cident/Acci iont Re in use? Morri (siej floor in next room o merry walker tippe	port": walkerPt oves, lying				
	following on a fax t "Your pt'(patient) floor in merri [sic]	[resident 14] was	ysician,	:			:
i i		k in his room next l	following lent) was				
	following on an "In "Was a restraint	ity nurse documen cident/Accident Re in use? Lap belt ing on back in rm (int head"	port": Res				
	14's medical recor	PM, a nurse's not d documented the	following				

ATEMEN D PLAN (FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDERSOPHOR IDENTIFICATION NO 465098	MBER.	(XC) MULTIFI A. BUSLDING B. WING	G CONSTRUCTION	(X3) DATE SU COMPLE	1ED
		403050		1		9/28	/2004
	ROVIDER OR SUPPLIER COUNTRY CARE	CENTER	1340 E	AST 300 NO UT 84501	DRTH		
(4) ID REFIX FAG	# (EACH DEFICIENC	ATEMENT OF DEFICIENC Y MUST BE PRECEEDED I LSC IDENTIFYING INFORM	3Y FULL :	PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS REI ERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE.	OVH: COMBLETICAL (XS)
F 221	Continued From p fallOne small bur on [right] temple"	np on top of head no	oled, bump	F 221			
	following on an "Inc (patient) tipped ove in room. 1. 2 x 4 c	ity nurse documente cident/Accident Repa er to [right] side in mo cm (centimeter) abra right] temple, 3. Al rist"	ori": "Pt erry walker ision 2.			er Vert	
	following on a fax t "[resident 14] too room- fell on [right]	ity nurse documente o resident 14's phys ik a fall in his geri-ch I side, hit his head fa shairLump on top c e"	ician, air in his nd] pinned				
		AM, resident 14 war ring in bed with full to les.					
		AM, resident 14 wa ring in bed with full lo les.		i i i			
		: AM, resident 14 wa ring in bed with full le les.					
		AM, resident 14 wa ving in bed with full is les.					
		AM, resident 14 wa ving in bed with full lo les.					5
F		0-PM, re sident 14 w I lway u p in a wheei c					
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	230 (02-33) I TIVIOUS V	eratorio Obstorito			4.0		
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ATEMENT OF D D PLAN OF COI	EFICIENCIES RRECTION	(X1) PROVIDER/SCIPE IF P/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. DUILDING	LE CONSTRUCTION	(X3) DA : : CG : 1	STRVEY
,%		465098	B. WING		1.7	28/2004
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.F 221 Cor	ntinued From	page 21	F 221		The second of th	
in the rest of the control of the co	se hallway up raint. 9/22/04 at 7:4 e in his room up on both sure was no doer for side rail chair in resident 14 tippe and resident 14 tippe and resident 14 required for the uwaist restrail ident 14 required that is afety. The Assistant's orders in bed. She length side rail.	5 PM, resident 14 was obse lying in bed with full length s	rved ide or a that eek ds.			
1		ded on the facility's SOU.				!
	eview of resid	lent 15's medical record was 23/04				

		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIFICATION NO 465098	IMPER:	(X2) MULTIP A. BUILDING 9. WING	E CONSTRUCTION	(X3) DATE S COMPL	ETEO	
CASTLE COUNTRY CARE CENTER 1340 EAST 300 NORTH PRICE, UT 84501 PRICE UT 84501					_ l		1972	8/2004	
PRICE, UT 84501 SUMMARY STATEMENT OF DEFICICITIES 18 PROVIDERS PLAN OF CORRECTION DEPOCHMENT OF DEFICICITIES 19 PROVIDERS PLAN OF CORRECTION DEPOCHMENT OF DEFICIENCY PLAN OF CORRECTION DEPOCHMENT OF DEFICIENCY PLAN OF CORRECTION DEPOCHMENT OF DEFICIENCY PLAN OF CORRECTION DEPOCHMENT DEPOCHMENT DEPOCHMENT DEPOCHMENT DEFICIENCY PLAN OF CORRECTION DEPOCHMENT DEPO				•					
FREED TAG (EACH DEFICIENCY MUST BE PRECEDENT IN THIT. TAG (EACH CORRECTIVE ACTION SIGHED BIE) F 221 Continued From page 22 Two quarterly MDS assessments were completed by facility staff on 4/21/04 and 7/8/94. Both assessments documented that resideal 15 had problems with her short and leng term memory and her cognitive skills for daily decision making were moderately impaired. The facility staff documented that resident 15 was able to transfor with supervision and ambutate with limited assistance. The facility staff documented that resident 15 s.s.m. The consent documented that resident 15 s.s.m. The consent documented ball 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 the following, " Side rails up X (times) 2 safety rif (related to) athletimors unaware to physical limitations" On 5/5/04, the IDT performed a "Restraint Evaluation and Quarterly Review for I binination" assessment for resident 15. The IDT documented that the side restraints. The IDT documented that the side rails were the least restrictive causeure. There was no documentation to indicate which alternatives or determined the need for the restraints. The IDT documented that the side rails were the least restrictive causeure. 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 I binination" assessment for resident 15. The IDT documented that the side rails were the least restrictive causeure. 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 I binination"	CASILE	COUNTRY CARE	CENTER						
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 doily decision making were moderately impaired. The facility staff documented that resident 15 was able to transfor with supervision and ambutate with limited assistance. The facility staff documented that resident 150 sear. The consent documented that resident 150 sear. The consent documented that resident 150 sear. 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 8/2002, documented the following, " Side rails up X (times) 2 safety rif (related to) alzheimors unaware to physical limitations" On 5/5/04, the IDT performed a "Restraint Evaluation and Quarterly Review for it Immantion" assessment for resident 15. The IDT documented that resident 19 had side rails on both sides of the bed. There was no documentation that the IDT b. If a rittempted alternatives or determined the need for the restraints. The IDT documented that line side rails were the least restrictive hagasane. 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 it Immantion"	PRÉFIX	(EACH DEFICIENC	DY MUST BE PRECEEDED.	BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TON SHOULD BE THE APPROPRIATE	COMPLETION	
by facility staff on 4/21/04 and 7/80/04, both assessments documented that resident 15 had problems with her short and long term memory and her cognitive skills for doily decision making were moderately impaired. The facility staff documented that resident 15 was able to transfer with supervision and ambutate with limited assistance. The facility staff documented that resident 15 was able to transfer with supervision and ambutate with limited assistance. The facility staff documented that resident 15 sear. The consent documented that restraints could be used if the appropriate healthcare professionats had assessed the need for such and a restrainty 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 (timos)? safety rif (related to) alzheimors unaware to physical limitations" On 5/5/04, the IDT performed a "Rostrant Evaluation and Quarterly Review for Elemination" assessment for resident 15. The IDT documented that the IDT b. of 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 "Rostraint Evaluation and Quarterly Review for Elemination" assessment for resident 15. The date of the restraints. The IDT documented that the side rails and Quarterly Review for Elemination."	F 221	Continued From p	page 22		€ 221	- TO STORY SOME OF MALL AND A STORY OF THE S	Andrew Control of the		
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 h. d 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"	by facility staff on 4/21/04 and 7/8/04. Bot assessments documented that resident 15 problems with her short and long term met and her cognitive skills for daily decision in were moderately impaired. The facility skill documented that resident 15 was able to twith supervision and ambutate with limited assistance. The facility staff documented resident 15 used full bed rails daily. On 5/18/01, a "Physical Restraint Consent was signed by resident 15's son. The condocumented that restraints could be used appropriate healthcare professionals had assessed the need-for such and a restraint device was indicated as part of the recondeduction.		Both I 15 had memory in making staff to transfer ited led that consent sed if the ad- iced if the iced iced iced iced iced iced iced ice		updated 10/12/04. A. Orders obtained therapy to re-evaluat B. Orders obtained to 10/05/04 and apply	or physical e on 9/29/04 o De SR's on fow bed with bed when ap in			
Evaluation and Quarterly Review for Elemination" 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 h. d attempted alternatives or determined the need for the restraints. The IDT documented that the side rails were the least restrictive accasine. 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 Elemination"		the following, "S (related to) alzheir	ide rails up X (times)	2 safety r/t					
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"		Evaluation and Quassessment for redocumented that rooth sides of the bedocumentation that	uarterly Review for FI sident 15. The IDT resident 15 had side ped. There was no at the IDT b. d attem;	mination" rails on ited					
		restraints. The ID rails were the leas was no document alternatives were On 7/20/04, the ID	T documented that it is restrictive measure ation to indicate which previously used. T performed a "Rest	ie side . There h saint					
				mination"					

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVES TUBULTURE MICHA IDENTIFICATION TO SHEET;	(XZ) MOR THE A. EUSCORG	5 CONSTRUCTION	(X3) DATE SURVEY GOVE THIED
		465098	B. WING		9/28/2004
	ROVIDER OR SUPPLIER COUNTRY CARE	CENTER 1340	DERESS, CITY, 51 EAST 300 NC E, UT 84501		
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F 221	both sides of the bidocumentation the alternatives or det restraints. The ID rails were the leas was no document alternatives were ID rails were the leas was no document alternatives were ID rails were the leas was no document alternatives were ID rails medical record entry: "Found on sm. (small) red are waistline" On 4/22/04, a faci following on an "Ir " Were bed rails present? YesFo (small) reddened alternative in her room rails up on both side on 9/22/04 at 3:10 to be in her room rails up on both side on 9/22/04 at 4:12.	esident 15 had side rells on ed. There was no it the IDT had attempted armined the need for the T documented the need for the T documented that the side trestrictive measure. There attent to indicate which previously used. DPM, a nume's note in resident documented the following floor next to bed. Side rails [up at on back [at] center. DPM to the total content of the following floor next to bed. Side rails [up at on back [at] center. DPM to the total content floor floor next to bed. Side rails [up at on back [at] bedside" DPM to the total content floor bed floor floor bed bed floor floor bed bed floor floor bed bed. Sin area on back [at] waist line" DPM to the total floor floor floor floor bed bed. Sin area on back [at] waist line" DPM to the total floor floor floor floor floor bed bed. Sin area on back [at] waist line"	1		

On 9/22/04 at 5:25 AM, resident 15 was observed to be in her room lying in bed with full length side ralls up on both sides.

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NO		A. BUILDING	LE CONSTRUCTION	(X3) DATE	IO. 0938-0391 SURVEY LETED
	1	465098		B. WING		er	28/2004
CASTLE	PROVIDER OR SUPPLIER COUNTRY CARE	CENTER			ATE, ZIP CODE		
			PRICE	AST 300 NO . UT 84501	ORTH		
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F 221	Continued From p	age 24		F 221	-		
	On 9/22/04 at 8:25 to be in her room ly rails up on both sid	PM, resident 15 was ring in bed with full le es.	observed ngth side				!
	On 9/22/04 at 6:05 to be in her room ly rails up on both sid	AM, resident 15 was ring in bed with full led es.	observed igth side				
т. •	On 9/22/04 at 12:00 that resident 15 "free bed."	PM, a facility nurse equently tries to climb	stated out of				
- 1	bed by going to the further stated that s	PM, a facility nursing 15 tries often to get o bottom of the bed. S he did not know why robably begause she ady."	out of her her			e e	
	stated that resident end of the bed. She	PM, a facility nursing 15 works her way do a stated that resident a "side rails" slow her red."	wn to the			*	
	5/17/04 with diagnor pneumonia, CVA (ca "stroke") with depres	is admitted to the fac ses which included ardiovascular accider ssive features, intrac- ogressive Alzheimer's	it or		Resident (1.6 was of	Scharged.	
	discase.	CL6's medical record	i				
1	acility staff on 5/17/0 DL6 had short and lo	assessment complete 04 documented that r ing term remory pro e skills for daily decis	esident blome				

TATEMEN ND PLAN :	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPI IDENTIFICATIONS	IETCUIA IUMOER:	(X2) MULTIF A. BUILDING	EE CONSTRUCTION	(X3) DATE	O: 0938-0391 SURVEY LETED	
		49500	30	B. WING				
	ROVIDER OR SUPPLIER		STREET AD	DRESS CITY S	TATE, ZIP GODE		28/2004	
CASTLE	COUNTRY CARE	CENTER	1340 E	AST 300 No				
(X4) ID PREFIX TAG	SEFIX (EACH DEFICIENCY MUST BE DEFICIEDED			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO: DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	Continued From p making were mode staff documented the extensive assistance ating, toilet use ar staff documented the daily and a trunk reperformed a "Restrance on 7/8/04, the interperformed a "Restrance on the extensive for Eliminal documented that reperformed a termitation of the extensive for Eliminal documented alternative were the least was no documental alternatives were pron 5/17/04, a "Physical Stage of the extensive for the extensi	prately impoired. That resident CL6 receive that resident CL6 receive that resident CL6 receive that resident CL6 us straint daily. I disciplinary team (I daint Evaluation and ion" assessment, sident CL6 had side mentation that the I resident that the I resident CL6 is continued that restrictive measure ion to indicate whose extraints could be us are to the I described as part of the received as part of the re	gaired gaired gaired galaxion, b. Facility ed full rails DT) Quarterly the IDT es rails. DT had no need for the side. There h restraint ed if the administration of the side of the administration of the side of the administration of the side of the administration of the side of the administration of the administration of the consent ed if the administration of the consent ed its administration of the consent ed its administration of the consent edition	F 221	DEFICIENC	74)		
C	out of bed times two limbs over the rail of on 6/21/04 at 2:00 A CL6's medical record ntry: "Ambulating limbed over rails") this shift: Appare r out of the bottom. M, a nurse's note if the bottom.	nitly" Lesident					
1								

STATEMENT OF DEF ND PLAN OF CORR		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE S	
:		£*		B. WING		LILD	
		465098	}	B. WING		9/2	8/2004
IAME OF PROVIDER	OR SUPPLIER		STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
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F 221 Contir	nued From pa	age 26		F 221			
medica "Had a her roo bed" "Incide	al record doc anew [sic] inc om and found There was	e's note in resident (umented the followin ident. [Facility aide] d her sithing on floor no documentation the Report" was comple	ng entry: went into next to nat an				
residor followir in front chair "Incide	nt CL6's med ng entry, "Pt t of w/c (whe ." There was	D PM, a nurse's note lical record document (patient) found sittin elchair). Said 'I slid no documentation l Report" was comple	nled the g on floor out of that an			·	
docum "Incide out of i	ented the fol int/Accident f	AM, a facility nurse lowing on an Report": "Pt (pale ked to door of reord					
CL6's i	medical reco	PM, a nume's note in rd documented the t attent) lying on floor	ollowing :				
followir "Fou	ng on an "Inc	y nurse documenter ident/Accident Repongron floor. Chest in ir"	ort":				
CL6's i entry: nurse o	medical reco "Pt (patient) catched [sic] anded on pt	PM, a nurse's note i rd documented the f untied restraint stoo pt to break fall, w/c sm (small) skin toar	ollowing d [up] (wheel				

On 7/29/04 at 5:30 PM, a facility nurse

ND PLAN	OF CORRECTION .	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 465098	MBER:	A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE COMPI	
CASTLE	PROVIDER OR SUPPLIER COUNTRY CARE		1340 E PRICE	DRESS, CITY, ST AST 300 NC , UT 84501	FATE, ZIP CODE DRTH		8/2004
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCE Y MUST BE PRECEEDED F LSC IDENTIFYING INFORM	is touch	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 221	documented the fol "Incident/Accident I from w/c (wheel ch pt to break fall, w/c skin tear [right] elbo	lowing on an Report": "pt unfied air) stood [up] - nursi fell on pt caused cm	e caught (small)	F 221			
	resident CL6's med following entry: "Pt	ical record document (patient) found with Restraints were sl	ited the wheel				
	documented the fol "Incident/Accident F	OAM, a facility nurse lowing on an Report": "Found pt in wheel chair restra	(patient) ;				
	There was no docur order for side rail or CL6's medical recor	nientation of a physic a chest restraint in r d.	cian's resident				
	Residents who had harm as a result of living without assessment following:	peing physically rest	rained				
	7 Resident 4 was a 11/28/04 with the did dementia, Alzheime	agnoses of pre-senil	e e				
v.	A review of resident completed on 9/23/0		vas				
	A quarterly MDS as: a significant change 5/25/04 were compli- assessments docum short and long term cognitive skills for da moderately impaired	MDS assessment deted by facility staff, nented that resident amemory problems a aily decision making	ated Both 4 had nd her				
M CMS-2	2567(02-99) Previous Ver	sions Obselete			4IB111	If continuation slige	t Page 28 of 109
e e		in the second	f:				

ERVICES FORM APPROVED RVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATIL SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A BUILDING B. WING 465098 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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION DYST PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION: CROSS-REFERENCED TO THE APPROPRIATE TAC DEFICIENCY) F 221 Continued From page 28 F 221 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 landl Red Resident 4 Bed entrapment updated entrapment Hazard Risk Assessment." The IDT on 9/22/04 documented, "Pt. (patient) attempts to get up A. Order for physical therapy refrequently unassisted and is not safe in doing so evaluation for restraints 9/29/04 [independently]. She would benefit from having a undate. seat belt restraint while in w/c (wheel chair)." B. De seat belt while up in wheel There was no documentation that the IDT had chair. attempted alternatives or determined the need for C. Ordered low bed, with bed alarm the restraint. The IDT documented that the side and wheel chair alarm on 10/06/04 rails and criss cross restraint were to be used and D. Physical restraint consent updated that they were the least restrictive measures. 10/07/04 There was no documentation to indicate which E. Monthly Summary... D.O.N. to restraint alternatives were previously used. inservice all nursing staff 10/28/04 on documenting skills. On 5/25/04, The IDT performed a "Restraint F. Order obtained 10/06/04 to Dc Evaluation and Quarterly Review for Elimination." SR's. The IDT documented, "SR's (side rails) [up], SB (seat belt) [up] in w/c (wheel chair) fand) 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 restrain. afternatives 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

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVINGING PROJECTION AND PROVINGING PROJECTION AND PROJECTION AND PROJECTION AND PROJECTION AND PROVINGING PROJECTION AND PROJECTION AN		(XX) MULTII A. BU'LDINI B. WING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				J. V. 1940	CONTRACTOR OF THE PROPERTY OF	9.12			
	ROVIDER OR SUPPLIER COUNTRY CARE	CENTER	1340 (DBB SS, GBY, SPATE, 2P CODE EAST 300 NORTH E, UT 84501					
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F 221	w/c." There was not had attempted after need for the restrait documentation that were recommended documentation that restraint were the le There was no docurestraint atternative On 6/7/04, a "Physi was signed by residedocumented," I define restraints until the farestraints u	ontinued From page 29 2." There was no documentation that the IDT diatempted alternatives or determined the ed for the restraint. There was no cumentation that the restraint and/or side rails recommended. There was no cumentation that the side rails and soft belt traint were the least restrictive measures, are was no documentation to indicate which traint alternatives were previously used, 6/7/04, a "Physical Rostraint Consent" form a signed by resident 4's daughter which cumented, "I defer judgment regarding."							
	On 11/29/03 at 10:0 resident 4's medica following entry: "!	ussessed the need." DPM, a needs not trecord documented Pt (patient), up in geri alAuxione [sic] (ar	e in Ethe e Isicl		11				
	resident 4's medica	00°PM, a nurse's neb I record documented up in geri - chair for d	the						
1	There was no docur order for a geri chai record.	mentation of a physi r in resident 4's me.	rian's cal						
	resident 4's medical following entry: "CN reported finding Pt ((wheel chair). Daug	i0 PM, a nurse's note frecord documented IA (certified nurse's ; patient) or floor next phter was observed n illingpt denies any	the issistant) io w/c emoving						
		ity nurse documented dent/Accident Repor							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPEIFRICEIA IDENTIFIE/ATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DASTERURYEY CONTRETTED	
		465008		B WING .		C/2	8/2004
NAME OF PROVIDER OR SUPPLIER		STREET ADI	RLSS, CITY, S	FATE, ZIP CODE			
CASTLE	COUNTRY CARE	CENTER		AST 30 0 NO , UT 84501	ORTH		
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F 221	"Was a restraint ordered)CNA (ce reported finding pt w/c (wheel chair) o	age 30 in use? No (has lap I rtified nurses assiste (patient) on floor sitti n her buttocks. Dan g safety belt. Pt deni	nt) ng below ghter was	F 221			
	to resident 4's physiobserved by a CNAw/c (wheel chair), removing safety be	ility nurse documents sician, "[resident 4] w A to be found on floo Daughter was obser It prior to pt falling. I bottom: No injury."	as r sitting by ved	; ; 			
} ·	resident 4's medica following entry: "pt	O AM, a nurse's note al record documente (patient) found know ates 'I don't know ho ted"	d the ding on				
	following on an "Ind "Were bed rails of present? YesWa (patient) found on t	ility nurse documente sident/Accident Repo ordered? YesWere s a restraint in use? door beside bed. No on't know how I got I noved."	ort": bed rails Yespt injuries		a.		
	resident 4's medica	g 0 AM, a nurse's note al record documente w/c (wheel chair) [wi nt on"	d the				
		"Nursing Monthly Sele rail X (times) 2, la					
	4's medical record	AM, a nurse's note i documented the follo found on iteor of BR	owing	į			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROV: D CENTERS FOR MEDICARE & MEDICAID OMP NO. 0938-0394 STATEMENT OF DEFICIENCIES. (X1) PROVIDER/SUPPLIED/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465098 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 SUMMARY STATEMENT OF DELIGIENCIES ID. PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRINCEL DED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLESS: PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DAIL TAG TAG CROSS-REFURENCED TO THE APPROPRIATE DEFIGIENCY) Continued From page 31 F 221 (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 kneed..." On 1/3/04 at 10:10 AM, a facility numes documented the following on an "Incident/Accident Report": "...i?hysical 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 nume'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 of (patient) removes... pt found silting on buttocks

alarm..."

below left bed corner, states she doesn't know how she got there...[no] s/s (signs and symptoms) injury...pt confused crawled ont [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 hed, [no] s/s (signs and symptoms) injury ...pt had removed bed

In February 2004, a "Nursing Monthly Summary"

STATEMEN	RS FOR MEDICARE IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLI	/ICES	(X2) MULTIP	LE CONSTRUCTION		MB NC. C		
AND PLAN	OF CORRECTION	IDENTIFICATION NO	IDENTIFICATION NUMBER:		A. SUILDING			(X3) DATE SURVEY COMPLETED	
	1	465098 U. WING			9/28/2004				
	ME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	TATE, ZIP CODE				
CASTLE	COUNTRY CARE	CENTER		AST 300 NO , UT 84501	ORTH				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCY MUST BE PRECEEDED I LSC IDENTIFYING INFORI	BYERL	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD TO THE APPROPE	BE [f	(X5) COMPLETION DATE	
F 221		age 32 le rail X (times) 2, ta	į)	F 221					
	4's medical record entry: "said w/c (tight. Checked and	PM, a nurse's note in documented the foll wheel chair) restrair I there was 2 finger d it a little looser"	owing at was too						
	In March 2004, a "N documented, "sid restraint"	Nursing Monthly Sun e rail X (times) 2, โล	nmary" µ						
	4's medical record	ear, slight swelling tor for 72 [hours] [wi	owing ng on on [right]						
1	following on an "Inc "Were bed rails or	a restraint in use? ded to light found pt e, pt staled she clim fell striking right sid	at": bed raits Yes bed (patient) bed over						
	On 3/3/04, a facility resident 4's physicia found on [right] side she climbed over bo small bump on [right]	on floor below bed. ottom of bed. Pt sus	nt 4] was pt stated stained						
	On 3/8/04 at 3:30 P å's medical record of entry: "bed rail ar	locumented the folio	wing						

STATEMEN AND PLAN	MENT OF DEFICIENCIES (X1) PROVIDENSUPPEUR VOLIA IDENTIFICATION NUMBER. 465098		(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION	CONS	rumed	
	PROVIDER OR SUPPLIER COUNTRY CARE		340 E	PRESS, CITY, SI AST 300 NO , UT 84501			28/2604
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCY MUST BE PRECEDED OF RESCRIPTION OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF T	roviduo 3	ID PREFIX FAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	COME LEGAL
F 221	F 221 Continued From page 33 On 3/15/04 at 7:00 PM, a named's note in residen 4's medical record documented the following entry: "can you take this belt off, so I can get out of chairSR (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: "w/c		lowing I can get " mary" seat belt 's medical : "w/c	F 221	CHALL		
3 5	record documente	e's note in residents d the following entry bed alarm - soft wa wheel chair)"	"SR (side			•	
	On 5/22/04, a nurs record documented	ursing Monthly Summ de rail X (times) 2, to e's note in resident 4 d the following entry: ng on floor, no injurie	ed alarm"				
A THE	On 5/22/04, a facili following on an "Ind "Were bed rails or present? YesWabelt restraintFour kitchen staff memb	ty nurse documents cident/Accident Reportered? YesWore s a restraint in use? Id on floor by memb- er, no injuriesassi) soft belt restraint pl	d the ort": bed rails Yes soft or of				
1		e's note in resident 4	's medical				
M CMS-2	567(02-99) Previous Ve	rsions Obsolete			4IB111	If continuation she	el Page 34 of 100

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION DENTIFICATION NUMBER: 465088		EVGLIA MBCR:	A. BUILDING	LE CONSTRUCTION	(X3) DATI	SURVEY LETED	
			B. WING			20/2004	
	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, 3	TATE, ZIP CODE		28/2004
CASTLE	COUNTRY CARE	CENTER	1340 E	AST 300 No UT 84501			
(X4)'ID PREFIX TAG	I (EACH DEFICIENC	ATEMENT OF DEFICIENCE Y MUST BE PRECEDED F LSC IDENTIFYING INFORM	V DHIII	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(85) COMPLETION DATE
F 221			·	F 221			
. 133	(patient) found sitti	d the following entry: ng on floor in bedroo ints of pain, fell on lo	m. no .			ä	
i mak	record documented	e's note in resident 4 I the following entry: eel chair) [with] soft !	"Pt ·	.			
\$.	On 5/24/04, a nurs	e's note in resident 4 I the following entry:	s medical "soft				
	4's medical record entry: "Has a bruto be resting earlier bed herself. Assist	PM, a nume's note in documented the follo- ise on [left] leg Did and was trying to go ed to w/o (wheel cha ries to go! up alone a	wing not want t out of				
İ	4's medical record of entry: "pt (patient) states she slid out u	PM, a nurse's note in documented the follo found on floor by bed inder w/c (wheel cha t self to bed[no] ap	wing , pt ir)				
	following on an "Inc (patient) found on fl	y nurse documented ident/Accident Repor oor by bed - states si t [and] was trying to p	t": "pt re slid				
	occurred, a facility resident 4's physicia	s after resident 41: fa urse documented of nn, "pt (patient) found lid under w/c (wheel to put self to bed"	a fax to on floor				

	TATEMENT OF DEFICIENCIES (XI) PROVIDERSUPPLIFICATION NO. SPECIAL IDENTIFICATION NO. SPECIAL 465058		A. BURDING	LL CONSTRUCTION		SURVEY LETED 28/2004	
	PROVIDER OR SUPPLIER COUNTRY CARE	CENTER	1340 E	DRESS, CITY, S DAST 300 NO , UT 84501	IAU, 20 CONC PRTH		
(X4) ID PREFIX TAG	: (EACH DEFICIENC	TATEMENT OF DEFICIENCY MUST BE PRECUEDED ESCIDENTER YING INFORM	BY FULL	19 FECER TAG	PROYIDER'S PLAN OF CACH CORRECTIVE AC CROSS-ROFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(Xf) COMPLETION DATE
F 221	On 6/1/04 at 10:30 4's medical record entry: "she does On 6/22/04 at 6:30	PM, a nurse's note documented the foll hate lap belt" PM, a nurse's note	owing in resident	F 221			
		documented the foll it) in w/c (wheel chai					
	4's medical record entry: "during rout	AM, a nurse's note documented the foll ne end of shift bed c ent) sitting cross lego	owing Jecks			* 55 *	
	following on an "ind "Were bed rails of present? YesWa alann/pt removed	ty nurse documento cident/Accident Repr ordered? YesWere s a restraid in use? .aide found et (palie open side of bed be d alarm"	ort": Used rails Yes bed nt) sitting				
	to resident 4's phys was found [with] an next to bed, [no] inj	ty nurse documento iician, "pt (patient) [i n bed checks sitting uryPt SR (side rail noved bed alarm per	esident 4] on floor s) were				
	4's medical record	PM, a nurse's note i documented the folio self with assistance	owing				
	record documented	s note in resident 4's I the following entry: ity when [up] [with] s	"w/c				
	On 8/17/04, a nurse	e's note in resident 4	's medical		4		:
RM CMS-	2567(02-99) Previous Ve	rsions Obsolete			4IB111	II continuationhe	pet Page 36 of 106

ND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPERIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DA11	Q. 0938-0391 SURVEY LETED
		465098	B. WING	The second of the second second	9/	28/2004
	PROVIDER OR SUPPLIER E COUNTRY CARE	CENTER 1	EE (ADORESS, CHY, : 340 E AST 300 N PRICE, UT 84501	ORTH		20,2304
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEPICIENCIES LY MUST BE PRECLEDED BY FULL LSC IDENTIFYING INFORMATION	D PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHGULD BE E APPROPRIATE	(X5) COMPLETON DATE
F 221		age 36 d the following entry: "'ta	F 221		The state of the s	
	record documente	e's note in esident 4's med the following entry: " [usoft belt restraint in place	inl in			
	record documente	e's note in resident 4's med d the following entry: "so e in w/c (wheel chair) [and]	ft		<u>:</u>	
	4's medical record entry: "soft waist	PM, a nurse's note in resid documented the following restraint on while in w/c SR (side rails) in bed"	dent			
	to be in her room h	AM, resident 4 was observing in bed. The side raif us the bed opposite the wall, y against the wall.	sed .			
	to be by the nurse's soft waist restraint		ved th a			
	this rail is up (pointi stated, "I don't like t	PM, resident 4 was tated, "Whenever I am in b tated, "Whenever I am in b to the side rail)." She all he side rails up. If I want to scool to the bottom of the	lso			
İ	to be in her room ly	PM, resident 4 was observing in bed. The side rail us the bed opposite the wall, wagainst the wall.	ed			
	On 9/22/04 at 3:10	AM, resident 4 was observe	ed			
M CMS-2	567(0 2 -99) Previous Ver	sions Óbsolete		4)B111	Mr W V.	d Fage 37 of tra

STATEMENT OF DEFICIE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(XZ) MULTIP A. BUILDING	LL CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		465 098		B. WING		9/	28/2004
NAME OF PROVIDER OR			,		FATE, ZIP CODE		
CASTLE COUNTRY	CARE C	ENTER		AST 300 NO UT 84501	ORTH		
PRÉFIX (EACH I	DEFICIENCY	ATEMENT OF DEPICIENCII MUST BE PRECEEDED 3 SC IDENTIFYING INFORM	y FULL	ID PRETIX TAG	FROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLET FOR
F 221 Continued record doc this belt of	cumented	ige 36 the following entry:	"'take	F 221			
record doc	cumented I chair) so	's note in resident 4 the following entry: oft belt restraint in play."	" [up] in	-			
record doc	cumented	e's note in resident 4 the following entry: in w/c (wheel chair)	"soft	1	,		
4's medica entry: "s	al record o soft waist	PM, a nurse's note in documented the follourestraint on while in SR (side rails) in boo	wing w/c ,				
to be in he was on the	er room ly e side of t	AM, resident 4 was o ing in bed. The side he bed opposite the against the wall.	rail used 🗄	:			
	ne nurse's	5 AM, resident 4 was station in a wheel con.					
interviewe this rail is stated, "Lo	d. She st up (pointi ton't like t bed I can	PM, resident 4 was tated, "Whomever I a ny to the side rail)." the side rails up. If I scoot to the bottom	She also want to				
to be in he was on the	er room ly e side of t	PM, resident 4 was eing in bed. The side he bed opposite the against the wall.	rail used 📙				
On 9/22/0	4 at 3:10	AM, resident 4 was a	observed	i			

DEPARTMENT OF HEALTH AND HUMAN THRVICES **ECRM APPROVED** CENTERS FOR MEDICARE & MEDICAID RVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES. (X1) PROVIDENSHIPPERINGER (X2) MULTIPLE CONSTRUCTION (X3) DATE GURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B WING 465099 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 SUMMARY STATEMENT OF DEFICIENCES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PERCEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 221 Continued From page 37 F 221 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. Resident 8 was discharged 9/28/04. 8. Resident 8 was admitted to the facility on 5/8/03 with diagnoses which included congestive heart failure, hypertension, pneumonia and If continuation sheet Page, 38 of 106

CENTER	HIVE NEW TOP HEALTH RS FOR MEDICARE	& MEDICAID (XI) PROVIDER/SUPFLI	VICES	(20, 100 777	L. C. Ochor Philosophia	OMB NO	MAPPROVED 0. 0938-0391
AND PLAN	OF CORRECTION	IDENTIFICATION 30	INDER:	A BUILDING B. WING	I E CONSTRUCTION	(X3) DATE S COMPL	ETED
NAME OF E	PROVIDER OR SUPPLIER	40303		NOTEGO CHA C	IATE, ZIP CODE	9/2	8/2004
	COUNTRY CARE (CENTER	1340 E	AST 300 NO , UT 84501			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENC 'MUST BE PRECEEDED SC IDENTIFYING INFOR	BY FUEL	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 221	Continued From pa Alzheimers.	ge 38		F 221			
	Resident 8 resided	on the facility's SCI	J.				į.
	A review of resident completed on 9/23/		! was				
	An annual MDS ass quarterly MDS asse completed by facility documented that re term memory proble daily decision makir The facility staff also wandered (moved v 'seemingly oblivious facility staff docume to transfer and amb facility staff docume use any type of rest	essment dated 7/24, y staff. Both assess sident 8 had short a messes and his cogniting were moderately o documented that with no rational purp to needs or safety) when the that resident a total purp the distribution of the tresident and that resident 4, was sments and long ve skills for r impaired. resident 8 bose, b. The 3 was able lence. The					
	On 4/27/04 and 5/5/ "Restraint Evaluatio Elimination" assessi documented that re	n and Quarterly Re ment for resident 8.	view for The IDT			· · · · · · · · · · · · · · · · · · ·	
	On 9/21/04 at 6:28 / to be in his room lying was on the side of the the bed positioned a	n g in be d. The side h e bed opposite the	rail used				
••	On 9/21/04 at 7:10 / to be in his room lying was on the side of the the bed positioned a	ng in bed. The side he bed opposite the	rail used	,			
	On 9/21/04 at 2:45 I to be in his room lyi was on the side of the the bed positioned a	ng in bed. The side he bed opposite the	rail used	:			
SEM CMS	2567(02-99) Previous Ver	rione Objective			4IB111	If continuation she	15 00 1111

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AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPELS. IDENTIFICATION NU	ABER:	A BUILDING	E CONSTRUCTION	(X3) DATE COMPL	
	ROVIDER OR SUPPLIER COUNTRY CARE	CENTER	1340 E	AST 300 NC , UT 84501	ATE, ZIP CODE	7.2	32004
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCE Y-MUST BE PRECEDED A LSC IDENTIFYING INFORM	SY FULL	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETION DAVE
F 221	On 9/22/04 at 7:45 to be in his room ly was on the side of the bed positioned	PM, resident 8 was ring in bed. The side the bed opposite the	rail used wall, with	F 221			
	On 9/22/04 at 12:0 that resident 8 had currently had a sid there was no phys when he started ha up against the wall the opposite side f On 9/23/04 at 9:45	in resident 8's modic 0 PM, a facility nurse been falling out of be e rail. She further st ician order for the sic aving falls the bed we and the side rail was	at record. stated ed and ated that le rail, but as moved s put up on				
	for side rails and a obtained for reside She stated that the obtained because a decline in function safety. After revier record the ADON resident/family corresident/family corresident/	soft waist restraint with 8 on 9/2/104 at \$55 side rail https://doi.org/10.0000/10.000000000000000000000000000	Fore 90 AM, order was I falls and ed for his dical not find a				
	8/2/04 with the dia atrial fibrillation, hy failure with anxious	is admitted to the fac gnoses of cellulitic of pertension, congesti is features, and edem at 11's medical recon-	lace, ve heart la.				
	An admission MDS was completed by	704. 5 assessment dated facility staff. The ass ésident 11 had short	essment		S.		

STATEMEN AND PLAN	NEOF DEFICIENCIES OF CORRECTION	(X1) PROVESTABLES IDENTIFY ATTOM	THI WOLIA SISSIFIE	1	NE CONSTRUCTION	(X3) F(A1)	SURVEY
				A BUT OING	Secretary desired and a single convergence of the second second	- COM-14	JETILD
		4650				9/2	8/2004
	PROVIDER OR SUPPLIER E COUNTRY CARE	CENTER	i	RESS CITY : AST 300 N	VAH . ZIP CODE	700	
			PRICE,	UT 84501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIE Y MUST BE PRECEED LSC IDENTIFYING INF:	DBV FILE	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFURENCED TO TH OFFICIENCY	ON SHOULD BE TE APPROPRIATE	COMPLITION COMPLITION
F 221	Continued From p her lying on floor of any injuries"		d symptoms)	F 221		A 1000 A	
	On 8/19/04, a facil following on an "In "Was a restraint restraint in usew	cident/Accident Re in use? Yes Lap I alked by room, fou	port": feltlap belt ind pt.	:			
:	(patient) lying on flasymptoms) of any On 8/27/04, a facili	injuries. [no] pain.		-		·	
	to resident 11's phy lying on floor when had no s/s (signs a belt restraint was s She stated she had	ysician, "I found pl I walked by her re nd symptoms) of fill attached to wh	. (patient) on. She njuriesLap	:			
	On 8/27/04 at 8:00 order documented evaluate for lap but	 PM, a physician's "PT (physical the					
	On 9/1/04, the phy "Restraint Evaluatic Elimination." It sho evaluation did not o physician's order w therapist document mile) X (times) 2."	on and Quarterly F ruld be noted that occur until 5 days a as obtained. The red, "Lap beddy"	(cesic w for lins after a physical sitts (side				
	that the IDT had at determined the nee no documentation t rails were recomme document that the the least restrictive	tempted alternatived for the restraint hat the restraint a conded. The iDT disideralls and lap to measures. There	es or				
	documentation to in alternatives were p On 9/4/04 at 11:30 11's medical record	reviously uned, PM, a nume's not	○ in resident				
	entry: "pt (patient)			:	••		
RM CMS-	2567(02-99) Previous Ve	rsions Obsoloto	· · · · · · · · · · · · · · · · · · ·		4!B111	Il continuatos, de	of Poor 45 of 106

AD PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVEN ON SUPPLE RICHA IDENT FATION NUMBER.	A. BURLDING	E CONSTRUCTION	(X3) DATE COMPT	
		46500B	D. WING	11 10pm = 10 mm - 10 m	9/3	8/2004
	ROVIDER OR SUPPLIER		ADDRESS, CTY, S O EAST 300 NO		·	
		3	CE, UT 84501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCES OY MUST BE PRECEDED BY FUEL LSC (DEN HEYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE LIFFICIENCY)	4 SHOULD BE	(X5) COGRETION DAP:
F 221	Continued From palipped trying to re (bathroom). No in	turn to bed nom BR	F 221			i
3	following on an "In "Were bed rails present? YesWa (patient) found on	y núrse documented fne icident/Accident Report"; ordered? YesWere bed rails as a restraint in use? Nopt floor in Room states "I got up iom and felt when I tried to ge				
i.	11's medical recor	O AM, a nurse's note in reside d documented the following EX (times) 2 at nite (sic) for	nt		*.	
		3:10 AM until 5:30 AM, reside to have side rails up times 2.	nt			
		50 AM, resident 11 was the nurse's station in a wheel ddy on.				
:		00 AM, resident 11 was the nurse's station in a wheel ddy on.				:
:		umentation of a physician's or a lap buddy in resident 11'	s			
·	reviewing resident	OON was interviewed. After 11's medical record she state find a physician's order for the or the lap buddy.				
I	8/24/02 with the di	was admitted to the facility or agnoses of prostate cancer, ailure, asthma, insulin	ר בי בי בי בי בי בי בי בי בי בי בי בי בי	Eesident CL 2 was disch	arged.	

CENTER	S FOR MEDICARE	& MEDICAID STRV	CES				.0938-0391
STATEMEN AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SULTER IDENTIFICATION NUM	VCLIA IBER:	(X2) MULTII A. BUILDIN	PLE CONDIRUCTION G	(X3) DATE ST COMPLE	
		465098		B. WING		9/28	/2004
	ROVIDER OR SUPPLIER COUNTRY CARE (CENTER	1340 E/	NUSS, CITY, S AST 300 N UT 84501			
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F 221	disease. A review of residen completed on 9/23/ A significant chang completed by facilit assessment docum short and long term cognitive skills for comoderately impaire documented that retransfer and ambul It was also docume fulf bed rails daily. On 2/27/04, the IDT Evaluation and Qua The IDT documented that "Newer recommended that "Newer recommended that "Newer recommended are cord documented that "In the IDT document of the IDT documented that "Newer recommended that "Newer recommended are commended are commended as a nurse medical record documented that "side rails [up] 2 (time commended that "side rails [up] 2 (time complete that is up 2 (time commended that "side rails [up] 2 (time complete that is up 2 (time compl	t CL2's medical records. t CL2's medical records. e MDS assessment by staff on 6/3/04. The facility staff on 6/3/04. The facility staff on facility staff sident CL2 was able at with extensive as inted that resident CL. I performed a "Restructerly Review for Efficied, "No Restraints." to restroints and/or staff. e's note in resident Cumented the followinnes two)."	vas e bi.2 had ind his were to sistance. 2 used aint mination." The IDT ide rails L2's g entry:	F 221	DEFICIENCY		
	CL2's medical reco	PM, a nurse's note in rd documented the fo found on floor by bed	ollowing				:
	following on an "Inc "Were bed rails o	y nurse documented ident/Accident Repo rdered? YesWere i patient) found on floo	rt": bed rails				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVER RASUPELL Fr. IDENTIFICATION NO		A. BUILDING	LE CONSTRUCTION	COM-	
	· .	46509	3	B. WING		9/3	28/2004
	ROVIDER OR SUPPLIER	001	1		FATE, ZIP CODE		
CASTLE	COUNTRY CARE	CENTER		AST 300 NO , UT 84501	жтн		
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F 221	Continued From postates he tried to g			F 221			
		umentation of a physin resident CL2's me					
	4/30/04 with the dia	was admitted to the agnoses of intestina ypercholesterolemia constipation.			Resident CL4 was discha	rged.	
p 1,9	A review of resider completed on 9/23	nt CL4's medical rec /04.	ord was				! !
	completed by faciliassessment document and long term cognitive skills for moderately impaire documented that retransfer and ambul	pe MDS assessment ty staff on 5/13/04, mented that resident in memory problems daily decision makin ad. The facility staff esident CL4 was ablate with extensive ented that resident C	The CL4 had and his ag were le to assistance.				
	"Admission Restra	umentation to evider int/Side Rail Evalual azard Risk Assessm	tion [and]				
	On 4/30/04, a "Phy	sical Restraint Cons	sent"	:		Ş.	

restraints...."

documented, "I Do Not consent to the use of

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, 5/11/04, 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,

DEPA	RIMENT OF HEALT ERS FOR MEDICARI	HÂND HUMAN SER E <mark>& MEDICA</mark> ID : (A	VICES /ICES				MAEPROVED O. 0938-0391
	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIEDEN HEIGATION NU.	IMBER:	(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE COME	
	F PROVIDER OR SUPPLIER LE COUNTRY CARE		1340 E	DRESS, CITY, S AST 300 NO , UT 84501	FATE, ZIP CODE DRTH		
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F 2:	6/13/04, 6/18/04, i On 6/26/04 at 11: documented the fi "Incident/Accident ordered? YesW YesWas a restri (patient) removed bed rail no injury r There was no doc order for side rails record. INTERVIEWS On 9/22/04 at 12: nurses) was intein to the facility. She members attend the also be obtained to physician's order s physical restraint a	5/30/04, 6/4/04, 6/5/0 5/21/04, 6/2//04 and 45 PM, a facility musc ollowing on an Report": ", Were be are bed rail: present' aint in use? Yes Bed bed alarm [and] clim	ed rails ed rails adarmpt bed over dician's *dical ector of no restraint admitted then family icin's will did that a icin apist will	J 221			
F 22 SS=	The facility must d policies and proce mistreatment, neg	AFF TREATMENT Of the evelop and implement adures that prohibit plect, and abuse of retion of resident propertion of resident propertion.	nt written	F 224			
		ciencies concerning lect or misappropriati	ion of				

465098

(X2) MULTIPLE CONSTRUCTION A BUILDING

COMPLETED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPERLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:

F 224 Continued From page 46

Findings include:

staff present on the SCU.

staff present on the SCU.

staff present on the SCU.

FORM CMS-2567(02-99) Previous Versions Obsolete

Observations:

onto the SCU.

(X4) ID

PREFIX

TAG

NAME OF PROVIDER OR SUPPLIER CASTLE COUNTRY CARE CENTER

SUMMARY STATEMENT OF DEFICILLICIES

(FACH DEFICIENCY MUST BE PRECEEDED BY FUEL

REGULATORY OR LSC IDENTIFYING INFORMATION)

This Requirement is not met as evidenced by:

implement policies and procedures that prohibited

Based on observation, interview and record

neglect. Seven out of 13 residents (residents

residents (CL2, CL4, CL5, CL6, 14 and 15)

falls, within this sampled and supplemental

CL1, 4, 8, 9, 10,11 and 12) and 6 supplemental

experienced multiple falls. Incidence of individual

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

implement and re-evaluate interventions to avoid

of falls. The facility neglected to develop, fully

physical harm associated with falls. Due to the

lack of assessment and subsequent harm, the facility was found to be in Immediate Jeepardy.

On 9/22/04 from 3:10 AM until 6:05 AM, a nurse

From 3:10 AM until 4:11 AM, there was no facility

At 4:11 AM, a facility nursing assistant came onto

From 4:12 AM until 4:18 AM, there was no facility

At 4:18 AM, two facility nursing assistants came

From 4:20 AM until 4:30 AM, there was no facility

AT 4:30 AM, three facility nursing assistants

surveyor made the following observations the

SCU (Special Care Unit), a secured unit:

review, the facility failed to develop and

STREET ADDRESS, CHY, STATE, ZIP CODE 1340 EAST 300 NORTH

F 224

B. Wind

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PREFIX

TAG

F 224

PRICE, UT 84501

CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY:

1. All other residents as well as those

mentioned in this document have also

been re-evaluated for the least

reduction/elimination of present

fall/restraint protocol and policies

utilizing present assessment tools.

2. All new admits will be assessed the

3. Quality Assurance meetings will be

Infections and to establish a plan of

action for residents identified. Once

4. The D.O.N. will keen a OA incident. Report Summary Log. This log will be

reviewed every month in QA meeting to

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

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

200 half or SCU every 2 hours

throughout the shift.

CNA's on night shift retate working

held every week. To review

Restraints, Falls, Injuries and

restraints according to new

restrictive restraints or

same manner

held monthly.

look for trends.

monitor.

4IB111

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE

9/28/2004

Established States

- OM6 FO. 0938-0351 (X3) DATE SURVEY
- (25) COMPLETION

DATE

substantial compliance is established Quality Assurance meeting will be

If communities sweet Page, 47 of Nov.

STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIE IDENTIFICATION BU	R/CLIA MILEO	į.	J. CONSTRUCTION	(X3) DATE: COMPL	
		465093		S. WING _		-	8/2004
NAME OF PRO	VIDER OR SUPPLIER		STREET AGE	RESS CITY, S	ATE, ZIP CODE		
CASTLE C	OUNTRY CARE	CENTER	1	AST 300 NC UT 84501	нтя		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCE Y MUST BE PRECEEDED E LISC IDENTIFYING INFORM	37 FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS REFERENCED TO TH DEFICIENCY	ON SHOULD BE IL APPROPRIATI	COMPLETION DATE
Ca First st TI tw tw uu fo R R 1.110 di di cy ppr A A aaada da da da da da da da da da da da	taff present on the SCU was observed hours and fifty- eriod the SCU was another sculptured by facility- eriod the SCU was another sculptured by facility- eriod the SCU was another sculptured by facility- eriod the SCU was another sculptured by facility- eriod the Sculptured by facility and re- eriod the sculptured by facility and re- eriod the sculptured by facility and facility staff als L1 resisted cares and resident CL1 was another facility staff als L1 resisted cares and resident CL1 with external focumented the staff documented to any service the service the staff documented to any service the staff documented to any service the staff documented to any service the staff documented to any service the staff documented to any service the staff documented to any service the service the staff documented to any service the staff documented to any service the staff documented to any service the staff documented to any service the staff documented to any service the staff documented to any service the service the staff documented to any service the staff documented to any service the staff documented to any service the staff documented to any service the staff documented to any service the service the	J. 16:05 AM, there was a SCU. erved by the nurse so five minutes. During as observed to be left ity staff for two hours. It is served to be left ity staff for two hours. It is a served to the following: It is a served to the following. It is medical recorded diametes medical elect by facility staff assident CL1 had sho ems and his cognification where the facility staff decas able to transfer a noive assistance. The facility staff decas able to transfer and lays and the last 3 to 104, facility nurses could, facility nurses could, facility nurses could, and the last 3 to 104.	that time time that time that time time time time time time time tim	F 224	6. A Nurse Consoltant was hit comply with the directed plan correction. Inservices were he 10/06/04 on fall and incident protocols, and assessment too Consultant and D.O.N. A Kn was given to staff in conjunction inservices on restraint and incident/accident. She has pa QA meetings. 7.D.O.N. to monitor track weekly. 8. Medical records to monitor charts monthly via charts monthly via charts yet. The Above was integrated by the charts in the charts weekly. 10. The above to be in cite. Resident CL1 was dischart charts and incident CL1 was dischart complete the charts was dischart charts.	of and 10/05/04, policies, old the/05/04, policies, old by RN owledge test ion with recipated in ing and logs and logs are transfer, and the control of the	
U	se" assessments ssessments, resid	ssment/Side Rail & F for resident CL1. O dent CL1's assessed licated the resident v	n both score				

465998 C. WING 5/28/2004 AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMEN' ND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUFFICE IDENTIFICATION NU	R/CLIA MBER:	(X2; MULTI A. BUILDIN	PLE CONSTRUCTION G.		C SURVEY PLETED
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RECH PERCIATORY BUST BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLETED BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETED BETT			CENTER	1340 E	AST 300 N	ORTH		
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 f-sliowing 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 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"	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEEDED B	BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETION
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUI		A. BUILDING	LE CONSTRUCTION	COV.1	LETEO
		465098		B. WING			20/2004
VAME OF PI	ROVIDER OR SUPPLIER			BESS ORV 9	ATE, ZIP CODE	57.	28/2004
	COUNTRY CARE		1340 E	AST 390 NO , UT 84501			
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F 224		page 49 t Rèport": "Aide resp of (patient) sitting on fl		F 224		:	
	CL1's medical recentry: "Pt (patient)	5 AM, a nurse's note in cord documented the f of found sitting on butto ed, crying it hurts"	ollowing				
	documented the for "Incident/Accident	5 AM, a facility nurse ollowing on an Report": " Aide foun buttocks against stati				,	
	on a "[Facility's na	sician documented the ime] Referral Physicia n- no fracture seen."	a following a/Clinic",			•	
	CL1's medical rec entry: "Nurse foun	AM, a nurse's note in ord documented the fid patient) lying und m[no] s/s (signs and"	oll owi ng dor bed				
	following on a fax "Your pt (patient)	ty nurse documented to reside a CLT's playswas found under his no] s/s (signs and syn	idian, bed [at]				
. :	documented the for "Incident/Accident (patient) lying und	AM, a facility nurse bllowing on an Report": "Nurse for er neath bedstring w it was still attached	vas so				
	CL1's medical rec	AM, a nurse's note in ord documented the found sitting on floor	ellowing				
					4IB111	If continuation of	<i>i</i>

FGRM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN STRVICES CENTERS FOR MEDICARE & MEDICARD SVICES

STATEMEN	NT OF DEFICIENCIES	& MEDICAID 2V (X1) PROVIDER/SUPPLE	E/CUA	(KS) MULTIP	.E CONSTRUCTION	(X3) DATE SU	<u>0938-0391</u> RVEY	
AND PLAN	OF CORRECTION	IDEN'U REATION NUM	MINER:	A PURDING	W	COMPLETED		
		465099		B. WING		9/28/2004		
	TROVIDER OR SUPPLIER		STREET AD	PRESS, CITY, S	ASE, ZIP COD!			
CASTLE	COUNTRY CARE	CENTER	!	AST 300 NO . UT 84501	DRTH			
(X4) ID + PROLIX + LAG	(EACH DEFICIENC)	ATEMENT OF DICHOLERUIL Y MUCT BILLER FOR OLD DECEM LSC IDENTH Y RIG INFORM	71001	ID FPLTIX FAG	PROVIDER'S PLAN OF CORRECT (LACH CORRECTIVE ACTION SHO CROSS-RULERENCED TO THE APPL DEFICIENCY)	UEDBI	DAH (X2) (X2)	
F 224	bed exchanged for	age 50 sound, no injuries no bed [with] side rails (getting out of bod"	lo ¦	F 224				
	attempted to get ou sound, pt slipped to	llowing on an Report": "Pt (patien it of bed, bed alarm f ofloor. No injuries, B [with] side railsHav	ailed to led			i		
f	CL1's medical reco entry: "Pt (patien	PM, a nurse's note in rd documented the fo t) found on floor by h d on back, slightly lift	ollowing is bed on			>		
e ta	documented the fol "Incident/Accident I on floor next to bed	PM, a facility nurse lowing on an Report": "Pt (patien Found out [after] of [left] hip fx'd (fracture	ent to ER i					
()	nurse on 9/21/04 at resident CL1 reside She stated that reside	vas held with a facilit 2:15 PM. She state of on the special nec- ident CL1 had constr She further stated to high fall risk.	d that ds unit. antly			*		
	on 9/22/04 at 3:15 / CL1 was able to sta stated that resident ever he was in bed further stated that be respond to the bed fallen. The facility re-	eld with a second tac AM. She stated that and but not walk. She CL1 had side rails u , as well as a bod ala by the time facility sta alarm he usually buc nurse further stated thany falls from his he	resident e further p when irm. She iff could I already					

	SFOR MEDICARE		OES OES				0. 0938-0391
	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPEUE IDENTIFICATION SUM		(X2) MULTIP A BUILDING	E CONSTRUCTION	(X3) DATEL 5 COMEL	GURVEY ETED
		465098		B WING		C/2	8/2004
NAME OF PI	ROVIDER OR SUPPLIER				FATE, ZIP CODE		
CASTLE	COUNTRY CARE (CENTER		AST 300 NO UT 84501	DRTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCE YMUST BE PROCEEDED B LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMELLIDE OATE
F 224	Continued From pa	age 51		F 224			
	that resident CL1 h 7/17/04. Two of the	mentation it was dete ad 7 falls from 3/23/6 e falls occurred on the falls occurred on the	04 until ee evening				
	that facility staff de-	mentation to provide veloped interventions sident CL1's needs to size potential injury.	5,				
			cility on		Resident CU5 was discharged		
	A review of resider completed on 9/23	d CL5's modical reso /04,	ord was	j			
	facility staff on 5/10 CL5 had severely it cognitive skills for a moderately impaire documented that reassistance with wa personal hygiene besupervision and warmobility. The facilities dent CL5 had redays. 7 On 4/27/04, a facilities Risk. Assessment/6 assessment. The	Gassessment compley/04, documented the mpaired victor and the daily decision making determined. The facility staff estimates a side of the facility staff documented to fall accidents in the facility nurse facility nurse documented so fall accidents in the facility nurse documented so facility nurse documented so facility nurse documented facility nurse documented facility nurse documented facility nurse documented facility nurse documented facility nurse documented facility nurse documented facility nurse documented facility nurse documented facility nurse documented facility nurse documented facility nurse documented facility nurse documented facility nurse documented facility nurse documented facility nurse documented facility nurse documented facility nurse documented facility nurse facility nurse documented facility nurse facility	extensive ing, and that that that that that that the past 180 ted a "Fall Use" and on				
	that resident CL5 v		!				

CENTER	RS FOR MEDICARE	AMU OSAAM IN	ICES		e de la companya de l		Минско∨. :: D. 0938-0391
	1 OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/GUPPELIC EDENTIFICATION NO		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE CONST	
		465090		B. WING		9/2	8/2004
	ROVIDER OR SUPPLIER		5		TATE, ZIP COUL		
CASTLE	COUNTRY CARE	CENTER		AST 300 NO UT 84501	DRTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCE Y MUST BE PRECEEDED B LSC IDENTE YING INFORM	Y FULL	ID PRILEIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	IN SHOULD BL E APPROPRIATE	COLFET COLL
F 224	entry: "Pt (patient ambulation. Is lead person SBA (stand (activities of daily li	rd documented the t c) uses walking stick gally [sic] blind. Reg by assist) with all Al ving). Family notes t k and will attempt to	with dires 1 DL's hat pt	F 224			
	revealed a compre 5/19/04, addressing There was no docu	it CL5's medical reco hensive care plan da g resident CL5's fail i imentation to eviden re plan had been upc	ited risk. se that the				
a management	resident CL5's med following entry: "W came, he told RN (pt (patient) on floor stated that sometin son stated that he a 'My father is blind (wanted to know wh	0 PM, a nurse's note fical record, documer (hen Rec (resident's) registered nurse) the , sitting next to bed res it is better to let y didn't think so becaus and) can't be left afore bed alarm was asn't been found"	ated the son at the found. Nurse of be-the said not, Also				
	documented the for "Incident/Accident I came [and] told RN	PM, a facility nurse llowing on an Report": Res (reside I (registered nurse) th n floor, sitting nexi to	hat he			*	
. (documented the for "Incident/Accident	AM, a facility nurse llowing on an Report": "Aide fou lloor in front of closel					
	CL6's medical reco	AM, a nuise's note in a documented the found sitting on floor	ollowing	· .			

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46509£ 8 WPGS 5/29/2004 WAME OF PROVIDER OR SUPPLIER CASTLE COUNTRY CARE CENTER 1340 EAST 360 NORTH PRICE, UT 34501		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIED/UJA IDEN EFECATION NOT SEED.	1	E CONSTRUCTION	(X3) DATE COME	
ASTECOUNTRY CARE CENTER AST 300 NOITH 1340 EAST 300 NOITH SUMMARY STATEMENT OF DEPENDENT PROJECT AND THE AST 300 NOITH SUMMARY STATEMENT OF DEPENDENT PROJECT AND THE AST 300 NOITH FEECH TO SOLVE AND THE PROJECT PROJEC				1			
Add EAST don NORTH PRICE, UT 3450 ADDRESS PLAN OF CORRECTION (CAS) DEPLOYMENT OF DEPLOYMENT	IAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZiP CODE		:012004
F 224 Continued From page 53 closet" On 5/22/04 at 12:15 AM, a facility nurse documented the following on an "Incident/Accident Report"P1 (patent) yelling in room. Sitting in chair fall busiside. 1 cm (centimeter) skin tear to [right] chlow. C/O (complains of) [right] in bip painP1 states he fell, no one saw pt fall, or saw him on the ground" On 5/22/04 at 12:15 AM, a mase'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 withoused his fall or bim on the ground. 1/2 cm (centimeter) skin tear to [right] elbew. 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) yelling from the ground. 1/2 cm (centimeter) skin tear to [right] elbew. 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 (comprency room). Daught in taw (all bedside. States he broke 3 ribs" Based on the documentation, it was determined that resident CL5 had 3 ribs. from 4:30°H unit 5/21/04. One fall occurred on the evening shift and two falls occurred on the revening shift and two falls occurred on the revening shift and two falls occurred on the inght 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, hypotrension, proumonia and			CENTER 1340 E	AST 300 NO			
closet" On 5/22/04 at 12:15 AM, a facility nurse documented the following on an "incident/Accident Report": "Pt (patient) yelling in room. Sitting in chair [at] badside. I dra (centimeter) skin tear to [right; elbow. C/O (complains of) [right] rib painPt 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 docume need the following entry, "Pt (patient) yelling from room. Went in [and] pt sitting in clain. States he fell. [No) one witnessed his fall or him on the ground. 1/2 cm (centimeter) skin tex to [right] elbow. Pt c/e (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 the ground. 1/2 cm (centimeter) skin tex to [right] elbow. Pt c/e (complains of) [right] rib pain" Based on the documentation, it was determined that resident CL5 had 3 falls from 4:30 Pt unit 5/21/04. One fall occurred on the verning shift and two falls occurred on the eight shalt. 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 cangestive heart failure, hypotension, preumonia and Resident 3 was discharged 9/38/04.	PREFIX	(EACH DEFICIEN:	CY MUST DE PRECCEDENT : PUIT	PREEK	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BL	COMPLETION DATE
"Incident/Accident Report": "LPT (patient) yelling in room. Sitting in chair [at] hadside. Tiera (centimeter) skin tear to fright allow. 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 nume's note in resident CL5's medical record documented the following entry, "Pt (patient) yelling from room. Went in fand] pt sitting in claim. States he fell [No] one witnessed his fall or him on the ground. 1/2 cm (centimeter) skin tea to [right] ellisow. Pt c/o (complains of) [right] rib pain" On 5/22/04 at 4:45 AM, a nume's note in resident CL5's medical record documented the following entry, "Pt (patient) ret (returned) from ER (emorgency room)Daughter in law [ai] bedside. States he broke 3 ribs" Based on the documentation, it was determined that resident CL5 had 3 falls from 4:30'-et unit 5/21/04. One fall occurred on the evening shift and two falls occurred on the oright 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 cangestive heart failure, hypertension, pneumonia and. Resident 8 was discharged 9/28/04.	F 224		page 53	F 224			!
resident CL5's medical record documented the following entry, "Pt (patient) yelling (nan room. Went in [and] pt sitting in chair. States he tell. [Noj one witnessed his fall or bitn on the ground. 1/2 cm (centimeter) skin tear to [right] etbow. Pt c/e (complains of) [right] rib pan" On 5/22/04 at 4:45 AM, a nume's note in resident CL5's medical record documented the following entry, "Pt (patient) ret (returned) from ER (omergency room)Daughter in law [at] Fedside. States he broke 3 ribs" Based on the documentation, it was determined that resident CL5 had 3 falls from 4:30% d until 5/21/04. One fall occurred on the evening shift and two falls occurred on the hight 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 Resident 8 was discharged 9/28/04.		documented the f "Incident/Accident in room. Sitting in (centimeter) skin (complains of) [rig	ollowing on the t Report": "Ft (patient) yelling n chair [at] badside. I cm tear to [right] elbow. C/O pht] rib painPt states ho fell, no				
CL5's medical record documented the following entry, "Pt (patient) ret (returned) from ER (emergency room)Daughter in law fail bedside. States he broke 3 ribs" Based on the documentation, it was determined that resident CL5 had 3 falls from 4/30°H until 5/21/04. One fall occurred on the evening shift and two falls occurred on the evening shift and two falls occurred 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 eangestive heart failure, hypertension, pneumonia and Resident 8 was discharged 9/28/04.		resident CL5's me following entry, "P Went in [and] pt s [No] one witnesse 1/2 cm (centimete	edical record documented the ft (patient) yelling from room, litting in chair statish he tell, ad his fall or him on the ground, or) skin tear to fright! elleyw. Pt				
that resident CL5 had 3 falls from 4/30/91 until 5/21/04. One fall occurred on the evening shift and two falls occurred on the hight 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 Resident 8 was discharged 9/28/04.	:	CL5's medical rec entry, "Pt (patient (emorgency room	cord documented the following) ret (returned) from ER i)Daughter in taw (at) bedside.				1 1 1 4
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 Resident 8 was discharged 9/28/04.	1 .	that resident CL5 5/21/04. One fall	had 3 falls from 4/30/04 until occurred on the evening shift				
5/8/03 with diagnoses which included engestive heart failure, hypertension, pneumonia and Resident 3 was discharged 9/28/04		that facility staff d individualized to re	eveloped inferventions, esident CLD's needs to reduce				
		5/8/03 with diagno	oses which included congestive		Resident 8 was discharged	9/28/04	

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLE	E/CUA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA1:	0. 0938-039 SURVEY
	OF CORRECTION	IDENTIFICATION NO		A. BUILDING		COM 1	
		465098		B. WING	The second secon	5.7	8/2004
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	RESS, CHY, ST	TATE, ZIP CODE		1.78-2.5
CASTLE	COUNTRY CARE	CENTER	· ·	AST 300.NC , UT 845 0 1	DRTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCE OF MUST BE PRECEDED B LECTIDENTIFYING INFORM	3Y FULL	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE DITHE APPROPRIATE.	COMPLETION DATE
F 224	Continued From p	page 54		F 224			
	A review of resider completed on 9/23	nt 8's medical record 3/04.	was				
	completed by facil documented that r term memory prob daily decision mak The facility staff al wandered (moved seemingly oblivious facility staff docum to transfer and am facility staff docum	rterly MDS assessmetity staff. Facility staff resident 8 had short a lems and his cognition where moderately so documented that with no rational purp is to needs or safety) tented that resident 8 shulate with independented that resident 8 days and the last 3 feet.	and long we skills for impaired, resident 8 ose, . The was able ence. The				
	Assessment/Side assessment for re documented on the	y nurse completed a Rail & Restraint Use' sident 8. The facility e assessment a scor at resident 8 was a b	nurse e of "20",				
:	Assessment/Side assessment for re documented on the	lity nurse completed Rail & Restraint Use' sident 8. The facility e assessment a scor at resident 8 was a h	nurse e of "16",				
	a comprehensive addressing reside documentation to	th 8's medical record care plan dated 5/4/0 nt 8's fall risk. There evidence that the an of care had been to	was no				

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If continuation, linet Page 55 of 1 %

	S FOR MEDICARI T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NO		(N2) MULTIPE A. BUHLDIEK	E CONSTRUCTION	(X3) DA	MO. 0938-039 LISURVEY PILETED
		465098		B. WING			7/2 8/20 04
	COUNTRY CARE	CENTER	1340 E.	RESS, CITY, ST AST 300 NC UT 84501	ATE, ZIP CODE PRTH	- This chair and the second se	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENC CY MUST BE PRECEEDED F RESC IDENTIFYING INFORM	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED T DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	COMPLETIO:1
F 224	following entry: "P floor" On 2/29/04 at 9:00 documented the fe "Incident/Accident found sitting on floor on 2/29/04, a faci following on a fax "[Resident 8] wato his bedHe rep On 3/19/04 at 5:30 8's medical record entry: "Aides found hed on floor"	al record documenter to the patient of the patient	nt) was tibe an, floor next e floor"	F 224			
	documented the for "Incident/Accident) AM, a facility nurse ollowing on an Report": " LPt (patie buttocks, stated he fe	n!) found li out of				
	following on a fax	ity nurse documented to resident 8's physic), [resident 8], was to tocks"	en,				
	record documente	se's note in resident 8 d the following entry: floor in his room by is "	"Pt				
	documented the for "Incident/Accident	Report": "CNA (ce reports pt (patient) fo	rtified ;				

TATEMENT OF DEFICIENCIES (X1) PROVIDER SUPPLY FACTOR IDENTIFICATION RUBBER: 465098			LE CONSTRUCTION]	SURVEY LETED 28/2004
JAME OF PROVIDER OR SUPPLIE CASTLE COUNTRY CARI !		TREET ADDRESS, CITY, ST 1340 EAST 300 NO PRICE, UT 84501		Anna ann an ann an an an an an an an an a	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEEDED BY FU IR LSC IDENTIFYING INFORMATION	ULIL PREFIX ON) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETION DATE
F 224 Continued From	page 56	F 224			
8's medical recor	to PM, a nurse's note in red documented the followints fallen in room on [left] or by aide on [left] hip [and	ng hipPt			
documented the "Incident/Acciden into room [with] [a	0 PM, a facility nurse following on an it Report": "Pt (patient) of gero] assistance. Aide wa loor on [left] hip and arm	ilked by:		;	
resident 8's medi following entry: "F stood up took ste against it out the	24 PM, a nurse's note is cal record documented the cal record documented the calienty toiletting self are p [with] pants down [and] door landing on floor in freet, not responding to	nd feli			
documented the functional document of the functional document of the function document of the fu	45 PM, a facility nurse following on an at tReport": "Pt (patient) of when he stood up he newalked lost balance and fedoor onto fleor"	ver			
following on a fax "[resident 8] had I 2245 (10:45 PM), up, stepped [with]	ility nurse documented the to resident 8's physician, nis second fall this evenin, He was toileting when he pants around ankles, los against and out the door	g [at] e stood t			
8's medical recon entry: "Visitor rep	5 AM, a nurse's note in red d documented the followin orted pt (patient) on floor i found pt lying flat on	\g			

5 S

	OVIDER/SUPPLIER/CLIA VIPPCATION NUMBER:	(X2) MULTIPE A. BUILDING	E CONSTRUCTION	(X3) DATE 8 COMPL	
	4650 98	B. WING		9/2	8/2004
NAME OF PROVIDER OR SUPPLIER CASTLE COUNTRY CARE CENTE	R 1340 (DRESH, CHY, ST EAST 300 NC E, UT 84501			
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST B TAG REGULATORY OR LSC IDEN	E PRECEEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
F 224 Continued From page 57 backside" There was no "Incident/Accident Report" regarding this fall. On 9/16/04 at 10:00 AM, a resident 8's medical record following entry: "Pt (patie room, 3 cm (centimeter) le eyebrow" On 9/16/04 at 10:00 AM, a documented the following "Incident/Accident Report" bed, fell out the left side, s 3 cm (centimeter) laceratic furrow area" On 9/16/04, a facility nurse following on a fax to reside	was completed inurse's note in d documented the art) found on floor of identity aurse on an i"Pt (patient) lying in truck head on dresser, on to above eyebrow in a documented the	F 224			
"[Resident 8]- fell out of laceration to [right] eyebro applied" On 9/16/04 at 11:30 AM, a tesident 8's medical record following entry: "Pt (patient of room. Cut top of head,	w. Steri strips a nurse's note in d documented the t) standing in doorway 1 [inch] laceration"				
On 9/16/04 at 11:30 AM, a documented the following "Incident/Accident Report"	on an				

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

standing in doorway of room, fell [and] struck top of head. I [inch] laceration to top of head. Pt also c/o (complains of) [right] clavicle pain..."

On 9/16/04, a facility nurse documented the

)	EPAR	HME	:Ni	OF HE	ALTH	AND	HUMAN	111	RVICE
`	ENTE	RSI	FOR	MEDIC	CARE	& ME	DICAID		PARCES

FORM APPROVED

OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE P/CEIA (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION IS AWDER: COMPLETED A. BUILDING B. WING 465093 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREEIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 224 Continued From page 58 F 224 (emergency room) via ambulance for sulures [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] drsg (dressing) to fleft] 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

STATEMEN AND PLAN	IL OF DEFICIENCIES OF CORRECTION	(X1) PEOVIDAREGO IDENTIFICATIO	CARLEGGERA ON DE MARKER	1	E CONSTRUCTION	(XD) DARL (COMEN	
			5098	E WINO			
MAME OF F	ROVIDER OR SUPPLIER	L	f citiest . Albin	Market Committee	125 212 222	9/28/2004	
	COUNTRY CARE	CENTER	1340 E/	NST 300 NC UT 84501	ATE, ZIP COUR BRTH		
(X4) ID	SUMMARY ST	ATEMENT OF DEFIC	i í	19 ;	PROVIDER'S PLAN OF CORRECT	Tiest:	(2)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEE LSC IDENTIFYING IN	DEU SVERET	FINERY TAG	(FACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPH DEFICIENCY)	ULD BE	(25) COMPLETION DATE
F 224	Continued From pa disorder, chronic ed dementia, anxiety, disorder.	dema, hype hyre		F 224			
1	Resident 9 resided	on the facility's	SCU.				:
	A review of residen completed on 9/23/	/04.			Resident 9 Fall risk score added 8/23/04 assessment completed a added to one plan.		
	An admission MDS facility staff on 6/1/h had short and long her cognitive skills moderately impaire documented that re with transfers and vilimited assistance, that resident 9 had A quarterly MDS as facility staff on 8/28 9 had fallen within t 31 to 180 days. On 6/1/104, a facility	04, documented term memory profor daily decision d. The facility sesident 9 require was able to amb. The facility staffallen within the seessment complot, documente the past 30 days	I that resident 9 roblems and n making were staff and supervision roblems with feducinented past 30 days.		Resident has been put on the T program that flags residents hig for falls. Resident 9 had consent form up with signatures 10/7/04; new ch documented. A. Bed entrapment updated 9/2. B. New physical therapy evolution restraint reduction 9/29/04. C. Removed side ratis and applied alarm. Bed moved away for wall. D. Physician orders obtained be	h risk dated oice 9/04, tton ico	
	Ascessment for results accessment on the documented on the which indicated that risk.	Rail & Resociat (ident 9. Her for Lassessment a	Use" Alliy muse score of "15",		A. D.O.N. to have inservice of documenting skills on 10,28%		
	On 8/23/04, a facilit Assessment/Side F assessment för res not decument a soc risk.	Rail & Resimint I ident 9. The fac	Use" odity nurse did 🍦				-
4	A review of residen a comprehensive c addressing residen	are plan daied (3/7/04,				

STATEMEN MID PLAN	FOR DEFICIENCIES OF CORRECTION	(X1) PRO 200 1/05USPUTER/CLIA IDENTE E AMOTHUMSTER:	(X2) MULTIPI A. PUILDING	E CONSTRUCTION	(X3) DA i : CGIJI F	
		465 098	III. WILIG		(-7	8/20 04
WAME OF P	ROVIDER OR SUPPLIER	Annual Control of the	. Í Ring, chr., si	AH, ZIP GODE	<u> </u>	0/2004
	COUNTRY CARE	CENTER 1340 F	AST 300 NC UT 84301			
(X4) ID Pel LIX TAG	(EACH DEFICIENC	ATEMENT OF BEFORENCES Y MUST BE FREGENOUS STATE LSC IDENTIFYING INFORMATION)	PRETIX TAG	PROVIDER'S PLAN OF CORRE (FAC) FORRECTIVE ACTION ST CROSS-REFERENCED TO THE APP DEFICIENCY)	IOUED BIE	COMPLETION UAIL
F 224	Continued From p decumentation to e comprehensive pla facility staff.		F 224			
	9's medical record entry: "Nurse fou assisted to WC (w	PM, a nurse's note its resident documented the following ind pt (patient) on floor, heel chair) and then to 2400 (12:00, AM) sitting on floor				
	documented the for "Incident/Accident she wanted to lie of (wheelchair) pt late	Report": "Pt (patient) stated down on floor from WC or found lying on floor assisted d found silting on buttocks next				
	9's medical record entry: "Woke-up a [and] climbing OO (side rails)" The	AM, a nurse's note in resident documented the following t 0400 (4:00 AM) in meming B (out of bed) [and] over SR are was no documentation that ent Report" was completed				
a ¹	'9's medical record entry: "Found pt (p bed and wall, state	5 AM, a nurse's note in resident I documented the following battent) on buttocks between as she was climbing OOB (out e when the bed shifted, s/o tj knee pain"				
	documented the fe	Report": "(patient) found between bed and wallPt c/o				

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AND PLAN	NT OF DEFICIENCIES LOF CORRECTION	(X1) PROVIDER/SUPPLIED/CLIA IDENTIFICATION NUMBER:	. A. BUILDING	E CONSTRUCTION	(X3) (A1) COM	SULTED
i		465098	D. WING		٤.	28/2004
	PROVIDER OR SUPPLIER E COUNTRY CARE	CENTER 1340 E	ORESS, CITY, C			The second secon
	·		. UT 84501			
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF BURIOF NORGS CY MUST BE PRECEDED BY FULL R LSG IDENTIFYING IMPORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	COMPLETION DATE
F 22	documented the f	PM, a facility nurse	F 224			
	resident 9's medic following entry: "D nursing assistant) fell out of bed at 9	00 PM, a nurse's note in sal record documented the ocumented in CNA (certified charting 7/9/04 that pt (patient) 30 PMbeen sitting horself on y the last few days"				
	9's medical record entry: "Pt (patient)	O AM, a nurse's note in resident I documented the following found sitting cross legged on [at] 0630 (6:30 AM) pt lound on f"				
Ì	following on a fax 0530 (5:30 AM) yo found sitting cross	lity nurse &-cumented the foresident Ps physician, "[at] our pt (paliest), tresident 9] was legged on tiour below rails on (6:30 AM) found on floor below				
	documented the formal strength of the formal depth of the document of the docu	Report": "aide found pt pss legged on floor [at] at toe nail area had a few gtts				
* *	9's medical record entry: "Aide found on floor beside be how she got there of being in bed [ar	O AM, a nurse's note in resident idocumented the following pt (patient) sitting cross legged d, pt states she doed not know , later she sixtes she was tired and climbed out. Pt does have 2 welling area under old senile antecubital"				

A BUILDING A65098 A65098 A65098 ACKED PROVIDER OR SUPPLIER CASTLE COUNTRY CARE CENTER ASSET ADDRESS, CITY, STATE, ZIP CODE 1340 EAST 300 NORTH PRICE, UT 84501 ASSET ADDRESS PLAN OF CORRECTION 100 SUMMARY STATEMENT OF DEFICIENCES 100 PROVIDERS PLAN OF CORRECTION (X2) MULTIFLE CONSTRUCTION (X2) MULTIFLE CONSTRUCTION (X3) MATE SURVEY COMPLETED (X4) MULTIFLE CONSTRUCTION (X5) MULTIFLE CONSTRUCTION (X6) MULTIFLE CONSTRUCTION (X6) MULTIFLE CONSTRUCTION (X6) MULTIFLE CONSTRUCTION (X6) MULTIFLE CONSTRUCTION (X6) MULTIFLE CONSTRUCTION (X7) MU	CENTER	RS FOR MEDICAR	E & MEDICA(D \$ 1)	VICES				M ZATEKO ZED JO: 0938-0391		
INVESTIGATION OF SUMMARY STATEMENT OF REPORT ADDRESS. CITY, STATE, ZIP CODE 1340 EAST 300 NORTH PRICE, UT 34501 SUMMARY STATEMENT OF REPORT ADDRESS. CITY, STATE, ZIP CODE 1340 EAST 300 NORTH PRICE, UT 34501 SUMMARY STATEMENT OF RECEDITIONS 1460 DEPORT MIST RE THE CERTIFICATION) FEAT. 140 CONTINUED MIST RE THE CERTIFICATION FEAT. 140 CONTINUED From page 62 On 7/28/04, a facility nurse documented the following on a fax to resident 9's physiciam, "North or pt (patient), fresident) 9' was formed stiting cross legged on floor, SRX2 (add rails lines 2). Pt has 2 cm (centimeter) hump under old senile purpura on [right] antecobilat" On 7/28/04 at 3:00 AM, a facility nurse documented the following on an individualized of being in the bod so she climbed out, pt was sitting cross legged on floor when found by aide 2 cm (centimeter) swelling under senile purpura [right] antecobilat" 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 vening shift and seven of the falls occurred on the vening shift and seven of the falls occurred on the vening shift and seven of the falls occurred on the vening shift and seven of the falls occurred to the vening shift and seven of the falls occurred to the vening shift and seven of the falls occurred to the vening shift and seven of the falls occurred to the product of the vening shift and seven of the falls occurred to the product of the vening shift and seven of the falls occurred to the product of the vening shift and seven of the facility on 9/1904 as a respite resident, with diagnoses which included seizures, urinary tract infections, neurogenic bladder, cancer of the product, the productions, neurogenic bladder, cancer of the product of the product of the product of the product of the product of the product of the product of the product of the product of the product of the product of the product of the product of the product of the product of the product of the product of the product of			IDENTIFICATION IS	Ret (E.P.)	A. BUILDING		(x3) DXT(COM	(X3) DX7C SURVEY COMPLETED		
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FREAT LAC Continued From page 62 On 7/28/04, a facility nurse desumented the following on a fax to resident 9's physician, " Your pt (patient), [resident , [resident), [resident), [resident, [resident], [resident], [resident], [resident], [resident], [resident], [resident], [resident], [resident], [resident, [resident], [resident				1340 E	AST 300 NO					
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 (sade rails times 2)Pt has 2 cm (centimeter) tump under old senile purpura on [right] antecabilat" On 7/28/04 at 3:00 AM, a facility nurse documented the following on an "Incident/Accident Report": "P1 (patient) states she was tired of being in the bod so she climbed out, pt was sitting cross legged on floor when found by aide 2 cm (centimeter) swelling under senile purpura [right] antecubitat" Based on the documentation if 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 evening shift and seven of the falls occurred on the evening shift and seven of the falls occurred on the evening shift and seven of the falls occurred that right 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 prositiet, hypothyroidism, cerebral vascular accident (stroke) with psychotic and agisted 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	PREFIX	EACH DEFICIENT	CY MUST BE PREICHEDED.	BY FULL	PREFIX	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI	ION SHOULD BE HE APPROPRIATE	COMPLETION		
"Your pt (patient), [resident 9's physician, "Your pt (patient), [resident 9] was found sitting cross legged on floor, SRX2 (ade ralk flines 2)Pt has 2 cm (centimeter) tump under old senile purpura on [right] antecebitat" On 7/28/04 at 3:00 AM, a facility nurse documented the following on an "Incident/Accident Report": "Pt (patient) states she was fired of being in the bud so she climbed out, pt was sitting cross legged on floor when found by aide 2 cm (centimeter) swelling under senile purpura [right] antecubitat" 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 avening shift and seven of the falls occurred on the report 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 agityted 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	F 224	Continued From	page 62		F 224			-		
documented the following on an "Incident/Accident Report": "Pt (patient) states she was tired of being in the bud 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 evening shift and seven of the falls occurred on the right 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 agisted 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		following on a fax "Your pt (patient cross legged on ft 2)Pt has 2 cm (d	to resident 9's physical), [resident 9] was to oor, SRX2 (side rails centimeter) Fump ung	tian, und sitting fitnes						
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 evening shift and seven of the falls occurred on the eight 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 agitoted 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		documented the following on an "Incident/Accident Report": "Pt (patient) states she was tired of being in the bod so she climbed out, pt was sitting cross legged on floor when found by aide 2 cm (centimeter) swelling under		ont) states le climbed r when						
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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		that facility staff de individualized to re	eveloped intervention esident 9's needs to r	ıs,	:					
completed on 9/23/04. Resident 10 had multiple stays in the facility for		9/19/04 as a respi which included se neurogenic bladdo hypothyroidism, of (stroke) with psyc	ite resident, with diag izures, urinary tract in er, cancer of the pros erebral vascular accid	noses nfections, tate, dent		Resident 10 was	dischaged.			
				rd was			e.	:		
	a New gr				,			** 1 1		

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSE, THEF/CLL IDENTIFICATION NUMBER	A. BUILDING	E CONSTRUCTION	(X3) DATE SI COMELL	
- :		465098	B. WING		9/28	/2004
NAME OF P	ROVIDER OR SUPPLIER	STE	REET ADDRESS, CITY, S	TATE, ZIP CODE		
CASTLE	COUNTRY CARE	CENTER	1340 EAST 300 NO	ORTH		
	1.1	and the second	PRICE, UT 84501		•	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	T ID :	PROVIDER'S PLAN GF	CORRECTION	(X5)
PREFIX TAG	REGULATORY OR	Y MUST BE PRECEEDED BY FUL LSC (DENTIFYING INFORMATIO)	I. PREFIX N) TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	COMPLÉTION DATE
F 224		age 63 an admission MDS	F 224			
	assessment was o	ompleted by facility staff of	on i	The state of the s		İ
	6/7/04. The MDS	documented that resident	10		,	
	had short and long	term memory problems a	and :		**	
	his cognitive skills	for daily decision making	were			
	clocumented that a	ed. The facility staff				
		esident 10 was able to tra istance and ambulate with				
		ce. The facility staff	'			1
	documented that r	esident 10 had no fall acci	idents	*		
	in the past 180 day					
	On 6/7/04 a facilit	y nurse had completed a "	l .			
	Risk Assessment/s	Side Rail & Rostraint Uce"				
	assessment for res	sident 10. The facility nurs	se			
ł	documented on the	e assessment a score of "	21",			
1	which indicated that	at resident 10 was a high f	all			
i	risk.					
	A review of resider	nt 10's medical record,				
		hensive care plan dated				
		g resident 11% fall rick. Ti	here			!
į		tion to evidence that the				
į	facility staff.	e plan had been updated	by			
i	racility start.					
	On 3/24/04 at 8:30	PM, a nurse's note in resi	ident			
	10's medical record	d documented the following	g			ŀ
	entry: "In DR (dinin	g'room), re:: (resident) wa	is		·	
	[with] granddaughte floor"	er [and] fell, she cased hir	n to			
	HOUL				i	
	On 3/24/04 at 6:00	PM, a facility nurse				
	documented the fo	llowing on an			į	1
1	"Incident/Accident	Report": "Res (resident)) :		!	
-	began to fall [and]	granddaughler eased him	to		ļ	
1	floor"					
	On 3/26/04, a facili	ty nurse socumented the				
1	following on a few t	G narso resumented the	-	e ²	4.00	
1	ronowing on a lax of	o resident 10's physician.		The second secon		

(X1) PROVIDE RISURTS LESSED A MODIFICATION (X1) PROVIDE RISURTS LESSED A MODIFICATION MASSER.		A WASELES	(X2) MULTIPLE CONSTRUCTION A IMPLEDING B. WING			TE SURVEY MELETED	
400000			· · · · · · · · · · · · · · · · · · ·				9/2 8/2004
CASTLE COUNTRY CARE CENTER 1340 E/				AST 300 NO UT 84501	TATE, ZIP CODE DRTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DECICIEN CY-MUST BE PRECEITORI R LSC-IDENTIFYING INFO	CESS OF BUILDING	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TI- DEFICIENCY	ON SHOULD BE IE APPROPRIATI	(25) COMPLETION DATE:
F 224		page 64 I a fall 3/24/04 - no	apparent	F 224	1		
	On 6/18/04 at 8:45 PM, a nurse's note in resident 10's medical record documented the inflowing entry: "pt (patient) crawled under seat belt restraint [and] fell on floor. [no] apparent injury"						
	following on a fax "Your Pt (patient waist restraint in w injury. Can we har agitation [and] for Remeron, Haldol r	n 6/18/04, a facility nurse documented the dowing on a fax to resident 10's physician, Your Pt (patient) [resident 10] slid under soft sist restraint in w/c (wheelchair) [and] fell. [no] sury. Can we have something to help his illation [and] for sleep. Resperdol [sic], meron, Haldol nothing still tries to climb out of d 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"						
	following on a fax t "[resident 10] clir [and] fell on floor - your information) a Haldol not working something. Consta	ty nurse documento o resident 10's phy nbed under seat be [no] apparent injurgain: Risperdal [sic. but [sic] about a santly crawling out of bed alarm too [and] o)"	sicien, It restraint /. FYI (for I, Remeron, leeper? or bed at				
ľ	On 6/21/04 at 9-50	PM, a facility nurse					

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDENCE OF RECEIA IDENTIFICATION NUMBER:	(X2) MUCTIFY A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE COMI	O. 0938-039 SURVEY SETED 28/2004
AME OF PROVIDER OR SUPPLIER ASTLE COUNTRY CARE	CENTER 1340 F	L DRESS, CHY, ST AST 300 NO UT 64501			26720114
REFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	'D PRI-FIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	LISHOULD BE	COMPLETION (X6)
F 224 Continued From p documented the fo "Incident/Accident waist restraint over [and] fell by bed	llowing on an Report": "Pt (patient) pulled head in w/c (wheel chair)	F 224		: '	
10's medical record entry: "sat in fron (wheel chair) (with) and stood up - was aide got by him and floor as he started Ativan 0.5 g mg po There was no docu	PM, a nurse's note in resident didocumented the following to finures station in w/c restraint. Got out o'r estraint walking holding onto chair did held him and eased him to to fall. Order from Dr. (doctor) (by mouth) ghs (every night)," imentation that an Report" was completed.				
10's medical record entry: "Aride respon (patient) lying on R bed, small superfice bed alarm secure, I On 7/5/04, a facility following on a fax to "your pt. (patient) [r R (right) side on flo	M, a nurse's note in resident documented the following ded to yelling found pi (right) side below left side of ial abrasion R (right) kneePt removed by pt" Thurse documented the president 10's physician, esident 10's physician, esident 10 was found lying on or below raused bed rails, age of motion), superficial 1 cm				
(centimeter) abrasi unclipped bed alarr On 7/5/04 at 3:00 A documented the fot "Incident/Accident I yelling found pt (pa	on R (right) kneed pt had m." M. a facility nume lowing on an Report: "Aide responded to tient) lying on R (right) side on on floor, superficial (4 cm)				
Resident 10 had an	other Respite stay from	-			

CENTER	S FOR MEDICARE	MEDICAPO	AUCES				MAPEROVED O. 0938-0391
STATEMEN AND PLANT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPIDENTIFICATION	NUMBERCE.	(X2) MUETIP A. BURDING B. WING	LE CONSTRUCTION	(X3) DATI	
		4650	93			- l g/	28/2004
	ROVIDER OR SUPPLIER		STRUET ADV	TESS, CITY, S	FATE, ZIP CODE		
CASTLE	COUNTRY CARE	CENTER -		AST 300 NO . UT 84501	ORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIE! Y MUST BE PRECEFOE LSC IDENTIFYING INFO	D BY FULL 1	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DUTICIE	CTION SHOULD BE DITHE APPROPRIATE	(X5) COMPLETION DATE
F 224	Continued From p 9/19/04 to 9/23/04. current respite stay completed on 9/23	Review of resider	nt 10's was	F 224			
	There was no docu current Fall Risk A Plan for resident 10	ssessment or Fall	ence of a Risk Care				
	On 9/20/04 at 10:1 resident 10's media following entry: "Fo (wheel chair)." At nurse documented (sic) that he hit the noted on back of himonitor for problem	cal record docume bund in room in froi 10:50 AM, the sam , "Told son when !: back of his head ead. Will contin. (c	nted the nt of W/C re facility ne came it Small (?)				
	On 9/20/04 at 10:1 documented the fo "Incident/Accident i on floor in front of V was looking for son son at 10:50 AM he	lfówing on an Report": "Found N/C (wheel chair). i. No apparent inju	pt (patient) Said he rry. Told				
	On 9/21/04 at appr surveyor observed bed against the wa open side of the be himself to a sitting over the side rail. f getting ready to clir alarm cord was obs inches long. The b he was at the edge bottom of the bed, and his upper body	resident 10 in his I II and a side rail up d. Resident 10 was position with both o Resident 10 appea nb over the side ra served to be appro ed alarm did not so of the bed, close I with his legs over to was leaning forwa	bed with the point the poi				
	time the surveyor to another room, to he fall. The aide came resident 10 what he	elp resident 10 so le into the room and	he would not I asked		,		

DELANTMENT OF HEALTH AND HUMAN SET VIOLS FORM APPROVED CENTERS FOR MEDICARE & MEDICAID ! OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROMBI R/SUPPER R/CHA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 465098 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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETICAL PREFIX (EACH DEFICIENCY MUST BE PRICEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 224 Continued From page 67 F 224 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 eatch 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 inpury. 6. Resident 14 was admitted to the facility on 12/2/03 with diagnoses which included left hip fracture, insomnia, neurogenic bladder, irondeficiency 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.

STATEMENT OF DEFICIENCES AND PLAN OF CHRESTOR AND PROVIDER OF CHRESTOR AND PROVIDER OF CHRESTOR AND PROVIDER OF CHRESTOR AND PROVIDER OF CHRESTOR AND PROVIDER OF CHRESTOR AND PROVIDER OF CHRESTOR AND PROVIDER OF CHRESTOR AND PROVIDER OF CHRESTOR AND PROVIDER OF CHRESTOR AND PROVIDER OF CHRESTOR AND PROVIDER OF CHRESTOR AND PROVIDER OF CHRESTOR AND PROVIDER OF CHRESTOR AND PROVIDER OF CHRESTOR AND PROVIDER OF CHRESTOR AND PROVIDER OF CHRESTOR AND PROVIDER OF CHRESTOR AND PROVIDER OF CHRESTOR AND PROVIDER	DEPART CENTER	MENT OF HEALTH RS FOR MEDICARE	AND HUWAN TEC	MOES IOES				A APPROVED
MAME OF PROVIDER OR SUPPLIER CASTLE COUNTRY CARE CENTER 1340 EAST 300 NORTH PRICE, UT 34501 PRICE, UT 345				1			SURVEY	
CASTLE COUNTRY CARE CENTER 1340 EAST 300 NORTH PRICE, UT 84501 PRICE, UT 84501 PRICE TAG PRODUCERS PLAN OF CORRECTION (EACH DEPOCENCY MUST BE PRECEDED BY FULL TAG PRICE CROSS REFERENCE OF THE APPROPRIATE DEFICIENCY) F 224		•	465098		B. WING		9/2	8/2004
PRICE, UT 84501 PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION RECOULT ONLY OR LSC DENTIFY TOLL RECOULT ONLY OR LSC DENTIFY TOLL PROVIDER'S PLAN OF CORRECTION RECOULT ONLY OR LSC DENTIFY TOLL PROVIDER'S PLAN OF CORRECTION PR				i				
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 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. Do 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 medical 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"	CASTLE	COUNTRY CARE	CENTER			ORTH		
A quarterly MDS assessment was completed by facility staff on 8/3/04. Facility staff obcumented 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	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEEDED I	Y FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
climbed out of foet 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	F 224	A quarterly MDS as facility staff on 8/3/that resident 14 ha memory and his comaking were modificated with no ratio oblivious to needs documented that reand ambulate with staff documented that reand ambulate with staff documented thin the past 30 days On 5/25/04 and 8/2 the "Fall Risk Asse Use" assessments assessments assessments, resident assessments, resident assessments. A review of resident revealed a comprel 12/3/03, addressing was no documenta comprehensive pla facility staff. On 3/17/04 at 3:45 documented the follower world in the resident assessments assessments assessments assessments assessments.	sessment was compod. Facility staff duc d problems with his signitive skills for daily ided independence. It is the that resident 14 was able to limited assistance. That resident 14 was able to limited assistance. That resident 14 had frand the last 31 to 18 is identified. A considerable of the last 31 to 18 is identified to	umented short term of decision of the facility wandered egly ty staff or transfer in the facility allen with 80 days. completed Restraint both both core was as a high decision. There the indicated by	F 224	Resident 14 care plan has be updated noting all listed incir. Resident has been put on the program that flags residents I for falls. D.O.N. to have inservice on documenting skills on 10/28/ 1DT meeting 10/21/04 W/C ala effective, resident removes clip times and continually get up with these. Gait unsteady. Lap	dences. Timber high risk 04. rm not 6	
entry: "Pt (patient) had fall kicked self over in WC		climbed out of foot X2 (times 2) Fell or On 3/27/04 at 2:00 14's medical record	of bed, SR (side rail n floor" PM, a nurse's note it I documented the fo	present n resident				

On 3/27/04 at 11:00 AM, a facility nurse documented the following on an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		N IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING IS WING		O. 0938-03 H SURVEY LETED
CASTLE COUNTRY CARE CENTER 1340 E/			DRESS, CITY, S EAST 300 NO E, UT 84501		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	28/2004	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENC LY MUST BE PRECEDED LSC IDENTIFYING INFOR	BY FOLL	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE
F 224	"Incident/Accident (wheel chair) kicked falling on back side shoulder" On 3/31/04, a facil following on a fax to	Report": "Patient and chair [and] flipped a. Red mark on [left all numbers documents to resident 14's plays to resident 14's plays	WC over	F 224			
	(patient) climbed out of foot of bed. SRX2 (side rails times 2) present. Found on floor" There was no decumentation that an "Incident/Accident Report" was completed regarding this fell. On 4/24/04 at 9:00 PM, a nurse's note in resident 14's medical record documented the following entry: "[At] 16:30 (4:30 PM) nos (resident) FOF (found on floor) in hallway outside his room- SR (side rails) were both up. Ros had swelling [and] bruising [with] scrapes above [right] eye [and] scratches to sm (small) finger on (right) hand, eyes unequal, unreactive to fight"						
	documented the fo "Incident/Accident climbed over [and] into hall- res found [and] swelling form	PM, a facility nurse flowing on an Report": "Res (res around SR (side rail on [right] side (with] ing above [right] eye - eye unequal, unrea) [and] fell bruise [with]				
	a "Referral Physicia climbed over side r head 4/24/04 (1630	e documented the following on an/Clinice", "Resident ail walked into hall [and] feil hit 0) (4:30 PM)Pupila are not reactive to light"					
-	record documented (patient) found on f	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"					
ORM-CMS-2	2567(02-99) Previous Vo	rsions Obsolete		ne e mane anno como como como em com <u>o de como e</u> essen	4lB111	If continuation : is	el Page 70 of 106
	$C = \frac{1}{2} \frac{1}{n^2} = 1$						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERVSORDER IDEN REICATION NU	MBER:	(X2) MULTIP A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE BURNEY CQL 11:155 5128/2004	
	ROVIDER OR SUPPLIER COUNTRY CARE	CENTER	1340 E	AS 7 300 NC . UT 84501	ATE, ZIP CODE DETH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATÉMENT OF DUFFCILTED Y MUST BE PRECEEDED I LSC IDENTIFY ING INFORM	JY FULL !	ID PREFIX FAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	MLD BE	OV 55 COMPLETION
F 224	Continued From pa	age 70		F 224		F TO 10 MARK	
9	On 7/4/04 at 6:00 F documented the fo "Incident/Accident crawling out of PVC	llowing on an Report": "Found o	n floor		en en en en en en en en en en en en en e	i de la companya de l	
	14's medical record entry: "Pt (patient)	PM, a nurse's note in I'documented the fo found on licer in nex nst bed in merri [pic]	llowing Croom	.			
		llowing on on Report": "Pt (patie m over, lying against					
	following on a fax t	r nurse documented o resident 14's physi [resident 14] was fo walker"	ician,				
	14's medical record entry: "[At] 1915 (7:	PM, a nurse's note in documented the focute (15 PM) resident in his room next to"	llowing () was				
er s	documented the for "Incident/Accident I	Report": "Res (res c in rm;(room) next to		.			
* * * * * * * * * * * * * * * * * * *	14's medical record entry: "Pt (patient):	PM, a nurse's note in documented the for found on floor [with] inp on top of head no	llowing a				

STATEMEN AND PLAN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/ISU, 9/UCB/ICLIA IDENTIFICATION RUMBER:	(CC) MULTIP A BUILDING	LE CONSTRUCTION	(X3) EAT: COMP	
	Îr	46 5098	B. WING		93	8/2004
	ROVIDER OR SUPPLIER		RESS, CHY, S	ATÉ, ZIP CODE		
CASTLE	COUNTRY CARE		AST 300 NC . UT -84501	DREH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCILS Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID FREEK TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REPERENCED TO THE DEFICIENCY	ON SHOULD BE LE APPROPRIATE	DATE COMPLETION (XA)
F 224	Continued From p	page 71	F 224			
	documented the for "Incident/Accident over to [right] side	Report": "Pt (patient) tipped in merry walker in room. 1. 2				
		r) abrasion 2. Reddened area 3. Abrasion (1 x 2 cm) [at right]				
	following on a fax "[resident 14] too room- fell on [right	ity nurse documented the to resident (4's physician,) of a fall in his geri-chair in his jede, hit his head [and] pioned chairLump on top of head le"	- 1			
	that resident 14 ha 9/14/04. One of the shift, six of the fall and one of the fall	mentation if was determined di 8 fails from 3/17/04 until le fails occurred on the day s occurred on the high shift sidd not have any to what time it occurred.				
	that facility staff de individualized to re falls or to minimize 7. Rosident 15 was 5/8/01 with diagnor dyspnea, angina, a Resident 15 reside A review of resider completed on 9/23 A quarterly MDS a facility staff on 7/8/	s admitted to the Lacility on ses which included Alzheimers, anxiety and arrhythmias. d on the facility's SCU.		Resident 15 Physical rest updated 10/12/04. A. Orders obtained for pitherapy to re-evaluate or B. Orders obtained to De 10/05/04 and apply low I alum and Iap buddy whe wheel chair. Resident 15 Care plan up all incidences and fall ris Resident has been put on program that flags reside for falls.	iysical 1 9/29/04 2 SR's on 2 od vith bed 2 op in 2 odded with 3 k scores. 1 the Timber	

	T OF DEFICIENCIES OF CORRECTION	(x1) PROVIDER/SUPPLE F IDENTIFE ATION HOS			E CONSTRUCTION	(X3) DA11	SURVEY LC44:D
VEHIN LEVEL C	OF COMPLECTION	STATEMENT AND AND DESIGNATION OF THE STATEMENT OF THE STA	20 1. J. K.	A DOMESTIC	a service of the second of the service of		11.11
		465098		B WING		S.	28/2004
NAME OF P	ROVIDUR OR GUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZP CODE		
CASTLE	COUNTRY CARE	CENTER		AST 300 NO , UT 84501	DRTH		
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F 224	Continued From	page 72		1- 224			
	term memory and decision making v facility staff docur able to transfer w	her cognitive skills for were moderately impainented that resident 1: ith supervision and on ance. The facility staff	ind. The ∋ was ibulate				
·	documented that	resident 15 had fallen the last 31 to 180 day:	within the			4	
	Assessment/Side assessment. The the assessment a	ly nurse completed a "I Rail & Restraint Use" a facility nurse, docume a score of "18", which i was a high fall risk	uted on				
1 -4 -4	Assessment/Side assessment. The the assessment a	ility nurse started a "Fa Rail & Restraint Use" e facility nurse docume a score of "24", which i vas a high fell risk.	inted on	-			
	rovealed a compr 2/16/04, addressi was no documen	ent 15's medical record rehensive care plan da ng resident 15's fall ris tation to evidence that lan of care had been u	ted k. There the				
	15's medical reco	io PM, a nurse's note in ord documented the for floor next to bed. Side ea on back [at] center	lowing				
	following on a fax	ility nurse decumented to resident 15's physiound on floor [at] bedsi	cian,				
	documented the	80 PM, a facility nurse following on an at Report": "Found c	on floor				

CENTER	S FOR MEDICARE	WIND LIGHT WORKS	IUES IDES				A.APERC VEO = 0. 0938-0 3 91 =
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIED IDENTIFICATION NUM		(X2) MULTIPL A. BUILDING	L CONSTRUCTION	(X3) DATE 1. COM: 1.	SURVEY
		465098		B. WING		9/2	8/2004
	ROVIDER OR SUPPLIER COUNTRY CARE (CENTER	1340 EX	REOS, CITY, ST AST 300 NC UT 84501			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF PERFORMORY Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORM	7 FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	DAH COMPLETION DAH
F 224	[at] waist line"	age 73 Måll) reddbried area ; PM, a nurse's note ir		F 224		The first contract of the cont	
	15's medical record entry: "Res (resider (room) next to bed.	I documented the felt nt) FOF (found on fle u"	lowing				
	documented the fol "Incident/Accident found on floor in rm in On 5/30/04, a facilit	Report": "Res (resi r (room) next to bed	the			, , ,	
	"[Resident 15] was PM) 5/30/04, it is u	found on floor [at] 18	340 (6:40				
37	15's medical record entry: "Found on Sitting on bottom"	I documented the foli floor [at] 2130 (9:303 There was no an "Incident/Accider	ewing ²M).				
	resident 15's medic following entry: "Re	DPM, a nurse's note sal record documents sident wanted to get elchair, tried to get u	ed the out of				
	documented the fol "Incident/Accident for bed- was up in V	: DPM, a faoiliú nurse llowing on ta Report": " Wanted t V/C (wheel chair) in fi up and slid down wa	o get out				
	following on an "Inc	rnurse documented I bident/Accident Repe g room) at 9:15 PM,	rt":		4		

STATEMEN	RS FOR MEDICARE BY OF DEFICIENCIES	(X1) PROVES REQUEEN	P.P. CD	(X2) MUL (IPI	E CONSTRUCTION		OMB NO. (X3) DATE SU	<u>0938-0391</u>
AND PLAN	OF CORRECTION	IDENTIFICATION 13		A. BUILDING	190 F1 (886m) 11 (97 (97 (97 (97 (97 (97 (97 (97 (97 (97		COMPLET	
		46509	8	B. WING		-	9/28/	2004
	ROVIDER OR SUPPLIER			ORESS, CITY, ST.				
CASTLE	COUNTRY CARE	CENTER	1	AST 300 NO , UT 84501	RTH			
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F 224	On 7/10/04, day st	erself on floor severa fall" nift, a nume's note in d documented the fo	r tesident	F 224				
- Property and the second seco	to nurse the res (r (evening) shift, 7/9 'fell in DR (dining r nurse assessed p	ied nursing assistant esident) had fallen or 0 CNA documented foom) at 9:15 (9:15 F. (patient). Pt has sa several times in the patient"	n 7/9 eve ollowing PM)', eve it nerself					
∳ - p = 1.	15's medical recor	PM, a nurse's note in d documented the fo oor in DR (dining roo	lowing				:	
	documented the fo	Report": "Pt (patie	ent) found	ļ		. **	,	
	following on a fax	y nurse documented to resident 15's physic found on the floor in	ician,					
	that resident 15 ha	imentation it was de id 6 falls from 4/22/0 ne falls occurred on t	4 until	,				
	that facility staff de individualized to re	umentation to provide eveloped intervention isident 15's needs to mize potential injury.	ıs,					
	5/17/04 with diagn	vas admitted to the footses which included cardiovascular accid	,		Resident CL 6 was di	scharged.		
ORM CMS-	2557(02-99) Previous V	ersions Obsoleio			4IB111	If con	tinuation : Levet	Page 75 of 100

AND PLAN OF CORRECTION	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A BUILDING		T-1ED T-1ED
	46509	ર	B. WING			
NAME OF PROVIDER OR SUPPLIE			DIVINO OUTV. O	TATE, ZIP CODE	9/2	28/2004
CASTLE COUNTRY CAR		1340 E	EAST 300 NO , UT 84501			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENC NCY MUST BE PRECEDED OR LSC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	COMPLETION DATE
hemorrhage, and disease. A review of resid completed on 9/2 An admission MI facility staff on 5/2 CL6 had short ar and that her cogg making were mo staff documented extensive assistate eating, toilet use facility staff docu fall accidents in the company of t	ent CL6's medical rec 23/04. DS assessment compliance of the comp	eted by at resident problems discone facility pured neutron, if the CL6 had no a "Fall Risk" tilly nurse the of "17", a high fall production. There I the pupdated by the problem of the p	F 224	DEFICIENC	Y)	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPERINDENTH REACTION FROM 18 465098	MOER	(X2) MULTIPI A BUILDING B. WING	E CONSTRUCTION		LETED
	ROVIDER OR SUPPLIER		1340 E	BRESS, CITY, STATE, ZIP CODE AST 300 NORTH , UT 84501			28/2004
(X4) ID PRLEIX TAG	I (EACH DEFICIEN)	TATEMENT OF DEFICIENCE CY MUST RE CHE CLEDED OF R LSC IDENTIFYING INFORM	VEFULL	ID I PREFIX I	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETIO.
F 224	On 6/18/04, a fact following on a fax	lity nurse documented to resident CL6's play ver chair on to bottom	sician,	F 224 ;			
	CL6's medical red entry: "Pt (patient down she missed	0 AM, a nurse's note is cord documented the lipeing toileted when seat [and] sat on floothout injury apparent,	following sitting r between	1 :			
	documented the f "Incident/Accident assisted to toilet,	o AM, a facility nurse ollowing on an EReport": "Pt (patics aide then left to get br d toilet seat sitting do	ief pt sat.	:			
	medical record do "Had anew [sic] in her room and four bed" There was	se's note in resident (icumented the followic cident. [facility aide] id her sitting on floor in documentation the Report" was completed	ig entry: went into next to at an	 - - - - - - -			
ere (Ar	resident CL6's me following entry, "P in front of w/c (wh chair" There wa	00 PM, a nurse's nete edical record document f (patient) found sittin eelchair). Said 'I slid is no documentation t Report" was complet	nted the g on floor out of hat an			\$ 	
	documented the f	O AM, a facility nurse ollowing on an Report": "Pt (patie alked to door of room "					
			[mu] silu				

elbow..."

landed on pt (patient) sm (small) skin lear fright].

"Incident/Accident Report": "Pt (patient) untied restraint from w/c (wheelchair) stood ug- 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) frund with wheel

On 7/29/04 at 5:30 PM, a facility nurse documented the following on an

Comment IC VIII AND DEPARTMENT OF HEALTH AND HUMAN - RVICES **FOLM APPROVED** CENTERS FOR MEDICARE & MEDICAID . RAVICES OMB NO 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPLIDER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED B. WING 465003 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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S FLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION FREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 224 Continued From page 78 F 224 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. Resident 4 Bed entrapment updated individualized to resident CL6's needs to reduce her falls or to minimize potential injury on 9/22/04. A. Order for physical therapy re-Residents who had potential for experiencing evaluation for restraints 9/29/04 harm as a result of falls included the following: update. B. De seat belt while up in wheel 9. Resident 4 was admitted to the facility on chair. 11/28/04 with the diagnoses of pre-senile C. Ordered low bed, with bed alarm dementia, Alzheimers, falls, and hypothyroidism. and wheel chair alarm on 10/06/04 D. Physical restraint consent updated A review of resident 4's medical record was 10/07/04. completed on 9/23/04. E. Monthly Summary... D.O.N. to inservice all nursing staff 10/28/04 on A quarterly MDS assessment dated 8/21/04 decumenting skills. documented that resident 4 had short and long F. Order obtained 10/06/04 to Determ memory problems and her cognitive skills SR's. for daily decision making were moderately Resident 4 care plan updated with fall impaired. The facility staff documented that dates applied. resident 4 was able to transfer with limited Resident has been put on the Timber 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

for falls.

program that flags residents high risk

EMENT OF DEFICIENCIES (X: PLAN OF CORRECTION	PROVIDENSUPPRIEDS IDENTIFICATION NUMB	OLIA IER.	(X2) MULTIPL A. BUILDIES	CONSTRUCTION		(X3) DV TU S COMPLI	URVEY JED	
	465098		n, which			9/28/2004		
E OF PROVIDER OR SUPPLIER		STREET ADDR	Las, CITY, Si	ATE, ZIF CODE	···			
STLE COUNTRY CARE CE	NTER		ST 300 NC JT 84501	RTH				
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224 Continued From page	∍ 79		F 224					
On 2/24/04, a facility Assessment/Side Rai assessment for resid documented on the a which indicated that risk.	L& Restraint Use" ent 4. The facility massessment a score of	arse of "21",						
On 5/25/04, a facility Assessment/Side Rai assessment for resid documented on the a which indicated that r risk.	I & Restraint Use" ent 4. The facility no ssessment a score	urse of "21",		\$				
On 8/16/04, a facility Assessment/Side Ra assessment for resid documented on the a which indicated that r risk.	I & Restraint Use" ent 4. The facility or ssessment a score	urse of "19",			•			
A review of resident 4 a comprehensive car addressing resident 4 documentation to evicomprehensive plan facility staff.	e plan dated 11/28/0 's fall risk. There w dence that the	o4, as no						
On 12/12/03 at 10:00 resident 4's medical r following entry: "CN/ reported finding Pt (p (wheel chair)"	ecord documented A (certified nurses as	the ssistant)						
On 12/12/04, a facility following on an "Incid" "CNA (certified nurshinding pt (patient) on	ent/Accident Report ses assistant) report	t": ted	:					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID FMICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCES. (X1) PROVIDER/SUPEREZ/CEA 0323 MULTIPLE CONSTRUCTION (X3) DA - C SURVEY AND PLAN OF CORRECTION IDENTIFICATION (JUDITER) COMMERCED A FUILDING hi wasa 465098 : /28/2004 STREET ADDRESS, CITY, STATE, 7IP CODE NAME OF PROVIDER OR SUPPLIER CASTLE COUNTRY CARE CENTER 1340 EAST 300 HORTH PRICE, UT 84501 PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PELICEEDED BY FULL LIZEROX REGULATORY OR LISC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 80 F 224 (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: "pf (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 nume's note a resident 4's medical record documented the following entry: "pt (patient) found on Boor of PH: (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 fleftl 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 (ballaroom) 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 butlocks between wc (wheel chair) [and] toilet, pt states she was moving to we when she slipped and fell to buttocks, denies pain..."

DEPARTMENT OF HEALTH AND HUMAN TERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID RVICES OMB 73O, 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPER BACLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COPPLETED ALPONEDISG. B. WING 465098 1/28/2004 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CASTLE COUNTRY CARE CENTER 1340 EAST 300 NORTH PRICE, UT 84501 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION PREFIX FREEK (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 81 F 224 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 wo when she slipped and fell to floor. Pt we 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 bod, bed rails up-X (times) 2...". On 1/15/04 at 5:40 AM, a facility nume 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...pl 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

FORM CMS-2567(02-99) Previous Versions Obside ac

[right] side, pt c/o (complains of) bump on [right]

ND PLAN OF COR	EFICIENCIES RECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NO		(X2) MULTIP! A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		465098	; F.	is. WING			9/28/2004	
ASTLE COLL	ER OR SUPPLIER	ENTED	1	DRESS, CITY, ST	J			
37001 EL COO	MINT OAKE C	ENTER		AST 300 NC , UT 84501	KIH			
(X4) ID PREFIX (I TAG E	EACH DEFICIENCY	TEMENT OF DEFICIENCE MUST BE PUT CEEDED: 0:1 SCIDENTE SINGING OFF	FF FULL	IO PRIDIX TAG	TROVIDER'S PL (EACH CORRECTA CROSS-REFERENCE 'DEF	Æ ACTION SHOL	ILD 185	COMBAT 1881 COMBAT 1881
susta	linued From pa sined small bun e ear"	ge 82 np on [dyin] side of	head	F 224	THE COMMISSION OF THE PARTY AND THE PARTY AN			
4's m entry	nedical record c	PM, a nurse's nore i locumented the felic lient) on Poor by be p [and] fell"	wing					The state of the s
docur "Incic	mented the foll lent/Accident F out of bed) [an	PM, a facility nume owing on an (eport": "PL (palie d] slid to foor - unse						
recor		's note in resident 4 the following entry: g on floor"		!				
docui "Incid	mented the foli fent/Accident R	PM, a fnolity nurce owing on an aport": ". Found of staff member"	i floor by			,		
4's m entry: states	iedičal record d : "pt (patient) f	PM, a nume's note in ocumented the folic ound on floor by be, nder w/c (wheel char self to bed"	owing 5, pt					
docui "Incid on flo	mented the folk tent/Accident R oor by bed - sta	PM, a facility nurse owing on an eport": "pt (patien tes she slid out of ç ying to put self to b	háir					
4's m entry: aide f	edical record d : "During routir	AM, a nurse's note in ocumented the folione end of shift bed on at) sitting cross legg	owing checks					
	2-99) Previous Ver	-i Ob- 1-i			4lB111	if en	ofinantian : Los	t Page 83 of 105

DEPARTMENT OF HEALTH AND HUMAN TERVICES FIG. IM APPROVED CENTERS FOR MEDICARE & MEDICAID OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES: (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION CONDAIL SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A SUILDING B. WANG 465098 1/28/2004 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CASTLE COUNTRY CARE CENTER 1340 EAST 300 NORTH PRICE, UT 84501 (X4) ID SUMMARY STATEMENT OF DEFIGIENCES PROVIDER'S PLAN OF CORRECTION (27) 3 (280) (110) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREEDX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE. DEFICIENCY) F 224 Continued From page 83 F 224 On 6/30/04 at 6:00 AM, a facility nurse documented the following on an "Incident/Accident Report": \...Aide found of (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. Resident 11 Entrapment risk updater There was no documentation of evidence that 9/22/04. facility staff developed interventions. A, order for physical restraint individualized to resident 4's needs to reduce her evaluation per physical therapy fails or to minimize potential injury. 9/22/04. B. Evaluation completed per physical 10. Resident 11 was admitted to the facility on therapy 9/29/04. 8/2/04 with the diagnoses of collulities of face. C. Recommended Deling, SR's appliatrial fibrillation, hypertension, congestive heart bed alarm. Keep lap buddy due to failure with anxious features, and edema. nation) request. D. Orders received 10/05/04 to De-A review of resident 11's medical record was SR's, ded alarm applied. completed on 9/23/04. E. Nurse to document Weekly soap notes of resident's ability to remove An admission MDS assessment completed by and replace lab buddy and also note facility staff on 8/15/04, documented that resident 11 had short term memory problems and her on ty rand. 2. D.O.N. to hold inservice on 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 10/28/04 covering documentation unit with supervision. The facility staff documented that resident 11 had no fall accidents skids.Eesident 11 care plan updated in the past 180 days. with all incidences. Resident has been put on the Timber

On 8/2/04, a facility nurse completed a "Fall Risk" Assessment/Side Rail & Restraint Use". assessment for resident 11. The facility nurse

*X 365 - 57

program that flags residents high rist. - 8 continuation inset Page 84 of 175

for falls.

465938 B. WING NAME OF PROVIDER OR SUPPLIER CASTLE COUNTRY CARE CENTER 1340 EAST 300 NORTH	5/28/2004
CASTLE COUNTRY CARE CENTED 4040 F CT 200 NORTH	
PRICE UT 84501	
PREFIX FOR (EACH DEFICIENCY MUST BE PERCUIDED BY FULL FOR PREFIX (EACH COL	FRS PLAN OF CORRECTION RECTIVE ACTION SHOULD BE COMPLETION FRENCED TO THE APPROPRIATI DEFICIENCY) OFFICIENCY
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 falt risk. There was no documentation to evidence that the comprehensive plan of care bad been updated by facility staff.	
On 8/5/04 at 3:15 AM, a numer's note in resident 11's medical record documemed the rellowing entry: "Nide was assisted pt (nationt) ambulate to bothroom, as he reached to him on hailinroom light, pt lost batance [with] wilker fell buckwards hitting back on wall [and] slid to floor, striking [left] dersal 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 fail.	
On 8/19/04 at 9:00 PM, a nurce'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 facifity 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 injuriesi.ap belt restraint was still attached to wheelchair. She stated she had [no] pain."	

STATEMEN AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SULFFLIE IDENTIFICATION NUM		A. BUILDING	LE CONSTRUCTION	(X3) DATE: S COMPL	SURVEY ETED		
		465098		B. WING	to the copy of the second seco	9/2	8/2004		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, 3	FATE, ZIP CODE				
CASTLE	COUNTRY CARE	CENTER		EAST 300 NORTH E, UT 84501					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE / MUST BE PRECEEDED R LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	COMPLITION DATE		
F 224				F 224					
		PM, a nurse's note in I documented the following							
	entry: "pt (patient)	found on floor. State							
	(bathroom)"	urn to bed from BR							
		e de la deservición de la defendación de la def							
20 (M)	documented the fo "Incident/Accident I on floor in Room st	PM, a facility nurse flowing on an Report": "pt (patier ates 'I got up to go to when I tried to get bac	the						
	resident 11 had 3 fa	ntation it was determinalls from 8/5/04 to 9/4 don the evening shift on the night shift.	4/04. Two						
	facility staff develop individualized to res	mentation of evidenc bed interventions, sident 11's needs to r nize potential injury.							
	1/28/04 with diagno	as admitted to the factions admitted to the faction of the faction	eft BKA		*				
	facility, a facility nur fallen after she had	the entrance tour of rse stated that reside her leg amputated to e leg was gone and t	nt 12 had ecause						
	12 was interviewed Resident 12 was at	oximately 10:25 AM, by a nurse surveyor ole to recount the reco. Resident 12 states	ent						

when she came back to the facility after her amputation she fell many times: "eight times in

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TATEMENT OF DEFICIENCIES	RE & MEDICAID AVICES (X1) PROVIDE RESUPPLIE ACIDA	(X2) MUCSET	1 GONSTRUCTION	(X3) DATE: S	
NND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING		COMPL	
	465090	B. W866:		9/2	8/2004
NAME OF PROVIDER OR SUPPL		ET ADERESS, CITY, ST			
CASTLE COUNTRY CA		340 EAST 300 NC RICE, UT 84501	e ctu		
PREFIX . (EACH DEFICI	Y STATEMENT OF DEFICIENCE S ENCY MUST BE THE CELDED BY FULL OR USC IDENTIFYING INFORMATION)	D PRELIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REPERENCED TO THE AP DEFICIENCY)	HOULD BE	COMPLETION DATE
12 was asked walter the falls to Resident 12 representation. A review of rescompleted on State of the same of the	ver there in that comer." Resi what action the facility had take "keep you safe or help you". liled "they kept adjusting my dent 12's medical record was /23/04. ay MDS assessment complete an 2/4/04, documented that gnitive skills for daily decision odified independent. The facil ad that resident 12 required tance with bed mobility, transfuse and personal hygiene. The unented that resident 12 had	ed lity ers,			
On 3/23/04, a f. Assessment for documented or which indicated risk. On 7/1/04, a fa Assessment/Si assessment for documented or which indicated risk. A review of resi revealed a come 2/17/04, addres was no docume assessment for documented or which indicated risk.	last 31 to 180 days, addity nurse completed a "Fall le Rail & Restraint Use" resident 12. The facility nurse the assessment a score of "1 that resident 12 was a high fall le Rail & Restraint Use" resident 12. The facility nurse the assessment a score of "1 that resident 12 was a high fall le Rail & Restraint Use" resident 12. The facility nurse the assessment a score of "1 that resident 12 was a high fall dent 12's medical record, prehensive care plan dated sing resident 12's fall risk. This nation to evidence that the plan of care had been update	e 7", "III"	Resident 12 care plan has be updated with all incidences in A. Resident 12 was assessed risk and restraints, none were at this time. Resident has been put on all program that flags residents for falls. Bed moved against wall per request. No side rails on because the property of the prostress in the prostress improve balance to decrease	e-falls. for fall e needed ne Timber high risk resident l. vith	

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 sheoting pains, to knee" On 3/22/04 at 10:15 PM, a facility nurse		T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE		(X2) MULTIPE	E CONSTRUCTION	(X3) DATE	
NAME OF PROVIDER OR SUPPLIER CASTLE COUNTRY CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1340 EAST 300 NORTH PRICE, UT 84501 (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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	AND PLAN (OF CORRECTION	IDENTIFICATION NO	MBER:			COMI	LETED
CASTLE COUNTRY CARE CENTER 1340 EAST 300 NORTH PRICE, UT 84501 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) F 224 Continued From page 87 F 224 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			465098	3	B. WING	9/2	28/2004	
PRICE, UT 84501 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 sheeting pains, to knee" PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (CACH CORRECTION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION) PREFIX (EACH CORRECTION EACH CORRECTION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION) PREFIX (EACH CORRECTION EACH CACH CORRECTION) PREFIX (EACH CORRECTIVE ACTION EACH CORRECTION) PREFIX (EACH CORRECTIVE ACTION EACH CORRECTION) PREFIX (EACH CORRECTIVE ACTION EACH CORRECTION) PREFIX (EACH CORRECTION PREFIX (EACH CORRECTION) PREFIX (EACH CORRECTION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION EACH CORRECTION) PREFIX (EACH CORRECTION) PREFIX (EACH CORRECTION) PREFIX (EACH CORRECTION) PREFIX (EACH CORRECTION) PREFIX (EACH CORRECTION) PREFIX (EACH CORRECTION) PREFIX (EACH CORRECTION) PREFIX (EACH CORRECTION) PREFIX (EACH CORRECTION) PREFIX (EACH CORRECTION) PREFIX (EACH CORRECTION) PREFIX (EACH CORRECTION) PREFIX (EACH CORRECTION) PREFIX (EACH CORRECTION) PREFIX (EACH CORRECTION) PREFIX (EACH CORRECTION) PREFIX (EACH CORRECTION) PROVIDER EACH CORRECTION PREFIX (EACH CORRECTION) PREFIX (EACH CO	NAME OF P	ROVIDER OR SUPPLIER	!	STREET ADD	OPESS, CITY, ST	AFE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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	CASTLE	COUNTRY CARE	CENTER			DRTH		
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	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEEDED E	BY FULL	PREFIX	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	COMPLETION
"Incident/Accident Report": "Attempting to transfer to chair alone, wheelchair slid she landed on floor on knees then bottomSore 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] fellmild c/o (complaints of) pain" On 4/14/04 at 9:00-PM, a nurse's note acresident 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		On 3/20/04 at 9:30 documented the foi "Incident/Accident Inursing assistant) [and] hitting stump stand. Pt c/o (compains, to knee" On 3/22/04 at 10:1: documented the foi "Incident/Accident It transfer to chair ald on floor on knees tileft] knee" On 3/29/04 at 10:3: documented the foi "Incident/Accident It asking for assistant fellmild c/o (compaint Incident/Accident It asking for assistant fellmild c/o (compaint Incident/Accident It asking for assistant fellmild c/o (compaint Incident/Accident Incident/Accident Incident/Accident Incident/Accident Incident/Accident Incident/Accident Incident/Accident Incident/Accident Incident/Accident Incident/Accident Incident/Accident Incident/Accident Incident/Accident Incident/Accident Incident/Accident Incident/Accident Incident/Accident Incident/Accident Incident/Accident Incident Incident/Accident Incident	AM, a facility nurse lowing on an Report": "CNA (ce eported pt (patient) to [left] leg while atteplains of) sharp should be	fell to floor ampting to ofting to she landed in [right and landed in [right]]. In resident allowing lerself from confused antation completed	F 224			

entry: "[at] 1830 (6:30 PM) res (resident) was found on floor next to bed, resistates 'I flipped out of bed', appear res rolled out of bed, resistates she hit her head..."

"Incident/Accident Report": "...Res (resident) states 'I flipped out of bed', it appears res rolled

On 4/17/04 at 6:30 PM, a facility nurse documented the following on an

STATEMEN	RS FOR MEDICARE IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIFIDENTIFICATION NU		1	E CONSTRUCTION	(X3) DATE S		
		465098		B. WING			9/28/2004	
	ROVIDER OR SUPPLIER COUNTRY CARE	CENTER	1340 E	DDRESS, CITY, STATE, ZIP CODE EAST 300 NCRTH E. UT 84501				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENC Y MUST BE PRECEEDED F LSC IDENTIFYING INFORM	RY FULL	ID PREFIX TAG	PROVIDER'S PLAN (I:ACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	OTHE APPROPRIATE	(X5) COMPLETION DATE	
F 224	out of bed- res ver lethargic at fall- sta On 4/20/04 at 11:4 resident 12's medi following entry: "F on kneesNoted pherselfBlanket [a when she was four	y confused, disorient stes she hit her head, 5 AM, a nurse's note cal record document ound pt (patient) to s thad tried to transfe ind] pillow were unde ind" There was no t an "Incident/Accide	in ed the ide of bed r r pt knees	F 224				
	resident 12's medi following entry: "[a (resident) FOF (for There was no door	0 PM, a nurse's noto cal record document it] 2115 (9:15 PM) re und on floor) next to d umentation that an Report" was complet	ed the s closet"		٠,			
4 5 - 22 2	12's medical recor- entry: "Aide respo found pt (patient) of was transferring to when WC overturn	AM, a nurse's note it d documented the fo nding to noc (night) in buttocks on floor s WC (wheelchair) to ried and dumped her floorC/O (complain	llowing noise tates she toilet on her					
	documented the fo "Incident/Accident	AM, a facility nurse illowing on an Report": "Pt (patie or stated she was trai						

to we (wheelchair) for toileting when we 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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SPECUL IDENTIFICATION RUS		(X2) MULTIP	E CONSTRUCTION		SURVEY PLETED
		465030		B. WING			28/2004
	ROVIDER OR SUPPLIER COUNTRY CARE		1340 E	STREET ADDIESS, CHY STATE, ZEPCODE 1340 EAST 300 NORTH PRICE, UT 84501			
(X4) ID PREFIX TAG	SUMMARY : (EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCE ICY MUST BE PRECEDED P R LSC IDENTIFYING INFORM	ES TY FULL YAHON)	ID FREETX : TAG :	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	F CORRECTION CTION SHOULD BE THE APPROPRIATE ICY)	(X5) COMPLETION DATE
F 224	shift, four of the fi shift and one of the shift. There was no do that facility staff of	alls occurred on the evene falls occurred on the curred on the curred on the current ation to provide leveloped interventions	e night e evidence s,	F 224			
	her falls or to min 12. Resident Cl 8/24/02 with the congestive heart dependant diabet disease.	resident 12's needs to imize potential injury L2 was admitted to the diagnoses of prostate of failure, asthma, insulintes mellitus, and Parki ent CL2's medical recording.	e facility on cancer, n rison's		- Resident CL2 w	⁄as di⊭charged.	
:	completed by fact that resident CL2 memory problem decision making facility staff docu able to transfer a e with extensive a documented that	nge MDS assessment, fility staff on 6/3/04, do thad short and long to s and his cognitive ski were moderately imparented that resident Conditions assistance. Facility stresident CL2 had a fa and the last 31-180 da	comented in its for daily ired. The CL2 was aff It within				
	revealed that a "I Restraint Use" as	ent GL2s medical reco Fall Risk Assessment/ ssessment, addressing old not be found.	Side Rail &				
a v	revealed that a c	ent CL2's medical reco omprehensive care pla ent CL2's fall risk, coul	ъъ, ;				
	On 3/25/04 at 2:	15 PM, a facility nurse	: :		4		
ORM OMS	-2567(02-99) Previous	Versions Obsolute			4IB111	If continuation	Jieet Page 90 ct 195

1340 EAST 300 NORTH 1340 EAST 300 NORTH		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NO	JVCHA MHER:	A. BUILDIN	LE CONSTRUCTION	(X3) DATH: COM:	SURVEY LETED			
PASTLE COUNTRY CARE CENTER 1340 EAST 300 NORTH PROC. UT 84501 PROC.			465098	1. 1. 1.	B. WING		90	28/2004			
FRICE, UT 84501 PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION SHOULD BE CACH CORRECTIVE ACTION BE CACH CORRECTIVE ACTION SHOULD BE CACH CORRECTIVE ACTION SHOULD BE CACH CORRECTIVE ACTION SHOULD BE CACH CORRECTIVE ACTION SHOULD BE CACH CORRECTIVE ACTION SHOULD BE CACH CORRECTIVE ACTION SHOULD BE CACH CORRECTIVE ACTION SHOULD BE CACH CORRECTIVE ACTION BE CACH CORRECTIVE ACTION SHOULD BE CACH CORRECTIVE ACTION BE CACH CORRECTIVE ACTION BE CACH CORRECTIVE ACTION BE CACH CORRECTIVE ACTION BE CACH CORRECTIVE ACTION BE CACH CORRECTIVE ACTION BE CACH CORRECTIVE ACTION BE CACH CORRECTIVE ACTION BE CACH CORRECTIVE ACTION BY CACH CORRECTIVE ACTION BE CACH CORRECTIVE ACTION BY CACH CORRECTIVE ACTION BY CACH CORRECTION BY CACH CORRECTIVE ACTION BY CACH CORRECTION			CENTED								
### CACH DEFICIENCY MIST BE PRINCE DEMY FILL ### CROSS-SEPTIMENT OF THE ATT-ROPHRATE ### CROSS-SEPTIMENCE OF THE ATT-ROPHRATE ### CROSS-SEPTIMENCE OF THE ATT-ROPHRATE ### CROSS-SEPTIMENCE OF THE ATT-ROPHRATE ### DEFICIENCY ### COntinued From page 90 documented the following on an "Incident/Accident Report": ". Pf (patient) leaned over in w/c(wheel chair) to pick sometising off the floor [and] slid out of w/c - faurating on batlocks." On 4/12/04 at 10:00 AM, a facility nurse documented the following on an "Incident/Accident Report": ". Pf (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": "Pf (patient) found lying on back in doorway to BRoom (haltbroom), 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": "Pf (patient) found lying supine in street clothes; jacket h.!f onstates [left] arm hurts" On 5/20/04 at 10:00 AM, a facility nurse documented the following on an "Incident/Accident Report": "Pf (patient) found on floor by side of bed. Said he slid out of bed" On 5/26/04 at 5:40 AM, a facility nurse documented the following on an "Incident/Accident Report": "Pf (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": "Pf (patient) found on floor [at 0540 (540 AM) states I was getting up"		OCCUPANT CARE	CENTER			ORTH					
documented the following on an "Incident/Accident Report": ". Pf (patient) leaned over in w/c(wheel chair) to pick sometaining off the floor [smd] slid out of w/c - landing on bibliocks" On 4/12/04 at 10:00 AM, a facility nurse documented the following on an "Incident/Accident Report": ". Pf (patient) stated he fell onto buttocks while trying to walk back to bod from bathroom" On 4/14/04 at 2:45 AM, a facility nurse documented the following on an "Incident/Accident Report": "Pf (patient) found lying on back in doorway to BRoom fastbroom), 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": "Pf (patient) found lying supine in street clothes; jacket h :// onstates [left] arm hurts" On 5/20/04 at 10:00 AM, a facility nurse documented the following on an "Incident/Accident Report": "Pf (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 floor [ati 0540 (5:40 AM), states "I was getting up"" On 5/26/04 at 5:40 AM, a facility nurse documented the following on an "incident/Accident Report": "Pf (patient) found on floor [ati 0540 (5:40 AM), states "I was getting up""	(X4) ID PREFIX TAG	(EACH DEFICIENC	EFICIENCY MOST BE ODDODED ON THE			(EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (ARE CROSS-KEFERENCED TO THE				ION SHOULD BE HE APEROPRIATE	* COMPLECON
documented the following on an "Incident/Accident Report": , "Pt (patient) found on floor [at] 0540 (5:40 AM) states 'I was getting		documented the for "Incident/Accident over in w/c (wheel of floor [and] stild out of floor [and] stild out of floor [and] stild out of floor [and] stild out of floor [and] stild out of floor incident/Accident he fell onto buttock bed from bathroom on 4/14/04 at 2:45 documented the for "Incident/Accident lying on back in do states going to BR his buttocks and the On 5/19/04 at 2:45 documented the for "incident/Accident I lying supine in street onstates [left] arm on 5/20/04 at 10:00 documented the for "Incident/Accident I on floor by side of the On 5/26/04 at 5:40 CL2's medical recontry: "pt (patient) to getting up""	Illowing on an Report": ". Pt (paties chair) to pick somethin of w/c - lawring on the control of w/c - lawring on the control of w/c - lawring on the Report": "Pt (paties while trying to walk" AM, a facility nurse llowing on an Report": "Pt (paties or way to BRoom (bat (bathroom) when he en laid back on floor. AM, a facility nurse llowing on an Report": "Pt (paties et clothes, jacket helf in hurts" DAM, a facility nurse llowing on an Report": "Pt (paties et clothes, jacket helf in hurts" AM, a facility nurse lowing on an Report": "Pt (paties et clothes, jacket helf in hurts"	at) found at) found of bed"	F 224						
		documented the fol "Incident/Accident F on floor [at] 0540 (5	lowing on an Report": , "Pt (patie	ent) found s getting							

STATEMEN	T OF DEFICIENCIES OF CORRECTION	& MEDICAID S	ER/CLIA	(X2) MULTII	LE CONSTRUCTION	(K3) DATE S	D. 0938-0391
AND PLAN	OF CORRECTION	IDENTIFICATION NU	MBER:	A. BUILDING		COML	
_		465098	}	B. WING	an exemption for absolute symmetry management and a constraint of the constraint of	9/2	8/2004
CASTLE	ROVIDER OR SUPPLIER COUNTRY CARE (CENTER	1	RESS, CITY, S	TATE, ZIP CODE		
	1		PRICE,	UT 84501			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCE Y MUST BE PRECEEDED E LSC IDENTIFYING INFORM	SY FURA	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
F 224	On 5/27/04 at 7:00 CL2's medical reco entry: "pt (patient): On 5/27/04 at 7:00 documented the fol "Incident/Accident Fon floor by bed. State Based on documen resident CL2 had 7 Three of the falls oc the falls occurred of	PM, a nurse's note in rid documented the found on floor by ber PM, a facility nurse towing on an Report': "Pt (patiented to got [utation it was determited falls from 3/25/04 to courred on the day shift all on the night shift.	ollowing it" Int) found up]" ined that ined that ined that ined that ined that	F 224			
	facility staff develop individualized to res his falls or to minimi 13. Resident CL4 w 4/30/04 with the diagobstruction, pure hy hypertension, and c	ident CL 2's needs to ize potential injury, was admitted to the fignoses of intestinal perchalesterolemia, onstipation. CL4's medical recoil	o reduce		Resident CL 4 was disc	harged.	
:	A significant change completed by facility documented that retterm memory proble daily decision makin The facility staff documented to transfer assistance. The fac	04. eMDS assessment,	t and long skills for mpaired. nt CL4 extensive				

The War Control of the State of

If continuation sheet Page, 92 of 106

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIDENTIFICATION N		(X2) MULTIPE A. BUILDING	E CONSTRUCTION	(X3) DAF: SURVEY COMPLETED 5/2 8/20 04		
		46509	18	B. WING	and the second of the second o			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	ADDRESS, CITY, STATE, ZIP CODE				
6				AST 300 NC . UT 84501	RTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIEN BY MUST BE PRICEEDED LESC IDENTIFYING INFOL	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE API DEFICIENCY)	SHOULD BE COMPLE		
F 224	documented on the which indicated the risk. A review of reside revealed a compre 5/18/04, addressing There was no docomprehensive placelity staff. On 5/11/04, a facility staff. On 5/11/04, a facility staff. On 5/11/04, a facility staff. Report": "Residented the resident CL4's fall Report": "Residented the rappy rest room transferring to w/c in reach P/T (physroom" On 6/26/04 at 11:4 resident CL4's me following entry: "F front of chair [with floor." On 6/26/04 at 11:4 documented the for "Incident/Accident removed bed alarr	sident CL4. The face assessment a social resident CL4 was at resident CL4 was at resident CL4's medical receivements of the care plant of	ore of "8", a low fall cord, lated li risk, noe that the updated by ed one of cident ican land) was as in for in she slid to se enty r bed rail"	F 224				
	resident CL4 had a One of the falls oc	ntation it was deterr 2 falls from 5/11/04 curred on the day st on the evening shif	to 6/26/04. hift and the					
	facility staff develo	umentation of evide ped interventions, esident CL4's needs nize potential injury.	to reduce					

TATEMENT ND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	MBER:	(X2) MULTIPLI A. BUILDING B. WING	CONSTRUCTION	 COM	ESURVEY PLETED
	RÓVIDER OR SUPPLIER COUNTRY CARE (465098 CENTER	STREET ADD	RESS, CITY, ST.		9	/28/2004
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PIRECEEDED BY FULL REGULATORY OR LSC 'DENTIFYING INFORMATION)		IF:S TY FULL	ID PREFIX TAG	(EACH CORRECT CROSS-REFEREN	SHOULD BE	(X5) COMPLETION DATE
F 224	Continued From pa	age 93		F 224	,	 	
	was interviewed. S resident had a fall a it. She stated that a nurse. She state complete an asses facility nurse stated of assessing for inj signs. She stated the experienced a fall, next shifts and the every shift for 72 he stated that the nurse they were the ones know what the nurse on 9/22/04 at 12:4 interviewed. She side of the stated that the nurse on 9/22/04 at 12:4 interviewed. She side of the stated that the nurse of the stated that the nurse they were the ones know what the nurse of the stated that the stated th	ty nurse who worked the stated that usual a nursing assistant of the nursing assistant of the nurse wood sment of the resident that an assessment of the assessment at the assessment it would be passed of resident would be clours. The facility nursing assistants see the who would let the ness might need to wood. OPM, the DON was tated that when a research that would have a seen that when a research that we would have the seen that when a research	lly when a vitnessed it would get ald then nt. The it consisted no vital on to the harted on rise further he most so aurses atch for.				
	doctor and family w report would be con may be a change to medications. The resident has had a shift for 72 hours, been watching falls decline in the falls DON further stated	ne assessed by a our vere to be called, and mpleted, and if need to the resident's payo DON further stated to fall they were charted that DON stated that and had felt there I since March of 2004 I that the SCU was a at all times and the inattended.	incident ded, there choactive that when a ed on every at she had had been a t. The taffed with				
F 253 SS=E	The facility must p	RONMENT: rovide housekeeping ces necessary to ma		F 253			

Tribe Of The Mizional DEPARTMENT OF HEALTH AND HUMAN FORM APPROVED CENTERS FOR MEDICARE & MEDICAID EVICES OMB HO, 0938-0391 STATEMENT OF DEFICIENCIES. (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A BUILDING B WING 465093 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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PROCEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 253 Continued From page 94 F 253 F 253 This Requirement is not met as evidenced by: 1. Maintenance to follow A calendar Based on observation, the facility did not provide of cleaning schedule to clean carpets housekeeping and maintenance services and buff floors on a monthly basis. necessary to maintain sanitary, orderly and comfortable interior(s) as evidenced by 2. Floors, drawer handles, faucets, inadequate housekeeping and maintenance thermostats, windows, floor tiles, and findings in fifteen of twenty-five resident rooms walls to be on maintenance rounds and resident common areas in three of three sheet. Maintenance will monitor wings of the facility. weekly 3. Maintenance will address identified Findings include: problems obtained though his rounds in QA committee meeting monthly. 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: All handles on doors and drawers of closets have been removed for safety. Rooms 201, 203, 204, 205, 206, 207, 208, 209, On rooms:

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

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.

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 201 and 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

patched. 10/19/04 Need to replace broken tile pieces. Will be repaired by 11/15/04 Bathroom for room 209 Fan cover

Towel bar replaced and holes

replaced, 10/19/04

was secured, 10/19/04 Floor was replaced, 10/20/04

DEPARTMENT OF HEALTH AND HUMAR TERVICES **ECRM APPROVED** CENTERS FOR MEDICARE & MEDICARD OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVINCR/SUBTRIFICE A (Ad) LIBERIETE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION REMBERS A. adalbino GOT PILETED B. WING 465098 2/28/2004 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STADE, 212 CODE CASTLE COUNTRY CARE CENTER 1340 EAST 300 NORTH PRICE, UT \$4501 (X4) ID SUMMARY STATEMENT OF DEFICIENCES m PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INCORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 253 Continued From page 95 F 250 Near the common dining room area designated "Castle Country Cafe", two nails were observed to Near the Dinning room Nails were be protruding from the wall near the entrance removed 10/19/04 door. Walls were scratched at a height of Walls painted 10/20/04 approximately two feet from the floor. A glass Window has been repaired pane in the corner of the window had been cracked and was secured in the window pane by tape. The dinning room bathroom Floor has been replaced 10/15/04 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 Bathroom near rooms 206 and 208 toilet. Floor needs replaced Will be repaired by 11/15/04, The bathroom near Rooms 208 and 206 was observed to have gray stains around the toilet base. The above to be in effect 11/15/64 -The bathroom near Room 204 was observed to Bathroom near room, des r loor was have brown and gray stains around the toilet replaced 10/21/94. 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 clameter was observed. This stain was observed to be Carpet being cleaned 10/20/04 seeping a faint reddish material in a 6 inch. Cleaned regularly every two weeks diameter area in its cepter. 2. Between Rooms 204 and 206, on the north 200 half carpet Stains on floor side of the hallway, dark blackish stains were cleaned 10/19/04 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 carnet. Rooms 304 and 306 were both observed to have FORM CMS-2567(02-99) Previous Versions Obsolute 4IB111 If continuation theet Page 99 of 166

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAIL OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLICE/CHA (A2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B WING 860038 9/28/2004 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER CASTLE COUNTRY CARE CENTER 1340 EAST 300 NORTH PRICE, UT 84504 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR USC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 253 Continued From page 96 F 250 black stains at tile edges the length of their entry areas and approximately eight inches into the Rooms 304 and 306 Walts above base entryway. The baseboard molding near the north board painted, 10/19/04 side of Room 304's entry and the basel oard Leaks in shower have been repaired. molding near the south side of Room 306's entry 10/15/04 were observed to have black stains above the baseboard molding. The entry areas for these 4.All Bathroom floors in the facility rooms border the common shower are stor Hull have been checked and a list of those 300. that need replaced made up. Will toplace over the next 3 months. F 371, 483,35(h)(2) DIETARY SERVICES F 371 SS=E 5. The above to be in effect 11/15/64 The facility must store, prepare, distribute, and serve food under sanitary conditions. This Requirement is not mot as evidenced by: F 371 Based on observation and interview, it was 1. On 9/20/04 the following finding determined that the facility did not store, distribute were corrected and stored properly: and serve food under sanitary conditions. The orange juice and fruit juice was labeled and dated. Findings included: The can of isosource, eranges, and apples were discarded from the The following observations were made during the cursing unit fridge. initial kitchen tour completed on 9/20/04 from The fridge was cleaned on 9/20/04. 3:15 PM until 3:30 PM. The can of chili beans, cottage cheese, and cheese were all discarded Refrigerator in kitchen: on 9/20/04. The freezer items including all meat 1. A container of chili beans, dated 9/15/04. and nackages were all clearly labeled 2. A container of cottage cheese, with a with package contents. manufacturer use by date 9/13/04, dated 9/15/04.

3. An opened package of orange cheese, dated

4. An opened package of white cheese, which

reference.

2. On 9/22/04 Dictary employees

were inserviced by registered dictitian

regarding proper storage of food. The facility "left over" policy was

reviewed and will remain posted for

9/15/04.

had no date.

ATEMEN ID PLAN (T OF DEFICIENCIES DF CORRECTION	(X1) PROVESTR/SUPPLIE IDENTIFICATION NU 465038	MDER:			(X3) DATE SURVEY COMPLETED 9/28/2004		
ME OF P	ROVIDER OR SUPPLIER	l	STREET ADD	PESS CRY ST	ATE ZIR CODE			
	COUNTRY CARE	CENTER	1340 C	duress, city, state, zip code CAST 300 NORTH E, UT 84501				
X4) ID REFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCE Y MUST BE PRECEEDED I LSC IDENTIFYING INFORM	RY FULL :	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (FACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(9:5) COMPLETION DATE	
F 371	Continued From p 5. A container of in	age 97 ce tea, dated 9/15/04		F 371				
	Freezer in kitchen:							
	1. A brown bag, w	hich had no label.			Additional measures in pla ensure continuing compliance			
	A clear package no label.	e of breaded patties.	witich had		include: A. Registered dietitian will c a report monthly including sa	nitation		
	3. Ten clear bags of meat, which had no label.				check of all refrigerator/freez for proper food storage. B. A copy of report will be gi			
	Four white pack label.	 Four white packages of meat, which had no label. 			Administrator for continued c assurance.	quality		
	On 9/20/04 at 4:00 PM, the following observations were made of the unit refrigerator.			1	C. All frozen food will be sto original boxes or removed an labeled.			
	A container of c and no date.	gange juice, which h	ad no label		and unit fridge daily, (when b	D. Dietary staff will check nursing and unit fridge daily, (when being restocked), for proper food storage.		
•	A.container of fi and no date.	no label		E. A cleaning schedule along fridge inspection for proper f storage will be posted at must	with cod			
,	3. A can of Isosou date of July, 04.	3. A can of Isosource, which had an ex date of July, 04.			stetion and to be completed a Dietary supervisor will overs	l as posted		
	4. Three oranges, discolored.	which were bruised	and		This plan of correction to be	in effect		
	5. Two apples, wh discolored.	lich were bruised and	!		OCh 22, 2004	:	and the same and the same	
	6. The bottom of t spots.	he refrig erator had ro	ed sticky					
	483.40(c)(1)&(2) P	HYSICIAN SERVICI	ES	F 387				
SS=E	The resident must be seen by a physician at least once every 30 days for the first 90 days after			!				

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.

9/28/04.

at ER per Dr. Potter on 9/22/04. Expired

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	VCLIA IBER:	(X2) MULTIP A: BUILDING B. WING	CE CONSTRUCTION		PLETED
	ROVIDER OR SUPPLIER COUNTRY CARE	<u> </u>	1340 E	PRESS, CITY, S AST 300 NO , UT 84501	TATE, ZIF CODE DRTH		28/2004
X4) ID REFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCE CY MUST BE PRECEDED DO R LSC IDENTHAYING INFORMA	r FULL	PREFIX TAG	PROVIDER'S PLAN OF (EACH COPRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE
F 387	Continued From	page 99		F 387			
	on or around 4/10		' *				
	record to provide	cumentation in the med evidence that resident nysician on or around≠	4 had	!			
	9/7/01 with the dia hemiplegia, senile	s admitted to the facilit agnoses of diabetes m adementia, congestive on, and diabetic neuro	ellitus, heart				į
	that the resident h	nt 5's medical record r lad been seen by a ph 3, 1/30/04, 2/18/04, 5/2 04.	ysician on				
	Resident 5 should on or around 4/18	have been seen by a //04 and 7/27/04	physician				:
	record to provide	umentation in the med evidence that resident nysician on or around 4	5 had				
	11/17/02 with the hypertension, chrodiabetes mellitus,	s re-admitted to the fact diagnoses of sepsis, nonic renal failure, cons gastroesophageal refl jestive heart failure.	ausea, lipation,				
	that the resident h	int 6's medical record read been seen by a phy 5/31/04 and 8/8/04.			,		
		Phave been seen by a 0/03 and 3/28/04.	physician	-!			
					The second section of		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	(X2) MULTIF	LE CONSTRUCTION	(X3) DA - 1 CQLah	
	•	465098		B. WING			
	DOUBER OF THE	1 455050		VI 200 0000 1	LATE TRACOCT	1	28/2004
	ROVIDER OR SUPPLIER	CENTED	1	DRESS, CITY, S AST 200 M	TATE, ZIP CODE		
SASILE	COUNTRY CARE	CENTER	J.	, UT 84501	,851 n		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCE	FG .	ID :	PROVIDER'S PLAN OF CO	DERECTION	(X5)
PREFIX TAG		CY MUST BE PRECEEDED A LISC IDENTIFYING INFORM		PREEIX TAG	(EACH CORRECTIVE ACTIO CROSS-RUFERENCED TO TH DEFICIENCY)	2 APPROPRIATE	DATE DOM
F 387	Continued From p	page 100		F 387			
•		umentation in the me	dical		69		
	record to provide evidence that resident 6 had						
	been seen by a physician on or around 11/30/04 and 3/28/04.						1
	und 0/20/04.			İ			
		admitted to the facil					
	5/6/04 with diagnoses which included pulmonary insufficiency, closed fracture dorsal spine, and						
	diabetes mellitus 1		ino, and				
	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 on or around 6/31/	have been seen by a /04 and 8/34/04.	ı physician				
	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.						
		nt 8's medical record					1
		ad been seen by a pl 12/29/03, 1/30/04 ar					
	Resident 8 should on or around 6/22	have been seen by a /04 and 8/22/04.	n physician				
	record to provide	umentation in the me evidence that residen nysician after 4/22/04					
. 4	records person wa) 04, and 7/23/04, the rasked by the surve missing physician vis	ey team to				

If continuation sheet Page 101 of 106

CENTERS FOR MEDICARE & MEDICAID RVICES FORM AFPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPECE RICEIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465098 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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 387 Continued From page 101 F 387 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 490 483.75 ADMINISTRATION F 490 F 496 SS=K 1.We have put into place a new A facility must be administered in a manner that fall/incident policy and a new restraint enables it to use its resources effectively and policy. Note: copy of Fall/ Restraint efficiently to attain or maintain the highest policy. practicable physical, mental, and psychosocial (A). Fall Policy includes: Fall well-being of each resident. Documentation procedure, Accidents/Incident/Fall Investigation, Fall This Requirement is not met as evidenced by: Protocol, Fall Risk Assessment form, Based on a re-certification survey with a Incident/Accident Report form, subsequent extended survey, conducted 9/20/04 Investigation Report form, Quality Assurance Incident Report Summary through 9/28/04, and resultant finding of Tracking Log form, a monthly Immediate Jeopardy and Sub-Standard Quality of Incident/Accident Log form, and Care, it was determined that the facility was not Individual Incident/Accident Tracking being administered in a manner that enabled it to Loo form use its resources either efficiently or effectively to (B). Restraint Policy includes: Physica? ensure that residents were provided the Restraint Documentation, Physical opportunity to attain or maintain their bidhest Restraint Protocol, Physical Restraint practicable physical, mental, and psychosocial Consent form, Admission Restraint/Sidwell-being for each resident in the areas of Rail Evaluation form, Side Rail Rational: physical restraints and fall interventions (seglect). Screen form, Bed and Side Rail The facility was found to be providing Entrapment Assessment form, Physical Sub-Standard Quality of Care (a patient of actual Restraint Etimination Assessment form. Accident/Incident Audit form, and harm) in these areas. The facility was cited in a Physical Restraint Audit form, D.O.N. to total of 6 areas, not including this descioncy monitor tracking and logs weekly, and Medical Records to monitor forms in Findings include: charts montialy via chart audits. 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

DEPARTMENT OF HEALTH AND HUMAN * * RVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIERCE/A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER CONCLETED AND PLAN OF CORRECTION. A. BUSEDING B. WING 465098 0/28/2004 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY STATE, ZIF CODE 1340 EAST 300 NORTH CASTLE COUNTRY CARE CENTER PRICE, UT 84501 FROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY TUD PRI FIX (SACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-RUFERENCED TO THE APPROPRIATE TAG REGULATORY OR USC IDENTIFYING INFORMATION). TAG DEFICIENCYL F 490 Continued From page 102 -F 490 2. The side rails on all unoccupied beds of Immediate Jeopardy and Sub-Standard Quality have been removed to ensure that no side of Care was based on the findings of significant rails are used without proper assessments non-compliance in the area of Resident Behavior or physician's orders on new admissions. and Facility Practices [42 Code of Federal Completed on 10/5/04. Regulations (CFR) 483.13 (b) (c) Tau 1 -221 and Tag F-2241. 3. All residents have had an emrapment a sessment completed. Completed on 9/22/04 1. Facility administration failed to ensure that the use of restraints were evaluated, ordered and 4. All residents in the facility have been used to treat a medical symptoms. (Scope and assessed by our Physical Therapy for fails severity "K", refer to Tag F 221) and restraints. Dr's orders have been written up following Physical Therapy's 2. Facility administration failed to ensure that recommendations. Those residents that policies and procedures were implemented that had side rails and Physical Therapy has prohibited neglect for residents that were recommended that they are not necessary experiencing multiple falls. (Scope and severity have been removed from the bed. "K", refer to Tag F-224) Completed on 10/07/04. 3. In addition to the areas of Immediate Jeopardy 5. On October 5th 2004, an inservice with the Department Heads was held to discuss and Sub-Standard Quality of Care stated above, these new policies. On October 6th 2004, the facility administration failed to effectively and an inservice was held for all mursing staff efficiently use its resources to ensure that each where theses new policies were discussed resident attained or maintained their highest and implemented. 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. Maintenance will address identified problems obtained though a. Facility administration failed to ensure that his rounds in QA committee meeting housekeeping and maintenance were provided to monthly. maintain a sanitary, orderly, and comfortable

(Scope and severity "E", refer to Tag F-253)

b. Facility administration failed to ensure the

c. Facility administration failed to ensure that

food under sanitary condition. (Scope and

severity "E", refer to Tag F- 371)

storage, preparing, distribution and the serving of

the report will be given to

assurance.

4IB111

B. Registered dictitian will complete a report monthly including sanitation

check of all refrigerator/freezer units

for proper food storage. A copy of

Administrator for continued quality

DEPARTMENT OF HEALTH AND HUMAN SHRVICES CENTERS FOR MEDICARE & MEDICAID STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 465098

F 490 Continued From page 103

F-521)

SS=K

PREFIX

TAG

OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION

(X3) DATH SURVEY COMPLETED

A BUILDING B. WING

NAME OF PROVIDER OR SUPPLIER

CASTLE COUNTRY CARE CENTER

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

residents were seen by a physician at least once

and at least once every 60 days thereafter.

quality assurance committee identified and

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

compliance of such committee with the

requirements of this section.

quality deficiencies.

FORM CMS-2567(02-99) Previous Versions Obsolete

Findings include:

disclosure of the records of such committee

except insofar as such disclosure is related to the

This Requirement is not met as evidenced by:

Review Quarterly Meeting" (the facility Quality

Assurance Committee) and interviews with the

nurses), it was determined that the facility did not

Based on a review of the facility "Utilization."

facility Administrator and DON (director of

elfectively developed and implemented

ensure that the quality assurance committee

appropriate plans of action to correct identified

F 521 483.75(o)(2)&(3) ADMINISTRATION

implemented plans of action to correct quality

issues. (Scope and severity "K", refer to Tag.

(Scope and severity "E", refer to Tag F-387) d: Facility administration did not ensure that the

every 30 days for the first 90 days after admission.

PRICE, UT 84501

STREET ADDRESS CITY, STATE, ZIP CODE 1340 EAST 300 NORTH

PREFIX

TAG

F 490

F 521

C. The physician visit log will be

D. New OA 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

I. Quality Assurance meetings will be

action for residents identified. Once

substantial compliance is established

Quality Assurance meeting will be

2.The D.O.N. will keep a QA incident

Report Summary Log. This log will be

reviewed every month in QA meeting to

3. The Timber program was implemented

that identifies residents that are high risk

resident's door. The staff was inserviced

on this program on 10/11/04, D.O.N. will

if continuation sheet Page, 104 of 106

for falls. These Trees are placed on the

4. A Nurse Consultant was hired to

comply with the directed plan of

every month.

reviewed in QA committee meeting by

Medical Records and the Administrator

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

10/22/04

COMPLETION DATE

FORM APPROVED

- 9/28/2004

Assurance Log, Quality Assurance Subcommittee form. Administrator will maintain these logs.

held every week. To review

held monthly.

look for trends.

monitor.

418111

Restraints, Falls, Injuries and Infections and to establish a plan of

The above to be in effect by

NAME OF PROVIDER OR SUPPLIER CASTLE COUNTRY CARE CENTER 1340 EAST 399 NORTH PRICE, UT 84501 (X4) ID SUMMARY STATEMENT OF DEFICIENCY BULL PRESX (EACH CORRECTION ALTON SHOULD BE REQUESTED BY FULL PRESX (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) F 521 Continued From page 104 1 During an intension with the DOLL on 9722/04	004	
CASTLE COUNTRY CARE CENTER 1340 EAST 300 NORTH PRICE, UT 84501 (x4) ID SUMMARY STATEMENT OF DEFICIENCES ID PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREEX (EACH CORRECTIVE ACTION SHOULD BE TAG CFOSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 521 Continued From page 104 1 During an intension with the DOISLON 9/22/04	9/28/2004	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 521 Continued From page 104 Deficiency with the DOLLON 9/2/2/04 PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMEDIA TAG CPOSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
1 During an interview with the DOist on 9/03/04	(X5) OMPLETION DATE	
at 12:40 PM, she stated that the facility had a quality assurance committee that met about every three months. She further stated that alter 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 the time period and decided what to do in the meeting. He further stated that they follow up on the incidents by 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" innutes 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 evidence that they incorporated an action plan to monitor the high percentage of resident falls. The minutes documentation did not indicate that the facility had identified any concerns with physical restraints. 4. The facility's quality assessment and assurance committee did net implement, and subsequently did not establish corrective action plans to ensure that rosidents were free from physical restraints not required to treat the residents medical symptoms, resulting in harm to residents. (Refer to Tag F-221)		

EPART CENTER	MENT OF HEALTH S FOR MEDICARE	AND HUMAN (TR)	/ICES ICES			FCR	M APPROVED 0. 0938-0091
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	UCTION (X3) DATE: SI COMPLE	
		465098		R MING	9/28/2004		
	ROVIDER OR SUPPLIER		1		TATE, ZIP CODE		
CASTLE	COUNTRY CARE (CENTER		AST 300 NO , UT 84501	DRTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCE Y MUST BE PRECEEDED & LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 521	not identify, and su corrective action pl residents that were	age 105 ality assurance commosequently did not evans that prohibited not experiencing multipe residents. (Refer to	tablish eglect for le falls,	F 521		er.	
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ODM CMS	: : : :2567(02-99) Previous Ve	ersions Obsolete			 483111	If continuation she	et Page: 106 of 106