STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465098	A. BUILDING _____ B. WING _____	C 07/19/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225		9/10/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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by:
Based on record review, incident report and interview it was determined that for 1 of 3 sample residents the facility did not ensure that all alleged violations involving injuries were reported immediately to the State survey and certification agency as required by law. Specifically resident 1 acquired injuries from a fall to the face, and had three teeth knocked out.

Findings include:

Resident 1 was admitted to the facility on 2/24/06 with diagnoses that included Schizoaffective, bipolar, Parkinson's disease, and osteoporosis.

Resident 1's medical record was reviewed on 7/19/07.

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

7/17/07 @ (at) 0545 (5:45 AM) ..."CNA (certified nurse aide) reports pt (patient) missing from bed. Pt could be missing for few minutes or {up} to 2 1/2 hrs (hours). Unit (secured unit doors) doors 1 open/ 1 shut by 0400 (4:00 AM) /c (with) CNA out to assist /c AM care. Immediate search of grounds et (and) facility, RN checked 200 Hall, N/A (nurse aide) et 300, 2 CNA's out around bldg. (building). By 0600 AM (6:00 AM) no pt. Called (phone contact) /c DON (Director of Nursing), et then called the police via 911. Reported missing resident et description...@ approx (approximally) 0616 (6:10 AM) et said police found pt...pt's injured from fall et to transfer to hospital".

On 7/19/07, at 4:30 PM by phone, an interview

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F 225	Continued From page 2 was conducted with RN 1 they confirmed that one of the doors to the secured unit had been propped open and that around 4:00 AM she had turned the alarm system off for the outside doors at the nurse station. In phone interviews with CNA 1, on 7/19/07 at 1:30 PM, and CNA 2, on 7/20/07 at 12:35 PM, they both confirmed that one of the doors to the secured was propped open and the outside door alarms had been turned off by the charge nurse. The emergency room report, dated 7/17/07, nursing assessment and observation documented that resident 1 had three teeth missing, abrasions of the right side of the face and nose, right hand swelling and rib tenderness. The physician's clinical impression was "Mandible Fx (fracture), Rib Contusion, 3 Tooth (teeth)". In an interview with the Administrator, on 7/19/07 at 1:00 PM, she confirmed that State agency had not been called, she stated that "an investigation had been started and the RN was on suspension pending investigation outcome but it had not been reported to the State".	F 225		
F 324 SS=G	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, it was determined that the facility failed to ensure that 1 of 3 sample residents received adequate supervision to prevent accidents.	F 324		9/10/07

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F 324	Continued From page 3 Resident identifier: 1. Findings include: On 7/19/07 at 9:15 AM an initial tour of the facility was conducted. On the special needs unit (SNU) resident 1 was observed to be in her room, lying in bed on her back. She was wearing her glasses which had scratches on the right lens. There was bruising around her eyes, especially the right eye. Her top lip was swollen, and it was observed that she was missing two to three teeth. Her nose was swollen with abrasions on and around her nose. She had crusted blood in both nostrils. When asked what had happened to her face, resident 1 stated that she fell crossing the road by herself. She could not recall how she got out of the locked doors of the SNU. On 7/19/07 resident 1's clinical record was reviewed. Resident 1 was admitted 2/24/06 with diagnoses that included Parkinson's disease, Schizoaffective disorder, Bi-polar disorder, hypothyroidism, and osteoporosis. In resident 1's clinical record, the Nursing Notes (NN) for resident 1 were reviewed. On 7/16/07 at 10:30 PM, RN 1 documented that resident 1 was delusional stating 'pimps in here, call police' and that resident 1 was "concerned about being in her room." RN 1 also documented that resident 1 had eloped from the SNU three times on the night of 7/16/07. On 7/17/07 at 5:45 AM, RN 1 documented that she received a report from a certified nurses aid (CNA) that resident 1 was "missing from bed" and so an immediate search of the facility and grounds was conducted. RN 1 also documented that she called the Director of Nursing (DON) and then the police to report	F 324		

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resident 1 missing, and that at approximately 6:10 received a phone call from the police stating that resident 1 was injured and being transported to the local emergency room for treatment. On 7/17/07 at 11:45 AM, RN 1 documented that upon returning from the emergency room resident 1 had a "top lip very swollen. Two front top teeth missing. Oozzing (sic) blood. Pt (patient) biting on sterile 4x4's. Nose red. Also oozzing (sic)blood. Dried blood around opening of R (right) nostril. Bruising et (and) scrapes on cheeks around nose et under eye R more than left. L (left) lens of glasses scratched, palms of hands scraped et red. Large bruise on back of head. Pt c/o (complains of) small finger on R hand hurting very bad. Also c/o pain in R side of rib cage."

On 7/19/07 at 10:00 AM the facility housekeeping/medical records supervisor was interviewed. She stated that approximately one week ago while in the open doorway of the SNU, that resident 1 came running down the hall and pushed her out of the way. The housekeeping/medical records supervisor stated that she hit her head on the door while resident 1 was eloping from the SNU, but that a CNA outside of the unit was able to redirect resident 1. The housekeeping/medical records supervisor also stated that resident 1 had eloped from the SNU previously and had walked to the front door.

On 7/19/07 at 10:10 AM the facility administrator was interviewed. She stated that an investigation was being conducted regarding resident 1's injuries. The administrator stated that RN 1 reported that RN 1 had turned off the facility alarm on the night of 7/16/07.

On 7/19/07 at 10:35 AM the facility DON was

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interviewed. She stated that she was not aware that RN 1 had propped the door to the SNU open and that it was facility policy to keep the SNU doors closed and locked at all times. The DON stated that resident 1 had a history of elopement attempts and that resident 1 frequently followed vistors out of the SNU doors. The DON also stated that resident 1 had been assessed as high risk for elopement.

On 7/19/07 at 10:50 AM an interview was held with the facility Minimum Data Set (MDS) Coordinator. The MDS Coordinator stated that she had observed resident 1 bang on the SNU doors to get out and that resident 1 runs when resident 1 thinks people are after her.

On 7/19/07 at 1:30 PM an interview was held by telephone with CNA 1. CNA 1 stated that she was working the night of 7/16/07 and the early morning of 7/17/07. CNA 1 stated that resident 1 "was agitated all night." CNA 1 stated that resident 1 kept leaving the SNU and eloped from the SNU three times, and had been found in the facility parking lot one of the those times. CNA 1 stated that at 6:00 AM she realized that resident 1 was missing. CNA 1 stated that the alarm had been turned off during the night by RN 1 and that the door to the SNU had been propped open. CNA 1 stated that if she goes "to help the other CNA then we prop the door (to the SNU) open and the RN keeps an eye on the open door."

On 7/19/07 at 4:30 PM an interview was held with RN 1. RN 1 stated that she was the nurse on duty for the night of 7/16/07. RN 1 stated she propped the doors to the SNU open so that "we could hear while the CNAs and I were out front working." RN 1 stated that someone is always assigned to

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F 324	Continued From page 6 watch the SNU if the doors are propped open. RN 1 stated that three CNAs were making rounds and that RN 1 was "in and out, but I don't stay at the nurses' station. I have things to do." RN 1 also stated that she had turned off the alarm because "it is really loud and it alarms at the nurses' station." On 7/20/07 at 12:35 AM an interview was held by telephone with CNA 2. CNA 2 confirmed that the door to the SNU had been propped open at approximately 4:00 AM on the morning of 7/17/07 and that the facility alarms had been turned off as well.	F 324		