STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465134	A. BUILDING _____ B. WING _____	C 10/25/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY VIEW MANOR	2901 WEST CENTER STREET PROVO, UT 84601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=E	483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS	F 225	F 225	11/25/05

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 by:

revised per IDR original POC approved 11/21/05 by L. Buenteank

To assure the timely reporting of all suspected abuse, the facility has implemented the following corrective measures:

Staff found to have been involved in the allegation of abuse against Resident 1, or who did not report according to policy have been terminated or reprimanded as appropriate.

All staff received additional in-service training concerning abuse and reporting protocol (information attached).

The employee handbook has been revised to give more emphasis to reporting protocol (excerpt attached).

A test is given to all current staff and new staff upon employment to further assure and document that they actually have received and understand Country View Manor's abuse reporting protocol.

Incident reports will be reviewed daily by the Director of Nursing. Any incidents of suspected abuse will be reported to the Administrator for investigation and reporting as appropriate. Incident reports will also be reviewed weekly in Safety Committee Meeting and monthly by the Quality Assurance Committee to

Utah Department of Health
1-11-06
JAN 13 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/12/06

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

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F 225	Continued From page 1 Based on interview and record review, it was determined that the facility staff did not timely report an allegation of staff to resident abuse to the facility administrator involving resident 1. Specifically, the incident occurred on 10/2/05, facility staff became aware on 10/6/05, and facility adminstration was not informed until 10/10/05. Findings include: Resident 1 was a 79 year old female admitted to the facility on 4/4/94, with diagnoses that included severe mental retardation, schizophrenia, depression and seizure disorder. Guideline $483.13 (b) and (c) "Abuse" means the willful infliction, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. On 10/24/05, resident 1's medical record was reviewed. Review of the record revealed that resident 1 was not verbal and had a history of taking her clothes and brief's off and was dependent upon facility staff for her cares. On 10/24/05 at 1:00 PM, CNA 1 (certified nursing assistant) was interviewed over the phone. He stated that on 10/6/05 he was informed by NA 1 (nursing assistant), that CNA 2 and NA 2 had given resident 1 a cold shower. He further stated that he advised NA 1 to go to facility administration and report the incident. CNA 1 stated that he waited a few days and then asked NA 1 if she reported the incident. He stated when he found out that NA 1 had not reported resident 1's cold shower he went to the charge nurse on 10/8/05. He also stated that he reported to the charge nurse that CNA 2 had placed mittens on	F 225	assure continued compliance with reporting protocol. Any deficiency will be immediately addressed with supplemental training and correction action as appropriate, as well as reporting to the State Agency, in accordance with our policies and procedures. All incidents are tracked in a monthly log, maintained by the D.O.N. Incidents that involve possible abuse, misappropriation, or injuries of unknown origin will be noted as such. For such incidents, there will be a copy of the "Resident Abuse Investigation and Reporting Log" attached (see copy) and noted in the log. This will be reviewed each business day by the Administrator or designee, to assure the investigative and reporting protocol, including reporting to APS, the State Agency and Ombudsman, is followed. In addition to the daily monitoring by the Administrator, the log and investigations will be reviewed by the Quality Assurance Committee.	

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F 225	Continued From page 2	F 225		

resident 1 that were so tight resident 1's hands were purple. CNA 1 stated that he also reported the incidents to the facility's CNA supervisor on 10/9/05.

On 10/24/05 at 1:50 PM, the CNA supervisor was interviewed. She stated that she received a call at home over a weekend from CNA 1 regarding resident 1's cold shower. She further stated that she reported the incident to facility administration on 10/10/05 in the Department Head meeting.

On 10/24/05 at 5:00 PM, NA 2 was interviewed over the phone. NA 2 stated that she did not remember the date but at the end of a shift her and CNA 2 found resident 1 with "pooh" smeared all over her. She stated that they brought resident 1 into the shower and sprayed her with the water and resident 1 "freaked out" and they felt the water and determined the water was cold.

On 10/24/05 at 5:30 PM, CNA 2 was interviewed over the phone. CNA 2 stated on 10/2/05, resident 1's roommate told them that resident 1 had taken off her clothing and brief. CNA 2 stated that they went into the room and found resident 1 had smeared bowel all over herself and chair. She stated that they brought resident 1 into the bathroom turned on the water and sprayed her with the water. CNA 2 stated that resident 1 "freaked out" because the water was cold, states they took the water off and then sprayed her again and resident 1 reacted again but not as bad as the first time because the water was too hot. CNA 2 stated that she informed NA 1 of the incident a few days later (10/4/05).

On 10/25/05 at 2:30 PM, NA 1 was interviewed over the phone. NA 1 stated the following, "while

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hanging outside a resident's room [CNA 2] stated they were really mad at resident 1 because she got feces all over herself at the end of shift and we had to give her a shower and we sprayed her with cold water for about 3 seconds." NA 1 further stated that 2 days after CNA 2 told her about the cold shower she reported the incident to CNA 1. She stated that CNA 1 advised her to report the incident to her supervisor but she was not comfortable because she was new to the facility and was not sure if it was going to cause problems. NA 1 stated when she was hired facility administration told her abuse was off limits, but she never knew she was to report abuse immediately to facility administration.

A review of CNA 2's time report provided documented evidence that CNA 2 continued to work at the facility on 10/4/05, 10/5/05 and 10/8/05.

A review of NA 2's time report provided documented evidence that NA 2 continued to work at the facility on 10/5/05.

A review of the facility investigation concerning CNA 2, NA 2 and resident 1 provided documented evidence that facility administration became aware of the incidents on 10/10/05 (8 days after the incident occurred and 6 days after other facility staff became aware of the incident).

Per State Survey and Certification Incident Tracking documentation, the facility administration contacted the State Agency after receiving the allegation of abuse to resident 1.