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DRAPER REHABILITATION & CARE	12702 SOUTH FOURTH STREET DRAPER, UT 84020

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F 224 SS=J	483.13(c)(1)(i) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (Use F224 for deficiencies concerning mistreatment, neglect or misappropriation of resident property.) This REQUIREMENT is not met as evidenced by : Based on interview and record review, it was determined the facility failed to develop and implement written policies and procedures to prohibit neglect of residents for 2 of 5 residents in the sample. Neglect means the failure by the facility to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. (Residents 1 and 2) (1) Resident 1, who required a mechanically altered diet, the facility neglected to provide the correct texture of foods. The resident aspirated food during a meal, resulting in her death. (2) Resident 2, who did not want a shower, the facility neglected to provide the bed bath he had agreed to and was bathed without his consent. As a result, the resident received multiple bruises and abrasions on his hands and arms. Findings included: 1. Resident 1 was a 41 year old female who was readmitted to the facility in January of 2004 with diagnoses that included Huntington's chorea and digestive disorders. Due to the resident's	F 224	The Residents involved in this deficiency have both been discharged from the facility. Direct Care Staff training, with an emphasis on protecting and advocating for Residents including dietary compliance, and protecting Resident's Rights—along with all staff's being empowered to advocate and protect the Resident appropriately, was completed on January 21, 2005. Training of staff concerning the new facility policy and procedure on resident abuse, and the reporting of same, using the incident investigation protocol, will continue for all staff. Training will be done quarterly for the next year. New employees will be given the information by their manager upon hire. The manager will discuss the information, before the employee works a regular shift. Later, during the New Employee Orientation, the information will be reviewed and discussed again. Utah Department of Health 510529 FEB 0 4 2005 Bureau of Health Facility Licensing, Certification and Resident Assessment	

2/8/05 plan of correction addendum completion date 1/26/05 Addendum RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Admin/Owner | (X6) DATE 2/04/05

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

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F 224	Continued From page 1 cognitive deficits and compromised ability to chew and swallow, secondary to Huntington's chorea disease, on 3/25/04 resident 1's physician ordered a "Mechanical Soft diet." On 1/12/05 at 4:00 PM, via the telephone, the facility's dietary supervisor (DS) was interviewed. The DS stated that with a mechanically soft diet, meats like chicken, sausage and hot dogs need to be finely ground or finely chopped. An incident report, dated 1/5/05, was prepared by a certified nursing assistant (CNA 1) and the Director of Nurses (DON). On 1/13/05 resident 1 's incident report, dated 1/5/05, was reviewed. CNA 1 documented that while passing dinner trays, she observed resident 1 having difficulty breathing. After CNA 1 encouraged resident 1 to cough, the resident still had difficulty breathing. An occupational therapist (OT) asked if the resident was choking. Then the OT started doing the Heimlich Maneuver. (The Heimlich Maneuver is an intervention meant to dislodge material stuck in the throat.). After repeated unsuccessful thrusts to clear the resident's airway, facility nursing was paged and the paramedics were called. Resident 1 was removed from the dining room and taken into the hallway near the elevator and laid supine on the floor. Cardio-pulmonary resuscitation (CPR) was initiated and the Heimlich Maneuver was continued until the paramedics arrived. The facility incident report, under the nature and extent of injuries, documented "Death (choking)." On 1/12/05 at 2:30 PM, a telephone interview was conducted with a facility OT. The OT stated that he did the Heimlich maneuver 3 times with resident 1 in her chair. He stated that he could	F 224	Monitoring of facility compliance with protecting Resident's Rights will be done by the facility's "champion for Resident's Rights," who is the Social Service Worker. She will use the following to help monitor the protection of Resident's Rights: 1) She coordinates the Resident Council; any concerns brought up by the Resident Council will be noted and taken to the Quality Assurance Committee. 2) The Social Service Worker participates in the Interdisciplinary Team Meeting. Issues raised in the meeting will be noted and taken to the Quality Assurance Committee. 3) She (along with Nursing Administration) will review the Incident Reports, and participate in the investigation of any concerns with Resident's Rights. The S.S.W. will note any issues found, and take them to the Quarterly Quality Assurance Committee for review.	

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F 224	Continued From page 2 not clear the airway. He further stated, " I assumed it was something from her meal." The OT then stated that he took her out to the elevator hallway and laid her down on the floor and proceeded to do the Heimlich thrust. He stated that he was unable to clear resident 1's airway. He stated that a nurse arrived and aided him but they were unsuccessful. The OT stated he continued attempts to clear the airway until the paramedics arrived. On 1/12/05 at 2:00 PM, RN 1 was interviewed. RN 1 stated that on 1/5/05 at 5:30 PM, upon hearing the emergency page from the main dining room, she immediately went downstairs to the dining room. RN 1 stated that she found resident 1 lying on her back, in the hallway in front of the elevator, just outside of the main dining room. RN 1 stated resident's face was purple and the OT was doing abdominal thrusts. RN 1 stated she helped the OT do CPR/Heimlich Maneuver until the paramedics came. RN 1 stated that the paramedics worked on resident 1 for a while and retrieved a 1 1/2 inch by 1 inch in diameter piece of hot dog from resident 1's throat. A review of resident 1's Advanced Directives contained in her medical record revealed resident 1 did not want to be resuscitated if her heart were to stop. A police report revealed the responsible family member arrived at the scene while resident 1 was receiving CPR. Per documentation in the police report, resident 1's family member asked the paramedics to stop the CPR if the resident's heart had actually stopped. The paramedics determined resident 1's heart had stopped and CPR was discontinued per the resident's	F 224	Please see attachments for examples of forms and training materials currently being used. Completed by ~~March 22, 2005 by~~ Social Service Worker and Staff Developer; monitored by Administrator. Reviewed by Quarterly Quality Assurance Committee, next meeting scheduled March 22, 2005. 11/4 changed per addendum MO 3/14/05	

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F 224	Continued From page 3 Advanced Directives. The Death Certificate for resident 1 revealed she was pronounced dead on 1/5/05 at 6:50 PM of aspiration secondary to Huntington's chorea. On 1/12/05 at 2:15 PM, LPN 1 was interviewed. LPN 1 stated that on 1/5/05 at 5:30 PM, upon hearing the emergency page from the main dining room, she immediately went downstairs and assisted the OT and RN 1 by taking resident 1's pulse. LPN 1 stated that the responsible family member of resident 1 was present. When the paramedics had to decide whether to continue CPR for resident 1, the resident's Advanced Directives were honored. In an interview with the dietary manager on 1/13/05, he stated the hot dogs should have been chopped or ground for the mechanical soft diets. The dietary manager stated that he had interviewed the cook, that the cook stated he had been "lazy" the evening of 1/5/05, and had not ground the hot dogs as the cook knew he should. On 1/12/05 at 2:00 PM, CNA 1 was interviewed. CNA 1 stated that on 1/5/05 at 5:30 PM, she gave resident 1 her meal tray with a whole hot dog on it . CNA 1 stated she knew that resident 1 was on a mechanical soft diet but stated she had thought hot dogs were a mechanically soft food. CNA 1 stated that while passing trays in the main dining room to other residents, she heard resident 1 coughing. CNA 1 stated that she encouraged resident 1 to cough and breath a "couple" of times but that resident 1 began to turn blue. CNA 1 stated the facility OT came over to resident 1, who was sitting up in her chair, and proceeded to do the Heimlich maneuver. CNA 1 stated that she	F 224		

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F 224	Continued From page 4 then went to page the nurse with a STAT (immediate attention), get the "Ambu" bag, get the resident's chart and then returned to help with resident 1. In an interview with CNA 1 on 1/12/05 at 4:35 PM, she stated that on 1/5/05, she did not know that a hot dog needed to be ground for a mechanical soft diet. On 1/11/05 at 3:05 PM, an interview was conducted with CNA 2. CNA 2 stated that on 1/5/05 at 5:30 PM, there were no diet cards on the resident's trays in the main dining room when she was giving the trays to the residents. CNA 2 stated that she went to the facility cook and complained that no diet cards were on the trays. CNA 2 stated that she had been afraid to serve the trays to the residents without the cards that specified each resident's diet restrictions. CNA 2 further indicated that the facility cook stated he wasn't using the meal cards that night and all mechanical soft diets were the same as regular diets for that meal. CNA 2 then continued to pass the trays without the diet cards. CNA 2 stated that every tray she passed had whole hot dogs and that any residents in the main dining room, who were on mechanical soft diets, received the regular textured meal of whole hot dogs. On 1/10/05, observation was made of the dinner meal in the middle area of the main dining room, where resident 1 ate her meals. The administrator provided a list of residents and their specified diets. Seven of the thirteen other residents who ate in that same area required mechanical soft diets. On 1/12/05 at 1:55 PM, RN 1 was interviewed. RN 1 stated that in the past, resident 1 was known to pick up and push big pieces of food into	F 224		

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F 224	Continued From page 5 her mouth and swallow it without chewing. On 1/12/05 at 2:40 PM, CNA 14 was interviewed. CNA 14 stated that resident 1 did not have patience with being helped and was known to stuff a whole sandwich in her mouth at one time. On 1/11/05, 1/12/05 and 1/13/05, approximately 1 week after the incident, nine CNAs were interviewed. On 1/13/05 at 2:30 PM, CNA 8 stated that a whole hot dog was a mechanically soft food. One of the other eight CNAs did not know that a hot dog needed to be ground or chopped to be considered part of a mechanical soft diet. The DON was interviewed on 1/13/05 at 4:20 PM. The DON was asked if following the incident with resident 1, had the CNAs received any training regarding what was an appropriate food texture for mechanical soft diets. She stated, "They are supposed to learn in CNA school and none of ours are not certified." The DON further stated she had previously identified concerns with dietary service and that she had implemented a new dietary protocol 1/11/05 and had conducted an inservice with the CNAs. The new protocol included moving residents to different dining rooms so that residents who required more assistance could be assisted in the same area. The new protocol did not include information regarding what types of food are allowable for the different textured diets and did not specify what nursing staff could to do if the wrong textured diets were being provided. On 1/12/05 at 1:15 PM, the Administrator was interviewed. The Administrator stated that on the evening of 1/5/05, after resident 1 died, he had	F 224		

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interviewed some of the facility staff as to what occurred. He stated that from the information he received from those interviews, he had determined that on the evening of 1/5/05, appropriate therapeutic diets were not prepared.
2. Resident 2 was admitted to the facility November 2004 with diagnoses that included miocardial infarction, acute renal failure, deconditioning and situational depression.

Resident 2's medical record was reviewed on 1/6/04. Resident 2's comprehensive Minimum Data Set (MDS) assessment was completed by the facility's Interdisciplinary Team (IDT) on 12/7/04. The IDT documented that resident 2 made his own decisions regarding tasks of daily life, with some difficulty in new situations only. Resident 2 was identified as being able to communicate with clear speech, was able to understand others and he was able to make himself understood. The IDT identified that resident 2 required extensive assistance of one staff member for some activities of daily living including dressing, personal hygiene and bathing. The IDT further documented that for 1 to 3 days of the 7-day assessment period, resident 2 had been resistive to staff providing cares. They documented that resident 2's resistance behavior was easily altered and that resident 2 had demonstrated no physically aggressive behaviors.

On 12/13/04, Licensed Practical Nurse 1 (LPN 1) documented in resident 2's nurse's notes that the resident had refused all showers and had accepted only one partial bed bath since he was admitted, a period of two weeks.

RN 2 was interviewed on 1/1/05 at 2:20 PM. RN 2 stated that he had not been assigned to care for

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resident 2, but that he had intervened with the resident's cares on occasion. RN 2 stated that resident 2 absolutely refused all showers. RN 2 stated that when he talked to the resident about hygiene, resident 2 would clean himself up.

Documentation showed that LPN 2 frequently worked directly with resident 2. LPN 2 was interviewed on 1/11/05 at 2:40 PM and stated resident 2 told her he didn't want to be shaved by the facility staff because he was waiting for his son to do it. LPN 2 stated that although resident 2 didn't like showers, the resident never had any body odor.

Resident 2 was receiving services from an Occupational Therapist (OT) and on 12/2/04, the OT documented resident 2 was pleasant and cooperative. On 12/11/04, the OT documented that resident 2 was completing all grooming tasks with set up.

LPN 1 was interviewed on 1/11/05 at 3:30 PM. LPN 1 stated that resident 2 had repeatedly refused to bath. LPN 1 stated that whenever she had approached resident 2 about bathing, he had gotten angry with her. LPN 1 stated that on 12/22 /04, she and resident 2's case manager (RN 1) assessed the resident's skin and found his perineal area to be reddened.

On 1/12/05, RN 1 and the social services worker (SSW) were interviewed separately. They independently stated that on 12/22/04, they talked with resident 2 in his room. They stated they were trying to educate resident 2 regarding the importance of personal hygiene and the ramifications of neglecting it. They each stated that on 12/22/04, resident 2 had agreed that he

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would accept a bed bath that evening. RN 1 documented in a nurse's note dated 12/22/04 " after a long discussion", resident 2 had agreed to have a bed bath. On 1/11/05 at 10:15 AM, RN I was interviewed. She stated that on 12/22/04, she left the building before resident 1 was bathed. RN 1 stated that to her knowledge, resident 2 had never struck anyone before.

In a progress note dated 12/22/04, the SSW documented that resident 2 had told her he did not take showers. The SSW documented that resident 2 was asked if he would prefer a bed bath by a male CNA. The SSW indicated that they had introduced resident 2 to CNA 3, a male CNA and that they seemed to get along. The progress note documented that an agreement was made that resident 2, after dinner on 12/22/04, would have a head to toe bed bath. The SSW documented that resident 2's nurse was advised the resident had agreed to a bed bath.

CNA 3 was interviewed by telephone on 1/12/05 at 2:13 PM. CNA 3 stated that after dinner on 12/22/04, he asked CNA 4 to bring resident 2 to the shower room. Even though resident 2 had a private room with a private bathroom, CNA 3 stated that he was already in the south hall shower room completing another shower.

CNA 3 stated that when he closed the shower room door, resident 2 seemed to become confused. CNA 3 stated that when he and CNA 4 began to remove resident 2's shirt, the resident became "uncomfortable" and "started swinging." CNA 3 stated resident 2 was reassured they would not give him a shower. CNA 3 stated resident 2 agreed to be shaved and then hit CNA 3. CNA 3 stated "That's when I saw skin tears on

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his hands." CNA 3 stated that throughout the " partial bath", resident 2 repeatedly called both CNAs "names."

CNA 3 stated that as he attempted to shave resident 2, the resident moved his head side to side. CNA 3 stated he told the resident, "It would be great if you didn't move your head." CNA 3 stated that, "By that time I already had the shaving cream on." CNA 3 stated the resident stopped moving until they had finished the shave. CNA 3 stated, "He probably realized I had the razor and he didn't want to get cut." CNA 3 stated the resident had been "nicked" once during the shave.

On 12/22/04 at 6:30 PM, CNA 3 documented in a report of the incident, ". . . As we approached to help (resident 2) take off his clothing. (sic) He seemed to be confused. As we got his sweater off he then became violent, I then noticed skin tears on his hands. He was squeezing are (sic) hands so tight that it ripped his skin. (Resident 2) starting (sic) calling me (expletives deleted). . . . We struggled getting his shirt off but eventually did."

"We then told (resident 2) to stop hitting us, he didn't care and the words kept coming out. We told (resident 2) that we needed to take off his pants. So (CNA 4) and I helped him stand up. He fought us at first but once he was standing he relaxed. . . . I went to take them off and he swung a punch at me. He missed so I asked (CNA 4) to hold his hands still and she did. So (resident 2's) pants finally came off."

"I then told (resident 2) that I was going to shave him, because he was scruffy. He said that I was (

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expletives deleted). I then approached him and let him know I was going to shave him. He got free from (CNA 4's) hands and punched me in the stomach hard as he could. I looked down and saw blood on my scrubs and noticed blood on (CNA 4's) sweater. I told him I was going to shave him, again so I did. . . . "

CNA 4 was interviewed by telephone on 1/12/05 at 3:45 PM. She stated that on 12/22/04, she assisted CNA 3 with a partial bath for resident 2 because resident 2 had become confused. She additionally stated that when they tried to take resident 2's sweater off, the resident refused and said it was too cold. She stated that was when the resident first hit CNA 3. Additionally, she stated she and CNA 3 took turns holding resident 2's hands and continued bathing the resident.

CNA 4 stated she had asked resident 2 why he was calling them names. She stated resident 2 said it was because he didn't want the bath any more. She stated that she had known the nurses and the SSW had told CNA 3 what to do so she felt CNA 3 was in charge and that she couldn't question his actions. She stated she didn't try to stop the bath because she felt she had to do what CNA 3 told her to do. CNA 4 indicated that after resident 2 was bathed, he was taken back to his room where he refused treatment for his hands and called his family to come get him. CNA 4 stated that resident 2's family arrived "with the paramedics" and that resident 2 was transported to a hospital by ambulance.

A surveyor review of the hospital emergency room (ER) report dated 12/22/04 indicated that at 8:30 PM, when resident 2 arrived at the ER, he was found to have multiple bruises and abrasions

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F 224	Continued From page 11 to both of his arms. Through interview and record review, it was determined that the facility had investigated the incident and had determined that no abuse had occurred. It was found that the facility counseled the two nursing assistants who were involved in the incident with resident 2, but that the facility did not implement any further inservicing or monitoring to ensure that residents were not mistreated through not being allowed personal choice in their daily cares.	F 224		
F 498 SS=J	483.75(f) ADMINISTRATION The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by : Based on interviews and record review, it was determined the facility failed to ensure that nurse aides were able to demonstrate competency in skills and techniques necessary to care for residents' identified needs for 2 of 5 residents sampled. (Residents 1 and 2): (1) Resident 1 had a physician's order for a mechanical soft diet and received a regular textured meal that was given to her by a Certified Nurses Aide. The resident aspirated some food and died at the facility. (2) Resident 2 required assistance with hygiene and bathing, agreed to receive a bed bath. The	F 498		

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	465091	A. BUILDING _____ B. WING _____	C 01/14/2005

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DRAPER REHABILITATION & CARE	**12702 SOUTH FOURTH STREET DRAPER, UT 84020**

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F 498	Continued From page 12 resident received multiple bruises and abrasions to his upper extremities when he was forcibly bathed by two nurse aides in a shower room. Findings include: 1. An onsite investigation revealed that resident 1 had an order for a mechanical soft diet. On the evening of 1/5/05, all resident's in the facility were served hot dogs for dinner. The kitchen sent whole, instead of chopped or ground, hot dogs for the residents who required mechanical soft diets. In the main dining room, the nurse aides served the whole hot dogs to the residents who required mechanical soft diets. Resident 1 should have received a ground hot dog on a bun, but was served a whole hot dog. A review of resident's 1 medical records was completed on 1/13/05. Resident 1's quarterly Minimum Data Set (MDS) assessment was completed by the facility Interdisciplinary Team (IDT) on 9/21/04. The IDT documented that resident 1 had a chewing problem. The Registered Dietician (RD) documented on resident 1's Nutritional Assessment dated 1/7/04. The RD documented that resident 1 had a chewing problem and required a mechanical soft diet. The Dietary Progress Note, dated 9/23/04 by the Dietary Supervisor and the RD, revealed resident 1 required a mechanically soft diet and the staff needed to set up her meals for her. Resident 1 had a care plan dated 1/9/04 for "At altered nutritional risk (secondary) to (diagnosis) Huntington's Chorea, her refusal to eat	F 498	On or before January 21, 2005, all Direct Care C.N.A.'s and Nursing Staff received training on the following: 1) Resident's Rights 2) Residents' Right to refuse treatment. 3) Basic information concerning Therapeutic Diets and Diet Textures 4) Dining Room Protocol, Part 2 (which teaches that Staff may refuse to serve an improper diet or texture to a Resident, and their obligation to inform dietary, and the Nurse of any difficulty in this area.) Testing was also completed to ensure that staff understood the concepts. Ongoing training will occur both during the hiring process, when managers review the information with new hires, and again, during the New Employee Orientation. To ensure facility compliance with the above, the following will occur.	

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F 498	Continued From page 13 occasionally." The care plan revealed that resident 1 should have received a "regular diet Mech Soft" (Mechanically soft). An interview was held with the nurse aides (CNA 1) who had served resident 1 the dinner meal on 1/5/05. CNA 1 stated that resident 1 had been served a whole hot dog on a bun. CNA 1 stated that she thought the hot dog was appropriate for a mechanical soft diet. CNA 1 stated that she continued to serve other residents their trays. She noticed that resident 1 appeared to be choking. CNA 1 and other facility staff intervened but were unable to dislodge the hot dog from resident 1's throat. Resident 1 died of aspiration at the facility. Further investigation revealed that the cook who had prepared the dinner meal for the residents on 1/5/05, had not prepared mechanical soft diets for the residents who had orders to have mechanically altered diets. In an interview with the dietary manager, on 1/13/04, he stated the hot dogs should have been chopped or ground for the mechanical soft diets. The dietary manager stated that he had interviewed the cook, that the cook stated he had been "lazy" the evening of 1/5/05, and had not ground the hot dogs as the cook knew he should. On 1/12/05 and 1/13/05, one week after the incident, nine of the facility's nurse aides were interviewed. One of the nine nurse aides stated he thought a whole hot dog was appropriate for a mechanical soft diet. The facility cook had not prepared the mechanical	F 498	Daily "Diet Grids" are posted in the dining areas, and on the nursing units. Nursing staff have been instructed on how to check the "Grid" to ensure that residents are being served the proper diet and texture. Per the Dining Room Protocol, the Nursing managers assigned to the respective dining rooms are the following: D.O.N. is over Autumn Ridge Dining Room; the Resident Care Managers are over the Middle Dining Room; the Staff Developer is over the Main Dining Room. For the next 90 days, these managers ill do a minimum of weekly audits/spot checks of dietary compliance, and turn in the checklists to the Quality Assurance Committee for review. These managers will also instruct floor nursing staff in using the checklists for continued, random audits, also turned into the Quality Assurance Committee for review. Please see attachments for example of forms currently being used. Completed by ~~March 22, 2005~~, by Director of Nursing, monitored by Administrator; reviewed quarterly by Quality Assurance Committee; next ~~scheduled meeting March 22, 2005~~.	

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soft diets properly on 1/5/05, according to the dietary manager. The nurse aide who served resident 1 the meal did not have the knowledge that a whole hot dog was not considered to be mechanical soft, according to the nurse aide. After the incident, another nurse aide did not have the knowledge that a whole hot dog was not considered to be mechanical soft, according to the second nurse aide.

On 1/13/05 at 4:20 PM, the Director of Nursing (DON) was interviewed. The DON was asked if the nurse aides had received any training regarding appropriate food texture for the different types of diets, either before or after the incident with resident 1. The DON stated, "They are supposed to learn in CNA (certified nursing assistant) school and none of ours are not certified." The DON stated she had implemented a new dining protocol on 1/11/05. The new protocol did not include inservice to ensure the staff understood what types of foods could or could not be acceptable for a mechanical soft diet .

On 1/12/05 at 1:15 PM, the Administrator was interviewed. The Administrator stated that he had terminated the employment of the cook who prepared the meal on 1/5/05 without regard to the special dietary needs of residents who were to receive mechanical soft diets. The Administrator stated that he did not feel any further actions were necessary.

2. Resident 2 was admitted to the facility November 2004 with diagnoses that included miocardial infarction, acute renal failure, deconditioning and situational depression.

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F 498	Continued From page 15 Resident 2's medical record was reviewed on 1/6/04. Resident 2's comprehensive Minimum Data Set (MDS) assessment was completed by the facility Interdisciplinary Team (IDT) on 12/7/04. The IDT documented that resident 2 made his own decisions regarding tasks of daily living with some difficulty in new situations only. Resident 2 was identified as being able to communicate with clear speech, was able to understand others and he was able to make himself understood. The IDT identified that resident 2 required extensive assistance of one staff member for some activities of daily living, such as dressing, personal hygiene and bathing. The IDT documented that for 1 to 3 days during the 7-day assessment period, resident 2 had been resistive to staff providing cares. They documented that resident 2's behavior of resisting was easily altered. The IDT documented that resident 2 had demonstrated no physically aggressive behaviors. The care plan for resident 2, dated 11/30/04, addressed a concern that the resident had a problem with bathing and hygiene. The care plan was updated on 12/5/04 because the resident refused showers. The facility staff were to intervene by: 1. Encouraging the resident to shower once or twice each week, 2. Offering different times for his shower, 3. Remind the resident of the need to care for his skin by cleansing and applying lotion. A care plan problem, dated 11/30/04, addressed	F 498		

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F 498	Continued From page 16 resident 2's dressing / grooming deficit secondary to severe deconditioning. The facility staff's interventions included "1. Treat resident with dignity." A care plan problem, dated 11/30/04, addressed resident 2's risk for skin breakdown secondary to decreased mobility. The facility staff's interventions included "1. Cheerful dialogue with resident while cleaning to encourage maintained self esteem." On 1/12/05, RN 1 and the social services worker (SSW) were interviewed separately. They stated that, on 12/22/04, they talked with resident 2 in his room. They each stated resident 2 had agreed that he would accept a bed bath that evening. On 12/22/04, resident 2 was taken to a shower room and two nurse aides began to assist the resident to undress for a bath. Resident 2 began to resist and wanted to be taken back to his room. The two nurse aides held the resident's hands and continued to undress and bathe resident 2 against his will. During the bath, resident 2 received bruises and abrasions to the backs of his hands, wrists and arms. The facility had investigated the incident and had determined that no abuse had occurred. The facility did counsel the two nursing assistants who were involved in the incident with resident 2. The facility did not implement any further inservices or monitoring to ensure that other residents remained free from mistreatment. See tag F 224.	F 498		