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

PRINTED: 02/14/2006 FORM APPROVED OMB NO 0938-0391

STATEMEN'	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	ILTIPLE CONSTRUCTION		(X3) DATE SURVEY	
		DETTI JOATION NUMBER.	A. BUILI	<del></del>	COMPL	ETED	
		465091	B. WING	3	02/	09/2006	
	PROVIDER OR SUPPLIER  REHABILITATION &	CARE	\$	STREET ADDRESS, CITY, STATE, ZIP C 12702 SOUTH FOURTH STREET DRAPER, UT 84020			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID .	PROVIDER'S PLAN OF CO	RRECTION	(VE)	
PREFIX TAG	REGULATORY OR L	MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
E 224	492 42/a) STAFE T	DEATHERIT OF DECISION OF	2	To protect resident 1 fi		<u> </u>	
SS=J	403.13(C) STAFF 1	REATMENT OF RESIDENTS	کہ F 22 محک	the following:	d or done		
	The facility must de	evelop and implement written	2 <b>78</b> /	We have counceled the	resident		
ĺ	policies and proced	Jures that prohibit	0/0	about why removal of		2-10-0	
	mistreatment, negle	ect, and abuse of residents	2	objects and changing h	-		
	and misappropriation	on of resident property.	E.	closer to the nurses sta			
		C	LA COLLON	best interest.	non is in noi		
	This REQUIREMEN	NT is not met as evidenced	્રે કેં	We have removed all s	harn objects		
	by:	9	م کے	from the residents roor			
ļ	Based on interviews	s and record review it was	` کی '	them in the Social Serv			
j	determined that the	facility failed to adequately nd monitor a resident with self	<b>4</b> 3	where she can request			
	injurious behaviors	which led to neglect for 1 of 3	5	We have made the room			
	sample residents (re	esident 1). Specifically	ر ب	closer to the nurses sta			
	resident 1 inflicted a	wound, which measured 4	10	better monitoring.	1011 TOT		
ļ	Inches by 2.5 inches	s by 1 inch in depth on her left	1/0	We have written a new	care nlan	-	
	thigh, with a pair of	SCISSOIS.	S/5				
!	The facility's failure	to adequately assess,	Shapanyou.	contract with her APR			
	monitor, care plan a	and intervene led to a finding	8	The administrator spok			
1	of Immediate Jeopa	rdy in the area of neglect.	\&	APRN and she signed of	o with the	f	
	Neglect is defined a	s failure to provide goods and	5	care plan we put into p			
Ì	mental anguish, or r	to avoid physical harm,	ج ہے	agreed to send us week			
		Territal miress.	75	A new psychosocial ass			
Ì	Findings included:			has been completed.	Sessificiti		
	1 Pooldont tours	1 24 1 2 2 2 2		Q15 minute checks hav	e heen		
	9/13/05, with diagno	admitted to the facility on		implemented and are be			
	schizo-affective bipo	plar with paranoia and		by our DON or designe	e each		
	borderline personalit	ty disorder, depression		shift.	c cach		
-	anxiety, ehler danlos	c/chronic pain syndrome and		An IDT was held with t	he recident		
1	seizure disorder.			and her closest relative.			
1	On 2/9/06 resident 1	1's medical record was		An all staff inservice w			
r	reviewed.	i o medical record was		to teach everyone about			
				one's BPD and her plan	of care		
(	On 12/15/05, resider	nt 1's APRN (advance		The Social Service work	ver will be		
F	practice registered n	urse) wrote a letter to the		responsible for this.	XCI WIII DC		
)RATORY [	DIBECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	TURE	HILE	<u></u>	X6) DATE	
Sa	Hulle 12		,	Adams I		•	
eficiency	stelement ending unto an	) asterisk (*) denotes a deficiency which		WMMM///	2-23	-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 of 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 he disclosable of 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.

FEB 2 4 2006

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

PRINTED: 02/14/2006 FORM APPROVED

STATEMEN AND PLAN (	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) M	ULTIF	PLE CONSTRUCTION	T	(X3) DATE SURVEY	
		OCM INICATION NOWREK	A. BUILDING			COMPLETED		
		465091	B. WIN	G		C 02/09/2006		
	PROVIDER OR SUPPLIER REHABILITATION 8	& CARE	,	12	EET ADDRESS, CITY, STATE, ZIP CODE 702 SOUTH FOURTH STREET RAPER, UT 84020		50,2000	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO	ULD RE	(X5) COMPLETIO	
·		THO SHA ORNIA HORY	TAG		CROSS-REFERENCED TO THE APPR To protect resident 1 from f		DATE	
F 224 SS=J	483.13(c) STAFF	FREATMENT OF RESIDENTS	F 2	24	harm we have instituted or on the following:			
	policies and proced	evelop and implement written dures that prohibit		Ì	We have counceled the resi-		2-10-6	
	mistreatment, negl	ect, and abuse of residents on of resident property.			about why removal of all shobjects and changing her ro	•	2 10 0	
ļ			•		closer to the nurses station i best interest.	s in her		
ļ 	This REQUIREMENT by:	NT is not met as evidenced			We have removed all sharp			
ĺ	Based on interview determined that the	s and record review it was facility failed to adequately		ļ	from the residents room and them in the Social Service of			
	assess, care plan a	and monitor a resident with self which led to neglect for 1 of 3			where she can request them. We have made the room cha			
	sample residents (r	esident 1). Specifically, a wound, which measured 4			closer to the nurses station f		ļ	
	inches by 2.5 inche thigh, with a pair of	s by 1 inch in depth on her left			better monitoring. We have written a new care	plan	į	
j		to adequately assess,			that incorporates resident 1' contract with her APRN.	S		
	monitor, care plan a	and intervene led to a finding ardy in the area of neglect.			The administrator spoke wit			
i	Neglect is defined a	s failure to provide goods and to avoid physical harm,			APRN and she signed off or care plan we put into place a		ı	
j :	mental anguish, or r	nental illness.			agreed to send us weekly up	dates.		
Findings inclu	Findings included:				A new psychosocial assessm has been completed.			
Ś	1. Resident 1 was a 9/13/05, with diagno	idmitted to the facility on		!	Q15 minute checks have bee implemented and are being a			
5	schizo-affective bipo	lar with paranoia and y disorder, depression,			by our DON or designee each shift.	n		
8	anxiety, ehler danlos seizure disorder.	/chronic pain syndrome and			An IDT was held with the res	sident		
	On 2/9/06, resident 1 eviewed.	's medical record was			and her closest relative. An all staff inservice will be			
}		t 1's APRN (advance			to teach everyone about resid one's BPD and her plan of ca	re.		
p	ractice registered ne	urse) wrote a letter to the			The Social Service worker waresponsible for this.	ill be		
KATORY D	BEOTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNAT	URE		5 THE	(×	(6) DATE	

2-23-06 Tommelle Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that of the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days in a collowing 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 11 calls. lays 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.

FEB 24 2006

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

PRINTED: 02/14/2006 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  (A. BUILDING			(X3) DATE SURVEY COMPLETED				
		465091	B. WIN	NG	<del></del>	С				
NAME OF	PROVIDER OR SUPPLIER	463091				02/09/2006				
DRAPER REHABILITATION & CARE				STREET ADDRESS, CITY, STATE 12702 SOUTH FOURTH STR DRAPER, UT 84020	, ZIP CODE EET			_		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	cy MUST BE PRECEEDED BY FULL R LSC IDENTIFYING INFORMATION)  page 1  rator which documented the		Y STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIC CR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE DEFICIENCY				TION SHOULD BE COMP THE APPROPRIATE DA		
	facility's administrate following, "I have some of the staff are supportive of any of She has been told I medications for her, doing therap (therap [Resident 1] needs to 24 hours notice that so she can arrange happening now is the last minute and told up and she won't unacceptable. It is absolutely essert health and psychiatricand encouraged to be I am disappointed the appear to want quiet, cause no figs, requeshave no life. [Reside human being who ne in supportive situation psychologically health she could she could devels quickly"  On 1/19/06 at 6:00 Predocumented the follow 'Notified [resident 1's changes]. She expresedent 1's] cutting canxious"	or which documented the become concerned that e either not aware or not [resident 1's] psychiatric plan. should not be prescribing sending her to groups, or by) each week ransportation for or at least transportation is not available for flex trans. What is at she is approached at the that 'something has come be able to go. This is notial for [resident 1's] mental c stability that she be allowed e at these groups at Nurses in your facility complacent people who est nothing, need nothing and ent 1] is/can be a vibrant eds to be around others and has in order to keep by. Without these supports deteriorate to disastrous  M, a facility nurse wing in a nurse's note, APRN] about order essed concerns about on herself when she is	F 2	To help identify of that might have the affected by the san to make sure it doe again, we have imprevised policy and resident change of inservice will be hepeople involved to the forms and char or designee will be both of these. A facenvironmental rour completed to ascer unknown hazards administrator. The be reported to our occumulate meeting	e potential to the practice esn't happer plemented a procedure of condition, and for those train them ages. The Expressible exists any by the expression of the expression any by the expression and was a findings we approximately Quarterly Quart	o be and on An e on OON e for				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/14/2006 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER** COMPLETED A. BUILDING B. WING 465091 02/09/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **DRAPER REHABILITATION & CARE** 12702 SOUTH FOURTH STREET DRAPER, UT 84020 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION . (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 224 Continued From page 2 F 224 was going to cut herself and needed help they further stated that it wasn't, until the last call they received that she stated her name, Nurse thanked [the crisis line] for their call and informed them that I would follow up. I then went into [resident 1's] room and found pt. (patient) with blankets covering her up and in bed. I asked pt. if she needed to talk, pt. responded "No" I asked pt, if she was in pain pt. reported, "No". I asked pt. if there was anything going on in her life that was making her feel uneasy, pt. responded "No". I felt pt. was not being honest with me so I left room. and asked charge nurse to go in and talk to her A facility nurse documented the following in a nurse's note, which was not dated or timed, "This nurse went into residents room [resident 1] was sitting on side of her bed. I noticed Blood on her gown [and] down her leg. I said where is the blood [and] I told her [the crisis line] called us. [Resident 1] said she cut herself. She showed me her left thigh her thigh was cut about 4 inches. long [and] 2 ? inches wide wound was oozing dark red blood ..." On 2/1/06 at 5:30 AM, a facility nurse documented the following in a nurses note. "Resident returned from hospital ... wound was about 3 ? -4 [inches] - 16 stitches [and] approximately 1 [inch] deep. [Resident 1] stated she had cut an artery ..." A review of resident 1's medical record revealed

that a comprehensive care plan, addressing resident 1's "cutting" behavior, prior to or after the self-injurious behavior on 1/31/06, could not

be found in the medical record.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (2)  NAME OF PROVIDER OR SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		465091	B. WI	NG		C 02/09/2006			
	REHABILITATION &	CARE		12	EET ADDRESS, CITY, STATE, ZIP CODE 702 SOUTH FOURTH STREET RAPER, UT 84020	1	03/2000		
(X4) ID PREFIX TAG	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JID BE	(X5) COMPLETION DATE	-	
	On 2/9/06 at 9:15 Al was interviewed. She history of harming he the facility. She furt not implement a car resident 1 regarding because resident 1 lyears. The facility suresident 1 injured he which belonged to reworker stated that si had made a contract stated the facility had plan for the actual set the facility had issued discharge notice. She discharge notice was because of resident and facility staff were social worker then strompleted any docur 1's self-injurious behaviors because the facility. He further staware of resident 1's o admission and thou esolved. The facility egarding the incident esident 1 cut herself has the scissors and objects from her room was not a care plan are	M, the facility social worker he stated that resident 1 had a erself prior to admission at her stated that the facility did e plan or contract with the self-injurious behaviors had not harmed herself in four ocial worker stated that treelf on 1/31/06 with scissors esident 1. The facility social nee the incident resident 1 with the APRN. She further d not implemented a care elf-injurious behavior because d resident 1 a 30 day is saled to resident 1 a 30 day is saled to provide care. The ated that she had not mentation regarding resident avior.  I, the facility administrator stated that the facility was le resident 1's self injurious behaviors prior up the behavior was administrator stated that the facility was self injurious behaviors prior up the behavior stated that the facility was self injurious behaviors prior up the behavior stated that the facility was self injurious behaviors prior up the behavior stated that the facility was self injurious behaviors prior up the behavior stated that the facility was self injurious behaviors prior up the behavior stated that the facility was self injurious behaviors prior up the behavior stated that the facility was self injurious behavior stated that the facility was self injurious behaviors prior up the behavior was administrator stated that the facility was self injurious behavior sprior up the behavior was administrator stated there ddressing resident 1's self cause the behavior was	F	224					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/14/2006

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/14/2006 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER COMPLETED A. BUILDING B. WING С 465091 02/09/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **DRAPER REHABILITATION & CARE** 12702 SOUTH FOURTH STREET DRAPER, UT 84020 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5)PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 224 Continued From page 4 F 224 On 2/9/06 at 9:35 AM, the facility's case manager for resident 1 was interviewed. She stated resident 1 had not had any self-injurious behavior for over a year. She further stated that the facility was aware of resident 1's history of self-injurious behavior prior to admission to the facility. The case manager stated resident 1 was issued a 30 day discharge notice after the incident of self-injurious behavior on 1/31/06 because the facility was not equipped to watch resident 1's psychiatric behaviors On 2/9/06 at 10:00 AM, resident 1 was interviewed. She stated that on 1/31/06 she cut her leg with scissors which belonged to her and were located in her room. She further stated she had a past history of cutting herself when " stressed out " . Resident 1 stated staff knew about the self-injurious behavior. Resident 1 stated that after the incident facility staff kept her out in the day room but the only thing the facility has done now, "was kick me out." On 2/9/06 at 10:10 AM, employee 1 was interviewed. She stated that a few days prior to 1/31/06, resident 1 told her that she had given her knife to the APRN. Employee 1 further stated, a few days prior to 1/31/06 she had told a facility nurse that she was worried about resident 1 and afraid resident 1 might cut herself. She also stated she told a facility nurse prior to 1/31/06 that resident 1 had told her she had called a suicide hotline. Employee 1 stated that no items have been removed from resident 1's room since 1/31/06. On 2/9/06 at 10:45 AM, the facility 's director of

nurses was interviewed. She stated she could not recall if she was aware that resident 1 had

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					M APPROVEL		
AND FLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		465091	B. WIN	G		С С			
NAME OF	PROVIDER OR SUPPLIER		<del> </del>		C CITY OTATE TIME		/09/2006	_	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	. ∤ (EAC⊩	OVIDER'S PLAN OF CO I CORRECTIVE ACTIO REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
	self injurious behavidirector of nurses states she was not searched for any she case had been turned she further stated she closer monitoring of behaviors. The direct facility staff have been 1's behaviors since in further stated that rect increase in "attention resident 1 did not quare of the control of the stated that rect increase in "attention resident 1 did not quare of the control of the stated she asked of the stated she asked of the stated she asked of the stated that she provided that she provided and the stated she made a control of the stated that she provided all to her about the control of the building."  The facility failed to providing adequate must behaviors.	ors prior to admission. The lated after resident 1 cut sure if resident 1's room was arp object, she stated the ed over to the social worker, he had not implemented resident 1 for self injurious ctor of nurses stated that allien concerned about resident resident 1's admission. She sident 1's has had an n seeking "behaviors since alify for flex care.  A, the APRN (advance urse) who counseled and ns for resident 1 was phone. She stated that prior e facility case manager that g thoughts of injuring herself. If the case worker to keep a lat 1 and do frequent checks didn't do this." The APRN led the facility with all of her did be reached when resident cility staff "never once interventions." She further even look at the contract or contract. She stated the just wanted resident 1 "out event neglect by not onitoring, supervision and fividual who had known self		24	JEFICIENCY)				
213 4	00.20(u), 403.20(K)(1	) COMPREHENSIVE	F 279			ĺ	Ì		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/14/2006

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDED SUPPLIER OF DEFICIENCIES

PRINTED: 02/14/2006 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		465091	B. WING			С	
DRAPER REHABILITATION & CARE			1	TREET ADDRESS, CITY, STATE, ZIP CODE 12702 SOUTH FOURTH STREET DRAPER, UT 84020		/09/2006	
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F 279	Continued From pa	age 6	F 279				
			1 213				
	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under o483.25; and any services that would otherwise be required under o483.25 but are not provided due to the resident's exercise of rights under o483.10, including the right to refuse treatment under o483.10(b)(4).  This REQUIREMENT is not met as evidenced by:  Based on medical record review and interview, it was determined that for 1 of 3 sample residents (Residents 1) the facility did not develop a			A new comprehensive care has been implemented to in resident one's contract with APRN and her other behave. We have revised the policy procedure about resident cle condition to better be award changing resident needs and to address them. The DON designee will do monthly a ensure compliance.  To help implement this plan care we have had an inservice explaining to our staff her nand our concerns. Resident APRN will also be holding inservice for our staff to hel us understand her needs and concerns. Our DON or designed will be responsible and reported.	nclude h her viors. v and hange of e of d how for udits to  n of ce eeds one's an p all of gnee	2-10-03	
0	n their individual neo taff.	plan for the resident based eds identified by the facility		findings to our QA committed quarterly basis.	ee on a		
F	indings include:			. , , , , , , , , , , , , , , , , , , ,			
9/   sc	13/05, with diagnos- chizo-affective bipola	Imitted to the facility on es which included ar with paranoia and disorder, depression,					

DEPAF CENTE	RTMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES  & MEDICAID SERVICES				FORM	D: 02/14/20 MAPPROVI	ED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	MULTIF	PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		465091	B. WI	NG		0.20	C 0 <b>9/2006</b>	
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 02/0	09/2006	$\dashv$
DRAPE	R REHABILITATION &	CARE		12	R702 SOUTH FOURTH STREET RAPER, UT 84020			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	N
F 279	Continued From pag	ge 7	F 2	279			+	
	anxiety, ehler danlos seizure disorder.	s/chronic pain syndrome and	•					
	On 2/9/06, resident reviewed.	1's medical record was						
	"Notified [resident 1's [changes]. She expr	PM, a facility nurse bying in a nurse's note, s APRN] about order ressed concerns about on herself when she is						
	was interviewed. She history of harming he the facility. She furth not implement a care resident 1 regarding to the sident of the same resident 1 regarding to the sident of the same the sident of the same the sident of the same the sident of the same the sident of the sident the sident of the sident the sident of the sident the sident of the sident the sident	f, the facility social worker e stated that resident 1 had a reself prior to admission at er stated that the facility did plan or contract with the self-injurious behaviors ad not harmed herself in four						
;   ;   1   g	was interviewed. He aware of resident 1's to admission and thousesolved. He further solan addressing resident	e behavior was resolved						
: 1   r   fe   W	or resident 1 was inte esident 1 had not hac or over a year.  She fi	any self-injurious behavior urther stated that the facility 1's history of self-injurious						

On 2/9/06 at 10:00 AM, resident 1 was

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/14/2006 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER. COMPLETED A. BUILDING B. WING 465091 02/09/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **DRAPER REHABILITATION & CARE** 12702 SOUTH FOURTH STREET DRAPER, UT 84020 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 279 Continued From page 8 F 279 interviewed. She stated she had a past history of cutting herself when "stressed out". Resident 1 stated staff knew about the self-injurious behavior. A review of resident 1's plan of care revealed that resident 1's self injurious behavior had not been incorporated into her plan of care.