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	(X3) DATE SURVEY COMPLETED
	465091	A. BUILDING ______ B. WING ______	C 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 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	(X5) COMPLETION DATE
F 224 SS=J	483.13(c) STAFF TREATMENT OF RESIDENTS	F 224		2-10-06

F 224 — 483.13(c) 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.

This REQUIREMENT is not met as evidenced by:

Based on interviews and record review it was determined that the facility failed to adequately assess, care plan and monitor a resident with self injurious behaviors which led to neglect for 1 of 3 sample residents (resident 1). Specifically, resident 1 inflicted a wound, which measured 4 inches by 2.5 inches by 1 inch in depth on her left thigh, with a pair of scissors.

The facility's failure to adequately assess, monitor, care plan and intervene led to a finding of Immediate Jeopardy in the area of neglect. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

Findings included:

1. Resident 1 was admitted to the facility on 9/13/05, with diagnoses which included schizo-affective bipolar with paranoia and borderline personality disorder, depression, anxiety, ehler danlos/chronic pain syndrome and seizure disorder.

On 2/9/06, resident 1's medical record was reviewed.

On 12/15/05, resident 1's APRN (advance practice registered nurse) wrote a letter to the

2/27/06 POC acceptable completion date 2/10/06 RN

Provider's Plan of Correction (F 224):

To protect resident 1 from further harm we have instituted or done the following:

We have counceled the resident about why removal of all sharp objects and changing her room to closer to the nurses station is in her best interest.

We have removed all sharp objects from the residents room and put them in the Social Service office where she can request them.

We have made the room change to closer to the nurses station for better monitoring.

We have written a new care plan that incorporates resident 1's contract with her APRN.

The administrator spoke with the APRN and she signed off on the care plan we put into place and agreed to send us weekly updates.

A new psychosocial assessment has been completed.

Q15 minute checks have been implemented and are being audited by our DON or designee each shift.

An IDT was held with the resident and her closest relative.

An all staff inservice will be held to teach everyone about resident one's BPD and her plan of care.

The Social Service worker will be responsible for this.

Completion date: 2-10-06

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 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 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.

Utah Department of Health
BIS
FEB 24 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

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F 224 SS=J	483.13(c) 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. This REQUIREMENT is not met as evidenced by: Based on interviews and record review it was determined that the facility failed to adequately assess, care plan and monitor a resident with self injurious behaviors which led to neglect for 1 of 3 sample residents (resident 1). Specifically, resident 1 inflicted a wound, which measured 4 inches by 2.5 inches by 1 inch in depth on her left thigh, with a pair of scissors. The facility's failure to adequately assess, monitor, care plan and intervene led to a finding of Immediate Jeopardy in the area of neglect. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Findings included: 1. Resident 1 was admitted to the facility on 9/13/05, with diagnoses which included schizo-affective bipolar with paranoia and borderline personality disorder, depression, anxiety, ehler danlos/chronic pain syndrome and seizure disorder. On 2/9/06, resident 1's medical record was reviewed. On 12/15/05, resident 1's APRN (advance practice registered nurse) wrote a letter to the	F 224	To protect resident 1 from further harm we have instituted or done the following: We have counceled the resident about why removal of all sharp objects and changing her room to closer to the nurses station is in her best interest. We have removed all sharp objects from the residents room and put them in the Social Service office where she can request them. We have made the room change to closer to the nurses station for better monitoring. We have written a new care plan that incorporates resident 1's contract with her APRN. The administrator spoke with the APRN and she signed off on the care plan we put into place and agreed to send us weekly updates. A new psychosocial assessment has been completed. Q15 minute checks have been implemented and are being audited by our DON or designee each shift. An IDT was held with the resident and her closest relative. An all staff inservice will be held to teach everyone about resident one's BPD and her plan of care. The Social Service worker will be responsible for this.	2-10-06

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

Administrator 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 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.

Utah Department of Health
815
FEB 24 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: GX6E11 Facility ID: UT0021 If continuation sheet Page 1 of 9

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F 224	Continued From page 1 facility's administrator which documented the following, " ...I have become concerned that some of the staff are either not aware or not supportive of any of [resident 1's] psychiatric plan. She has been told I should not be prescribing medications for her, sending her to groups, or doing therap (therapy) each week ... [Resident 1] needs transportation for or at least 24 hours notice that transportation is not available so she can arrange for flex trans. What is happening now is that she is approached at the last minute and told that ' something has come up ' and she won ' t be able to go. This is unacceptable. It is absolutely essential for [resident 1's] mental health and psychiatric stability that she be allowed and encouraged to be at these groups ... I am disappointed that Nurses in your facility appear to want quiet, complacent people who cause no fuss, request nothing, need nothing and have no life. [Resident 1] is/can be a vibrant human being who needs to be around others and in supportive situations in order to keep psychologically healthy. Without these supports she could she could deteriorate to disastrous levels quickly..." On 1/19/06 at 6:00 PM, a facility nurse documented the following in a nurse's note, "Notified [resident 1's APRN] about order [changes]. She expressed concerns about [resident 1's] cutting on herself when she is anxious ..." On 1/31/06 at 11:00 PM, a facility nurse documented the following in a nurse's note, "...Nurse received a call from [a psychiatric crisis line] stating that one of the residents here [at] [the facility] had been calling them stating that she	F 224	To help identify other residents that might have the potential to be affected by the same practice and to make sure it doesn't happen again, we have implemented a revised policy and procedure on resident change of condition. An inservice will be held for those people involved to train them on the forms and changes. The DON or designee will be responsible for both of these. A facility wide environmental round was completed to ascertain any unknown hazards by the administrator. The findings will be reported to our quarterly QA committee meeting.	

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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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F 224	Continued From page 3 On 2/9/06 at 9:15 AM, the facility social worker was interviewed. She stated that resident 1 had a history of harming herself prior to admission at the facility. She further stated that the facility did not implement a care plan or contract with resident 1 regarding the self-injurious behaviors because resident 1 had not harmed herself in four years. The facility social worker stated that resident 1 injured herself on 1/31/06 with scissors which belonged to resident 1. The facility social worker stated that since the incident resident 1 had made a contract with the APRN. She further stated the facility had not implemented a care plan for the actual self-injurious behavior because the facility had issued resident 1 a 30 day discharge notice. She stated the 30 day discharge notice was issued to resident 1 because of resident 1's self-injurious behavior and facility staff were unable to provide care. The social worker then stated that she had not completed any documentation regarding resident 1's self-injurious behavior. On 2/9/05 at 9:25 AM, the facility administrator was interviewed. He stated that the facility was not equipped to handle resident 1's self injurious behaviors because they were not a psychiatric facility. He further stated that the facility was aware of resident 1's self injurious behaviors prior to admission and thought the behavior was resolved. The facility administrator stated that regarding the incident on 1/31/06 he was told resident 1 cut herself with scissors and she still has the scissors and they have not removed any objects from her room. He further stated there was not a care plan addressing resident 1's self injurious behaviors because the behavior was resolved prior to admission to the facility.	F 224		

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F 224	Continued From page 4 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	F 224		

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F 224	Continued From page 5 self injurious behaviors prior to admission. The director of nurses stated after resident 1 cut herself she was not sure if resident 1's room was searched for any sharp object, she stated the case had been turned over to the social worker. She further stated she had not implemented closer monitoring of resident 1 for self injurious behaviors. The director of nurses stated that all facility staff have been concerned about resident 1's behaviors since resident 1's admission. She further stated that resident 1's has had an increase in " attention seeking " behaviors since resident 1 did not qualify for flex care. On 2/9/06 at 2:30 AM, the APRN (advance practice registered nurse) who counseled and prescribed medications for resident 1 was interviewed over the phone. She stated that prior to 1/31/06 she told the facility case manager that resident 1 was having thoughts of injuring herself. She stated she asked the case worker to keep a closer eye on resident 1 and do frequent checks but " apparently they didn't do this. " The APRN stated that she provided the facility with all of her numbers so she could be reached when resident 1 was in crisis and facility staff " never once called me to help with interventions." She further stated she made a contract with resident 1 but the facility staff would not even look at the contract or talk to her about the contract. She stated the facility administration just wanted resident 1 " out of the building." The facility failed to prevent neglect by not providing adequate monitoring, supervision and assessment to this individual who had known self injurious behaviors.	F 224		
F 279	483.20(d), 483.20(k)(1) COMPREHENSIVE	F 279		

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F 279 SS=D	Continued From page 6 CARE PLANS 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 comprehensive care plan for the resident based on their individual needs identified by the facility staff. Findings include: 1. Resident 1 was admitted to the facility on 9/13/05, with diagnoses which included schizo-affective bipolar with paranoia and borderline personality disorder, depression,	F 279	A new comprehensive care plan has been implemented to include resident one's contract with her APRN and her other behaviors. We have revised the policy and procedure about resident change of condition to better be aware of changing resident needs and how to address them. The DON or designee will do monthly audits to ensure compliance. To help implement this plan of care we have had an inservice explaining to our staff her needs and our concerns. Resident one's APRN will also be holding an inservice for our staff to help all of us understand her needs and concerns. Our DON or designee will be responsible and report the findings to our QA committee on a quarterly basis.	2-10-06

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F 279	Continued From page 7 anxiety, ehler danlos/chronic pain syndrome and seizure disorder. On 2/9/06, resident 1's medical record was reviewed. On 1/19/06 at 6:00 PM, a facility nurse documented the following in a nurse's note, "Notified [resident 1's APRN] about order [changes]. She expressed concerns about [resident 1's] cutting on herself when she is anxious ..." On 2/9/06 at 9:15 AM, the facility social worker was interviewed. She stated that resident 1 had a history of harming herself prior to admission at the facility. She further stated that the facility did not implement a care plan or contract with resident 1 regarding the self-injurious behaviors because resident 1 had not harmed herself in four years. On 2/9/05 at 9:25 AM, the facility administrator was interviewed. He stated that the facility was aware of resident 1's self injurious behaviors prior to admission and thought the behavior was resolved. He further stated there was not a care plan addressing resident 1's self injurious behaviors because the behavior was resolved prior to admission to the facility. 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. On 2/9/06 at 10:00 AM, resident 1 was	F 279		

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F 279	Continued From page 8 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.	F 279		