COMPLAINT NUMBER 4319

MAR-31-00 04:01PM FROM- T-218 P.02/08 F-128

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465049	A. BUILDING _____ B. WING _____	03/01/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN CANYONS HEALTH & REHABILITA	4600 SOUTH HIGHLAND DRIVE SALT LAKE CITY, UT 84117

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F 000	Memo INITIAL COMMENTS An abbreviated survey was conducted for complaint # 4319 from 2/28/00 through 3/1/00.	F 000	**DISCLAIMER CLAUSE** PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.	
F 224 SS=G	483.13(c)(1)(i) Requirement 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. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This Requirement is not met as evidenced by: Based on observations, staff interviews and resident record review it was determined that the facility failed to provide goods and services necessary to avoid physical harm (neglect) for 1 of 5 sample residents. (Resident 1) Findings include: Resident 1 was admitted to the facility on 11/15/96 with diagnoses that included myocardial infarction, coronary artery disease, and dementia with obsessive compulsive disorder traits. Review of the interdisciplinary progress note, dated 1/14/00, documented that the facility had been notified by the SLC sheriff's office that resident 1 had been struck by an automobile and transported to the hospital. The note documented that resident 1 was found to have a skin tear, bruising and possible head injury.	F 224	OK 4/10/00 LB. Completion dates acceptable. Ubsenbank F Tags F241 494 acceptable & attached additions faxed 4/6/00	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathryn Richards — TITLE: Administrator — (X6) DATE: 3/32/00

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is 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 Staff interviews, observation, review of facility incident reports, review of facility policies and a review of resident 1's MDS (comprehensive resident assessment) comprehensive care plan, and progress notes revealed the following: MDS: A review of resident 1's MDS's dated 9/24/99 and 12/29/99 revealed documentation that resident 1 was assessed as having wandering behavior, as evidenced by the following: 1. Resident 1's comprehensive resident assessment (MDS), section E.4.a. (Mood and Behavior Patterns), dated 9/24/99, documented that resident 1 had wandering behaviors that had occurred 4 to 6 days in the last seven days and that the behaviors were not easily altered. 2. Resident 1's MDS, section E.4.a., dated 12/29/99, documented that resident 1 had wandering behaviors 4 to 6 days in the last seven days and that the behaviors were not easily altered. 3. Review of the care plan conference summary form, dated 1/4/00, documented in the care plan conference summary section that resident 1 was on every 30 minute checks for one week and that these checks would stop on 1/10/00. CARE PLAN: A review of resident 1's current comprehensive plan of care and a discontinued plan of care started 2/20/97 and last updated 7/7/98 revealed that resident 1 had wandering behaviors, as evidenced by the following:	F 224		

MAR-30-00 10:16AM FROM- T-196 P.06/37 F-101

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F 224	Continued From page 2 1. Review of resident 1's comprehensive care plan documented a care plan problem 7B, which identified resident 1 as wander risk related to impaired individual coping/maladjustment to the long term care facility and lifestyle changes. The care plan problem 7B documented that this problem was due to resident 1's cognitive loss and short term memory loss secondary to dementia. Care plan problem 7B documented a start date of 2/20/97 and documented that problem 7B had be updated on 2/25/97, 5/20/97, 7/22/97, 10/21/97, 1/20/98, 4/14/98, and last updated 7/7/98. There were no further updates noted and problem 7B had a line drawn through the problem, indicating that problem 7B had been discontinued. There was no documented discontinue date found on this care plan problem. The approaches for this care plan problem included "2. Inform all staff to monitor for attempts of leaving. Contact charge nurse, DON (director of nurses), DSD (director of staff development) SS (social services) immediately. 3. Insure that alarmed exits remain functional @ (at) all times. 9. Check/document resident's whereabouts q (every) 15 mins. (minutes) and prn (as needed) - document." 2. Resident 1's current comprehensive care plan revealed a care plan problem, dated 1/21/00, for "acute mental status change r/t (related to) dementia m/b (manifested by) (increase) in wandering leaving facility..." The documented goal was, "1) Res. (resident) will 0 (No) episodes of leaving facility s (without) supervision daily TNR (through next review)." The documented approaches were "1) (increased) supervision q 30 min (checks), 2) (increased) activities, 3) r/o (rule out) med	F 224		

MAR-30-00 10:15AM FROM- T-195 P.07/37 F-101

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F 224	Continued From page 3 (medication) environmental reasons for behavior, 4) 1:1 (one on one) visits prn (as necessary)." PROGRESS NOTES: Review of resident 1's nurse's note and interdisciplinary progress notes from 12/28/98 through 2/16/00, revealed that resident 1 was being monitored for wander behaviors. The progress notes revealed that resident 1 had wandered from the facility on 1/14/00 and continued to attempt to wander from the facility or had actually wandered from the facility 8 times until his discharge from the facility on 2/16/00, as evidenced by the following: 1. The nurse's notes/interdisciplinary progress notes from 12/27/98 through 12/9/99 included the following documentation regarding resident 1's wandering behaviors: 12/28/98 - "...O (no) attempts to leave facility..." 1/17/99 - "... O attempts to leave the facility..." 2/1/99 - "... O attempts to leave the facility..." 3/3/99 - "... O attempts to leave the facility..." 10/7/99 - "...No AWOL (absence without leave) behaviors..." 12/9/99 - "... No AWOL behaviors noted..." 2. The interdisciplinary progress notes dated from 1/14/00 through 2/16/00 revealed the following documentation: 1/14/00, 6:45 PM - "Notified by the SLC sheriffs that (resident 1) was struck by a automobile... & transported to (hospital) ER (emergency room) c (with) possible head injuries R/T (related to) neuro (neurological) checks resident found to be confused.	F 224		

MAR-30-00 10:15AM FROM- T-185 P.08/37 F-101

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F 224	Continued From page 4 Informed SLC sheriff that resident alert and oriented to self only, normal condition, approximate time of elopement was 20 minutes. Dr. ... notified..." 1/15/00, 3:00 AM - "Pt (patient) was back to facility p (after) HS (hospital stay) through family transport. Spoke c (with) ER nurse ... r/t (related to) injuries. Pt also given drsg (dressing) change to minor 1 1/2 'v' shape skin tear, surrounded by superficial ecchymosis (bruising) laterally near L (left) elbow. Also has RUE (right upper extremity) hematoma just below deltoid. ROM (range of motion) WNL (within normal limits), et (and) s (without) s/s (signs/symptoms) fx (fracture). Pt is A/O (alert and oriented) WNL (within normal limits) of self... pt is considered to continue to be an AWOL risk." 1/15/00, 3:00 PM - "1 attempt to leave facility today...." 1/16/00, 3:00 AM - " Pt up OOB (out of bed) p (after) HS (hospital stay) x (times) 2 c (with) slight disorientation, et (and) desire to leave facility..." 1/16/00, 3:00 PM - "One attempt to leave facility p (after) lunch..." 1/18/00, 11:00 AM - "one attempt to leave facility..." 1/20/00, Midnight - "wandering facility, but responsive to 1:1 (one on one) intervention. 2/1/00, 4:45 PM - "Family meeting c (with) ombudsman (resident advocate) to discuss concerns of LOA (leave of absences) et (and) inappropriate behaviors. Will continue to monitor behaviors et (and) continue to eval by mental health." 2/2/00, 11:45 AM - "Resident found trying to get on elevator - Validation not effective. CNA (certified nursing assistant) accompanied him on elevator & to 1st floor - assisted by 2nd CNA in returning to unit 'we're going to have lunch upstairs'." 2/7/00, 4:00 PM - "Resident wandered out of building	F 224		

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F 224	Continued From page 5 @ (at) 0730 (7:30 AM) this morning was found by off going nurse in parking lot..." 2/10/00, 3:00 PM - Resident found in parking lot by staff..." 2/14/00, 4:00 PM - Found in front of building - came inside voluntarily - family here & stated that 'someone' from (other facility) would be in tomorrow to eval. (evaluate) for discharge to their facility..." 3. The social work progress note dated 1/5/00 revealed that following documentation, " Resident with two episodes of leaving floor since room change - staff to check frequently and redirect. Monitor for a week while adjusts to room change...." 4. The social work progress notes dated 1/14/00 through 2/14/00 revealed the following documentation: 1/14/00 - "Two sheriff's deputies in about 6:30 PM wondering if have patient named (resident 1) - state he was hit by auto trying to cross ... - stated was hit on back of head by outside mirror on vehicle and has been transported to (hospital) ER for evaluation - report he was conscious on transport. They have obtained demographic information and will notify family members of incident and location. I called (hospital) ER got fax # (number) and have faxed to them demographic info ... nurse to complete incident report." 1/21/00 - "...Verbal reports and observation show increased attempts to leave facility being in parking lot and out various doors throughout week, also generally wandering in facility between floors..." 2/1/00 - "Mtg. (meeting) today with resident's daughters, ombudsman, administrator, DON, and myself. Discussed incident of leaving facility,	F 224		

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...follow up on possible contributing factors; plan for monitoring whereabouts that has been started. Family voice strong preference for having resident remain in this facility - don't want to move him unless absolutely necessary. At this time will remain in facility on monitoring program and if any further incidents of elopement to be transferred to secure facility..."
2/7/00 - "...Also verbal reports of efforts to leave facility - will find written reports on these reported incidents."
2/14/00 - "Verbal and inappropriate behavior reports that has left facility through last week - did speak with dau. (daughter) and family has requested that (other facility) eval. him for placement today..."

INCIDENT REPORTS:

Review of the facility incident reports from November 1999 through February 2000 revealed 1 report regarding resident 1 wandering from the facility on 1/14/00. No other incident reports regarding resident 1's documented wandering from the facility after 1/14/00 were found, as evidenced by the following:

1. The "Facility Investigation Information" records, dated 1/14/00, documented in the "Type of injury or reported abuse/neglect" section that the nature of the occurrence for resident 1 was a missing person/elopement. The corrective action section was left blank. The referral to social services was left blank. The "Final Outcome" section had 2 entries written in different handwriting. The first entry documented, "Resident placed on 30 min. checks, UA (urinalysis) done, meds re-evaluated, alarms working". The second entry documented, " Resident returned to facility R arm ecchymosis & L elbow skin tear, O evidence of head injury." The Facility

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F 224	Continued From page 7 Investigation Information form was signed as being reviewed by the DON and Administrator on 1/17/00. STAFF INTERVIEWS: In the interviews with the facility staff, the staff stated, that resident 1 had wandering behaviors and would leave the facility via the elevator and unsecured doors, as evidenced by the following: 1. In an interview with a facility nurse on 2/29/00, at 7:15 AM, he stated that resident 1 had resided on the second floor and that resident 1 had left the facility via the door to the ourside resident smoking area. The nurse further stated that the alarms were battery operated and that at times the alarms would not work due to low batteries. He stated that after the incident with resident 1, the facility changed the alarms so that they were hard wired and no longer needed batteries. 2. The charge nurse for the second floor was interviewed on 2/29/00. When asked regarding resident 1's behaviors, the nurse stated that as resident 1's dementia increased, his wandering behaviors also increased. The nurse stated resident 1 was always well dressed and distinguished looking, so visitors would help him on to the elevator and he would leave the second floor. The nurse stated resident 1 left the facility multiple times by using the elevator. The nurse stated resident 1 would leave the facility during the busy times for the staff, such as during meal times and during the change of shift. The nurse stated she was not working on 1/14/00, the day the incident occurred, but thinks resident 1 left the facility per the elevator. When asked regarding the alarm on the door to the	F 224		

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outside smoking area, the charge nurse stated that the alarm had been a battery operated alarm and that the batteries would constantly run out and would need to be replaced.

3. In an interview with the facility social services worker on 3/1/00, at 9:00 AM, she stated that resident 1 walked away from the facility and had been hit by a car. She stated that he had wandering behaviors prior to this incident. She stated that the facility had concluded that the battery alarms on the doors were not working and the only thing that the facility could determine, from the time frame of the incident, was that resident 1 went up the elevator and out the front doors although resident 1 was on visual checks. She further stated that the facility found out resident 1 was missing when the police came to the facility to ask is they had a resident missing. The social worker stated that when resident 1 continue to leave the facility even though resident 1 was on visual checks, the facility recommended that the resident be moved.

OBSERVATIONS:

Observation of the facility during the survey on 2/28/00 through 3/1/00 revealed that the facility had exit doors that did not have alarms on them, nor did the facility elevator have an alarm that would have alerted the staff that a resident with wandering behavior was trying to leave the facility, as evidenced by the following:

1. Observation on 2/29/00 at 6:45 AM, revealed the front doors on the third floor of the facility were unlocked and an alert and oriented resident was observed bringing in newspapers from outside. The fire doors approximately 50 feet for the front doors

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were closed and the only visible staff member was the nurse. The nurse was approximately 500 feet down the hall passing medications to the residents at that end of the hall. The facility elevators were observed to be across from the nursing station, approximately 250 feet from were the nurse was standing. There was no alarm noted on the elevator that would have alerted staff that a wandering resident was entering the elevator.

2. Observation of all exit doors and the elevator at the facility on 3/1/00 revealed that the stairway doors at the ends of each hall on the second and third floors had working alarms on them. The stairway door in the middle of the halls on the second and third floor had working alarms on them, but the middle hall door on the first floor did not have an alarm. The elevator doors on each floor were not alarmed. The third floor front door did not have any alarms.

3. Observation of the door to the outside resident smoking area during the survey for the dates 2/28/00 through 3/2/00, revealed the door alarm was being disarmed by residents who knew the alarm code and that residents were propping the door open. One of the residents using the smoking area stated that residents prop the door open so that they do not have to wait for a staff member to come and open the locked door when they are finished smoking. Observation of the smoking area revealed there was an unsecured gate that opened to a stairway that lead to the front of the building and the street. The practice of propping the door would allow a resident to be able to leave the facility without an alarm alerting the staff.

FACILITY POLICIES:

224 With all due respect the facility chooses to dispute this tag

Resident 1 is no longer at this Facility. Resident 1 was transferred to a more appropriate setting.

All residents will be assessed prior to and on admission for potential elopement risks.

To avoid further incident of residents wandering, the facility has alarms on doors. Administration will assess the need for putting a wander guard system in. Elopement risk assessments will be done quarterly during IDT meeting and/or on any change in cognitive status, Room change, increased behavior patterns or during Medication reduction process to insure elopement risks Are eliminated.

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Review of the facility policies revealed that the door to the smoking area was to be locked at all times and observation revealed that this was not occurring. Review of the facility policy for responding to an incident revealed that the facility staff failed to completely follow this policy, as evidenced by the following:

1. On 3/1/00, the facility smoking policy was reviewed. The policy documented the following: " Procedure: Any resident wishing to smoke will be able to go on the second floor patio. For safety reasons the patio door must remained closed at all times. When the resident wishes to come back in they can ring the doorbell and an employee will open the door immediately."

2. Review of the facility policy and procedures revealed the following:

"Procedure When responding To An Incident:..
4. Post Assessment (after an incident)...
B. Assess for environmental hazards...
D. If there is any history of other incidents like this one? (if so team will need to review previous ones.)...
E. Predisposing events, medical status, related medications or situations that have happened in the past?
F. Document what preventive actions are in place and what changes have been implemented.
G. Review care plan for any necessary changes to prevent occurrences. (Changes made, inservice and record inservice for direct care givers.)
H. If abuse or neglect suspected, protect residents affected during continuation of investigation. Immediately notify Administrator, DNS (Director of

Any change of condition to include change in behaviors, medication change, room change, or an actual change medical condition (UTI, infection, pneumonia etc.) or if a resident shows possible signs of elopement, the charge nurse will address on the 24 hour report which is done daily by the nursing staff and will be discussed during our daily census/admissions meeting which includes all department heads. Nursing staff will be required to chart every shift for 72 hours to monitor changes. Nursing staff will continue to do Q shift visual checks to account for all Residents. The Director of Nursing Services will monitor weekly for effectiveness.

These changes were addressed on 3/31/00 by the CQI committee. The committee will monitor at least monthly unless warranted more frequently for the appropriateness of the system. Any of the above changes will be put in the communication book so all staff are aware of the potential risks. This will be monitored weekly or as needed by the Staff Developer

Staff developer will in service staff at least quarterly on the importance of recognizing and monitoring resident with any of the above changes.

Medication pass will be adjusted so that a nurse by the nurses station to monitor elevator during busy times to include meals

3/31/00

MAR-30-00 10:18AM FROM- T-195 P.15/37 F-101

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465049	A. BUILDING _____ B. WING _____	03/01/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN CANYONS HEALTH & REHABILITA	4600 SOUTH HIGHLAND DRIVE SALT LAKE CITY, UT 84117

(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) COMPLETE DATE
F 224	Continued From page 11 Nursing Services), if not available, required agency." SUMMARY: Resident 1 was assessed by the facility staff as having wandering behaviors prior to the 1/14/00 wandering incident which resulted in the resident sustaining injuries. The facility staff care planned resident 1's wandering behavior prior to the 1/14/00 incident. The facility failed to fully assess, care plan and document preventive measures taken to ensure that resident 1 did not have any further incidents of injuries or wandering from the facility until 1/21/00. Resident 1 continued to wander from the facility, putting him at risk for injury. The facility failed to re-assess and care plan alternate approaches to prevent resident 1's continued wandering behaviors and to meet his current care needs.	F 224		
F 225 SS=D	483.13(c)(1)(ii) Requirement 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	F 225		

MAR-31-00 04:04PM FROM- T-218 P.05/08 F-128

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

2567L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	CLIA IDENTIFICATION NUMBER:	A. BUILDING _____ B. WING _____	COMPLETED
	465049		03/01/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN CANYONS HEALTH & REHABILITA	4600 SOUTH HIGHLAND DRIVE SALT LAKE CITY, UT 84117

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F 225	Continued From page 12 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: Based on clinical record review, staff interview, resident interview, and review of the facility abuse protocol and policy, it was determined that the facility did not ensure that all alleged violations of abuse, injuries of unknown origin and neglect were completed for 3 of 5 residents on the survey sample (Residents 1, 4, 5) as required. The facility failed to: 1. Report immediately to officials in accordance with State law, including the State survey agency; 2. Ensure all allegations were thoroughly investigated; 3. Protect residents against further abuse while the investigation was in progress; 4. Report findings of all investigations to officials in accordance with State law, including the State survey agency; and 5. Did not verify that the appropriate corrective action was taken.	F 225	F225 OIC 4/10/00 LB Because all resident could be affected by this the facility will Take the following steps to ensure residents are free from any kind of abuse. Facility will continue to do BCI and reference checks upon hire. The employee will also receive and will need to sign a copy of the abuse policy stating that they understand the abuse policy and the importance of reporting abuse and/ or suspected abuse . An in service was given on 3/10/00 by the Social Service Director regarding the above. Social Service Director will do at least a quarterly in service on abuse to all staff and during the initial orientation period with new employees Attached you will find a check list that will be at the nurses station so every employee knows the proper procedure for reporting abuse. 1) Who to report it to. 2) Nurse to call Administrator, DNS, and social services. 3) Social Services will notify the proper authorities to include State survey agency And sheriff department if deemed necessary.	

MAR-31-00 04:05PM FROM- T-219 P.06/08 F-128

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	CLIA IDENTIFICATION NUMBER: 465049	A. BUILDING _____ B. WING _____	COMPLETED 03/01/2000
NAME OF PROVIDER OR SUPPLIER: EVERGREEN CANYONS HEALTH & REHABILITA	STREET ADDRESS, CITY, STATE, ZIP CODE: 4600 SOUTH HIGHLAND DRIVE SALT LAKE CITY, UT 84117		

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F 225	Continued From page 13 Findings include: RESIDENT 5 - Failure to ensure all allegations were thoroughly investigated, failure to prevent further potential abuse while the investigation was in progress and failure to immediately notify officials in accordance with State law, including the State survey agency. Resident 5 is an 83 year old male admitted to the facility on 2/19/99 with diagnoses of chronic obstructive pulmonary disease, aspiration pneumonia, prostate cancer, cerebrovascular accident with left hemiparesis, chronic left sided pain and osteoporosis. Review of resident 5's MDS, dated 11/29/99, revealed the following documentation: 1. Behavioral symptoms of verbal and physical abuse, socially inappropriate behavior and resisting care. 2. Total dependence on staff for transfers to and from bed, locomotion on and off the unit, toileting and bathing. 3. Extensive assistance with dressing and personal hygiene. 4. Limited assistance with bed mobility. 5. Functional limitations with full loss of voluntary movement of the left arm, hand, leg and foot. 6. Bowel and bladder incontinence. 7. Pain symptoms daily. During the observation of resident 5's personal care on 2/29/00 at 9:15 AM, the nurse surveyor observed the resident had a large bruise on each forearm. When asked how the bruising occurred, the resident stated a nurses aide (NA 1) was rough with his care,	F 225	Social Service Director will in service staff on what is to be reported and by whom. We will Do the in service at least quarter and during the initial orientation period when new employees Are hired. The facility will strictly enforce the abuse policy and will suspend any alleged violators until a thorough investigation is complete. Facility administrator will inform all proper authorities of findings within 5 days. This policy will be monitored on a daily Basis by the administrator or designee. This will be monitored for effectiveness monthly by the CQI committee and the Director of Nursing Services.	5/31/00

MAR-30-00 10:19AM FROM- T-196 P.19/37 F-101

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	465049	A. BUILDING _____ B. WING _____	03/01/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN CANYONS HEALTH & REHABILITA	4600 SOUTH HIGHLAND DRIVE SALT LAKE CITY, UT 84117

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F 225	Continued From page 14	F 225		

grabbed his arms to turn him and caused the bruising. The resident also stated that NA 1 had "shoved an electric razor in his mouth" and that he had hit her.

The resident was asked when the alleged abuse occurred and he stated "Last Saturday" (2/26/00). When asked if he had reported the incident, he stated "Yes, I told another nurse aide that NA 1 hurts me." The resident also stated he told the nurse in charge on the day of the incident, that he did not want NA 1 to care for him because NA 1 hurt him.

Resident 5 stated that the nurse aide he reported the incident to, reported it to the facility's weekend manager on 2/26/00. The resident stated the weekend manager visited with him on 2/26/00 and he told her the details of the alleged abuse.

Resident 5 stated that after the weekend manager talked with him, the charge nurse then came to his room and told him that NA 1 would be reassigned and a different nurse aide would provide his care for the rest of the day. Resident 5 stated that another nurse aide provided his care for the rest of the day. However, the resident stated that the next day (2/27/00), NA 1 was again assigned to provide his care.

The weekend manager was interviewed on 2/29/00 at 10:30 AM. The weekend manager stated a nurse aide had reported to her that resident 5 had complained that NA 1 had hurt him. The weekend manager stated she then went to resident 5's room and interviewed him regarding the allegation of abuse by NA 1. The weekend manager stated she then talked with the charge nurse and asked him to reassign NA 1 so she would not be working with resident 5 for the rest of

MAR-30-00 10:32AM FROM- T-197 P.20/37 F-101

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	465049	A. BUILDING _____ B. WING _____	03/01/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 225	Continued From page 15	F 225		

the day. The weekend manager stated she informed the Director of Nurses and the CNA supervisor of the incident regarding the alleged abuse of resident 5 by NA 1.

When asked if on the day of the incident she noticed any bruising on resident 5's arms, the weekend manager stated she was not aware of any bruising.

The charge nurse that was on duty on the day the alleged abuse occurred was interviewed per telephone on 3/3/00 at 7:30 AM. When asked regarding the incident, the nurse stated on 2/26/00, NA 1 came to him and reported that resident 5 had hit her as she was providing personal care. The charge nurse stated he told NA 1 to stay out of resident 5's room. He then went to resident 5's room and interviewed him regarding the incident. The nurse stated resident 5 told him that NA 1 had put the shaver in his mouth and he had hit her. The charge nurse stated that resident 5 was alert and oriented during the interview.

The charge nurse stated that he then talked to the weekend manager and filled out an incident report. The charge nurse also stated that he reassigned NA 1 so she would not be providing care to resident 5 for the rest of the day.

When asked if he noticed any bruising on resident 5's forearms on the day the alleged abuse occurred or since that day, the charge nurse stated he had notice "old" bruises on resident 5's arms today (3/3/00).

Review of the facility's daily staffing schedules for February 2000 revealed NA 1, was assigned to provide care for resident 5 on the following dates: 2/1, 2/5, 2/6 (a double shift), 2/7, 2/8 (a double shift),

MAR-30-00 10:32AM FROM- T-187 P.21/37 F-101

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F 225	Continued From page 16 2/10, 2/11, 2/12, 2/13, 2/14 (a double shift), 2/15, 2/19/00, 2/20 (a double shift), 2/21, 2/24, 2/26 (the date of the alleged abuse), 2/27 (a double shift) and 2/28/00. Review of the facility's "Investigation Information Record" report, dated 2/26/00, revealed the following: 1. Resident involved: (Resident 5) 2. Type of injury or reported abuse/neglect: "No injury noted". Nature of occurrence: "Res (resident) c/o abuse." 4. Notifications: Physician on 2/26/00 at 2:00 PM, and the Responsible Party (son) on 2/26/00 at 2:11 PM. 5. Physician's orders: "No new orders." 11. Injury involved, was cause identified: a. "If yes what was it: No injury." b. "If report of abuse/neglect, describe incident: (left blank)." 13. What approaches were added to plan of care to prevent further injuries/incidents? "N/A (not applicable)." 14. Findings and Actions Taken. Findings: "Origin Established." Action Taken: "Staff training/counselling." 15. Was the Administrator/Director of Nurses notified: "Yes." 16. Summary Conclusion Of Investigation: "(Resident 5) c/o (NA 1) being to rough (with) him. C/O during shave (NA 1) put razor in my mouth. No injuries noted. (Resident 5) hit (NA 1) in the mouth (with) a closed hand. 2 CNA in room at time of incident. Both CNA'S denies incident. Calmed resident easily (with) 1:1. Transferred care to another CNA." 17. Final Outcome: (left blank). 18. Resident/Family: Satisfied with investigation? "Yes." Corrective action? (left blank). Referral to	F 225		

MAR-30-00 10:37AM FROM- T-199 P.22/37 F-101

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F 225	Continued From page 17	F 225		

Social Services? (left blank).

The facility's Interdisciplinary Progress Notes were reviewed on 3/2/00 and revealed the following:
2/26/00 at 12:30 PM: "CNA stated res hit her in the mouth (with) a closed fist. Res c/o (complained of) staff member to rough. Res stated CNA put the electric razor in my mouth (and) I reacted + hit her (with) my fist...No reddened area, no new ecchymosis. Transferred res care to another CNA....No open areas on tongue or lips."
2/27/00 at 10:30 AM: "(No) ecchymosis or abrasions noted on face, tongue or lips. (No) trauma noted..."

After 2/27/00, no further documentation was noted on the facility's Interdisciplinary Progress Notes regarding the incident of alleged abuse.

Review of the facility's Social Work Progress Notes for the dates 1/20/00 through 2/29/00 revealed the following documentation of the incident regarding alleged abuse by NA 1:
2/29/00 "Received yesterday incident report, inappropriate behavior report about same episode over weekend-investigation underway and APS (Adult Protective Services) called (with) report..."

The alleged abuse occurred on 2/26/00 and notification to APS was not until 4 days later on 2/29/00. There was no documentation in the Social Work Progress notes that the State agency was notified of the alleged staff abuse.

Review of the facility's Policy and Procedure for Prohibiting Abuse revealed the following:

"Investigation and reporting procedures:

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F 225	Continued From page 18	F 225		

...2. The administration will immediately notify Adult Protective Services or the local law enforcement authority (and if staff abuse is alleged, also notify the Bureau of Facility Review) and the local long-term care ombudsman.

...7. If the complaint alleges abuse by staff, that staff member will be suspended until the investigation has been completed." In accordance with the facility policies, the facility failed to prevent further potential abuse while the investigation was in progress by continuing to allow NA I to provide direct patient care.

RESIDENT 4 - Failure to ensure all allegations were thoroughly investigated, failure to report immediately to officials in accordance with State law, including the State survey agency, and failure to report findings of all investigations to officials in accordance with State law, including the State survey agency.

Resident 4 was admitted to the facility on 10/21/99 with diagnoses that included depression with anxious features, dementia, urinary tract infection, cerebral vascular accident, weakness, hypertension, congestive heart failure, dehydration, and osteoporosis.

Resident 4's medical record was reviewed on 3/1/00. The following documentation was revealed.

The nursing notes dated 12/14/99 documented that resident 4's left arm and shoulder were bruised and edematous. The note documented that resident 4 was complaining of increased pain in her neck and arm. The note further stated that resident 4's left shoulder was raised "much" higher that the right shoulder. The note stated that resident 4's physician had been

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F 225	Continued From page 19	F 225		

notified and had instructed the facility to transport the resident to the hospital for evaluation and treatment.

The physician progress note, dated 12/15/99, written by the nurse practitioner, documented that the staff had reported that resident 4 had been sent to the emergency room on 12/14/99 secondary to complaints of a painful shoulder. The note further documented that neither the resident nor the staff knew how the injury occurred and that everyone denies that resident 4 had a fall.

Review of the facility "Investigation Information Record", regarding resident 4, dated 12/14/99, documented the following:

"2. Type of injury or reported abuse/neglect: Bruising, swelling and warmth." (The nature of occurrence section under number 2 documented) Other: Unknown Etiology."

In an interview with the facility administrator on 2/29/00, she stated that the facility social service worker (SSW) was in charge of doing the investigations of alleged abuse.

The facility social worker was interviewed on 2/29/00. When asked to describe the facility's abuse protocol, the SSW stated that any staff member who reported abuse would fill out an incident report and then she would start the investigation. The SSW stated that she would notify APS, depending on how serious she determined the allegation was. She stated that if she determined the allegation was serious, she would then contact the employee's department head to recommend suspension of the employee. The SSW stated that she felt that she was following the facility

MAR-30-00 10:37AM FROM- T-199 P.25/37 F-101

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F 225	Continued From page 20 abuse policy as she understood it. The SSW stated that she was unaware that she needed to report all suspected abuse and neglect, including bruising and injuries of unknown origin to the State survey agency and APS immediately. She also stated that she was unaware that she needed to report the findings of the facility investigation to the State agency within 5 days. Review of the facility's Policy and Procedure for Prohibiting Abuse revealed the following: "Investigation and reporting procedures: 1. Any person who suspects that abuse, neglect, or misappropriation of property has occurred, will immediately report the alleged violation to the facility administration and/or advocacy agencies. 2. The administration will immediately notify Adult Protective Services or the local law enforcement authority (and if staff abuse is alleged, also notify the Bureau of Facility Review) and the local long-term care ombudsman." This policy does not include the facility's procedure for the investigation and reporting of bruising and injuries of unknown origin. RESIDENT 1 - Failure to notify officials in accordance with State law, including the State survey agency, failure to report findings of all investigations to officials in accordance with State law, including the State survey agencyand failure to verify that the appropriate corrective action was taken. Resident 1 was admitted to the facility on 11/15/96 with diagnoses that included myocardial infarction, coronary artery disease, and dementia with obsessive compulsive disorder traits.	F 225		

MAR-30-00 10:38AM FROM- T-199 P.26/37 F-101

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F 225	Continued From page 21 Review of resident 1's comprehensive care plan documented a care plan problem 7B, which identified resident 1 as wander risk related to impaired individual coping/maladjustment to the long term care facility and lifestyle changes. The care plan problem 7B documented that this problem was due to resident 1's cognitive loss and short term memory loss secondary to dementia. Care plan problem 7B documented a start date of 2/20/97. Review of resident 1's MDS section E.4.a. (Mood and Behavior Patterns), dated 9/24/99, documented that resident 1 had wandering behaviors that had occurred 4 to 6 days in the last seven days and that the behaviors were not easily altered. Review of the MDS, section E.4.a., dated 12/29/99, documented that resident 1 had wandering behaviors 4 to 6 days in the last seven days and that the behaviors were not easily altered. Review of the interdisciplinary progress notes dated from 1/14/00 through 1/15/00 revealed the following documentation. 1/14/99, 6:45 PM - "Notified by the SLC sheriffs that (resident 1) was struck by a automobile... & transported to (hospital) ER c (with) possible head injuries R/T neuro checks resident found to be confused. Informed SLC sheriff that resident alert and oriented to self only, normal condition, approximate time of elopement was 20 minutes. Dr. ... notified..." 1/15/00, 3:00 AM - "Pt was back to facility p HS through family transport. Spoke c ER nurse ... r/t injuries. Pt also given drsg change to minor 1/1/2 'v' shape skin tear, surrounded by superficial ecchymosis laterally near L elbow. Also has RUE hematoma just	F 225		

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below deltoid. ROM WNL, et s s/s fx. Pt is A/O WNL of self... pt is considered to continue to be an AWOL risk."

Review of the social work progress notes dated 1/14/00 through 2/14/00 revealed the following documentation.
1/14/00 - "Two sheriff's deputies in about 6:30 PM wondering if have patient named (resident 1) - state he was hit by auto trying to cross ... - stat was hit on back of head by outside mirror on vehicle and has been transported to (hospital) ER for evaluation - report he was conscious on transport. They have obtained demographic information and will notify family members of incident and location. I called (hospital) ER got fax # and have faxed to them demographic info ... nurse to complete incident report."
1/21/00 - "...Verbal reports and observation show increased attempts to leave facility being in parking lot and out various doors throughout week, also generally wandering in facility between floors..."

In an interview with the facility social services worker on 3/1/00, at 9:00 AM, she stated that she had done an investigation regard resident 1. She stated that resident 1 walked away from the facility and had been hit by a car. She stated that he had wandering behaviors prior to this incident. She stated that the facility had concluded that the battery alarms on the doors were not working and the only thing that the facility could determine, from the time frame of the incident, was that resident 1 went up the elevator and out the front doors although being on visual checks. She further stated that the facility found out resident 1 was missing on 1/14/00, when the police came to the facility to ask is they had a resident missing. The social worker stated that when resident 1 continued to

MAR-30-00 10:38AM FROM- T-199 P.28/37 F-101

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

AIG
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2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465049	A. BUILDING _____ B. WING _____	03/01/2000

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN CANYONS HEALTH & REHABILITA	4600 SOUTH HIGHLAND DRIVE SALT LAKE CITY, UT 84117

(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) COMPLETE DATE
F 225	Continued From page 23 leave the facility, even with visual checks, the facility recommended that the resident be moved. Review of the facility's Policy and Procedure for Prohibiting Abuse revealed the following: "Investigation and reporting procedures: ...2. The administration will immediately notify Adult Protective Services or the local law enforcement authority (and if staff abuse is alleged, also notify the Bureau of Facility Review) and the local long-term care ombudsman. In a telephone conversation with the state survey agency complaint manager on 2/29/00, he stated that the facility had not notified the State agency of any alleged abuse or neglect incident in the last year.	F 225		
F 241 SS=D	483.15(a) Requirement QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This Requirement is not met as evidenced by: Based on observation, clinical record review, and staff and resident interview, it was determined that the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality for 1 of 5 sample residents. (Resident 5) Findings include:	F 241		

APR-06-00 04:49PM FROM- T-261 P.02/03 F-209

FORM APPROVED 2567-L

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) [redacted] COMPLETED
	465049	A. BUILDING _____ B. WING _____	03/01/2000

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F 241	Continued From page 24	F 241		

Resident 5 is an 83 year old male admitted to the facility on 2/19/99 with diagnoses of chronic obstructive pulmonary disease, aspiration pneumonia, prostate cancer, cerebrovascular accident with left hemiparesis, chronic left sided pain and osteoporosis.

Review of resident 5's MDS, dated 11/29/99, revealed the following documentation:
1. Behavioral symptoms of verbal and physical abuse, socially inappropriate behavior and resisting care.
2. Total dependence on staff for transfers to and from bed, locomotion on and off the unit, toilering an bathing.
3. Extensive assistance with dressing and personal hygiene.
4. Limited assistance with bed mobility.
5. Functional limitations with full loss of voluntary movement of the left arm, hand, leg and foot.
6. Bowel and bladder incontinence.
7. Pain symptoms daily.

Review of resident 5's Care Plans, dated 3/4/99, revealed the following documentation:
Problem #5A: "ADL (activities of daily living)/Self Care Deficit R/T: impaired physical mobility, cognitive decline (secondary to) medical conditions. M/B requires staff A (assistance) to complete ADL tasks. Note: Resident is resistant to bathing/being OOB."
Goal: "All ADL cares and needs will be met with the required staff assistance daily."
Approach: "Level of staff assistance required for: 1. Bed Mobility: Mod (moderate) A x 2 (requires the assist of 2 staff for bed mobility). Turn Q 2 (hours) + prn. Position for comfort.
2. Transfers: Max (maximum) A x 2 / Hoyer lift to

OK 4/10/00 LB

F 241 Since all residents could be Effected by this the facility is doing the following.

The Staff Developer in serviced staff on 3/10/00 regarding the importance of answering call lights in a timely manner. Not to exceed 5 min. Staff developer will do in services at least monthly and shift to shift when needed.

Nursing staff will change the way that medication pass is done so they can view of the entire hall at all times.
Staff nurses will be in serviced by the Director of Nursing Services on setting priorities and doing required patient care as required by them when C N A's are busy with other residents.

All staff will monitor and answer Call lights. If unable to assist will Get c n a to help
Facility to continue to do call light audits 2x per each shift on both floors. Any call lights not answered within correct time frame Will be taken to CQI committee for correction and review. The CQI committee will monitor for effectiveness on a monthly basis and through resident satisfaction surveys.

3/3/

HEALTH CARE FINANCING ADMINISTRATION

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F 241	Continued From page 25 recliner/gerichair..." Problem #6A: "Altered Urinary Elimination Patterns R/T: urinary incontinence. Refuses to use bedpan, toilet." Goal: "Will demonstrate (no) s/sx of UTI'S (urinary tract infections)." Approach: "1. Comprehensive B&B (bowel and bladder) assessment. 2. Check/change brief/pad Q 2 hours and prn...Keep clean and dry. 3. Keep call light in reach at all times. Encourage to request toileting assistance as soon as the need to void is known..." Problem #16A: "Potential Altered/Impaired Skin Integrity R/T: impaired physical mobility (secondary) severe L hemiplegia R/T H/O (history of) CVA, generalized weakness, bowel + bladder incontinence, fair skin turgor, bedfast most of the time." Goal: "Will have no breaks, tears, rashes or irritations to skin integrity daily." Approaches: "1. Assist/supervise/cue to turn/reposition at least Q 2 hours and prn while in bed. Position for comfort. 2. Assist/supervise/cue to reposition frequently while out of bed in w/c (wheelchair) or chair. 3. Use pressure relieving/reduction devices as ordered. 4. Monitor/assess skin integrity Q weekly, during showers, and prn, and document. Report breaks, tears, irritations, rashes to MD. 5. Apply emollient creams after showers & prn..." Review of resident 5's Interdisciplinary Progress Notes revealed the following documentation: 2/29/00: "Pt is A/O to self (and) surroundings...Pt uses call light frequently...No (changes) (with) skin status in spite of B+B incont. (incontinence) (and)	F 241		

HEALTH CARE FINANCING ADMINISTRATION

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F 241	Continued From page 26	F 241		

bed-bound status."
2/4/00 at 4:30 PM: "...Res continues to push call light numerous times for non-medical reasons..."
2/22/00 at 2:00 PM: "Res cont (continues) to complain of vertigo and nausea. Res also conts to ring call light repeatedly. Will push call light approx (approximately) 3-5 (times) per hour asking for meds (medication) 15 min after meds have been given, then asks if it is going to snow, pushes call light for non-medical reasons."

On 2/29/00 at 8:40 AM, resident 5's call light was observed to turn on and the resident was heard calling for help. The charge nurse was observed passing medications to residents at the other end of the hall from resident 5's room. There were no nurse aides observed working in the hallway or assisting residents in their rooms. The 3 nurse aides assigned to work the day shift were all observed to be assisting residents in the dining room which was located at the other end of the hall from resident 5's room. No facility staff were observed at the nurses station where resident 5's call light was alarming.

At 8:50 AM the call light for resident 5's room continued to be on and the resident was heard to continue to call out for help. The charge nurse was observed to go past the nurses station, where resident 5's call light was alarming, and continued to pass medications. The nurse surveyor informed the charge nurse that resident 5's light had been observed to be on for 10 minutes and that he was calling for help. The charge nurse was observed to continue to pass medications and answered resident 5's call light at 9:00 AM. This was 20 minutes after resident 5 had turned on the call light.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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2567-L

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F 241	Continued From page 27 The charge nurse and the nurse surveyor entered resident 5's room and he stated he was nauseated and uncomfortable. The charge nurse was observed to administer resident 5's medications at this time. The charge nurse and nurse surveyor observed that resident 5 had been incontinent of stool and that there was stool on the resident's hands, clothing, legs and bedding. The charge nurse stated "I'll tell your aide to come clean you up. When they're done in the dining room, you'll be the first on the list." The charge nurse was then observed to leave resident 5's room without providing for his personal care and dignity. At 9:15 AM, 2 nurse aides were observed to enter resident 5's room. This was 35 minutes after resident 5 first put on the call light and asked for help. The nurse surveyor also entered the resident's room and observed the 2 aides provide peri care, skin care, and a linen change for resident 5. When the care was completed, the resident stated he was much more comfortable and appreciated the care. On 2/29/00, resident 5's call light was observed to be on at 8:00 AM and the resident was calling out for help. No staff was observed at the nurses station where the call light was alarming and no staff were noted to be working in resident's rooms. The 3 day shift nurse aides were observed to be working in the dining room at this time. The light was not observed to be answered until 8:15 AM. This was 15 minutes after resident 5 turned on his call light. Observations revealed the facility failed to promote care for resident 5 in a manner that maintained the resident's dignity by not answering the call light in a timely manner and by delaying personal care even after the staff had observed that he was incontinent.	F 241		

APR-06-00 04:46PM FROM- T-261 P.03/03 F-209

FORM APPROVED 2567-L

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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F 494	Continued From page 28	F 494		
SS=D	483.75(e)(2)-(3) Requirement ADMINISTRATION A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of WW483.151-483.154 of this part; that individual has been deemed or determined competent as provided in W483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. This Requirement is not met as evidenced by: Based on staff interview, review of the facility employee records, and telephone conversations with the state CNA registry , it was determined that 2 nurse assistants employed full time by the facility had been employed longer than four months without completing a training and competency program. Findings include: On 3/1/00, a list of all current nursing assistants (NA's) and certified nursing assistants (CNA's) employed by the facility was reviewed. This list was compared with a list of all current employees and their hire dates. The facility staff developer identified all nursing assistants that had not completed the training and competency program. These lists revealed that NA 1 was hired by the facility on 9/15/99 and is currently working full time at the facility and NA 2	F 494	C N A #1 completed the C N A course but failed to pass off skills Testing within the 4 months. She was suspended day of survey and will not be returning C N A #2 Certification had expired Without our knowledge. Suspended until certification was reinstated on 3/00. Please see copy of her certification attached. The CQI met on 3/31/00 and discussed the following plan to prevent further occurrences. Staff Developer will keep a log when Certifications are do and will review on a monthly basis to recognize potential expiration deadlines. Any employee that is not certified with 4 months from date of hire will be placed on suspension and/or terminated until certification is obtained. Director of Nursing services will monitor monthly for compliance	

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HCFA-2567L

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN CANYONS HEALTH & REHABILITATION CENTER	4600 SOUTH HIGHLAND DRIVE SALT LAKE CITY, UT 84117

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F 494 SS=D	Continued From page 29 was hired by the facility on 10/31/96. In a telephone conversation on 3/1/00 and again on 3/2/00, with the state CNA registry, the registry stated that NA 1 was not certified and had not completed the CNA training program. The registry stated that NA 2 had been certified originally in February 1997 and that the certification had expired in February of 1999. The registry further stated that the facility had recently requested the paperwork for NA 2 to re-test for renewal of her CNA certification. In a telephone interview with the facility staff developer on 3/2/00, she stated that NA 2 had worked at the facility since October 31, 1996 and had become certified nursing assistant in February 1997. The staff developer further stated that NA 2 had worked as a CNA at the facility until April 1, 1999, when she changed positions at the facility and began working in the housekeeping department. The staff developer stated that NA 2 had worked in the housekeeping department until July 17, 1999, at which time she again began to work as a nursing assistant, full time, for the facility. The staff developer stated that NA 2 was in the process of re-testing to become re-certified, but has not completed the testing as of yet. NA 1 had been employed full time by the facility for 5 1/2 months and had not completed the nurse aide training and competency program. NA 2 had been employed full time by the facility and had resumed working as a nursing assistant for the facility in July of 1999. At the time NA 2 resumed working as a nursing assistant she was not currently certified.			

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F 494	Continued From page 30 NA 2 has worked at the facility full time for the last 7 1/2 months without completing the competency program to renew her certification.	F 494		