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

PRINTED: 04/06/2005
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
	465107	A. BUILDING ______ B. WING ______	C 03/16/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HILLS HEALTH CARE CT — COMPLAINT NUMBER. UT00003273	1100 NORTH 400 EAST NEPHI, UT 84648

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=B	483.13(c)(1)(ii) STAFF TREATMENT OF RESIDENTS	F 225	F225	

483.13(c)(1)(ii) 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 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:

4/25/05 POC acceptable with additional information completion date 5/16/05 [signature] RN

F225

Resident 1 allegation of abuse was reported to the appropriate authorities on 3/14/05 and 3/17/05.

By 4/21/05 the Administrator will ensure that all staff are re-in-serviced on the abuse policy and procedures and requirements of abuse reporting.

In addition the Administrator/designee will perform abuse focused rounds three times a week.

Any trends identified will be reported to the Quality Assurance Committee monthly and PRN. Until a lesser frequency is deemed appropriate.

4-18-05

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 18 Ap 05

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

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F 225	Continued From page 1 Based on interview and record review, it was determined the facility did not have evidence that all allegations of neglect were thoroughly investigated and reported immediately to officials in accordance with State law, to include the State survey and certification agency. Findings include: On 3/3/05, following an unusual occurrence at the facility on 3/2/05, an allegation of neglect was made by a staff member. (see F 309) The reports made by the facility to the State survey and certification agency were reviewed on 3/15/05. There was no evidence that the allegation had been made or investigated. The facility's Director of Nursing (DON) was interviewed on 3/15/05. The DON stated that she was aware of the concern and had taken a statement from the person making the allegation. The DON stated that, due to previous plans, the other staff involved had been unavailable for interview since the allegation had been made.	F 225		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m).	F 309	F309 **The facility has requested an informal dispute resolution hearing on this survey deficiency.** Resident 1 no longer resides at the facility.	

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F 309	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility did not provide the necessary care and services for 1 of 5 closed case residents reviewed. The investigation found that facility staff had neglected to provide cardio pulmonary resuscitation (CPR) to a resident as was directed by the resident's Medical Treatment Plan. Further, it was determined that facility staff had neglected to remain with a resident during a significant change in the resident's condition in order to assess and monitor the resident during the acute episode and that during the period that the resident was unattended, the resident expired. (Resident 1) Findings include: Resident 1 was admitted to the facility February 2003 with diagnoses including cerebral vascular accident, congestive heart failure and dementia. INTERVIEWS A review of the nursing schedule for March 2005 revealed that one Licensed Practical Nurse (LPN) and two Certified Nursing Assistants (CNAs) were scheduled by the facility to work night shifts and that LPN 1, CNA 1 and CNA 2 worked the night shift of 3/2/05. 1. On 3/15/05 at 4:30 PM, a telephone interview was conducted with LPN 1, the nurse who was in charge the night of 3/2/05. LPN 1 stated that on the night of 3/2/05, resident 1 was complaining about being in bed, but that she told him that he had to wait a few minutes to get up because of the swelling in his lower extremities. LPN 1	F 309	The Director of Nursing will re-in-service all nursing staff on emergency response to change of condition on 4/22/05. The Director of Nursing/designee will conduct significant change in condition focused rounds three times per week. The Director of Nursing/designee will also conduct mock codes on varying shifts weekly. Any identified trends will be reported to Quality Assurance Committee PRN and monthly until a lesser frequency is deemed appropriate. 4/25/05 In a telephone call with administor, completion date for both tags is 5/16/05 added c permission Busenbark RN	

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F 309	Continued From page 3 stated that CNA 1 got the resident up, but by that time, resident 1 was upset and anxious. LPN 1 stated that she had seen resident 1 have "little anxiety attacks" before and did not feel that his behavior was out of the ordinary. She stated that resident 1 was yelling for them to get out of the room, so they exited. LPN 1 stated CNA 1 advised her resident 1 was upset. LPN 1 stated the resident's oxygen saturation was checked and was below 80. LPN 1 stated she put oxygen on resident 1 and that at that time, resident 1 was no longer yelling but was breathing hard. LPN 1 stated that at that time resident 1's oxygen saturation was in the upper 80s and the lower 90s. LPN 1 stated she left the room and told CNA 1 to keep an eye on resident 1. LPN 1 stated that within a few minutes, resident 1 was pale, diaphoretic and his oxygen saturation had dropped. LPN 1 stated she tried to call resident 1's family member but the family member was out of town. LPN 1 stated she called her Director of Nursing (DON) and told the DON resident 1's blood pressure was 60/20. LPN 1 stated she was instructed by the DON to have resident 1 transported to the hospital. LPN 1 stated that she was the only nurse on duty and that "everything was happening at once." LPN 1 stated she had to do the transport paperwork for the ambulance and the pharmacy delivery had arrived. LPN 1 stated that in hindsight, she could have stayed with resident 1 more, but that he had "looked okay" to her. When asked about any previous experience with this kind of incident, LPN 1 stated that she had	F 309		

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been involved in calling a "code" once before. LPN 1 stated during that first incident, she could stay with the resident because another nurse was involved.

2. On 3/16/05 at 3:50 PM, a telephone interview was conducted with CNA 1. CNA 1 stated she had arrived at work on 3/2/05 at 9:00 PM. CNA 1 stated that she had received a report from the nursing assistant who had been providing care for resident 1. The nursing assistant going off duty reported that resident 1's legs were badly swollen and resident 1 needed to keep them elevated in bed for another hour. CNA 1 stated she knew resident 1 did not like to stay in bed and she went down to check the resident.

CNA 1 stated that she had found resident 1 to be very agitated and yelling that he wanted to get up. CNA 1 stated she needed the nurse's permission to get resident 1 up, so she "literally ran down the hall" to the South side where the nurse was working. CNA 1 stated she was advised by the nurse to try to keep resident 1 in bed if possible. CNA 1 stated that she returned to resident 1's room but could not keep resident 1 in bed. CNA 1 stated that she got resident 1 into his wheelchair and resident 1 continued to be unusually agitated and confused, making contradictory demands of her. CNA 1 stated resident 1 was sweaty and was spitting up from his mouth. CNA 1 stated she went to an off duty nurse, LPN 2, who advised her to tell the night nurse. CNA 1 stated that LPN 2 looked in on resident 1 and stated they needed to get the resident some oxygen.

CNA 1 stated LPN 1 returned to check on the resident and that LPN 1 stated she had seen the resident like that before. CNA 1 stated that

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resident 1 had become more anxious with both of them in the room and he kept yelling at them to get out. CNA 1 stated that LPN 1 told her to keep checking on the resident and that LPN 1 went back to the South side. CNA 1 stated she stood just outside resident 1's room to listen.

CNA 1 stated that she was becoming increasingly "nervous" because resident 1 did not calm down as he usually did and that "he was sweating like crazy." CNA 1 stated that resident 1 appeared to be really scared and confused and that his state alarmed her. When asked why she was alarmed, CNA 1 stated that she had witnessed a close family member having a heart attack and resident 1's situation seemed very similar to that incident.

According to the interview, CNA 1 had been monitoring the resident's vital signs and documenting what was occurring. CNA 1 stated that she went back to get LPN 1 at the South hall. CNA 1 stated LPN 1 obtained an oxygen concentrator for the resident. CNA 1 further stated that LPN 1 began taking resident's blood pressure and CNA 1 left the room to assist the other residents who were calling for assistance. CNA 1 stated the last time she saw resident 1, the resident was no longer screaming, he was very clammy, his chest was moving, he was sitting erect, and LPN 1 was checking the resident's blood pressure. CNA 1 stated that after she left LPN 1 in the resident's room and that she did not return to resident 1's room until sometime after the EMTs left with the resident.

CNA 1 stated that it seemed to her that it took a very long time for the Emergency Medical Technicians (EMTs) to arrive. CNA 1 clarified that she was so nervous that what seemed like 15

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F 309	Continued From page 6 minutes could have actually been 5 minutes. She stated it was a very busy time and while waiting for the EMTs to arrive, she had to provide care to other residents. CNA 1 stated that when the EMTs arrived, she was at the North nurse's station washing her hands, LPN 1 was doing the transfer paperwork and CNA 2 was at the North nurse's station to advise LPN 1 that a pharmacy delivery had arrived. CNA 1 stated that LPN 1 followed the EMTs to resident 1's room. CNA 1 stated she had documented her assessments and observations of resident 1 and gave them to LPN 1. 3. On 3/16/05 at 3:30 PM, a telephone interview was conducted with CNA 2. CNA 2 stated that she was doing "rounds" of the residents on the South side of the facility when CNA 1 advised her the ambulance would be coming. CNA 2 stated that when she had finished her rounds, the pharmacy delivery arrived and CNA 2 went to the North side to inform LPN 1. CNA 2 stated that when she got to the nurse's station, she saw that the nurse was "getting paperwork ready" for the ambulance. CNA 2 stated that the ambulance staff arrived at the nurse's station while she was still there. CNA 2 stated that she didn't stay at the north nurse's station because she had to assist as resident. 4. On 3/17/05 at 10:45 AM, an interview was conducted with LPN 2. LPN 2 stated she was at the facility the night of 3/2/05, that she was not on duty around the time of resident 1's issues but had remained in the facility to complete "paperwork". LPN 2 stated she was not aware of what was happening with resident 1 and that LPN 1 had not asked for any assistance with resident	F 309		

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F 309	Continued From page 7 1. 5. On 3/15/05 at 3:40 PM, an interview was conducted with EMT 1. EMT 1 stated a call had been received on 3/2/05 from the facility for a non-emergency transport of resident 1 to the hospital. EMT 1 stated that when the emergency team entered the facility, they found "all the staff" at the North nurses station. EMT 1 stated that LPN 1 advised him resident 1 might have had a stroke. EMT 1 stated he advised his team to "step it up" because it appeared that it was not a routine transport as previously indicated. EMT 1 stated they found no staff in resident 1's room when they entered it. EMT 1 stated the resident had oxygen on but that the resident's head and fingers were blue, his pupils were fixed, and his cardiac activity was "flat line" (no cardiac activity). EMT 1 stated that CPR was started and resident 1 was rushed to the hospital where resident 1 was pronounced dead. 6. On 3/17/05, a telephone interview was conducted with EMT 2. EMT 2 stated that on 3/2/05, a page was received for a non-emergency transport to the hospital. EMT 2 stated that upon entering the facility from the South side, the emergency response team could find no one at the South nurse's station. EMT 2 stated they proceeded through the doors that separated the two halls and went to the North hall. EMT 2 stated that 3 nursing staff were observed to be at the North nurses station. EMT 2 stated the nursing staff advised the team that resident 1 "may have had a stroke". EMT 2 stated that upon entering resident 1's room, the emergency staff identified the resident	F 309		

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HERITAGE MANAGEMENT Fax:801-596-9001 Apr 18 2005 14:12 P.10

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was deceased. EMT 2 stated resident 1 was found to be sitting in a wheelchair with his chin on his chest and he had secretions at the corner of his mouth. He/she stated that the resident's head was lifted to open his airway. EMT 2 stated the resident was tested for a heart beat and found to have a "flat line". EMT 2 stated that the emergency team began CPR immediately and the resident was transported to the hospital's emergency room. When questioned, EMT 2 stated that LPN 1 entered the room as resident 1 was being transferred to a gurney for transportation to the hospital.

7. Interviews were conducted with the DON on 3/15/05 and 3/17/05. The DON stated that on 3/2/05 at about 10:30 PM, she had received a call from LPN 1. LPN 1 told the DON about resident 1 but, the DON stated, "she wasn't making it sound like a big thing". The DON stated LPN 1 thought that resident 1 might have had a stroke. The DON stated she advised LPN 1 to send resident 1 to the hospital.

MEDICAL RECORD REVIEW

Resident 1's medical record was reviewed on 3/15/05. The Medical Treatment Plan for resident 1, dated 4/14/03, had been signed by the resident's physician and the resident's family member. The Medical Treatment Plan revealed that resident 1 was to receive treatments as needed to include CPR (cardiopulmonary resuscitation), cardiac medication during CPR, and defibrillation. This type of treatment is commonly referred to as "full code".

A Physician Order for Life-Sustaining Treatment had been signed by the physician on 4/28/04 and

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F 309	Continued From page 9 signed by a facility representative and by resident 1's family on 4/16/04. The order indicated that if resident 1 had no pulse and was not breathing, the resident should be resuscitated. The physician's order for resident 1 listed additional interventions to include oxygen, suction, treatment of airway obstruction, bag-mask / demand valve, monitor cardiac rhythm, medication, intravenous fluids and transfer to hospital if indicated. The physician's order for these life sustaining treatments included the statement that, "When need occurs, first follow these orders, then contact the physician." Nurses notes for resident 1 were reviewed. The LPN 1 documented in resident 1's Nursing Notes, on 3/2/05 at 10:45 PM, that the resident complained of "being unable to breath, diaphoretic (sweating), color pale, yelling at staff to call son". The nurse documented the following information concerning resident 1's condition; temperature of 98.8, pulse of 58, respirations of 54, blood pressure of "62/?" and that the resident's oxygen saturation was 50 percent with oxygen being delivered at the rate of 3 liters per minute. The nurse documented that resident 1's son was out of town and not reachable. The nurse further indicated that the Emergency Room (ER) and the DON had been contacted, the ambulance was called for transport and that resident 1 was "full code". LPN 1 documented in resident 1's nursing notes, on 3/2/05 at 11:00 PM, that the resident was checked "often while waiting for ambulance, cont. {continued} to be non-responsive, diaphoretic, pale and weak". LPN 1 documented in resident 1's nursing notes,	F 309		

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F 309	Continued From page 10 on 3/2/05 at 11:20 PM, that the ambulance crew had arrived. The nurse noted that one emergency medical technician (EMT) "came running up to the nurse's station for a stethoscope, then asked if {resident 1} was full code". LPN 1 documented that the EMT was informed that resident 1 was full code. The record revealed that LPN 1 followed the EMT to resident 1's room where the resident was found to be "very pale". The nurse documented that the EMTs found no heart rhythm.	F 309		

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