| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 465107 | A. BUILDING ____<br>B. WING ____ | 09/21/2006 |

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| HERITAGE HILLS HEALTH CARE CENTER | 1100 NORTH 400 EAST<br>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 |
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| F 248<br>SS=B | 483.15(f)(1) ACTIVITIES<br><br>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based upon observation, interview, and record review, it was determined that the facility did not provide activities in accordance with the physical, mental, and psychosocial well-being of residents. Specifically, interviews with key staff members illustrated that the activities program did not offer activities that appeal to all residents. Residents in the Special Needs Unit (SNU) were observed during various scheduled activities at times throughout the recertification survey. It was observed that some residents were not being offered an opportunity to engage in activities. Record review revealed that residents "need assistance to and from activities", but observations illustrated that assistance was not being offered.<br>(Resident Identifiers: 7, 5, 8, SR 4, SR 5, SR 7, SR 8, SR 9 )<br><br>Findings included:<br><br>1. During an interview with LPN 1(licensed practical nurse), on 09/19/06 at 4:10 PM, she stated that the facility did not provide activities that all the residents enjoy, and that "especially the younger residents are bored" and do not enjoy some of the same activities that the "older" residents prefer. | F 248 | F 248<br>The TRT/ designee will review and update as necessary, the activity assessments for resident 7, 5, 8, SR 4, SR 5, SR 7, SR 8, and SR 9, by November 17th 2006, with the residents participation, focusing on the residents physical, mental, and psychosocial well being of the resident.<br><br>The TRT/ designee will review all residents' activity assessments to ensure accuracy and appropriateness for each individual resident. The activity calendar will be reviewed by Administrator/ designee to ensure all activities are appropriate and meet the needs of each resident. This will be completed by November 17th 2006.<br><br>An in-service will be held by the corporate consultant to address the importance of the residents receiving appropriate activities and stimulation per each residents need by November 17th 2006.<br><br>Each resident, resident's activity assessment, and activity calendar will be reviewed by Administrator/ designee monthly and with change of condition to ensure activities are in place and appropriate for each resident until lesser frequency is deemed appropriate and then quarterly there after. | November 17th 2006 |

11/17/06 POC acceptable completion date 11/17/06 [illegible] RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John E [illegible] — TITLE: Administrator — (X6) DATE: 10-10-06

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.

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| F 248 | Continued From page 1<br>2. During an interview with CNA 1 (certified nursing assistant), on 09/20/06 at 3:24 PM, she stated that "most of the activities are in the morning" and that it "would help if there were more activities in the afternoon because the residents are bored". She also indicated that there is an increase in disruptive behaviors in the afternoon because there is a lack of engaging activities for residents.<br><br>3. On 9/20/06 from 9:00 AM to 10:16 AM, resident 11, SR 8 (supplemental resident) and SR 9 sat in the hallway of the SNU. At 9:57 AM, one of the staff asked resident 11 if he wanted to lie down. Resident 11 said, "No." At 10:17 AM, an aid wheeled SR 9 into the activity room. These three residents sat for over an hour in the hallway without being engaged in any activity.<br><br>4. On 9/21/06 from 9:00 to 9:34 AM, the SNU Activity Room, hallways, and Nursing Station were observed. The scheduled activity to begin at 9:00 AM was to be "Prim and Pamper". Three residents were seated in the activities room (resident 7, SR 4, and SR 7). At 9:04 AM, the Activities Staff Member (ASM 1) arrived and began combing resident 7's hair. SR 7 tried to leave the room and ASM 1 attempted to distract her with chatting, but continued combing resident 7's hair. At 9:10 AM, SR 7 wandered to the Nurses Station. At 9:20 AM, there were two residents in the Activities Room with ASM 1. Both of these residents received lotion and had help from ASM 1 to apply the substance to their hands. At 9:22 AM, ASM 1 left the Activities Room.<br><br>5. On 9/14/06 ASM 1 noted in Resident 8's (R 8) | F 248 | Identified trends will be reported monthly and as needed at Quality Assurance committee until lesser frequency is deemed appropriate. | |

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| F 248 | Continued From page 2 | F 248 | | |

medical record: "All approaches have been attempted by rec. (recreation) staff. Resident is currently involved 1/3 - 2/3 of her leisure time in activities. Resident is friendly upon approach and enjoys the company of others. Resident enjoys having her hair and make-up done... Resident needs assistance to and from activities".

On 09/21/06, resident 8 was sitting quietly in her wheelchair at the hallway wall across from the Nurses Station alongside other residents. During this time, the activity "Prim and Pamper" was taking place in the SNU Activities Room. "Prim and Pamper" was observed to consist of combing residents hair and applying lotion to their hands.

6. On 9/20/06 at 10:40 A.M., SR 5 was observed sitting alone in her room. At this time, other residents were observed in the SNU Activities Room, engaged in an activity.

7. Resident 5 was re-admitted to the facility on 2/22/06 with diagnoses that included Alzheimer's disease, hypertension, and congestive heart failure. Resident 5 's room was 28 bed 1.

On 9/19/06 resident 5's quarterly MDS (minimum data set) dated 9/1/06 was reviewed. It was documented in section N that resident 5 was awake in the morning and afternoons and it was documented in section E that the resident likes to wander.

On 9/19/06 resident 5 was observed wandering, in her wheel chair in the hallway from 1:35 PM to 3:30 PM. At 1:35 PM, resident 5 was seen in another resident's room, room 27. At 2:10 PM, resident 5 was at the end of north hallway near

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| F 248 | Continued From page 3<br>the activity room. At 3:30 PM, resident 5 was observed wandering up and down the north hallway.<br><br>On 9/20/06 at approximately 3:00 PM, resident 5 was observed wandering up and down the north hallway in her wheelchair.<br><br>On the morning of 9/21/06, resident 5 was observed wandering up and down the hallway from 9:00 AM through 9:55 AM. At 9:30 AM to 9:35 AM, resident 5 was given lotion therapy. At 9:35 AM resident 5 was taken to her room by staff and told that someone else would come and put her to bed. At 9:55 AM, resident was wandering up and down the hallway. At 10:15 AM resident 5 was seen in the Bible study class with her head bowed and eyes closed. | F 248 | | |
| F 323 SS=E | 483.25(h)(1) ACCIDENTS<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview it was determined that the facility did not ensure that the environment was as accident free as possible .<br><br>Findings included:<br><br>On 9/20/06 at 4:05 PM, the water temperatures in the north shower room were tested by the maintenance supervisor. The sink water | F 323 | F 323<br>On September 20th 2006 at 4:30 PM, maintenance adjusted the temperatures and water temperatures were retested and noted to be within range in the north shower room, south shower room, and sink at 4:45 PM.<br><br>On September 20th 2006 at 4:55 PM random rooms and all shower rooms, water temperatures were checked and all found to be within appropriate range. Drain cover was fixed on October 9, 2006.<br><br>Environment focused rounds to include shower rooms and water temperatures, | November 17th 2006 |

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| F 323 | Continued From page 4<br>temperature and a shower water temperature registered 129 degrees Fahrenheit.<br><br>On 9/20/06 at 4:15 PM, the water temperatures in the south shower room were tested by the maintenance supervisor. The sink water temperature and a shower water temperature registered 128 degrees Fahrenheit.<br><br>On 9/20/06 at 4:15 PM, the drain cover, that was located in the south shower room in the middle of the floor by the entrance door, was not securely attached to the drain. | F 323 | will be completed at random times through out the day and at least 3-4 times per week, by the Administrator/ designee, to ensure all water temperatures remain within range, necessary adjustments will be made as needed.<br><br>Identified trends will be reported monthly and as needed to the Quality Assurance committee until lesser frequency is deemed appropriate. | |
| F 329<br>SS=D | 483.25(l)(1) UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that the facility did not ensure that each resident's drug regimen was free from unnecessary drugs for 2 of 12 sample residents.<br><br>Resident 9 and 10<br><br>Resident 9 was admitted to the facility on 3/29/05 | F 329 | F 329<br>Resident 9's chart was reviewed by DON/ designee on September 22nd . The physician was notified and a new order was obtained for resident 9. Ambien 10mg po qhs PRN with a drug holiday q 10 days.<br><br>DON/ designee will complete a chart audit of all residents receiving a sedative/ hypnotic for appropriate use, by November 17th 2006.<br><br>All licensed staff will be in-serviced by the DON/designee, to review the appropriate use of sedative/ hypnotics, by November 17th 2006.<br><br>Focused rounds will be completed by DON/ designee weekly to ensure compliance. | November 17th 2006 |

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| F 329 | Continued From page 5<br>with readmission on 5/11/06. Her diagnoses included: borderline personality, deep vein thrombosis, cardiovascular disease, osteoporosis, anxiety disorder, and insomnia.<br><br>Resident 9's medical record was reviewed on 9/20/06. The physician recertification orders for August and September 2006 showed an order for Ambien 10 mg (milligrams) PO (orally) Q HS (every hour of sleep) PRN (as needed.) The Medication Administration Record (MAR) for September showed the PRN (as needed) had been dropped. The MAR stated Ambien 10 mg PO Q HS. During the month of September 2006, Ambien 10 mg was given every evening September 1 through 20.<br><br>There was no documentation in the medical record that a drug reduction had been tried. | F 329 | Identified trends will be reported monthly and as needed to the Quality Assurance committee until lesser frequency is deemed appropriate. | |
| F 444<br>SS=E | 483.65(b)(3) PREVENTING SPREAD OF INFECTION<br><br>The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based upon multiple observations, it was determined that the facility did not require staff to cleanse their hands between each direct contact with residents. Specifically, Certified Nursing Assistants (CNA's) were observed assisting residents with their utensils and then immediately | F 444 | F444<br>All staff will be in-serviced, by the DON/designee on proper hand washing technique and cross contamination issues by November 17th 2006. Hand sanitizer is made available to all staff members to be used between surface contacts as appropriate.<br><br>Focused rounds will be completed 3 times a week by the Administrator/ designee to ensure staff wash and sanitize their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. | November 17th 2006 |

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| F 444 | Continued From page 6<br>assisting other residents without first cleaning their hands.<br>Residents: 3, SR 2, SR 3, SR 4, SR 5, SR 7.<br>Findings Included:<br><br>1. On 09/20/06 at 6:04 P.M., evening meal was observed. CNA 1 was sitting at a table with four individuals requiring dining assistance. Supplemental Resident 1 (SR 1) was handling his glass of milk. He took a sip and handed the glass to CNA 1. She took the glass and placed it upon the table. At 6:07 P.M., CNA 1 assisted Supplemental Resident 2 (SR 2) with her glass. CNA 1 did not cleanse her hands between contact with SR 1 and SR 2.<br><br>2. On 09/20/06 at 6:10 P.M., CNA 2 was seated at a table with four individuals requiring dining assistance. Supplemental Resident 3 (SR 3) attempted to drink from her glass and CNA 2 assisted her to avoid spillage. Without first cleansing her hands, CNA 2 immediately assisted Supplemental Resident 4 (SR 4) to drink from his glass.<br><br>3. On 09/21/06, the "Prim and Pamper" activity was observed in the Special Needs Unit. Activities Staff Member 1 (ASM 1) left the Activities Room and went to Resident 3's (R 3) room. ASM 1 was seen brushing Resident 3's hair and applying lotion on her hands. At 9:27 A.M., Staff Member 1 went back to the hallway where Supplemental Resident 5 (SR 5) was sitting in her wheelchair. SM 1 offered SR 5 lotion and helped her to apply the lotion. SM 1 did not wash her hands between direct contact with Resident 3 and Supplemental Resident 5. | F 444 | The Director of Nursing/ designee will train every new staff member regarding cross contamination and proper hand washing techniques at general orientation upon hire. Skills check off and continued training with each new<br><br>The Administrator/ designee will monitor bi-monthly for compliance. Identified trends will be reported monthly and as needed to the Quality Assurance committee until lesser frequency is deemed appropriate. | |

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4. On 9/19/06 at 7:50 AM, observations were made in the dining room during breakfast. An aid was sitting at the half round assistive table. She was observed holding the fork of resident 1 to stab pancakes. She placed the fork in resident 1's hand and he ate the bite of pancakes. Then the aid took the fork back to pick up more food and gave the fork again to resident 1.

Without washing or sanitizing her hands the aid moved to supplemental resident 3 (SR3 )who was blind. The aid picked up SR3's cereal spoon which she had been using to feed herself. The aid scooped some food onto the spoon into an area of the bowl to make it easier for the blind resident to get the food and gave the cereal spoon back to SR3.

The aid assisted another female resident (SR7) at the half round table without washing her hands between helping residents. This resident SR7 had been feeding herself with a spoon. The aid took the spoon from SR7 and fed her a few bites of cereal with the spoon. The aid put the spoon back in the hand of SR7.

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| F 514 SS=D | 483.75(l)(1) CLINICAL RECORDS<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based upon record review and interview, it was determined that the facility did not maintain complete and accurate documentation. Specifically, the facility did not update the Medication Administration Record (MAR) to include current physician's orders and an ordered weekly blood pressure reading. It was determined that the physician recertification orders did not match the MAR.<br>(Resident identifiers: SR 6, 10 and 3.)<br><br>Findings included:<br><br>1. The morning medication administration for Supplemental Resident 6 (SR 6) was observed on 09/19/06. SR 6 was to receive a weekly blood pressure reading on 09/18/06, to be taken on Mondays. The MAR had no entry for a blood pressure reading on Monday 09/18/06. SR 6 had an order for the medication Metoprolol 25 milligrams, to be given each day. The order further stated to notify the physician if the systolic | F 514 | F 514<br>The clinical records for resident SR 6, 10, and 3, including the MAR, the physicians recertification, and telephone orders, were reviewed and updated as appropriate by the DON/ designee on September 22nd 2006.<br><br>A complete audit of all residents' clinical records will be completed by DON/ designee for accuracy and completion by November 17th 2006.<br><br>All licensed nurses will be in-serviced, by the DON, on the triple check process and accuracy of the resident's clinical record by November 17th 2006.<br><br>The physician recertification orders and triple check will be reviewed monthly by the DON/ designee to ensure accuracy and completion.<br><br>Identified trends will be reported monthly and as needed to the Quality Assurance committee until lesser frequency is deemed appropriate. | November 17th 2006 |

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blood pressure (SBP) is greater than 180 milligrams of mercury (mmHg) or the diastolic blood pressure (DBP) is less than 50 mmHg.

The Charge Nurse (LPN 1) caring for SR 6 on Tuesday 09/19/06 verified that the entry for the blood pressure reading was blank and had not been entered on Monday 09/18/06. She stated that SR 6's blood pressure reading had been taken the morning of Tuesday 09/19/06, and she ascertained that the blood pressure reading was within specified limits before administering Metoprolol on Tuesday morning.

2. Resident 3 was admitted to the facility on 2/8/06 with diagnoses including: anoxic brain damage, diabetes, aphasia, dysphagia, depression, anxiety, and hemiparesis.

The medical record of resident 3 was reviewed on 9/19/06.

The physician recertification orders for September 2006 had an order for Risperdal 5 mg (milligrams) via G-tube (by gastric tube) Q PM (every evening). The medication administration record (MAR) showed an order for Risperdal 0.5 mg per tube Q PM. The physician orders and the MAR must be consistent and accurately documented.

3. Resident 10 was admitted to the facility on 8/10/03 with diagnoses that included severe mental retardation, hypertension and dementia.

A review of resident 10's medical chart was completed on 9/21/03.

There was a telephone order written for resident

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| F 514 | Continued From page 10<br><br>10 that was not dated. It was documented that resident 10 was ordered "prostat 30 cc (cubic centimeters) qd (every day)."<br><br>It was documented on the September 2006 MAR that resident 10 was to be administered "Prostat 30 cc qd start when available". It was dated 9/18/06.<br><br>It was determined that the telephone order and the MAR did not match. The telephone order was incomplete. | F 514 | | |
| F 518 SS=D | 483.75(m)(2) DISASTER AND EMERGENCY PREPAREDNESS<br><br>The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on 3 staff interviews, two charge nurses and a certified nursing assistant, it was determined that the facility did not provide sufficient training in emergency procedures to ensure staff were knowledgeable about emergency power. (Employee identifiers: Charge Nurse 1, Charge Nurse 2 )<br><br>Findings included:<br><br>On 9/19/06 at 4:45 PM, Charge Nurse 1 was interviewed. When asked if there were | F 518 | F 518<br>Nurse 1 and nurse 2 were re-in serviced on red outlets, generators and emergency procedures to follow, on October 10th 2006, by the maintenance/ designee.<br><br>An all staff in-service will be held by the Administrator/ designee on the emergency procedures, on October 13th 2006.<br><br>Focused rounds will be completed 3-4 times per week to ensure all staff knows the proper emergency procedure.<br><br>Maintenance/ designee will complete training of the emergency procedures to all new hired staff during new hire orientation. | November 17th 2006 |

| 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 ______ | 09/21/2006 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HERITAGE HILLS HEALTH CARE CENTER | 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 518 | Continued From page 11<br>emergency electrical outlets she stated that she didn't know and paged a maintenance man to answer the questions. The maintenance man stated that the facility has an emergency generator and that only the red outlets supplied electricity in the event of lose of electricity.<br><br>On 9/20/06 at 9:00 AM, Charge Nurse 2 was interviewed. When charge nurse 2 asked if there were emergency electrical outlets she stated that she didn't know. | F 518 | Identified trends will be reported monthly and as needed to the Quality Assurance committee until lesser frequency is deemed appropriate. | |

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # **465107** | MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______ | DATE SURVEY COMPLETE **9/21/2006** |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **HERITAGE HILLS HEALTH CARE CENTER** | STREET ADDRESS, CITY, STATE, ZIP CODE **1100 NORTH 400 EAST NEPHI, UT** | | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
|---|---|
| **F 460** | 483.70(d)(1)(iv)-(v) RESIDENT ROOMS<br><br>Bedrooms must be designed or equipped to assure full visual privacy for each resident.<br><br>In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations of the resident's rooms on 9/19/06, it was determined that the facility did not assure full visual privacy for every resident in the facility as evidenced by 1 of 35 rooms had a privacy curtain that allowed visualization of a resident receiving cares. Room identifier: 28<br><br>Findings included:<br><br>Room 28 bed 2 had a privacy curtain that when fully extended allowed a 4 foot space between the privacy curtain for bed 2 and and the exterior wall. This would allow visualization of the resident in bed 2 while receiving cares. Room 28 had residents 5 and 6 sharing the room.<br><br>Privacy curtains were changed on 22nd of September to allow for full visual privacy for the residents in room 28.<br><br>It was found that when laundering of the curtains, the two curtains in the room had been reversed.<br><br>Laundry services and maintenance personnel will be properly orientated as proper installation and to the need of having full visual privacy for residents. This item will be completed by November 17th 2006. |

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

The above isolated deficiencies pose no actual harm to the residents