STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	C 03/20/2006*

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

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F 225 SS=H	483.13(c)(1)(ii)-(iii) 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:	F 225	F225 The facility will report all Injuries of unknown origin/ Abuse to the proper state Agencies in accordance to State law along with an Investigation report within 5 days of the incident. Licensed nurses will complete more detailed information on the incident reports and nurses notes describing how the injuries bruises, etc occurred so as to properly identify abuse/injuries of unknown origin. Licensed nurses will complete a Resident Incident Follow-up Report on all Incidents reports to assist in the investigation process of injuries of unknown origin Resident 2,4,5 & 6 Incident Reports, nurses notes were Reviewed and an Investigation Report completed and reported to the proper state agency clarifying the incidents. An in-service will be given to Staff regarding facility Policy & Procedureson Abuse and neglect as wellas reporting abuse/bruises etc and that an incident report is to be completed on bruises, skin tears, etc.	3/28/06

3/28/06 POC acceptable Compliance date 3/28/06 Ubuombong RN

Utah Department of Health 75581S MAR 27 2006 Bureau of Health Facility Licensing, Certification and Resident Assessment

* DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Terry Dennison	Adm	3/24/06

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

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F 225	Continued From page 1 Based on medical record review, incident report review and interview it was determined that for 4 of 6 sampled residents the facility did not ensure that all alleged violations involving injuries of unknown source were reported immediately to the State survey and certification agency or that the alleged injuries of unknown origin were thoroughly investigated to prevent further potential abuse. Specifically, residents 2, 4, 5, and 6 aquired bruising of unknown origin on different parts of the body. These bruises were not investigated nor reported to the State survey agency. Findings include: A. On 3/20/06 the facilities policies and procedures for prohibiting abuse were reviewed. The "Investigation and reporting procedures" portion of the policy states the following: "1. Any person that suspects that abuse, neglect, or misappropriation of property may have occurred, will immediately report the alleged violation to the facility administration and or advocacy agencies.... 2. Administration will immediately notify... Injuries of unknown origin, significant incidence between residents, abuse, and misappropriation of resident's property must be immediately reported.... to the State survey and certification agency. 3. The administration will initiate the investigation process by interviewing all staff and residents having any knowledge of allegation as soon as is practicable....	F 225	Director of Nursing will review all incident reports daily during the work week to assure that abuse/injuries of unknown origin are investigated and reported to the proper state agencies according to state law and report to the Adm/Quality Assurance Committee daily for the next 30 days then weekly thereafter.	

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F 225	Continued From page 2 5. The administration will complete the investigation within the next 5 days and will document all interviews including the date, time, and content of the interview.... 8. After investigation is complete the administration will document a summary of its findings as to whether the alleged abuse was verified and report its findings to the agencies which were notified at the beginning of the investigation. If the nature of the incident required that survey and certification was initially notified the results of the investigation must be faxed to the agency." B. Staff Interviews: 1. On 3/20/06 at 3:50 PM the facility Abuse Coordinator was interviewed. He stated that every injury of unknown origin is reported to the state agency immediately. He further stated that the facility will report first and investigate later with all allegations of abuse. The Abuse Coordinator stated that the staff have been instructed to report any hint of abuse immediately to him or Administration. He stated that if the abuse is an injury of unknown origin the facility will report the allegation to the state agency that day and then investigate. He further stated that just recently they did an investigation due to a resident falling and two aides put the resident back into bed before having the nurse examine the patient so the facility considered that abuse. 2. On 3/20/06 3 facility CNA's (Certified Nursing Assistants) were interviewed regarding abuse. All three CNA's stated that if they find a bruise on a	F 225		

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F 225	Continued From page 3 resident they report the bruise to the nurse, so the nurse can go and check it out. The CNA's further stated that the facility had just had an inservice on abuse and who to report to. 3. On 3/20/06 3 facility nurses were interviewed regarding abuse. All three nurses stated that if a bruise is found on a resident or reported to them from a CNA they go and check it out and then document it in the chart. The nurses further stated that they do not fill out an incident report for a bruise unless they witness the injury occurring. The nurses stated that if they don't witness the injury then they don't fill out an incident report they just talk with the other shifts to find out who first observed it and why didn't the other nurse chart it in the medical record. The nurses further stated that the facility just had an inservice on abuse and they were instructed to report the abuse immediately to Administration. C. Injuries of Unknown Origin: 1. Resident 2 was originally admitted to the facility on 1/2/03 with diagnosis which included, Alzeheimers, anemia, hypertension, and gastric ulcer. On 3/20/06 resident 2's medical record was reviewed. The following entries were documented in the nurse's notes by facility staff: 2/23/06 "Res (resident) attempted to transfer self to bed. Was found lying upside down in bed. Bruising to L (left) eye lid." 2/24/06 "Pt. (patient) [with] dark purplish bruising	F 225		

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F 225	Continued From page 4 both eyes, L (left) eye lid [with] slight swelling [with] dark purple bruise, pt. slept well through NOC (night) [with] [no] c/o's (complaints) or distress noted..." 2/25/06 "pt. rested well [with] [no] c/o's or s/s (signs or symptoms) distress noted, both eye lids [with] purplish bruises..." 2/26/06 "NOC. Res cont. (continues) to have bruising to both eye lids more so to the L lid. Appears to be in [no] pain or discomfort...." Review of the facility incident reports on 3/20/06 revealed an incident report filled out by facility staff on 2/23/06 regarding resident 2. It was documented, by a facility nurse, in the "Narrative of incident and description of injuries" section of the "Resident Incident Report" that, "CNA (certified nursing assistant) reported that he went to put Res (resident) to bed and found that Res was already in bed - lying upside down. CNA also noticed bruising and swelling to L (left) eye lid and eye brow area." Review of the incident report revealed that no staff members witnessed the injury that resident 2 sustained. Review of state agency documentation revealed that the injury of unknown origin was not reported to the State survey and certification agency nor did the agency receive a final investigation report. No documentation could be found in the facility to show that the facility adminstration conducted an investigation of the injury of unknown origin. 2. Resident 4 was admitted to the facility on	F 225		

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F 225	Continued From page 6 show that the facility adminstration conducted an investigation of the injury of unknown origin. 3. Resident 5 was admitted to the facility on 11/11/03 with diagnosis which included, Alzeheimers, Hypothyroidism and incontinence. On 3/20/06 resident 5's medical record was reviewed. The following entries were documented in the nurse's notes by facility staff: 3/6/06 "A report was received from NOC (night) shift nurse that a large bruise on L (left) side of neck of pt (patient) was noted pt assess and ask How did the bruise happen pt. unable to verbalize! pt c/o (complains of) pain @ (at) touch..." 3/8/06 "1600 (4:00 PM) - Bruise noted on L neck area in healing process. Getting smaller [with] yellow [and] greenish colors. Res. (resident) denies pain but is alert to bruise. Cannot verbalize knowledge of how happened." 3/9/06 "1200 (12:00 PM) - ....Bruise on L neck and throat area getting smaller Dark purple, yellow [and] greenish colored." Review of facility incident reports on 3/20/06 revealed an incident report completed by facility staff on 3/5/06 regarding resident 5. It was documented, by a facility nurse, in the "Narrative of incident and description of injuries" section of the "Resident Incident Report" that " 1930 (7:30 PM) resident noticed to have large New Bruise on L (left) side of front part of neck - Also she has a small cut in L hand that looks like a claw mark -	F 225		

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F 225	Continued From page 5 4/1/02 with diagnosis which included, Dementia, small bowel obstruction, and diabetes. On 3/20/06 resident 4's medical record was reviewed. The following entry was documented in the nurse's notes by facility staff on 2/18/06. "Late entry. MD assess yellowish bruise on pubic area [no] orders given @ this time assessment done 2/14/06." Review of the facility incident reports on 3/20/06 revealed an incident report completed by facility staff on 2/12/06 regarding resident 4. It was documented, by a facility nurse, in the "Narrative of incident and description of injuries" section of the "Resident Incident Report" that, "Res (resident) was being transferred from chair to bed by her CNA (certified nursing assistant) at bed time when incident occured. There is also a slight bruising to the pubic area." It should be noted that no additional documentation could be found on the incident report regarding bruising to the pubic area. The incident report was orginally completed for a skin tear that resident 4 sustained during the transfer from the chair to the bed. Review of the incident report revealed that no staff members witnessed the bruising injury that resident 4 sustained. Review of state agency documentation revealed that the injury of unknown origin was not reported to the State survey and certification agency nor did the agency receive a final investigation report No documentation could be found in the facility to	F 225		

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F 225	Continued From page 7 Pt. denies pain - does not recall how she obtained the bruise -" Review of the incident report completed for resident 5 revealed that no staff witnessed the bruise or injury ot resident 5. Review of state agency documentation revealed that the injury of unknown origin was not reported to the State survey and certification agency nor did the agency receive a final investigation report No documentation could be found in the facility to show that the facility adminstration conducted an investigation of the injury of unknown origin. 4. Resident 6 was readmitted to the facility on 11/28/05 with diagnosis which included, dementia, B-Complex deficiency, esophageal reflux, diabetes mellitus type II and dysphagia. On 3/20/06 resident 6's medical record was reviewed. The following entry was documented in the nurse's notes by facility staff on 3/7/06. "Large bruise was noted by myself on L (left) deltoid area. Pt (patient) c/o (complains of) pain @ (at) touch. Resident unable to verbalize how bruise was caused." Review of facility incident reports on 3/20/06 revealed an incident report completed by facility staff on 3/7/06 regarding resident 6. It was documented, by a facility nurse, in the "Narrative of incident and description of injuries" section of the "Resident Incident Report" that, "Lg (large) bruise noted on deltoid area."	F 225		

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F 225	Continued From page 8 Review of state agency documentation revealed that the injury of unknown origin was not reported to the State survey and certification agency nor did the agency receive a final investigation report No documentation could be found in the facility to show that the facility adminstration conducted an investigation of the injury of unknown origin.	F 225		