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

TN to LB 12-4-03

PRINTED: 11/24/2003
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING ______ B. WING ______	11/10/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 221 SS=E	483.13(a) PHYSICAL RESTRAINTS	F 221	Corrective Actions For Residents Affected	12-12-03

F 221 — 483.13(a) PHYSICAL RESTRAINTS

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

This REQUIREMENT is not met as evidenced by:

Based on observations, record review and facility staff interviews, it was determined that the facility failed to assess resident medical symptoms that would necessitate the implementation and use of physical restraints for 3 of 10 sample residents. (Resident identifiers 2,19, and Cl 1.)

Findings include:

1. Resident 19 was admitted to the facility on 07/16/01 with diagnoses, which include hypertension, arthritis, dementia and seizure disorders.

On 11/04/03, at approximately 6:30 AM, resident 19 was observed in the dining room in a Geri-chair sleeping. Resident 19 was observed to be fed while in the Geri-chair and removed from the dining room at approximately 8:20 AM. At approximately 9:10 AM, resident 19 was observed in his room sleeping in a Geri-chair.

On 11/05/03, at approximately 7:10 AM, and again at 12:35 PM, resident 19 was observed in the dining room being fed in a Geri-chair.

On 11/06/03, at approximately 7:45 AM, resident 19 was observed in the dining room in a Geri-chair.

A review of resident 19 MDS (minimum data set), dated 09/23/03, documented the following:

Provider's Plan of Correction — F 221

Corrective Actions For Residents Affected

Resident 19 was assessed by a physical therapist on 01/24/2003 and again on 04/17/2003 and a physicians order for the Geri-chair was obtained on 11/05/2003 which was clarifying an order written on 05/16/2002. Care plan written on 11/05/2003. Section P,4 on MDS will be reviewed and revised to match residents needs.

Resident 2 will be checked every 30 minutes and released every 2 hours for personal cares. Section P,4 will be reviewed and revised to match residents needs.

Resident CL 1 has been discharged from facility on 9/7/03.

In the above cases the residents were placed in Geri chairs to prevent sliding out of a standard wheelchair. Resident 2 and 19 have a tendency to push into trunk extension which leads to a need for an increased seat depth. The geri chair provides this necessary increase in seat depth. It is not intended to prevent either resident from rising due to the fact they both require maximum assistance of two people to transfer and are unable to rise safely from any surface.

Identification of Residents with the Potential to be Affected

All residents in Geri Chairs have the potential to be affected.

Measures to Prevent Reoccurrence

The facility will assess resident medical symptoms that would necessitate the implementation and use of physical restraints. We will accomplish this by assessing the resident during IDT for potential need of restraint. If IDT recommends restraint use, will contact PT to assess resident. If PT recommends restraint, a physicians order will be obtained before placing resident in a Geri-chair or any other restraint.

All staff will be/were in serviced on checking of residents in Geri chairs and other restraints and to be released every 2 hours for personal cares on 11/25/03 .

Monitoring Corrective Action and Responsibility

It is the philosophy of this facility to utilize the least restrictive methods as possible for resident safety. The DON will monitor these residents with a physical restraint and those high risk residents for compliance with regulation. Care plans will be done by IDT when residents is at risk for need of restraint.

DATE OF COMPLETION

Utah Department of Health
Utah Department of Health

409977

DEC 03 2003
DEC 03 2003

Bureau of Medicare/Medicaid Program Certification and Resident Assessment

Bureau of Licensing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] | TITLE: Administrator | (X6) DATE: 12-3-3

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 221	Continued From page 1 Section B, 4 Cognitive skills for Daily Decision Making. Resident 19 was assessed as being severely impaired. Section G1, Ab. Transfer: Resident 19 was assessed as requiring total dependence with two person physical assist. Section P, 4. Devices and Restraints: Resident 19 was assessed as using a chair to prevent rising on a daily basis. A review of resident 19 medical record did not reveal a physician's order for the Geri chair, or a care plan for a Geri chair, or a restraint assessment for a Geri chair by a physical therapy or the interdisciplinary team, with a medical symptom that would warrant the use of physical restraints for resident 19. 2. Resident 2 was admitted to the facility on 12/04/93 with medical diagnoses, which include dementia, seizures, constipation and pneumonia. On 11/05/03 at 10:35 AM, 2:10 PM and 3:55 PM resident 2 was observed in a Geri-chair. On 11/06/03 at 6:30 AM resident 2 was observed in a Geri-chair in the dining room and again at 8:15 AM in a Geri-chair in her room. A review of resident 2's annual MDS, dated 08/09/03, documented the following: Section B, 4 Cognitive skills for Daily Decision Making: Resident 2 was assessed as being severely impaired. Section G1, Ab. Transfer: Resident 2 was assessed as requiring total dependence with two person physical	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 221	Continued From page 2 assist. Section P, 4. Devices and Restraints: Resident 2 was assessed as using a chair to prevent rising on a daily basis. A review of resident 2's medical records revealed a care plan for the use of restraints, dated 06/02, with an approach plan that the use of restraints will be reviewed quarterly. There were no quarterly reviews completed after 08/31/03 in resident 2's medical record. A nurses note, dated 10/21/03, documented the following: "Orderly came to nurses station to report resident had fallen out of her chair ...had a skin break on [her] forehead and small [skin break] on [her] L (left) hand. A "Restraint Release Record" dated 03/03 was reviewed. Based on documentation, resident 2's restraints were not always being checked every 30 minutes, and released every 2 hours for personal cares. The nurses were documenting the reason codes for having the restraint off, care provided by CNA (certified nurse aide). The documentation did not reflect the total number of hours per shift the resident was not restrained. A review of resident 2's medical record did not reveal a physician's order for a Geri chair, or a restraint assessment for a Geri chair by a physical therapist or an interdisciplinary team, with a medical symptom that would warrant the use of physical restraints for resident 2. 3. Resident CL 1 was admitted to the facility on 06/12/03 with diagnoses including severe extra pyramidal syndrome osteoporosis, urinary tract	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 221	Continued From page 3 infection and end stage Alzheimer's. She was discharged from the facility on 9/07/03. A nurse's note, dated 06/17/03, revealed documentation that resident CL 1 was placed in a Geri-chair prior to facility staff obtaining a physician's order or having a restraint evaluation completed or obtaining a consent signed by a legal representative. On 11/05/03 at 4:00 PM, the DON (director of nursing) stated she did not know who put resident CL1 in a Geri chair "someone stuck her in it". She further stated a physician's order was obtained shortly after resident CL1 was placed in the Geri chair. A physician's order, dated 07/09/03, documented the following order, "Geri-chair to be used while out of bed r/t (related to) posturing et (and) unsteadiness [with] body movements during observation periods." A review of resident CL1's medical record did not reveal a restraint assessment for a Geri chair by physical therapy or the interdisciplinary team, with a medical symptom that would warrant the use of physical restraints for resident CL 1.	F 221		
F 224 SS=K	483.13(c)(1)(i) 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. (Use F224 for deficiencies concerning mistreatment, neglect or misappropriation of resident property.) This REQUIREMENT is not met as evidenced by:	F 224	(Corrective Action for Resident(s) Affected) Resident 4 - We have not been able to find the cause of the bruising in September and October. We had a complete physical evaluation by RN on 11-14-03. We did have a physical therapist observe transfers of this resident and her conclusion was that the bruising came from the transferring. Resident 17 - We are unable to conclude how this resident obtained the bruise on her upper thigh. This is an injury of unknown origin. A complete physical evaluation by RN was done on 11-14-03. Physician was consulted regarding adjusting of anticoagulants on 11-11-3. Resident 18 - We are unable to determine what happened to this resident. We interviewed staff, family, and other residents and they are unaware of any other incidents of slapping concerning this staff member and any other resident. It is our conclusion that this staff member did not	12-12-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 224	Continued From page 4 Based on staff and resident interview and record review, the facility failed to develop and implement policies and procedures that prohibited neglect, misappropriation of resident property and abuse. Specifically, one resident (Resident 5) sustained a serious injury from a fall, which did not receive any medical treatment. Another resident (Resident 21) alleged misappropriation of his property by a facility staff member, which did not receive a complete investigation. Another resident's (Resident 18) family member alleged a staff to resident abuse, which did not receive a complete investigation. Additionally, 5 of 14 sampled residents (Resident 4, 5, 13, 17 and CL2) sustained injuries of unknown origin and there was no documentation that the causative factors of the injuries were investigated. Findings Include: During an interview with the DON on 11/03/03 at 2:30 PM, the surveyor asked the DON what the facility procedures were if a resident was found to have an injury of unknown origin. The DON stated, "We write incident reports when any injury or bruise is found." During an interview with a facility nurse on 11/10/03 at 7:40 AM, the surveyor asked when she would write up an incident report. The facility nurse responded by stating if an injury "looks really bad" she would write an incident report up and "give it to the DON, who would sign it and place it in the physician's box". The facility nurse further stated if it's a "smaller injury, she might not write up an incident report, but she would document it in the nursing notes." During an interview with the facility Administrator on 11/06/03 at 11:30 AM, the surveyors asked the Administrator for an explanation for the facility's failure to investigate and report injuries of unknown	F 224	staff Resident 18. ~~This staff member will not work with~~ Resident 18 error. Resident 21 - We have identified the staff member responsible for this complaint through statements and interviews from other residents in the facility. We terminated this employee on November 16th, 2003. The facility provided to Resident 21 a copy of the policy for reporting misappropriation of funds and items that will assist him and the administrator to validate any future report on 11-13-3. The facility reimbursed Resident 21 $140.00 on 11-13-3. Facility administrator, Business office manager, and Ombudsman met with Resident 21 on 11-25-03 to review once again facility policy and to state to resident that Business Office Manager is the only one to accept money from resident for purchases with a signed receipt to be given by the BOM. Resident 5 - This resident is now on a low bed with a mattress on the floor to prevent any injury from falls. Resident 5 has seen her orthopedic surgeon and has been treated. The stage II has been resolved. Resident 13 - Resident was observed by the RN and other staff over a 72 hour period to determine if she has behaviors or actions that result in skin tears. This will be done on 12-3,4,5,-03. This resident has received a PT evaluation. Evaluation states the resident sits well and that the chair is appropriate. Her skin is very fragile. Comments are that resident may benefit from foam padding around arm rests to decrease bruising and skin tears. Padding was placed on resident chair on 11-24-03. Identification of Residents with the Potential to be Affected All resident have the potential to be affected. Measures to Prevent Reoccurrence Resident 4 - Physical Therapist did an in service on how to transfer this particular resident on 11-12-03. This included training for staff on proper use of gait belts. Resident 17 - We will continue to monitor this resident as well as all others for more immediate resolutions to these types of injuries. We will in service staff regarding safe gentle transfer for this resident on 11-13-03. Resident 18 - ~~This staff member will not work with~~ error. Resident 18. Nursing and Social work staff will explore with this resident the reasons why she feels that the staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 224	Continued From page 5 origin and allegations of resident to resident abuse, staff to resident abuse, and misappropriation of resident property to the required agencies. The Administrator stated that he might have been "laxed" on the reporting and then asked the surveyors if he should have been reporting those incidents. RESIDENTS 1. Resident 4 was admitted to the facility on 06/28/02 with diagnoses of hypercholesterolemia, edema, Alzheimer, coronary artery disease, hyperlipidemia, cataracts, congestive heart failure, osteoporosis, malnutrition, angina, incontinence and leg deep vein thrombosis. A review of resident 4's medical record was completed on 11/10/03. A significant change minimum data set (MDS) completed on 08/05/03, documented that resident 4's cognitive skills for daily decision-making were severely impaired. The MDS documented that resident 4 would resist care and this behavior was not easily altered. On 09/22/03 at 7:00 PM, a nurse's note in resident 4's medical record documented the following entry: "CNA noted large fleshy bruise under [left] arm- asked CNA if bruise was there last evening and she stated no." A review of the facility's Incident Reports was completed during the survey and there were no incident reports to document how resident 4 may have received the bruise under her left arm, which was first noted on 09/22/03. On 10/24/03 at 9:00 PM, a nurse's note documented the following, "[large] bruise noted on [left] breast from underneath extending up to nipple- States it doesn't hurt at all"	F 224	have harmed her and will amend the plan of care to reflect this behavior and methods to respond to her anxiety or fear. Resident 21 – All staff have been in-serviced on the policy for misappropriation of funds and reporting. All staff have been told that only person allowed to accept funds from Resident 21 is the BOM with a receipt book to acknowledge funds taken and returned with receipt of purchase. Resident 5 – This resident is now on a low bed with a mattress on the floor to prevent any injury from falls. Resident 5 has seen her orthopedic surgeon and has been treated. The stage II has been resolved. Resident 13 – All staff have been in-serviced on the proper use of gait belts and the proper methods to transfer residents on 11-13-03. This resident and all others with the potential for skin tears will be monitored by staff to determine if they have behaviors or actions that will result in skin tears. IDT will care plan results. Monitoring Corrective Action and Responsibility The QA committee will monitor the implementation of the procedures on a daily basis until the committee recommends a different frequency. Non performance will be evaluated for further action on and revision of the plan by the QA committee (or subcommittee). Tests of the system will be implemented on a random and routine basis until such time that the committee believes the policy and procedure to be understood and followed by all staff members. The nurse consultant will monitor for several days.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 224	Continued From page 6 A review of the facility's Incident Reports was completed during the survey and there were no incident reports to document how resident 4 may have received the bruise on her left breast extending up to her nipple, which was first noted on 10/24/03. On 11/03/03 at 2:30 PM, the facility DON was interviewed, she stated that she did not know about the bruise on 09/22/03, but knew about the bruise on 10/24/03. She stated that she thought the bruising on 10/24/03, had occurred from lifting resident 4 up in the wheelchair. When asked for a written investigation of the bruise from 10/24/03, she stated that she did not write it. On 11/05/03 at 9:10 AM, the facility DON stated that she could not find any incident reports or investigations concerning resident 4's bruising on 09/22/03 and 10/24/03. On 11/06/03 at 8:20 AM, the facility Administrator was interviewed and he provided the surveyor with a letter, signed by the DON, concerning resident 4's bruise noted on 10/24/03. The letter did not indicate a date as to when it was written. The letter documented that "...the bruising was probably due to the manner in which she was transferred...." The DON's investigation did not document specifically which aides, which times, nor which dates she observed. Additionally, there was no information concerning how she came to the conclusion that the bruising was caused by transferring, nor did it document which aides she specifically counseled concerning the bruising and transferring. The facility administration was not able to provide any documented evidence that the bruising found on resident 4 on 09/22/03 and 10/24/03, had been	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 224	Continued From page 7 investigated or reported to State Survey Agency. 2. Resident 5 was admitted to the facility on 07/09/03 with diagnoses of organic brain syndrome with psychotic features, hypercholesterolemia, hypothyroidism, digestive system disorder, hypertension, aphasia and diabetes mellitus. A review of resident 5's medical record was completed on 11/10/03. A quarterly MDS completed by facility staff on 10/23/03, documented that resident 5's cognitive skills for daily decision-making were moderately impaired. The MDS documented that resident 5 was socially inappropriate and had disruptive behaviors. The MDS documented that these behaviors were not easily altered. a. NEGLECT On 07/12/03 at 4:45 PM, a facility nurse documented that resident 5 was found on the floor, in the dining room, laying on her left hip. On 07/13/03 at 11:30 AM, a facility nurse documented that resident 5 was found laying on her left side in the day room. The x-ray results contained in resident 5's medical record concerning these two falls indicated they resulted in an impacted left acetabular fracture. On 07/19/03 at 10:00 AM, a facility nurse documented that resident 5 was found on the floor, in her room, on her right side. On 08/01/03 at 1:55 PM, a facility nurse documented the following, "...[found on floor] on [left] side in day room- apparently fall from Geri chair (tried to stand) ...[right] great toe reddish/purple [and] swelling..."	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 224	Continued From page 8 On 08/1/03 at 2:45 PM, a facility nurse documented the following, "...[resident's daughter] was called she wants to have her mother sent out for an x-ray...She also stated 'I don't give a damn what state says put a posey [and] or lap buddy on her before she kills herself by falling out of chair'..." A physician order dated 08/01/03, documented that staff was to obtain an x-ray of both resident 5's hips and her right foot. The results of the x-rays could not be found in resident 5's medical record. Twice during the survey (11/05/03 and 11/06/03), the DON was asked for a copy of the x-rays. On 11/10/03, the DON provided a copy of the x-ray results, which were dated 08/01/03. The x-ray results provided to the surveyors by the DON, included documentation that they were faxed to the facility on 11/07/03, at 12:23 AM. The x-ray results documented the following, "...Comminuted left acetabular fracture with some increased displacement of the main fracture fragments compared to earlier...First proximal phalangeal fracture..." Essentially, this information indicated that there was additional damage done to the previously fractured hip and that the large toe was newly fractured. There was no evidence in resident 5's medical record that the resident's attending physician or orthopedic surgeon was notified of the 08/01/03 x-ray results either at the time of the x-rays, or after 11/07/03, when the facility received the results by fax. On 11/10/03 at 10:00 AM, resident 5's physician was interviewed. He stated that he could not recall if he was contacted concerning the fractures on 08/01/03.	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 224	Continued From page 9 He then stated that it seemed to him that they should have contacted the orthopedic that was caring for resident 5. On 11/10/03 at 10:15 AM, resident 5's orthopedics' physician assistant was contacted. He stated that the only fracture they were aware of was the left hip fracture, which occurred either on 07/12/03 or 07/13/03. The physician assistant further stated that he was not aware that resident 5 had a fall on 08/01/03, which caused further displacement of the hip fracture and that they did not know about the right foot fracture. When asked if they would treat a phalangeal (toe) fracture, he stated they could place a walking cast, a hard cast or depending how bad the fracture was, possibly a plate. In addition to the fractures, it was reported during the initial tour on 11/03/03, by the facility DON, that resident 5 had a right popliteal stage II pressure ulcer. On 09/29/03, a facility nurse documented that resident 5 developed a wound on her right popliteal (back of knee) due to her "Ted" hose being too tight. There was no documented evidence in the medical record that the wound had received any treatments until 10/25/03 when it was documented as a Stage II. b. INJURY OF UNKNOWN ORIGIN On 10/14/03 at 8:30 PM, a facility nurse documented the following in resident 5's medical record, "...She does have two large bruises on [left] hand [and] wrist..." On 11/10/03 at 8:20 AM, the facility DON stated that resident 5 was another resident that she had a concern with transferring techniques used by staff and felt that the bruising had occurred as a result of a transfer.	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 224	Continued From page 10 When asked how long she has had concerns with how staff were transferring residents, the DON stated "about 1 month." She further stated that an in-service concerning transferring was to be held on 11/07/03. She stated the in-service was postponed until 11/10/03, due to that day being a payday. A review of the facility's Incident Reports was completed during the survey and there were no incident reports to document how resident 5 may have received the bruise on her hand and wrist, which was first noted on 10/14/03. The facility administration was not able to provide any documented evidence that the bruising found on resident 5's hand and wrist on 10/14/03, had been investigated or reported to State Survey Agency. 3. Resident 13 was admitted to the facility on 07/25/96 with diagnoses of Alzheimer, hypertension, congestive heart failure and failure to thrive. A review of resident 13's medical record was completed on 11/10/03. A quarterly MDS completed by facility staff on 09/14/03, documented that resident 13's cognitive skills for daily decision-making were severely impaired. On 09/19/03, a facility nurse documented the following, "skin tear to [right lower extremity no signs and symptoms] pain...." There was no information concerning how resident 13's skin tear might have occurred. A review of the facility's Incident Reports was completed during the survey and there were no incident reports to document how resident 13 may have received the skin tear to her lower extremity, which was first noted on 09/19/03.	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 224	Continued From page 11 On 11/05/03 at 4:00 PM, during an interview with the facility DON she stated that she was not aware of resident 13's skin tear. She stated that she believed it had not been reported to her. Additionally, she stated that all skin tears found by facility staff should have an incident report and an investigation discussing how the skin tear could have occurred. The facility administration was not able to provide any documented evidence that the skin tear found on resident 13's lower extremity on 09/19/03, had been investigated or reported to State Survey Agency. 4. Resident 17 was admitted to the facility on 08/14/03 with diagnoses of hypothyroidism, chronic dizziness, deep vein thrombosis, thrombocytopenia and Alzheimer with depressive features. On 08/18/03 at 10:00 AM, a nurse's note in resident 17's medical record documented the following entry: "When getting her up this AM CNA noticed large bruise on top of [right] thigh about 3 in (inches) wide and all around leg. Fresh bruise- she did not know how she got it...". A review of the facility Incident Reports was completed during the survey and there was an incident report dated 08/18/03 concerning resident 17, which documented the following: "...When getting her up [and] dressed CNA's noticed [large] 3 in wide bruise around upper thigh...Doesn't know how she got it...". On 11/06/03 at 10:25 AM, the DON was interviewed and she stated that she did not complete an investigation concerning the bruise found on resident 17's upper thigh, first noted on 08/18/03. She further stated that the resident had a diagnosis of thrombocytopenia, which may contribute to easy	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 224	Continued From page 12 bruising. On 11/10/03 at 7:40 AM, the facility nurse who wrote the nursing note and incident report on 08/18/03 was interviewed. The facility nurse stated that the bruise on 08/18/03 went down resident 17's leg and at the time she noted it, it had crossed her mind that something more happened, then the resident just bumping it. The facility nurse stated "it looked like someone popped her on the leg." When asked if the resident could have forgotten if someone had popped her on the leg, the facility nurse replied that she could have. The facility administration was not able to provide any documented evidence that the bruising on resident 17's leg, first noted on 08/18/03, had been investigated or reported to State Survey Agency. 5. Resident 18 was admitted to the facility on 03/24/03 with diagnosis of schizo-affective disorder with depressive, anxious and psychotic features. A review of resident 18's medical record was completed on 11/10/03. A quarterly MDS completed by facility staff on 09/04/03, documented that resident 18's cognitive skills for daily decision-making were moderately impaired. The MDS documented that resident 18 was physically abusive and socially inappropriate and had disruptive behaviors. The MDS documented that these behaviors were not easily altered. On 11/06/03 at 8:20 AM, the facility Administrator gave the surveyor a letter signed by the DON about an allegation of staff to resident abuse (slapping) concerning resident 18. The letter signed by the DON did not document a date	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 224	Continued From page 13 as to when it was written. The letter did document that on 09/02/03 at 3:00 PM, resident 18's family member stopped her in the parking lot and told her that resident 18 had told him employee 1 had slapped her. The letter did not document that the DON talked with the resident's roommate, or with other resident who have been cared for by employee 1, or to other staff members who might have had contact with resident 18 during the period of the alleged incident. The letter did document that employee 1 would not work with resident 18. When the Administrator was asked for his investigation regarding the allegations of abuse involving resident 18, he stated that he had written it in his "personal notebook" and provided the surveyor with a copy of his investigation, dated 09/04/03, of resident 18 being "slapped" by employee 1. The Administrator's report of the investigation, dated 09/04/03, consisted of an interview with employee 1. Employee 1 stated to the administrator that "...[resident 18's] brief was dry but clothes were wet (however it was not urine) She was pulling her clothes off and he tried to keep her from doing so. There was some 'hand wrestling' (my phrase) nothing at all physical he [employee 1] said he was frustrated but not angry...". A review of the facility's Incident Reports was completed during the survey and there were no incident reports concerning this allegation of staff to resident abuse, which was reported to the DON on 09/22/03. The investigation of the alleged staff to resident abuse, lacked sufficient evidence to determine if the abuse had occurred.	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 224	Continued From page 14 When the Administrator was asked if this allegation of staff to resident abuse was reported to the State Survey Agency, he replied, "No". In an interview with the DON on 11/06/03 at 9:50 AM, she stated that employee 1 had not worked with resident 18 since the alleged staff to resident abuse had occurred. She stated that due to an injury, employee 1 has been out of the facility since the end of October 2003. A review of the September 2003 and October 2003 ADL (activities of daily living) sheets was completed on 11/10/03. (The facility's ADL sheet indicates the care that was given to a resident and which staff person had delivered that care.) The ADL sheets documented evidence that employee 1 had not given cares to resident 18 following the date of the allegation in September 2003. However, the October 2003 ADL sheet did document that employee 1 had given care to resident 18 on 8 different occasions, after employee 1 was prohibited from caring for resident 18. 6. Resident 21 was admitted to the facility on 08/06/03 with diagnoses of diabetes mellitus, hypertension, hyperlipidemia, renal insufficiency and chronic obstructive pulmonary disease. A review of resident 21's medical record was completed on 11/10/03. An admission MDS completed by facility staff on 8/20/03, documented that resident 21's cognitive skills for daily decision-making were modified independence. A surveyor interviewed resident 21 on 11/06/03 at 7:10 AM. Resident 21 relayed allegations of misappropriation of his property, by a facility staff member. Resident 21 provided the following information regarding employee 2, a facility	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 224	Continued From page 15 restorative nurse aide: September 2003 a. Employee 2 had taken $30 from him when he took money out of an ATM; b. The resident gave employee 2 $20 to buy him some fruit, but the resident never received the fruit and employee 2 did not return the money; and, c. Employee 2 had borrowed $20 from resident 21 and had still not paid the $20 back. October 2003 a. The resident gave employee 2, $20 to buy the resident underwear and he never received the underwear and employee 2 did not return the money; and, b. The resident gave employee 2, $50 to buy him a jacket. The resident stated he had received the jacket, but when he asked employee 2 for a receipt and any change from the purchase, employee 2 stated she did not have them. Further, resident 21 stated that whenever he asked employee 2 about the incident, employee 2's story always changed about the cost of the jacket. A review of resident 21's medical record revealed a social worker note dated 09/02/03, which documented the following, "...[resident 21] stated he withdrew some money from ATM machine at 7-11 and [employee 2] took $30.00 (thirty dollars) from him and refused to give it back." On 11/06/03 at 8:20 AM, the Administrator was interviewed concerning the 09/02/03 alleged misappropriation of resident 21's property. When	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 224	Continued From page 16 asked for his investigation report, he stated that he had written it in his "personal notebook" and provided the state surveyor with a copy of his investigation. The investigation dated 09/02/03, documented that the Administrator had talked with the facility's social worker and with employee 2. There was no documentation that the investigation had taken any further steps, including interviewing resident 21, to determine if the alleged misappropriation of the resident's property had occurred. The Administrator stated that he did not feel resident 21 was "accurate with his information". On 11/06/03 at 9:50 AM, when the facility social worker was interviewed concerning these allegations, he stated that he was aware that employee 2 was buying personal items for resident 21. He stated he had not been made aware that resident 21 had not received the items. He stated he documented a progress note regarding resident 21's allegation that employee 2 had taken $30.00 from him at an ATM. The social worker stated he reported resident 21's allegation to the Administrator. On 11/06/03 at 10:00 AM, during an interview with the facility DON, she stated that she was aware of each of the allegations reported by resident 21, involving employee 2. She stated she had reported resident 21's allegations of misappropriation of property to the social worker and the Administrator. When asked if she had documented any of resident 21's allegations, she replied that she had not. The facility administration was not able to provide documented evidence that each of resident 21's allegations of misappropriation of property were investigated and reported to the appropriate advocacy agencies, as stated in their policy and procedures..	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 224	Continued From page 17 7. Resident CL2 was admitted to the facility on 10/04/03 with diagnoses of hypothyroidism, organic mental disorder, glaucoma, hypertension, atrial fibrillation and asthma. On 10/07/03 at 8:00 PM, a facility nurse documented the following, "...She has a large bruise (fresh) on [left] bicep. We noticed this at [4:30 PM]..." A review of the facility's Incident Reports was completed during the survey and revealed an incident report dated 10/08/03. The incident report documented a description of the incident that was the same as what was documented in the nurse's note, with the additional remarks of "...unsure of how this happened..." On 11/06/03 at 9:50 AM, during an interview with the facility DON, she stated that she could not remember this incident, nor if she received a report on it or not. The facility administration was not able to provide any documented evidence that the bruise found on resident CL2's bicep on 10/7/03 had been investigated or reported to State Survey Agency.	F 224		
F 225 SS=K	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	F 225 (F225)	(Corrective Action for Resident(s) Affected) Resident 4 - We have not been able to find the cause of the bruising in September and October. We had a complete physical evaluation by RN on 11-14-03. We did have a physical therapist observe transfers of this resident and her conclusion was that the bruising came from the transferring. Resident 17 - We are unable to conclude how this resident obtained the bruise on her upper thigh. This is an injury of unknown origin. A complete physical evaluation by RN was done on 11-14-03. Physician was consulted regarding adjusting of anticoagulants on 11-11-03.	12-12-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 18 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: Based on resident and staff interviews and record review, the facility failed to investigate and report incidents of potential abuse (including injuries of unknown origin) and therefore, was not preventing facility residents from further potential abuse and injury. Additionally, the facility did not report resident to resident abuse, staff to resident abuse or misappropriation of resident property, in accordance with state law and federal regulations. During the survey, completed 11/03/03 through 11/10/03, record review indicated six incidents of injuries of unknown origin (Residents 4, 5, 13, 17, and CL2.), and two incidents of resident to resident abuse	F 225	Resident 18 - We are unable to determine what happened to this resident. We interviewed staff, family, and other residents and they are unaware of any other incidents of slapping concerning this staff member and any other resident. It is our conclusion that this staff member did not slap Resident 18. ~~This staff member will not work with Resident 18.~~ error. Resident 21 - We have identified the staff member responsible for this complaint through statements and interviews from other residents in the facility. We terminated this employee on November 16th, 2003. The facility provided to Resident 21 a copy of the policy for reporting misappropriation of funds and items that will assist him and the administrator to validate any future report on 11-13-03. The facility reimbursed Resident 21 $140.00 on 11-13-03. Facility administrator, Business office manager, and Ombudsman met with Resident 21 on 11-25-03 to review once again facility policy and to state to resident that Business Office Manager is the only one to accept money from resident for purchases with a signed receipt to be given by the BOM. Resident 5 - This resident is now on a low bed with a mattress on the floor to prevent any injury from falls. Resident 5 has seen her orthopedic surgeon and has been treated. The stage II has been resolved. Resident 13 - Resident was observed by the RN and other staff over a 72 hour period to determine if she has behaviors or actions that result in skin tears. This was done on 12-03-03. This resident has received a PT evaluation. Evaluation states the resident sits well and that the chair is appropriate. Her skin is very fragile. Comments are that resident may benefit from foam padding around arm rests to decrease bruising and skin tears. Padding was placed on resident chair on 11-24-03. Identification of Residents with the Potential to be Affected All resident have the potential to be affected. Measures to Prevent Reoccurrence Resident 4 - Physical Therapist did an in service on how to transfer this particular resident on 11-12-03. This included training for staff on proper use of gait belts. Resident 17 - We will continue to monitor this resident as well as all others for more immediate resolutions to these	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 19 (Residents 5, 6, and 17), where the facility failed to investigate or report these occurrences. Additionally, interviews indicated allegations of staff to resident abuse (Resident 18) and misappropriation of resident property (resident 21), by facility staff members, where the facility failed to thoroughly investigate and report these occurrences. Findings include: 1. A review of the facility's policies and procedures, relating to abuse, was completed on 11/06/03. The policies directed the following, "...Any person who suspects that abuse, neglect or misappropriation of property may have occurred will immediately report the alleged violation to the charge nurse, who immediately notifies the administrator or director of nursing and/or advocacy agencies (Adult Protective Services or the Police)..." 2. A review of the facility's abuse policy and procedures under "Prevention of Abuse" indicated the following. "...Initial orientation for new hires and yearly update training for all staff will occur, they will include topics such as identification and reporting of abuse, dealing with stressful situations, and managing behavioral challenges...A yearly in-service will be given, training staff to identify potential signs and symptoms of abuse, including behavioral changes and injuries of unknown cause..." 3. On 11/03/03, surveyors reviewed records maintained by the State Survey Agency, which related to the facility. Incidents of facility self reported allegations of abuse, neglect, misappropriation of resident property, and injuries of unknown origin were among the records reviewed. Since July 2003, the	F 225	types of injuries. We will in-service staff regarding safe gentle transfer for this resident on 11-13-03. Resident 18 Nursing and Social work staff will explore with this resident the reasons why she feels that the staff have harmed her and will amend the plan of care to reflect this behavior and methods to respond to her anxiety or fear. Resident 21 All staff have been in-serviced on the policy for misappropriation of funds and reporting. All staff have been told that only person allowed to accept funds from Resident 21 is the BOM with a receipt book to acknowledge funds taken and returned with receipt of purchase. Resident 5 This resident is now on a low bed with a mattress on the floor to prevent any injury from falls. Resident 5 has seen her orthopedic surgeon and has been treated. The stage II has been resolved. Resident 13 All staff have been in-serviced on the proper use of gait belts and the proper methods to transfer residents on 11-13-03. This resident and all others with the potential for skin tears will be monitored by staff to determine if they have behaviors or actions that will result in skin tears. IDT will care plan results. Monitoring Corrective Action and Responsibility The QA committee will monitor the implementation of the procedures on a daily basis until 2-1-03 and then monthly. Non performance will be evaluated for further action on and revision of the plan by the QA committee (or subcommittee). Tests of the system will be implemented on a random and routine basis until such time that the committee believes the policy and procedure to be understood and followed by all staff members. The nurse consultant will monitor for several days.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 20 facility had not reported any of these incidents. In addition to a review of facility self reported allegations of abuse, neglect, misappropriation of resident property, and injuries of unknown origin, the surveyors reviewed documentation of reports received by Adult Protective Services (APS). On 9/12/03, APS had received a report of a resident to resident altercation in which resident 17 allegedly hit resident 6 on the arm. There were no other incidents reported to APS since July 2003. 4. Upon medical record review of survey sampled residents, surveyors identified two incidents of resident-to resident abuse since the previous re-certification survey completed 05/07/03. a. On 09/12/03, in resident 6's medical record, nursing staff documented a resident to resident altercation in which resident 17 allegedly hit resident 6 on the arm. Additionally, facility staff completed an Incident Report for this altercation. (This incident was reported to APS 09/12/03.) b. On 09/27/03, a facility nurse documented in resident 5's medical record that resident 5 and another resident, ". . . both gave each other 2 punches [with] their hands . . ." (This incident of resident to resident abuse was not reported to APS.) During an interview with the Administrator on 11/06/03, at approximately 10:30 AM, he stated that a "Resident to Resident Contact" form should be completed and faxed to the appropriate agencies with the fax confirmation attached to the forms. On 11/06/03, the surveyor reviewed the "Resident to Resident Contact" forms completed by facility staff since July 2003. Facility staff had completed a	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 20 facility had not reported any of these incidents. In addition to a review of facility self reported allegations of abuse, neglect, misappropriation of resident property, and injuries of unknown origin, the surveyors reviewed documentation of reports received by Adult Protective Services (APS). On 9/12/03, APS had received a report of a resident to resident altercation in which resident 17 allegedly hit resident 6 on the arm. There were no other incidents reported to APS since July 2003. 4. Upon medical record review of survey sampled residents, surveyors identified two incidents of resident-to resident abuse since the previous re-certification survey completed 05/07/03. a. On 09/12/03, in resident 6's medical record, nursing staff documented a resident to resident altercation in which resident 17 allegedly hit resident 6 on the arm. Additionally, facility staff completed an Incident Report for this altercation. (This incident was reported to APS 09/12/03.) b. On 09/27/03, a facility nurse documented in resident 5's medical record that resident 5 and another resident, ". . . both gave each other 2 punches [with] their hands . . ." (This incident of resident to resident abuse was not reported to APS.) During an interview with the Administrator on 11/06/03, at approximately 10:30 AM, he stated that a "Resident to Resident Contact" form should be completed and faxed to the appropriate agencies with the fax confirmation attached to the forms. On 11/06/03, the surveyor reviewed the "Resident to Resident Contact" forms completed by facility staff since July 2003. Facility staff had completed a	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 21 "Resident to Resident Contact" form for the incident involving resident 5 on 09/27/03. There was no documentation, fax confirmation or otherwise, which indicated APS was notified of this incident. 5. An interview was held with the Administrator on 11/06/03 at 8:20 AM. The surveyor asked the Administrator if the facility had investigated any allegations of abuse, including: staff to resident abuse; resident to resident abuse; injuries of unknown origin; and misappropriation of resident property, since the previous re-certification survey on 05/07/03. The Administrator responded by providing the surveyor with two letters signed by the DON. a. The first letter signed by the DON did not document a date as to when it was written. The letter did document that on 09/02/03 at 3:00 PM, resident 18's family member stopped her in the parking lot and told her that resident 18 had told him, employee 1 had slapped her. When the Administrator was asked for his investigation he stated that he had written it in his "personal notebook" and provided the state surveyor with a copy of his investigation, dated 09/04/03, of resident 18 being "slapped" by employee 1. The report of the investigation, dated 09/04/03, consisted of an interview with employee 1. Employee 1 stated to the administrator that "...[resident 18's] brief was dry but clothes were wet (however it was not urine) She was pulling her clothes off and he tried to keep her from doing so. There was some "hand wrestling" (my phrase) nothing at all physical he (employee 1) said he was frustrated but not angry..." A review of the facility's Incident Reports was completed during the survey and there was no incident	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 22 report concerning this allegation of staff to resident abuse, which was first reported to the DON on 09/02/03. The Administrator, or another individual designated by the Administrator, did no investigation of the alleged staff to resident abuse, involving resident 18, beyond an interview with the alleged perpetrator to determine when the incident was to have occurred or if the allegation could be substantiated. The surveyor asked the Administrator if this allegation of staff to resident abuse was reported to the State Survey Agency. He replied, "No". b. The second letter, signed by the DON, did not document a date as to when it was written. The letter did document that on 10/24/03, resident 4 had a bruise of unknown origin on her left breast that extended up to her nipple. The letter documented that "...the bruising was probably due to the manner in which she was transferred..." This letter, the only documentation of any investigation regarding resident 4's injury of unknown origin, did not document specifically which aides, which times, nor which dates she observed. Additionally, there was no information concerning how she came to the conclusion that the bruising was caused by transferring, nor did it document which aides she specifically counseled concerning the bruising and transferring. Review of resident 4's medical record revealed a nursing noted dated 10/24/03 at 9:00 PM, which documented the following, "[large] bruise noted on [left] breast from underneath extending up to nipple-States it doesn't hurt at all." On 11/03/03 at 2:30 PM, a surveyor interviewed the DON. This interview was three days before the	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 Administrator provided the letter, signed by the DON, concerning resident 4's injury of unknown origin, first documented on 10/24/03. The DON stated that she knew about resident 4's bruise, to her left breast, on 10/24/03. She stated that she thought the bruising had occurred from lifting resident 4 up in the wheelchair. When asked for a written investigation of the bruise from 10/24/03, she stated that she did not write one. A review of the facility's Incident Reports was completed during the survey and there was no incident report to document how resident 4 may have received the bruise on her left breast extending up to her nipple, which occurred on 10/24/03. When the administrator was asked if resident 4's injury of unknown origin was reported to the State Survey Agency, he replied, "No". 6. Further review of survey sampled residents medical records revealed five other injuries of unknown origin since the re-certification survey on 05/07/03: a. On 09/22/03 at 7:00 PM, a nurse's note in resident 4's medical record documented the following entry: "CNA noted large fleshy bruise under [left] arm- asked CNA if bruise was there last evening and she stated no." A review of the facility's Incident Reports was completed during the survey and there was no incident report to document how resident 4 may have received the bruise under her left arm, which occurred on 09/22/03. On 11/03/03 at 2:30 PM, the facility DON was interviewed, she stated that she did not know about resident 4's left, under arm bruise, which was first documented on 09/22/03.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 24 On 11/05/03 at 9:10 AM, the facility DON stated that she could not find any incident reports or investigations concerning resident 4's bruising, noted on 09/22/03. The facility administration was not able to provide any documented evidence that the bruising found under resident 4's left arm on 09/22/03, had been investigated or reported to State Survey Agency. b. On 10/14/03 at 8:30 PM, a nurse's note in resident 5's medical record documented the following entry: "...She does have two large bruises on [left] hand [and] wrist... .". An interview was held with the DON on 11/10/03 at 8:20 AM. The DON stated that resident 5's bruising could have been received from transferring techniques. A review of the facility's Incident Reports was completed during the survey and there was no incident report to document how resident 5 may have received the bruise on her hand and wrist, which was first documented on 10/14/03. The facility administration was not able to provide any documented evidence that the bruising found on resident 5's hand and wrist on 10/14/03, had been investigated or reported to State Survey Agency. c. On 9/19/03, a nurse's note in resident 13's medical record documented the following entry: "skin tear to [right lower extremity no signs and symptoms] pain...." There was no documentation concerning how resident 13's skin tear might have occurred. A review of the facility's Incident Reports was completed during the survey and there was no incident	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 25 report to document how resident 13 may have received the skin tear to her lower extremity, which was first documented on 9/19/03. On 11/05/03 at 4:00 PM, during an interview with the facility DON, she stated that she was not aware of the skin tear to resident 13's right lower extremity. She stated that she believed that it had not been reported to her. The facility administration was not able to provide any documented evidence that the skin tear found on resident 13's lower extremity on 09/19/03, had been investigated or reported to State Survey Agency. d. On 08/18/03 at 10:00 AM, a nurse's note in resident 17's medical record documented the following entry: "When getting her up this AM CNA noticed large bruise on top of [right] thigh about 3 in (inches) wide and all around leg. Fresh bruise- she did not know how she got it..." A review of the facility Incident Reports was completed during the survey and there was an incident report dated 08/18/03, concerning resident 17, which documented the following: "...When getting her up [and] dressed CNA's noticed [large] 3 in wide bruise around upper thigh... .Doesn't know how she got it..." On 11/06/03 at 10:25 AM, the facility DON was interviewed and she stated that she did not complete an investigation concerning the bruise found on resident 17's upper thigh, first noted on 08/18/03. She stated that resident 17 had thrombocytopenia and bruises easily. On 11/10/03 at 7:40 AM, the facility nurse who wrote the nursing note and incident report on 08/18/03 was interviewed. The facility nurse stated that the bruise	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 26 went down resident 17's leg and, at the time she noted it, it had crossed her mind that something had happened more than the resident just bumping it. The facility nurse stated,"It looked like someone popped her on the leg." The facility administration was not able to provide any documented evidence that the bruising found on resident 17's leg, first noted on 08/18/03, had been investigated or reported to State Survey Agency. e. On 10/07/03 at 8:00 PM, a nurse's note in resident CL2's medical record documented the following entry: "...She has a large bruise (fresh) on [left] bicep. We noticed this at [4:30 PM]..." A review of the facility's Incident Reports was completed during the survey and revealed an incident report dated 10/08/03. The incident report documented that resident CL2 was found to have a large bruise on her left bicep. The incident report included the following documented statement, "...unsure of how this happened...". On 11/06/03 at 9:50 AM, during an interview with the facility DON, she stated that she could not remember the bruise to resident CL2's left bicep, nor if she had received a report regarding it. The facility administration was not able to provide any documented evidence that the bruise found on resident CL2's left bicep, first noted on 10/7/03, had been investigated or reported to State Survey Agency. 7. During an interview with the DON on 11/03/03 at 2:30 PM, the surveyor asked the DON what the facility procedures were if a resident was found to have an injury of unknown origin. The DON stated, "We write incident reports when any injury or bruise is found."	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 27 8. During an interview with a facility nurse on 11/10/03 at 7:40 AM, the surveyor asked when she would write up an incident report. The facility nurse responded by stating if an injury "looks really bad" she would write an incident report up and "give it to the DON, who would sign it and place it in the physician's box". The facility nurse further stated if it's a "smaller injury, she might not write up an incident report, but she would document it in the nursing notes." 9. A surveyor interviewed resident 21 on 11/06/03 at 7:10 AM. Resident 21 relayed allegations of misappropriation of his property, by a facility staff member. Resident 21 provided the following information regarding employee 2, a facility restorative nurse aide: September 2003 a. Employee 2 had taken $30 from him when the he took money out of an ATM; b. The resident gave employee 2 $20 to buy him some fruit, but the resident never received the fruit and employee 2 did not return the money; and, c. Employee 2 had borrowed $20 from resident 21 and had still not paid the $20 back. October 2003 a. The resident gave employee 2, $20 to buy the resident underwear and he never received the underwear and employee 2 did not return the money; and, b. The resident gave employee 2, $50 to buy him a jacket. The resident stated he had received the jacket, but when he asked employee 2 for a receipt and any	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 28 change from the purchase, employee 2 stated she did not have them. Further, resident 21 stated that whenever he asked employee 2 about the incident, employee 2's story always changed about the cost of the jacket. A review of resident 21's medical record revealed a social worker note dated 09/02/03, which documented the following, "...[resident 21] stated he withdrew some money from ATM machine at 7-11 and [employee 2] took $30.00 (thirty dollars) from him and refused to give it back." On 11/06/03 at 8:20 AM, the Administrator was interviewed concerning the 09/02/03 alleged misappropriation of resident 21's property. When asked for his investigation report, he stated that he had written it in his "personal notebook" and provided the state surveyor with a copy of his investigation. The investigation dated 09/02/03, documented that the Administrator had talked with the facility's social worker and with employee 2. There was no documentation that the investigation had taken any further steps, including interviewing resident 21, to determine if the alleged misappropriation of the resident's property had occurred. The Administrator stated that he did not feel resident 21 was "accurate with his information". On 11/06/03 at 9:50 AM, when the facility social worker was interviewed concerning these allegations, he stated that he was aware that employee 2 was buying personal items for resident 21. He stated he had not been made aware that resident 21 had not received the items. He stated he documented a progress note regarding resident 21's allegation that employee 2 had taken $30.00 from him at an ATM. The social worker stated he reported resident 21's allegation to the Administrator.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 29 On 11/06/03 at 10:00 AM, during an interview with the facility DON, she stated that she was aware of each of the allegations reported by resident 21, involving employee 2. She stated she had reported resident 21's allegations of misappropriation of property to the social worker and the Administrator. When asked if she had documented any of resident 21's allegations, she replied that she had not. The facility administration was not able to provide documented evidence that each of resident 21's allegations of misappropriation of property were investigated or reported to the appropriate advocacy agencies. 10. During an interview with the facility Administrator on 11/06/03 at 11:30 AM, the surveyors asked the Administrator for an explanation for the facility's failure to investigate and report injuries of unknown origin and allegations of resident to resident abuse, staff to resident abuse, misappropriation of resident property to the required agencies. The Administrator stated that he might have been "laxed" on the reporting and then asked the surveyors if he should have been reporting those incidents.	F 225		
F 226 SS=K	483.13(C)(1)(i) 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. (Use F226 for deficiencies concerning the facility's development and implementation of policies and procedures.)	F 226 F226	(Corrective Action For Resident(s) Affected Resident 4 - We have not been able to find the cause of the bruising in September and October. We had a complete physical evaluation by RN on 11-14-03. We did have a physical therapist observe transfers of this resident and her conclusion was that the bruising came from the transferring. Resident 17 - We are unable to conclude how this resident obtained the bruise on her upper thigh. This is an injury of unknown origin. A complete physical evaluation by RN	12-12-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 226	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, record review and review of the facility's abuse policies and procedures, the facility failed to implement written policies and procedures concerning neglect, resident to resident abuse, staff to resident abuse, prevention of abuse from occurring. As a result, neglect (Resident 5), allegations of staff to resident abuse (Resident 18), injuries of unknown origin (Resident 4, 5, 13, 17, and CL2), resident to resident abuse (Resident 5) and misappropriation of resident property (Resident 21) were occurring in the facility without appropriate interventions. Findings include: A review of the facility's policies and procedures relating to abuse was completed on 11/10/03. The policies and procedures directed the following: a. "... Any person who suspects that abuse, neglect or misappropriation of property may have occurred will immediately report the alleged violation to the charge nurse, who immediately notifies the administrator or director of nursing and/or advocacy agencies (Adult Protective Services or the Police)..." b. Who should be notified - "...The administrator will immediately notify Adult Protective Services or local law enforcement authority, and the local long-term care ombudsman as soon as abuse is reported. The State Survey and Certification Agency must also be notified...Injuries of unknown origin, where abuse cannot be ruled out, significant incidents between residents, abuse and misappropriation of resident's property must be immediately reported (during normal business hours) to the State Survey and Certification	F 226	was done on 11-14-03. Physician was consulted regarding adjusting of anticoagulants on 11-11-03 Resident 18 - We are unable to determine what happened to this resident. We interviewed staff, family, and other residents and they are unaware of any other incidents of slapping concerning this staff member and any other resident. It is our conclusion that this staff member did not slap Resident 18. ~~This staff member will not work with Resident 18.~~ [illegible] Resident 21 - We have identified the staff member responsible for this complaint through statements and interviews from other residents in the facility. We terminated this employee on November 16th, 2003. The facility provided to Resident 21 a copy of the policy for reporting misappropriation of funds and items that will assist him and the administrator to validate any future report on 11-13-3. The facility reimbursed Resident 21 $140.00 on 11-13-3. Facility administrator, Business office manager, and Ombudsman met with Resident 21 on 11-25-03 to review once again facility policy and to state to resident that Business Office Manager is the only one to accept money from resident for purchases with a signed receipt to be given by the BOM. Resident 5 - This resident is now on a low bed with a mattress on the floor to prevent any injury from falls. Resident 5 has seen her orthopedic surgeon and has been treated. The stage II has been resolved. Resident 13 - Resident was observed by the RN and other staff over a 72 hour period to determine if she has behaviors or actions that result in skin tears. This was done on 12-3,4,5-03. This resident has received a PT evaluation. Evaluation states the resident sits well and that the chair is appropriate. Her skin is very fragile. Comments are that resident may benefit from foam padding around arm rests to decrease bruising and skin tears. Padding was placed on resident chair on 11-24-03. Identification of Residents with the Potential to be Affected All resident have the potential to be affected. Measures to Prevent Reoccurrence Resident 4 - Physical Therapist did an in-service on how to transfer this particular resident on 11-12-03. This included training for staff on proper use of gait belts.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 226	Continued From page 31 Agency..." c. How should abuse be investigated - "...The administrator will initiate an investigative process as soon as a report has been made. This investigation may consist of:...Review of the completed incident report, and any supporting documents....Interview with the person or persons reporting the incident....Interviews with any witness to the incident...Interviews with staff members (on all shifts) having contact with the resident during the period of the alleged incident....Interviews with the resident's roommates, family members, and visitors who might have knowledge of the incident....Interview with other resident who have been cared for by the staff member in suspicion..." d. Investigation of Injuries of Unknown Origin - "...Bruising or injuries that were not witnessed by staff or another person will be investigated to ensure that they have not been sustained by abuse....The charge nurse or investigator will ask the resident what happened....An incident report will be completed at this time for the discovered injury..." The following incidents were noted during the re-certification survey completed on 11/10/03 and illustrates the facility's failure to implement it's own policies and procedures and Long Term Care Federal Requirements. 1. NEGLECT: Resident 5 was admitted to the facility on 07/09/03 with diagnoses of organic brain syndrome with psychotic features, hypercholesterolemia, hypothyroidism, digestive system disorder, hypertension, aphasia and diabetes mellitus.	F 226	Resident 17 - We will continue to monitor this resident as well as all others for more immediate resolutions to these types of injuries. We will in-service staff regarding safe gentle transfer for this resident on 11-13-03 Resident 18 - This staff member will not work with Resident 18. Nursing and Social work staff will explore with this resident the reasons why she feels that the staff have harmed her and will amend the plan of care to reflect this behavior and methods to respond to her anxiety or fear. Resident 21 - All staff have been in-serviced on the policy for misappropriation of funds and reporting. All staff have been told that only person allowed to accept funds from Resident 21 is the BOM with a receipt book to acknowledge funds taken and returned with receipt of purchase. Resident 5 - See 224 Resident 13 - All staff have been in-serviced on the proper use of gait belts and the proper methods to transfer residents on 11-13-03. This resident and all others with the potential for skin tears will be monitored by staff to determine if they have behaviors or actions that will result in skin tears. IDT will care plan results. Monitoring Corrective Action and Responsibility The QA committee will monitor the implementation of the procedures on a daily basis until 2-1-03 and then monthly. Non performance will be evaluated for further action on and revision of the plan by the QA committee (or subcommittee). Tests of the system will be implemented on a random and routine basis until such time that the committee believes the policy and procedure to be understood and followed by all staff members. The nurse consultant will monitor for several days.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 226	Continued From page 32 On 07/12/03 at 4:45 PM, a facility nurse documented that resident 5 was found on the floor, in the dining room, laying on her left hip. On 07/13/03 at 11:30 AM, a facility nurse documented that resident 5 was found laying on her left side in the day room. The x-ray results contained in resident 5's medical record concerning these two falls indicated they resulted in an impacted left acetabular fracture. On 07/19/03 at 10:00 AM, a facility nurse documented that resident 5 was found on the floor, in her room, on her right side. On 08/01/03 at 1:55 PM, a facility nurse documented the following, "...[found on floor] on [left] side in day room- apparently fall from Geri chair (tried to stand) ...[right] great toe reddish/purple [and] swelling..." On 08/1/03 at 2:45 PM, a facility nurse documented the following, "...[resident's daughter] was called she wants to have her mother sent out for an x-ray...She also stated 'I don't give a damn what state says put a posey [and] or lap buddy on her before she kills herself by falling out of chair'..." A physician order dated 08/01/03, documented that staff was to obtain an x-ray of both resident 5's hips and her right foot. The results of the x-rays could not be found in resident 5's medical record. Twice during the survey (11/05/03 and 11/06/03), the DON was asked for a copy of the x-rays. On 11/10/03, the DON provided a copy of the x-ray results, which were dated 08/01/03. The x-ray results,	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 226	Continued From page 33 provided to the surveyors by the DON, included documentation that the they were faxed to the facility on 11/07/03, at 12:23 AM. The x-ray results documented the following, "...Comminuted left acetabular fracture with some increased displacement of the main fracture fragments compared to earlier...First proximal phalangeal fracture..." Essentially, this information indicated that there was additional damage done to the previously fractured hip and that the large toe was newly fractured. There was no evidence in resident 5's medical record that the resident's attending physician or orthopedic surgeon was notified of the 08/01/03 x-ray results either at the time of the x-rays, or after 11/07/03, when the facility received the results by fax. On 11/10/03 at 10:00 AM, resident 5's physician was interviewed. He stated that he could not recall if he was contacted concerning the fractures on 08/01/03. He then stated that it seemed to him that they should have contacted the orthopedic who was caring for resident 5. On 11/10/03 at 10:15 AM, resident 5's orthopedic's physician assistant was contacted. He stated that the only fracture they were aware of was the left hip fracture which occurred either on 07/12/03 or 07/13/03. The physician assistant further stated that he was not aware that resident 5 had a fall on 08/01/03, which caused further displacement of the hip fracture and that they did not know about the right foot fracture. When asked if they would treat a phalangeal (toe) fracture, he stated they could place a walking cast, a hard cast or depending how bad the fracture was, possibly a plate. In addition to the fractures, it was reported during the initial tour on 11/03/03, by the facility DON, that	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 226	Continued From page 34 resident 5 had a right popliteal stage II pressure ulcer. On 09/29/03, a facility nurse documented that resident 5 developed a wound on her right popliteal (back of knee) due to her "Ted" hose being too tight. There was no documented evidence in the medical record that the wound had received any treatments until 10/25/03 when it was documented as a Stage II. 2. STAFF TO RESIDENT ABUSE: Resident 18 was admitted to the facility on 03/24/03 with diagnosis of schizo-affective disorder with depressive, anxious and psychotic features. On 11/06/03 at 8:20 AM, the facility Administrator gave the surveyor a letter signed by the DON about an allegation of staff to resident abuse (slapping) concerning resident 18. The letter signed by the DON did not document a date as to when it was written. The letter did document that on 09/02/03 at 3:00 PM, resident 18's family member stopped her in the parking lot and told her that resident 18 had told him employee 1 had slapped her. The letter did not document that the DON talked with the resident's roommate, or with other resident who have been cared for by employee 1, or to other staff members who might have had contact with resident 18 during the period of the alleged incident. The letter did document that employee 1 would not work with resident 18. When the Administrator was asked for his investigation regarding the allegations of abuse involving resident 18, he stated that he had written it in his "personal notebook" and provided the surveyor with a copy of his investigation, dated 09/04/03, of resident 18 being "slapped" by employee 1.	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 226	Continued From page 35 The Administrator's report of the investigation, dated 09/04/03, consisted of an interview with employee 1. Employee 1 stated to the administrator that "...[resident 18's] brief was dry but clothes were wet (however it was not urine) She was pulling her clothes off and he tried to keep her from doing so. There was some 'hand wrestling' (my phrase) nothing at all physical he [employee 1] said he was frustrated but not angry...". When discussing the hand wrestling, the Administrator demonstrated that employee 1 had indicated that this action involved both hands being held in front of him, alternately moving the hands up and down in a "slapping" motion against resident 18's hands. A review of the facility's Incident Reports was completed during the survey and there were no incident reports concerning this allegation of staff to resident abuse, which was reported to the DON on 09/22/03. The investigation of the alleged staff to resident abuse, lacked sufficient evidence to determine if the abuse had occurred. When the Administrator was asked if this allegation of staff to resident abuse was reported to the State Survey Agency, he replied, "No". In an interview with the DON on 11/06/03 at 9:50 AM, she stated that employee 1 had not worked with resident 18 since the alleged staff to resident abuse had occurred. She stated that due to an injury, employee 1 has been out of the facility since the end of October 2003. A review of the September 2003 and October 2003 ADL sheets was completed on 11/10/03. The ADL	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 226	Continued From page 36 sheets documented evidence that employee 1 had not given cares to resident 18 following the date of the allegation in September 2003. However, the October 2003 ADL sheet did document that employee 1 had given care to resident 18 on 8 different occasions, after employee 1 was prohibited from caring for resident 18. Employee 1 initialed resident 18's, October 2003, ADL sheets on 10/04, 10/06, 10/07, 10/09, 10/14, 10/16, 10/20, and 10/21. 3. INJURIES OF UNKNOWN ORIGIN: a. Resident 4 was admitted to the facility on 06/28/02 with diagnoses of hypercholesterolemia, edema, Alzheimer, coronary artery disease, hyperlipidemia, cataracts, congestive heart failure, osteoporosis, malnutrition, angina, incontinence and leg deep vein thrombosis. On 09/22/03 at 7:00 PM, a nurse's note in resident 4's medical record documented the following entry: "CNA noted large fleshy bruise under [left] arm- asked CNA if bruise was there last evening and she stated no." A review of the facility's Incident Reports was completed during the survey and there were no incident reports to document how resident 4 may have received the bruise under her left arm, which was first noted on 09/22/03. On 10/24/03 at 9:00 PM, a nurse's note documented the following, "[large] bruise noted on [left] breast from underneath extending up to nipple- States it doesn't hurt at all" A review of the facility's Incident Reports was completed during the survey and there were no incident reports to document how resident 4 may have received the bruise on her left breast extending up to	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 226	Continued From page 37 her nipple, which was first noted on 10/24/03. On 11/03/03 at 2:30 PM, the facility DON was interviewed, she stated that she did not know about the bruise on 09/22/03, but knew about the bruise on 10/24/03. She stated that she thought the bruising on 10/24/03, had occurred from lifting resident 4 up in the wheelchair. When asked for a written investigation of the bruise from 10/24/03, she stated that she did not write it. She further stated that all injuries/bruising of unknown origin should be written up on an incident report when they are found. On 11/05/03 at 9:10 AM, the facility DON stated that she could not find any incident reports or investigations concerning resident 4's bruising on 09/22/03 and 10/24/03. On 11/06/03 at 8:20 AM, the facility Administrator was interviewed and he provided the surveyor with a letter, signed by the DON, concerning resident 4's bruise noted on 10/24/03. The letter did not indicate a date as to when it was written. The letter documented that "...the bruising was probably due to the manner in which she was transferred...." The DON's investigation did not document specifically which aides, which times, nor which dates she observed. Additionally, there was no information concerning how she came to the conclusion that the bruising was caused by transferring, nor did it document which aides she specifically counseled concerning the bruising and transferring. The facility administration was not able to provide any documented evidence that the bruising found on resident 4 on 09/22/03 and 10/24/03, had been investigated or reported to State Survey Agency. b. Resident 5 was admitted to the facility on 07/09/03	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 226	Continued From page 38 with diagnoses of organic brain syndrome with psychotic features, hypercholesterolemia, hypothyroidism, digestive system disorder, hypertension, aphasia and diabetes mellitus. On 10/14/03 at 8:30 PM, a facility nurse documented the following in resident 5's medical record, "...She does have two large bruises on [left] hand [and] wrist..." On 11/10/03 at 8:20 AM, the facility DON stated that resident 5 was another resident that she had a concern with transferring techniques used by staff and felt that the bruising had occurred as a result of a transfer. When asked how long she has had concerns with how staff were transferring residents, the DON stated "about 1 month." She further stated that an in-service concerning transferring was to be held on 11/07/03. She stated the in-service was postponed until 11/10/03, due to that day being a pay day. A review of the facility's Incident Reports was completed during the survey and there were no incident reports to document how resident 5 may have received the bruise on her hand and wrist, which was first noted on 10/14/03. The facility administration was not able to provide any documented evidence that the bruising found on resident 5's hand and wrist on 10/14/03, had been investigated or reported to State Survey Agency. c. Resident 13 was admitted to the facility on 07/25/96 with diagnoses of Alzheimer, hypertension, congestive heart failure and failure to thrive. On 09/19/03, a facility nurse documented the following, "skin tear to [right lower extremity no signs and symptoms] pain...." There was no information	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 226	Continued From page 39 concerning how resident 13's skin tear might have occurred. A review of the facility's Incident Reports was completed during the survey and there were no incident reports to document how resident 13 may have received the skin tear to her lower extremity, which was first noted on 09/19/03. On 11/05/03 at 4:00 PM, during an interview with the facility DON she stated that she was not aware of resident 13's skin tear. She stated that she believed it had not been reported to her. Additionally, she stated that all skin tears found by facility staff should have an incident report and an investigation discussing how the skin tear could have occurred. The facility administration was not able to provide any documented evidence that the skin tear found on resident 13's lower extremity on 09/19/03, had been investigated or reported to State Survey Agency. d. Resident 17 was admitted to the facility on 08/14/03 with diagnoses of hypothyroidism, chronic dizziness, deep vein thrombosis, thrombocytopenia and Alzheimer with depressive features. On 08/18/03 at 10:00 AM, a nurse's note in resident 17's medical record documented the following entry: "When getting her up this AM CNA noticed large bruise on top of [right] thigh about 3 in (inches) wide and all around leg. Fresh bruise- she did not know how she got it...". A review of the facility Incident Reports was completed during the survey and there was an incident report dated 08/18/03 concerning resident 17, which documented the following: "...When getting her up [and] dressed CNA's noticed [large] 3 in wide bruise	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 226	Continued From page 40 around upper thigh...Doesn't know how she got it...". On 11/06/03 at 10:25 AM, the DON was interviewed and she stated that she did not complete an investigation concerning the bruise found on resident 17's upper thigh, first noted on 08/18/03. She further stated that the resident had a diagnosis of thrombocytopenia, which may contribute to easy bruising. On 11/10/03 at 7:40 AM, the facility nurse who wrote the nursing note and incident report on 08/18/03 was interviewed. She stated that if an injury "looks really bad" she will write an incident report up and "give it to the DON." She stated further if it's a "smaller injury, she might not write up an incident report, but she would document it in the nursing notes." The facility nurse stated that the bruise on 08/18/03 went down resident 17's leg and at the time she noted it, it had crossed her mind that something more happened, then the resident just bumping it. The facility nurse stated "it looked like someone popped her on the leg." When asked if the resident could have forgotten if someone had popped her on the leg, the facility nurse replied that she could have. The facility administration was not able to provide any documented evidence that the bruising on resident 17's leg, first noted on 08/18/03, had been investigated or reported to State Survey Agency. e. Resident CL2 was admitted to the facility on 10/04/03 with diagnoses of hypothyroidism, organic mental disorder, glaucoma, hypertension, atrial fibrillation and asthma. On 10/07/03 at 8:00 PM, a facility nurse documented the following, "...She has a large bruise (fresh) on [left] bicep. We noticed this at [4:30 PM]..."	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 226	Continued From page 41 A review of the facility's Incident Reports was completed during the survey and revealed an incident report dated 10/08/03. The incident report documented a description of the incident that was the same as what was documented in the nurse's note, with the additional remarks of "...unsure of how this happened..." On 11/06/03 at 9:50 AM, during an interview with the facility DON, she stated that she could not remember this incident, nor if she received a report on it or not. The facility administration was not able to provide any documented evidence that the bruise found on resident CL2's bicep on 10/7/03 had been investigated or reported to State Survey Agency. 4. RESIDENT TO RESIDENT ABUSE: Resident 5 was admitted to the facility on 07/09/03 with diagnoses if organic brain syndrome with psychotic features, hypercholesterolemia, hypothyroidism, digestive system disorder, hypertension, aphasia and diabetes mellitus. On 09/27/03 at 10:30 AM, a facility nurse documented the following, "Resident was in day room when an other (sic) resident told her to shut up as she was propelling herself by her in her [wheelchair]. They both gave each other 2 punches [with] their hands/ to their hands when CNA saw it and intervened..." During an interview with the Administrator on 11/06/03, at approximately 10:30 AM, he stated that a "Resident to Resident Contact" form should be completed and faxed to the appropriate agencies with the fax confirmation attached to the forms.	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 226	Continued From page 42 On 11/06/03, the surveyor reviewed the "Resident to Resident Contact" forms completed by facility staff since July 2003. Facility staff had completed a "Resident to Resident Contact" form for the incident involving resident 5 on 09/27/03. There was no documentation, fax confirmation or otherwise, which indicated APS was notified of this incident. 5. MISAPPROPRIATION OF RESIDENT PROPERTY: Resident 21 was admitted to the facility on 08/06/03 with diagnoses of diabetes mellitus, hypertension, hyperlipidemia, renal insufficiency and chronic obstructive pulmonary disease. A surveyor interviewed resident 21 on 11/06/03 at 7:10 AM. Resident 21 relayed allegations of misappropriation of his property, by a facility staff member. Resident 21 provided the following information regarding employee 2, a facility restorative nurse aide: September 2003 a. Employee 2 had taken $30 from him when the he took money out of an ATM; b. The resident gave employee 2 $20 to buy him some fruit, but the resident never received the fruit and employee 2 did not return the money; and, c. Employee 2 had borrowed $20 from resident 21 and had still not paid the $20 back. October 2003 a. The resident gave employee 2, $20 to buy the resident underwear and he never received the underwear and employee 2 did not return the money;	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 226	Continued From page 43 and, b. The resident gave employee 2, $50 to buy him a jacket. The resident stated he had received the jacket, but when he asked employee 2 for a receipt and any change from the purchase, employee 2 stated she did not have them. Further, resident 21 stated that whenever he asked employee 2 about the incident, employee 2's story always changed about the cost of the jacket. A review of resident 21's medical record revealed a social worker note dated 09/02/03, which documented the following, "...[resident 21] stated he withdrew some money from ATM machine at 7-11 and [employee 2] took $30.00 (thirty dollars) from him and refused to give it back." On 11/06/03 at 8:20 AM, the Administrator was interviewed concerning the 09/02/03 alleged misappropriation of resident 21's property. When asked for his investigation report, he stated that he had written it in his "personal notebook" and provided the state surveyor with a copy of his investigation. The investigation dated 09/02/03, documented that the Administrator had talked with the facility's social worker and with employee 2. There was no documentation that the investigation had taken any further steps, including interviewing resident 21, to determine if the alleged misappropriation of the resident's property had occurred. The Administrator stated that he did not feel resident 21 was "accurate with his information". On 11/06/03 at 9:50 AM, when the facility social worker was interviewed concerning these allegations, he stated that he was aware that employee 2 was buying personal items for resident 21. He stated he had not been made aware that resident 21 had not	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 226	Continued From page 44 received the items. He stated he documented a progress note regarding resident 21's allegation that employee 2 had taken $30.00 from him at an ATM. The social worker stated he reported resident 21's allegation to the Administrator. On 11/06/03 at 10:00 AM, during an interview with the facility DON, she stated that she was aware of each of the allegations reported by resident 21, involving employee 2. She stated she had reported resident 21's allegations of misappropriation of property to the social worker and the Administrator. When asked if she had documented any of resident 21's allegations, she replied that she had not. The facility administration was not able to provide documented evidence that each of resident 21's allegations of misappropriation of property was investigated and reported to the appropriate advocacy agencies, as stated in their policy and procedures.	F 226		
F 241 SS=E	483.15(a) 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 observations and interviews, it was determined the facility did not ensure care in a manner and a environment that maintained or enhanced resident's dignity and respect in full recognition of his or her individuality. Residents who arrived in dining areas either independently or with staff assistance were not served their meals in a timely fashion. These residents were left to wait up to 60 minutes for their meals as residents around them were eating. A	F241	(Corrective Action for Resident(s) Affected There are no individual residents mentioned for this deficiency. Identification of Residents with the Potential to be Affected All residents have the potential to be affected. Measures to prevent Reoccurrence All staff have been in-serviced as to the proper procedure for timeliness of meals, passing of meals, the usage of gloves when assisting residents on 11-27-03. and utensils Monitoring, Corrective Action and Responsibility Charge nurses are responsible for monitoring the timeliness of a resident placement in the dining room at the tables. The dietary manager and/or another department head will be responsible for monitoring the meal pass, timeliness, passing of trays to one table at a time and proper use of utinsels to cut food.	12-12-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 241	Continued From page 45 resident's meal was handled with the bare hands of a staff member. Findings include: Observations of meal service were made in the, main dining room on 11/04/03 and 11/05/03. The observations were made at the breakfast meals. Residents were observed to either enter the dining room independently or with staff assistance. As residents arrived in the dining room, staff assisted residents to dining tables. Staff were observed to serve the meal to resident tables in random order, without regard to the amount of time residents had been waiting. Residents who had been waiting for prolonged periods of time, and were seated next to residents who were served in a prompt manner. Observations of residents not served in a timely manner were as follows: On 11/05/03 at 6:30 AM, 13 residents were observed seated in the dining room at various tables. Staff members assisted nine of those residents into the dining room. There was no offers of juice or snacks to the residents. At 7 AM one more resident was seated. At 7:20 AM 6 more residents were seated. At 7:25 AM the dietary manager and another staff member walked around the room waking up residents who had fallen asleep in their seats. At 7:35 AM, the first meal was served. There were two aides and the dietary manager serving trays. Thirteen residents had waited in excess of 60 minutes for their meal. On 11/06/03 at 6:45 AM, 6 residents were observed seated in the dining room at various tables. At 7:15 AM 8 more residents had been seated.	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 241	Continued From page 46 At 7:40 AM, the first meal was served. Two aides and the dietary manager served the breakfast trays. Six residents had waited a minimum of 55 minutes for their meal and 8 residents waited a minimum of 25 minutes for their meal. One newly admitted resident was observed to enter the dining room at approximately 7:15 AM he was directed to sit at a table that 4 other residents were eventually seated at. All the other residents were served their meal first. At 7:50 AM the new resident was observed not to have a meal tray. All the other residents had been served their meal and were already eating when this resident was heard to ask for a tray. This resident waited a minimum of 35 minutes for his meal. On 11/06/03, at approximately 7:55 AM, the dietary manger was observed to assist residents and set-up of their trays. She was observed to tear up a resident's pancake using her bare hands. The surveyor asked when she last washed her hands and she stated that she had not touched any resident before she used her hands.	F 241		
F 253 SS=E	483.15(h)(2) ENVIRONMENT The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations on 11/03/03, 11/05/03, and 11/06/03, it was determined that the facility did not provide housekeeping and maintenance services to maintain a sanitary, orderly and comfortable interior in 6 of 13 resident rooms, resident bathrooms, the main dining room and the shower room.	F 253 F253	(Corrective Action for Resident(s) Affected) There are no individual residents mentioned for this deficiency. The following deficiencies will be corrected by Brett Crockett and Maintenance Director David Ramerez between 12-1-03 and 12-12-03. Room 3 - Sink - fixed leak and cleaned Toilet - new seat installed Odor - cleaned Room 4 - Floor -cleaned Screens - straightened	12-12-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 253	Continued From page 47 Findings include: Observations of resident rooms and the bathrooms revealed the following: Room 3 a. Rusty sink b. Rusty toilet c. Strong urine odor in the bathroom Room 4 a. Black marks on the flooring in the bedroom b. Bent window screen Room 7 a. Leaky faucet in the bathroom sink b. Rusty sink c. Rusty toilet Room 9 a. Stained flooring around toilet b. Rusty sink c. Black marks on bedroom flooring Room 12 a. Stained flooring around toilet Room 13 a. Stained flooring around toilet b. Leaky sink c. Rusty toilet Observation of the bath/shower room revealed the following: a. Duct tape covering a hole in the wall by the toilet b. Rusty toilet c. Dirty and stained tile around the toilet d. No working light in the #16 shower stall	F 253	Room 7 – Leaky Faucet –repaired leak Sink – repaired and cleaned Toilet– cleaned Room 9 – Flooring around sink – cleaned and repaired Sink –repaired Marks on bedroom flooring– cleaned Room 12 – Flooring around toilet –replaced flooring Room 13 – Flooring around toilet –repaired Sink –repaired Toilet –cleaned Bath/Shower Room – Holes in the wall – repaired Toilet – cleaned Tiles –replaced Lighting –repaired Dining/Recreation Area – Pink Spots –replaced Scuffed Flooring –replaced Cracked tile –replaced Identification of Residents with the Potential to be Affected All residents have the potential to be affected. Measures to Prevent Reoccurrence Maintenance and Housekeeping will be involved in daily stand up meeting. If a concern is noticed, this will be brought up at Stand up meeting and a plan of correction to provide the services necessary to maintain a sanitary, orderly, and comfortable interior will be developed. • Maintenance log in place Monitoring Corrective Action and Responsibility The administrator, or other department head, will tour entire facility at least 5 days a week, inspecting resident rooms, resident bathrooms, the main dining room, and the shower room to ensure that the facility is clean and in proper repair for the safety and comfort of our residents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 253	Continued From page 48 Observations of the dining/recreation area revealed the following: a. Debris and pink sticky spots on the floor b. Black scuffed flooring c. Cracked tile under the window, the whole length of the room	F 253	F314 Corrective Action for Resident(s) Affected Resident 5's Ted hose are applied and removed correctly and skin is checked two times weekly. The wound is healed at this time. Identification of Residents with the Potential to be Affected All residents have the potential to be affected Measures to Prevent Reoccurrence 1. In-serviced on pressure ulcer prevention on 11/25/2003 2. Shower checks done daily beginning 12/02/2003 3. Turn clocks on beds and chairs beginning 11-30-03 4. Braden scales for all residents 12-01-03 5. High risk residents have pressure relieving devices on chairs and beds beginning 12-01-03 6. In-service on processing physicians orders on 12-10-03 7. A copy of "Care and Prevention of Pressure Ulcers" to all staff nurses on 11-25-03 8. In-service on application and removal of Ted hose on 12/01/2003 9. Weekly skin and weight meeting initiated 11-25-03. Monitoring, Corrective Action and Responsibility These items will be monitored through the use of monitoring tools and reported weekly to the sub-committee of the QA committee. DON Does shower ✓ audit DON Does Turn Clock audit. DON Does Skin weight meeting	12-03-03
F 314 SS=G	483.25(c) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the medical record, the facility failed to ensure that 1 of 14 sampled resident (resident 5) did not develop pressure ulcer. Specifically, one resident developed a stage II pressure ulcer in September 2003, the physician was not notified and no orders were obtained to treat the pressure ulcer until October 2003. The facility did not care plan for actual skin breakdown/pressure ulcer. The facility did not follow its own policy and procedures concerning pressure ulcers. Findings Include: 1. Resident 5 was admitted to the facility on 07/09/03 with diagnosis of organic brain syndrome with depressive and psychotic features, hypercholesterolemia, hypothyroidism, digestive	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 314	Continued From page 49 system disorder, eosinophilia, hypertension, aphasia and diabetes mellitus. An MDS, a mandatory comprehensive assessment for resident 5 was completed by the facility staff, dated 07/23/03. The MDS documented that the cognitive skills for resident 5 were severely impaired and that she was totally dependent when moving from a lying position, turning side to side, postioning herself while in bed and moving to and from a bed or wheelchair. On 11/03/03, at approximately 2:00 PM, the DON stated during tour that resident 5 had a stage II pressure ulcer on her right popliteal. The "Pressure Ulcer Risk Assessment" completed by a facility LPN (licensed practical nurse) on 07/09/03, documented a score of 10, "High Risk". On 09/29/03 at 8:00 PM, a facility nurse documented, "CNA noted bleeding under [right] knee when taking TED hose off- TED hose appear too tight about knee- Open laceration cleaned [and] has 2 x 2 on it" On 11/05/03, the medical record of resident 5 was reviewed and there was no documentation to evidence that the physician was notified of the laceration identified on 09/29/03. There was no evidence that physician orders were obtained to provide treatment for this laceration. The facility's policy documented, "...The nurse is responsible for carrying out the treatment as ordered by the attending physician and for implementing measures to prevent pressure ulcers..." The care plan for resident 5, dated 09/10/03, included the problem "Potential for alteration in skin integrity..." The goal the facility documented was that the resident will be "...free from any skin breakdown daily..." There was no evidence that the care plan was	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 314	Continued From page 50 updated on 09/29/03, to reflect the actual skin breakdown on resident 5's right popliteal. On 10/9/03, a facility nurse documented on a "Monthly Summary", "...Skin intact except for small area behind [right] knee..." On 10/25/03 at 12:00 PM, a physician's telephone order was obtained to provide treatment to resident 5 right popliteal. This order was obtained 26 days after the wound was first identified on 09/29/03. On 10/25/03 at 3:50 PM, the facility DON documented, "...drsg (dressing) to popliteal space today. Wound is approx (approximately) 2 inches in length, [and] varies from 1/2 cm to 1.5 cm wide..." A review of the September 2003 and October 2003 treatment sheets did not provide any documented evidence that the facility was providing treatment to the right popliteal until 10/25/03. On 11/05/03 at 2:00 PM, the DON stated that resident 5 had a stage II pressure ulcer on her right popliteal that was caused by her ted hose. The DON further stated that she was not made aware of the pressure ulcer until 10/25/03, when she obtained a physician's order for treatment and wrote a nursing progress note. This was 26 days after the wound was first noted on 09/29/03. On 11/06/03 at 6:00 AM, a registered nurse surveyor observed a skin check on resident 5 performed by a facility nurse. The nurse surveyor observed a pressure ulcer located on the right popliteal. The facility nurse stated that it was a stage II pressure ulcer, 1.5 centimeters by 1.2 millimeters. He further stated that the pressure ulcer was a lot bigger a week ago and has really improved in the past week.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 314	Continued From page 51 There was no documentation in the nurse's notes or treatment sheets to evidence that facility staff were following the "Care and Prevention of Pressure Ulcer" as directed by the facility's policy, such as skin checks, documentation of the pressure ulcer, identification of the underlying cause and repositioning.	F 314	Corrective Action for Residents(s) Affected Resident 6 has been assessed for a bowel and bladder continence program. The results indicate that this resident is unable to participate in a retraining program due to dementia. This resident's program consists of routine toileting with physical assistance to transfer. Her briefs are checked q 2 h and the C.N.A.'s are dating and timing the brief with a marker to ensure that this resident's briefs are changed in timely fashion. This resident has completed a course of antibiotics for a UTI. The resident is afebrile since the antibiotic course and is unable to voice other subjective symptoms of UTI.	12-12-03
F 316 SS=D	483.25(d)(2) QUALITY OF CARE A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and resident medical record review the facility failed to ensure that 1 of 14 sampled residents (resident 6) received appropriate treatment and services to prevent UTI's (urinary tract infections). Resident 6 was not toileted every two hours as assessed and care planned and acquired a UTI. Findings include: 1. Resident 6 was admitted to the facility on 05/24/03 with diagnosis of senile dementia with depressive and psychotic features, congestive heart failure, history of myocardial infarction, constipation, hypothyroidism, angina, chronic UTI's, neuropathy and vitamin B deficiency. An MDS, a mandatory quarterly assessment for resident 6 was completed by facility staff, dated 09/06/03. The MDS documented that resident 6's cognitive skills were severely impaired and that she required total dependence with using the toilet, cleaning herself, changing her pads and adjusting her	F 316	Identification of Residents with the Potential to be Affected All residents have the potential to be affected by this deficient practice Measures to Prevent Reoccurrence ◦ A Bowel and Bladder assessment has been done on each resident. ◦ Based on the assessment, each resident has a specialized program of either bowel and or bladder retraining, scheduled toileting, or brief checking and changing incorporated into their Plan of Care ◦ Each CNA has been issued a sharpie for marking the briefs as they are applied with the date and time. CNA's are marking the brief as "dry" and a time if the brief does not require changing. ◦ Each CNA has been inserviced on the correct way to perform pericare on 11-25 03 ◦ An "ADL/Toileting plan/Brief use" information sheet has been hung in the closet of each resident to ensure that all caregiving staff can easily access this information. The sheet includes specific information about the residents needs for bowel and bladder management. ◦ Charge nurses who take physician orders that would indicate a change in bowel and or bladder management needs will update the form. ◦ One CNA has been assigned to review with the DON these forms and will keep them current Monitoring Corrective Action and Responsibility ◦ Audits are conducted weekly by the DON or assignee and will be reported to the subcommittee weekly for additional actions ◦ The QA committee will determine when the audits can be completed on a less frequent basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 316	Continued From page 52 clothing. It also documented that resident 6 had not had a UTI in the past 30 days. A care plan dated 06/10/03, identified the following problem for resident 6, "Altered ability to use toilet for bowel movements [and] voiding..." The goal stated, "resident will remain clean [and] dry..." The care plan interventions included, "1) Staff will assist resident [with] toileting [every two hours and as needed]. 2) Staff will apply new brief [and] clean peri area as needed [with every] voiding [and] BM (bowel movement)." On 10/30/03, a physician's order was obtained to get a urine analysis and culture and sensitivity for resident 6. On 10/31/03, the lab results documented that resident 6 had a UTI. The organism identified was Proteus Mirabilis. The facility started resident 6 on antibiotics. On 11/05/03 at 6:25 AM, resident 6 was observed to be up in her wheelchair she continued to be observed up in her wheelchair until 10:25 AM. On 11/05/03 at 10:25 AM, the nurse surveyor asked to do a skin check on resident 6 with a facility nurse. When the facility nurse and facility aide removed the brief it was saturated in urine and stool. When the facility nurse was asked when resident 6's brief was last changed she stated when she got up in the morning. When asked if that was before 6:30 AM, the facility nurse stated it was. On 11/06/03 at 6:31 AM, a facility aide was observed to be providing peri care to resident 6. The aide did not wear any gloves, she was observed to remove a brief saturated with urine. The aide was then observed to take one wet wipe and rub it in a circular motion all over the front of resident 6's peri area, the aide then	F 316		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 316	Continued From page 53 rolled resident 6 onto her side and took a wipe and rubbed it in a circular motion all over resident 6's backside. After changing the urine saturated brief the aide was not observed to wash her hands and she continued to get resident 6 dressed for the day. On 11/6/03 at 6:45 AM, the aide who had provided peri care to resident 6 was interviewed. She stated that peri care should go from front to back she further stated that she should have worn gloves. Perineal care reference guide: Basic Nursing Theory and Practice, Second Edition 1991 Mosby, pages 683 and 684: "...Don disposable gloves...Wipe in direction from perineum to rectum. Repeat on opposite side using separate section of washcloth..."	F 316	F332 Corrective Action for Resident(s) Affected Resident 18 has no noted side effects from not receiving celebrex and macrobid on 11/04 Resident 25 is not identified on the confidential resident list Resident 17 has no noted side effects from not receiving lansoprazole on 11/04 Identification of Residents with the Potential to be Affected All residents have the potential to be affected. Measures to Prevent Reoccurrence: ○ Each licensed nurse has been inserviced on correct procedures for administering medications at this facility ○ Each licensed nurse has been directly observed by the DON administering medications. ○ Licensed nurses who perform medication administration correctly and without errors will be evaluated quarterly. ○ Licensed nurses who perform medication adminsitration incorrectly will be evaluated and retrained daily until they perform correctly Monitoring, Corrective Action and Responsibility Reports of the direct observations will be evaluated each Thursday by a subcommittee of the QA committee. The QA committee will determine the frequency of the direct observations after the first month.	12-12-03
F 332 SS=E	483.25(m)(1) QUALITY OF CARE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation and medical record review, the facility failed to ensure that it was free of a medication error rate of less than 5%. Medications that were administered to residents during the survey observations were assessed further through medical record review. It was determined that the noted medication errors resulted in an error rate of 7.27%. (Residents 17, 18 and 25) Findings Include: On 11/04/03 from 6:55 AM until 7:50 AM the medication administrations were observed as the LPN's prepared and delivered the morning medications. As each medication was put into each	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 332	Continued From page 54 individual medication cup the information contained on the medication container label was noted. Then, as well as after, the label was also checked against what the MAR (medication administration record) had documented. Later, after the medication administration was completed, the information obtained during the observation was compared with the physician orders in each resident's medical record. 1. On 11/04/03, at approximately 6:55 AM, resident 18's medications were prepared and delivered by the LPN passing medications. Six different medications were observed to be received by resident 18. Later, upon review of the physician orders, it was noted that resident 18 should have received Celebrex 200 mg (milligrams) and Macrobid 100 mg. The LPN was not observed to administer the Celebrex or the Macrobid. 2. On 11/04/03, at approximately 7:00 AM, resident 25's medications were prepared and delivered by the LPN passing medications. Seven medications were observed to be received by resident 25. Later, upon review of the physician orders, it was noted that resident 25 should have received Lansoprazole 30 mg. The LPN was not observed to administer the Lansoprazole. 3. On 11/04/03, at approximately 7:40 AM, resident 17's medications were prepared and delivered by the LPN passing medications. Six different medications were observed to be received by resident 17. Resident 17 was observed to receive a 400 IU (international unit) Vitamin E capsule.	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 332	Continued From page 55 Later, upon review of the physician orders, it was noted that resident 17 should have received a 100 IU Vitamin E capsule.	F 332		
F 333 SS=D	483.25(m)(2) QUALITY OF CARE The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation of the medication pass, medical record review and interview, the facility failed to ensure that residents were free of significant medication errors. Specifically, resident 18 did not receive her scheduled antibiotic. Findings include: 1. During an observation of the medication administration on 11/04/03, at approximately 6:55 AM, resident 18 was observed to receive her scheduled AM medications. Review of the physician orders for resident 18 was completed on 11/04/03 at 7:35 AM. A physician order dated 10/31/03, documented Macrobid 100 mg (milligrams) twice a day for 7 days, diagnosis UTI (urinary tract infection). Resident 18 was not observed to receive the Macrobid 100 mg from the nurse passing medications on 11/04/03 at approximately 6:55 AM. The medication administration record, for resident 18 dated 11/04/03, reflected the physician order dated 10/31/03 for the scheduled Macrobid 100 mg.	F 333	F333 Corrective Action for Resident(s) Affected Resident 18 has had no noted side effects from receiving the dose of macrobid at the time the surveyor noted the error Identification of Residents with the Potential to be Affected All residents have the potential to be affected. Measures to Prevent Reoccurrence o Each licensed nurse has been inserviced on correct procedures for administering medications at this facility o Antibiotics are being counted with narcotics o Each licensed nurse has been directly observed by the DON administering medications. o Licensed nurses who perform medication administration correctly and without errors will be evaluated quarterly. o Licensed nurses who perform medication adminsitration incorrectly will be evaluated and retrained daily until they perform correctly Monitoring Corrective Action and Responsibility Reports of the direct observations will be evaluated each Thursday by a subcommittee of the QA committee. The QA committee will determine the frequency of the direct observations after the first month.	12-12-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 333	Continued From page 56 On 11/04/03 at 7:35 AM, the nurse administering medications gave the Macrobid 100 mg to resident 18, after the nurse surveyor asked her why it was not administered with the other medications.	(GSA) F 333	Corrective Action for Residents(s) Affected No residents were listed as affected by the deficient practice Identification of Residents with the Potential to be Affected All residents have the potential to be affected Measures to Prevent Reoccurrence The DON and administrator will assure that an RN is scheduled every day at least 8 hours per day. The DON will provide this service on 5 of the 7 days per week. Agency nursing will be used when other nurses are not available. Monitoring Corrective Action and Responsibility The DON and Administrator will monitor daily with a plan in place for each day and for the weekend days on Friday when there is no clear person assisgned as the RN for the day. An ad has been placed in the paper listing an opening for an RN 2 days per week.	12-12-03
F 354 SS=E	483.30(b)(1)-(3) NURSING SERVICES Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interviews with the facility DON and review of the facility nursing schedule, the facility failed to have a registered nurse (RN) for at least 8 consecutive hours a day, 7 days a week, since September 28, 2003. Findings include: Review of the facility September 2003, October 2003 and November 2003 schedule on 11/10/03, revealed that the facility did not have 8 hours of RN coverage on 09/05/03, 10/05/03, 10/11/03, 10/12/03, 10/18/03, 10/19/03, 10/26/03, 11/02/03, 11/08/03 and 11/09/03. On 11/10/03 at 9:35 AM, the facility DON stated that she works on Monday thru Friday and at times on Saturday and Sunday, if needed. She further stated that the RN who worked on the weekends has not	F 354		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 354	Continued From page 57 worked since 09/28/03.	F 354	Corrective Action for Residents(s) Affected Please see tags that specify the residents that have been affected. Identification of Residents with the Potential to be Affected All residents have the potential to be affected	
F 490 SS=K	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on a re-certification survey with a subsequent extended survey, conducted 11/03/03 through 11/10/03, and resultant finding of Immediate Jeopardy and Sub-Standard Quality of Care, it was determined that the facility was not being administered in a manner that enabled it to use its resources either efficiently or effectively to ensure that residents were provided the opportunity to attain or maintain their highest practicable physical, mental, and psychosocial well-being for each resident in the areas of neglect, resident to resident abuse, staff to resident abuse, misappropriation of resident property and resident injuries of unknown etiology. The facility was found to be providing Sub-Standard Quality of Care (a pattern of actual harm) in these areas. The facility was cited in a total of 15 areas, not including this deficiency. Findings include: On 11/03/03, a re-certification survey was initiated. On 11/10/03, facility administration was notified of the elements of Immediate Jeopardy and Sub-Standard Quality of Care. The determination of Immediate Jeopardy and Sub-Standard Quality of Care was based on the findings of significant non-compliance in the area of Resident Behavior and Facility Practices [42	F 490	Measures to Prevent Reoccurrence The facility has taken immediate action to correct the problems that have occurred as a result of poor administration. The facility has terminated the previous administrator as of 11/13/2003 and hired an administrative consultant and an acting administrator until an appropriate candidate can be located. Policies and Procedures have been implemented to prohibit neglect, misappropriation of resident property and abuse, and to investigate injuries of unknown origin Facility has thoroughly investigated and reported to appropriate agencies all instances of abuse, neglect, misappropriation of resident property and injuries of unknown origin. Written policies and procedures concerning neglect, staff to resident abuse, resident to resident abuse, the investigation of injuries of unknown origin, misappropriation of resident property and how to prevent abuse from occurring have been presented to all staff in Spanish and English and are being implemented on an ongoing basis. Done 11-12 & 13. Monitoring Corrective Action and Responsibility New administrative staff will follow all policies and procedures as outlined in this plan of correction. Current procedure for preventing, reporting and investigating abuse will be followed appropriately	12-12-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 490	Continued From page 58 Code of Federal Regulations (CFR) 483.13 (b) (c) Tag F-224, Tag F-225 and Tag F-226]. 1. Facility administration failed to ensure that policies and procedures were implemented that prohibited neglect, misappropriation of resident property and abuse and failed to investigate injuries of unknown origin. (Scope and severity "K", refer to Tag F-224) 3. Facility administration failed to thoroughly investigate, and report to appropriate agencies the abuse, neglect, misappropriation of resident property and injuries of unknown origin. (Scope and severity "K", refer to Tag F-225) 4. Facility administration failed to implement written policies and procedures concerning neglect, staff to resident abuse, resident to resident abuse, the investigation of injuries of unknown origin, misappropriation of resident property and how to prevent the abuse from occurring. (Scope and severity "K", refer to Tag F-226) 5. In addition to the areas of Immediate Jeopardy and Sub-Standard Quality of Care stated above, the facility administration failed to effectively and efficiently use its resources to ensure that each resident attained or maintained their highest practicable, physical, mental and psychosocial well-being in the following areas of deficient practice cited during the annual and extended survey completed 11/10/03. a. Facility administration failed to ensure that the use of restraints were evaluated, ordered, care planned and used to treat a medical symptoms. (Scope and severity "E", refer to Tag F-221) b. Facility administration failed to ensure that each	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 490	Continued From page 59 resident was treated with dignity and respect. (Scope and severity "E", refer to Tag F-241) c. Facility administration failed to ensure that housekeeping and maintenance were provided to maintain a sanitary, orderly, and comfortable interior. (Scope and severity "E", refer to Tag F-253) d. Facility administration failed to ensure that pressure ulcers did not develop. (Scope and severity "G", refer to Tag F-314) e. Facility administration failed to ensure that incontinent care was provided to prevent urinary tract infections and restore as much normal bladder function as possible. (Scope and severity "D", refer to Tag F-316) f. Facility administration failed to ensure that the medication error rate was less than 5%. (Scope and severity "E", refer to Tag F-332) g. Facility administration failed to ensure that significant medication errors did not occur. (Scope and severity "D", refer to Tag F-333) h. Facility administration failed to ensure that they had services of a registered nurse for 8 consecutive hours a day, 7 days a week. (Scope and severity "E", refer to Tag F-354) i. Facility administration failed to ensure that the State Nurse Aide Registry was contacted prior to a nurse aide providing care to facility residents. (Scope and severity "D", refer to Tag F-496) j. Facility administration did not ensure that laboratory tests were completed as ordered by physicians.	F 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 490	Continued From page 60 (Scope and severity "E", refer to Tag F-502) k. Facility administration failed to ensure that the physician attended quality assurance meetings at least quarterly. (Scope and severity "K", refer to Tag F-520) l. Facility administration did not ensure that the quality assurance committee identified and implemented plans of action to correct quality issues. (Scope and severity "K", refer to Tag F-521)	F 490	1490 Corrective Action for Residents(s) Affected There has been no indication of any residents affected by this tag. Identification of Residents with the Potential to be Affected All residents have the potential to be affected Measures to Prevent Reoccurrence The Business Office Manager was instructed by the Administrator on 12/1/03 of the importance of receiving registry verification before allowing a newly hired nurses aide to provide care to the residents. Monitoring Corrective Action and Responsibility The administrator will review each new hire packet to ensure that the Business Office Manager has received registry verification that the individual has met competency evaluation requirements unless the individual is a full term employee in a training and competency evaluation program approved by the State or before allowing an individual to serve as a nurses aide. The facility will seek information from every State registry the facility believes will include information on the hiree.	12-12-03
F 496 SS=D	483.75(e)(5)-(7) ADMINISTRATION Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility personnel files, the facility failed to call the nurse aide registry	F 496		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 496	Continued From page 61 for 2 of 4 nurse aides hired in the past 6 months, there was no documented evidence that the facility had contacted the State Nurse Aide Registry and the nurse aides had been providing resident care since their hire dates. (Employee identifiers: E3 and E4.) Findings include: 1. E3 was hired as a nurse aide on 10/08/03. The personnel file of E3 was reviewed on 11/06/03. The personnel file did not contain any documentation to evidence that the facility had sought information from the State Nurse Aide Registry regarding E3 prior to allowing him to serve as a nurse aide and provide care to residents. 2. E4 was hired as a nurse aide on 10/25/03. The personnel file of E4 was reviewed on 11/06/03. The personnel file did not contain any documentation to evidence that the facility had sought information from the State Nurse Aide Registry regarding E4 prior to allowing her to serve as a nurse aide and provide care to residents. On 11/06/03 at 11:15 AM an interview was conducted with the facility's office manager. She stated that she thought she had called the registry but might not have documented that she had called. The office manager was not able to provide any documented evidence that she had contacted the State Nurse Aide Registry prior to E3 and E4 providing care to residents.	F496 F 496	Corrective Action for Residents(s) Affected o Resident # 4's K level is 3.9 on 1-13 which is WNL and the PT INR has fluctuated, but is being used to adjust coumadin doses. All Res 4 labs have been drawn per the orders o Res 6 UA on 11-20 was negative and PT INR is being used to adjust coumadin doses as well. Identification of Residents with the Potential to be Affected All residents have the potential to be affected Measures to Prevent Reoccurrence o A lab binder has been placed with a procedure for ordering and managing labs has been placed at the nurses station,. All nurses have been inserviced on the ordering of labs o The procedure is: o The nurse fills out a lab order form and places it in the "to be drawn" box. o The order is transcribed into the MAR o The nurse will initial on the MAR when the lab is drawn, o the nurse will initial on the MAR when the results are returned, what the results are and who was notified o The client copy of the lab draw will be placed in the front of the lab binder when the lab is obtained o Every am the DON will take the client copies and check them against the labs drawn to ensure that labs are drawn in a timely fashion o The physician will be notified of the results and a notation made regarding the date time and initial of the person notifying the md. Monitoring Corrective Action and Responsibility The DON will complete lab audit documents weekly to detect any breaks in the system The DON will report weekly to the QA subcommittee the results of the audits and complete any recommended actions. The QA committee will determine the frequency of the audits	12-12-03
F 502 SS=E	483.75(j) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 502	Continued From page 62 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure that timely laboratory services were provided as ordered by physicians for 2 of 14 sample residents (residents 4, and 6). The facility did not ensure that adequate monitoring of anticoagulation therapy was done as ordered for 2 sample residents (resident 4, and 6). In addition, the facility did not obtain other laboratory services to meet the needs of 2 sample residents (resident 4 and 6). Coumadin is an oral anticoagulant used to control and prevent blood clotting disorders. Prescribing the dose that both avoids bleeding complications and achieves therapeutic range of clotting times requires monitoring through laboratory tests. The protime (PT) is a laboratory test used to monitor blood clotting in a specific individual. (Reference Guide: Brunner and Sarddarth's textbook of Medical-Surgical Nursing 8th Edition 1996 Lippincott pages 802-803.) Findings include: 1. Resident 4 was originally admitted to the facility on 06/28/02 and re admitted 07/03/03 with diagnoses of hypercholesterolemia, edema, Alzheimer, coronary artery disease, hyperlipidemia, cataracts, congestive heart failure, osteoporosis, malnutrition, angina, incontinence and leg deep vein thrombosis. Resident 4's medical record was completely reviewed on 11/03/03. A physician's order dated 07/13/03, revealed resident 4 was to have her potassium checked every other day. Results of a potassium every other day could not be	F 502		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 502	Continued From page 63 located in the medical record. A clarification order for the potassium every other day could not be located in the medical record. A review of resident 4's medical record showed that the resident was re-admitted on coumadin. A physician's order dated 07/31/03, revealed resident 4 was to have a PT every two weeks. Laboratory results for a PT on 08/14/03, 08/28/03, 09/11/03 and 09/25/03 could not be found in resident 4's medical record. On 11/03/03 at 2:30 PM, the DON was asked to provide copies of the missing labs for resident 4. On 11/05/03 at 9:10 AM, the DON stated that she had got a clarification order for the potassium. She further stated that she was not able to find any of the missing labs. 2. Resident 6 was admitted to the facility on 05/24/03 with diagnoses of senile dementia with psychotic and depressive features, congestive heart failure, hypertension, history of myocardial infarction, constipation, hypothyroidism, angina, chronic urinary tract infection, neuropathy and vitamin B deficiency. Resident 6's medical record was completely reviewed on 11/05/03. Review of the medical record revealed that resident 6 was admitted on coumadin. A physician's order dated 06/25/03, revealed resident 6 was to have a PT every month. Laboratory results for a PT, in July 2003 could not be found in the medical record.	F 502		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 502	Continued From page 64 On 11/05/03 at 10:00 AM, the DON stated that the PT in July 2003 was not completed. A physician's order dated 08/20/03, revealed resident 6 was to have a urine analysis (UA). Laboratory results for the UA could not be found in the medical record. On 11/05/03 at 10:00 AM, the DON stated that the UA was not done. A physician's order dated 09/03/03, revealed resident 6 was to have a PT/INR in one week (09/10/03). Laboratory results for a PT/INR on 09/10/03 could not be found in resident 6's medical record. On 11/05/03 at 10:00 AM the DON stated that the PT/INR was done on 09/03/03 instead of 09/10/03.	F 502		
F 520 SS=K	483.75(o)(1) ADMINISTRATION A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. This REQUIREMENT is not met as evidenced by: Based on interview with the acting DON, the facility failed to maintain a quality assurance (QA) committee which consisted of all required members. Findings include: During interview with the acting DON on 11/10/03 at 9:10 AM, she stated that the meetings consisted of the	F 520	Corrective Action for Residents(s) Affected A new medical director was hired on 12/01/2003. He has agreed to attend regularly scheduled QA committee meetings, along with the DON, and at least three other members of the facility staff, on the first Tuesday of every month at 11:00 am. The first meeting was held 12/02/2003 please see QA notes for details. Identification of Residents with the Potential to be Affected All residents have the potential to be affected Measures to Prevent Reoccurrence QA meetings will be held monthly for the next 4 - 6 months and quarterly thereafter. Regular documentation will be maintained in a QA folder. Monitoring Corrective Action and Responsibility The QA meetings will be monitored by the facility administrator.	12-12-3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 520	Continued From page 65 administrator, director of nursing, social service worker, recreational worker, dietary manager and the office manager. When the DON was asked if the physician attended the meeting quarterly, the DON stated "the physician won't come to the QA meeting because they are not very good."	F 520		
F 521 SS=K	483.75(o)(2)&(3) ADMINISTRATION The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. This REQUIREMENT is not met as evidenced by: Based on a review of the facility quality assurance meeting minutes, facility monitoring system and interview with the facility director of nursing, the facility failed to ensure that the quality assurance committee effectively identified quality issues. Findings include: 1. During an interview with the facility director of nursing on 11/10/03 at 9:10 AM, she stated that they had a quality assurance meeting in June 2003 with the old administrator and one in August 2003 with the new administrator. She further stated that the meetings consisted of the administrator, director of nursing, social service worker, recreational worker, dietary manager and the office manager. When asked what	F 521	Corrective Action for Residents(s) Affected There has been no evidence that any residents were affected by this tag. All residents have the potential to be affected Measures to Prevent Reoccurrence A log of all QA meetings will be completed and maintained by the administrator. All issues identified in the meeting will be delegated and reviewed by the QA committee at the following meeting or earlier if necessary. Monitoring Corrective Action and Responsibility Monitoring will be conducted on an ongoing basis, and more frequently at first to assure compliance. The administrator will keep a log of all meetings.	12-12-3 Identification o

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A047	A. BUILDING _____ B. WING _____	11/10/03

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE RIDGE CARE CENTER	433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115

(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 521	Continued From page 66 the last meeting consisted of, she stated, it was only about diabetic issues. 2. A review of resident medical records and facility incident reports on 11/03/03 through 11/10/03 revealed several incidents documenting that resident had been injured. The facility could not provide documentation that the incidents had been thoroughly investigated to find a cause of the injury or to rule out abuse. 3. The facility's quality assurance committee did not identify, and subsequently did not establish corrective action plans to ensure that resident's were not neglected. (Refer to Tag F-224) 4. The facility's quality assurance committee did not identify, and subsequently did not establish corrective action plans to ensure that all alleged staff to resident abuse, resident to resident abuse, injuries of unknown origin and misappropriation of resident funds were thoroughly investigated and/or reported to the appropriate agencies. (Refer to F-225) 5. The facility's quality assurance committee did not identify, and subsequently did not establish corrective action plans to ensure that the facility implemented written policies regarding misappropriation of resident funds, staff to resident abuse, resident to resident abuse, the investigation of injures of unknown origin and how to prevent abuse from occurring. (Refer to F-226)	F 521		

How corrective action will be accomplished for those residents found to have been affected by the defician practice for the following tags and or residents

0221-Resident 2 was assessed by a phusical therapist for the need for a geri chair and the care plan was updated. There is a physician's order for the chair in Sept of 02 and it reads "Geri Chair for meals"

0225-The resident to resident incident occurred in September and to date there have been no reported adverse effects from the "2 punches" that were sustained by this resident from the unnamed resident.

0226-The resident to resident incident occurred in September and to date there have been no reported adverse effects from the "2 punches" that were sustained by this resident from the unnamed resident.

0332-Resident 25 has had no noted side effects from not receiving the dose of lansoprazole at the time the surveyor noted the error

What measures have been put in to place or systemic changes made to ensure that deficient practice will not recur for the following tags.

0224-Measures put in placed to ensure that the deficient practice will not recur

The facility has developed and operationalized policies and procedures for screening and training employees, protection of residents, and for the prevention, identification, investigation, and reporting ofabuse, neglect, mistreatment, and misappropriation of property. Please see the enclosed policy and procedures and document

All Staff have been inserviced and have demonstrated competence through post test exam the use of the process for reporting abuse

The administrator has been inserviced on the use of the process to investigate and report allegations of abuse.

0225-

The facility has developed and operationalized policies and procedures for screening and training employees, protection of residents, and for the prevention, identification, investigation, and reporting ofabuse, neglect, mistreatment, and misappropriation of property. Please see the enclosed policy and procedures and documents

0226-

The facility has developed and operationalized policies and procedures for screening and training employees, protection of residents, and for the prevention, identification, investigation, and reporting ofabuse, neglect, mistreatment, and misappropriation of property. Please see the enclosed policy and procedures and documents

All Staff have been inserviced and have demonstrated competence through post test exam the use of the process for reporting abuse

The administrator has been inserviced on the use of the process to investigate and report allegations of abuse.

Indications of how the facility plans to monitor its performance to make sure that solutions are sustained for the following tags:

0221--The DON is completing a monitor to assure that all the requirements are met. The monitor will be completed on a monthly basis and will be reported to the monthly QA committee. Additionally, a weekly report of all new restraints is made to the daily QA subcommittee.

0224--Bi weekly skin checks are done to identify new "marks " on residents, daily shower forms indicating the condition of each resident's skin and daily reports from the CNA's regarding issues with the residents are reported to the daily QA subcommittee. Recommendations are made and open items or assignments are reviewed and reported the following day. The administrator is responsible to follow up on the open items.

0226-Bi weekly skin checks are done to identify new "marks " on residents, daily shower forms indicating the condition of each resident's skin and daily reports from the CNA's regarding issues with the residents are reported to the daily QA subcommittee. Recommendations are made and open items or assignments are reviewed and reported the following day. The administrator is responsible to follow up on the open items.

0241-A monitor tool will be utilized on a weekly basis and the meals will be selected randomly. A report to the subcommittee of the QA committee that is held daily will be made the day after the monitor is performed (on Monday if the monitor was performed on a weekend meal). The QA committee will assess and recommend changes to the practice or procedure. The administrator is responsible to follow up on open items in the QA committee.

0316-

- Audit tools for brief use and changing, observation of peri cares, performance of routine bowel and bladder assessments, accuracy and presence of the "ADL/Toileting/Brief Use" information sheet are conducted weekly by the DON or assignee and are reported to the QA subcommittee weekly for review and recommendations.
- The QA committtee will determine when the audits can be completed on a less frequent basis.
- The administrator is responsible to follow up on open items from the QA committee
- The administrator is responsible to follow up on open items from the QA committee

0490-New administrative staff will follow all policies and procedures as outlined in this plan of correction. Current procedure for preventing, reporting and investigating abuse will be followed appropriately

The administrators performance will be monitored monthly by the owner using a routine visit checklist, calls by the owner to the state survey agence regarding complaints during the previous 30 days, attendance by the owner one qa committee or subcommitte meeting in a 60 day period, and a monthly meeting with an approved nursing consultant which includes the administrator and the owner.

0520-The QA meetings will be monitored by the facility administrator and will be reviewed by the approved nurse consultant on a monthly basis. They will be monitored for performance and frequency but not for content.

0521-The QA meetings will be monitored by the facility administrator and will be reviewed by the approved nurse consultant on a monthly basis. They will be monitored for performance and frequency but not for content.

Indications of how often the monitoring will be done for the following tags

0221--The DON is completing a monitor to assure that all the requirements are met. The monitor will be completed on a monthly basis and will be reported to the monthly QA committee. Additionally, a weekly report of all new restraints is made to the daily QA subcommittee.

0225--Bi weekly skin checks are done to identify new "marks " on residents, daily shower forms indicating the condition of each resident's skin and daily reports from the CNA's regarding issues with the residents are reported to the daily QA subcommittee. Recommendations are made and open items or assignments are reviewed and reported the following day. The administrator is responsible to follow up on the open items.

0241-A monitor tool will be utilized on a weekly basis and the meals will be selected randomly. A report to the subcommittee of the QA committee that is held daily will be made the day after the monitor is performed (on Monday if the monitor was performed on a weekend meal). The QA committee will assess and recommend changes to the practice or procedure. The administrator is responsible to follow up on open items in the QA committee.

0490-New administrative staff will follow all policies and procedures as outlined in this plan of

correction. Current procedure for preventing, reporting and investigating abuse will be followed appropriately
The administrators performance will be monitored monthly by the owner using a routine visit checklist, calls by the owner to the state survey agence regarding complaints during the previous 30 days, attendance by the owner one qa committee or subcommitte meeting in a 60 day period, and a monthly meeting with an approved nursing consultant which includes the administrator and the owner.

0520-The QA meetings will be monitored by the facility administrator and will be reviewed by the approved nurse consultant on a monthly basis. They will be monitored for performance and frequency but not for content.

Indications of the person responsible for monitoring
224-DON with reports to the QA committee
225-DON with reports to the QA committee
226-DON with reports to the QA committee
521-Owner and approved nurse consultant

0521 - Who will be responsible to monitor the performance of the QA Committee?

The Administrator Consultant will monitor the performance of the QA Committee until substantial compliance is achieved. When she is no longer retained by Pine Ridge the Administrator will provide a copy of the written QA Committee minutes to the owner of the nursing home within one week of the meeting in order for him to monitor problems within the building and the resolution of those problems.

0490 - The deficient practices of the Administrator was taken to the QA Committee held on 12-2-03. The deficient administrator was terminated on 11-11-03 and a new Administrator was hired on 11-19-03.

0496 - The termination of the deficient Administrator was taken to the QA Committee on 12-2-03. The new Administrator was hired on 11-19-03. His administrative practices will be monitored through weekly meetings with the owner of the nursing home.