NUMBER. JINT PRINTED: 02/18/2005

A. MONON PERM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465158		(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	(X3) DATE S COMPLI	
		465158	B. WING		02/03/2005	
	PROVIDER OR SUPPLIER DGE CARE CENTER		s	TREET ADDRESS, CITY, STATE, ZIP CO 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS-	(X5) COMPLETION DATE
SS=G	Upon written autho facility must hold, s account for the per deposited with the paragraphs (c)(3)-(The facility must defunds in excess of account (or accound of the facility's oper credits all interest ethat account. (In pa separate account in petty cash fund. NOTE The Socal amended \$1819(c) \$50.00 to \$100.00 resident funds that interest bearing account, in petty cash fund. NOTE The Socal amended \$1819(c) \$50.00 to \$100.00 resident funds that interest bearing account in the resident funds that interest bearing account for the facility must esparate accounting accepted accepte	eposit any resident's personal \$50 in an interest bearing ints) that is separate from any rating accounts, and that earned on resident's funds to booled accounts, there must be sing for each resident's share.) aintain a resident's personal acceed \$50 in a non-interest interest-bearing account, or Security Amendments of 1994 (6)(B)(i) to raise the limit from for the minimum amount of facilities must entrust to an count. This increase applies NF residents. While a facility flow a minimum of \$50.00, the require it. Istablish and maintain a is a full and complete and g, according to generally apprinciples, of each funds entrusted to the facility ehalf. Interclude any commingling of facility funds or with the funds	monde will be monde	There will be written authorization from each resident or resident per of attorney allowing the facility to manage their personal funds. All funds in excess of \$50.00 will be deposited into an interest bearing that will be separate from the factoperating account. There will be commingling of resident funds we facility funds or other resident funds are facility funds or other resident funds to facility funds or other resident funds we facility funds or other resident funds we facility funds or other resident person During IDT, which is held quarter resident or power of attorney will the IDT form acknowledging their received their quarterly financial. Any resident that is admitted with sum of money will be asked if it is setup an interest bearing account written permission to setup an act the facility will deduct from that enough to pay for their stay for the month. Once the funds are deduced withdrawal receipt showing the adeducted and remaining balance shown and signed by the resident is aware of all account activity. Addistributed to the resident for perswill be signed for by the resident accounting will be kept on a ledge amount, date and purpose of with All PIF accounts will be setup and by the Office Manager. She will Administrator monthly and will resident financial accounts which funds at a financial institution and given to the resident through famor the spending allowance provid Utah Department of MAR 0 3 2005	resident account; illities no ith inds. iarterly al account. riy the sign y have statement. ia a large is ok to After count account ite current oted a mount will be y, so he/she Any money sonal activity and an er, to verify idrawal. d organized report to the eview all is would include d any money illy, friends ed by Medicaid. Health	OSA/15/05
.ABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	1 TITLE /		(X6) DATE
/	C Last	Ihills	A	(min) STratore	3	-2-a

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION NG	COMPLETED	
	465158		B. WING			C 02/03/2005	
NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER				4	REET ADDRESS, CITY, STATE, ZIP CODE 133 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 PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 159	The individual finar through quarterly since resident or his. The facility must not receives Medicaid the resident's acconstruction 1611(a)(3)(amount in the accontent resident's other resident may lose of the resident in the facility did and account for the resident in the facility (resident in the facility (resident). The facility did not into a private interest deposited his funds banking account. The facility and the resident's another residen	r than another resident. Incial record must be available tatements and on request to or her legal representative. Otify each resident that benefits when the amount in unt reaches \$200 less than the for one person, specified in B) of the Act; and that, if the unt, in addition to the value of monexempt resources, source limit for one person, the eligibility for Medicaid or SSI. NT is not met as evidenced by aff interview and review of ital records it was determined not hold, safeguard, manage expersonal funds of one ity. Specifically, for 1 resident ent 1), the following events and the facility deposited resident ty's operating account but its into the facility's operating. The facility deposited resident ty's operating account and into account thus co-mingling them found that the facility had co-sident accounts (residents 2).	F	159			
	on generally accep	not maintain a system based ted accounting principles to ant for expenditures made out					

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	465158		B. WING			C 02/03/2005	
NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER				4:	EET ADDRESS, CITY, STATE, ZIP CODE 33 EAST 2700 SOUTH ALT LAKE CITY, UT 84115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 159	of the resident's fundation. 3. The resident was statements from the his personal funds. Findings include: Resident 1 was adwith diagnoses include depressive and any and the statement of the	mitted to the facility on 4/28/04 uding dementia with kious features. all record was reviewed on 1/ hosocial Assessment" was SW (licensed clinical social ssment documented that and short term memory his decision making ability. Under the "special concerns" essment, the LCSW esident 1 had no family. (minimum data set) completed for resident 1 had ed cognitive skills and had long mory problems. It was also esident 1 was diagnosed with in Alzheimer's.	F1	59			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) DATE SU COMPLE	(X3) DATE SURVEY COMPLETED	
		465158	A. BUILDING B. WING			C 02/03/2005		
NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER			<u> </u>	43	EET ADDRESS, CITY, STATE, ZIP CODE 33 EAST 2700 SOUTH ALT LAKE CITY, UT 84115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CÓRRE (EACH CORRECTIVE ACTION SHOULI REFERENCED TO THE APPROPRIATE	D BE CROSS-	(X5) COMPLETION DATE	
F 159	best interest and he)." A documented handling money and On 7/28/04, a PAS resident review) Le completed for resident 1 had no glegal representative resident 1 gave " inaccurate respons severe memory los documented that rewere disorganized and that his insight 1. The facility did into a private interedeposited his fund banking account, funds into the facilianother resident's Additionally, it was mingled 2 other resident 1, the faciliand the bank accowere reviewed. Resident 1 was additing an interview facility with a large been hoarding in heing admitted to being admitted to the complete service of the complete service o	ealth daily BNR (by next review intervention was give cues on d keeping extra money safe. RR (pre-admission screening evel II assessment was lent 1. It was documented in Information" section that guardian, legal guardian or e. It was documented that vague, incomplete, and les to my inquiries" indicating is. The PASRR Level II also esident 1's thought processes that he was easily confused and judgement were impaired. In the facility's operating the facility deposited resident ty's operating account and into account thus co-mingling them. found that the facility had co-	F	159				

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM	02/18/2005 APPROVED 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465158		(X2) M A. BUI B. WII	LDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C 02/03/2005		
NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 159	documented that he admission. On 1/31/05 and 2/3 manager was interresident was admit amount of cash and checks that had no approximately 2 ye totaled approximate. The facility's busine using the \$8,148.00 admission, he prefor 3 days in April (for the month of Mi 00 and left the residucumented evide was deposited into his name. An undated entry of documented, "[che security for unclaims.]	t 1's financial ledger had \$8,148.00 upon 0/05, the facilitys' office viewed. She stated that the ted to the facility with a large d a "stack" of social security t been cashed for ars the amount of which	F	159			

documented evidence that this money was placed into an interest bearing account in resident 1's name.

A review of the facility's operating account ledger documented a deposit was made on 10/8/04 for \$ 21,161.60. Under the deposit was documented that the \$21,161.60 deposit was money from resident 1 and another resident in the facility.

On 2/3/05, the facility office manager stated in an interview that the account the \$21,161.60 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	465158		-	3. WING			C 02/03/2005	
NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER				43	REET ADDRESS, CITY, STATE, ZIP CODE 33 EAST 2700 SOUTH ALT LAKE CITY, UT 84115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD IN REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE	
F 159	used to pay bills and On 2/3/05, the facility resident 1 had been and had agreed to the in the facility's operations stay in the facility. There was no docute 687.00 was placed account in resident money had been plated for him, he could have residing at the facility continued to draw in money. On 2/3/05, during an office manager, she still waiting for an affrom social security. On 2/3/05, a review account ledger docute for \$8383.00 office manager from Under the transaction. " On 2/3/05, at approoffice manager was She stated that the of the money owed and that she had be	the facility's general account d for payroll. ty office manager stated that a approached by facility staff use the \$19,687.00 deposited ating account to pre-pay for y through May 23, 2005. mented evidence that the \$19, into an interest bearing 1's name. If resident 1's acced into a personal account ave paid his monthly bill for ty from the account and interest on the remaining. In interview with the facility's e stated that the resident was approximate \$8,000.00 check	F 1	59				
	On 2/3/05, at 4:15 F	PM, the facilty office manager				:		

PRINTED: 02/18/2005 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING C B. WING 465158 02/03/2005 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-(EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX REFERENCED TO THE APPROPRIATE DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG F 159 F 159 Continued From page 6 stated in an interview that she had contacted the facility's owner about the entry made on 11/10/04 for \$8,383.00 and that the owner stated that resident 1's social security check had been deposited into the facility's operating account and that the office manager had been made aware of it. The office manager stated that maybe she had been informed of the deposit but could not remeber being told. She stated that if she was out of the facility for any reason, that all checks that came into the facility would be deposited in the facility's operating account and that she would then transfer the money into the correct account when she returned. There was no documented evidence that the \$ 8383,00 was deposited into an interest bearing account for resident 1. On 2/3/05, the facility office manager stated in an interview that after resident 1 had pre-paid for his stay in the facility through May 23, 2005 using the \$19,687.00 that he had a balance left over totalling \$205.33. The facility office manager stated that she deposited this money into another resident's account. She stated that the reason for doing that was because if she opened an account in resident 1's name, he would be charged a

monthly fee of \$5.00 from the bank because he had less than \$300.00. When asked if the

The facility office manager gave the name of 2 additional residents (resident 2 and 3) in the facility that had their money co-mingled together in one account. She stated that the way the

interest but were unsure how to do it.

residents were being paid interest on their money, she stated that she and the administrator had both tried to figure out how to distribute resident

PRINTED: 102/18/2005 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** OMB NO: 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING C B. WING 02/03/2005 465158 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID. (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-(EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** PREFIX REFERENCED TO THE APPROPRIATE DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG Continued From page 7 F 159 F 159 interest was distributed was that which ever of the residents had more money they just got more interest given to them. 2. The facility did not maintain a system based on generally accoepted accounting principles to manage and account for expenditures made out of the resident's funds. On 2/3/05, the facility office manager was interviewed and asked to provide written documentation and/or receipts to account for resident 1's expenditures. She stated that the facility's former activity director (who was no longer employed in the facility) kept track of resident 1's money and that she and the facility administrator had been unable to locate any receipts for expenditures made by resident 1 or for resident 1 by facility staff. She stated that resident 1's checks were deposited into the facility's operating account and that the owner would then write a check for \$45.00 to the previous activity director who would keep the money in an envelope and issue it to resident 1 as he asked for it. She produced a hand written " ledger", listed transactions from May 2004 through January 2005 documented that resident 1 was given money in varying amounts each week for "outings" but there was no documentation detailing what the money was being used for. There was 1 receipt kept with the handwritten steno pad "ledger", dated 5/26/04, for a pair of suspenders. The facility was unable to locate any other documentation to account for resident 1's money.

医多次试验 學論 化重量 囊叶 医医二氏性胆管 医生红病 變響 医牙线内 原生

his personal funds.

3. The resident was not sent quarterly financial statements from the facility detailing the activity of

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	465158		B. WIN	B. WING			C 3/2005
NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER				43	EET ADDRESS, CITY, STATE, ZIP CODE 33 EAST 2700 SOUTH ALT 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 PREFII TAG	,	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 159	facility's office manathe statement submithe detailed the office the facility. At approximately 1: monthly statements statements docume section "Family Liab was no detailed inforesident 1 was being On 2/3/05, at 5:15 Foffice manager state were not provided with detailing their accounts of the facility administrator the facility that the facility was manager stated.	ge 8 ximately 11:00 AM, the ager was asked for a copy of nitted to resident 1 each month costs for his monthly stay in 00 PM, copies of resident 1's were provided. The ented under the "description" bility for [the month]". There ormation explaining what g charged for by the facility ed that residents in the facility with quarterly statements and activity. The beautiful provide a statement. She further	F1	59			
	keep a hard copy of residing in the facilit template on her corresident's who did not their money, she was statement/bill using then would change resident until all star She stated that she statements for Octo 2004 and January 2 them so the amoun could be seen. She facility handled the	f statements for the residents ty. She stated that she had a imputer and each month for not allow the facility to manage build prepare a monthly the template, print a copy and the template for the next tements had been completed. had just prepared resident 1's ober, November, December 2005 after she was asked for the resident paid each month the stated that she thought if the resident's money that they did quarterly financial statments.					



Raising the Standard of Care

Addendum to Plan of Corrections regarding Resident Accounts

We will review and discuss the handling of PIF accounts and other resident financial activity pertaining to the plan of correction at each quarterly QA meeting. Our first QA will be held on March 29, 2005.

The completion date for the plan of correction has been changed from 3-15-05 to 04-01-05.

Any questions feel free to call me at 801-487-2248.

Sincerely,

Frank Kilby

Administrator