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

PRINTED: 11/18/2005
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465158	A. BUILDING ______ B. WING ______	11/03/2005

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

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F 159 SS=G	483.10(c)(2)-(5) PROTECTION OF RESIDENT FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the	F 159	F159 This facility does and will continue to hold, safeguard, manage and account for the personal funds of the resident deposited with the facility. There will be a written authorization form that the resident or resident POA will sign authorizing the facility to hold, safeguard, manage and account for their personal funds. Any of the residents personal funds that exceed $50.00 will be deposited into an interest bearing account. This facility will pool all the accounts together, but there will be a separate accounting for each residents share. The resident trust account will not be commingled with any operating funds. There will be an individual financial record for each resident that has money either in the facility or in an interest bearing account. The amount of money that will be held in the facility for each resident will not exceed $50.00 at any given time. If resident's use all there funds before a month expires they will not be allowed to borrow from other resident's trust fund. Either family or facility will provide to the resident what they need in respect to their account. If a resident trust account exceeds $2000.00 and they are a Medicaid recipient they will be asked to do a spend-down in order to remain qualified for the Medicaid benefits. The spend-down will be facilitated by the Office Manager, whereby she will either contact the resident or resident POA to begin the process.	12-15-05

12/1/05 POC acceptable with addendum completion date 12/15/05 BBoemork RN

Utah Department of Health
631973
DEC 01 2005
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 12-1-05

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

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F 159	Continued From page 1 SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for 3 of 10 residents the facility did not obtain written authorization from the residents to hold, safeguard, manage and account for the personal funds of the residents, deposited with the facility. It was also determined, that for 10 of 10 residents, the facility did not credit all interest earned on the resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) Specifically, for residents 8, 12, and 13 the facility could not provide documentation to show that written authorization was obtained to manage the resident's funds. In addition, all residents who had the facility manage their money were not given quarterly statements. Excess funds found in the resident trust fund account were being divided amongst all residents with money co-mingled in the account and not reconciled to find which resident the money belonged to. Administration used excess money found in the resident trust fund account to satisfy two bills that should have been paid from the operating account. Findings included: On 11/2/05 the resident trust fund account and book keeping ledgers were reviewed.	F 159	**Each quarter the resident or resident POA will be notified in writing the balance of their account and will be shown a current bank statement. On the form that will be used during IDT meetings, the resident or resident POA will sign acknowledging the balance of their trust account, and current funds in the facility.** **Interest earned on the account will be calculated in the following manner: Our facility currently does not have a computer system that calculates interest, so based on our resources we will do the following. We will take the total amount in the trust account and divide it by the resident's portion of the account. This will give us a percentage of how much of the trust is theirs. Once we know the interest earned, we will take that same percentage and apply that much interest to that individuals account.** **Each month there will be a reconciliation of bank statements, resident money being held at the facility and each resident financial ledger. Each ledger will show the interest earned. Reconciling the financial ledgers will determine how the money will be disbursed in individual's accounts.** **The trust account will be monitored daily by the Office Manager. The office manager will report to the Administrator once a week to review any activity on the trust accounts and will review any reconciliation that has been done. In the Quarterly Assurance Meetings we will discuss and review any changes to the trust account. Our next QA meeting will be held December 13th 2005.**	

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F 159	Continued From page 2 Review of the Admission Authorization Form, that residents sign upon admission, revealed that for residents 8, 12, and 13 there were no authorization forms signed, giving the facility the right to manage the resident's personal funds. Review of the financial records on 11/2/05, for the trust fund accounts of 10 residents revealed a note written on the July 2005 bank statement. The note read, "- As of 7/29/05 facility has $1,443.42 more in trust account than necessary. - A withdrawal of 1443.42 will be taken out on 8/8/05 making the balance exact. - $ 1,000.00 will be used to satisfy an overpayment of a resident stay check [#....] - $ 443.00 will be used to pay on an agency bill required for nursing care. Check [#....] The 1443.42 was supposed of been deposited into the facility operating account instead of the resident trust account." Review of the facilities check register on 11/2/05 showed that the money was not withdrawn from the resident trust fund account and deposited into the operating funds account, as noted above. It was determined that facility staff had written two different checks on 8/8/05 out of the resident trust fund account to satisfy two bills that should have been written out of the operating funds account. A separate note, signed by the administrator and business office manager, dated 8/17/05, was found in the financial records reviewed on 11/2/05. The note stated that the withdrawal completed on "8/8/05 in the amount of 1,443.42 should of never happened This has been as accounting error..." and the facility will deposit	F 159		

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F 159	Continued From page 3 back into ' trust account the first week of Septembe , 1,443.42. Based on the calculations the office manager and administrator divided the money amongst all residents with money in the account. Those residents who had the most money in the trust fund account were given the most money when the money was divided. The facility did not reconcile the bank statements and financial ledgers to determine if the money belonged to all of the residents or just one resident. Review of bank statements showed that interest gained on the trust fund account was divided between residents with money in the trust fund account. The interest divided amongst the residents was calculated based on how much money each resident had in the account. (For example: If resident 11 had 30% of the total funds in the trust account, then resident 11 received 30% of the interest.) The interest was not figured based on the percentage of return the bank account was earning and then how much money each resident had in the account. On 11/2/05 at 2:30 PM, resident 15 was interviewed regarding quarterly statements. Resident 15 stated that she had not received quarterly bank statements from the facility detailing how much money she had in the trust fund account and how much interest she had accrued on her money in the trust fund account. On 11/3/05 at 10:00 AM, the administrator was interviewed. He stated that the facility had not been giving the residents a quarterly statement showing the amount of money they had in their trust fund account or how much interest they had accrued. The Administrator further stated that he	F 159		

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F 159	Continued From page 4 did not realize that the overage found in the trust fund account should have been reconciled. He stated he believed that since there seemed to be an overage it was operating funds monies and that he could use that money to pay two bills. On 11/2/05 at 4:00 PM, the business office manager was interviewed. The business office manager confirmed that she maintains the resident trust fund accounts and was not aware that she should have been providing the quarterly statements to residents with money in the account. She further stated that the Administrator has helped her calculate the interest that each resident has received and she was unaware of the percentage of return the fund received from the bank on money in the account. Review of individual resident financial ledgers on 11/2/05 revealed that on 10/30/05 varying amounts of money were added into each residents ledger. The entry on each ledger read, "Interest added." On 11/3/05 at 1:00 PM, the business office manager was interviewed in regards to the interest most recently added into the financial ledgers. The business office manager stated that the new interest added was from a $ 300 overage she had found in the residents trust account. The business office manager stated that they had not reconciled the financial statements to determine who the money belonged to. She stated the money had been divided based on the percentage of money each resident had in the fund. For example, the resident with the most funds received the most interest. The business office manager further stated that the facility had not received the October financial statement but	F 159		

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F 159	Continued From page 5 just wrote it down in the ledgers that way (Interest added) even though it was not interest to account for the $ 300 overage found in the account. The facility did not reconcile the financial ledgers to determine how the money should be disbursed to individual resident accounts.	F 159		
F 167 SS=B	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not have the most recent survey results posted in a place readily accessible to residents and notice of their availability could not be found. Findings include: On 10/31/05 at 1:28 PM, the Director of Nursing (DON) was interviewed. When asked where the survey results were posted, she stated "they are behind the two entry doors, on the table." When the DON and surveyor checked on the table, they were not there. The DON, then asked the	F 167	F-167 This facility does and will continue to make Surveys available for examination and will be posted and readily accessible to all residents and will include the plan of corrections. The survey binder will be marked "Survey Result". An in-service will be completed to all staff regarding what the binder contains and where it is located. This information will be passed on to all residents through resident council meeting. This will be completed by December 15th 2005, and will be monitored by the Administrator on a weekly basis.	12-15-05

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F 167	Continued From page 6 administrator where they were located, he replied "behind the Social Services door." On 10/31/05 and 11/01/05, the survey results were found hanging in an unmarked binder, on the wall behind the Social Services door. In this location it was not viewable to persons entering or exiting the facility. In addition, it was posted between two entry doors, which was not accessible to residents unable to open the doors. On 10/31/05, a confidential group interview was conducted with six alert and oriented residents. During the interview, all six residents stated that they have never seen the survey results posted, and did not know that the results were to be posted. In addition to the survey results not being accessible, the facility did not post the results of a recent complaint investigation from February 2005. During the exit conference on 11/2/05, the Administrator stated that he was not aware that the complaint investigation results were supposed to be posted with the results of the most recent survey.	F 167		
F 223 SS=K	483.13(b), 483.13(b)(1)(i) ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.	F 223		

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F 223	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and medical record review, it was determined that the facility did not ensure that residents were free from verbal, physical and mental abuse. Specifically, a facility certified nursing assistant physically abused resident 1 and continued to provide care to facility residents after the incident was reported to a facility nurse. The facility's administrative employee 1 allegedly mentally and verbally abused resident 2 and continued to interact with facility residents after the incident was reported to the facility's director of nurses. In addition, the facility did not protect resident 3 from physical abuse from resident 4, resulting in physical injuries to resident 3. State Operations Manual Interpretive guidelines at 42 CFR 483.13 (b) and (c) states: " 'Abuse' means the willful infliction, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." " 'Verbal abuse ' is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability." Findings include: A review of the facility's policies and procedures relating to abuse was completed on 10/26/05. The polices directed the following, "Any employee	F 223	This facility does and will continue to insure the right of residents to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. This facility does not use verbal mental sexual or physical abuse, corporal punishment, or involuntary seclusion. Screening process – All C.N.A.'s have been screened through the State Nurse Aid Registry for history of abuse. This was completed on October 29, 2005. A copy of the results was put in each individual employee file. N.A.' s will be checked by calling the Registry and the findings will be placed in their file also. All Licensed Nurses were screened through the DOPL internet site and results of the screening were filed in each employee record. BCI checks are in the process of being completed on existing employees. All new employees will have a BCI checks done upon hire.	12-15-05

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F 223	Continued From page 8 who suspects that there has been abuse, neglect, or misappropriation of property towards a resident, employee or visitor should follow the following routine for reporting. 1. Report to your direct supervisor..." STAFF TO RESIDENT ABUSE: 1. Resident 1 was admitted to the facility on 10/24/02 with diagnoses which included vascular dementia, depression, anxiety and insomnia. On 10/26/05, the facility's incident reports were reviewed. On 10/24/05, facility nurse 2 completed an incident report regarding resident 1. Facility nurse 2 documented the following, "...CNA (certified nursing assistant) on morning shift noticed bruises to residents hands. Pt (patient) not oriented enough when asked what happened. I asked day shift if they knew how these bruises occurred and then I asked swing shift which one CNA had witnessed incident. Bruises to BL (bilateral) hands; large across entire hands b/t (back to) thumb and index fingers...[CNA 1] (saw incident) nurse found bruises..." On 10/24/05 at approximately 2:00 PM, the facility administrator provided the nurse surveyor with an "Employee Warning Notice" regarding CNA 2. The following was documented on the warning, "... CNA was bringing a resident from outside patio to DR (dining room) in a very rude way from her under arms and [left] upper arms. Nurse asked CNA to be more gentle [with] pt (patient) and leave her on [sic] place she wants to stay at this point..."	F 223	**Failure to establish training - In-service on abuse prevention and reporting was conducted, by the administrator October 28 – October 30, 2005, to 32 of the 37 employees of the facility.** **The 5 employees that were not in-serviced were unable to be contacted. These (5) employees will complete the in-service training upon the start of their next shift. This instruction and training will be completed by the Administrator, or the Director of Nursing, for each individual.** **Every new employee hired at Pine Ridge Care Center will have an in-service on abuse and neglect prevention and reporting, upon hire. Each employee will also attend a mandatory new employee in-service class that will focuses on the prevention of resident abuse and neglect and reporting requirements if abuse is observed or suspected. The in-service will be given every third Thursday of each month. Mandatory in-services on abuse will also be given twice a year to every employee as scheduled on the in-service calendar. An in-service binder will be kept in the Director of Nurses office and will constitute a record of all in-service training conducted by the facility.** **Failure to identify potential abuse and failure to investigate – New policies and procedures implemented regarding:** **A. Abuse Prevention, Investigation, and Reporting (policy AD-1)**	

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F 223	Continued From page 9 On 10/26/05 at 2:05 PM, the facility nurse (facility nurse 1) who completed the "Employee Warning Notice" was interviewed. She stated on 10/23/05, CNA 2 was bringing resident 1 in from the patio and he was holding resident 1 under the left arm pulling her and then pushing her on the back. Facility nurse 1 further stated that "It looked like he was pulling and pushing on her, he was being rough." Facility nurse 1 stated that she talked with CNA 2 about not forcing residents. Facility nurse 1 stated on 10/25/05 resident 1 had bruising on both her hands. Facility nurse 1 stated that she gave CNA 2 a verbal warning regarding the incident but did not report the incident to anyone. At 3:30 PM, facility nurse 1 was interviewed for a second time. Facility nurse 1 stated that if abuse is reported to her she would investigate and was suppose to call the administrator/supervisor. She further stated, "I feel I'm able to determine if it's abuse or not." Facility nurse 1 stated that on 10/23/05, she did not feel abuse had occurred. When facility nurse 1 was reminded that she stated CNA 2 was being rough with resident 1 facility nurse 1 stated, "he was being rough but didn't consider it was abuse, it was cold outside and she needed to be inside." On 10/26/05 at 2:25 PM, 3 days after the above incident, resident 1's hands were observed by two nurse surveyors. Resident 1's left hand had a 5-7x4 cm (centimeter) black and purple bruise on the back of her hand, a small cut by her index finger and a 2x2 cm black and purple bruise on the wrist and her right hand had a 5 cm black and purple bruise on the back of the hand. Resident 1 was oriented only to herself and not able to tell the surveyors what had happened to her hands.	F 223	B. Abuse – Allegation and Reporting (policy AD-2) C. Abuse – Prohibiting (policy NS-001) In-service training will be given to Director of Nursing and facility staff on new policies and procedures. Further in-services will be given to facility staff regarding identification and reporting requirements related to injuries of unknown origin, misappropriation of property, and how to deal with residents with aggression and/or catastrophic reactions. Protection from further abuse – In-service training has been given and ongoing continuing education will be done with all staff related to the procedures to be followed in the proper, identification of abuse, how to protect and prevent abuse in the future and how to report incidents of suspected or alleged abuse. This will be done during semi-annual Abuse prevention in-services training sessions that will follow the new policy and procedures and using the abuse rounds form that was implemented.	

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F 223	Continued From page 10 On 10/26/05 at 2:30 PM, CNA 1 was interviewed over the phone. CNA 1 stated on 10/23/05 during the lunch meal resident 1 was in her room and CNA 2 went and got her. He stated CNA 2 firmly grabbed resident 1's hands and was "tugging" her down the hall. CNA 1 stated resident 1 left the dining room and went out on to the patio. CNA 1 stated that CNA 2 went out on the patio and got resident 1. He stated CNA 2 had his "left arm around her waist and with his right hand was holding her left hand- he had her lifted off the ground and dragged her to her chair." CNA 1 stated that he reported the incident to facility nurse 1 and facility nurse 1 stated she had already talked to CNA 2. CNA 1 stated on 10/24/05 when he came into work, facility nurse 2 asked if he knew what happened to resident 1. CNA 1 stated he told facility nurse 2 and wrote a report regarding the incident. He stated when he looked at resident 1's hands they were bruised. On 10/23/05, CNA 1 documented the following on a "CNA Notes", "On 10-23-05, I witnessed [resident 1] being treated cruelly. She was in the dining room for lunch, she waited for about 2-3 minutes, then left outside. When her tray came out, approximately 10 minutes later, I observed [CNA 2], pulling [resident 1] rather harshly by the hands into the dining room. Again she left, and I witnessed [CNA 2], CNA; dragging [resident 1] into dining room. He had his left arm around her waist, and his right hand clinched around [resident 1's] left hand...I told [facility nurse 1] about it, and she said she was going to talk to him, but that not much would happen, because she had already talked to him." On 10/26/05 at 3:45 PM, the facility administrator	F 223	**Reporting – Education has been given to all facility staff identifying to whom all suspected abuse incidents should be reported. The Administrator is the abuse coordinator and the individual to whom all suspected incidents of abuse should be reported. Abuse Reporting Procedures have been posted throughout the building on the advice of social service consultant. Administrator has also in-serviced every employee. All Staff have received 3 x 5 cards explaining what constitutes abuse, the prevention of abuse, and how to report suspected incidents of abuse. All new employees will be given the abuse 3 x 5 cards upon hire. The Resident Services Coordinator will be the "point of contact" for the administrator and staff in completing proper documentation, reporting, and continuing education of all employees on semi-annual basis. Abuse identification and prevention rounds will be conducted 6 times per year and p.r.n., to random employees and supervisors. The Abuse reporting investigation log will be kept in the Resident Services Coordinator office. A copy of the Abuse policies and procedures will be kept at the nurse's station for referral as needed by facility staff.** **An AD-HOC Quality Assurance meeting was held Monday, October 31, 2005, in regards to Abuse Prevention and Reporting.**	

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F 223	Continued From page 11 was interviewed. He stated he was informed of the incident involving resident 1 and CNA 2 on 10/24/05 in the afternoon (24 hours after the incident occurred). He stated "have not suspended [CNA 2] yet awaiting results of 5 day investigation to determine if abuse occurred or not and then will either suspend or terminate." The administrator further stated that the DON (director of nurses) was out of town until 11/3/05 and he would wait for her to return before suspending or terminating CNA 2. On 10/27/05 at approximately 8:00 AM, facility nurse 2 was interviewed over the phone. She stated on 10/24/05 the bruising on resident 1's hands was found and she reported the incident to the administrator. Facility nurse 2 further stated that she spoke to CNA 1 and he told her about CNA 2 pulling on resident 1's hands. Facility nurse 2 further reported that CNA 1 reported the incident to facility nurse 1 and nothing was written up involving the incident. On 10/27/05 at 8:30 AM, the DON was interviewed over the phone. She stated that on 10/23/05 she worked a graveyard shift and was not informed of the incident involving CNA 2 and resident 1 until 10/25/05 (2 days after the incident occurred). On 10/27/05 at approximately 9:30 AM, CNA 2 was interviewed. He stated he worked on 10/23/05 with resident 1. He stated he did bring resident 1 in from the patio to eat her meal. CNA 2 further stated that "nobody told me what happened to her [resident 1] until yesterday [10/26/05] about the bruises." When CNA was shown the "Employee Warning Notice" with his signature, he stated that was not his signature	F 223	**Monthly Quality Assurance meetings will also be held the second Tuesday of each month, beginning in November 8, 2005. Mandatory Staff Meetings will be held twice each month to provide educational tools and to discuss issues/concerns, beginning on November 10, 2005.** **Screening, training, prevention, identification, investigation, protection, and reporting/response of abuse are all addressed and covered in the above paragraphs and corresponding policies and procedures.** **Screening**: paragraph (1) **Training**: paragraph (2) **Prevention**: paragraph (2) (5) **Investigation:** paragraph (3) **Identification:** paragraph (3) **Protection**: paragraph (4) **Reporting**: paragraph (3) (5) POLICY: **AD-1, AD-2 and NS-001** **All in-services, actual abuse towards residents regardless of how and when, and any other issues affiliated with abuse such as an abuse log, weekly questionnaire towards staff on "what is abuse" will be monitored daily by the Administrator.**	

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F 223	Continued From page 12	F 223		

and he had never seen that paper. He further stated that the DON worked the night of 10/23/05 and saw him the morning of 10/24/05 and did not talk to him regarding the incident involving resident 1. CNA 2 stated he worked his entire shift on 10/23/05 and also worked an extra shift on 10/24/05.

On 10/27/05 at approximately 10:00 AM, the facility housekeeper was interviewed. She stated on 10/23/05, CNA 2 was cutting resident 1's nails and resident 1 was asking CNA 2 to stop. She further stated, "I watched her [resident 1] yank her hand away, then he [CNA 2] yanked it back." The housekeeper stated she reported the incident to the DON on 10/24/05 in the morning and the DON told her to "write it up."

On 10/25/05, the facility housekeeper documented the following in a note, "On Sunday Oct 23.05 [CNA 2] was cutting [resident 1's] nails she was asking him to stop she pulled her hand back form [sic] him. I was moping down the hallway when I saw him yank her hand back towards him really hard come Monday I noticed her hand was cut and bruised really bad."

A review of CNA 2's time report provided documented evidence that CNA 2 continued to work at the facility on 10/23/05 until 2:00 PM.

2. Resident 2 was admitted to the facility on 6/30/04 with diagnoses which included diabetes mellitus, hypertension and dementia with depressive and anxious features.

On 10/27/05 at 7:30 AM, A phone interview with facility nurse 3 was completed. When facility nurse 3 was interviewed about any allegations of

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F 223	Continued From page 13 abuse in the facility she stated she was aware of a report that went to the DON regarding administrative employee 1 and resident 2. She stated that CNA 1 reported the incident. On 10/27/05 at 8:30 AM, a phone interview with the DON was completed. She stated she was not aware of an incident involving resident 2 and administrative employee 1. On 10/27/05 at 10:30 AM, a phone interview with CNA 1 was completed. He stated sometime in September 2005 resident 2 was in the dining room being very loud. He stated resident 2 is often very verbal. CNA 1 stated that administrative employee 1 took resident 2 in her wheelchair and pushed her in front of the couch and told her to stay there. CNA 1 stated that resident 2 flipped onto the couch and administrative employee 1 told resident 2 "that's what you get" and left the resident there. CNA 1 stated he reported the incident to facility nurse 4 and facility nurse 4 helped get resident 2 back into the wheelchair and told CNA 1 he would take care of it. On 10/27/05 at 12:15 PM, administrative employee 1 was interviewed. She stated she was aware of an incident concerning herself and resident 2. She stated resident 2 was throwing herself out of her wheelchair and she placed resident 2 in front of the couch. Administrative employee 1 stated that the DON talked to her about the incident but she was not suspended or removed from the resident while an investigation was completed. On 10/27/05 at approximately 4:00 PM, during an exit conference the administrator stated he knew	F 223		

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F 223	Continued From page 14 nothing about the incident involving resident 2 and administrative employee 1. On 11/1/05 at 8:00 AM, the DON was interviewed. She stated she was aware of the incident involving resident 2 and administrative employee 1. She stated she found out a few days after the incident occurred and she interviewed staff and administrative employee 1 and determined abuse did not occur. She stated she did not report the incident to the facility administrator because she felt abuse did not occur. RESIDENT TO RESIDENT ABUSE: 1. On 10/26/05 at 3:30 PM, facility nurse 1 was interviewed. She stated she was aware of only one resident to resident altercation involving resident 3 and resident 4. She further stated that the altercation was reported to the facility administrator. On 10/27/05 at 9:35 AM, the administrator was interviewed. He stated he was only aware of one resident to resident altercation involving resident 3 and resident 4. On 10/27/05 at 8:30 AM, a phone interview with the DON was completed. The DON stated that she was aware of a resident to resident altercation involving resident 3 and resident 4 that occurred about 1 month ago. She stated resident 3 had an injury. On 10/27/05 at 10:30 AM, a phone interview with CNA 1 was completed. CNA 1 stated he was only aware of a resident to resident altercation involving resident 3 and resident 4 that occurred in the dining room.	F 223		

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F 223	Continued From page 15 On 10/26/05, the facility's incident reports were reviewed. On 9/19/05 at 5:00 PM, facility nurse 1 completed an incident report regarding resident 3. Facility nurse 1 documented the following on the incident report, "...Resident to Resident Altercation...A staff member yelled "stay away from her" this nurse went in to DR (dining room) [resident 4] was very upset agitated/violent and [resident 3] was hit by [resident 4] on her [left] side of face - bruise, redness [with] bump on [left] side forehead..." Facility administrative staff did not indicate under the section of the form any "Interventions/Follow up". On 10/26/05, resident 3's medical record was reviewed. On 9/19/05 at 5:00 PM, facility nurse 1 documented the following in a Nurse's Note", "Pt (patient) on [sic] DR (dining room) on [sic] w/c (wheelchair), suddenly a staff member yelled "Stay away from her" this nurse went in to the DR, "a male resident just hit [resident 3]...at the assessment a bruise/bump small size noted on [left] forehead [and] redness around eye..." On 10/26/05, resident 4's medical record was reviewed. On 9/19/05 at 5:00 PM, facility nurse 1 documented the following in a "Nurse's Note", "Pt (patient) on [sic] DR (dining room), suddenly a staff member yelled "Stay away from her", this nurse went into DR, Pt very upset agitated walking in DR. Pt removed from DR. A staff member state [sic] [resident 4] hit a female	F 223		

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F 223	Continued From page 16 resident on face..."	F 223	This facility does and will continue to implement written policies and procedures that prohibit the mistreatment, neglect, and abuse of residents and misappropriation of resident property.	12-15-05
F 224 SS=G	483.13(c) 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. This REQUIREMENT is not met as evidenced by: Based on interview and closed record review, it was determined that the facility did not develop and implement policies and procedures that prohibited neglect. Specifically, Resident CL 1 experienced multiple falls and sustained actual harm as a result of the falls. The facility neglected to develop, fully implement and re-evaluate interventions to avoid physical harm associated with the falls. Findings include: Resident CL 1 was admitted to the facility on 7/7/05 with diagnoses which included Parkinsons, Dementia with psychotic features, diabetes type II and peripheral neuropathy. Resident CL 1's closed medical record was reviewed on 11/3/05. On 7/7/05, the transferring facility documented the following on a "Nursing Discharge Summary/Assessment" regarding resident CL 1, "...Is a fall risk..." An admission minimum data set (MDS) was	F 224	A new fall program, "The Falling Leave Program" will be implemented by December 15, 2005. Every resident will have a Fall Risk Assessment completed by December 15, 2005. Interventions will be determined by the completion of Fall Risk Assessment. Interventions will be implemented immediately and an individualized comprehensive care plan will be completed for each resident to include interventions. All new residents will have a Fall Risk Assessment completed with 24 hours of admission and appropriate interventions will be implemented immediately and an individualized care plan will be completed at that time. All Fall Risk Assessments will be reviewed and updated on a quarterly basis and as needed changes occur. The Interdisciplinary Team will review these during the interdisciplinary Team Meeting. Actual falls will be addressed after each fall occurs and will be care planned with new interventions that will be put into place. All assessments and care plans will be monitored by the Director of Nursing to help ensure proper interventions are in place. As in-service will be completed to Licensed Nurses and Interdisciplinary Team Members on or before December 15, 2005. We will review the Fall Assessment Program during each of our QA meetings, the first being held on 12-13-05.	

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F 224	Continued From page 17 completed by facility staff on 7/17/05. Facility staff documented that Resident CL 1 had short and long term memory problems and his cognitive skills for daily decision making were moderately impaired. The facility staff documented that Resident CL 1 was able to transfer and ambulate short distances with limited assistance. The facility staff documented that Resident CL 1 required partial physical support for balance while standing. The facility staff also documented that Resident CL 1 had a fall in the last 30 days. A fall risk assessment could not be found in Resident CL 1's closed medical record. A review of resident CL 1's medical record, revealed a comprehensive care plan dated 7/17/05, addressing resident CL 1's fall risk. The care plan documented the following under goal, "have no incidence of falling by 10/17/04". Under approaches the following was documented, " 1) Encourage resident to have rest periods. 2) Refer for evaluation by restorative nursing to encourage exercise and mobility to maximize and maintain strength, balance, and coordination. 3) Encourage self mobile residents to rise slowly and be sure of their steadiness prior to walking. 4) Collaborate with therapy to increase strength and mobility. 5) Keep bed wheels locked and bed in lowest position. 6) Ensure that glasses and hearing aides are in working order and available for use. 7) Have mobility aides at hand and ensure proper use. 8) Inform the resident and if appropriate the family that the resident is on the Fall Risk Prevention Program.	F 224		

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F 224	Continued From page 18 9) Put on nonskid footwear. 10) Instruct the resident about what to do should they experience a fall. Encourage the resident to not get up by himself but rather to call for help. 11) Document the fall risk measures in the resident care plan and update as needed (Quarterly and after each fall)." On 7/8/05 at 5:30 PM, a nurse's note in Resident CL 1's medical record documented the following entry: "...Pt. (patient) put self to bed- bed rolled away pt landed on the floor. A small skin tear left arm..." On 7/8/05 at 5:30 PM, a facility nurse documented the following on a "Post Incident Report" Form: "...Pt.(patient) tried to place self in his bed, "bed rolled away from me, I landed on the floor..."" Facility administrative staff did not indicate under the section of the form any "Interventions/Follow up". On 7/17/05 at 6:30 AM, a nurse's note in Resident CL 1's medical record documented the following entry: "Called to room by roommate, RM (roommate) states resident tried to sit in w/c (wheel chair) but it rolled back. Resident found sitting on buttocks [with] BLE (bilateral lower extremities) extended in front..." On 7/17/05 at 6:30 AM, a facility nurse documented the following on a "Post Incident Report" Form: "...Called to room by roommate who states resident attempted to sit in w/c but w/c rolled backward. Resident found sitting on buttocks." Facility administration documented under the section of the form "...Interventions/Follow up: MD (medical doctor) to review medication [and] may [increase]	F 224		

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F 224	Continued From page 19 Trazodone (a sleep medication) [at] HS (hour of sleep) to promote more restful sleep..." On 7/24/05 at 5:30 AM, a nurse's note in Resident CL 1's medical record documented the following entry: "Found sitting on floor beside bed..." On 7/24/05 at 5:30 AM, a facility nurse documented the following on a "Post Incident Report" Form: ..."Resident found by CNA (certified nursing assistant) checking on residents. Resident sitting upright on floor..." Facility administration documented under the section of the form "...Interventions/Follow up: Would like to see bed alarm used..." On 8/3/05 at 2:30 PM, a nurse's note in Resident CL 1's medical record documented the following entry: "Resident FOF (found on floor) next to bed states he tried to sit on bed and slid to the floor was noted to have large abrasion purple in color on [right] back...." On 8/3/05 at 2:30 PM, a facility nurse documented the following on a "Post Incident Report" Form: "... Resident FOF next to bed states he slid to floor while attempting to sit on bed. Abrasions noted on [right] back...." Facility administration documented under the section of the form "...Interventions/Follow up: Wife will bring walker in for resident as cane does not support him when rising from bed..." On 8/4/05 at 2:10 PM, a nurse's note in Resident CL 1's medical record documented the following entry: " Resident continues [with] bruising to Rt (right) mid back [after] recent fall. Fall [and] Safety Precautions implemented....."	F 224		

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F 224	Continued From page 20 On 11/3/05 at 10:00 AM, the Director of Nursing was interviewed regarding a Fall Prevention Program. The Director of Nursing stated the facility did not have a Fall Prevention Program yet and she was working on putting one into place. The facilities policy and procedure for falls was reviewed on 11/3/05. The procedure stated," ...The following steps should be followed to assess a resident for being at risk for restraints / falls / wandering...2. Apply Fall Assessment Tool and Guidelines for use...3. ...Devise a plan of action with specific interventions if needed...4. Develop a written care plan with specific interventions listed....Discuss with staff...5. Pass on plan of care in report to all three shifts until all staff have received information about individual plan of care...Residents who are newly admitted and are at risk for falls need to be given immediate care to maintain safety. The above steps need to be completed promptly upon admission....." There was no documentation to provide evidence that facility staff developed interventions, individualized to resident CL 1's needs to reduce his falls or to minimize potential injury.	F 224		
F 225 SS=K	483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would	F 225	F-225 Same Plan of correction as F-223 Or see Policy and Procedures regarding abuse. Will be monitored by Administrator And discussed in QA meetings, the first being on December 13, 2005.	12-15-05

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F 225	Continued From page 21 indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: 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, were not preventing facility residents from further potential abuse and injury. Additionally, the facility did not report staff to resident abuse, resident to resident abuse and injuries of unknown origin, in accordance with state law and federal regulations.	F 225		

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F 225	Continued From page 22 During the survey, completed 10/26/05 through 11/3/05, record review and staff interviews indicated two allegations of staff to resident abuse (Residents 1 and 2), by facility staff members, where the facility failed to thoroughly investigate and report these occurrences. Additionally, record review and staff interviews indicated one incident of resident to resident abuse (resident 3 and 4) and four incidents of injuries of unknown origin (Residents 7, 9 and CL 1), where the facility failed to investigate or report these occurrences. Findings include: 1. A review of the facility's policies and procedures, relating to abuse, was completed on 10/26/05. The policies directed the following, "...Any employee who suspects that there has been abuse, neglect, or misappropriation of property towards a resident, employee or visitor should follow the following routine for reporting. 1. Report to your direct supervisor a. If this is not possible or the supervisor is involved, report to a Department Head, Director of Nursing or Administrator. 2. The Administrator or designee will follow the Abuse Reporting Protocol... The DON or Administrator will continue the investigation. 1. Visit with person involved in incident. Ask them if they feel they have been treated wrongly. 2. Interview with suspect to determine their perception of the incident. 3. Interview any witnesses... 4. Review chart or file for any other reports. 5. Fax results within 5 days as per Abuse Reporting Protocol... If the investigation shows probable abuse, then appropriate agencies will be notified...If an	F 225		

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F 225	Continued From page 23 employee is involved, they will be put on suspension until the investigation is complete..." 2. A review of the facility's abuse policy and procedures indicated the following. "...All employees will receive an initial orientation to the facility on issues related to abuse, neglect and misappropriation of resident property. Once a year an in-service will be given to all employees that will review the above topics. The in-service will also train employees how to deal with aggression and/or catastrophic reactions of resident, how to report their knowledge of related allegations without fear of reprisal..." 3. On 10/26/05, 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 August 2004, the facility had not reported any of these incidents to the State Survey Agency. 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). Since November 2004, the facility had not self reported any of the incidents to APS. STAFF TO RESIDENT ABUSE: 1. Resident 1 was admitted to the facility on 10/24/02 with diagnoses which included vascular dementia, depression, anxiety and insomnia.	F 225		

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F 225	Continued From page 24 On 10/26/05, the facility's incident reports were reviewed. On 10/24/05, facility nurse 2 completed an incident report regarding resident 1. Facility nurse 2 documented the following, "...CNA (certified nursing assistant) on morning shift noticed bruises to residents hands. Pt (patient) not oriented enough when asked what happened. I asked day shift if they knew how these bruises occurred and then I asked swing shift which one CNA had witnessed incident. Bruises to BL (bilateral) hands; large across entire hands b/t (back to) thumb and index fingers...[CNA 1] (saw incident) nurse found bruises..." On 10/24/05 at approximately 2:00 PM, the facility administrator provided the nurse surveyor with an "Employee Warning Notice" regarding CNA 2. The following was documented on the warning, "...CNA was bringing a resident from outside patio to DR (dining room) in a very rude way from her under arms and [left] upper arms. Nurse asked CNA to be more gentle [with] pt (patient) and leave her on [sic] place she wants to stay at this point..." On 10/26/05 at 2:05 PM , the facility nurse (facility nurse 1) who completed the "Employee Waring Notice" was interviewed. She stated on 10/23/05, CNA 2 was bringing resident 1 in from the patio and he was holding resident 1 under the left arm pulling her and then pushing her on the back. Facility nurse 1 further stated that "It looked like he was pulling and pushing on her, he was being rough." Facility nurse 1 stated that she talked with CNA 2 about not forcing residents. Facility nurse 1 stated on 10/25/05 resident 1 had	F 225		

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F 225	Continued From page 25 bruising on both her hands. Facility nurse 1 stated that she gave CNA 2 a verbal warning regarding the incident but did not report the incident to anyone. At 3:30 PM, facility nurse 1 was interviewed for a second time. Facility nurse 1 stated she had been employed at the facility for 6 weeks and they had not provided her with any abuse training. Facility nurse 1 stated that if abuse is reported to her she would investigate and was suppose to call the administrator/supervisor. She further stated, "I feel I'm able to determine if it's abuse or not." Facility nurse 1 stated that on 10/23/05, she did not feel abuse had occurred. When facility nurse 1 was reminded that she stated CNA 2 was being rough with resident 1, facility nurse 1 stated, "he was being rough but didn't consider it was abuse, it was cold outside and she needed to be inside." On 10/26/05 at 2:25 PM, resident 1's hands were observed by two nurse surveyors. Resident 1's left hand had a 5-7x4 cm (centimeter) black and purple bruise on the back of her hand, a small cut by her index finger and a 2x2 cm black and purple bruise on the wrist and her right hand had a 5 cm black and purple bruise on the back of the hand. Resident 1 was oriented only to herself and not able to tell the surveyors what had happened to her hands. On 10/26/05 at 2:30 PM, CNA 1 was interviewed over the phone. CNA 1 stated on 10/23/05 during the lunch meal resident 1 was in her room and CNA 2 went and got her. He stated CNA 2 firmly grabbed resident 1's hands and was "tugging" her down the hall. CNA 1 stated resident 1 left the dining room and went out on to the patio. CNA 1	F 225		

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F 225	Continued From page 26 stated that CNA 2 went out on the patio and got resident 1. He stated CNA 2 had his "left arm around her waist and with his right hand was holding her left hand- he had her lifted off the ground and dragged her to her chair." CNA 1 stated that he reported the incident to facility nurse 1 and facility nurse 1 stated she had already talked to CNA 2. CNA 1 stated on 10/24/05 when he came into work facility nurse 2 asked if he knew what happened to resident 1. CNA 1 stated he told facility nurse 2 and wrote a report regarding the incident. He stated when he looked at resident 1's hands they were bruised. On 10/23/05, CNA 1 documented the following on a "CNA Notes", "On 10-23-05, I witnessed [resident 1] being treated cruelly. She was in the dining room for lunch, she waited for about 2-3 minutes, then left outside. When her tray came out, approximately 10 minutes later, I observed [CNA 2], pulling [resident 1] rather harshly by the hands into the dining room. Again she left, and I witnessed [CNA 2], CNA; dragging [resident 1] into dining room. He had his left arm around her waist, and his right hand clinched around [resident 1's] left hand...I told [facility nurse 1] about it, and she said she was going to talk to him, but that not much would happen, because she had already talked to him." On 10/26/05 at 2:50 PM, 3:45 PM and 6:00 PM, the facility administrator was interviewed. He stated he was informed of the incident involving resident 1 and CNA 2 on 10/24/05 in the afternoon (24 hours after the incident occurred). He stated "have not suspended [CNA 2] yet awaiting results of 5 day investigation to determine if abuse occurred or not and then will either suspend or terminate." The administrator	F 225		

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F 225	Continued From page 27 further stated that the DON (director of nurses) was out of town until 11/3/05 and he would wait for her to return before suspending or terminating CNA 2. The administrator stated when an allegation of abuse is brought to his attention APS (Adult Protective Services) is contacted, an incident report is completed and the facility starts a 5 day investigation. He stated the SSW (social service worker) should have contacted APS regarding resident 1 and CNA 2. When asked if he should report to any one else, he queried "that's it, right?". The administrator further stated at this time they did not do any new hire orientation regarding abuse but hope to start doing it once a month. He stated that last abuse in-service was November 2004. On 10/26/05 at 2:55 PM, the SSW was interviewed. The SSW stated she was new at reporting allegations of abuse. She further stated that she became aware of the incident involving resident 1 and CNA 2 on 10/25/05 at 1:00 PM (2 days after the incident occurred). The SSW stated the following, "Papers are ready to be turned into APS. I understand I have 24 hours to turn it in." When the SSW was asked if there were any other agencies she would report to, she stated "no". On 10/27/05 at approximately 8:00 AM, facility nurse 2 was interviewed over the phone. She stated on 10/24/05 the bruising on resident 1's hands was found and she reported the incident to the administrator. Facility nurse 2 further stated that she spoke to CNA 1 and he told her about CNA 2 pulling on resident 1's hands. Facility nurse 2 further reported that CNA 1 reported the	F 225		

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F 225	Continued From page 28 incident to facility nurse 1 and nothing was written up involving the incident. Facility nurse 2 stated that she re-hired with the facility last year. She further stated that the facility provided her papers to fill out, but could not recall if any information regarding abuse was provided. On 10/27/05 at 8:30 AM, the DON was interviewed over the phone. She stated that on 10/23/05 she worked a graveyard shift and was not informed of the incident involving CNA 2 and resident 1 until 10/25/05 (2 days after the incident occurred). The DON further stated that she hired on at the facility August 2005 and the first week she was there she attended an in-service regarding theft, she further stated the in-service touched on abuse and neglect "a little". On 10/27/05 at approximately 9:30 AM, CNA 2 was interviewed. He stated he worked on 10/23/05 with resident 1. He stated he did bring resident 1 in from the patio to eat her meal. CNA 2 further stated that "nobody told me what happened to her [resident 1] until yesterday [10/26/05] about the bruises." When CNA was shown the "Employee Warning Notice" with his signature, he stated that was not his signature and he had never seen that paper. He further stated that the DON worked the night of 10/23/05 and saw him the morning of 10/24/05 and did not talk to him regarding the incident involving resident 1. CNA 2 stated he worked his entire shift on 10/23/05 and also worked an extra shift on 10/24/05. CNA 2 stated he had not received any abuse training at this facility. On 10/27/05 at approximately 10:00 AM, the facility housekeeper was interviewed. She stated on 10/23/05, CNA 2 was cutting resident 1's nails	F 225		

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F 225	Continued From page 29 and resident 1 was asking CNA 2 to stop. She further stated, "I watched her [resident 1] yank her hand away, then he [CNA 2] yanked it back." The housekeeper stated she reported the incident to the DON on 10/24/05 in the morning and the DON told her to "write it up." The housekeeper stated she had been working at the facility for 5 months and had not received any training on abuse. She further stated "I only clean residents room." On 10/25/05, the facility housekeeper documented the following, "On Sunday Oct 23.05 [CNA 2] was cutting [resident 1's] nails she was asking him to stop she pulled her hand back form [sic] him. I was moping down the hallway when I saw him yank her hand back towards him really hard come Monday I noticed her hand was cut and bruised really bad." On 10/27/05 at 1:22 PM, APS was contacted by phone. APS stated they received a report involving resident 1 yesterday (3 days after the incident occurred). 2. Resident 2 was admitted to the facility on 6/30/04 with diagnoses which included diabetes mellitus, hypertension and dementia with depressive and anxious features. On 10/27/05 at 7:30 AM, A phone interview with facility nurse 3 was completed. Facility nurse 3 stated she has worked at the facility for about three years and her last in-service on abuse was the 1st year she worked for the facility. When facility nurse 3 was asked about reporting abuse she stated, "I'm confused on what to do. I'm confused because they [facility administration] are confused on what to do." When facility nurse 3	F 225		

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F 225	Continued From page 30 was asked about any allegations of abuse in the facility she stated she was aware of a report that went to the DON regarding administrative employee 1 and resident 2. She stated that CNA 1 reported the incident. On 10/27/05 at 8:30 AM, a phone interview with the DON was completed. She stated she was not aware of an incident involving resident 2 and administrative employee 1. On 10/27/05 at 10:30 AM, a phone interview with CNA 1 was completed. He stated sometime in September 2005 resident 2 was in the dining room being very loud. He stated resident 2 is often very verbal. CNA 1 stated that administrative employee 1 took resident 2 in her wheelchair and pushed her in front of the couch and told her to stay there. CNA 1 stated that resident 2 flipped onto the couch and administrative employee 1 told resident 2 "that's what you get" and left the resident there. CNA 1 stated he reported the incident to facility nurse 4 and facility nurse 4 helped get resident 2 back into the wheelchair and told CNA 1 he would take care of it. CNA 1 stated he re-hired with the facility September 2005. He further stated he has received no training regarding abuse at this facility. CNA 1 stated he signed some papers and was not sure if there was information regarding abuse on them. He further stated he had never been talked to about the abuse policy and procedures from facility administration. On 10/27/05 at 12:15 PM, administrative employee 1 was interviewed. She stated she was aware of an incident concerning herself and resident 2. She stated resident 2 was throwing herself out of her wheelchair and she placed	F 225		

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F 225	Continued From page 31 resident 2 in front of the couch. Administrative employee 1 stated that the DON talked to her about the incident but she was not suspended or removed from the resident while an investigation was completed. On 10/27/05 at approximately 4:00 PM, during an exit conference the administrator stated he knew nothing about the incident involving resident 2 and administrative employee 1. On 11/1/05 at 8:00 AM, the DON was interviewed. She stated she was aware of the incident involving resident 2 and administrative employee 1. She stated she found out a few days after the incident occurred and she interviewed staff and administrative employee 1 and determined abuse did not occur. She stated she did not report the incident to the facility administrator because she felt abuse did not occur. On 10/27/05 at 1:22 PM, APS was contacted by phone. APS stated they have not had any reports involving resident 2 since July 2004. RESIDENT TO RESIDENT ABUSE: 1. On 10/26/05 at 2:55 PM, the SSW was interviewed. The SSW stated the DON completed an investigation involving an altercation between resident 3 and resident 4. She further stated that the DON should have reported the altercation to APS. On 10/26/05 at 3:30 PM, facility nurse 1 was interviewed. She stated she was aware of only one resident to resident altercation involving resident 3 and resident 4. She further stated that the altercation was reported to the facility	F 225		

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F 225	Continued From page 32 administrator. On 10/27/05 at 9:35 AM, the administrator was interviewed. He stated he was only aware of one resident to resident altercation involving resident 3 and resident 4. On 10/27/05 at 8:30 AM, a phone interview with the DON was completed. The DON stated that she was aware of a resident to resident altercation involving resident 3 and resident 4 that occurred about 1 month ago. She stated resident 3 had an injury. She further stated that she reported the altercation to the SSW who reported to APS. On 10/27/05 at 10:30 AM, a phone interview with CNA 1 was completed. CNA 1 stated he was only aware of a resident to resident altercation involving resident 3 and resident 4 that occurred in the dining room. On 10/26/05, the facility's incident reports were reviewed. On 9/19/05 at 5:00 PM, facility nurse 1 completed an incident report regarding resident 3. Facility nurse 1 documented the following on the incident report, "...Resident to Resident Altercation...A staff member yelled "stay away from her" this nurse went in to DR (dining room) [resident 4] was very upset agitated/violent and [resident 3] was hit by [resident 4] on her [left] side of face - bruise, redness [with] bump on [left] side forehead..." Facility administration did not indicate under the section of the form any "Interventions/Follow up". On 10/26/05, resident 3's medical record was	F 225		

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F 225	Continued From page 33 reviewed. On 9/19/05 at 5:00 PM, facility nurse 1 documented the following in a Nurse's Note", "Pt (patient) on [sic] DR (dining room) on [sic] w/c (wheelchair), suddenly a staff member yelled "Stay away from her" this nurse went in to the DR, "a male resident just hit [resident 3]...at the assessment a bruise/bump small size noted on [left] forehead [and] redness around eye..." On 10/26/05, resident 4's medical record was reviewed. On 9/19/05 at 5:00 PM, facility nurse 1 documented the following in a "Nurse's Note", "Pt (patient) on [sic] DR (dining room), suddenly a staff member yelled "Stay away from her", this nurse went into DR, Pt very upset agitated walking in DR. Pt removed from DR. A staff member state [sic] [resident 4] hit a female resident on face..." On 10/27/05 at 1:22 PM, APS was contacted by phone. APS stated they have not had any reports involving resident 3 since 2003 and they have never had anything reported involving resident 4. INJURIES OF UNKNOWN ORIGIN: 1. On 10/20/05 at 1:00 PM, a nurse's note in resident 7's medical record documented the following entry: "CNA (certified nursing assistant) reported to this nurse a skin tear on resident [left] hand, at the assessment a skin tear noted. 2.8 cm (centimeter) x (by) 1.8 cm..." A review of the facility Incident Reports was completed during the survey and there was an	F 225		

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F 225	Continued From page 34 incident report dated 10/20/05, concerning resident 7, which documented the following: "...CNA (certified nursing assistant) reported to this nurse while passing lunch trays a skin tear on [left] hand. Skin tear measured 2.8 cm (centimeters) x (by) 1.8 wide..." The facility administration was not able to provide any documented evidence that the skin tear found on resident 7's hand on 10/20/05, had been investigated or reported to State Survey Agency. 2. On 6/16/05 at 6:00 AM, a nurse's note in resident 9's medical record documented the following entry: "CNA (certified nursing assistant) found 2 purplish on pt (patient's) [left] wrist (lateral) [and] [left] lateral upper arm, [left] wrist 3 x 1 1/2 cm 9 (centimeter) oblong, [left] upper arm 4 x 1 cm..." A review of the facility Incident Reports was completed during the survey and there was an incident report dated 6/16/05, concerning resident 9, which documented the following: "...CNA (certified nursing assistant) noted 2 purplish bruises on [left] lateral wrist [and] upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm 4 x 1 oblong..." The facility administration was not able to provide any documented evidence that the bruising found on resident 9's wrist and arm on 6/16/05, had been investigated or reported to State Survey Agency. 3. On 7/10/05 at 10:30 AM, a nurse's note in resident CL 1's medical record documented the following entry: "...Noted small cut 1.5 cm (centimeter) to back of head..."	F 225		

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F 225	Continued From page 35 A review of the facility's Incident Reports was completed during the survey and there was no incident report to document how resident CL 1 may have received the cut to the back of his head, which was first documented on 7/10/05. The facility administration was not able to provide any documented evidence that the cut found on resident CL 1's head on 7/10/05, had been investigated or reported to State Survey Agency. 4. On 7/27/05 at 10:30 PM, a nurse's note in resident CL 1's medical record documented the following entry: "Lrg (large) blue bruise approx. (approximately) 5 cm (centimeter) diameter found on [left] abdomen..." A review of the facility Incident Reports was completed during the survey and there was an incident report dated 7/27/05, concerning resident CL 1, which documented the following: "...CNA (certified nursing assistant) noted lrg (large) blue/purple bruise on [left] abdomen approx (approximately) 5 cm (centimeter) diameter..." The facility administration was not able to provide any documented evidence that the bruising found on resident CL 1's abdomen on 7/27/05, had been investigated or reported to State Survey Agency. INTERVIEWS: 1. On 10/27/05 at 8:30 AM, the DON was interviewed over the phone. She stated when she receives an allegation of abuse she investigates and reports to the administrator "who is the abuse coordinator from my understanding."	F 225		

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	465158	A. BUILDING _____ B. WING _____	11/03/2005

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F 225	Continued From page 36 2. On 10/27/05 at 9:30 AM, the SSW was interviewed. She stated "I think [the administrator] is the abuse coordinator, but I don't know." 3. On 10/27/05 at 9:35 AM, the administrator was interviewed. He stated, "I guess I'm the abuse coordinator." He further stated that the building was a small building and everyone was involved.	F 225		
F 226 SS=K	483.13(c) 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. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and review of the facility's abuse policies and procedures, the facility failed to establish effective abuse prevention and protection policies and procedures to ensure that the residents of the facility were free from actual and potential abuse. Additionally, based on interview and record review, the facility failed to screen potential employees for a history of abuse, the facility failed to provide any on going in-service training on the identification and reporting of abuse, the facility failed to thoroughly investigate allegations of abuse (including injuries of unknown origin), the facility failed to protect residents from further abuse and the facility failed to report to the State Survey Agency and others in accordance with	F 226	F-226 Same Plan of correction as F-223 and F-225 Or see Policy and Procedures regarding abuse Reporting. Will be monitored by Administrator And discussed in QA meetings, the first being on December 13, 2005.	12-15-05

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F 226	Continued From page 37 state law. During the survey, completed 10/26/05 through 11/3/05, record review and staff interviews indicated two allegations of staff to resident abuse (Residents 1 and 2), by facility staff members, where the facility failed to thoroughly investigate, report and protect the alleged victims from these occurrences. Additionally, record review and staff interviews indicated one incident of resident to resident abuse (resident 3 and 4) and four incidents of injuries of unknown origin (Residents 7, 9 and CL 1), where the facility failed to investigate or report these occurrences. Findings Include: 1. SCREENING: a. A review of the facility's policy and procedures relating to screening was completed on 10/26/05. The policies and procedures directed the following: "Screening: Prior to employment all candidates will be interviewed by the Department Head for which department they are interviewing for...After an individual chosen to be hired, they will then need to be willing to undergo a criminal background check. Each employee will also provide references if possible from previous employers. If the position the individual is hiring for, involves patient care then the correct licensing boards will be contacted to verify licenses are in good standing..."	F 226		

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F 226	Continued From page 38 b. On 10/26/05, 6 CNA's (certified nursing assistants) employee files were reviewed. Four out of the six files did not have a completed background screening and five out of the six files did not have reference checks completed or proof that the Utah State Nurse Aide Registry was contacted prior to providing care to facility residents. On 10/26/05, 3 facility nurse's employee files were reviewed. Three out of the three files did not have a completed background screening or proof references were checked. In addition, two of the files had documented evidence that the licenses were not checked until after their date of hire. c. On 10/27/05 at 11:15 AM, the office manager was interviewed. The office manager stated she has looked through employee files and noticed information regarding screening was missing. She further stated that she was not aware that she needed to contact the Utah State Nurse Aide Registry for findings of abuse against CNAs. 2. TRAINING: a. A review of the facility's policy and procedures relating to training was completed on 10/26/05. The policies and procedures directed the following: "Training All employees will receive an initial orientation to the facility on issues related to abuse, neglect and misappropriation of resident property. Once a year an in-service will be given to all the employees..."	F 226		

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F 226	Continued From page 39 b. On 10/26/05 at 3:30 PM, facility nurse 1 was interviewed. Facility nurse 1 stated she had been employed at the facility for 6 weeks and they had not provided her with any abuse training. On 10/26/05 at 4:00 PM, the facility administrator was interviewed. He stated at this time they did not do any new hire orientation regarding abuse but hope to start doing it once a month. He stated that last abuse in-service was November 2004. On 10/26/05 at 7:30 AM, facility nurse 3 was interviewed over the phone. Facility nurse 3 stated she has worked at the facility for about three years and her last in-service on abuse was the 1st year she worked for the facility. On 10/27/05 at approximately 8:00 AM, facility nurse 2 was interviewed over the phone. Facility nurse 2 stated that she re-hired with the facility last year. She further stated that the facility provided her papers to fill out, but could not recall if any information regarding abuse was provided. On 10/27/05 at 8:00 AM, facility nurse 4 was interviewed. He stated he has worked at the facility for 3 years. He further stated he could not recall if he received any training regarding abuse at this facility. On 10/27/05 at 8:22 AM , CNA 3 was interviewed. She stated she began working for the facility July 2005. CNA 3 stated she had not received any training regarding abuse at this facility. On 10/27/05 at 8:40 AM, CNA 4 was interviewed. CNA 4 stated she had not received any training regarding abuse at this facility.	F 226		

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F 226	Continued From page 40 On 10/27/05 at 8:30 AM, the DON was interviewed over the phone. The DON further stated that she hired on at the facility August 2005 and the first week she was there she attended an in-service regarding theft, she further stated the in-service touched on abuse and neglect "a little". On 10/27/05 at approximately 9:30 AM, CNA 2 was interviewed. CNA 2 stated he had not received any abuse training at this facility. On 10/27/05 at approximately 10:00 AM, the facility housekeeper was interviewed. The housekeeper stated she had been working at the facility for 5 months and had not received any training on abuse. She further stated "I only clean residents room." On 10/27/05 at 10:30 AM, a phone interview with CNA 1 was completed. CNA 1 stated he re-hired with the facility September 2005. He further stated he has received no training regarding abuse at this facility. CNA 1 stated he signed some papers and was not sure if there was information regarding abuse on them. He further stated he had never been talked to about the abuse policy and procedures from facility administration. 3. IDENTIFICATION AND INVESTIGATION: a. A review of the facility's policy and procedures relating to identification was completed on 10/26/05. The policies and procedures directed the following: "Identification There will be an in-service training and procedure in place for all staff at the time of	F 226		

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F 226	Continued From page 41 orientation and annually regarding ways to identify suspicious bruising of residents. They will also be trained on how to recognize patterns, occurrences or trends that may constitute abuse. Teaching the staff on the above procedures will enable proper direction for investigation." b. Based on interviews with 4 CNA's, 4 facility nurses, a housekeeper, the DON and the Administrator on 10/26/05 and 10/27/05 it was determined that the facility failed to provide any on going in-service training on the identification and reporting of abuse. Four of the CNA's and two of the facility nurse's stated they had been hired within the past year and had not received any new hire orientation to the facilities policies and procedures regarding abuse. This information was confirmed by the administrator in an interview conducted on 10/26/05 at 4:00 PM. (Refer to above interviews.) c. On 10/24/05, facility nurse 2 completed an incident report regarding resident 1. Facility nurse 2 documented the following, "...CNA (certified nursing assistant) on morning shift noticed bruises to residents hands. Pt (patient) not oriented enough when asked what happened. I asked day shift if they knew how these bruises occurred and then I asked swing shift which one CNA had witnessed incident. Bruises to BL (bilateral) hands; large across entire hands b/t (back to) thumb and index fingers...[CNA 1] (saw incident) nurse found bruises..." On 10/24/05 at approximately 2:00 PM, the facility administrator provided the nurse surveyor with an "Employee Warning Notice" regarding CNA 2. The following was documented on the warning, "...CNA was bringing a resident from outside patio	F 226		

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F 226	Continued From page 42 to DR (dining room) in a very rude way from her under arms and [left] upper arms. Nurse asked CNA to be more gentle [with] pt (patient) and leave her on [sic] place she wants to stay at this point..." On 10/26/05 at 2:05 PM , the facility nurse (facility nurse 1) who completed the "Employee Waring Notice" was interviewed. She stated on 10/23/05, CNA 2 was bringing resident 1 in from the patio and he was holding resident 1 under the left arm pulling her and then pushing her on the back. Facility nurse 1 further stated that "It looked like he was pulling and pushing on her, he was being rough." Facility nurse 1 stated that she talked with CNA 2 about not forcing residents. Facility nurse 1 stated on 10/25/05 resident 1 had bruising on both her hands. Facility nurse 1 stated that she gave CNA 2 a verbal warning regarding the incident but did not report the incident to anyone. Facility nurse 1 stated that on 10/23/05, she did not feel abuse had occurred. When facility nurse 1 was reminded that she stated CNA 2 was being rough with resident 1 facility nurse 1 stated, "he was being rough but didn't consider it was abuse, it was cold outside and she needed to be inside." On 10/26/05 at 2:25 PM, resident 1's hands were observed by two nurse surveyors. Resident 1's left hand had a 5-7x4 cm (centimeter) black and purple bruise on the back of her hand, a small cut by her index finger and a 2x2 cm black and purple bruise on the wrist and her right hand had a 5 cm black and purple bruise on the back of the hand. Resident 1 was oriented only to herself and not able to tell the surveyors what had happened to her hands.	F 226		

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F 226	Continued From page 43 On 10/26/05 at 2:30 PM, CNA 1 was interviewed over the phone. CNA 1 stated on 10/23/05 during the lunch meal resident 1 was in her room and CNA 2 went and got her. He stated CNA 2 firmly grabbed resident 1's hands and was "tugging" her down the hall. CNA 1 stated resident 1 left the dining room and went out on to the patio. CNA 1 stated that CNA 2 went out on the patio and got resident 1. He stated CNA 2 had his "left arm around her waist and with his right hand was holding her left hand- he had her lifted off the ground and dragged her to her chair." CNA 1 stated that he reported the incident to facility nurse 1 and facility nurse 1 stated she had already talked to CNA 2. CNA 1 stated on 10/24/05 when he came into work facility nurse 2 asked if he knew what happened to resident 1. CNA 1 stated he told facility nurse 2 and wrote a report regarding the incident. He stated when he looked at resident 1's hands they were bruised. On 10/23/05, CNA 1 documented the following on a "CNA Notes", "On 10-23-05, I witnessed [resident 1] being treated cruelly. She was in the dining room for lunch, she waited for about 2-3 minutes, then left outside. When her tray came out, approximately 10 minutes later, I observed [CNA 2], pulling [resident 1] rather harshly by the hands into the dining room. Again she left, and I witnessed [CNA 2], CNA; dragging [resident 1] into dining room. He had his left arm around her waist, and his right hand clinched around [resident 1's] left hand...I told [facility nurse 1] about it, and she said she was going to talk to him, but that not much would happen, because she had already talked to him." On 10/26/05 at 2:50 PM, 3:45 PM and 6:00 PM, the facility administrator was interviewed. He	F 226		

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F 226	Continued From page 44 stated he was informed of the incident involving resident 1 and CNA 2 on 10/24/05 in the afternoon (24 hours after the incident occurred). On 10/26/05 at 2:55 PM, the SSW was interviewed. She stated that she became aware of the incident involving resident 1 and CNA 2 on 10/25/05 at 1:00 PM (2 days after the incident occurred). The SSW stated the following, "Papers are ready to be turned into APS. On 10/27/05 at 8:30 AM, the DON was interviewed over the phone. She stated that on 10/23/05 she worked a graveyard shift and was not informed of the incident involving CNA 2 and resident 1 until 10/25/05 (2 days after the incident occurred). On 10/27/05 at approximately 10:00 AM, the facility housekeeper was interviewed. She stated on 10/23/05, CNA 2 was cutting resident 1's nails and resident 1 was asking CNA 2 to stop. She further stated, "I watched her [resident 1] yank her hand away, then he [CNA 2] yanked it back." The housekeeper stated she reported the incident to the DON on 10/24/05 in the morning and the DON told her to "write it up." On 10/25/05, the facility housekeeper documented the following, "On Sunday Oct 23.05 [CNA 2] was cutting [resident 1's] nails she was asking him to stop she pulled her hand back form [sic] him. I was moping down the hallway when I saw him yank her hand back towards him really hard come Monday I noticed her hand was cut and bruised really bad." Interviews and record review conducted during the survey showed direct care staff did not inform	F 226		

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F 226	Continued From page 45 administration of the allegation of abuse that was reported to facility nurse 1 on 10/23/05 until 10/24/05. Through interviews with administrative staff, even though they were informed of the abuse on 10/24/05 and 10/25/05, no investigation of the alleged abuse occurred until 10/26/05 (approximately 72 hours after the incident occurred). d. On 10/27/05 at 7:30 AM, A phone interview with facility nurse 3 was completed. When facility nurse 3 was asked about any allegations of abuse in the facility she stated she was aware of a report that went to the DON regarding administrative employee 1 and resident 2. She stated that CNA 1 reported the incident. On 10/27/05 at 8:30 AM, a phone interview with the DON was completed. She stated she was not aware of an incident involving resident 2 and administrative employee 1. On 10/27/05 at 10:30 AM, a phone interview with CNA 1 was completed. He stated sometime in September 2005 resident 2 was in the dining room being very loud. He stated resident 2 is often very verbal. CNA 1 stated that administrative employee 1 took resident 2 in her wheelchair and pushed her in front of the couch and told her to stay there. CNA 1 stated that resident 2 flipped onto the couch and administrative employee 1 told resident 2 "that's what you get" and left the resident there. CNA 1 stated he reported the incident to facility nurse 4 and facility nurse 4 helped get resident 2 back into the wheelchair and told CNA 1 he would take care of it. On 10/27/05 at 12:15 PM, administrative	F 226		

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F 226	Continued From page 46 employee 1 was interviewed. She stated she was aware of an incident concerning herself and resident 2. She stated resident 2 was throwing herself out of her wheelchair and she placed resident 2 in front of the couch. Administrative employee 1 stated that the DON talked to her about the incident. . On 10/27/05 at approximately 4:00 PM, during an exit conference the administrator stated he knew nothing about the incident involving resident 2 and administrative employee 1. Interview and record review conducted during the survey showed the DON did not inform the administrator of the allegation of abuse that was reported to her on or around 9/9/05. There was no documentation of an investigation of the alleged abuse. e. On 10/20/05 at 1:00 PM, a nurse's note in resident 7's medical record documented the following entry: "CNA (certified nursing assistant) reported to this nurse a skin tear on resident [left] hand, at the assessment a skin tear noted. 2.8 cm (centimeter) x (by) 1.8 cm..." A review of the facility Incident Reports was completed during the survey and there was an incident report dated 10/20/05, concerning resident 7, which documented the following: "...CNA (certified nursing assistant) reported to this nurse while passing lunch trays a skin tear on [left] hand. Skin tear measured 2.8 cm (centimeters) x (by) 1.8 wide..." The facility administration was not able to provide any documented evidence that the skin tear found on resident 7's hand on 10/20/05, had been	F 226		

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F 226	Continued From page 47 investigated. f. On 6/16/05 at 6:00 AM, a nurse's note in resident 9's medical record documented the following entry: "CNA (certified nursing assistant) found 2 purplish on pt (patient's) [left] wrist (lateral) [and] [left] lateral upper arm, [left] wrist 3 x 1 1/2 cm 9 (centimeter) oblong, [left] upper arm 4 x 1 cm..." A review of the facility Incident Reports was completed during the survey and there was an incident report dated 6/16/05, concerning resident 9, which documented the following: "...CNA (certified nursing assistant) noted 2 purplish bruises on [left] lateral wrist [and] upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm 4 x 1 oblong..." The facility administration was not able to provide any documented evidence that the bruising found on resident 9's wrist and arm on 6/16/05, had been investigated. g. On 7/10/05 at 10:30 AM, a nurse's note in resident CL 1's medical record documented the following entry: "...Noted small cut 1.5 cm (centimeter) to back of head..." A review of the facility's Incident Reports was completed during the survey and there was no incident report to document how resident CL 1 may have received the cut to the back of his head, which was first documented on 7/10/05. The facility administration was not able to provide any documented evidence that the cut found on resident CL 1's head on 7/10/05, had been investigated.	F 226		

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F 226	Continued From page 48 h. On 7/27/05 at 10:30 PM, a nurse's note in resident CL 1's medical record documented the following entry: "Lrg (large) blue bruise approx. (approximately) 5 cm (centimeter) diameter found on [left] abdomen..." A review of the facility Incident Reports was completed during the survey and there was an incident report dated 7/27/05, concerning resident CL 1, which documented the following: "...CNA (certified nursing assistant) noted lrg (large) blue/purple bruise on [left] abdomen approx (approximately) 5 cm (centimeter) diameter..." The facility administration was not able to provide any documented evidence that the bruising found on resident CL 1's abdomen on 7/27/05, had been investigated. 4. PROTECTION: a. A review of the facility's policy and procedures relating to protection was completed on 10/26/05. The policies and procedures directed the following: "...If an employee is involved, they will be put on suspension until the investigation is complete...Protection The facility will provide procedures to all the staff in how to protect the residents at all times. If an investigation is necessary, we will ensure the resident's will be safe from harm and retaliation..." b. On 10/23/05, an allegation of staff to resident abuse involving CNA 2 and resident 1 was brought to facility nurse 1's attention. CNA 2 was resident 1's assigned aide and continued to	F 226		

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F 226	Continued From page 49 provide care to resident 1 on 10/23/05. A housekeeper documented on a note dated 10/25/05, another incident that occurred on 10/23/05, where she observed the following, CNA 2 was cutting resident 1's nails and resident 1 was asking CNA 2 to stop. She further stated, "I watched her [resident 1] yank her hand away, then he [CNA 2] yanked it back." No documentation was provided regarding the investigation of the incident or what steps were taken to protect resident 2. On 10/26/05 at 2:50 PM, 3:45 PM and 6:00 PM, the facility administrator was interviewed. He stated he was informed of the incident involving resident 1 and CNA 2 on 10/24/05 in the afternoon (24 hours after the incident occurred). He stated "have not suspended [CNA 2] yet awaiting results of 5 day investigation to determine if abuse occurred or not and then will either suspend or terminate." The administrator further stated that the DON was out of town until 11/3/05 and he would wait for her to return before suspending or terminating CNA 2. c. The incident involving administrative employee 1 and resident 2 occurred sometime on or around 9/9/05. When interviewed, administrative employee 1 stated that the DON had talked to her about the incident. Administrative employee 1 stated that the DON talked to her about the incident but she was not suspended or removed from the resident while an investigation was completed. No documentation was provided regarding the investigation of the incident or what steps were taken to protect resident 2. d. Resident 7, resident 9 and resident CL 1 all had injuries of unknown origin. Facility staff were	F 226		

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F 226	Continued From page 50 not able to provide any documentation regarding the investigation and what steps were taken to protect the residents. 5. REPORTING: a. A review of the facility's policy and procedures relating to abuse was completed on 10/26/05. The policies and procedures directed the following: "Any employee who suspects that there has been abuse, neglect, or misappropriation of property towards a resident, employee or visitor should follow the following routine for reporting. 1. Report to your direct supervisor a. If this is not possible or the supervisor is involved, report to a Department Head, Director of Nursing or Administrator. 2. The Administrator or designee will follow the Abuse Reporting Protocol. The person receiving the report will begin the investigation by observing the resident, employee or visitor for any possible injury. Assist the person making report to fill out an incident report. The incident report will be given to the DON and administrator. The DON or Administrator will continue the investigation. 1. Visit with person involved in incident. Ask them if they feel they have been treated wrongly. 2. Interview with suspect to determine their perception of the incident. 3. Interview any witnesses... 4. Review chart or file for any other reports. 5. Fax results within 5 days as per Abuse Reporting Protocol... If the investigation shows probable abuse, then appropriate agencies will be notified...If an	F 226		

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F 226	Continued From page 51 employee is involved, they will be put on suspension until the investigation is complete..." b. On 10/26/05, 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 August 2004, the 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). Since November 2004, the facility had not self reported any of the incidents. c. On 10/26/05 at 2:05 PM , the facility nurse (facility nurse 1) was interviewed regarding the incident involving CNA 2 and resident 1. Facility nurse 1 stated that she gave CNA 2 a verbal warning regarding the incident but did not report the incident to anyone. At 3:30 PM, facility nurse 1 was interviewed for a second time. Facility nurse 1 stated that if abuse is reported to her she would investigate and was suppose to call the administrator/supervisor. She further stated, "I feel I'm able to determine if it's abuse or not." On 10/26/05 at 2:30 PM, CNA 1 was interviewed over the phone regarding the incident involving CNA 2 and resident 1. CNA 1 stated that he reported the incident to facility nurse 1 and facility nurse 1 stated she had already talked to CNA 2. CNA 1 stated on 10/24/05 when he came into work facility nurse 2 asked if he knew what	F 226		

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F 226	Continued From page 52 happened to resident 1. CNA 1 stated he told facility nurse 2 and wrote a report regarding the incident On 10/26/05 at 2:50 PM, 3:45 PM and 6:00 PM, the facility administrator was interviewed. He stated he was informed of the incident involving resident 1 and CNA 2 on 10/24/05 in the afternoon (24 hours after the incident occurred). The administrator stated when an allegation of abuse is brought to his attention APS (Adult Protective Services) is contacted, an incident report is completed and the facility starts a 5 day investigation. He stated the SSW (social service worker) should have contacted APS regarding resident 1 and CNA 2. When asked if he should report to any one else, he stated "that's it right?". On 10/26/05 at 2:55 PM, the SSW was interviewed. The SSW stated she was new at reporting allegations of abuse. She further stated that she became aware of the incident involving resident 1 and CNA 2 on 10/25/05 at 1:00 PM (2 days after the incident occurred). The SSW stated the following, "Papers are ready to be turned into APS. I understand I have 24 hours to turn it in." When the SSW was asked if there were any other agencies she would report to, she stated "no". On 10/27/05 at 8:30 AM, the DON was interviewed over the phone. She stated that on 10/23/05 she worked a graveyard shift and was not informed of the incident involving CNA 2 and resident 1 until 10/25/05 (2 days after the incident occurred). On 10/27/05 at approximately 10:00 AM, the facility housekeeper was interviewed. She stated	F 226		

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F 226	Continued From page 53 on 10/23/05, CNA 2 was cutting resident 1's nails and resident 1 was asking CNA 2 to stop. She further stated, "I watched her [resident 1] yank her hand away, then he [CNA 2] yanked it back." The housekeeper stated she reported the incident to the DON on 10/24/05 in the morning and the DON told her to "write it up." On 10/27/05 at 1:22 PM, APS was contacted by phone. APS stated they received a report involving resident 1 yesterday (3 days after the incident occurred). d. On 10/27/05 at 10:30 AM, a phone interview with CNA 1 was completed. He stated sometime in September 2005 resident 2 was in the dining room being very loud. He stated resident 2 is often very verbal. CNA 1 stated that administrative employee 1 took resident 2 in her wheelchair and pushed her in front of the couch and told her to stay there. CNA 1 stated that resident 2 flipped onto the couch and administrative employee 1 told resident 2 "that's what you get" and left the resident there. CNA 1 stated he reported the incident to facility nurse 4 and facility nurse 4 helped get resident 2 back into the wheelchair and told CNA 1 he would take care of it. On 10/27/05 at 12:15 PM, administrative employee 1 was interviewed. She stated she was aware of an incident concerning herself and resident 2. Administrative employee 1 stated that the DON talked to her about the incident but she was not suspended or removed from the resident while an investigation was completed. On 10/27/05 at approximately 4:00 PM, during an exit conference the administrator stated he knew	F 226		

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F 226	Continued From page 54 nothing about the incident involving resident 2 and administrative employee 1. On 11/1/05 at 8:00 AM, the DON was interviewed. She stated she was aware of the incident involving resident 2 and administrative employee 1. She stated she found out a few days after the incident occurred and she interviewed staff and administrative employee 1 and determined abuse did not occur. She stated she did not report the incident to the facility administrator because she felt abuse did not occur. On 10/27/05 at 1:22 PM, APS was contacted by phone. APS stated they have not had any reports involving resident 2 since July 2004. e. On 10/26/05 at 2:55 PM, the SSW was interviewed. The SSW stated the DON completed an investigation involving an altercation between resident 3 and resident 4. She further stated that the DON should have reported the altercation to APS. On 10/26/05 at 3:30 PM, facility nurse 1 was interviewed. She stated she was aware of only one resident to resident altercation involving resident 3 and resident 4. She further stated that the altercation was reported to the facility administrator. On 10/27/05 at 8:30 AM, a phone interview with the DON was completed. The DON stated that she was aware of a resident to resident altercation involving resident 3 and resident 4 that occurred about 1 month ago. She stated resident 3 had an injury. She further stated that she reported the altercation to the SSW who reported to APS.	F 226		

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F 226	Continued From page 55 On 10/27/05 at 1:22 PM, APS was contacted by phone. APS stated they have not had any reports involving resident 3 since 2003 and they have never had anything reported involving resident 4. f. Resident 7, resident 9 and resident CL 1 all had injuries of unknown origin. Facility staff were not able to provide any documented evidence that the injuries of unknown origin were reported to the State Survey Agency. 6. INTERVIEWS: Based on the investigation, surveyors were unable to determine if a facility staff person had been designated with the primary responsibility for conducting the abuse investigations. The following interviews were conducted on 10/27/05: a. On 10/27/05 at 7:30 AM, A phone interview with facility nurse 3 was completed. When facility nurse 3 was asked about reporting abuse she stated, "I'm confused on what to do. I'm confused because they [facility administration] are confused on what to do." b. On 10/27/05 at 8:30 AM, the DON was interviewed over the phone. She stated when she receives an allegation of abuse she investigates and reports to the administrator "who is the abuse coordinator from my understanding." c. On 10/27/05 at 9:30 AM, the SSW was interviewed. She stated "I think [the administrator] is the abuse coordinator, but I don't know." d. On 10/27/05 at 9:35 AM, the administrator was	F 226		

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F 226	Continued From page 56 interviewed. He stated, "I guess I'm the abuse coordinator." He further stated that the building was a small building and everyone was involved.	F 226		
F 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility did not complete a significant change Minimum Data Set (MDS) assessment for 2 of 10 sample residents (residents 1 and 2) who had been documented by the facility as having a significant change in status. Findings include: 1. Resident 1 was admitted to the facility on 10/24/02 with diagnoses which included vascular dementia, depression, anxiety and insomnia.	F 274	All residents were reviewed by the Director of Nursing, to determine if a significant change Minimum Data Set (MDS) is required. Any significant change MDS that is triggered will be completed by Director of Nursing. All residents will be monitored for need of a significant change MDS, by the Director of Nursing on a quarterly basis, during the scheduled quarterly review for that resident. A significant change MDS will also be completed on those residents that exhibit a significant change if it is before their quarterly review. All residents that require a significant change will be discussed in morning department head meeting every week on Tuesday. We will have MDS review during QA meeting held each quarter, the first will be held on December 13, 2005.	12-15-05

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F 274	Continued From page 57 On 2/3/05, an annual comprehensive MDS was completed for resident 1. On 5/7/05, a quarterly MDS was completed for resident 1. A comparison of the two assessments documented a significant change in the resident's condition. These significant changes triggered the need for a comprehensive MDS assessment to be done. The areas that documented significant change included: Resident 1 had a documented improvement in Behavioral Symptoms, Socially Inappropriate/Disruptive Behavioral Symptoms: a. MDS (2/3/05) Section E4d (1- Behavior was not easily altered) b. MDS (5/7/05) Section E4d (0-Behavior not present or behavior was easily altered) Resident 1 had a documented improvement in Behavioral Symptoms, Resists Care: a. MDS (2/3/05) Section E4e (1-Behavior was not easily altered) b. MDS (5/7/05) Section E4e (0-Behavior not present or behavior was easily altered) Resident 1 had a documented improvement in Personal Hygiene: a. MDS (2/3/05) Section G1j (3-Extensive assistance) b. MDS (5/7/05) Section G1j (2-Limited assistance) On 11/2/05 at 1:10 PM, an interview with the	F 274		

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F 274	Continued From page 58 director of nurses was completed. She stated that a significant change MDS on resident 1 had not been completed. 2. Resident 2 was admitted to the facility on 6/30/04 with diagnoses which included diabetes mellitus, hypertension and dementia with depressive and anxious features. On 7/13/05, an annual comprehensive MDS was completed for resident 2. On 10/11/05, a quarterly MDS was completed for resident 2. A comparison of the two assessments documented a significant change in the resident's condition. These significant changes triggered the need for a comprehensive MDS assessment to be done. The areas that documented significant change included: Resident 2 had a documented improvement in Mood Persistence: a. MDS (7/13/05) Section E2 (2-Indicators present, not easily altered) b. MDS (10/11/05) Section E2 (1-Indicators present, easily altered) Resident 2 had a documented improvement in Behavioral Symptoms, Wandering: a. MDS (7/13/05) Section E4d (1- Behavior was not easily altered) b. MDS (10/11/05) Section E4d (0-Behavior not present or behavior was easily altered) Resident 2 had a documented improvement in Behavioral Symptoms, Verbally Abusive Behavioral Symptoms:	F 274		

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F 274	Continued From page 59 a. MDS (7/13/05) Section E4e (1-Behavior was not easily altered) b. MDS (10/11/05) Section E4e (0-Behavior not present or behavior was easily altered)	F 274		
F 279 SS=E	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and observation, it was determined that for 6 of 10 sample residents (Residents 1, 2, 7, 8, 9 and CL 1) the facility did not develop comprehensive care plans	F 279	All resident care plans will be reviewed and changes made as appropriate, to meet the individual needs for each resident by December 15, 2005. All new admissions will have a comprehensive care plan initiated upon admission and will be completed within 14 days of admission. A comprehensive care plan will be ongoing for each resident and will be changed as necessary to help meet the individual needs of that resident. Care plans will be updated as a change in condition arises on individual residents. These will be monitored by the Director of Nursing upon notification of a change of condition and upon a quarterly review at the Interdisciplinary Team Meeting. The Director of Nurses will complete an in-service to each appropriate department by December 15, 2005, covering the process of care plans. Care planning will be discussed at least once a quarter in our QA meetings. The first review will be December 13, 2005.	12-15-05

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F 279	Continued From page 60 for each resident based on their individual needs identified by the facility staff. Findings include: 1. Resident 1 was admitted to the facility on 10/24/02 with diagnoses which included vascular dementia, depression, anxiety and insomnia. On 11/3/05, resident 1's medical record review was completed. The medical record documented that resident 1 wandered around the facility, outside of the facility and into other resident rooms. From 10/26/05 until 11/3/05, resident 1 was observed by the survey team. Resident 1 was observed to wander around the facility, outside of the facility and into other resident rooms. A review of resident 1's plan of care revealed that resident 1's wandering around the facility, outside of the facility and into other resident rooms had not been incorporated into her plan of care. A review of resident 1's plan of care revealed that resident 1 had a care plan completed on 1/11/05 and last updated on 7/6/05, which documented a "Alteration in nutrition." A review of resident 1's weighs documented a significant weight loss. A review of resident 1's plan of care revealed that a significant weight loss had not been incorporated into her plan of care. On 10/14/05, a physician's order was obtained to	F 279		

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F 279	Continued From page 61 provide resident 1 with finger foods every meal and to monitor the intake. From 10/31/05 until 11/2/05, resident 1 was not observed to receive finger foods with her meals. A review of resident 1's plan of care revealed that finger foods every meal had not been incorporated into her plan of care. 2. Resident 2 was admitted to the facility on 6/30/04 with diagnoses which included diabetes mellitus, hypertension and dementia with depressive and anxious features. On 11/3/05, resident 2's medical record review was completed. A review of resident 2's plan of care revealed that resident 2 had a care plan completed on 7/12/05, which documented a "Potential for altered nutrition." A review of resident 2's weighs documented a significant weight loss. A review of resident 2's plan of care revealed that a significant weight loss had not been incorporated into her plan of care. 3. Resident 7 was admitted to the facility on 03/02/01 with diagnoses which included dementia with psychosis, osteoarthritis, Parkinsons, congestive heart failure, edema, hypothyroidism, constipation and renal insufficiency. On 11/3/05, resident 7's medical record review was completed.	F 279		

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F 279	Continued From page 62 A review of resident 7's plan of care revealed that resident 7 had a care plan completed on 7/5/05, which documented a "Alteration in nutrition." A review of resident 7's weighs documented a significant weight loss. A review of resident 7's plan of care revealed that a significant weight loss had not been incorporated into her plan of care. A review of the "Alteration in nutrition" also revealed under approaches resident 7 would receive total assistance with her meals. Resident 7's meals on 11/1/05 dinner, 11/2/05 breakfast and 11/2/05 lunch were observed by a nurse surveyor. Resident 7 was not observed to receive total assistance with her meals. 4. Resident 8 was admitted to the facility on 7/25/96 with diagnoses which included dementia with anxious and depressive features, hypertension and congestive heart failure. On 11/3/05, resident 8's medical record review was completed. A review of resident 8's plan of care revealed that resident 8 had a care plan completed on 3/22/05 and updated on 7/6/05, which addressed "Alteration in nutrition." One approach the facility documented was that they would provided total assistance with meals. Resident 8's meals on 11/1/05 dinner and 11/2/05 breakfast were observed by a nurse surveyor. Resident 7 was not observed to receive total assistance with her meals.	F 279		

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F 279	Continued From page 63 5. Resident 9 was admitted to the facility on 8/13/03 with diagnoses which included Alzheimer - Dementia type, hypothyroidism, chronic dizziness, thrombocytopenia and dysphagia. On 11/3/05, resident 9's medical record review was completed. A review of resident 9's care plan revealed that resident 9 had a care plan completed on 9/5/05, which addressed "Alteration in visual function." Approaches the facility documented were that they would assist with glasses, assist with wearing and maintaining cleanliness of lenses. On 11/2/05, resident 9 was observed continuously throughout the day. Resident 9 was not observed to wearing her glasses. 6. Resident CL 1 was admitted to the facility on 7/7/05 with diagnosis which included Parkinsons, Dementia with psychotic features, diabetes type II and peripheral neuropathy. On 11/13/05, resident CL 1's medical record review was completed. The medical record documented that resident CL 1 had falls on the following dates: 7/8/05 7/17/05 7/24/05 8/3/05 A review of resident CL 1's plan of care revealed that resident CL 1 had a care plan completed on 7/17/05, which documented "INJURY, HIGH RISK FOR (FALLS)."	F 279		

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F 279	Continued From page 64 A review of resident CL 1's plan of care revealed that actual falls had not been incorporated into his plan of care.	F 279		
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on review of resident's medication records, it was determined that the facility nursing staff were not monitoring resident's conditions prior to administrating medications which required assessment. Specifically, nursing staff were not consistently documenting assessment of blood sugar levels on all 7 of 7 diabetic residents, with physician orders for blood sugar monitoring. (Residents 2, 3, 5, 11, 17, 18, and 19) Findings include: 1. On 11/03/05 resident 2's medical record was reviewed. On 12/20/04, a physician's order was written to provide regular insulin based on the results of resident 2's blood sugars (Blood glucose). The sliding scale ordered was as follows: 201-250 =2 units 251-300 =4 units 301-350 =6 units 351-400 =8 units >400 Call MD.	F 281	**Resident 2,3,5,11,17,18 and 19 (all diabetic residents)** **a)Employee education completed. Instruction in individual orders and treatment plan of blood glucose finger-sticks and diabetic care. Employee education completed. Instruction in professional standard of care includes the implementation of physician orders, documentation of treatments in the medical record, and reporting to physician and responsible party alternations in condition of a resident.** **An in-service will be completed to all license Nurses on documentation and appropriate charting of blood glucose levels. An audit of blood glucose documentation will be completed at random through out the week by the Director of Nurses and will report noted problems, or concerns, to MD as appropriate, Administrator, and to the Quality Improvement Committee at least quarterly.**	12-15-05

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F 281	Continued From page 65 Nursing staff at the facility were to monitor resident 2's blood sugar four times a day (at 6:00 AM, 12:30 PM, 4:30 PM and at 8:00 PM). Review of the October 2005 and November 2005 blood glucose monitoring (BGM) sheet for resident 2 revealed that on 10/02/05 at 4:30 PM, 10/07/05 at 8:00 PM, 10/10/05 at 12:30 PM, and on 10/31/05 at 4:30 PM the blood sugars were not documented as being monitored. On 10/10/05 at 12:30 PM, a facility nurse documented "no strip" 2. On 11/03/05 resident 3's medical record was reviewed. Resident 3 had a physician order, dated 10/07/02, for BGM every AM on Monday, Wednesday and Friday. Review of the October 2005 and November 2005 BGM sheet for resident 3 revealed that the BGM's, scheduled to be done at 6:00 AM, were not documented as being completed on 10/10/05 and on 10/31/05. On 10/10/05 at 6:00 AM, a facility nurse documented "no strip". 3. On 11/03/05, resident 5's medical record was reviewed. Resident 5 had a physician's order, dated 01/06/03, for BGM every week on Saturday and Wednesday at 6:00 AM. Review of the October 2005 and November 2005 BGM sheets for resident 5 revealed that the BGM's scheduled to be done at 6:00 AM, were not documented as being completed on 10/01/05	F 281		

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F 281	Continued From page 66 and 10/19/05. 4. On 11/03/05, resident 11's medical record was reviewed. Nursing staff at the facility were to monitor resident 11's blood glucose every Monday, Wednesday and Friday at 6:00 AM. Review of the October 2005 and November 2005 BGM sheets for resident 11 revealed that the BGM's scheduled to be done at 6:00 AM, were not documented as being completed on 10/10/05, 10/19/05 and 10/31/05. On 10/10/05 at 6:00 AM, a facility nurse documented "no strip". 5. On 11/03/05, resident 17 's medical record was reviewed. On 06/01/05, a physicians's order was written to provide regular insulin based on the results of resident 17's blood glucose. The sidling scale ordered was as follows: 151-200 =2 units 201-250 =4 units 251-300 = 6 units 301-350 =8 units Day time only, no sliding scale after 10:00 PM. Resident 17 had a physician's order, dated 11/12/03, for BGM BID (twice a day) at 6:00 AM, and 4:30 PM. Review of the October 2005 and November 2005 BGM sheets for resident 17 revealed that the BGM's scheduled to be done at 6:00 AM on 10/10/05 was documented as "no strip". There was no documentation that the blood glucose had	F 281		

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F 281	Continued From page 67 been completed. 6. On 11/03/05, resident 18 's medical record was reviewed. Nursing staff at the facility were to monitor resident 11's Blood glucose twice a day at 6:00 AM and at 4:30 PM. Review of the October 2005 and November 2005 BGM sheets for resident 18 revealed that the BGM's scheduled to be done at 6:00 AM on 11/03/05 and at 4:30 PM on 11/1/05 and 11/02/05, were not documented as being completed. 7. On 11/03/05, resident 19's medical record was reviewed. There was documentation on resident 19's November 2005 BGM sheet, that resident 19 was to have regular insulin sliding scale as follows: 150-250 =2 units 251-350 =4 units 351-450 =8 units > 450 =Call MD Resident 19 had a physician's order, dated 08/15/05, for BGM twice a day at 6:00 AM and at 8:00 PM. Review of the October 2005 and November 2005 BGM sheets for resident 19 revealed that the BGM's scheduled to be done at 6:00 AM on 10/10/05, 10/25/05, 11/01/05 and at 8:00 PM on 10/07/05 were not documented as being completed. On 10/10/05, a facility nurse documented "no strip".	F 281		

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F 281	Continued From page 68 "...Blood glucose monitoring helps evaluate effectiveness of medication: reflects glucose excursion after meals; assesses glucose response to exercise regimen; and assists in the evaluation of episodes of hypoglycemia and hyperglycemia to determine appropriate treatment..." (Reference Guidance: Manual of Nursing Practice, 7th edition, 2001, page 843.)	F 281		
F 312 SS=H	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility did not ensure that residents received the necessary services to maintain good nutrition for 4 of 10 sample resident (Residents 1, 2, 7 and 8). Three of the four residents experienced severe unplanned weight losses: Resident 1 lost 19.4 pounds (15.38% of body weight) from 4/26/05 to 10/19/05. Resident 2 lost 23.1 pounds (12.97% of body weight) from 5/11/05 to 10/19/05. Resident 7 lost 17 pounds (15.13% of body weight) from 5/11/05 to 10/19/05. (Refer to F Tag 325 for weight loss calculation method.)	F 312	This facility does and will continue to provide residents who are unable to carry out activities daily the necessary services to maintain good nutrititon, grooming, and personal and oral hygiene. 1. Resident 1. a. Resident treatment plan has been reviewed and updated. i. Comprehensive assessment completed ii. Registered Dietician updated dietary assessment iii. Physician order for "finger foods" is incorporated into treatment plan and provided. iv. Three day calorie count v. Alternative food choices or supplements will be made available for all meals. vi. Will be offered nutrient dense foods throughout the day between meals. vii. Regular meals will be provided during meal times in the dining room or after the meals in the dining room, if need to promote a positive eating environment. viii. Resident will be seated at the assistive dining table to provide support with meals. b. Employee education completed specific to resident treatment plan. 2. Resident 2. a. Resident treatment plan has been reviewed and updated. i. Comprehensive assessment completed ii. Registered Dietician updated dietary assessment. iii. Three day calorie count. iv. Alternate food choices or supplements will be made available at meals. v. Will be offered high protein supplements at meals. vi. Therapeutic diet provided as ordered by the physician. vii. Resident will be seated at the assistive dining table to provide support with meals. c. Employee Education completed specific to resident treatment plan.	12-15-05

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Findings include:

1. Resident 1 was admitted to the facility on 10/24/02 with diagnoses which included vascular dementia, depression, anxiety and insomnia.

A quarterly Minimum Data Set (MDS) assessment, dated 9/16/05, was completed by facility staff for resident 1. Facility staff documented on the MDS assessment that resident 1's cognitive skills for daily decision making were moderately impaired. Facility staff documented on the assessment that resident 1 resisted cares and wanders and the behaviors were not easily altered. Facility staff also documented that resident 1 received one person physical support for setting up the meal and limited assistance with eating.

On a care plan dated 1/11/05 and updated 7/6/05, facility staff documented as a problem that resident 1 had an alteration in nutrition due to inadequate calorie intake and difficulty staying seated. The goal was that resident 1 would have no significant weight loss. One of the approaches was to provide a calm atmosphere at meals with one on one assistance.

A review of resident 1's weight log revealed that on 4/26/05 resident 1 weighed 126.1 lbs (pounds) and on 10/19/05 resident 1 weighed 106.7 lbs. Between 4/26/05 and 10/19/05 (176 days) resident 1 lost 19.4 lbs (15.38%) which is considered a severe weight loss.

The following observations were made:

10/31/05 Breakfast:
Resident 1 was observed to be brought into the

3. Resident 7.
A Resident treatment plan has been reviewed and updated.
   i. Registered Dietician updated dietary assessment.
   ii. Three day calorie count
   iii. Alternate food choices or supplements will be made available for all meals.
   iv. Will be offered high protein supplements at meals.
   v. Therapeutic diet provided as ordered by the physician.
   vi. Resident will be seated at the assistive dining table to provide support with meals.
   d. Employee Education completed specific to resident treatment plan.

4. Resident 8
   a. Resident treatment plan has been reviewed and updated.
      i. Registered Dietician updated dietary assessment
      ii. Three day calorie count
      iii. Alternate food choices or supplements will be made available for all meals
      iv. Will be offered high protein supplements at meals.
      v. Therapeutic diet provided as ordered by the physician.
      vi. Resident will be seated at the assistive dining table to provided support with meals.
      vii. Swallow evaluation completed by Speech Therapist to evaluate ability and tolerance of meal consistency.

   b. Employee Education completec specific to resident treatment plan.

5. All resident nutritional need treatment plans will be reviewed and updated to insure adequate nutrition and assistance provided to each resident. Nutritional assessments have been reviewed and updated.
6. Employee education provided that includes: verification of correct diet offered, assisting residents with eating, encouraging residents to eat, offering alternative meal choices if 50% or less of a meal is eaten.
7. Implementation of meal monitoring tool. Administration Staff will monitor random meals 5-7 days a week. Monitoring tool evaluates the quality of food, the method of serving, distributing, and assisting with meal, offering of alternatives, use of adaptive equipment, and other concerns as they arise.
8. The Dietary Manager or Designee will maintain the Meal Monitoring Tool.
9. The Dietary Manager will track and trend data from the tool and report to the Quality Assurance committee at least quarterly.
10. This plan of correction will be completed by December 15, 2005.

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F 312	Continued From page 70 dining room at 7:40 AM by a nursing assistant. The nursing assistant sat her down in front of her tray and then left. Resident 1 remained at the table for 1 minute. At 7:45 AM the nursing assistant brought resident 1 back to the table and sat her down and the nursing assistant left. Resident 1 immediately got up and left the table and went and sat on a couch. Resident 1 then wandered outside. At 7:50 AM, a nursing assistant attempted to bring resident 1 back into the dining room, resident 1 went back outside. The nursing assistant was not observed to hand resident 1 any finger food or fluids. At 7:53 AM, a nursing assistant went outside and got resident 1 and brought her in and sat her on the couch with a blanket. The nursing assistant was not heard to offer resident 1 any food or fluids. At 7:55 AM resident 1 got up and went back outside, a nursing assistant went and got her and had her sit on the couch. The nursing assistant offered resident 1 the HiPro supplement. Resident 1 was observed to drink 50% of the supplement. The nursing assistant was not heard to offer resident 1 any food items and no finger foods were offered to resident 1. At 7:59 AM resident 1 got up off of the couch and went outside, a nursing assistant redirected resident 1 back inside and sat resident 1 on the couch. The nursing assistant was not heard to offer resident 1 any food or fluids, nor was she observed to provide resident 1 with any food or fluid. At 8:05 AM, a nursing assistant offered resident 1 some milk. Resident 1 refused and the nursing assistant left. At 8:10 AM until 9:00 AM, resident 1 continued to sit on the couch. None of the nursing assistants were observed to offer resident 1 any food or fluids. Resident 1's meal tray was removed from the dining room at 8:20 AM.	F 312		

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F 312	Continued From page 71 Resident 1 was served a regular diet of milk, HiPro supplement, water, juice, hot cereal, eggs and a muffin. Resident 1 was observed to drink 50% of the supplement. No alternatives were offered, nor were any other finger foods besides the muffin observed on the tray. From 7:40 AM until 9:00 AM (1 hour, 20 minutes), resident 1 was continuously observed by a nurse surveyor. Resident 1 was only offered fluid from the nursing assistants 2 times during that time period. Resident 1 was not observed to receive one on one assistance with her meal. 11/1/05 Dinner: Resident 1 was observed to be in her room sleeping at 5:00 PM. At 5:44 PM, resident 1's tray was placed on one of the assisted tables. Resident 1 continued to be in her room sleeping until 6:01 PM. At 6:01 PM, resident 1 came into the day room and sat down on the couch, the facility nurse acknowledged her but did not direct resident 1 into the dining room. At 6:03 PM, a nursing assistant brought resident 1 into the dining room and sat her down at the table. The nursing assistant gave resident 1 a glass of water, but did not offer to heat up resident 1's food. The nursing assistant was observed to immediately walk away from resident 1. Resident 1 drank 100% of the milk and then got up and left. Resident 1 was observed to walk around the dining room, go up to the kitchen window and then walk back over to the couch and sat down. At 6:11 PM, resident 1 got up from the couch and went down a hall. At 6:24 PM, the director of nurses (DON) brought resident 1 back into the dining room and sat resident 1 down at the table. The DON placed resident 1's juice in front of	F 312		

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F 312	Continued From page 72 resident 1, got some hand sanitizer and then left the dining room. Resident 1 was observed to drink the juice and take a few bites of the bread. At 6:27 PM, a nursing assistant sat by resident 1 and offered her fish, the resident refused, then offered resident 1 some rice, resident 1 took a few bite and then was offered some pudding which resident 1 took a few bites. At 6:32 PM, the nursing assistant took the clothing protector off resident 1. Resident 1 asked the nursing assistant what she was doing and the nursing assistant told her she was taking it to the laundry. The nursing assistant then picked up the tray and left. Resident 1 continued to sit at the table until 6:34 PM. Resident 1 was served a regular diet of milk, water, juice, fish, rice, spinach, buttered bread and pudding. Resident 1 was observed to drink 100% of the milk, 25% of the water, 80% of the juice and take a few bites of the rice, bread and pudding. No alternatives were offered, nor were any other finger foods besides the fish and bread observed on the tray. From 5:44 PM until 6:34 PM (50 minutes), resident 1 was continuously observed by a nurse surveyor. Resident 1 was observed to receive one on one assistance with her meal for 5 minutes (6:27 PM until 6:32 PM). 11/2/05 Breakfast: Resident 1 was observed to be sitting on the couch at 7:00 AM. At 7:47 AM, resident 1 breakfast tray was placed at the assist table. A facility nursing assistant tried to direct resident 1 over to the table and resident 1 refused. The nursing assistant did not offer any food or fluids. From 7:47 AM until 8:16 AM (29 minutes)	F 312		

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F 312	Continued From page 73 resident 1 was observed to sit on the couch without any facility staff attempting to redirect resident 1 into the dining room or offer any food or fluids. At 8:16 AM, a nursing assistant went over to resident 1 and offered her a drink of the HiPro supplement, resident 1 took a sip. After 30 seconds the nursing assistant walked away. At 8:36 AM, the DON picked up resident 1's tray and gave it to the dietary manager. Resident 1 was served a regular diet of milk, HiPro supplement, water, juice, eggs, corn flakes and a muffin. Resident 1 was observed to drink a sip of the HiPro supplement. No alternatives were offered, nor were any other finger foods besides the muffin observed on the tray. From 7:47 AM until 8:36 AM (49 minutes), resident 1 was continuously observed by a nurse surveyor. Resident 1 was only offered fluid from the nursing assistants 2 times during that time period. Resident 1 was not observed to receive one on one assistance with her meal. 2. Resident 2 was admitted to the facility on 6/30/04 with diagnoses which included diabetes mellitus, hypertension and dementia with depressive and anxious features. A quarterly MDS assessment, dated 10/9/05, was completed by facility staff for resident 2. Facility staff documented on the MDS assessment that resident 2's cognitive skills for daily decision making were moderately impaired. Facility staff documented on the assessment that resident 2 resisted care and had socially inappropriate/disruptive behaviors that were not easily altered. Facility staff also documented that resident 2 received set up help with her meals	F 312		

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	465158	A. BUILDING _____ B. WING _____	11/03/2005

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F 312	Continued From page 74 and required supervision while eating. On a care plan, dated 7/12/05, facility staff documented as a problem that resident 2 had a potential for altered nutrition related to gradual weight loss. The goal was that resident 2 would have a food and fluid intake between 50-75% to reduce significant weight loss. One of the approaches was to encourage a variety of foods and fluid. Another approach was to provide a HiPro supplement with meals. On 8/30/05, the RD (registered dietitian) documented in a "Nutritional Progress Note" that resident 2 had a weight loss of 11.3 lbs. She documented to "...add 8 oz (ounces) [increased] pro (protein) supplement at each meal to prevent further weight loss..." On 10/14/05, the RD documented in a "Nutritional Progress Note" that resident 2's "weight loss is continuing [with] 23 [pounds] weight loss in past year...Needs total assist [with] ADL's (activities of daily living) [and] meals..." A review of resident 2's weight log revealed that on 5/11/05 resident 2 weighed 178 lbs and on 10/19/05 resident 2 weighed 154.9 lbs. Between 5/11/05 and 10/19/05 (161 days) resident 2 lost 23.1 lbs (12.97%) which is considered a severe weight loss. The following observations were made: 10/31/05 Breakfast: Resident 2 was observed to be in the dining room in her wheelchair at an assisted dining table at 7:34 AM. At 7:44 AM, resident 2 received her breakfast tray. From 7:44 AM until 7:50 AM,	F 312		

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F 312	Continued From page 75 resident 2 was observed to pick up her milk and drink. She was not observed to pick up any utensils and eat her meal. At 7:50 AM, a nursing assistant sat by resident 2 and assisted her with the meal. At 8:20 AM, resident 2 was removed from the assisted table and placed in front of the TV. Resident 2 was served hot chocolate, water, juice, milk, eggs, cornflakes and a muffin. Resident 2 was observed to drink 50% of the hot chocolate, 25% of the juice, 100% of the milk, eat 50% of the eggs and 25% of the cornflakes. No alternatives were offered. An 8 ounce high protein supplement was not observed on resident 2's tray. From 7:44 AM until 8:20 AM (36 minutes), resident 2 was continuously observed by a nurse surveyor. Resident 2 was observed to eat 25% of her meal and facility staff were not observed to encourage resident 2 to eat more food. 11/1/05 Dinner: Resident 2 was observed to be in the dining room up in her wheelchair sleeping at 5:00 PM. At 5:42 PM resident 2 was observed to receive her tray. The nursing assistant set the tray up and then left resident 2 at 5:44 PM. At 5:49 PM, the nursing assistant placed a bite of fish into resident 2's mouth and then left. At 5:54 PM until 5:57 PM, a nursing assistant assisted resident 2 with her milk, resident 2 drank 100%. At 6:01 PM, a nursing assistant went over by resident 2 and then left at 6:03 PM. At 6:07 PM until 6:25 PM, a nursing assistant sat down and fed the resident next to resident 2. The nursing assistant was not heard to encourage resident 2, to eat her meal. At 6:25 PM, resident 2 was observed to be	F 312		

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F 312	Continued From page 76 sleeping. At 6:30 PM, the nursing assistant picked up resident 2's tray. Resident 2 was served milk, water, juice, fish, rice, spinach, buttered bread and tarter sauce. Resident 2 was observed to drink 100% of the milk and 50% of the water. No alternatives were offered. An 8 ounce high protein supplement was not observed on resident 2's tray. From 5:44 PM until 6:30 PM (46 minutes), resident 2 was continuously observed by a nurse surveyor. Resident 2 was assisted with her meal for 3 minutes. Resident 2 was not observed to receive encouragement to eat her meal. 3. Resident 7 was admitted to the facility on 03/02/01 with diagnoses which included dementia with psychosis, osteoarthritis, Parkinsons, congestive heart failure, edema, hypothyroidism, constipation, failure to thrive and renal insufficiency. A quarterly MDS assessment, dated 10/02/05, was completed by facility staff for resident 7. Facility staff documented on the MDS assessment that resident 7's cognitive skills for daily decision making were severely impaired. Facility staff documented on the assessment that resident 7 resisted cares and the behavior was not easily altered. Facility staff also documented that resident 7 received one person physical support for setting up the meal and required extensive assistance with eating. On a care plan, which was not dated, facility staff documented as a problem that resident 7 had an alteration in nutrition related to failure to thrive, excessive weight loss, inadequate caloric intake	F 312		

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F 312	Continued From page 77 to sustain weight. The goal was that resident 7 would have a food and fluid intake of at least 50% at meals. One of the approaches was to provide a puree diet with total assist at meals. A review of resident 7's weight log revealed that on 5/11/05 resident 7 weighed 112.3 lbs and on 10/19/05 resident 7 weighed 95.3 lbs. Between 5/11/05 and 10/19/05 (161 days) resident 7 lost 17 lbs (15.13%) which is considered a severe weight loss. The following observations were made: 11/1/05 Dinner: Resident 7 was observed during the dinner meal. At 5:30 PM, resident 7 was observed to be in her wheelchair sitting at an assisted table. Her son was sitting next to her. At 5:50 PM, resident 7 was observed to receive her tray. At 6:03 PM, resident 7's son left. At 6:04 PM, a nursing assistant came over to resident 7 and asked the resident if she was okay and then left. At 6:05 PM until 6:14 PM, a nursing assistant was observed to sit by resident 7 and assist her with the meal. At 6:26 PM, a nursing assistant picked up resident 7's tray. Resident 7 was served liquefied rice, liquefied fish, liquefied spinach, water, milk, juice, HiPro supplement and buttered bread. Resident 7 was observed to drink 50% of the HiPro supplement and 25% of the juice. No alternatives were offered. From 5:50 PM until 6:26 PM (36 minutes), resident 7 was continuously observed by a nurse surveyor. Resident 7 was observed to receive total assistance with her meal for a total of 9	F 312		

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F 312	Continued From page 78 minutes. 11/2/05 Breakfast: Resident 7 was observed during the breakfast meal. At 7:10 AM, resident 7 was brought into the dining room and placed at an assisted table. At 7:44 AM, resident 7 was served breakfast. At 7:47 AM, resident 7 was offered a bite of her muffin. The nursing assistant then started feeding another resident at the table. At 7:51 AM, resident 7 was offered another bite of her muffin. The nursing assistant then began feeding another resident at the table. At 7:55 AM, resident 7 was offered two bites of her muffin. At 7:56 AM, resident 7 was offered two bites of her muffin and a drink of her HiPro supplement. At 7:58 AM, resident 7 was offered two bites of her muffin. At 7:59 AM, another nursing assistant came and sat down next to resident 7. This nursing assistant was observed to provided resident 7 consistent one on one assistance for the rest of resident 7's meal. Resident 7 was served milk, HiPro supplement, water, juice, liquefied hot cereal, liquefied eggs and a muffin. Resident 7 was observed to consume 75% of the juice, 75% of the Hi-Pro, 50% of the cereal, 25% of the eggs, and 6 bites of the muffin. No alternatives were offered. From 7:44 AM until 7:59 AM (15 minutes), resident 7 was observed to be offered 8 bites of her muffin, and one drink of her HiPro supplement. Resident 7 was not observed to receive one on one assistance with her meal during this time period. 4. Resident 8 was admitted to the facility on	F 312		

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F 312	Continued From page 79 7/25/96 with diagnoses which included dementia with anxious and depressive features, hypertension and congestive heart failure. A quarterly MDS assessment, dated 9/15/05, was completed by facility staff for resident 8. Facility staff documented on the MDS assessment that resident 8's cognitive skills for daily decision making were severely impaired. Facility staff documented on the assessment that resident 8 resisted cares and the behavior was not easily altered. Facility staff also documented that resident 1 received a one person physical assist to set up meal and she was totally dependent upon staff for eating. On a care plan, dated 3/22/04 and updated on 7/6/05, facility staff documented as a problem that resident 8 had an alteration in nutrition related to need for total assist with meals. The goal was that resident 8 would have an intake of 50-75% at all meals. One of the approaches was to assist with meals. Another approach was to encourage a variety of foods and fluid and offer alternatives if intake was less than 75%. The following observations were made: 11/1/05 Dinner: Resident 8 was observed to be in the dining room at 5:30 PM. At 5:47 PM, a nursing assistant provided resident 8 with her tray and left the resident at 5:48 PM. Resident 8 was observed to pick up her juice and drink it. Resident 8 was observed to continuously pick up the glass of juice and try to drink it even when all of the fluids were gone, she was also observed to pick up the buttered bread and eat it. At 6:13 PM, a nursing assistant was observed to place resident 8's milk	F 312		

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F 312	Continued From page 80 in front of resident 8 and left. Resident 8 picked the milk up and drank it. At 6:23 PM, resident 8 was observed to pick up the bowl of spinach but was not able to lift it and set it back onto the tray. At 6:26 PM, a nursing assistant was observed to sit by resident 8 and offer her a bite of the fish, the resident refused and the nursing assistant left the resident at 6:27 PM. At 6:34 PM, a nursing assistant sat by resident 8 and assisted her with the pudding. At 6:40 PM, the nursing assistant picked the tray up and left. Resident 8 was served thickened milk, juice and water and pureed rice, fish and spinach. She was also served pudding as well as buttered bread. Resident 8 was observed to drink 100% of the milk and juice, eat 50% of the pudding and 80% of the bread. No alternatives were offered and resident 8 was not observed to receive a high protein high caloric supplement or Nubasics with her meal. From 5:47 PM until 6:40 PM (53 minutes), resident 8 was continuously observed by a nurse surveyor. Resident 8 was observed to receive total assistance with her meal for a total of 7 minutes. 11/2/05 Breakfast: Resident 8 was observed to be brought into the dining room at 7:15 AM and placed at an assisted table. At 7:45 AM, resident 8 received her tray, a facility nursing assistant set the tray up and then left. Resident 8 was observed to pick up the toast with jelly and eat it. At 7:51 AM a nursing assistant sat beside resident 8 and readjusted her tray. Resident 8 was observed to continue eating the toast. The nursing assistant placed the HiPro supplement in front of resident 8 and resident 8	F 312		

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F 312	Continued From page 81 was observed to pick up the glass and drink the supplement. The nursing assistant left resident 8 at 7:55 AM. Resident 8 then picked up the regular eggs with her hands. It was noted there was no fork on the tray. Resident 8 then picked up her muffin. At 8:30 AM, the nursing assistant moved the tray away from the resident while resident 8 was still picking at items on her tray. The resident was observed to lean forward and take a piece of the egg off of the tray. The nursing assistant left the resident at 8:32 AM. At 8:40 AM, the nursing assistant returned and picked up the plate and put it in resident 8's face, the resident ignored the plate of food in her face and picked up the glass of water and took a sip. At 8:41 AM, the nursing assistant picked up resident 8's tray of food. Resident 8 was served thickened juice, water and HiPro supplement and pureed eggs and hot cereal as well as regular eggs, a muffin and 2 piece of toast with jelly. Resident 8 was observed to drink 100% of the juice, 20% of the water and 20% of the HiPro supplement. Resident 8 was observed to eat 50% of the regular eggs, 75% of the toast and 50% of the muffin. While resident 8 was eating the muffin she would cough after she swallowed a bite. No alternatives were offered and Nubasics was not served with her meal. From 7:45 AM until 8:41 AM (56 minutes), resident 8 was continuously observed by a nurse surveyor. Resident 8 was observed to receive total assistance with her meal for a total of 7 minutes.	F 312		
F 325 SS=H	483.25(i)(1) NUTRITION Based on a resident's comprehensive	F 325		

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F 325	Continued From page 82 assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations and staff interviews it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by 3 of 10 sampled residents (Residents 1, 2 and 7) experienced severe weight loss without adequate dietary interventions, re-evaluations or implementation of new dietary interventions to prevent further weight decline. Calculating weight loss percentages is done by subtracting the current weight from the previous weight, dividing the difference by the previous weight and multiplying by 100. Significant weight losses are as follows: 5% in one month, 7.5% in 3 months and 10% in 6 months. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000). The facility was found to be providing sub-standard quality of care (a pattern of actual harm) in this area. Findings include: 1. Resident 1 was admitted to the facility on 10/24/02 with diagnoses which included vascular dementia, depression, anxiety and insomnia. A review of resident 1's weight log revealed that	F 325	1. Resident 1 a. Resident treatment plan has been reviewed and updated. i. Comprehensive assessment completed ii. Registered Dietician updated dietary assessment iii. Physician order for "finger foods" is incorporated into treatment plan and provided. iv. Three day calorie count v. Alternate food choices or supplements will be made available for all meals. vi. Will be offered nutrient dense foods throughout the day between meals. vii. Regular meals will be proved during meal times in the dining room or after the meals in the dining room if need to promote a positive eating environment. viii. Dietician has reviewed lab values of resident. ix. High protein supplements are provided to address albumin levels. x. Resident will be seated at the assistive dining table to provide support with meals 2. Resident 2 a. Resident treatment plan has been reviewed and updated. i. Comprehensive assessment completed. ii. Registered Dietician updated dietary assessment iii. Three day calorie count iv. Alternate food choices or supplements will be made available for all meals. v. Will be offered high protein supplements at meals vi. Therapeutic diet provided as ordered by the physician. vii. Resident will be seated at the assistive dining table to provide support with meals 3. Resident 7 a. Resident treatment plan has been reviewed and updated. i. Registered Dietician updated dietary assessment ii. Three day calorie count iii. Alternate food choices or supplements will be made available for all meals. iv. Will be offered high protein supplements at meals v. Therapeutic diet provided as ordered by the physician. vi. Resident will be seated at the assistive dining table to provide support with meals. 4. Nursing department will maintain a log of lab work that is completed. The dietician will review the log at each visit to determine need for additional nutritional assessment. 5. Monthly Weight and Skin Meeting will evaluate residents identified as at risk through comprehensive assessment or changes in medical condition, including lab values. a. A log will be maintained of monthly meetings and residents that are discussed. b. The physician and responsible party of residents will be notified when the initial identification of nutritional risk is determined. c. Nursing and Dietician will complete a Significant Change in Status - Weight will be completed. 6. Dietary Manager will track and trend nutritional status changes and report to the Quality Assessment and Assurance Committee at least monthly. 7. This plan of correction will be completed by December 15, 2005.	12-15-05

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F 325	Continued From page 83 on 4/26/05 resident 1 weighed 126.1 lbs (pounds) and on 10/19/05 resident 1 weighed 106.7 lbs. Between 4/26/05 and 10/19/05 (176 days) resident 1 lost 19.4 lbs (15.38%) which is considered a severe weight loss. A lab (laboratory) value taken at the facility and dated 8/22/05 showed a Prealbumin (protein) level of 15. According to the laboratory values the reference range was 18-45. A quarterly MDS (minimum data set) assessment was completed on 9/16/05. Facility staff documented under section K., Oral/Nutritional Status, 1. Oral problems, no chewing or swallowing problems or mouth pain. 3. no weight loss. A review of resident 1's medical record dietary notes revealed that no RD (registered dietitian) assessment addressing the weight loss and low prealbumin had been completed for resident 1. Resident 1 had a nutritional assessment completed 2/15/05. The RD documented that resident 1 received a regular mechanical soft diet. The RD calculated that resident 1 required 1500-1700 calories per day and 50-55 grams of protein per day. On 5/24/05, the RD documented in a "Nutritional Progress Note" that resident 1 had a weight loss of 9 pounds. She documented that resident 1's "...meal intake average 50-60% Resident is very active - up [and] down a lot- may not receive adequate calorie intake..." There was no documented evidence that the RD calculated resident 1's intake to determine if resident 1's nutritional needs were being met.	F 325		

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F 325	Continued From page 84 On 7/19/05, the RD documented in a "Nutritional Progress Note" that resident 1 had a weight loss of 4 more pounds. She documented that resident 1 "...is often agitated- wanders during meals from assist table. Continued weight loss is of concern as average meal intake is [less than] 50%. House supplements and 1:1 attention from staff are given daily in effort to increase nutrient intake..." There was no documented evidence that the RD calculated resident 1's intake to determine if resident 1's nutritional needs were being met. On 9/6/05, the RD, DON (director of nurses) and DM (dietary manager) documented the following on their "Skin/Weight Review", "Resident is at assisted dining, requires cueing to remain seated. Gradual wt (weight) loss, receives HiPro 5 [times] day, restorative nursing 3 [times] wk (week). Enriched foods..." There was no documented evidence that resident 1's intake was calculated to determine if resident 1's nutritional needs were being met. On 9/13/05, the RD documented in a "Nutritional Progress Note" that resident 1 had a weight increase of a 1/2 pound. She documented "...continue supplements [with] meals and medication pass [and] continue 1:1 encouragement [at] meals. Cont (continue) plan of care. There was no documented evidence that the RD calculated resident 1's intake to determine if resident 1's nutritional needs were being met. On 10/20/05, the DON and DM documented the following on their "Skin/Weight Review", "Continues to have wt (weight) loss. She is provided finger foods, Hi pro supplement,	F 325		

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F 325	Continued From page 85 assisted dining. Anticipate decline will reduce complications assoc (associated) [with] wt loss." There was no documented evidence that resident 1's intake was calculated to determine if resident 1's nutritional needs were being met. A nutritional care plan for resident 1 was completed on 1/11/05 and last updated on 7/6/05. Facility staff identified the following problem, "Alteration in nutritional status [related to] inadequate caloric intake need for redirection [at] meals...Frequent state of anxiety [with] difficulty staying seated [at] meals. Declining status..." Facility staff documented the following under interventions, "...Restorative aide to improve nutritional intake...Provide calm atmosphere [at] meals [with] 1:1 and TLC (tender loving care)..." On 11/2/05 at 1:10 PM, the director of nurses was interviewed. She stated at this time there was no restorative dining program in place. On 10/14/05, the following physician order was obtained, "Finger Foods [every] Meal. Monitor intake." On 10/31/05 resident 1's breakfast was observed. For breakfast resident 1 received milk, hi-pro house supplement, water, juice, hot cereal, eggs and a muffin. Resident 1 was observed to drink 50% of the hi-pro supplement. Resident 1 was not observed to receive 1:1 assistance with her meal. On 11/1/05 at 7:30 AM, resident 1 was observed to be in bed. Facility staff were not observed to go in and wake resident 1 for breakfast. On 11/1/05 at 1:40 PM, a facility nursing assistant	F 325		

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F 325	Continued From page 86 was interviewed. He stated that he works with resident 1 five days a week. He stated that resident 1 "did not end up getting up for breakfast. Got up after breakfast, don't know what they provided when she got up." He further stated that he had not seen any finger foods provided to resident 1 except for bread and rolls. Review of resident 1's diet card on 11/1/05, revealed she was on a regular diet. It did not indicate that resident 1 was to receive finger foods with her meals. On 11/1/05, resident 1's dinner was observed. For dinner resident 1 received milk, water, juice, pudding, fish, rice, spinach and buttered bread. Resident 1 ate a few bites of pudding, rice and bread. Resident 1 was observed to drink 100% of the milk, 80% of the juice and 25% of the water. Resident 1 was not observed to receive 1:1 assistance with her meal. On 11/2/05 at 6:15 AM, a facility nurse was interviewed. She stated that she works one day a week. She further stated that resident 1 wanders at night and she can get her to eat sandwiches if she sits with her one on one. She further stated that her shift begins at 6:00 PM and that she has not seen any finger foods provided for resident 1. On 11/2/05 at 6:45 AM, a facility nursing assistant was interviewed. She stated that resident 1 was a poor eater and wanders around. She further stated that she had not seen any finger foods provided to resident 1. The nursing assistant stated that resident 1 receives the same meal trays as every one else. On 11/2/05, resident 1's breakfast was observed.	F 325		

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F 325	Continued From page 87 Resident 1 received eggs, muffin, corn flakes, milk, water, juice and hi-pro house supplement. Resident 1 was observed to have a sip of the hi-pro supplement. Resident 1 was not observed to receive 1:1 assistance with her meal. A review of resident 1's "Food and Fluid Intake Monitor" sheet from 10/1/05 until 11/2/05 revealed resident 1 received 99 meals. Six of the 99 meals provided no documentation that any of the meal was consumed. Out of the 93 meals that the facility documented on, the charting revealed that resident 1 consumed less than 50% of her meals 77 times. On 10/23/05, a facility staff member documented the following on the "Food and Fluid Intake Monitor" sheet for breakfast, "Aide didn't bring to DR (dining room) to eat." On 11/3/05 at 1:00 PM, the DM was interviewed. She stated that resident 1 was on a regular diet but is now on finger foods. The DM further stated that resident 1 was not on an enriched diet. The DM stated that the last time resident 1's caloric and protein needs were calculated was on 2/15/05. She further stated that the RD has not re-assessed resident 1's nutritional needs since the weight loss. The RD did not calculate caloric and protein requirements to ensure resident 1 was receiving adequate calories and protein for her needs. Without this calculation, staff would not know whether or not the diet would meet the caloric and protein needs for resident 1. 2. Resident 2 was admitted to the facility on 6/30/04 with diagnoses which included diabetes mellitus, hypertension and dementia with depressive and anxious features.	F 325		

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F 325	Continued From page 88 A review of resident 2's weight log revealed that on 5/11/05 resident 2 weighed 178 lbs and on 10/19/05 resident 2 weighed 154.9 lbs. Between 5/11/05 and 10/19/05 (161 days) resident 2 lost 23.1 lbs (12.97%) which is considered a severe weight loss. A lab value taken at the facility and dated 9/21/05 showed an albumin (protein) level 2.9 g/dl (grams per deciliter). The normal reference range, according to the lab used by the facility, was 3.3-4.8 g/dl. An albumin level of 2.4-2.9 g/dl is considered a moderate visceral protein deficit. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000, page 22). The albumin of 2.9 g/dl dated 9/21/05 was the most current in resident 2's medical record and was not acknowledged by the RD. A quarterly MDS assessment was completed on 10/11/05. Facility staff documented under section K., Oral/Nutritional Status, 1. Oral problems, no chewing or swallowing problems or mouth pain. 3. significant weight loss. A review of resident 2's medical record dietary notes revealed that no RD assessment addressing the weight loss and low albumin had been completed for resident 2. Resident 2 had a nutritional assessment completed 7/6/04. The RD documented that resident 2 received a 1800 calories regular diet. The RD calculated that resident 2 required 1500-1800 calories per day and 55-60 grams of protein per day.	F 325		

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F 325	Continued From page 89 On 5/24/05, the RD documented in a "Nutritional Progress Note" that resident 2 had a weight loss of 6 pounds. She documented that resident 2's "...Appetite is fair and FSS (food service supervisor) states intake is improving past few days..." There was no documented evidence that the RD re-calculated resident 2's intake to determine if resident 2's nutritional needs were being met. On 7/12/05, the RD documented in a "Nutritional Progress Note" that resident 2 had a weight loss from 174 lbs to 164 lbs, the RD requested increased protein supplements with meals. She documented that resident 2's "...table was changed [at] meals [due to] 2 other res (residents) taking food from her tray..." There was no documented evidence that the RD re-calculated resident 2's intake to determine if resident 2's nutritional needs were being met. On 8/30/05, the RD documented in a "Nutritional Progress Note" that resident 2 had a weight loss of 11.3 lbs. She documented to "...add 8 oz (ounces) [increased] pro (protein) supplement at each meal to prevent further weight loss..." There was no documented evidence that the RD re-calculated resident 2's intake to determine if resident 2's nutritional needs were being met. On 9/6/05, the RD, DON and DM documented the following on their "Skin/Weight Review", "Continue enriched foods, propass 3 [times] day...Change to dining table moved to facilitate better eating environment. gradual decline noted..." There was no documented evidence that resident 2's intake was calculated to determine if resident 2's nutritional needs were being met.	F 325		

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F 325	Continued From page 90 A physician order for an enriched diet could not be found in the medical record. A physicians order for 8 oz of increased protein supplement could not be found in the medical record. On 9/13/05, the DON and DM documented the following on their "Skin/Weight Review", "...[down] 3 [pounds] this wk (week) had increase anxiety this past wk..." There was no documented evidence that resident 2's intake was calculated to determine if resident 2's nutritional needs were being met. On 10/14/05, the RD documented in a "Nutritional Progress Note" that resident 2 had a weight loss of 5.5 lbs. She documented "...weight loss is continuing [with] 23 [pound] weight loss in past year intake [at] meals seems to be adequate to maintain weight. Needs total assist [with] ADL's (activities of daily living) [and] meals - Some refusal of meals noted in past week..." There was no documented evidence that the RD calculated resident 2's intake to determine if resident 2's nutritional needs were being met. On 10/20/05, the DON and DM documented the following on their "Skin/Weight Review", "...gradual decline continues. Behaviors have inhibited eating...Will continue current diet plan..." There was no documented evidence that resident 2's intake was calculated to determine if resident 2's nutritional needs were being met. A nutritional care plan for resident 2 was completed on 7/12/05. Facility staff identified the following problem, "Potential for altered nutrition R/T (related to) DX (diagnoses) of diabetes, low albumin level...gradual weight loss" Facility staff	F 325		

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F 325	Continued From page 91 documented the following under interventions, "...Regular LCS (low concentrated sweets) diet...Hi Pro supplements [with] meals...encourage variety of foods [and] fluid [and] offer snacks..." On 4/26/05, the following physician order was obtained, "Diet: LCS (low concentrated sweets), regular." On 11/3/05, the DM provided the surveyors with a diet list. It was noted, that resident 2 was receiving a low concentrated sweet regular diet. On 10/31/05, resident 2's breakfast was observed. For breakfast resident 2 received milk, hot chocolate, water, juice, corn flakes, eggs and a muffin. Resident 2 was observed to drink 50% of her hot chocolate, 25% of her water, 100% of her milk and she ate 50% of her eggs and 25% of her corn flakes. On 11/1/05, resident 2's dinner was observed. For dinner resident 2 received milk, water, juice, pudding, fish, rice, spinach and buttered bread. Resident 2 was observed to drink 50% of her water and 100% of her milk. Review of resident 2's diet card on 11/1/05, revealed she was on a regular LCS (low concentrated sweet) diet. It did not indicate that resident 2 was to receive 8 ounces of increased protein supplement with her meals. During the two meal observations, it should be noted that resident 2 was not observed to receive 8 ounces of a protein supplement. A review of resident 2's "Food and Fluid Intake Monitor" sheet from 10/1/05 until 11/2/05 revealed	F 325		

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F 325	Continued From page 92 resident 2 received 99 meals. Out of the 99 meals that the facility documented on, the charting revealed that resident 2 consumed less than 50% of her meals 34 times. On 11/3/05 at 1:00 PM, the DM was interviewed. She stated that resident 2 was on a mechanical soft low concentrated sweet diet. The DM further stated that resident 2 was not on an enriched diet. The DM stated that the last time resident 2's caloric and protein needs were calculated was on 7/6/04. She further stated that the RD has not re-assessed resident 2's nutritional needs since the weight loss. The RD did not calculate caloric and protein requirements to ensure resident 2 was receiving adequate calories and protein for her needs. Without this calculation, staff would not know whether or not the diet would meet the caloric and protein needs for resident 2. 3. Resident 7 was admitted to the facility on 03/02/01 with diagnoses which included dementia with psychosis, osteoarthritis, Parkinsons, congestive heart failure, edema, hypothyroidism, constipation, failure to thrive and renal insufficiency. A review of resident 7's weight log revealed that on 5/11/05 resident 7 weighed 112.3 lbs and on 10/19/05 resident 7 weighed 95.3 lbs. Between 5/11/05 and 10/19/05 (161 days) resident 7 lost 17 lbs (15.13%) which is considered a severe weight loss. A quarterly MDS assessment was completed on 10/2/05. Facility staff documented under section K., Oral/Nutritional Status, 1. swallowing problems. 3. no weight loss.	F 325		

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F 325	Continued From page 93 A review of resident 7's medical record dietary notes revealed that no RD assessment addressing the weight loss had been completed for resident 7. On 1/11/05, the RD documented in the "Nutrition Progress Notes" that resident 7 weighed 118.8 lbs on 1/3/05, "Continued wt (weight) loss due to inadequate calorie [and] nutrient intake..... Cont (continue) to assist [and] encourage intake [of] 8 ounce HiPro supps (supplements) between meals". There was no documented evidence that the RD calculated resident 7's intake to determine if resident 7's nutritional needs were being met. On 4/11/05, the RD documented in the "Yearly Assessment", that resident 7 had a weight loss of 19 lbs in the last year and resident 7 received a mechanical soft diet. The RD also documented that resident 7 had less than 50% intake at all meals, and to increase protein supplements between meals and at bedtime. The RD documented under "specific comments: " "continued weight loss of 17 [lbs] since 7/5/04. Wt. (weight) stable since 3/21/05. Receiving Hospice care [secondary to] declining status. Res (resident) is DNR (do not resuscitate) [with] no feeding tube Cont. (continue) to assist [with] all meals [and] offer [increase] Pro (protein) supps. (supplements) if [less than] 50% meal intake. Cont. CP (care plan)". There was no documented evidence that the RD calculated resident 7's intake to determine if resident 7's nutritional needs were being met. No new interventions or alternatives were put into place to maintain resident 7's weight. On 7/03/05, the RD documented in the "Nutrition	F 325		

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F 325	Continued From page 94 Progress Notes" that resident 7's weight was 109.5 lbs, "Continued weight loss of 10 [lbs] since last review. Resident receives Hospice care Resident has DX (diagnosis) of failure to thrive... needs assist [with] all meals. Intake [at]all meals is less than 50%. Cont CP (care plan)". There was no documented evidence that the RD calculated resident 7's intake to determine if resident 7's nutritional needs were being met. On 10/04/05, the RD documented in the "Nutrition Progress Notes", "...Continued weight loss to 99.6 [lbs] Resident continues on Hospice care Appetite is poor [with] 1:1 (one on one) assist [at] meals... supplements are offered but often refused Resident physical status declining [with] failure to thrive Observe resident for adequate hydration status [and] skin breakdown." There was no documented evidence that the RD calculated resident 7's intake to determine if resident 7's nutritional needs were being met. There was no documentation that RD had implemented any new interventions or alternatives, despite resident 7's refusals of the supplement. From 5/11/05 until 11/03/05 (6 months), resident 7 lost 20.8 lbs (18.52%), the RD documented about resident 7's weight loss twice. There was no evidence that the RD evaluated resident 7's caloric needs. There was no documentation that the RD implemented any new interventions or alternatives, despite resident 7's refusals of the supplement. A review of resident 7's "Food and Fluid Intake Monitor " sheet from 10/01/05 until 11/02/05 revealed that resident 7 received 99 meals. Out of the 99 meals provided, the charting revealed	F 325		

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F 325	Continued From page 95 that resident 7 consumed less than 50% of her meals 72 times. In addition, the charting revealed that resident 7 consumed less than 25% of the meals 41 out of the 72 meals. Resident 7 was observed during the dinner meal on 11/1/05. At 5:30 PM, resident 7 was observed to be in her wheelchair sitting at an assisted table. Her son was sitting next to her. At 5:50 PM, resident 7 was observed to receive her tray. At 6:03 PM, resident 7's son left. At 6:04 PM, a nursing assistant came over to resident 7 and asked the resident if she was okay and then left. At 6:05 PM until 6:14 PM, a nursing assistant was observed to sit by resident 7 and assist her with the meal. At 6:26 PM, a nursing assistant picked up resident 7's tray. Resident 7 was served liquefied rice, liquefied fish, liquefied spinach, water, milk, juice, HiPro supplement and buttered bread. Resident 7 was observed to drink 50% of the HiPro supplement and 25% of the juice. No alternatives were offered. From 5:50 PM until 6:26 PM (36 minutes), resident 7 was continuously observed by a nurse surveyor. Resident 7 was observed to receive total assistance with her meal for a total of 9 minutes. Resident 7 was observed during the breakfast meal on 11/2/05. At 7:10 AM, resident 7 was brought into the dining room and placed at an assisted table. At 7:44 AM, resident 7 was served breakfast. At 7:47 AM, resident 7 was offered a bite of her muffin. The nursing assistant then started feeding another resident at the table. At 7:51 AM, resident 7 was offered another bite of	F 325		

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F 325	Continued From page 96 her muffin. The nursing assistant then began feeding another resident at the table. At 7:55 AM, resident 7 was offered two bites of her muffin. At 7:56 AM, resident 7 was offered two bites of her muffin and a drink of her HiPro supplement. At 7:58 AM, resident 7 was offered two bites of her muffin. At 7:59 AM, another nursing assistant came and sat down next to resident 7. This nursing assistant was observed to provided resident 7 consistent one on one assistance for the rest of resident 7's meal. Resident 7 was served milk, HiPro supplement, water, juice, liquefied hot cereal, liquefied eggs and a muffin. Resident 7 was observed to consume 75% of the juice, 75% of the Hi-Pro, 50% of the cereal, 25% of the eggs, and 6 bites of the muffin. No alternatives were offered. From 7:44 AM until 7:59 AM (15 minutes), resident 7 was observed to be offered 8 bites of her muffin, and one drink of her HiPro supplement. Resident 7 was not observed to receive one on one assistance with her meal during this time period. On 11/2/05 observations of resident 7 was made during the lunch meal. Resident 7 was observed during the lunch meal on 11/2/05. At 12:10 PM, resident 7 was served lunch. Resident 7 was served milk, Hi-Pro supplement, juice, liquefied carrots, liquefied chicken parmesan, a whole banana, a garlic roll and banana pudding. At 12:15 PM, a nursing assistant offered resident 7 a drink of the Hi-Pro supplement. Resident 7 was observed to consume 75% of the	F 325		

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F 325	Continued From page 97 juice, 25% of the milk, 25% of the carrots, 25% of the chicken parmesan, and 80% Hi-Pro supplement. No alternatives were offered. A physician's order for a liquefied diet could not be located in resident 7's medical record. On 11/3/05 at 1:00 PM the dietary manager was interviewed. She stated that resident 7 was to receive a pureed enriched diet. The dietary manager stated that she noticed the resident was not doing as well so they were now providing resident 7 with a liquefied diet. The dietary manager stated that she did not think there was a physician's order for a liquefied diet.	F 325	F-354 This facility makes every effort to provide eight consecutive hours of registered nurse services seven days a week. There is limited availability of Registered Nurses (RN) in the community. This facility is activiely recruiting for an RN by running a continuous ad in the community newspaper. This facility utilizes agency services to meet RN needs as they are available. This facility will schedule an RN for eight consecutive hours per day. The Director of Nursing or Designee will maintain a copy of the schedule. The Director of Nursing of Designee will maintain a log of days when RN coverage is less than 8 consecutive hours. The Director of Nursing will track and trend RN hours and report to the Qualtiy Assessment and Assurance committee at least quarterly. This plan of correction will be completed by December 15, 2005.	
F 354 SS=E	483.30(b) NURSING SERVICES - REGISTERED NURSE 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 director of nurses (DON) and review of the facility nursing			12-15-05

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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) COMPLETION DATE
F 354	Continued From page 98 schedule, the facility failed to have a registered nurse (RN) for at least 8 consecutive hours a day, 7 days a week, since September 10, 2005. Findings include: Review of the facility September 2005 and October 2005 on 11/2/05, revealed that the facility did not have 8 hours of RN coverage on 9/10/05, 9/17/05, 9/24/05, 10/26/05, 10/27/05, 10/28/05 and 10/29/05. On 11/2/05 at approximately 10:00 AM, the facility DON stated that she works Monday thru Friday and at times on Saturday and Sunday, if needed. She further stated that when she was out of town there was no RN coverage in the building.	F 354		
F 363 SS=E	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not follow the approved menus for the breakfast, lunch and dinner meals observed on 10/31/05, 11/1/05, 11/2/05 and 11/3/05. Specifically, residents were not served food items per the menu and the dietary staff members were not using appropriate	F 363	This facility does and will continue to provide menus that meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of National Research Council, National Academy of Sciences; be prepared in advance and be followed. Employee in-service training provided by Dietician for all dietary employees. 1.Proper serving sizes and utensils use 2.Following posted menu 3.All residents will receive meals containing adequate nutrition and serving size. 4.All residents will receive meals prepared as directed by the recipe. 5.All ingredients for recipes will be available in the kitchen.	12-15-05

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F 363	Continued From page 99 sized utensils to serve food items which resulted in incorrect amounts of food being provided to the residents. Findings include: The menu documented the following to be served for breakfast on 10/31/05: Oatmeal Scrambled eggs with onion Glazed cinnamon roll Whole milk Juice Observations made during the breakfast meal served on 10/31/05 revealed that the eggs served had no onions and a muffin was served instead of a cinnamon roll. The menu documented the following to be served for dinner on 11/01/05: Crunchy fish Creamed spinach Fruit mix Bread Whole milk Tarter Sauce Observations made during the dinner meal on 11/01/05 revealed that the spinach served was not a creamed spinach and that only those with a diabetic diet were served fruit and those on a regular diet did not receive fruit as the menu indicated. Further observation of the tray line revealed random servings of spinach were being served by	F 363	6.All servings will be measured using appropriate serving tool. 7.Purchase of serving tools completed 8.Alternative food choices will be available at every meal and is posted in the dining area. 9.Dietary Manager will conduct random audits to insure compliance. 10.A log of audits will be maintained by the Dietary Manager or Designee. The Dietary manager will track and trend results of audits and report to the Quality Assessment and Quality Assurance Committee at least quarterly. The Dietary manager will report to the Administrator the results of the audits. This plan of correction will be completed by December 15, 2005	

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F 363	Continued From page 100 the kitchen staff. The correct serving size that the spread sheets documented was 1/2 cup and was to be served with a #8 scoop. The kitchen aide serving the spinach was using tongs and not measuring the serving size. Observations of the meal trays revealed random serving sizes and none that resembled a 1/2 cup serving size. Observations were made of the tray line during the lunch meal on 11/3/05. The following serving utensils and menu items were observed. Beef Burgundy -8 oz. ladle Noodles -serving spoon (no documented measurement) Rice - serving spoon (no documented measurement) Mixed vegetables - 8 oz. spoon Further observation revealed that the serving size of the noodles or rice varied from one spoonful to three spoonfuls. The residents received from a quarter of a ladle to a full ladle of beef burgundy and a full spoon to a quarter of a spoon of vegetables. It was observed that the vegetable were being served at a smaller rate towards the end of the tray line. When questioning the dietary manager about the serving sizes, she stated that she likes to over feed the residents and tends to give them too much. She also stated that she ran out of vegetables. The following are the menu's documented serving sizes and menu items for the lunch meal on 11/3/05: Beef Burgundy - 4 oz. Rice - 1/2 cup Broccoli - 1/2 cup	F 363		

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F 363	Continued From page 101 In an interview with the dietary manager on 11/03/05 she stated that she had made some changes to the recipe for the beef burgundy. She stated that she likes to add her own touches.	F 363	F367: Therapeutic Diets This facility does and will continue to provide therapeutic diets as prescribed by the attending physician. 1. Resident 1 a. Resident treatment plan has been reviewed and updated. i. Comprehensive assessment completed ii. Registered Dietician updated dietary assessment iii. Physician order for "finger foods" is incorporated into treatment plan and provided. iv. Three day calorie count v. Alternate food choices or supplements will be made available for all meals. vi. Will be offered nutrient dense foods throughout the day between meals. vii. Regular meals will be proved during meal times in the dining room or after the meals in the dining room, if need to promote a positive eating environment. viii. Resident will be seated at the assistive dining table to provide support with meals b. Employee Education completed specific to resident treatment plan. 2. Resident 2 a. Resident treatment plan has been reviewed and updated. i. Comprehensive assessment completed. ii. Registered Dietician updated dietary assessment iii. Three day calorie count iv. Alternate food choices or supplements will be made available for all meals. v. Will be offered high protein supplements at meals vi. Therapeutic diet provided as ordered by the physician. vii. Resident will be seated at the assistive dining table to provide support with meals	
F 367 SS=H	483.35(e) THERAPEUTIC DIETS Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, it was determined that 4 out of 10 sampled residents and 2 additional residents did not receive a therapeutic diet as ordered by the physician or assessed as being necessary by an interdisciplinary team. (Residents 1, 2, 7, 8, 10, 20.) Findings include: 1. Resident 1 was admitted to the facility on 10/24/02 with diagnoses which included vascular dementia, depression, anxiety and insomnia. A review of resident 1's weight log revealed that on 4/26/05 resident 1 weighed 126.1 lbs (pounds) and on 10/19/05 resident 1 weighed 106.7 lbs. Between 4/26/05 and 10/19/05 (176 days) resident 1 lost 19.4 lbs (15.38%) which is considered a severe weight loss. A review of the dietary notes revealed an order dated 4/26/05, for a regular diet with house supplements between meals.	F 367		12-15-05

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F 367	Continued From page 102 A physician order, dated 10/14/05, documented an order for finger foods every meal. The following observations were made: 10/31/05 Breakfast: Resident 1 was served a regular diet of milk, HiPro supplement, water, juice, hot cereal, eggs and a muffin. Resident 1 was observed to drink 50% of the supplement. No alternatives were offered and there were no other finger foods besides the muffin observed on the tray. 11/1/05 Dinner: Resident 1 was served a regular diet of milk, water, juice, fish, rice, spinach, buttered bread and pudding. Resident 1 was observed to drink 100% of the milk, 25% of the water, 80% of the juice and take a few bites of the rice, bread and pudding. No alternatives were offered and there were no other finger foods besides the fish and bread observed on the tray. 11/2/05 Breakfast: Resident 1 was serves a regular diet of milk, HiPro supplement, water, juice, eggs, corn flakes and a muffin. Resident 1 was observed to drink a sip of the HiPro supplement. No alternatives were offered and there were no other finger foods besides the muffin observed on the tray. On 11/1/05, a nursing assistant who provided care to resident 1 five days a week was interviewed. He stated that resident 1 received a regular tray like all of the other residents. He further stated other than breads, there were no finger foods provided on her trays.	F 367	3. Resident 7 a. Resident treatment plan has been reviewed and updated. i. Registered Dietician updated dietary assessment ii. Three day calorie count iii. Alternate food choices or supplements will be made available for all meals. iv. Full liquid diet provided. 1. No bread is offered. v. Will be offered high protein supplements at meals vi. Therapeutic diet provided as ordered by the physician. vii. Resident will be seated at the assistive dining table to provide support with meals. 4. Resident 8 a. Resident treatment plan has been reviewed and updated. i. Registered Dietician updated dietary assessment ii. Three day calorie count iii. Alternate food choices or supplements will be made available for all meals. iv. Will be offered high protein supplements at meals v. Therapeutic diet provided as ordered by the physician. vi. Resident will be seated at the assistive dining table to provide support with meals. vii. Swallow evaluation completed by Speech Therapist to evaluate ability and tolerance of meal consistency. 1. Bread products offered slurried per mechanical soft diet.	

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F 367	Continued From page 103 On 11/2/05, a facility nurse was interviewed. She stated that she works with resident 1 one day a week. She stated that she had not seen any finger foods provided on resident 1's tray. On 11/3/05 at 1:00 PM, the dietary manager was interviewed. She stated that resident 1 was on a regular diet but is now on finger foods. She further stated that resident 1 does not receive a diet which is enriched which is inaccurate according to the physician order dated 4/26/05. Further, observations made during the survey revealed that resident 1 did not receive any finger foods other than those on a regular diet. This did not reflect the physician order of 10/14/05 for finger foods with every meal. 2. Resident 2 was admitted to the facility on 6/30/04 with diagnoses which included diabetes mellitus, hypertension and dementia with depressive and anxious features. A review of resident 2's weight log revealed that on 5/11/05 resident 2 weighed 178 lbs and on 10/19/05 resident 2 weighed 154.9 lbs. Between 5/11/05 and 10/19/05 (161 days) resident 2 lost 23.1 lbs (12.97%) which is considered a severe weight loss. A review of dietitian notes revealed that she was to receive a enriched diet with 8 ounces of increased protein supplement with each meal. A physician re-certification order, dated 10/3/05, documented an order for a low concentrated sweet regular diet. The following observations were made:	F 367	5. Employee education to dietary employees by Dietician a. Powder supplements added to foods i. Measuring and serving size b. Mechanically Altered diets i. Bread choices and consistency ii. Consistency differences c. Finger foods d. Alternative foods 6. Nursing employees educated a. Offer and assist residents with meals b. Offer and assist residents with supplements c. Offer residents who have intake less than 50% alternative food choices. 7. Implementation of Meal Monitoring Tool. Administration Staff will monitor random meals 5-7 days a week. Monitoring tool evaluates the quality of food, the method of serving, distributing, and assisting with meal, offering of alternatives, use of adaptive equipment, and other concerns as they arise. 8. Dietary Manager will conduct random audits to insure compliance. a. A log of audits will be maintained by the Dietary Manager or Designee 9. The Dietary manager will track and trend results of audits and report to the Quality Assessment and Assurance Committee at least quarterly. 10. This plan of correction will be completed by December 15, 2005.	

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F 367	Continued From page 104 10/31/05 Breakfast: Resident 2 was served hot chocolate, water, juice, milk, eggs, cornflakes and a muffin. Resident 2 was observed to drink 50% of the hot chocolate, 25% of the juice, 100% of the milk, eat 50% of the eggs and 25% of the cornflakes. No alternatives were offered. An 8 ounce high protein supplement was not observed on resident 2's tray. 11/1/05 Dinner: Resident 2 was served milk, water, juice, fish, rice, spinach, buttered bread and tarter sauce. Resident 2 was observed to drink 100% of the milk and 50% of the water. No alternatives were offered. An 8 ounce high protein supplement was not observed on resident 2's tray. 11/2/05 Breakfast: Resident 2 was served milk, water, juice, hot chocolate, eggs, corn flakes and a muffin. Resident 2 was observed to drink 100% of the juice, 95% of the milk, 75% of the water, 100% of the hot chocolate and eat 80% of the eggs, 25% of the muffin and 100% of the corn flakes. An 8 ounce high protein supplement was not observed on resident 2's tray. On 11/3/05 at 1:00 PM, the dietary manager was interviewed. She stated that resident 2 received a mechanical soft low concentrated sweet diet. The dietary manager further stated "residents not on puree do not get an enhanced diet" which is oppositional to the recommendation of the dietician. 3. Resident 7 was admitted to the facility on 03/02/01 with diagnosis which included: dementia with psychosis, osteoarthritis, Parkinsons,	F 367		

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F 367	Continued From page 105 congestive heart failure, edema, hypothyroidism, constipation, failure to thrive and renal insufficiency. A review of resident 7's weight log revealed that on 5/11/05 resident 7 weighed 112.3 lbs and on 10/19/05 resident 7 weighed 95.3 lbs. Between 5/11/05 and 10/19/05 (161 days) resident 7 lost 17 lbs (15.13%) which is considered a severe weight loss. A review of the dietary notes revealed a diet order, dated 4/26/05, for a puree diet with no salt on tray, and house supplements, [increase] Pro [three times a day]. The following observations were made: 11/1/05 Dinner: Resident 7 was served a diet which was liquefied, except for the buttered bread. The meal consisted of liquefied rice, liquefied fish, liquefied spinach, water, milk, juice, HiPro supplement and buttered bread. Resident 7 was observed to drink 50% of the HiPro supplement and 25% of the juice. No alternatives were offered. 11/02/05 Breakfast: Resident 7 was served a diet which was liquefied, except for the muffin. The tray consisted of orange juice, milk, HiPro supplement, water, hot cereal, eggs, and a muffin mixed with milk. It was observed that resident 7 was never offered any alteratives, or to have her meal tray heated up. Resident 7 was observed to drink 75% of the juice, 75% of the HiPro supplement, 50% of the hot cereal, 25% of the eggs and 6 bites of the muffin. No alternatives were offered.	F 367		

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F 367	Continued From page 106 11/02/05 Lunch: Resident 7 was served a diet which was liquefied, except for the banana and garlic roll. The meal consisted of HiPro supplement, milk, juice, carrots, chicken parmesan, whole banana, banana pudding, and a garlic roll. It was observed that resident 7 consumed 75% of the juice, 25% of the milk, 25% of the carrots, 25% of the chicken parmesan, 25% of the HiPro supplement, and 80 % of the milk. No alternatives were offered. A physician's order for a liquefied diet could not be located in resident 7's medical record. On 11/3/05 at 1:00 PM the dietary manager was interviewed. She stated that resident 7 was to receive a pureed enriched diet. The dietary manager stated that she noticed the resident was not doing as well so they were now providing resident 7 with a liquefied diet. The dietary manager stated that she did not think there was a physician's order for a liquefied diet. 4. Resident 8 was admitted to the facility on 7/25/96 with diagnoses which included dementia with anxious and depressive features, hypertension and congestive heart failure. A review of the dietary notes revealed a diet order dated 4/26/05 for a puree honey thick liquids, high protein, high caloric supplement with meals Nubasics 120 cc (cubic centimeters) three times a day. A physician re-certification order, dated 10/3/05, documented an order for a honey thick liquids, high protein, high caloric supplement with meals Nubasics 120 cc (cubic centimeters) three times	F 367		

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F 367	Continued From page 107 a day. The following observations were made: 11/1/05 Dinner: Resident 8 was served thickened milk, juice and water and pureed rice, fish and spinach. She was also served pudding as well as buttered bread. Resident 8 was observed to drink 100% of the milk and juice, eat 50% of the pudding and 80% of the bread. No alternatives were offered and resident 8 was not observed to receive a high protein high caloric supplement or Nubasics with her meal. 11/2/05 Breakfast: Resident 8 was served thickened juice, water and HiPro supplement and pureed eggs and hot cereal as well as regular eggs, a muffin and 2 piece of toast with jelly. Resident 8 was observed to drink 100% of the juice, 20% of the water and 20% of the HiPro supplement. Resident 8 was observed to eat 50% of the regular eggs, 75% of the toast and 50% of the muffin. While resident 8 was eating the muffin she would cough after she swallowed a bite. No alternatives were offered and Nubasics was not served with her meal. 11/3/05 Breakfast: Resident 8 was served thickened HiPro supplement, water and juice and puree bacon, french toast, cereal, as well as a regular banana. Nubasics was not served with her meal. On 11/3/05 at 1:00 PM, the dietary manager was interviewed. She stated that resident 8 has always been a bread eater and "if [resident 8] didn't get bread she would starve." The dietary manager further stated that resident 8 was on a	F 367		

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F 367	Continued From page 108 puree diet but will not eat puree foods. 5. Resident 10 was admitted to the facility with diagnoses which included depression, dementia, hypothyroidism, hypertension and gastrointestinal distress. A review of the dietary notes revealed a diet order, dated 4/26/05, for a mechanical soft diet, small portions and a high protein and high calorie [three times a day] with meals. A physician re-certification order, dated 10/21/05, documented an order for a mechanical soft, small portion, high calorie, high protein diet. The following observations were made: 11/01/05 Dinner: Resident 10 was served a regular diet of fish, rice, spinach, bread and cake. No alternatives were offered and a high protein and high caloric supplement was not observed on her tray. 11/2/05 Lunch: Resident 10 was served a regular diet of chicken parmesan, spaghetti noodles, carrots, pudding, garlic bread and milk. Resident 10 was observed to drink all of her fluids and one bite of pudding. No alternatives were offered and a high protein and high caloric supplement was not observed on her tray. 11/03/05 Lunch: Resident 10 was served a regular diet of beef burgundy, noodles, mixed vegetables and sherbet. No alternatives were offered and a high protein and high caloric supplement was not observed on her tray.	F 367		

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F 367	Continued From page 109 In an interview with a dietary cook on 11/01/05, he stated that he does not add anything to the food to increase the calories or the protein. He stated that the only "enrichment" that he is aware of is the supplements on the resident's trays. On 11/3/05 at 1:00 PM, the dietary manager was interviewed. She stated that the residents on pureed diets receive a powder supplement called BeneCal added to their cereal. A review of the label of the supplement documented that this would add 330 calories and 7 grams of protein to their cereal if they were to consume 100% of their cereal. Additionally, she stated that she adds 1 teaspoon of ProPass (a protein supplement) to 8 oz. (ounces) of milk to increase the protein. A review of the protein supplement revealed the instructions documented that "one scoop" (provided in the can of supplement) would add 6 grams of protein to the milk. Further review of the instructions revealed that one scoop of supplement was an 8 gram measurement which does not equal a teaspoon measurement. 6. Meal observations on 11/1/05, 11/2/05 and 11/3/05 revealed that residents on a puree diet received whole foods which were not pureed or slurried. Resident 7, 8 and 20 had diet orders for a pureed diet signed by the physician and documented in their dietary notes. None of the residents had an order for whole foods to be added to their diets. On 11/1/05, residents 7, 8 and 20 were observed to receive a dinner roll with their evening meal. The therapeutic spread sheets documented that the resident on a pureed diet would have received	F 367		

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F 367	Continued From page 110 a pureed bread. On 11/02/05, residents 7, 8 and 20 were observed to receive a muffin on their breakfast meal tray. The therapeutic spread sheets documented that the resident on a pureed diet would have received a slurried muffin. On 11/02/05, residents 7, 8 and 20 were observed to receive garlic bread on their lunch trays. The therapeutic spread sheets documented that the resident on a pureed diet would have received a slurried bread. On 11/03/05, residents 7, 8 and 20 were observed to receive a dinner roll on their lunch trays. The therapeutic spread sheets documented that the resident on a pureed diet would have received a pureed bread. On 11/3/05 at 1:00 PM, the dietary manager was interviewed. She stated that she has always put bread on their trays because that is the way they have been doing it for along time. The dietary manager stated that she was not sure if the dietitian was aware that bread was put on the puree trays, but was pretty sure she was. She further stated that the dietitian has never told her not to put bread on the puree trays. The dietary manager stated that she "does not get much" guidance from the dietitian.	F 367		
F 371 SS=E	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions.	F 371		

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	465158	A. BUILDING _____ B. WING _____	11/03/2005

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F 371	Continued From page 111 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not prepare, distribute and serve food under sanitary conditions. Findings include: During the initial inspection of the kitchen on 10/31/05 the following was observed. Refrigerator by the spice rack: One slice of ham dated 10/21, an open package of deli turkey and three opened packages of cheese dated 10/27, an opened package of unlabeled meat dated 10/22 and another opened package of cheese dated 10/23. Refrigerator in the dry storage room: One container of opened sour cream with an expiration date of 10/29/05, an opened pitcher of tomato juice dated 10/27, two pitchers of thickened punch dated 10/27, three containers of thickened hi protein drink dated 10/28, one container of thickened milk dated 1/30 and one container of chocolate hi protein drink dated 10/2. There was a container of thickened water stored in a non-reusable plastic jar dated 10/30. These containers are defined as single-use and are not approved for re-use. "89 (a) "single-use articles" means utensils and bulk food containers designed and constructed to be used once and discarded. (b) "single-use articles" includes items such	F 371	F371: Sanitary Conditions- Food Prep and Service This facility does and will continue to store, prepare, distribute, and serve food under sanitary conditions 1. Employee education of dietary staff by dietician a. Proper storage and usage of food products b. Proper labeling and dating i. Beverage preparation for following day c. Use of appropriate storage containers 2. Purchase of approved food storage containers 3. Dietary Manager will conduct random audits to insure compliance. a. A log of audits will be maintained by the Dietary Manager or Designee 4. The Dietary manager will track and trend results of audits and report to the Quality Assessment and Assurance Committee at least quarterly. 5. This plan of correction will be completed by December 15, 2005. The Dietary Manager will monitor all food items stored in refrigerators bi-weekly to ensure that food is marked and dated. DM will also monitor for dates of all food items in refrigerators and dry storage room. New containers will be ordered for storage of multiple use items. All single use item containers will be discarded after use. All dietary staff will be in-serviced on using proper utensils for dishing of food. An in-service will also be given on wearing of gloves during meal times and the proper time of changing gloves during meals. HI-Pro Medication Pass- All Hi-Pro Medication pass supplement will be kept in a 2 quart, or smaller, container and on ice during med pass times. If more supplement is needed then the nurse will get more out of the refrigerator to help finish med pass. After med pass, the supplement will be put back into the refrigerator until next medication pass. Containers will be marked with date and time removed from refrigerator. All License Nurses will be in-serviced regarding Hi Pro Medication Pass supplement and proper storage by December 15, 2005. Rounds will be completed bi-weekly by D.O.N. on proper storage of supplement.	

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F 371	Continued From page 112 as wax paper, butcher paper, plastic wrap, formed aluminum food containers, jars, plastic tubs or buckets,... which do not meet the materials, durability, strength, and cleanability under 4-101.11, 4-201.11, and 4-202.11 for multi-use utensils. (Food Code, FDA, 2001. pg.17)" Refrigerator by the sink: Eight pink ice cream dated 10/26, one rainbow ice cream dated 10/25 and one container of prune juice dated 10/26. There were also two trays equaling 84 cups of milk and juice stored on trays with no dates. In an interview with a dietary aide she stated that the milk and juices were poured the night before for use the next day. Food Preparation: On 11/2/05 at 7:32 AM, the dietary manager was observed on tray line for the breakfast meal. The dietary manager was observed to be wearing gloves. She was observed to dish up eggs for three of the resident trays with her gloved hand. The dietary manager then went and got a scoop to dish up the eggs. The dietary manager was observed to handle plates, trays, scoops, pan lids and the countertop without changing her gloves, she was then observed to touch with her gloved hands the muffins as well as the eggs that were spilled over from the scoop and plates. These items were served to the facility residents. The dietary manager was only observed to change her gloves one time during the breakfast tray line. Hi-Pro Medication Pass On 11/2/05 from 6:45 AM until 8:52 AM, a gallon milk jug of Hi-pro medication pass was observed	F 371		

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F 371	Continued From page 113 on the medication cart and administered to facility residents during the medication pass. The Hi-pro medication pass was not observed to be on ice or refrigerated. At 8:52 AM, a facility nurse placed the Hi-pro medication pass in the refrigerator. At 8:53 AM, a nurse surveyor checked the temperature of the Hi-pro medication pass and found the temp to be 62 degrees Farenheit. At 11:45 AM, the facility nurse took the same Hi-pro medication pass out of the refrigerator and administered it to facility residents. At 12:10 PM, a nurse surveyor checked the temperature of the Hi-pro medication pass and found the temperature to be 58 degrees Farenheit. According to the 2001 U.S. Public Health Service Food Code, "Potentially Hazardous Foods (milk) shall be maintained at a temperature of 5 degrees Celsius or 41 degrees Fahrenheit."	F 371		
F 372 SS=E	483.35(h)(3) SANITARY CONDITIONS - GARBAGE DISPOSAL The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility did not dispose of garbage or refuse properly. Specifically the facility did not ensure that the waste receptacle was covered with a lid. Findings include: On 10/31/05 at 7:00 AM, the waste dumpster located in front of the facility was observed to	F 372	Rounds will be completed on a daily basis by the maintenance director to ensure that dumpsters remain closed at all times. An in-service will be given to all staff ensuring that the waste receptacle is covered. They will be instructed on proper sanitation, and why leaving the lid open on the dumpsters could cause a health hazard. The inservice will be completed on or before the 15th of December 2005. Sanitation in respect to garbage disposal will be discussed in our QA meetings, the first being held on Dec 13, 2005. The maintenance director will keep a log, on how often he finds the lids open on the dumpsters. He will meet with the Administrator monthly to review findings.	12-15-05

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F 372	Continued From page 114 contain garbage and the lid was not closed. On 11/1/05 at 7:20 AM and 1:20 PM, the waste dumpster located in front of the facility was observed to contain garbage and the lid was not closed. On 11/2/05 at 6:20 AM, the waste dumpster was observed to contain garbage and the lid was not closed.	F 372		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that 1 of 10 sample residents (Resident 8) and 1 supplemental resident (resident 10) were not seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days as required. Findings include: 1. Resident 8 was admitted to the facility on 7/25/96 with diagnoses which included dementia		F 387: Frequency of Physician Visits This facility provides physician visits at least once every 30-day for the first 90-days after admission and at least once every 60-day thereafter. 1. Resident 8/10 has been scheduled to be examined by the physician on December 15, 2005 or before. 2. All resident records have been audited for frequency of physician visits. a. Residents requiring a physician visit has been scheduled and will be examined by the physician by December 15, 2005 3. The physician visit tracking tool has been revised to schedule one year of visits. a. The physician will receive a copy of the yearly schedule at least monthly or more frequently as changes arise. b. The Medical Records Director or Designee will provide to the physician a list of required visits with dates each month. c. The Medical Records Director or Designee will contact the physician of visits that are not completed by the scheduled date and schedule a visit within the ten-day grace period. d. The Medical Records Director will maintain a log of physician visits. e. The Medical Records Director will track and trend physician visits and report to the Quality Assessment and Assurance Committee at least quarterly. f. This plan of correction will be completed by December 15, 2005.	12-15-05 fter.

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F 387	Continued From page 115 with anxious and depressive features and hypertension. A review of resident 8's medical record revealed that the resident had been seen by a physician on 10/10/04 and 1/5/05. Resident 8 should have been seen by a physician on or around 12/10/04. There was no documentation in the medical record to provide evidence that resident 8 had been seen by a physician on or around 12/10/04. 2. Resident 10 was admitted to the facility with diagnoses which included depression, dementia, hypothyroidism, hypertension and gastrointestinal distress. A review of resident 10's medical record revealed that the resident was last seen by a physician on 6/19/05. Resident 10 should have been seen by her physician on or around 8/19/05 and 10/19/05. There was no documentation in the medical record to provide evidence that resident 10 had been seen by a physician on or around 8/19/05 and 10/19/05. On 11/2/05, during a meeting with administration staff the missing physician visits were requested. The facility was not able to provide any missing physician visits.	F 387	F388: Frequency of Physician Visits This facility provides all required physician visits to be made personally by the physician. All required visits will be performed by the physician. The physician may alternate required visits with a nurse practitioner or clinical nurse specialist. 1. Resident 1 has been examined by the physician on 11/5/05. 2. Resident 2 has been examined by the physician on 11/15/05. 3. All resident records have been audited for frequency of physician visits. a. Residents requiring a physician visit has been scheduled and will be examined by the physician by December 15, 2005 b. All required visits will be completed by the physician. c. The nurse practitioner will provide ancillary visits as need to address lab values, psychotropic drug review, and changes in condition that may arise between required visits as directed by the physician.	
F 388 SS=D	483.40(c)(3)-(4) FREQUENCY OF PHYSICIAN VISITS	F 388		12-15-05

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F 388	Continued From page 116 Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review it was determined that for 2 of 10 sample residents (residents 1 and 2), the physician visits did not alternate between the visits of a nurse practitioner. Findings include: 1. Resident 1 was admitted to the facility on 10/24/02 with diagnoses which included vascular dementia, depression, anxiety and insomnia. A review of resident 1's medical record showed that the nurse practitioner had seen the resident on 8/9/05 and 10/13/05. The physician should have seen resident 1 on the 10/13/05 visit. 2. Resident 2 was admitted to the facility on 6/30/04 with diagnoses which included diabetes mellitus, hypertension and dementia with depressive and anxious features. A review of resident 2's medical record showed that the nurse practitioner had seen the resident on 12/17/05, 1/9/05, 2/6/05 and 2/16/05. The	F 388	4. **The physician visit tracking tool has been revised to schedule one year of visits.** a. **The physician will receive a copy of the yearly schedule at least monthly or more frequently as changes arise.** b. **The Medical Records Director or Designee will provide to the physician a list of required visits with dates each month.** c. **The Medical Records Director or Designee will contact the physician of visits that are not completed by the scheduled date and schedule a visit within the ten-day grace period.** d. **The Medical Records Director will maintain a log of physician visits.** e. **The Medical Records Director will track and trend physician visits and report to the Quality Assessment and Assurance Committee at least quarterly.** 5. **This plan of correction will be completed by December 15, 2005.** **F490: Administration** **This facility does and will continue to be administered in such 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.**	

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F 388	Continued From page 117 physician should have seen resident 2 on the 2/16/05 visit.	F 388		
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 complaint survey with a subsequent re-certification/extended survey, conducted 10/26/05 through 11/3/05, and resultant finding of Immediate Jeopardy and Substandard 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 staff to resident abuse, resident to resident abuse and resident injuries of unknown etiology. The facility was found to be providing Substandard Quality of Care (a pattern of actual harm) in these areas. The facility was cited in a total of 19 areas, not including this deficiency. Findings include: On 10/26/05, a complaint survey was initiated. On 10/27/03, facility administration was notified of the elements of Immediate Jeopardy and Substandard Quality of Care. The determination	F 490	**This facility does and will continue to be administered in such 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.** **Plan of Correction for all 19 deficiencies please see pages 1 through 124 of the form CMS 2567.** **No later than December 15, 2005 the facility will be in substantial compliance. All POC's will be followed up by the Administrator and discussed in our Quality Assurance meetings. Our first meeting will be December 13, 2005.**	12-15-05

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F 490	Continued From page 118 of Immediate Jeopardy and Substandard Quality of Care was based on the findings of significant non-compliance in the area of Resident Behavior and Facility Practices [42 Code of Federal Regulations (CFR) 483.13 (b) (c), cross reference Tag F-223, Tag F-225 and Tag F-226]. 1. Facility administration failed to ensure that each resident was free from physical abuse. (Scope and severity "K", refer to Tag F-223) 2. Facility administration failed to thoroughly investigate, and report to appropriate agencies the abuse, neglect, and injuries of unknown origin. (Scope and severity "K", refer to Tag F-225) 3. 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 and how to prevent the abuse from occurring. Scope and severity "K", refer to Tag F-226) 4. In addition to the areas of Immediate Jeopardy and Substandard 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 11/3/05. a. Facility administration failed to ensure that personal funds of the residents deposited with the facility were safeguarded, and managed. (Scope and severity "G", refer to Tag F-159)	F 490		

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F 490	Continued From page 119 b. Facility administration failed to ensure that the most recent survey was available for examination in a place readily accessible to the residents. (Scope and severity "B", refer to Tag F-167) c. Facility administration failed to ensure that policies and procedures were implemented that prohibited neglect. (Scope and severity "G", refer to Tag F-224) d. Facility administration failed to ensure that significant change minimum data sets were completed when a resident experienced a significant change. (Scope and severity "D", refer to Tag F-224) e. Facility failed to ensure that comprehensive care plans were developed and implemented with measurable objectives and timetables to meet the resident's needs. (Scope and severity "E", refer to Tag F-279). f. Facility administration failed to ensure that blood sugar checks were completed as ordered by the resident's attending physicians. (Scope and severity "E", refer to Tag F-281) g. Facility administration failed to ensure that residents who required assistance with their meals received the necessary services to maintain good nutrition. (Scope and severity "H", refer to Tag F-312) h. Facility administration failed to ensure that each resident maintained an acceptable parameter of nutritional status. (Scope and severity "H", refer to Tag F-325)	F 490		

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F 521 SS=K	Continued From page 121 ASSURANCE 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. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. 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 administrator, the facility failed to ensure that the quality assurance committee effectively identified quality issues. Findings include: 1. During an interview with the facility administrator on 11/2/05 at 12:25 PM, he stated that they had a quality assurance meeting in June 2005 and September 2005. He further stated that the meetings consisted of the administrator, director of nursing, social service worker, recreational worker, dietary manager, office manager, social service consultant and medical director.	F 521	The facility does and will continue to meet as a quality assessment and assurance committee at least quarterly to identify issues with respect to which quality Assessment and assurance activities are necessary; and develop and implement appropriate plans of action to correct identified quality deficiencies. A new policy and procedure manual will be in place by December 13, 2005 regarding Quality Assurance/Improvement meetings. Quaitity improvement Committee meeting will be on a monthly basis on the second Tuesday of the month. The committee will identify and discuss issues, concerns, and corrective actions that will be taken to help ensure quality improvement. Quality Assurance Team will include: minutes from the previous months meeting will be reviewed and discussed by committee members. Issues, concerns, and follow up will also be discussed to see if improvements were made, or if other interventions are needed.	12-15-05

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F 521	Continued From page 122	F 521		

2. A review of resident medical records and facility incident reports on 10/26/05 through 11/3/05 revealed several incidents documenting that resident's 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 and injuries of unknown origin 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 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)

6. The facility's quality assurance committee identified weight loss concerns, but failed to establish corrective plans to ensure interventions were implemented to prevent further weight decline. (Refer to F-325)

7. The facility's quality assurance committee did not identify, and subsequently did not establish corrective plans to ensure that the resident's trust

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465158	A. BUILDING _____ B. WING _____	11/03/2005

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) COMPLETION DATE
F 521	Continued From page 123 funds were safeguarded and managed. (Refer to F-159)	F 521		

Addendum to POC

Fax Cover Sheet

Pine Ridge Care Center
433 East 2700 South
Salt Lake City, Utah 84115
Phone Number (801) 487-2248
Fax Number (801) 487-9011

Send to: Residi Assessment	From: Pine Ridge Care Center
Attention: Leslie B.	Date: 12-15-05
Office Location: Program Certification	Office Location: RA
Fax Number: 538-6163	Phone Number: (801) 487-2248

- ☒ Urgent
- ☐ Reply ASAP
- ☐ Please comment
- ☒ Please Review
- ☐ For your information

Total pages, including cover: 4

Comments:

Addendum TO 2567
Survey Nov 3, 2005

Addendum to Plan of Correction for Pine Ridge Care Center

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice for the following tags/ and or residents:
   a. F167
      i. The survey results will be posted **in the central hallway** at the information board that provides the resident rights, ombudsman information and other required posted information.
   b. F354
      i. This facility **will** provide eight consecutive hours of registered nurse services seven days a week.
      ii. There is limited availability of Registered Nurses (RN) in the community. This facility is actively recruiting for an RN by running a continuous ad in the community newspaper.
      iii. This facility utilizes agency services to meet RN needs as they are available.
      iv. This facility will schedule an RN for eight consecutive hours per day.
      v. The Director of Nursing or Designee will maintain a copy of the schedule.
      vi. The Director of Nursing or Designee will maintain a log of days when RN coverage is less than eight consecutive hours.
      vii. The Director of Nursing will track and trend RN hours weekly and report to the Quality Assessment and Assurance committee at least quarterly.
      viii. This plan of correction will be completed by December 15, 2005.
   c. F367
      i. **Resident 10 is Resident 8**
         1. Resident treatment plan has been reviewed and updated.
         2. Registered Dietician updated dietary assessment
         3. Three day calorie count
         4. Alternate food choices or supplements will be made available for all meals.
         5. Will be offered high protein supplements at meals
         6. Therapeutic diet provided as ordered by the physician.
         7. Resident will be seated at the assistive dining table to provide support with meals.
         8. Swallow evaluation completed by Speech Therapist to evaluate ability and tolerance of meal consistency.
            a. Bread products offered slurried per mechanical soft diet.
   d. **Resident 20**
      i. Resident treatment plan has been reviewed and updated.
         1. Registered Dietician updated dietary assessment
         2. Three day calorie count
         3. Alternate food choices or supplements will be made available for all meals.
         4. Will be offered high protein supplements at meals
         5. Therapeutic diet provided as ordered by the physician.

6. Resident will be seated at the assistive dining table to provide support with meals.
7. Swallow evaluation completed by Speech Therapist to evaluate ability and tolerance of meal consistency.
    a. Bread products offered slurried per pureed diet.

2. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained for the following tags
    a. F354
        i. This facility will provide eight consecutive hours of registered nurse services seven days a week.
        ii. There is limited availability of Registered Nurses (RN) in the community. This facility is actively recruiting for an RN by running a continuous ad in the community newspaper.
        iii. This facility utilizes agency services to meet RN needs as they are available.
        iv. This facility will schedule an RN for eight consecutive hours per day.
        v. The Director of Nursing or Designee will maintain a copy of the schedule.
        vi. The Director of Nursing or Designee will maintain a log of days when RN coverage is less than eight consecutive hours.
        vii. **The Director of Nursing will track and trend RN hours weekly and report to the Quality Assessment and Assurance committee at least quarterly.**
    b. F490
        i. Will have outside consulting meet with the administrator at least monthly.
            1. will review survey and quality assurance minutes
            2. will evaluate performance and plan of correction as identified by the QA &A committee
            3. Consultant will participate in the QA&A meeting at least quarterly
            4. Concerns in performance of the Administrator will be reported to the owners of the organizations as needed.
    c. F521
        i. Outside consultants and Medical Director will attend QA&A meetings at least quarterly.
        ii. Consultants and Medical Director will submit written notice to the Administrator and Owner of the organization of any concerns that relate to the QA&A process as it pertains to not identifying and developing an acceptable plan of correction for identified problems.

3. Indicate how often the monitoring will be done for the following tags
    a. F224
        i. The Director of Nursing or Designee will track falls and trend falls **weekly** and report to the Quality Assessment and Assurance Committee quarterly.
    b. F225

1. Allegations of abuse investigation will be followed up in **the morning stand-up interdisciplinary meeting Monday through Friday.**

c. F354
   i. The Director of Nursing will track and trend RN hours **weekly** and report to the Quality Assessment and Assurance committee at least quarterly.

d. F363
   i. Dietary Manager will conduct random **weekly** audits to insure compliance.

e. F521
   i. Consultants and Medical Director will submit written notice to the Administrator and Owner of the organization **quarterly** of any concerns that relate to the QA&A process as it pertains to not identifying and developing an acceptable plan of correction for identified problems.

4. Indicate who is responsible for the monitoring of the plan of correction for the following tags
   a. F521
      i. **Consultants and Medical Director** will submit written notice to the Administrator and Owner of the organization of any concerns that relate to the QA&A process as it pertains to not identifying and developing an acceptable plan of correction for identified problems.
5. Indicate when the plan of correction was integrated into the facility's quality assurance system for the following tags.
   a. F 167
      i. November 8, 2005

12/19/05 @ 0800 phone interview Kari-DON
521 - monitored monthly
367 - Wrong name for resident 10 - should be Louise Larsen - will correct name & put actions into plan.

Frank Kilby, Administrator

Karie Jones, Director of Nursing

PINE RIDGE CARE CENTER
POLICY/PROCEDURE

TITLE: Abuse Prevention, Investigation & Reporting **POLICY#** AD-1

FORMULATED: October 30th 2005 **DISTRIBUTION:** October 30th 2005

REVIEWED/REVISED: October 30th 2005 EFFECTIVE: October 30th 2005

PROPONENT: Administrator

PURPOSE:
To minimize the potential risk for resident and/or employee abuse to occur at Pine Ridge Care Center of Salt Lake City Utah.

POLICY:
The management will ensure that the residents residing in this facility will remain free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, and is appropriation of resident property. This will be demonstrated by providing screening of potential employees and residents, early intervention of alleged abuse, as well as identification of perpetrators and potential victims. The management will also ensure that education and training are offered to the staff at this facility upon hire, annually, and as needed to prevent incidents of abuse. In addition, all incidents will be reviewed to determine if abuse is suspected, and if abuse is suspected it will be investigated thoroughly.

Definition of Abuse

1. Abuse - The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish (42 CFR 488.301). This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psycho social well-being. This presumes that instances of abuse of all residents, even those in a coma, caused physical harm, pain, or mental anguish.

2. Sexual Abuse - Includes, but is not limited to, sexual harassment, sexual coercion or sexual assault..

3. Physical Abuse - Includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.

4. Mental Abuse - Includes, but is not limited to, humiliation, harassment, sexual coercion, or sexual assault.

5. Involuntary Seclusion - Separation of a resident from other residents to his/her

room of confinement, (with or without roommates), against the resident's will, or the resident's legal representation. This may include residents who are living in an area of the facility which restricts their movement throughout the facility or temporarily separating a resident from other residents. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs.

6. Neglect - Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

7. Misappropriation of Resident Property - The deliberate misplacement, exploitation of wrongful temporary or permanent use of a resident's belongings or money without the resident's consent.

PROCEDURE:

Employee Screening

1. All qualified selected applicants will receive a person to person interview prior to hire.

2. All potential employees will be screened as part of the application process prior to hire to determine employment history. At least *two* professional references will be checked and the findings documented on the potential employee's application. The date, name and title of the person giving the reference, a brief description of job performance, length of employment, and a signature of the facility employee obtaining the reference will be documented. If unable to obtain two references or an ambiguous/vague reference is obtained, request direction from the facility Administrator.

3. All potential employees will be screened as part of the application process prior to hire to determine if there is a history of abuse, neglect or mistreatment of individuals. This will include completion of the BCI form 95-5-01 (request for criminal history information for employment purposes). Will be completed upon hire and submitted within 10 days of hire. Copies of the BCI form may be obtained from BCI at (801) 965-4445.

4. All potential employees will be screened by telephone contact with the appropriate licensing board at the Division of Occupational and Professional licensing or the Nursing Assistant registry. Document on the application verification of license/certificate and whether or not it is active and in good standing.

5. *If any of the pre-employment screening indicates a history of abuse, misappropriation of property, or unsatisfactory work history, the applicant will not be considered for employment.* Continued employment is contingent upon a positive Criminal Background Investigation report.

6. Department Heads are responsible to monitor employee abuse prevention with in their work areas.

Screening of Potential Residents

1. All potential residents will be screened by the admissions coordinator to determine if there is a prior pattern of abusive behavior, including, but not limited to, sexual or physical abuse. Documentation as to whether or not a potential resident has a pattern of abusive behavior or aggression will be recorded on the facility admission inquiry form prior to admission. The admissions coordinator will notify administrator and/or Director of Nursing Services.

2. If it is determined that the potential resident has a history of abusive behavior/aggression, the interdisciplinary team, with the involvement of the appropriate professionals, will assess the needs of the resident. If the IDT determines that the facility is able to adequately meet the potential resident's needs without negatively impacting its current residents, the IDT will develop a care plan with behavioral approaches designed to prevent the potential resident from engaging in any abusive behavior.

3. Director of social services is assigned to monitor residents abuse prevention throughout the facility.

Education

1. All employees will receive written information pertaining to the definition, prohibition, reporting of abuse and dealing with stressful situations and managing behavioral challenges. Acknowledgment of receipt will be contained in the employee file.
    a. The following safety procedures will be used by staff when dealing with combative residents.
        1. Avoid providing care unless assisted by another staff member. The second care giver can keep a "light" hand on the appendage(s) most likely to strike out. (This will allow the care giver to quickly restrain a sudden attempt to strike-out by the resident.)
        2. Stand close to the resident. (The resident can deliver more force if he/she has a greater distance to swing.)
        3. Stand close to the proximal end of an appendage. (The

resident can deliver more force from the distal end of an appendage.)

4. Stand on the side of the patient where the resident has the greatest strength. (This will reduce the force that can be delivered with the strongest appendage.)
5. Avoid standing in front of the resident. (The resident can usually deliver greater force to the front than to the side.)
6. Keep the side of your body toward the resident. (Injury is less likely to result from a hit to the side of the care giver than from a hit to the front or to the read of the care giver.)
7. Do not reach across the resident in close proximity to the head. (This leaves the care giver vulnerable to being bitten.)
8. Obtain the resident's consent and cooperation prior to providing care. (If the resident refuses, return later and try again.)
9. Describe each step of the care being provided and ensure that the resident continues to consent.
10. Engage in friendly conversation while providing care. Thank the resident for his/her cooperation periodically throughout the activity

2. Inservices on prohibiting, identifying and reporting abuse will be done in general orientation and with mandatory inservices offered at least twice a year.

3. Ongoing education will be provided to employees with administrative focused round tools and immediate inservicing provided to staff as needed.

4. Significant trends identified with focused round tools will be addressed in facility Quality Assurance meetings as applicable.

5. The Administrator and Director of Nursing will be responsible for ensuring adequate staffing levels and adequately trained staff to promote a safe living environment.

6. The interdisciplinary team will meet and review the care plan of residents with challenging behaviors as often as necessary.

7. The interdisciplinary team will attempt with each review to obtain the goals stated for residents with challenging behaviors while maintaining a safe environment for all residents. Staff will be educated in regards to new problems, goals, and intervention as applicable.

Residents

1. Residents will be educated on admission to the facility and at least twice a year, offered at Resident Council, on the identification, reporting and their right to be free from abuse.

2. Information regarding reporting abuse will be posted throughout the facility.

Identification of Perpetrators of Potential Victims

1. The facility will offer to all staff training in ways to identify potential signs and symptoms of abuse including behavior changes and injuries of unknown origin at least twice a year.

2. Ongoing education will be provided to employees with administrative focused round tools with immediate inservicing provided to staff as needed.

3. Significant trends identified with focused round tools will be addressed in ther facility Quality Assurance meeting.

4. All residents will be assessed on admission, quarterly and with a significant change in condition, for changes in mood, behavior patterns, and level of dependence. Assessments will be documented on the residents Minimum Date Set.

5. If a resident is determined to be at risk, the interdisciplinary team will initiate appropriate monitoring and behavioral approaches using the care plan process.

Reporting Abuse

Any person who suspects that abuse, neglect, or the misappropriation of property may have occurred, must immediately report the alleged violation to their immediate supervisor or the Administrator of the facility. (Please refer to Abuse Allegation and Investigation Policy and Procedure.)

1. Investigation

    1. Employees who suspect abuse should report to their immediate supervisor. If the employee feels uncomfortable in talking to their supervisor, they may report abuse to either the Director of Nursing Services, the Director of Social Services, or to the Administrator. Any employee who reports an abuse incident can be assured it will remain confidential to the extent possible and will not jeopardize his/her employment status, unless he/she is the abusive party.

    2. All incidents will be scrutinized as to the potential of abuse. If abuse is alleged or suspected, it will be referred to the Director of Social Services for an immediate preliminary investigation.

3. The Administrator will assure immediate notification of Adult Protective Services or local law enforcement that an allegation was made and a facility investigation is under way. The Administrator/Designee will also notify the Department of Health Resident Assessment Section (RAS). The following steps will assist you in this process:
   a. Call RAS at (801) 538-6158 or (800) 662-4157 - toll free. Indicate that you have a complaint. Your call will be directed to an RAS nurse who will assist you.
   b. State your name and title and that this is a facility "initial" report.
   c. Describe the incident.
   d. Inform the RAS nurse as to "how" the resident is being protected from the alleged perpetrator, e.g., suspension, termination, etc.
   e. Indicate if you have referred this complaint to another agency (such as APS, Ombudsman, police) and the name of the person it was referred to.

The RAS nurse will give the complaint a number and inform you that you have five working days to complete your investigation.

*Note: When the alleged incident involves a resident of a long-term facility, APS is required to notify the ombudsman. The facility may wish to notify the ombudsman in conjunction with APS.

4. The Director of Social Services / Director of Nursing will assure notification of the responsible party and physician of alleged incident for all residents involved.

5. The Administrator, or his/her designee, will complete the investigation within five (5) working days. Document all interviews with the date, time and content of the conversation.

6. During the investigation process, the facility must prevent further physical abuse, mistreatment, or verbal aggression, up to and including suspension of the alleged individual or individuals pending complete investigation and, in cases involving resident to resident abuse, ensure increased monitoring of at risk residents. After all evidence has been obtained, facility administration makes a decision as to whether the alleged violation has been verified and documents this decision.

7. The results of all internal investigations must be documented by Director of Social Services with in one normal business day from date of incident. Incident will also be reported to the Administrator, or his/her designated representative and to other officials in accordance with state law (including the state program violation is verified, appropriate corrective action must be taken. The results of the investigation and the complaint number **must** be faxed within five business days to the State Health Department at (801) 536-0948, Attn: Kelly Criddle, RN Manager of the PCRA Complaint Team. Retain a copy of the verification of fax transmittal with the investigation file. If the facility fax machine does not have the ability to generate a receipt, then confirm transmission via telephone noting the date, time and person with whom the facility verified transmission.

This information will also be kept in the investigation file

8. If the alleged violation by staff is verified, corrective action up to and including termination will be instituted by the facility.
   1. Employee to resident incident - If abuse is alleged, or suspected, the employee will not be permitted to provide care to the resident until results of the preliminary investigation are revealed. If evidence is found that supports abuse, the employee(s) will be suspended immediately without pay and the administrator will direct a full-scale investigation
   2. Resident to resident incident - The abusive resident will be involuntarily separated from other residents for a limited period of time as a therapeutic intervention to reduce agitation. Other interventions will also be considered to include but not limited to family assistance, change of roommates, physician review of appropriate medication(s), and/or consult with psychology. Resident will be referred to IDT and CSW for behavioral evaluation and PCP.
   3. Resident to employee incident - The resident will receive care from at least two care givers until the results of the preliminary investigation are revealed. The guidelines listed in Education Paragraph #1 regarding combative residents will be followed by employees.

9. The Director of Nursing Services will notify the Department of Professional Licensing of facility findings and conclusions if the alleged perpetrator is a licensed nurse.

10. The Director of Nursing Services / Staff Development Coordinator will notify the State Nurse Aide Registry/State Board of Licensure of facility findings and conclusions if NA/CNA are involved.

11. Keep all abuse investigations filed in a secure area under professional standards. Ensure that <u>all</u> documentation is complete.

12. If the alleged incident involves patient harm/injury, an incident report must be completed per facility policy.

13. The Director of Social Services will maintain records of all suspected or substantiated abusive behavioral incidents.

PINE RIDGE CARE CENTER
POLICY/PROCEDURE

TITLE: Abuse – Allegation and Reporting **POLICY#** AD-2

FORMULATED: October 30th 2005 **DISTRIBUTION:** Oct 30, 2005

REVIEWED/REVISED: October 30th 2005 EFFECTIVE: October 30th 2005

PROPONENT: Administrator

POLICY:

1. 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 or in his/her absence, his/her designee, of the facility and to other officials in accordance with State Law through established procedures (including to the State survey and certification agency).

2. The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

3. The results of all investigations must be reported to the Administrator or his/her 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 violations is verified by the Administrative Team, appropriate corrective action must be taken.

PROCEDURE:

1. Report any knowledge of all alleged violations involving mistreatment, neglect or abuse immediately to a Supervisor or Administrator or in his/her absence, to his/her designee. Bruises, cuts, skin tears or other injury unknown origin will be investigated and reported as potential resident abuse. All allegations will be reviewed daily, Monday - Friday, by the Administrative Team. Allegations occurring on weekends and holidays will be reported to the Administrator/designee.

2. The Administrator or his/her designee will promptly ensure safety of alleged victim, interview all staff, visitor and residents having any knowledge of the alleged abuse immediately to determine validity of allegation. This may include other residents who may have been cared for or affected by the alleged perpetrator. (Complete **Appendix A** for employee to resident alleged abuse, **Appendix B** for resident to resident alleged abuse and **Appendix C** for non-employee to resident alleged abuse and **Appendix D** for all investigations. **Appendix E** will be used to assist in the direction of the investigation.

PINE RIDGE CARE CENTER
POLICY/PROCEDURE

Employee to Resident Alleged Abuse Investigation Report

Facility Name: _____ Administrator Name: _____

Complaint Number: _____

Date alleged abuse reported to Administrator/designee: _____

Date alleged abuse incident occurred: _____

Employee Information

Name: _____ SS#. _____

Ethnic Background: _____ Home Phone _____

Address: _____

License/Certification Number: _____

Alleged Victim Information

Name: _____ D.O.B. _____

Diagnosis: _____

Witness Information

Name: _____ Phone No. _____

Name: _____ Phone No. _____

Name: _____ Phone No. _____

The following measures were implemented to ensure the safety of the alleged victim and to prevent possible reoccurrence of an incident.

- ☐ Employee assignment changed
- ☐ Employee suspended
- ☐ Employee not scheduled to work
- ☐ Employee terminated/resigned
- ☐ Police Notified
- ☐ Physician intervention
- ☐ Staff Education
- ☐ Resident education
- ☐ Social Services intervention
- ☐ Other: _____

Policy , Appendix A

PINE RIDGE CARE CENTER
POLICY/PROCEDURE

Resident to Resident Alleged Abuse Investigation Report

Facility Name: _____ Administrator Name: _____

Complaint Number: _____

Date alleged abuse reported to Administrator/designee: _____

Date alleged abuse incident occurred: _____

Alleged Victim Information

Name: _____ D.O.B. _____

Diagnosis: _____

Alleged Perpetrator Information

Name: _____ D.O.B. _____

Diagnosis: _____

Witness Information

Name: _____ Phone No. _____

Name: _____ Phone No. _____

Name: _____ Phone No. _____

The following measures were implemented to ensure the safety of the alleged victim and to prevent possible reoccurrence of an incident.

☐ Room Change	☐ Resident Education
☐ Social Service Intervention	☐ Staff Education
☐ Physician Intervention	☐ New Care Plan Intervention
☐ Other _____	

Policy AD-9, Appendix B

PINE RIDGE CARE CENTER
POLICY/PROCEDURE

Non-Employee to Resident Alleged Abuse Investigation Report

Facility Name: _____ Administrator Name: _____

Complaint Number: _____

Date alleged abuse reported to Administrator/designee: _____

Date alleged abuse incident occurred: _____

Non-Employee Information

Name: _____ Phone No. _____

Relationship: _____ Visitor _____ Family Member Other: _____

Alleged Victim Information

Name: _____ D.O.B. _____

Diagnosis: _____

Witness Information

Name: _____ Phone No. _____

Name: _____ Phone No. _____

Name: _____ Phone No. _____

The following measures were implemented to ensure the safety of the alleged victim and to prevent possible reoccurrence of an incident.

- ☐ Physician Intervention
- ☐ Police notified
- ☐ Social Service intervention
- ☐ Other: _____
- ☐ Non-employee education
- ☐ IDT conference
- ☐ Other family intervention

Policy AD-9, Appendix C

Summary of Incident: _____

Follow Up: _____

Date investigation completed: _____
(must be completed within 5 days of Administrator/designee notification)

_____
Administrator/Designee

Policy AD-9, Appendix D

Prohibiting and Reporting Abuse
Focus Round

Facility: _____ Date: _____

EMPLOYEES

Employees – Five (5) staff, from multiple departments *Supervisors* – Three (3) supervisors from multiple departments	List Three (3) forms of abuse; (physical, emotional, mental, sexual, verbal, neglect, isolation, and financial	*Whom do you report suspected abuse to? (Supervisor/Administrator)	*What are the signs/symptoms of abuse? Bruises, skin tears, change in behavior, sad depressed, fearful)	*What patients are at risk? (confused, dependant, and behavioral problems)	*List three (3) ways to prevent abuse: (education, patients, and compassion)	*How does the facility screen for abuse prior to the hire with registry, licensure, and references, BIC	Have you attended any abuse in-service this year? (Y) (N)	Who can be a perpetrator? (staff, family, visitor)
1)								
2)								
3)								
4)								
5)								

SUPERVISORS

1)								
2)								
3)								

√ - Employee able to answer question accurately/completely.

× - Employees able to answer question accurately/partially/education provided).

O - Employees unable to answer question (education provided).

PINE RIDGE CARE CENTER
POLICY/PROCEDURE

TITLE: Abuse – Prohibiting	SOP # NS-001
FORMULATED:	DISTRIBUTION:
REVIEWED/REVISED: Oct 30, 2005	EFFECTIVE:
PROPONENT: Director of Nursing	

PURPOSE:
To provide a safe environment for all residents.

POLICY:
The Administrator will ensure that the residents residing in this facility will remain free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, and misappropriation of residents, early intervention of alleged abuse, as well as identification of perpetrators and potential victims. The Administrator will also ensure that education and training are offered to the staff at this facility upon hire annually and as needed to prevent incidents of abuse.

Definitions of Abuse:

1. Abuse - The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish (42 CFR 488.301). This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, caused physical harm, pain, or mental anguish.

2. Verbal Abuse - The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.

3. Sexual - Abuse Includes, but is not limited to, sexual harassment, sexual coercion or sexual assault.

4. Physical Abuse - Includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.

5. Mental Abuse - Includes, but is not limited to, humiliation, harassment, sexual coercion, or sexual assault.

6. Involuntary Seclusion - Separation of a resident from other residents to his/her room of confinement (with or without roommates) against the resident=s will, or the resident=s legal representation. This may include residents who are living in an area of the facility which restricts their movement throughout the facility or temporarily separating a resident from other residents. Emergency of short term

monitored separation from other residents will not be considered involuntary seclusion and may be permitted id used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident=s needs.

PROCEDURE:

Employee Screening:

1. All qualified selected applicants will receive a person to person interview prior to hire.

2. All potential employees will be screened as part of the application process prior to hire to determine employment history. At least two professional references will be checked and the findings documented on the potential employee=s application. The date, name and title of the person giving the reference, a brief description of job performance, length of employment, and a signature of the facility employee obtaining the reference will be documented. If unable to obtain two references or an ambiguous/vague reference is obtained, request direction from the facility Administrator.

3. A l potential employees will be screened as part of the application process prior to hire to determine if there is a history of abuse, neglect or mistreatment of individuals. This will include completions of the BCI form 95-5-01 (request for criminal history information for employment purposes). Will be completed upon hire and submitted within 10 days of hire. Copies of the BCI form may be obtained from BIC at (801) 965-4445.

4. All potential employees will be screened by telephone contact with the appropriate licensing board at the Division of Occupational and Professional licensing or the Nursing Assistant Registry. Document on the application verification of license/certificate and whether or not it is active and in good standing.

5. If any of the pre-employment screening indicates a history of abuse, misappropriation of property, or unsatisfactory work history, the applicant will not be considered for employment. Continued employment is contingent upon a positive Criminal Background Investigation report.

Screening of Potential Residents:

1. All potential residents will be screened to determine of there is a prior pattern of abusive behavior, including, but not limited to, sexual or physical abuse. Documentation as to whether or not a potential resident has a pattern of abusive behavior or aggression will be recorded on the facility admission inquiry form prior to admission.

2. If it is determined that the potential resident has a history of abusive behavior/aggression, the interdisciplinary team, with the involvement of the appropriate professionals, will assess the needs of the resident. If the IDT determines that the facility is able to adequately meet the potential resident=s

needs without negatively impacting its current residents, the IDT will develop a care plan with behavioral approaches designed to prevent the potential resident from engaging in any abusive behavior.

Education:

1. All employees will receive written information pertaining to the definition, prohibition, reporting of abuse and dealing with stressful situations and managing behavioral challenges. Acknowledgment of receipt will be contained in the employee file.

2. In services on prohibiting, identifying and reporting abuse will be done in general orientation and with mandatory in services offered at least twice a year.

3. Ongoing education will be provided to employees with administrative focused round tools and immediate in servicing provided to staff as needed.

4. Significant trends identified with focused round tools will be addresses in facility Quality Assurance meetings as applicable.

5. The Administrator and the Director of Nursing will be responsible for ensuring adequate staffing levels and adequately trained staff to promote a safe living environment.

6. The interdisciplinary team will meet and review the care plan of residents with challenging behaviors as often as necessary.

7. The interdisciplinary team will attempt with each review to obtain the goals stated for residents with challenging behaviors while maintaining a safe environment for all residents. Staff will be educated in regards to new problems, goals, and intervention as applicable.

Residents:

1. Residents will be educated on admission to the facility and at least twice a year, offered at Resident Council, on the identification, reporting and their right to be free from abuse.

2. Information regarding reporting abuse will be posted throughout the facility.

Identification of Perpetrators of Potential Victims:

1. The facility will offer to all staff training in ways to identify potential signs and symptoms of abuse including behavior changes and injuries of unknown origin at least twice a year.

2. Ongoing education will be provided to employees with administrative focused round tools with immediate in servicing provided to staff as needed.

3. Significant trends identified with focused round tools will be addressed in the facility Quality Assurance meeting.

4. All residents will be assessed on admission, quarterly, and with a significant change in condition, for changes in mood, behavior patterns, and level of dependence. Assessments will be documented on the residents Minimum Day Set.

5. If a resident is determined to be at risk, the interdisciplinary team will initiate appropriate monitoring and behavioral approaches using the care plan process.

Reporting Abuse:

Any person who suspects that abuse, neglect, or the misappropriation of property may have occurred must immediately report the alleged violation to their immediate supervisor to the Administrator of the facility. (Please refer to Abuse Allegation and Investigation Policy and Procedure.)

PINE RIDGE CARE CENTER
POLICY/PROCEDURE

Alleged Resident Abuse/Neglect Investigation Checklist

Date Alleged Abuse Reported: _____ Resident Name: _____
Date Alleged Abuse Occurred: _____
Complaint Number: _____

	DATE	TIME
Resident protected from repeated danger if necessary		
Notification of Administrator		
Incident Report Completed		
Medical Record documentation reviewed		
Notification to APS upon receiving abuse allegation (To be completed immediately upon receiving report of allegation)		
Notification to Division of Licensure, if applicable		
Notification to Corporate Office		
Completed written investigation submitted to the State Health Department within 5 working days		
Education provided to staff, if applicable		
Social Service intervention, if applicable		
Care Plan updated, if applicable		

* Keep original with investigation file

_____ _____
Administrative/Designee Signature Date

Policy AD-9, Appendix E

Summary of Incident:

Follow Up:

Date investigation completed _____
(must be completed within 5 days of Administrator notification)

_____
Administrator/Designee

PINE RIDGE CARE CENTER

Alleged Abuse Investigation Report

Facility Name: _____ Administrator Name: _____

Complaint Number: (from the State) # UT _____

Date alleged abuse reported to Administrator/designee: _____

Date alleged abuse incident occurred: _____

Alleged Victim Information ___ Employee ___ Resident ___ Other _____

Name: _____ SS#: _____ D.O.B#. _____
Ethnic Background: _____ Home Phone (If not a resident): _____
Diagnosis (resident only): _____

Alleged Perpetrator Information ___ Employee ___ Resident ___ Other _____

Name: _____ SS#: _____ D.O.B#. _____
Ethnic Background: _____ Home Phone (If not a resident): _____
Diagnosis (resident only): _____
License/Certification #: _____

Witness Information

Name: _____ Phone No. _____

Name: _____ Phone No. _____

Name: _____ Phone No. _____

The following measures were implemented to ensure the safety of the alleged victim and to prevent possible reoccurrence of an incident.

- ☐ Room Change
- ☐ Social Service Intervention
- ☐ Physician Intervention
- ☐ Employee assignment changed
- ☐ Employee suspended
- ☐ Employee not scheduled to work
- ☐ Employee terminated/resigned
- ☐ Police Notified
- ☐ Other _____

- ☐ Resident Education
- ☐ Staff Education
- ☐ Non-Employee Education
- ☐ New Care Plan Intervention
- ☐ IDT Conference
- ☐ Other Family Intervention

Summary of Incident:

Follow Up:

Date investigation completed
(must be completed within 5 days of Administrator notification)

Administrator/Designee

ADULT PROTECTIVE SERVICES
RESIDENT TO RESIDENT INCIDENT SUMMARY REPORT

645 East 4500 South Salt Lake City, Utah 84107
Fax: 1 (801) 268-5422

PLEASE PRINT CLEARLY

Date:_____

Facility Name:_____
Facility Address:_____
City, State, Zip:_____
Facility Telephone:_____

Your name and
title:_____

Name of person who reported to facility or
witness:_____

Resident #1_____DOB_____SS#_____
Diagnosis_____

Resident #2_____DOB_____SS#_____
Diagnosis_____

Date and time of incident:_____
Description of incident:_____

Describe injuries, if any:_____
What steps have been taken to prevent incident from recurring?_____

Summary of Incident:

Follow Up:

Date investigation completed _____
(must be completed within 5 days of Administrator notification)

_____
Administrator/Designee

PINE RIDGE CARE CENTER
POLICY/PROCEDURE

TITLE: Abuse – Prohibiting	SOP # NS-001
FORMULATED:	DISTRIBUTION:
REVIEWED/REVISED: Oct 30, 2005	EFFECTIVE:
PROPONENT: Director of Nursing	

PURPOSE:
To ensure a secure and protective environment for all residents.

POLICY:
1. 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 or in his/her designee, of the facility and to other officials in accordance with State Law through established procedures (including to the State survey and certification agency).

2. The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

3. The results of all investigations must be reported to the Administrator or his/her 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 by the Administrative Team, appropriate corrective action must be taken

PROCEDURE:
1. Report any knowledge of all alleged violations involving mistreatment, neglect or abuse ***immediately*** to the Supervisor of Administrator or in his/her absence, to his/her designee. Bruises, cuts, skin tears, or other injury of unknown origin will be investigated and reported as potential resident abuse. All allegations will be reviewed daily, Monday - Friday, by the Administrative Team. Allegations occurring on weekends and holidays will be reported to the Administrator/designee.

2. The Administrator or his/her designee will promptly ensure safety of alleged victim, interview all staff, visitors and residents having any knowledge of the alleged abuse immediately to determine validity of allegation. This may include other residents who may have been cared for or affected by the alleged perpetrator. (Complete the forms as it pertains to the investigation.

3. The Administrator will assure immediate notification of Adult Protective Services or local law enforcement that an allegation has been made and a facility investigation is under way. The Administrator/Designee will also notify the Department of Health Resident Assessment Section (RS). The following steps

will assist you in this process:

a. Call RAS at (801) 538-6158 or (800) 662 -4157 - toll free. Indicate that you have a complaint. Your call will be directed to an RAS nurse who will assist you.
b. State your name and title and that this is a facility "Initial" report.
c. Describe the incident.
d. Inform the RAS nurse as to "how" the resident is being protected from the alleged perpetrator, e.g., suspension, termination, etc.
e. Indicate if you have referred this complaint to another agency (such as APS, Ombudsman, police) and the name of the person it was referred to. The RAS nurse will give the complaint a number and inform you that you have five working days to complete your investigation.

*Note: When the alleged incident involves a resident of a long-term facility, APS is required to notify the ombudsman. The facility may with to notify the ombudsman in conjunction with APS.

4. The director of nursing will assure notification of the responsible party and physician of alleged incident for all residents involved.

5. The Administration of his/her designee will complete the investigation within five (5) working days. ***Document*** all interviews with the date, time, and content of the conversation.

6. During the investigation process, the facility must prevent further physical abuse, mistreatment, or verbal aggression, up to and including suspension of the alleged individual or individuals pending complete investigation and, in cases involving resident to resident abuse, ensure increased monitoring of at risk residents. After all evidence has been obtained, facility administration makes a decision as to whether the alleged violation has been verified and documents this decision.

7. The results of all internal investigations must be reported to the Administrator or his/her designated representative and to other officials in accordance with State law (including the state program certification and resident assessment) within five (5) working days of the incident and, if the alleged violation is verified, appropriate corrective action must be taken. The results of the investigation and the complaint number may be faxed to the State Health Department at (801) 536-0948, Attn: Kelly Criddle, RN Manager of the PCRA Complaint Team. Retain a copy of the verification of fax transmittal with the investigation file. If the facility fax machine does not have the ability to generate a receipt, then confirm transmission via telephone noting the date, time, and person with whom the facility verified transmission. This information will also be kept in the investigation file.

8. If the alleged violation by staff is verified, corrective action up to and including termination will be instituted by the facility.

9. If the violation is between residents, refer to IDT with CSW fro behavioral evaluation and care planning.

10. Notify the Department of Professional Licensing of facility findings and

conclusions if the alleged perpetrator is a licensed nurse.

11. Notify the State Nurse Aide Registry/State Board of Licensure of facility findings and conclusions if NA/CNA are involved.

12. Keep all abuse investigations filed in a secure area under professional standards. Ensure that all documentation is complete.

13. If the alleged incident involves patient harm/injury, an incident report must be completed per facility policy.

Abuse Log

Resident	Date	Contact Res Asses	Contact APS	Investigation Started	Completed	Resolution

Appendix D, Policy AD-9

PRINTED: 01/27/2006
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465158	A. BUILDING 01 - PINE RIDGE CARE CENTE B. WING _____	R 01/19/2006

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) COMPLETION DATE
{K 000}	INITIAL COMMENTS	{K 000}		
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observations made in the presence of the administrator during a revisit on 1-19-06, it was determined that the facility's antifreeze loop, control valve, tamper switch was not hard-wired	K 051		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 2-6-06

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