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

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

AND PLAN C	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	II TIPLE CONSTRUCTION	<u>OMB NO. 0938-0</u>	
AND FEATING	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
AME OF P	ROVIDER OR SUPPLIER	465158	B. WING	<u> </u>	11/03/2005	
	GE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH	11/03/2005	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		SALT LAKE CITY, UT 84115		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE	
00-0	1 01102	OTECTION OF RESIDENT	O F 15	9 F159		
8	account for the pers	ization of a resident, the afeguard, manage, and onal funds of the resident acility, as specified in	Sec.	This facility does and will continute to hold, safeguard, manage and action for the personal funds of the residual.	count ent	
fi a ti a a	The facility must depleted in excess of \$1 account (or accounts he facility's operating all interest earned or account. (In pooled in the facility is the facility in the facility is the facility in the facility is the facility in the faci	posit any resident's personal 50 in an interest bearing 5) that is separate from any of gracounts, and that credits	The Control of the Co	form that the resident or resident F	POA HERALINA POR COUNTRY WILL BE COUNTRY WITH WITH WILL BE COUNTRY WITH WITH WITH WITH WILL BE COUNTRY WITH WITH WITH WITH WITH WITH WITH WITH	
be	mine mando not exc	ntain a resident's personal eed \$50 in a non-interest rest-bearing account, or	200	accounting for each residents share The resident trust account will not commingled with any operating fur There will be an individual financial	Utah Depar	
ac ac fur	counting, according counting principles.	ablish and maintain a system discomplete and separate to generally accepted of each resident's personal facility on the resident's	MOUNDANTO	the facility or in an interest bearing. The amount of money that will be he facility for each resident will not ex \$50.00 at any given time. If resider all there funds before a month expire	ther in account. neld in the ceed nt's use	
100	anderit iniins Mith 190	lude any commingling of sility funds or with the funds an another resident.	S. J.	will not be allowed to borrow from trust fund. Either family or facility to the resident what they need in restheir account.	vill provide	
10116	ough quarterly state	record must be available ments and on request to er legal representative.		If a resident trust account exceeds \$2 and they are a Medicaid recipient the asked to do a spend-down in order to qualified for the Medicaid benefits.	ey will be	
resi	ident's account read	hes \$200 less than the		spend-down will be facilitated by the Manager, whereby she will either corresident or resident POA to begin the	Office	
	tollh	REPRESENTATIVE'S SIGNATU		Admin STORT	(X6) DATE	

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 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 m participation.

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	TMENT OF HEALTH): 11/18/20(I APPROVE	
		& MEDICAID SERVICES			OMB NO. 0938-039		
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S COMPLI	URVEY	
		465158	B. WING		44,0		
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS OF COLUMN		3/2005	
PINE RI	DGE CARE CENTER		١	TREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115	<u>:</u>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 159	Continued From pa	ge 1	F 15	9	 -		
	section 1611(a)(3)(I amount in the accounter resident's other reaches the SSI res	or one person, specified in B) of the Act; and that, if the unt, in addition to the value of nonexempt resources, ource limit for one person, the ligibility for Medicaid or SSI.		Each quarter the resident or resident on resident on notified in writing the balance account and will be shown a curstatement. On the form that will during IDT meetings, the reside POA will sign acknowledging to of their trust account, and current	ce of their rrent bank Il be used ent or resident he balance		
	This REQUIREMEN	T is not met as evidenced		Interest earned on the account w in the following manner: Our fa	rill be calculat	ed	
	determined that for a did not obtain writter residents to hold, sa account for the persideposited with the fadetermined, that for did not credit all interfunds to that account must be a separate a resident's share.) Spand 13 the facility co documentation to shows obtained to man	10 of 10 residents, the facility rest earned on the resident's t. (In pooled accounts, there accounting for each pecifically, for residents 8, 12.		does not have a computer system interest, so based on our resource following. We will take the total trust account and divide it by the portion of the account. This will percentage of how much of the tour Once we know the interest earned take that same percentage and approach interest to that individuals. Each month there will be a recompose of bank statements, resident month at the facility and each resident for Each ledger will show the interest.	n that calculate es we will do all amount in the eresident's I give us a rust is theirs. ad, we will oply that account. acciliation acy being held inancial ledges at earned.	es the e	
	their money were not Excess funds found it account were being of with money co-mingle reconciled to find whit belonged to. Administ found in the resident	t given quarterly statements. In the resident trust fund divided amongst all residents and in the account and not ch resident the money stration used excess money trust fund account to satisfy have been paid from the		Reconciling the financial ledgers determine how the money will be in individual's accounts. The trust account will be monitor the Office Manager. The office r will report to the Administrator of to review any activity on the trust will review any reconciliation that In the Quarterly Assurance Maest	red daily by manager nice a week t accounts and thas been dor	ne.	

Findings included:

On 11/2/05 the resident trust fund account and book keeping ledgers were reviewed.

Event ID: BZ5911

Facility ID: UT0064

If continuation sheet Page 2 of 124

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.

ORM CMS-2567 (03-69) Provious Versions Obsolete
Department of Health 631973 DEC 012005

PRINTED: 11/18/2005 DEPARTMENT OF HEALTH AND HUMAN RVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 159 Continued From page 2 F 159 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

DEPARTMENT OF HEALTH AND HUMAN PRINTED: 11/18/2005 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 159 Continued From page 3 F 159 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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DA	TE SURVEY MPLETED
		465158	B. WIN	IG			1/03/2005
	PROVIDER OR SUPPLIER DGE CARE CENTER			433	ET ADDRESS, CITY, STATE, ZIP (EAST 2700 SOUTH LT LAKE CITY, UT 84115		1103/2009
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	did not realize that if fund account should stated he believed it an overage it was of that he could use the On 11/2/05 at 4:00 manager was interving manager confirmed resident trust fund at that she should have statements to reside account. She further has helped her calcoresident has received the percentage of resident has received the bank on money. Review of individual 11/2/05 revealed the amounts of money was residents ledger. The "Interest added." On 11/3/05 at 1:00 For manager was interving interest most recent ledgers. The busines the new interest add she had found in the business office manager conciled the finance who the money below money had been divipercentage of money fund. For example, if funds received the moffice manager further office manager further office manager further moffice manager further moffice manager further funds received the moffice funds received the moffice funds received the moffice funds received the fu	the overage found in the trust of have been reconciled. He that since there seemed to be perating funds monies and at money to pay two bills. PM, the business office iewed. The business office that she maintains the accounts and was not aware to been providing the quarterly ents with money in the er stated that the Administrator ulate the interest that each and she was unaware of eturn the fund received from in the account. Tesident financial ledgers on at on 10/30/05 varying were added into each the entry on each ledger read, PM, the business office ewed in regards to the y added into the financial ss office manager stated that the dwas from a \$ 300 overage residents trust account. The ager stated that they had not ital statements to determine the aget to. She stated the	F 1	59			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	<u> </u>	465158	B. WII	۱G _		11/1	03/2005
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F 159	just wrote it down ir added) even though for the \$ 300 overage facility did not recor	n the ledgers that way (Interest in it was not interest to account ge found in the account. The noile the financial ledgers to money should be disbursed to	F	159			
F 167 SS=B	RESULTS A resident has the rithe most recent surfederal or State surfederation in effect via the facility must make examination and must make the statement of the facility must make	ight to examine the results of vey of the facility conducted by veyors and any plan of with respect to the facility. Ike the results available for list post in a place readily ents and must post a notice of	F 1	67	F-167 This facility does and will continu Surveys available for examination posted and readily accessible to a and will include the plan of correct The survey binder will be marked "Survey Result". An in-service we completed to all staff regarding we binder contains and where it is loc This information will be passed or	camination and will be ssible to all residents in of corrections, be marked -service will be garding what the ere it is located.	
	by: Based on observation determined that the recent survey results accessible to resider availability could not Findings include: On 10/31/05 at 1:28 (DON) was interview survey results were pubehind the two entry the DON and survey	T is not met as evidenced on and interview, it was facility did not have the most is posted in a place readily nts and notice of their be found. PM, the Director of Nursing ed. When asked where the posted, she stated "they are doors, on the table." When for checked on the table, they DON, then asked the			all residents through resident coun This will be completed by Deceml will be monitored by the Administ on a weekly basis.	ber 15 th 2005	5, and

DEPARTMENT OF HEALTH AND HUMAN PRINTED: 11/18/2005 RVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING_ 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

PINE R	IDGE 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 PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 167	Continued From page 6	F 1	67			
	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 223 SS=K	483.13(b), 483.13(b)(1)(i) ABUSE	F 223	3			
	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.					

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

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		465158	B. WING			11/03/2005	
	PROVIDER OR SUPPLIER DGE CARE CENTER			4	REET ADDRESS, CITY, STATE, ZIP CODE 133 EAST 2700 SOUTH SALT LAKE CITY, UT 84115	1170	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊΧ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	This REQUIREMENT by: Based on interview was determined that that residents were mental abuse. Specifically, a facility physically abused reprovide care to facility was reported to a fact administrative employer bally abused resinteract with facility was reported to the addition, the facility physical abuse from physical injuries to reside the confinement, intimided as the confinement, intimid	and medical record review, it at the facility did not ensure free from verbal, physical and y certified nursing assistant esident 1 and continued to ity residents after the incident acility nurse. The facility's oyee 1 allegedly mentally and ident 2 and continued to residents after the incident facility's director of nurses. In did not protect resident 3 from resident 4, resulting in esident 3.	F:	223	This facility does and will continue insure the right of residents to be from verbal, sexual, physical, and in abuse, corporal punishment, and invisculsion. This facility does not use mental sexual or physical abuse, corpunishment, or involuntary seclusion. Screening process – All C.N.A.'s has screened through the State Nurse Air Registry for history of abuse. This is completed on October 29, 2005. A of the results was put in each individe employee file. N.A.'s will be check calling the Registry and the findings placed in their file also. All License were screened through the DOPL in and results of the screening were file employee record. BCI checks are in process of being completed on existing employees. All new employees will BCI checks done upon hire.	nental voluntary e verbal rporal in. ave been id was copy dual ked by s will be ed Nurses ternet site ed in each the ing	12-15-05

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

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	ULTIPLE CONS	STRUCTION	(X3) DATE S COMPLE	
		465158	B. WIN	IG		11/0	3/2005
	PROVIDER OR SUPPLIER DGE CARE CENTER			433 EAST	DRESS, CITY, STATE, ZIP COI 2700 SOUTH IKE CITY, UT 84115		
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	or misappropriation resident, employee following routine for direct supervisor" STAFF TO RESIDE 1. Resident 1 was a 10/24/02 with diagnorm dementia, depression on 10/26/05, the fact reviewed. On 10/24/05, facility incident report regar nurse 2 documented (certified nursing as noticed bruises to renot oriented enough I asked day shift if the occurred and then I CNA had witnessed (bilateral) hands; large (back to) thumb and incident) nurse found incident incident was bringing to DR (dining room) under arms and [left] CNA to be more gen	there has been abuse, neglect, of property towards a or visitor should follow the reporting. 1. Report to your ENT ABUSE: admitted to the facility on oses which included vascular on, anxiety and insomnia. cility's incident reports were In nurse 2 completed an reding resident 1. Facility dithe following, "CNA sistant) on morning shift esidents hands. Pt (patient) when asked what happened hey knew how these bruises asked swing shift which one incident. Bruises to BL ge across entire hands b/t index fingers[CNA 1] (saw	F 2	Failure abuse p by the a to 32 of The 5 e unable comple of their will be Directo Every n Center neglect Each er new em on the p and rep or suspthird Tl in-servi year to in-servi be kept will contraining	to establish training - In prevention and reporting administrator October 28 of the 37 employees of the employees that were not to be contacted. These set the in-service trainings next shift. This instruction of Nursing, for each in new employee hired at P will have an in-service of prevention and reporting mployee will also attend apployee in-service class to prevention of resident absorting requirements if all sected. The in-service will have an abuse will also be every employee as scheices on abuse will also be every employee as scheice calendar. An in-service in the Director of Nurse in the Director of Nurse institute a record of all in gronducted by the facility conducted by the facility and Reporting (police and Reporting (police).	was conducted, 8 – October 30, 19 e facility. in-serviced were (5) employees g upon the start ion and training nistrator, or the adividual. Fine Ridge Care on abuse and 19 g, upon hire. I a mandatory that will focuses ouse and neglect buse is observed ill be given ever Mandatory be given twice a duled on the vice binder will es office and 1-service ity.	2005, re will s

DEPARTMENT OF HEALTH AND HUMAI ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		465158	B. Wil	NG		1 11/6	3/2005
	PROVIDER OR SUPPLIER DGE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115			73/2005
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	On 10/26/05 at 2:05 nurse 1) who comple Notice" was interviee CNA 2 was bringing and he was holding pulling her and then Facility nurse 1 furth he was pulling and prough." Facility nurse with CNA 2 about no nurse 1 stated on 10 bruising on both her stated that she gave regarding the incider incident to anyone. At 3:30 PM, facility necond time. Facility is reported to her she suppose to call the afurther stated, "I feel abuse or not." Facility is reported to her she suppose to call the afurther stated, "I feel abuse or not." Facility is reported to her she suppose to call the afurther stated, "I feel abuse or not." Facility is reported to her she suppose to call the afurther stated, "I feel abuse or not." Facility is reported to her she suppose to call the afurther stated, "I feel abuse or not." Facility is reported to her she stated CNA 2 was be facility nurse 1 stated didn't consider it was and she needed to be on 10/26/05 at 2:25 lincident, resident 1's two nurse surveyors. 5-7x4 cm (centimeter the back of her hand, finger and a 2x2 cm to the wrist and her righ ourple bruise on the box oriented only to have oriented orien	PM, the facility nurse (facility eted the "Employee Warning wed. She stated on 10/23/05, resident 1 in from the patio resident 1 under the left arm pushing her on the back. Her stated that "It looked like bushing on her, he was being se 1 stated that she talked of forcing residents. Facility 0/25/05 resident 1 had hands. Facility nurse 1 CNA 2 a verbal warning int but did not report the urse 1 was interviewed for a remark unurse 1 stated that if abuse is would investigate and was dministrator/supervisor. She I'm able to determine if it's ty nurse 1 stated that on the feel abuse had occurred. Was reminded that she sing rough with resident 1 I, "he was being rough but abuse, it was cold outside	F 2		B. Abuse – Allegation and I C. Abuse – Prohibiting (pol. In-service training will be given to Nursing and facility staff on new procedures. Further in-services w facility staff regarding identification requirements related to injuries of misappropriation of property, and residents with aggression and/or contract with aggression and/or contract will be done with all staff related to be followed in the proper, identification to protect and prevent abuse how to report incidents of suspects. This will be done during semi-anniprevention in-services training session follow the new policy and procedut the abuse rounds form that was improved the semi-anniprocedure of	icy NS-001) o Director of policies and ill be given to on and report unknown or how to deal atastrophic reservice trainuing educate the procedural Abuse sions that witers and usin	to ting igin, with eactions. ning tion lures abuse, and abuse.

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	TMENT OF HEALTH	I AND HUMAN RVICES				FORM	11/18/200 APPROVE 0938-039
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	PROVIDER OR SUPPLIER		!	433	ET ADDRESS, CITY, STATE, ZIP CODE BEAST 2700 SOUTH LT LAKE CITY, UT 84115		3/2003
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	On 10/26/05 at 2:30 over the phone. CN the lunch meal resident 1's down the hall. CNA dining room and we stated that CNA 2 w resident 1. He state around her waist an holding her left hand ground and dragged stated that he report nurse 1 and facility r already talked to CN 10/24/05 when he ca asked if he knew wh CNA 1 stated he told report regarding the looked at resident 1's On 10/23/05, CNA 1 a "CNA Notes", "On [resident 1] being tre dining room for lunch minutes, then left output the looked at the left output t	PM, CNA 1 was interviewed IA 1 stated on 10/23/05 during dent 1 was in her room and ther. He stated CNA 2 firmly shands and was "tugging" her 1 stated resident 1 left the int out on to the patio. CNA 1 rent out on the patio and got ed CNA 2 had his "left arm dowith his right hand was 1-he had her lifted off the 1 her to her chair." CNA 1 red the incident to facility hurse 1 stated she had IA 2. CNA 1 stated on ame into work, facility nurse 2 at happened to resident 1. If facility nurse 2 and wrote a incident. He stated when he is hands they were bruised. documented the following on 10-23-05, I witnessed ated cruelly. She was in the 1, she waited for about 2-3 tside. When her tray came	F 2	223	Reporting – Education has be facility staff identifying to wh suspected abuse incidents sho The Administrator is the abus and the individual to whom a incidents of abuse should be r Abuse Reporting Procedures I posted throughout the building advice of social service consu Administrator has also in-servemployee. All Staff have rece 3 x 5 cards explaining what co abuse, the prevention of abuse how to report suspected incide All new employees will be gid 3 x 5 cards upon hire. The Reservices Coordinator will be the "point of contact" for the a and staff in completing proper reporting, and continuing educemployees on semi-annual basidentification and prevention in be conducted 6 times per year to random employees and sup The Abuse reporting investiga will be kept in the Resident Se	nom all uld be reported e coordinator ll suspected eported. nave been g on the ltant. riced every ived enstitutes e, and ents of abuse. ven the abuse sident administrator documentatio cation of all sis. Abuse counds will and p.r.n., ervisors. tion log ervices	
	out, approximately 10 [CNA 2], pulling [resi	0 minutes later, I observed dent 1] rather harshly by the room. Again she left, and I			Coordinator office. A copy of policies and procedures will be the purse's station for referred	the Abuse e kept at	

ORM CMS-2567(02-99) Previous Versions Obsolete

she had already talked to him."

witnessed [CNA 2], CNA; dragging [resident 1]

about it, and she said she was going to talk to

him, but that not much would happen, because

waist, and his right hand clinched around [resident 1's] left hand...I told [facility nurse 1]

into dining room. He had his left arm around her

the nurse's station for referral as needed

An AD-HOC Quality Assurance meeting

in regards to Abuse Prevention and Reporting.

was held Monday, October 31, 2005,

by facility staff.

DEPARTMENT OF HEALTH AND HUMAN RVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** QMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING

465158

B. WING

NAME OF PROVIDER OR SUPPLIER

PINE RIDGE CARE CENTER

(X4) ID

PREFIX

TAG

STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH

SALT LAKE CITY, UT 84115 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY)

F 223

F 223 i 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

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.

PRINTED: 11/18/2005

11/03/2005

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.

DEPARTMENT OF HEALTH AND HUMAN ERVICES PRINTED: 11/18/2005 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465158 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PRÉFIX (X5) COMPLETION DATE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) -TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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

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

depressive and anxious features.

DEPARTMENT OF HEALTH AND HUMAI ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL		IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		465158	B. WING		11/	03/2005	
	VIDER OR SUPPLIER		43	EET ADDRESS, CITY, STATE, ZIP 3 EAST 2700 SOUTH ALT LAKE CITY, UT 84115	CODE	00/2005	
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of the average of the	report that went dministrative empated that CNA 1 in 10/27/05 at 8:3 in DON was compared of an incided lministrative empated to the total dependent 2 flipped of ministrative empated to the total her to stay sident 2 flipped of ministrative empated to the reported of facility nurse 4 in the wheelchair e of it. 10/27/05 at 12:1 ployee 1 was interested to the reported of the wheelchair e of it. 10/27/05 at 12:1 ployee 1 was interested to the reported of the wheelchair e of an incident ident 2. She stated the incident between the incident th	y she stated she was aware of to the DON regarding ployee 1 and resident 2. She reported the incident. O AM, a phone interview with pleted. She stated she was not intolving resident 2 and	F 223				

DEPARTMENT OF HEALTH AND HUMAI. ERVICES PRINTED: 11/18/2005 **CENTERS FOR MEDICARE & MEDICAID SERVICES** FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 465158 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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 223 Continued From page 14 F 223 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

in the dining room.

only aware of a resident to resident altercation involving resident 3 and resident 4 that occurred

DEPARTMENT OF HEALTH AND HUMAN ERVICES PRINTED: 11/18/2005 **CENTERS FOR MEDICARE & MEDICAID SERVICES** FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465158 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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (X5) COMPLETION DATE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 223 Continued From page 15 F 223 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
- ·· ·		465158	B. WING _		11/03	3/2005
	PROVIDER OR SUPPLIER DGE CARE CENTER		4	REET ADDRESS, CITY, STATE, ZIP CODE 133 EAST 2700 SOUTH SALT LAKE CITY, UT 84115	1 1 1/03	5/2003
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	resident on face" 483.13(c) STAFF To the facility must despolicies and proceds mistreatment, negle and misappropriation. This REQUIREMENT by: Based on interview a was determined that and implement policies prohibited neglect. Sexperienced multiple harm as a result of the theorem as a	REATMENT OF RESIDENTS velop and implement written ures that prohibit ct, and abuse of residents n of resident property. T is not met as evidenced and closed record review, it the facility did not develop ies and procedures that Specifically, Resident CL 1 e falls and sustained actual he falls. The facility o, fully implement and ions to avoid physical harm alls. dmitted to the facility on s which included Parkinsons, otic features, diabetes type II	F 224	This facility does and will continue implement written policies and pro that prohibit the mistreatment, negl and abuse of residents and misappropriation of resident proper A new fall program, "The Falling Leave Program" will implemented by December 15, 200 Every resident will have a Fall Risk Assessment completed by December 2005. Interventions will be determ by the completion of Fall Risk Asse Interventions will be implemented and an individualized comprehensive will be completed for each resident interventions. All new residents will a Fall Risk Assessment completed value to a fall Risk Assessment completed value and an individualized care plan will completed at that time. All Fall Risk Assessments will be reviewed and upon a quarterly basis and as needed changes occur. The Interdisciplinar Team will review these during the interdisciplinary Team Meeting. Act will be addressed after each fall occur will be care planned with new interventions will be monitored by Director of Nursing to help ensure printerventions are in place. As in-ser interventions are in place. As in-ser interventions are in place.	be 5. cer 15, ined essment. immediately ve care plan to include ll have with ate mmediately be k apdated y ctual falls ars and rentions sments the roper vice will	12-15-05
1	the following on a "Nເ	ursing Discharge off regarding resident CL 1,		be completed to Licensed Nurses and Interdisciplinary Team Members on before December 15, 2005.	or	
,	An admission minimu	m data set (MDS) was		We will review the Fall Assessment during each of our QA meetings, the being held on 12-13-05.	Program first	

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

STATEMENT OF DEFICIENCIES (X1) PI AND PLAN OF CORRECTION ID		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE S			
		465158	B. WING	G	- 11/	11/03/2005		
	PROVIDER OR SUPPLIER DGE CARE CENTER			STREET ADDRESS, CITY, STATE, 2 433 EAST 2700 SOUTH SALT LAKE, CITY, UT 841	ZIP CODE	03/2005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C	OF CORRECTION ICTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
	completed by facilit staff documented the and long term memognitive skills for demoderately impaired documented that Retransfer and ambulated assistance. The face Resident CL 1 requifor balance while stated documented that Retransfer and ambulated assistance. The face Resident CL 1 requifor balance while stated accumented that Retransfer and days. A fall risk assessme Resident CL 1's closs A review of resident revealed a comprehe 7/17/05, addressing care plan documented "have no incidence of approaches the follor "1) Encourage reside 2) Refer for evaluation encourage exercise maintain strength, basic encourage self mand be sure of their self that the sure of their self that the sure of their self that mobility. 5) Keep bed wheels position. 6) Ensure that glass working order and average ruse.	y staff on 7/17/05. Facility nat Resident CL 1 had short ory problems and his aily decision making were d. The facility staff esident CL 1 was able to ate short distances with limited cility staff documented that ired partial physical support anding. The facility staff also esident CL 1 had a fall in the ant could not be found in sed medical record. CL 1's medical record, ensive care plan dated resident CL 1's fall risk. The ed the following under goal, of falling by 10/17/04". Under wing was documented, ent to have rest periods. on by restorative nursing to and mobility to maximize and alance, and coordination. To be sidents to rise slowly steadiness prior to walking, therapy to increase strength locked and bed in lowest es and hearing aides are in sailable for use. Es at hand and ensure	F 22	24				

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

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY LETED
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	PROVIDER OR SUPPLIER DGE CARE CENTER			43.	EET ADDRESS, CITY, STATE, ZIP CO 3 EAST 2700 SOUTH LLT LAKE CITY, UT 84115		03/2005
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	9) Put on nonskid to 10) Instruct the rest they experience a fanot get up by himse 11) Document the resident care plan a Quarterly and after On 7/8/05 at 5:30 PCL 1's medical recordentry: "Pt. (patien away pt landed on the arm" On 7/8/05 at 5:30 Pl documented the folion away pt landed on the floor" Facility indicate under the se "Interventions/Follow On 7/17/05 at 6:30 ACL 1's medical recordentry: "Called to roo (roommate) states re (wheel chair) but it resitting on buttocks [wextremities) extended on 7/17/05 at 6:30 Adocumented the follon of th	footwear. ident about what to do should all. Encourage the resident to all but rather to call for help. fall risk measures in the and update as needed (leach fall)." M, a nurse's note in Resident red documented the following to put self to bed-bed rolled the floor. A small skin tear left all the floor. A small skin tear left all the floor. A small skin tear left all the floor administrative staff did not be floor administrative staff did not be form any and the following may roommate, RM be sident tried to sit in w/c bolled back. Resident found with the following may roommate all the form and may be sident tried to sit in w/c bolled back. Resident found with the form and may be sident found sitting on a "Post Incident all the form by roommate all the form by up: MD (medical doctor) to make the form by up: MD (medical doctor) to the form by up: MD (medical doctor) to the form the form by up: MD (medical doctor) to the form th	F2	224			

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

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	ULTIPLI LDING	E CONSTRUCTION		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER DGE CARE CENTER			433	T ADDRESS, CITY, STATE, ZIP CO EAST 2700 SOUTH T LAKE CITY, UT 84115		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Trazodone (a sleep sleep) to promote in On 7/24/05 at 5:30 and CL 1's medical recomments are sleep sleep) to promote in On 7/24/05 at 5:30 and documented the foll Report" Form:"R (certified nursing as residents. Resident Facility administration section of the form "Would like to see be On 8/3/05 at 2:30 PM CL 1's medical recomments are sleep to states he tried to sit was noted to have lated on [right] back" On 8/3/05 at 2:30 PM documented the followed. Abrasions note administration documents he form "Intervention of the	medication) [at] HS (hour of nore restful sleep" AM, a nurse's note in Resident and documented the following gon floor beside bed" AM, a facility nurse owing on a "Post Incident esident found by CNA sistant) checking on sitting upright on floor" on documented under theInterventions/Follow up: ed alarm used" M, a nurse's note in Resident and documented the following F (found on floor) next to bed on bed and slid to the floor arge abrasion purple in color and on [right] back" Facility nented under the section of ons/Follow up: Wife will sident as cane does not ing from bed" I, a nurse's note in Resident documented the following from bed" I, a nurse's note in Resident documented the following nationes [with] bruising to Rt recent fall. Fall [and]	F 2	24			
	Safety Precautions im	ipiomonteu					

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

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE CONSTRUCTION LDING	(X3) DATE	SURVEY PLETED
		465158	B. WIN	IG	- 11	/03/2005
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 433 EAST 2700 SOUTH SALT LAKE CITY, UT 841	ZIP CODE	103/2003
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 224	On 11/3/05 at 10:00 was interviewed reg Program. The Dire facility did not have and she was working. The facilities policy reviewed on 11/3/05 The following step assess a resident for falls / wandering 2 and Guidelines for unaction with specific in Develop a written call interventions listed on plan of care in restaff have received in plan of care Reside and are at risk for fall immediate care to mosteps need to be con admission"	AM, the Director of Nursing parding a Fall Prevention of Nursing stated the a Fall Prevention Program yet g on putting one into place. and procedure for falls was and procedure stated," as should be followed to be being at risk for restraints / Apply Fall Assessment Tool ase3Devise a plan of anterventions if needed4. The plan with specific and the plan with specific and the plan with staff5. Pass port to all three shifts until all anto who are newly admitted antended to be given a maintain safety. The above an entation to provide evidence aloped interventions, dent CL 1's needs to reduce	F 2	24		
F 225 SS=K	483.13(c)(1)(ii)-(iii) S RESIDENTS	TAFF TREATMENT OF	F 22	F-225		12-15-05
	been found guilty of a mistreating residents had a finding entered registry concerning a of residents or misap and report any knowle	employ individuals who have abusing, neglecting, or by a court of law; or have into the State nurse aide buse, neglect, mistreatment propriation of their property; edge it has of actions by a n employee, which would		Same Plan of correction of see Policy and Progregarding abuse. Will be monitored by And discussed in QA rational first being on December	cedures Administrator neetings, the	

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

AND PLAN	OF CORRECTION	iDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE COMPL	
		465158	B. WI	1G		11/	03/2005
	PROVIDER OR SUPPLIER DGE CARE CENTER			43	EET ADDRESS, CITY, STATE, ZIP COD 3 EAST 2700 SOUTH ALT LAKE CITY, UT 84115		00/2000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	indicate unfitness for other facility staff to or licensing authorical author	or service as a nurse aide or of the State nurse aide registry ties. Insure that all alleged violations arent, neglect, or abuse, funknown source and fresident property are reported administrator of the facility and accordance with State law function of the procedures (including to the extification agency). Inve evidence that all alleged ughly investigated, and must ential abuse while the regress. Investigations must be reported or his designated to other officials in accordance ding to the State survey and within 5 working days of the alleged violation is verified we action must be taken. In it is not met as evidenced and staff interviews and record alled to investigate and report I abuse (including injuries of therefore, were not sidents from further potential additionally, the facility did not not abuse, resident to resident funknown origin, in	F 2	25			

DEPARTMENT OF HEALTH AND HUMAN . _RVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		465158	B. WII	NG		11/	N3/200E	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	During the survey, of 11/3/05, record revision indicated two allegation (Residents 1 and 2) where the facility far and report these occrecord review and sincident of resident and 4) and four incitioning (Residents 7, failed to investigate). A review of the faprocedures, relating 10/26/05. The policion. Any employee who been abuse, neglect property towards a reshould follow the follow. Report to your direction and follow the follow. The Administrator will contain the familiar and the following or Administrator will contain the fitter feel they are reported in the fitter feel they are results with suspense for the incident of the incident following protocol Interview any with Review chart or fit for Fax results within Reporting Protocol Interview greater the investigation should follow the fitter feel they are results within Reporting Protocol Interview any with the investigation should follow the fitter feel they are results within Reporting Protocol Interview any with the investigation should follow the fitter feel they are results within Reporting Protocol Interview any with the investigation should follow the fitter feel they are results within Reporting Protocol Interview any with the investigation should feel they are results within Reporting Protocol	completed 10/26/05 through ew and staff interviews ations of staff to resident abuse to by facility staff members, alled to thoroughly investigate currences. Additionally, taff interviews indicated one to resident abuse (resident 3 dents of injuries of unknown 9 and CL 1), where the facility or report these occurrences. Acility's policies and to abuse, was completed on ies directed the following, o suspects that there has to or misappropriation of esident, employee or visitor owing routine for reporting. Sect supervisor ble or the supervisor is Department Head, Director of ator. To designee will follow the otocol The DON or intinue the investigation. Involved in incident. Ask have been treated wrongly, pect to determine their dent. Section of the supervisor is designee will follow the otocol The DON or intinue the investigation. Involved in incident. Ask have been treated wrongly, pect to determine their dent. Section of the supervisor is designee will follow the otocol The DON or intinue the investigation. Involved in incident. Ask have been treated wrongly, pect to determine their dent. Section of the supervisor is determined the investigation.	F2	225	DEFICIENCY)			
	hhinhiare agencies	will be notifiedIf an					1	

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

AND PLAN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLI ILDING	E CONSTRUCTION	(X3) DATE COMPI	
		465158	B. Wil	NG		444	
	PROVIDER OR SUPPLIER DGE CARE CENTER		_	433	T ADDRESS, CITY, STATE, ZIP COL EAST 2700 SOUTH T LAKE CITY, UT 84115		03/2005
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	employee is involve suspension until the 2. A review of the fa procedures indicated "All employees will to the facility on issu and misappropriation a year an in-service that will review the a will also train employ aggression and/or caresident, how to report allegations without feather than the facility. The service allegations of the service of unknown origin we reviewed. Since Augreported any of these survey Agency. In addition to a review allegations of abuse, resident property, and the surveyors reviewed esceived by Adult Pro-	d, they will be put on investigation is complete" acility's abuse policy and dethe following. I receive an initial orientation es related to abuse, neglect nof resident property. Once will be given to all employees bove topics. The in-service rees how to deal with atastrophic reactions of out their knowledge of related ear of reprisal" reyors reviewed records ate Survey Agency, which Incidents of facility self of abuse, neglect, esident property, and injuries are among the records ust 2004, the facility had not incidents to the State of facility self reported neglect, misappropriation of dinjuries of unknown origin, and documentation of reports tective Services (APS). 4, the facility had not self cidents to APS.	F 2	225			
1	0/24/02 with diagnos	mitted to the facility on es which included vascular anxiety and insomnia.					

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

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T.,,,,,			OMR N	O. 0938-0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		MULTIP ILDING	LE CONSTRUCTION		SURVEY
: 		465158	B. WI	NG		14	/02/200E
	PROVIDER OR SUPPLIER DGE CARE CENTER			433	ET ADDRESS, CITY, STATE, ZIP CODE BEAST 2700 SOUTH LLT LAKE CITY, UT 84115	<u>. </u>	/03/2005
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	UID RE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 24	F2	225			
	On 10/26/05, the fac reviewed.	cility's incident reports were					
	Incident report regar nurse 2 documented (certified nursing associated bruises to renot oriented enough I asked day shift if the occurred and then I is CNA had witnessed (bilateral) hands; larg (back to) thumb and incident) nurse found incident) nurse found "Employee Warning I'mployee Warning I'mplo	eximately 2:00 PM, the facility of the nurse surveyor with an Notice" regarding CNA 2. Excumented on the warning, a resident from outside pation a very rude way from her upper arms. Nurse asked le [with] pt (patient) and see she wants to stay at this					
p F h	nurse 1) who complet Notice" was interviewed to 2 was bringing read then pulling her and then practity nurse 1 further ewas pulling and publich." Facility nurse	PM, the facility nurse (facility red the "Employee Waring red. She stated on 10/23/05, resident 1 in from the pation resident 1 under the left arm resident 1 under the back. It is taken that "It looked like shing on her, he was being 1 stated that she talked forcing residents. Facility 25/05 resident 1 had					

DEPARTMENT OF HEALTH AND HUMAI __ERVICES PRINTED: 11/18/2005 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115 (AS) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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 its 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 dion't consider it was abuse, it was cold outside and she needed to	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(72)	ALE TIPE	15.000	OWR NO	<u>0. 0938-039</u>
NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER \$\frac{\text{SINMARY STATEMENT OF DEFICIENCIES}}{\text{SUMMARY STATEMENT OF DEFICIENCIES}} \text{SUMMARY STATEMENT OF DEFICIENCIES} \text{PREFIX TAG} \text{SUMMARY STATEMENT OF DEFICIENCIES} \text{REGULATORY OR LSC IDENTIFYING INFORMATION} \text{DPREFIX TAG} \text{DPROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY} \text{DPROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY} \text{DEFICIENCY} \text{TAG} \text{TAG} \text{TAG} \text{TAG} \text{TAG} \text{TAG} \text{TAG} \text{PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY} \text{DEFICIENCY} \text{TAG} \text{TAG} \text{TAG} \text{TAG} \text{TAG} \text{TAG} \text{TAG} \text{PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY} \text{DEFICIENCY} \text{TAG} T	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	- 1				
PINE RIDGE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FRETIX TAG Continued From page 25 bruising on both her hands. Facility nurse 1 stated that she gave CNA 2 a verbal warning regarding 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 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			465158	B. WI	NG			
PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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 she stated CNA 2 was being rough with resident 1, facility nurse 1 stated 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					433	BEAST 2700 SOUTH		03/2005
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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	(X4) ID	SUMMARY STA	TEMENT OF BERIOLEN		_ SA	LI LAKE CITY, UT 84115		
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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		bruising on both her stated that she gave regarding the incide incident to anyone. At 3:30 PM, facility resecond time. Facility been employed at the had not provided her Facility nurse 1 stated her she would invest call the administrator stated, "I feel I'm ablinot." Facility nurse 1 did not feel abuse had nurse 1 was reminde being rough with resistated, "he was being was abuse, it was cobe inside." On 10/26/05 at 2:25 Fobserved by two nurseft hand had a 5-7x4 burple bruise on the boy her index finger and pruise on the wrist and lack and purple bruise sesident 1 was orient ble to tell the surveyor hands. On 10/26/05 at 2:30 Power the phone. CNA in elunch meal resider NA 2 went and got her was a stated of the lands and got her was a stated of	r hands. Facility nurse 1 c CNA 2 a verbal warning int but did not report the nurse 1 was interviewed for a y nurse 1 stated she had be facility for 6 weeks and they r with any abuse training. check that if abuse is reported to be tigate and was suppose to r/supervisor. She further be to determine if it's abuse or listed that on 10/23/05, she and occurred. When facility be that she stated CNA 2 was dent 1, facility nurse 1 g rough but didn't consider it lid outside and she needed to PM, resident 1's hands were be surveyors. Resident 1's cm (centimeter) black and back of her hand, a small cut and a 2x2 cm black and purple and had a 5 cm be on the back of the hand.	F2	225	DEFICIENCY)		

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
· · · · · · · · · · · · · · · · · · ·		465158	B. WING		11/0	03/2005	
	PROVIDER OR SUPPLIER DGE CARE CENTER		s	TREET ADDRESS, CITY, STATE, ZIP CO 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(XS) COMPLETION DATE	
	stated that CNA 2 we resident 1. He state around her waist an holding her left hand ground and dragged stated that he report nurse 1 and facility already talked to CN 10/24/05 when he casked if he knew wh CNA 1 stated he tole report regarding the looked at resident 1 on 10/23/05, CNA 1 a "CNA Notes", "On [resident 1] being tredining room for lunch minutes, then left out out, approximately 1 [CNA 2], pulling [resident 4], pulling [resident 6], and his right he waist, and his right he waist, and his right he waist, and she said him, but that not mushe had already talked On 10/26/05 at 2:50 the facility administrated he was inform resident 1 and CNA 2 afternoon (24 hours a waiting results of 5 determine if abuse of determine if abuse of determine if abuse of the stated in the state of the s	rent out on the patio and got ad CNA 2 had his "left arm d with his right hand was dhe had her lifted off the her to her chair." CNA 1 ted the incident to facility nurse 1 stated she had lA 2. CNA 1 stated on ame into work facility nurse 2 hat happened to resident 1. It facility nurse 2 and wrote a incident. He stated when he is hands they were bruised. I documented the following on 10-23-05, I witnessed eated cruelly. She was in the high had her tray came of minutes later, I observed dent 1] rather harshly by the proom. Again she left, and I CNA; dragging [resident 1] had his left arm around her and clinched around diI told [facility nurse 1] the she was going to talk to ch would happen, because hed to him." PM, 3:45 PM and 6:00 PM, where was interviewed. He had of the incident involving 2 on 10/24/05 in the lafter the incident occurred). Suspended [CNA 2] yet	F 22	5			

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

STATEMENT OF DE	FEICIENCIES	(V4) PDOLED COLOR				OMB N	<u>10. 0938-039</u>	
AND PLAN OF COR	RECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		465158	B. Wil	NG_			1.100.100.0	
NAME OF PROVIDE	ER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP GODE	11	1/03/2005	
PINE RIDGE C	ARE CENTER			4	133 EAST 2700 SOUTH SALT LAKE CITY, UT 84115			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	T	<u> </u>				
PRÉFIX (E	EACH DEFICIENCY	MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	UID BE	(X5) COMPLETION DATE	
F 225 Cont	inued From pag	ge 27	F	225				
furthe was o	er stated that the out of town unties or to return before	ne DON (director of nurses) il 11/3/05 and he would wait ore suspending or terminating						
Prote- report invest worke reside report right?' time th regard month Noven On 10, intervie reporti that sh resider days a stated turned turn it i were a stated of	e is brought to a ctive Services) to is completed a tigation. He state is to any one else it is included it included it is included it	ated when an allegation of his attention APS (Adult is contacted, an incident and the facility starts a 5 day ated the SSW (social service contacted APS regarding 2. When asked if he should e, he queried "that's it, trator further stated at this any new hire orientation hope to start doing it once a at last abuse in-service was W stated she was new at of abuse. She further stated are of the incident involving 2 on 10/25/05 at 1:00 PM (2 to occurred). The SSW Papers are ready to be derstand I have 24 hours to SSW was asked if there ies she would report to, she wimately 8:00 AM, facility ed over the phone. She bruising on resident 1's she reported the incident to						
CNA 2	spoke to CNA pulling on resid	cility nurse 2 further stated 1 and he told her about lent 1's hands. Facility ed that CNA 1 reported the						

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

STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE S	
	465158	B. WING			32/2005
NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER		43	ET ADDRESS, CITY, STATE, ZIF 3 EAST 2700 SOUTH LAKE CITY, UT 84115	CODE	03/2005
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
written up involving stated that she re-hi She further stated the papers to fill out, but information regarding. On 10/27/05 at 8:30 interviewed over the 10/23/05 she worked not informed of the itersident 1 until 10/25 occurred). The DON on at the facility Aug she was there she at regarding theft, she it touched on abuse and touched on abuse are on 10/27/05 at approximation was interviewed. He 10/23/05 with resident 1 in from the 2 further stated that "happened to her [restand to her [restand he had never see stated that the DON wand saw him the more talk to him regarding resident 1. CNA 2 stated that the normal talk to him regarding resident 1. CNA 2 stated that the normal talk to him regarding resident 1. CNA 2 stated that the normal talk to him regarding resident 1. CNA 2 stated that the normal talk to him regarding resident 1. CNA 2 stated that the normal talk to him regarding at the normal talk to him regarding resident 1. CNA 2 stated that the normal talk to him regarding at the normal talk to him regarding resident 1. CNA 2 stated that the normal talk to him regarding at the normal talk to him regarding resident 1. CNA 2 stated that the normal talk to him regarding at the normal talk to him regarding resident 1. CNA 2 stated that the normal talk to him regarding at the normal talk to him regarding the normal talk to him rega	the incident. Facility nurse 2 ired with the facility last year. That the facility provided her to could not recall if any agabuse was provided. AM, the DON was a phone. She stated that on a graveyard shift and was incident involving CNA 2 and 5/05 (2 days after the incident of the first week attended an in-service further stated that in-service further stated the in-service further stated the in-service further stated the did bring a patio to eat her meal. CNA incompany bruises." When CNA was a Warning Notice" with his that was not his signature en that paper. He further worked the night of 10/23/05 ning of 10/24/05 and did not the incident involving ated he worked an extra shift stated he had not received	F 225			

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	JCTION (X3) DATE SURV COMPLETE	
		465158	B. WIN	IG		1111	03/2005
	PROVIDER OR SUPPLIER DGE CARE CENTER		•	43	ET ADDRESS, CITY, STATE, ZIP CODE 3 EAST 2700 SOUTH LLT LAKE CITY, UT 84115		03/2005
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
1	and resident 1 was further stated, "I wa hand away, then he housekeeper stated the DON on 10/24/0 DON told her to "wristated she had beer months and had not abuse. She further room." On 10/25/05, the fact documented the folk [CNA 2] was cutting asking him to stop s [sic] him. I was mop saw him yank her ha hard come Monday I and bruised really be On 10/27/05 at 1:22 phone. APS stated to	asking CNA 2 to stop. She tched her [resident 1] yank her [CNA 2] yanked it back." The she reported the incident to 5 in the morning and the ite it up." The housekeeper working at the facility for 5 received any training on stated "I only clean residents will be was he pulled her hand back form and back towards him really noticed her hand was cut	F 2	25			
	 Resident 2 was at 6/30/04 with diagnos mellitus, hypertension depressive and anxid 	dmitted to the facility on es which included diabetes on and dementia with ous features.					
1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	facility nurse 3 was o stated she has worke three years and her la the 1st year she work facility nurse 3 was a she stated, "I'm confu confused because the	AM, A phone interview with ompleted. Facility nurse 3 and at the facility for about ast in-service on abuse was used for the facility. When sked about reporting abuse used on what to do. I'm are [facility administration] are do." When facility nurse 3					

DEPARTMENT OF HEALTH AND HUMAN PRINTED: 11/18/2005 **RVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 225 | Continued From page 30 F 225 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.

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

On 10/27/05 at 12:15 PM, administrative

DEPARTMENT OF HEALTH AND HUMAN PRINTED: 11/18/2005 **IRVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 225 Continued From page 31 F 225 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:

reported the altercation to APS.

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

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

DEPARTMENT OF HEALTH AND HUMAN PRINTED: 11/18/2005 **RVICES CENTERS FOR MEDICARE & MEDICAID SERVICES** FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465158 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 225 Continued From page 32 F 225 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]

"Interventions/Follow up".

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

On 10/26/05, resident 3's medical record was

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

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

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

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		465158	B. WING		11/	11/03/2005		
NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER			43	EET ADDRESS, CITY, STATE, ZIP 3 EAST 2700 SOUTH ALT LAKE CITY, UT 84115				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
	reviewed. On 9/19/05 at 5:00 documented the foli (patient) on [sic] DR (wheelchair), sudde "Stay away from he "a male resident just assessment a bruis [left] forehead [and] On 10/26/05, reside reviewed. On 9/19/05 at 5:00 If documented the foli (patient) on [sic] DR staff member yelled nurse went into DR, walking in DR. Pt remember state [sic] [resident on face" On 10/27/05 at 1:22 phone. APS stated involving resident 3 never had anything in INJURIES OF UNKN 1. On 10/20/05 at 1: resident 7's medical following entry: "CNA reported to this nurse hand, at the assessment (centimeter) x (by	PM, facility nurse 1 lowing in a Nurse's Note", "Pt (dining room) on [sic] w/c mly a staff member yelled r" this nurse went in to the DR, thit [resident 3]at the e/bump small size noted on redness around eye" Int 4's medical record was PM, facility nurse 1 owing in a "Nurse's Note", "Pt (dining room), suddenly a "Stay away from her", this Pt very upset agitated emoved from DR. A staff resident 4] hit a female PM, APS was contacted by they have not had any reports since 2003 and they have reported involving resident 4. NOWN ORIGIN: 00 PM, a nurse's note in record documented the A (certified nursing assistant) a skin tear on resident [left] nent a skin tear noted. 2.8 by 1.8 cm"	F 225					
	A review of the facilit completed during the	y Incident Reports was e survey and there was an						

(X2) MULTIPLE CONSTRUCTION

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

AND PLAN OF CORRECTION (XT) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
	465158		B. WING			11/03/2005		
NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER			***	STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLÉTION		
	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 ncident report dated 6/16/05, concerning resident 9, which documented the following: "CNA certified nursing assistant) noted 2 purplish oruises on [left] lateral wrist [and] upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm, wrist 3 x 1 1/2 cm (centimeter) oblong, upper arm, wrist 3 x		F2	225				

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

STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED		L
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NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER				4	REET ADDRESS, CITY, STATE, ZIP CODE 33 EAST 2700 SOUTH 6ALT LAKE CITY, UT 84115	<u> 11</u>	/03/2005	_
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F 225	Continued From page 35		F 2	25				-
	completed during the incident report to do may have received thead, which was firs. The facility administrany documented eviresident CL 1's head investigated or report. 4. On 7/27/05 at 10: resident CL 1's medifollowing entry: "Lrg (approximately) 5 cm on [left] abdomen" A review of the facility completed during the incident report dated CL 1, which documer (certified nursing ass.	ty's Incident Reports was e survey and there was no cument how resident CL 1 he cut to the back of his t documented on 7/10/05. ration was not able to provide dence that the cut found on 1 on 7/10/05, had been ted to State Survey Agency. 30 PM, a nurse's note in cal record documented the (large) blue bruise approx. In (centimeter) diameter found by Incident Reports was a survey and there was an 7/27/05, concerning resident the following: "CNA istant) noted Irg (large) [left] abdomen approx						
	(approximately) 5 cm The facility administra any documented evid on resident CL 1's ab	(centimeter) diameter" ation was not able to provide ence that the bruising found domen on 7/27/05, had reported to State Survey						
I	NTERVIEWS:							
i r a	eceives an allegation	hone. She stated when she of abuse she investigates ninistrator "who is the abuse						

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

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		465158	B. WING		1 44	201000=	
	PROVIDER OR SUPPLIER DGE CARE CENTER		İ	REET ADDRESS, CITY, STATE, ZIP CO 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115		03/2005_	-
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F 225	2. On 10/27/05 at 9 interviewed. She st	9:30 AM, the SSW was	F 225				
	interviewed. He sta coordinator." He fui	t:35 AM, the administrator was ted, "I guess I'm the abuse ther stated that the building and everyone was involved.					
	The facility must developolicies and procedures and procedures and misappropriation. This REQUIREMEN by: Based on staff intervereview of the facility's procedures, the facility procedures to ensure facility were free from Additionally, based or review, the facility fair employees for a histoto provide any on goil dentification and representations.	ct, and abuse of residents of resident property. T is not met as evidenced iews, record review and abuse policies and ity failed to establish effective diprotection policies and ethat the residents of the nactual and potential abuse. In interview and record led to screen potential pry of abuse, the facility failed ing in-service training on the porting of abuse, the facility vestigate allegations of	F 226	F-226 Same Plan of correction as F-2 Or see Policy and Procedures regarding abuse Reporting. Will be monitored by Adminis And discussed in QA meetings first being on December 13, 20	strator s. the	12-15-05	
	procedures to ensure facility were free from Additionally, based or eview, the facility fait employees for a history or provide any on goil identification and represented to thoroughly in abuse (including injurtiacility failed to proted abuse and the facility	e that the residents of the nactual and potential abuse. In interview and record led to screen potential bry of abuse, the facility failed and in-service training on the porting of abuse, the facility					

DEPARTMENT OF HEALTH AND HUMA , ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES						NIND NO	. 0938-0391
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	X2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER			4331	T ADDRESS, CITY, STATE, ZIP (CODE	11/0	3/2005
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TAG REGULATORY OR LE	MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	,	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE APPROP) RE	(X5) COMPLETION DATE
F 226 Continued From page state law.	ge 37	F 2	226				
indicated two allegat (Residents 1 and 2), where the facility fail report and protect th occurrences. Additionally, record reindicated one incider abuse (resident 3 and injuries of unknown of	completed 10/26/05 through aw and staff interviews tions of staff to resident abuse, by facility staff members, ed to thoroughly investigate, e alleged victims from these eview and staff interviews at of resident to resident d 4) and four incidents of origin (Residents 7, 9 and CL failed to investigate or report						
a. A review of the fac	cility's policy and procedures was completed on 10/26/05. edures directed the						
individual chosen to be to be willing to undergo check. Each employed references if possible if the position the individual chosen to be willing to undergo check.	partment Head for which interviewing forAfter an experience hired, they will then need to a criminal background experience will also provide from previous employers. idual is hiring for, involves porrect licensing hoards will						
CMS-2567(02-99) Previous Versions Obsc	olete Event ID: BZ5911	Facility	ID: UTO	7054	tinuation st		

DEPARTMENT OF HEALTH AND HUMA. PRINTED: 11/18/2005 **ERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING_

465158

NAME OF PROVIDER OR SUPPLIER

PINE RIDGE CARE CENT	ER
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STREET ADDRESS, CITY, STATE, ZIP CODE 433 FAST 2700 SOUTH

11/03/2005

NE RII	DGE CARE CENTER		433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115			
X4) ID REFIX 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) COMPLETIO DATE		
F 226	Continued From page 38	F 226				
	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.					
i	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	2. TRAINING:			l		
	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 ollowing:					
tł m	Training All employees will receive an initial orientation to the facility on issues related to abuse, neglect and nisappropriation of resident property. Once a tear an in-service will be given to all the imployees"					

PRINTED: 11/18/2005 DEPARTMENT OF HEALTH AND HUMA. **ERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PRÉFIX (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 226 Continued From page 39 F 226 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

On 10/27/05 at 8:40 AM, CNA 4 was interviewed. CNA 4 stated she had not received any training

training regarding abuse at this facility.

regarding abuse at this facility.

DEPARTMENT OF HEALTH AND HUMA .ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE	SURVEY LETED
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NAME OF	PROVIDER OR SUPPLIER	1 100100			ET ADDRESS OUTVOTATE TO ACCOUNT		/03/2005
PINE RII	DGE CARE CENTER			433	ET ADDRESS, CITY, STATE, ZIP CODE 3 EAST 2700 SOUTH LLT LAKE CITY, UT 84115		
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F 226	Continued From page	ge 40	F 2	26			
3 a re 1	and the first week slin-service regarding in-service touched or On 10/27/05 at appropriate	e phone. The DON further don at the facility August 2005 he was there she attended an theft, she further stated the in abuse and neglect "a little". Oximately 9:30 AM, CNA 2 NA 2 stated he had not training at this facility. Oximately 10:00 AM, the was interviewed. The she had been working at the end had not received any he further stated "I only clean of AM, a phone interview with ed. CNA 1 stated he re-hired inber 2005. He further ed no training regarding CNA 1 stated he signed is not sure if there was a abuse on them. He further been talked to about the endures from facility AND INVESTIGATION: ility's policy and procedures.					
ויי	dentification There v	vill be an in-service training e for all staff at the time of					

DEPARTMENT OF HEALTH AND HUMA! PRINTED: 11/18/2005 **ERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CHA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 226 | Continued From page 41 F 226 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

DEPARTMENT OF HEALTH AND HUMA! PRINTED: 11/18/2005 **ERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 465158 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 226 Continued From page 42 F 226 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

her hands.

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

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

and she needed to be inside."

DEPARTMENT OF HEALTH AND HUMAI **ERVICES** PRINTED: 11/18/2005 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 465158 NAME OF PROVIDER OR SUPPLIER 11/03/2005 STREET ADDRESS, CITY, STATE, ZIP CODE PINE RIDGE CARE CENTER 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 226 Continued From page 43 F 226 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...l told [facility nurse 1]

about it, and she said she was going to talk to him, but that not much would happen, because

On 10/26/05 at 2:50 PM, 3:45 PM and 6:00 PM, the facility administrator was interviewed. He

she had already talked to him."

DEPARTMENT OF HEALTH AND HUMAI ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X4) MULTIPLE CONSTRUCTION A. BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH	,	
NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH		
PINE RIDGE CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH	\ <i>E</i>	
SALT LAKE CITY, UT 84115	<u>15</u>	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY) OUT OF THE PROPRIATE DEFICIENCY)	LETION	
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 affermon (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). On 10/25/05 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		

DEPARTMENT OF HEALTH AND HUMAI **ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES**

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE	SURVEY LETED
-total		465158	B. WII	NG_		11/	03/2005
	PROVIDER OR SUPPLIER DGE CARE CENTER			4	REET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115		03/2003
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	administration of the reported to facility in 10/24/05. Through staff, even though the abuse on 10/24/05 of the alleged abuse (approximately 72 hoccurred). d. On 10/27/05 at 7: with facility nurse 3 was asked abuse in the facility a report that went to administrative employstated that CNA 1 results of an incident administrative employstated that CNA 1 results of an incident administrative employstated that CNA 1 was completed September 2005 results of the complete september 2005 r	e allegation of abuse that was aurse 1 on 10/23/05 until interviews with administrative hey were informed of the and 10/25/05, no investigation e occurred until 10/26/05 iours after the incident. 30 AM, A phone interview was completed. When facility about any allegations of she stated she was aware of the DON regarding eyee 1 and resident 2. She exported the incident. AM, a phone interview with eted. She stated she was not involving resident 2 and eyee 1. D AM, a phone interview with eted. He stated sometime in ident 2 was in the dining if. He stated that eyee 1 took resident 2 in her ed her in front of the couch there. CNA 1 stated that eyee 1 told resident 2 "that's it the resident there. CNA 1 e incident to facility nurse 4 elped get resident 2 back and told CNA 1 he would take	F	226			

DEPARTMENT OF HEALTH AND HUMAI **ERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) I	ALII TO	PLE CONSTRUCTION		<u>U. 0936-0391</u>
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: A. BUILDING				SURVEY PLETED	
		465158	B. WI	NG_		1 11	/02/200E
	PROVIDER OR SUPPLIER DGE CARE CENTER			43	EET ADDRESS, CITY, STATE, ZIP CODE 33 EAST 2700 SOUTH ALT LAKE CITY, UT 84115		/03/2005
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	employee 1 was into aware of an incident resident 2. She statherself out of her who resident 2 in front of employee 1 stated to about the incident. On 10/27/05 at apprexit conference the anothing about the incident and administrative enterview and record survey showed the Dadministrator of the areported to her on or no documentation of alleged abuse. e. On 10/20/05 at 1: resident 7's medical infollowing entry: "CNA reported to this nurse hand, at the assessment (centimeter) x (by A review of the facility completed during the incident report dated resident 7, which documented evidents in the facility administration of the facility and the facility administration of the facility and the facility	erviewed. She stated she was a concerning herself and ted resident 2 was throwing neelchair and she placed the couch. Administrative that the DON talked to her coximately 4:00 PM, during an administrator stated he knew cident involving resident 2 mployee 1. Treview conducted during the DON did not inform the allegation of abuse that was around 9/9/05. There was an investigation of the cord documented the cord documented the cord documented the cord field nursing assistant) as a skin tear on resident [left] then a skin tear noted. 2.8 cm" Incident Reports was survey and there was an 10/20/05, concerning umented the following: sing assistant) reported to ng lunch trays a skin tear on measured 2.8 cm	F2	226			

PRINTED: 11/18/2005 DEPARTMENT OF HEALTH AND HUMAN **ERVICES** FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

PINE RI	OGE 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 (X5)			
F 226	Continued From page 47	F 22	26			
j	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"					
i	A review of the facility's Incident Reports was completed during the survey and there was no neident report to document how resident CL 1 may have received the cut to the back of his nead, which was first documented on 7/10/05.					
ı	The facility administration was not able to provide any documented evidence that the cut found on esident CL 1's head on 7/10/05, had been nestigated.					

PRINTED: 11/18/2005 DEPARTMENT OF HEALTH AND HUMA **ERVICES FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 226 Continued From page 48 F 226 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 Irg (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

safe from harm and retaliation "

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

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

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
l		405450	B. WII					
NAME OF	PROVIDER OR SUPPLIER	465158		r		11/0	03/2005	
	OGE CARE CENTER			43	EET ADDRESS, CITY, STATE, ZIP CO 3 EAST 2700 SOUTH ALT LAKE CITY, UT 84115	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
	provide care to resist housekeeper docur 10/25/05, another in 10/23/05, where sh 2 was cutting reside was asking CNA 2 watched her [reside then he [CNA 2] yar documentation was investigation of the taken to protect resist on 10/26/05 at 2:50 the facility administrated he was informated the stated that the 11/3/05 and he would suspending or terminated. The incident involution of the incident of the was informated that the DON incident but she was informated that the DON incident but she was informated the was incompleted. No document of the resident who completed the investigated was also were taken to put the stated that the DON incident but she was informated the was informated that the DON incident but she was incident but she was incident but she was incide	dent 1 on 10/23/05. A mented on a note dated ncident that occurred on e observed the following, CNA ent 1's nails and resident 1 to stop. She further stated, "I ent 1] yank her hand away, nked it back." No provided regarding the incident or what steps were ident 2. PM, 3:45 PM and 6:00 PM, ator was interviewed. He ned of the incident involving 2 on 10/24/05 in the after the incident occurred). suspended [CNA 2] yet day investigation to occurred or not and then will rminate." The administrator e DON was out of town until d wait for her to return before nating CNA 2. lving administrative employee urred sometime on or around iewed, administrative iat the DON had talked to her administrative employee 1 talked to her about the not suspended or removed ille an investigation was mentation was provided gation of the incident or what	F2	226				

DEPARTMENT OF HEALTH AND HUMA PRINTED: 11/18/2005 **ERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB_NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 465158 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (X5)**PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 226 Continued From page 50 F 226 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.

Reporting Protocol...

perception of the incident.

3. Interview any witnesses...

 Visit with person involved in incident. Ask them if they feel they have been treated wrongly.
 Interview with suspect to determine their

4. Review chart or file for any other reports.5. Fax results within 5 days as per Abuse

If the investigation shows probable abuse, then appropriate agencies will be notified...If an

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE : COMPL		
		465158 B. WING		11/	11/03/2005		
	PROVIDER OR SUPPLIER DGE CARE CENTER			43	EET ADDRESS, CITY, STATE, ZIP COD 3 EAST 2700 SOUTH ALT LAKE CITY, UT 84115		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	employee is involve suspension until the b. On 10/26/05, surmaintained by the S related to the facility reported allegations misappropriation of of unknown origin w reviewed. Since Aureported any of thes In addition to a reviewed allegations of abuse resident property, are the surveyors review received by Adult Pr Since November 20 reported any of the incident involving CN nurse 1 stated that swarning regarding the incident to anyon 1 was interviewed for nurse 1 stated that if would investigate an administrator/superv feel I'm able to deter On 10/26/05 at 2:30 over the phone regar CNA 2 and resident reported the incident nurse 1 stated she had CNA 1 stated on 10/26/05 at 2:30 over the phone regar CNA 2 and resident reported the incident nurse 1 stated she had CNA 1 stated on 10/26/05 at 2:30 over the phone regar CNA 2 and resident reported the incident nurse 1 stated she had CNA 1 stated on 10/26/05 at 2:30 over the phone regar CNA 2 and resident reported the incident nurse 1 stated she had CNA 1 stated on 10/26/05 at 2:30 over the phone regar CNA 2 and resident reported the incident nurse 1 stated she had CNA 1 stated on 10/26/05 at 2:30 over the phone regar CNA 2 and resident reported the incident nurse 1 stated she had CNA 1 stated on 10/26/05 at 2:30 over the phone regar CNA 2 and resident reported the incident nurse 1 stated she had CNA 1 stated on 10/26/05 at 2:30 over the phone regar CNA 2 and resident reported the incident nurse 1 stated she had CNA 1 stated on 10/26/05 at 2:30 over the phone regar CNA 2 and resident reported the incident nurse 1 stated she had CNA 1 stated on 10/26/05 at 2:30 over the phone regar CNA 2 and resident nurse 1 stated she had CNA 1 stated on 10/26/05 at 2:30 over the phone regar CNA 2 and resident nurse 1 stated she had CNA 1 stated on 10/26/05 at 2:30 over the phone regar CNA 2 and resident nurse 1 stated she had CNA 2 and 2	d, they will be put on a investigation is complete" Veyors reviewed records state Survey Agency, which of abuse, neglect, resident property, and injuries are among the records gust 2004, the facility had not e incidents. Ew of facility self reported and injuries of unknown origin, and injuries of unknown origin, ared documentation of reports otective Services (APS).	F 2	226			

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		PLE CONSTRUCTION	(X3) DATE S	
	,	465158	B. Wil				
NAME OF E	PROVIDER OR SUPPLIER	403130	<u> </u>			11/0	03/2005
	OGE CARE CENTER			4	REET ADDRESS, CITY, STATE, ZIP CODE 33 EAST 2700 SOUTH ALT LAKE CITY, UT 84115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	Continued From pa	ge 52	F	226			_
		nt 1. CNA 1 stated he told wrote a report regarding the					
	the facility administr stated he was inforr resident 1 and CNA afternoon (24 hours The administrator stabuse is brought to Protective Services) report is completed investigation. He staworker) should have resident 1 and CNA report to any one else On 10/26/05 at 2:55 interviewed. The State of the incide stated the following, turned into APS. In turn it in." When the were any other agents at the incide stated "no". On 10/27/05 at 8:30 interviewed over the 10/23/05 she worked not informed of the informed of	SW stated she was new at of abuse. She further stated are of the incident involving 2 on 10/25/05 at 1:00 PM (2 nt occurred). The SSW "Papers are ready to be nderstand I have 24 hours to SSW was asked if there cies she would report to, she					
	On 10/27/05 at appro	oximately 10:00 AM, the was interviewed. She stated				·	

DEPARTMENT OF HEALTH AND HUMA SRVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIP	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		465158	465158 B. WING				11/03/2005	
	PROVIDER OR SUPPLIER DGE CARE CENTER			43:	EET ADDRESS, CITY, STATE, ZIP (3 EAST 2700 SOUTH LT LAKE CITY, UT 84115		00/2000	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	,	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
	on 10/23/05, CNA 2 and resident 1 was further stated, "I was hand away, then he housekeeper stated the DON on 10/24/0 DON told her to "wr On 10/27/05 at 1:22 phone. APS stated involving resident 1 incident occurred). d. On 10/27/05 at 1:22 with CNA 1 was cor in September 2005 room being very lou often very verbal. Coadministrative employee wheelchair and pusi and told her to stay resident 2 flipped or administrative employement and facility nurse 4 finto the wheelchair a care of it. On 10/27/05 at 12:15 employee 1 was interesident 2. Administrative employee 1 was interesident 2.	2 was cutting resident 1's nails asking CNA 2 to stop. She atched her [resident 1] yank her [CNA 2] yanked it back." The dishe reported the incident to 05 in the morning and the rite it up." 2 PM, APS was contacted by they received a report yesterday (3 days after the 0:30 AM, a phone interview inpleted. He stated sometime resident 2 was in the dining d. He stated resident 2 is ENA 1 stated that expect 1 took resident 2 in her ined her in front of the couch there. CNA 1 stated that into the couch and expect 1 told resident 2 "that's eff the resident there. CNA 1 includent to facility nurse 4 includent 2 back and told CNA 1 he would take the incident back and told conditions that the resident to the resident but she or removed from the resident	F2	226				
	exit conference the a	administrator stated he knew						

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		465158	B. WII	۹G		11/0	03/2005
	PROVIDER OR SUPPLIER			4:	REET ADDRESS, CITY, STATE, ZIP COI 33 EAST 2700 SOUTH FALT LAKE CITY, UT 84115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	IÐ PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	nothing about the in and administrative On 11/1/05 at 8:00 She stated she was involving resident 2 1. She stated she incident occurred a administrative emp did not occur. She incident to the facilit felt abuse did not o On 10/27/05 at 1:22 phone. APS stated involving resident 2 e. On 10/26/05 at 2 interviewed. The Scompleted an investal altercation between She further stated to reported the altercation was administrator. On 10/26/05 at 3:30 interviewed. She sident 3 and resident	AM, the DON was interviewed aware of the incident and administrative employee found out a few days after the nd she interviewed staff and loyee 1 and determined abuse stated she did not report the ty administrator because she ccur. 2 PM, APS was contacted by they have not had any reports since July 2004. 2:55 PM, the SSW was SW stated the DON tigation involving an resident 3 and resident 4. hat the DON should have	F 2	226			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	, ,	(X3) DATE SURVEY COMPLETED	
		465158	B. WING	S	11/03/2005		
	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZII 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 226	On 10/27/05 at 1:22 phone. APS stated involving resident 3 never had anything f. Resident 7, resid had injuries of unknot able to provide the injuries of unknot the State Survey Age 6. INTERVIEWS: Based on the invest unable to determine been designated wifor conducting the afollowing interviews a. On 10/27/05 at 7 with facility nurse 3 nurse 3 was asked stated, "I'm confuse because they [facilition what to do." b. On 10/27/05 at 8 interviewed over the receives an allegatic and reports to the accordinator from my c. On 10/27/05 at 9 interviewed. She st administrator] is the know."	2 PM, APS was contacted by they have not had any reports since 2003 and they have reported involving resident 4. Ient 9 and resident CL 1 all town origin. Facility staff were any documented evidence that own origin were reported to gency. Itigation, surveyors were if a facility staff person had the primary responsibility abuse investigations. The were conducted on 10/27/05: In 30 AM, A phone interview was completed. When facility about reporting abuse she do now hat to do. I'm confused by administration] are confused as a phone. She stated when she can of abuse she investigates dministrator "who is the abuse of understanding."	F 22	26			

DEPARTMENT OF HEALTH AND HUMA! ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		465158	B. WING		11/0	3/2005
	PROVIDER OR SUPPLIER DGE CARE CENTER		43	EET ADDRESS, CITY, STATE, ZIP CODE 3 EAST 2700 SOUTH ALT LAKE CITY, UT 84115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226	interviewed. He sta coordinator." He fu	ge 56 ted, "I guess I'm the abuse ther stated that the building and everyone was involved.	F 226			
F 274 SS=D	A facility must condust assessment of a restractive determines, of that there has been resident's physical of purpose of this section means a major declification of the treatment of the treatment of the treatment of the resident's status that itself without further implementing standard interventions, that has one area of the resident.	act a comprehensive sident within 14 days after the or should have determined, a significant change in the remental condition. (For on, a significant change ne or improvement in the twill not normally resolve intervention by staff or by and disease-related clinical as an impact on more than lent's health status, and nary review or revision of the	F 274	All residents were reviewed by the Director of Nursing, to determine a significant change Minimum E (MDS) is required. Any signification change MDS that is triggered with completed by Director of Nursine All residents will be monitored for a significant change MDS, by Director of Nursing on a quarter during the scheduled quarterly refor that resident. A significant change will also be completed on the residents that exhibit a significant if it is before their quarterly reviewed. All residents that require a significant change will be discussed in morrodepartment head meeting every won Tuesday.	e if Data Set ant II be g. or need the ly basis, eview hange those at change ew. icant	12-15-05
	by: Based on record revidetermined that the five significant change M assessment for 2 of (residents 1 and 2) with a facility as having status. Findings include: 1. Resident 1 was as 10/24/02 with diagnosidetermined.	ew and interview, it was facility did not complete a sinimum Data Set (MDS) 10 sample residents the had been documented by a significant change in dimitted to the facility on ses which included vascular in, anxiety and insomnia.		We will have MDS review during QA meeting held each quarter, the first will be held on December 13	he	

PRINTED: 11/18/2005 DEPARTMENT OF HEALTH AND HUMA ERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 274 | Continued From page 57 F 274 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)

Personal Hygiene:

a. MDS (2/3/05)

b. MDS (5/7/05)

Resident 1 had a documented improvement in

On 11/2/05 at 1:10 PM, an interview with the

Section G1j (3-Extensive assistance)

Section G1j (2-Limited assistance)

DEPARTMENT OF HEALTH AND HUMA' ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		465158	B. WING _		11/03/2005		
	PROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP CO 33 EAST 2700 SOUTH SALT LAKE CITY, UT 84115	· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 274	that a significant ch not been completed 2. Resident 2 was a 6/30/04 with diagno mellitus, hypertenside depressive and anx On 7/13/05, an annicompleted for reside quarterly MDS was comparison of the to a significant change These significant change These significant cha a comprehensive M The areas that documeluded: Resident 2 had a do Mood Persistence: a. MDS (7/13/05) Section E2 (2-Indica altered) b. MDS (10/11/05)	vas completed. She stated ange MDS on resident 1 had it. admitted to the facility on ses which included diabetes on and dementia with	F 274				
	Resident 2 had a do Behavioral Sympton	ocumented improvement in ns, Wandering:					
	b. MDS (10/11/05)	avior was not easily altered)					
İ	Resident 2 had a do Behavioral Sympton Behavioral Sympton						

DEPARTMENT OF HEALTH AND HUMA PERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	ie	ATÉ SURVEY OMPLETED
		465158	B. WING _		11/03/2005
	PROVIDER OR SUPPLIER DGE CARE CENTER		4	REET ADDRESS, CITY, STATE, ZIP CODE 133 EAST 2700 SOUTH SALT LAKE CITY, UT 84115	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 274	a. MDS (7/13/05) Section E4e (1-Beh b. MDS (10/11/05)	ge 59 avior was not easily altered) avior not present or behavior	F 274		
	A facility must use to develop, review a comprehensive plan. The facility must develop for each reside objectives and times medical, nursing, an needs that are ident assessment. The care plan must to be furnished to at highest practicable psychosocial well-be §483.25; and any se be required under §4due to the resident's §483.10, including the under §483.10(b)(4) This REQUIREMEN by: Based on medical residents (Residents	velop a comprehensive care nt that includes measurable ables to meet a resident's id mental and psychosocial ified in the comprehensive describe the services that are tain or maintain the resident's ohysical, mental, and eing as required under rivices that would otherwise 183.25 but are not provided exercise of rights under the right to refuse treatment	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 ongoin for each resident and will be changed as necessary to help meet the individual need of that resident. Care plans will be update 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 Meet 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.	t g s d

DEPARTMENT OF HEALTH AND HUMA' ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		465158	B. WING _		11/0	3/2005	
	PROVIDER OR SUPPLIER DGE CARE CENTER		4	REET ADDRESS, CITY, STATE, ZIP CO 133 EAST 2700 SOUTH SALT LAKE CITY, UT 84115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 279	Continued From pa	ge 60	F 279				
	for each resident baidentified by the fac	ased on their individual needs illity staff.					
	Findings include:						
	10/24/02 with diagn	admitted to the facility on oses which included vascular on, anxiety and insomnia.					
	On 11/3/05, residen was completed.	it 1's medical record review				7	
:		documented that resident 1 ne facility, outside of the facility ent rooms.					
	observed by the sur observed to wander	11/3/05, resident 1 was vey team. Resident 1 was around the facility, outside of other resident rooms.					
	resident 1's wanderi of the facility and int	1's plan of care revealed that ng around the facility, outside o other resident rooms had ed into her plan of care.					
	resident 1 had a car	1's plan of care revealed that e plan completed on 1/11/05 7/6/05, which documented a n."					
	A review of resident significant weight los	1's weighs documented a					
	A review of resident a significant weight I incorporated into he	1's plan of care revealed that oss had not been plan of care.					
	On 10/14/05, a phys	ician's order was obtained to					

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		465158	B. WING _		11/0	03/2005
	PROVIDER OR SUPPLIER		4	EET ADDRESS, CITY, STATE, ZIP C 33 EAST 2700 SOUTH ALT LAKE CITY, UT 84115	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-RÉFÉRÉNCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 279	and to monitor the From 10/31/05 unti observed to receive A review of resident finger foods every rincorporated into he 2. Resident 2 was 6/30/04 with diagnormellitus, hypertenside depressive and anx On 11/3/05, resident was completed. A review of resident resident 2 had a car which documented nutrition." A review of resident significant weight to A review of resident 3. Resident 7 was a 03/02/01 with diagn with psychosis, oster congestive heart fair constipation and resident and resident re	with finger foods every meal intake. I 11/2/05, resident 1 was not e finger foods with her meals. It 1's plan of care revealed that meal had not been er plan of care. admitted to the facility on uses which included diabetes on and dementia with cious features. Int 2's medical record review It 2's plan of care revealed that re plan completed on 7/12/05, a "Potential for altered It 2's weighs documented a use. It 2's plan of care revealed that loss had not been er plan of care. Indicated to the facility on oses which included dementia exparthritis, Parkinsons, lure, edema, hypothyroidism,	F 279			

DEPARTMENT OF HEALTH AND HUMA' ERVICES 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) M A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465158				11/0	3/2005
	ROVIDER OR SUPPLIER			4:	REET ADDRESS, CITY, STATE, ZIP CODE 33 EAST 2700 SOUTH SALT LAKE CITY, UT 84115	1170	3/2003
(X4) ID PREFIX TAG				IX i	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 279	resident 7 had a ca which documented A review of resident significant weight to a significant weight incorporated into he a significant weight incorporated into he a review of the "Alterevealed under appreceive total assistated assistated as a review of the assistated as a review total assistated. Resident 7's meals breakfast and 11/2/nurse surveyor. Refereeive total assistated. Resident 8 was 7/25/96 with diagnowith anxious and dehypertension and completed. A review of resident resident 8 had a car and updated on 7/6/8 "Alteration in nutrition."	to 7's plan of care revealed that are plan completed on 7/5/05, a "Alteration in nutrition." to 7's weighs documented a ss. to 7's plan of care revealed that loss had not been er plan of care. eration in nutrition" also reaches resident 7 would ince with her meals. on 11/1/05 dinner, 11/2/05 05 lunch were observed by a sident 7 was not observed to ince with her meals. admitted to the facility on ses which included demential expressive features, ongestive heart failure. It 8's medical record review to 8's plan of care revealed that the plan completed on 3/22/05 (05, which addressed on." One approach the facility at they would provided total	F	279			
	breakfast were obse	on 11/1/05 dinner and 11/2/05 erved by a nurse surveyor. observed to receive total					

assistance with her meals.

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	ENT OF DEFICIENCIES N OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		465158	B. WII	۷G	U-1	11/0	3/2005
	ROVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, ZIP CODE 33 EAST 2700 SOUTH SALT LAKE CITY, UT 84115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279	5. Resident 9 was a 8/13/03 with diagnous permentia type, hy dizziness, thrombodous On 11/3/05, resident was completed. A review of resident resident 9 had a car which addressed "A Approaches the fact they would assist with wearing and mainta On 11/2/05, resident throughout the day. To wearing her glass 6. Resident CL 1 w 7/7/05 with diagnosis Dementia with psycham peripheral neuron On 11/13/05, reside review was complete.	admitted to the facility on ses which included Alzheimer pothyroidism, chronic cytopenia and dysphagia. It 9's medical record review It 9's care plan revealed that re plan completed on 9/5/05, alteration in visual function." illity documented were that ith glasses, assist with ining cleanliness of lenses. It 9 was observed continuously Resident 9 was not observed ses. as admitted to the facility on its which included Parkinsons, hotic features, diabetes type II opathy. Int CL 1's medical record	F	279			
	1 had falls on the for 7/8/05 7/17/05 7/24/05 8/3/05 A review of resident that resident CL 1 had						

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		465158	B. WING _		11/0	03/2005	
	PROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP 133 EAST 2700 SOUTH SALT LAKE CITY, UT 84115	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 279		ge 64 t CL 1's plan of care revealed not been incorporated into his	F 279				
F 281 SS=E	The services provided must meet profession. This REQUIREMENT by: Based on review of it was determined the were not monitoring administrating medical assessment. Specific consistently docume sugar levels on all 7 physician orders for (Residents 2, 3, 5, 15). Findings include: 1. On 11/03/05 residenties are viewed. On 12/20/04, a physician order regular insurance in the control of the contr	dent 2's medical record was sician's order was written to lin based on the results of ugars (Blood glucose). The	F 281	Resident 2,3,5,11,17,18 and (all diabetic residents) a) Employee education in individual or treatment plan of blood glus and diabetic care. Employed Instruction in professional includes the implementation documentation of treatment and reporting to physician alternations in condition of An in-service will be complicense Nurses on document appropriate charting of blood An audit of blood glucose will be completed at random by the Director of Nurses a noted problems, or concern as appropriate, Administration the Quality Improvement Cat least quarterly.	ation completed. ders and cose finger-sticks be education completed standard of care of physician orde ts in the medical re and responsible part a resident. cleted to all tatation and od glucose levels. documentation on through out the vand will report us, to MD tor, and to	ers, cord, rty	

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		465158	B. WIN			44/00/000	
	PROVIDER OR SUPPLIER DGE CARE CENTER			4	REET ADDRESS, CITY, STATE, ZIP CODE 33 EAST 2700 SOUTH SALT LAKE CITY, UT 84115	11/0	3/2005
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 281	Continued From pa	ge 65	F 2	81			
	resident 2's blood si AM, 12:30 PM, 4:30	facility were to monitor ugar four times a day (at 6:00 PM and at 8:00 PM).					
	blood glucose monit resident 2 revealed 10/07/05 at 8:00 PM on 10/31/05 at 4:30	per 2005 and November 2005 toring (BGM) sheet for that on 10/02/05 at 4:30 PM, I, 10/10/05 at 12:30 PM, and PM the blood sugars were being monitored. On M, a facility nurse p"					
:	2. On 11/03/05 residueviewed.	dent 3's medical record was					
	Resident 3 had a ph for BGM every AM o Friday.	ysician order, dated 10/07/02, n Monday, Wednesday and					
	BGM sheet for reside BGM's, scheduled to not documented as the second se	per 2005 and November 2005 ent 3 revealed that the be done at 6:00 AM, were being completed on 10/10/05 in 10/10/05 at 6:00 AM, a ented "no strip".				i	
	3. On 11/03/05, residence of the control of the con	dent 5's medical record was					
1	Resident 5 had a phy 01/06/03, for BGM ev Wednesday at 6:00 A	ysician's order, dated very week on Saturday and AM.					
	BGM sheets for reside BGM's scheduled to lead	er 2005 and November 2005 dent 5 revealed that the be done at 6:00 AM, were seing completed on 10/01/05					

DEPARTMENT OF HEALTH AND HUMA' 'ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		465158	B. WING		11/	11/03/2005	
	PROVIDER OR SUPPLIER		433	ET ADDRESS, CITY, STATE, ZIF 3 EAST 2700 SOUTH LLT LAKE CITY, UT 84115	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	reviewed. Nursing staff at the resident 11's blood Wednesday and Fr Review of the Octol BGM sheets for res BGM's scheduled to not documented as 10/19/05 and 10/31 a facility nurse documented as 10/19/05 and 10/31 a facility nurse documented as 10/19/05 and 10/31 a facility nurse documented as 10/19/05, reswas reviewed. On 06/01/05, a physoprovide regular insuresident 17's blood ordered was as followed ordered was as followed as 151-200 = 2 units 201-250 = 4 units 201-250 = 4 units 201-350 = 8 units 201-350 =	facility were to monitor glucose every Monday, iday at 6:00 AM. ber 2005 and November 2005 ident 11 revealed that the be done at 6:00 AM, were being completed on 10/10/05, /05. On 10/10/05 at 6:00 AM, imented "no strip". sident 17 's medical record sicians's order was written to lin based on the results of glucose. The sidling scale	F 281				

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		465158	465158 B. WING			11/03/2005	
NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER				4	REET ADDRESS, CITY, STATE, ZIP CODE 33 EAST 2700 SOUTH SALT LAKE CITY, UT 84115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 281	was reviewed. Nursing staff at the resident 11's Blood AM and at 4:30 PM. Review of the Octob BGM sheets for resident 11/03/05 and at 4:30 11/02/05, were not occumpleted. 7. On 11/03/05, resident 19 reviewed. There was documer November 2005 BG to have regular insuits 251-350 =4 units 251-350 =4 units 351-450 =8 units > 450 =Call MD Resident 19 had a p 08/15/05, for BGM to 8:00 PM. Review of the Octob BGM sheets for resident 19 had a p 08/15/05, for BGM to 8:00 PM.	facility were to monitor glucose twice a day at 6:00 per 2005 and November 2005 ident 18 revealed that the be done at 6:00 AM on 0 PM on 11/1/05 and documented as being ident 19's medical record was matation on resident 19's M sheet, that resident 19 was lin sliding scale as follows: hysician's order, dated wice a day at 6:00 AM and at ler 2005 and November 2005 dent 19 revealed that the be done at 6:00 AM on 11/01/05 and at 8:00 PM on locumented as being 0/05, a facility nurse	F	281			

DEPARTMENT OF HEALTH AND HUMA 'ERVICES PRINTED: 11/18/2005 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 281 Continued From page 68 F 281 "...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 312 483.25(a)(3) ACTIVITIES OF DAILY LIVING 12-15-05 F 312 SS=H A resident who is unable to carry out activities of daily living receives the necessary services to This facility does and will continue to provide residents who are unable to carry out maintain good nutrition, grooming, and personal activities daily the necessary services to maintain good nutrititon, grooming, and personal and orai hygiene. and oral hygiene. 1. Resident 1. a. Resident treatment plan has been reviewed and updated. Comprehensive assessment completed íi. Registered Dietician updated dietary assessment This REQUIREMENT is not met as evidenced iii. Physician order for "finger foods" is incorporated into treatment plan and provided. by: iv. Three day calorie count Based on observation, interview and record Alternative food choices or supplements will be made available for review, it was determined that the facility did not vi. Will be offered nutrient dense foods throughout the day between ensure that residents received the necessary vii. Regular meals will be provided during meal times in the dining 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.)

- room or after the meals in the dining room, if need to promote a positive eating environment.
- 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.

Resident treatment plan has been reviewed and updated.

- Comprehensive assessment completed
- Registered Dietician updated dietary assessment. ii.
- Three day calorie count.
- Alternate food choices or supplements will be made available at meals.
- ٧. Will be offered high protein supplements at meals.
- vi. Therapeutic diet provided as ordered by the physician.
- Resident will be seated at the assistive dining table to provide support with meals.
- c. Employee Education completed specific to resident treatment plan.

PRINTED: 11/18/2005 DEPARTMENT OF HEALTH AND HUMA BERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CHA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 312 Continued From page 69 F 312 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 3. Resident 7. resident 1's cognitive skills for daily decision Resident treatment plan has been reviewed and updated. Registered Dietician updated dietary assessment. making were moderately impaired. Facility staff ii. Three day calorie count documented on the assessment that resident 1 tii Alternate food choices or supplements will be made available for resisted cares and wanders and the behaviors all meals. Will be offered high protein supplements at meals. were not easily altered. Facility staff also Therapeutic diet provided as ordered by the physician. documented that resident 1 received one person vi. Resident will be seated at the assistive dining table to provide support with meals. physical support for setting up the meal and d. Employee Education completed specific to resident treatment plan. limited assistance with eating. 4. Resident 8 a. Resident treatment plan has been reviewed and updated. On a care plan dated 1/11/05 and updated 7/6/05. Registered Dietician updated dietary assessment facility staff documented as a problem that ii. Three day calorie count resident 1 had an alteration in nutrition due to iii. Alternate food choices or supplements will be made available for all meals inadequate calorie intake and difficulty staying iv Will be offered high protein supplements at meals. seated. The goal was that resident 1 would have Therapeutic diet provided as ordered by the physician. no significant weight loss. One of the approaches Resident will be seated at the assistive dining table to provided support with meals. was to provide a calm atmosphere at meals with Swallow evaluation completed by Speech Therapist to evaluate

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 b. Employee Education completee specific to resident treatment plan.

ability and tolerance of meal consistency.

 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.

 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.

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.

one on one assistance.

DEPARTMENT OF HEALTH AND HUMAI ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER			43	EET ADDRESS, CITY, STATE, ZII 3 EAST 2700 SOUTH ALT LAKE CITY, UT 84115	P CODE		
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	dining room at 7:40 The nursing assistat tray and then left. It table for 1 minute, assistant brought resat her down and the Resident 1 immedia and went and sat or wandered outside, assistant attempted the dining room, resorthe nursing assistant we and brought her in a a blanket. The nursing assistant we and brought her in a a blanket. The nursing assistant we on the couch. The resident 1 got up annursing assistant we on the couch. The resident 1 the HiPro observed to drink 50 nursing assistant wa 1 any food items and to resident 1. At 7:5 the couch and went redirected resident 1 on the couch. The heard to offer reside was she observed to food or fluid. At 8:05 offered resident 1 so and the nursing assis 9:00 AM, resident 1 in None of the nursing as offer resident 1 any fooffer resident 1 any fooffer resident 1 any for the nursing as offer resident 1 any fooffer AM by a nursing assistant. Int sat her down in front of her Resident 1 remained at the At 7:45 AM the nursing sident 1 back to the table and e nursing assistant left. Intely got up and left the table in a couch. Resident 1 then At 7:50 AM, a nursing to bring resident 1 back into ident 1 went back outside. In the was not observed to hand if food or fluids. At 7:53 AM, a cent outside and got resident 1 and sat her on the couch with ing assistant was not heard to food or fluids. At 7:55 AM is ent and got her and had her sit in supplement. Resident 1 was 1% of the supplement. The is not heard to offer resident if no finger foods were offered 9 AM resident 1 got up off of outside, a nursing assistant back inside and sat resident in nursing assistant was not in 1 any food or fluids, nor in provide resident 1 with any is AM, a nursing assistant was not in 1 any food or fluids, nor in provide resident 1 refused stant left. At 8:10 AM until continued to sit on the couch assistants were observed to food or fluids. Resident 1's feed from the dining room at	F 312					

DEPARTMENT OF HEALTH AND HUMA **ERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	(X3) DATE SURVEY COMPLETED	
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	HiPro supplement, and a muffin. Resident 50% of the supplem offered, nor were are the muffin observed. From 7:40 AM until resident 1 was continued assistant and a muffin observed. Resident 1 was observed. Resident 1 was observed on one on one assistant 11/1/05 Dinner: Resident 1 was observed on one on one assistant one on one assistant 11/1/05 Dinner: Resident 1 was observed on one one one one one one one one one	ved a regular diet of milk, water, juice, hot cereal, eggs dent 1 was observed to drink eent. No alternatives were ny other finger foods besides on the tray. 9:00 AM (1 hour, 20 minutes), nuously observed by a nurse 1 was only offered fluid from ts 2 times during that time was not observed to receive	F 31				

PRINTED: 11/18/2005 DEPARTMENT OF HEALTH AND HUMAN **ERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5)**PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 312 | Continued From page 72 F 312 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)

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F 312	resident 1 was obse without any facility s resident 1 into the co or fluids. At 8:16 Al over to resident 1 a HiPro supplement, seconds the nursing 8:36 AM, the DON I gave it to the dietang Resident 1 was sen HiPro supplement, and a muffin. Resident 1 was conti- sip of the HiPro sup- were offered, nor we besides the muffin of From 7:47 AM until resident 1 was conti- surveyor. Resident the nursing assistant period. Resident 1 one on one assistant 2. Resident 2 was a 6/30/04 with diagno- mellitus, hypertensid depressive and anxi- A quarterly MDS assistant one on the resident 2's cognitive making were moder documented on the resisted care and has inappropriate/disrup- easily altered. Facil	erved to sit on the couch staff attempting to redirect dining room or offer any food M, a nursing assistant went and offered her a drink of the resident 1 took a sip. After 30 g assistant walked away. At bicked up resident 1's tray and y manager. Wed a regular diet of milk, water, juice, eggs, corn flakes dent 1 was observed to drink a plement. No alternatives are any other finger foods observed on the tray. 8:36 AM (49 minutes), inuously observed by a nurse 1 was only offered fluid from ats 2 times during that time was not observed to receive nee with her meal. admitted to the facility on ses which included diabetes on and dementia with fous features. sessment, dated 10/9/05, was a staff for resident 2. Facility in the MDS assessment that the skills for daily decision ately impaired. Facility staff assessment that resident 2	F 31				

DEPARTMENT OF HEALTH AND HUMAI ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE COMPI	
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	and required super On a care plan, da documented as a potential for altered weight loss. The ghave a food and flureduce significant vapproaches was to and fluid. Another HiPro supplement of the coumented in a "Noresident 2 had a wedocumented in a "Noresident 2 had a wedocumented to "a pro (protein) supple further weight loss. On 10/14/05, the R Progress Note" that continuing [with] 23 yearNeeds total adaily living) [and] model of the continuing for the contin	ted 7/12/05, facility staff problem that resident 2 had a dinutrition related to gradual oal was that resident 2 would aid intake between 50-75% to weight loss. One of the encourage a variety of foods approach was to provide a with meals. O (registered dietitian) Nutritional Progress Note" that eight loss of 11.3 lbs. She aidd 8 oz (ounces) [increased] ement at each meal to prevent" D documented in a "Nutritional tresident 2's "weight loss is [pounds] weight loss in past ssist [with] ADL's (activities of eals" t 2's weight log revealed that 2 weighed 178 lbs and on weighed 154.9 lbs. Between 05 (161 days) resident 2 lost	F 312			
	weight loss. The following obser 10/31/05 Breakfast: Resident 2 was obs in her wheelchair at 7:34 AM. At 7:44 Al	vations were made: erved to be in the dining room an assisted dining table at M, resident 2 received her n 7:44 AM until 7:50 AM,				

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 312	resident 2 was obsedrink. She was not utensils and eat her assistant sat by resthe meal. At 8:20 A from the assisted ta TV. Resident 2 was senjuice, milk, eggs, con Resident 2 was obsedocolate, 25% of th 50% of the eggs an alternatives were of protein supplement 2's tray. From 7:44 AM until resident 2 was contisurveyor. Resident 12 was contisurveyor. Resident 11/1/05 Dinner: Resident 2 was obsequence and facility encourage resident 11/1/05 Dinner: Resident 2 was obsequence and facility encourage resident 11/1/05 Dinner: Resident 2 was obsequence and facility encourage resident 2 was obsequence and facility encourage resident 2 was obsequence and facility encourage resident 2 was obsequence and facility encourage resident 2 was obsequence and facility encourage assistant as mouth and then left. nursing assistant as milk, resident 2 dramursing assistant we then left at 6:03 PM. nursing assistant sa next to resident 2. The eard to encourage	erved to pick up her milk and observed to pick up any meal. At 7:50 AM, a nursing ident 2 and assisted her with M, resident 2 was removed able and placed in front of the ved hot chocolate, water, rnflakes and a muffin. erved to drink 50% of the hot he juice, 100% of the milk, eat d 25% of the cornflakes. No fered. An 8 ounce high was not observed on resident 8:20 AM (36 minutes), nuously observed by a nurse 2 was observed to eat 25% of staff were not observed to	F 312			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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Resident 2 was service, spinach, buttere Resident 2 was obsermilk and 50% of the offered. An 8 ounce not observed on resident 2 was continuously of the resident 2 was continuously of a minutes. Resident 2 for 3 minutes. Resident 2 for 3 minutes. Resident 2 for 3 minutes. Resident 2 for 3 minutes. Resident 2 for 3 minutes. Resident 2 for 3 minutes. Resident 2 for 3 minutes. Resident 2 for 3 minutes. Resident 7 was a 03/02/01 with diagnowith psychosis, osteocongestive heart failure constipation, failure trinsufficiency. A quarterly MDS asservas completed by face Facility staff document assessment that resident 7 for sisted cannot easily altered. Fathat resident 7 receives support for setting up extensive assistance. On a care plan, which documented as a prolateration in nutrition resident 7 in nutrition resident in nutrition nutrition in nutrition in nutrition in nutrition in nutrition in	M, the nursing assistant 2's tray. Yed milk, water, juice, fish, ed bread and tarter sauce. erved to drink 100% of the water. No alternatives were high protein supplement was ident 2's tray. 3:30 PM (46 minutes), nuously observed by a nurse 2 was assisted with her meal lent 2 was not observed to ent to eat her meal. Admitted to the facility on isses which included dementia parthritis, Parkinsons, ure, edema, hypothyroidism, of thrive and renal. Ressment, dated 10/02/05, cility staff for resident 7. Inted on the MDS dent 7's cognitive skills for 1 were severely impaired. Inted on the assessment that ares and the behavior was incility staff also documented and one person physical the meal and required	F3	312			

DEPARTMENT OF HEALTH AND HUMA PRINTED: 11/18/2005 **ERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465158 11/03/2005

NAME OF PROVIDER OR SUPPLIER

PINE RIDGE CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH

SALT LAKE CITY, UT 84115

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F 312	Continued From page 77	F 312		
	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.			
r	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			
RM CMS-2567	7(02-99) Previous Versions Obsolete Event ID: 875011			

DEPARTMENT OF HEALTH AND HUMA PRINTED: 11/18/2005 **ERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ΙD PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 312 Continued From page 78 F 312 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),

during this time period.

resident 7 was observed to be offered 8 bites of

4. Resident 8 was admitted to the facility on

her muffin, and one drink of her HiPro supplement. Resident 7 was not observed to receive one on one assistance with her meal

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	7/25/96 with diagno with anxious and de hypertension and con A quarterly MDS as completed by facility staff documented or resident 8's cognitive making were severed documented on the resisted cares and the altered. Facility staff resident 1 received to set up meal and supon staff for eating On a care plan, date 7/6/05, facility staff or resident 8 had an altered for total assist that resident 8 would all meals. One of the with meals. Another a variety of foods an intake was less than The following observed to continuo di pick up her juice and observed to continuo di juice and try to drink were gone, she was buttered bread and estate and continuo di pick up her and observed to continuo di pick up her juice and try to drink were gone, she was buttered bread and estate and continuo di pick up her and continuo di pick up her juice and try to drink were gone, she was buttered bread and estate and continuo di pick up her juice and try to drink were gone, she was buttered bread and estate and continuo di pick up her juice and try to drink were gone, she was buttered bread and estate and continuo di pick up her juice and try to drink were gone, she was buttered bread and estate and continuo di pick up her juice and try to drink were gone, she was buttered bread and estate and try to drink were gone and t	ses which included dementia epressive features, ongestive heart failure. sessment, dated 9/15/05, was y staff for resident 8. Facility in the MDS assessment that e skills for daily decision ely impaired. Facility staff assessment that resident 8 he behavior was not easily if also documented that a one person physical assist she was totally dependent. ed 3/22/04 and updated on documented as a problem that teration in nutrition related to with meals. The goal was di have an intake of 50-75% at e approaches was to encourage diluid and offer alternatives if 175%.	F 3	12			

PRINTED: 11/18/2005 DEPARTMENT OF HEALTH AND HUMA **ERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED. A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID 10 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 312 | Continued From page 80 F 312 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

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

with jelly and eat it. At 7:51 AM a nursing

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION					
		465158	B. WING _		11/(03/2005
	PROVIDER OR SUPPLIER DGE CARE CENTER		4	REET ADDRESS, CITY, STATE, ZIP 33 EAST 2700 SOUTH SALT LAKE CITY, UT 84115	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY)	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	was observed to pic supplement. The nuat 7:55 AM. Reside regular eggs with he was no fork on the tup her muffin. At 8: moved the tray away resident 8 was still p. The resident was obtake a piece of the enursing assistant lef 8:40 AM, the nursing picked up the plate at the resident ignored and picked up the gl At 8:41 AM, the nurs resident 8's tray of for Resident 8 was serv HiPro supplement arcereal as well as regpiece of toast with jet to drink 100% of the 20% of the HiPro sup observed to eat 50% the toast and 50% of was eating the muffir swallowed a bite. No and Nubasics was not From 7:45 AM until 8 resident 8 was contir surveyor. Resident 8	ck up the glass and drink the ursing assistant left resident 8 int 8 then picked up the er hands. It was noted there ray. Resident 8 then picked 30 AM, the nursing assistant by from the resident while picking at items on her tray. Esserved to lean forward and egg off of the tray. The it the resident at 8:32 AM. At g assistant returned and and put it in resident 8's face, the plate of food in her face ass of water and took a sip.	F 312			
SS=H	483.25(i)(1) NUTRIT		F 325			
	Based on a resident's	s comprehensive				

PRINTED: 11/18/2005 DEPARTMENT OF HEALTH AND HUMA **ERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 325 Continued From page 82 F 325 assessment, the facility must ensure that a 1. Resident I 12-15-05 a. Resident treatment plan has been reviewed and updated. resident maintains acceptable parameters of i. Comprehensive assessment completed nutritional status, such as body weight and protein ii. Registered Dietician updated dietary assessment levels, unless the resident's clinical condition iii. Physician order for "finger foods" is incorporated into treatment demonstrates that this is not possible. plan and provided. Three day calorie count Alternate food choices or supplements will be made available for all meals. vi. Will be offered nutrient dense foods throughout the day between This REQUIREMENT is not met as evidenced 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 Based on clinical record review, observations and eating environment. staff interviews it was determined that the facility viii. Dietician has reviewed lab values of resident. did not ensure that each resident maintained an ix. High protein supplements are provided to address albumin levels. x. Resident will be seated at the assistive dining table to provide acceptable parameter of nutritional status as support with meals evidenced by 3 of 10 sampled residents 2. Resident 2. (Residents 1, 2 and 7) experienced severe weight Resident treatment plan has been reviewed and updated. i. Comprehensive assessment completed. loss without adequate dietary interventions, ii. Registered Dietician updated dietary assessment re-evaluations or implementation of new dietary iii. Three day calorie count iv. Alternate food choices or supplements will be made available for interventions to prevent further weight decline. all meals. v. Will be offered high protein supplements at meals vi. Therapeutic diet provided as ordered by the physician. Calculating weight loss percentages is done by vii. Resident will be seated at the assistive dining table to provide subtracting the current weight from the previous support with meals weight, dividing the difference by the previous 3. Resident 7 a. Resident treatment plan has been reviewed and updated. weight and multiplying by 100. Significant weight i. Registered Dietician updated dietary assessment losses are as follows: 5% in one month, 7.5% in 3 ii. Three day calorie count months and 10% in 6 months. (Reference iii. Alternate food choices or supplements will be made available for all meals. guidance: Manual of Clinical Dietetics, American Will be offered high protein supplements at meals Dietetic Association, 6th edition, 2000). v. Therapeutic diet provided as ordered by the physician. vi. Resident will be seated at the assistive dining table to provide support with meals. The facility was found to be providing 4. Nursing department will maintain a log of lab work that is completed. The dietician sub-standard quality of care (a pattern of actual will review the log at each visit to determine need for additional nutritional harm) in this area. Monthly Weight and Skin Meeting will evaluate residents identified as at risk

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

through comprehensive assessment or changes in medical condition, including lab values

A log will be maintained of monthly meetings and residents that are

- 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
- This plan of correction will be completed by December 15, 2005.

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIPLE CONSTRUCTION	(X3) DATE : COMPL	
		465158	B. WIN	NG	11/	03/2005
	PROVIDER OR SUPPLIER DGE CARE CENTER			STREET ADDRESS, CITY, STATE, Z 433 EAST 2700 SOUTH SALT LAKE CITY, UT 8411	IIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	and on 10/19/05 resident 1 lost 19.4 considered a severed A lab (laboratory) variated 8/22/05 show level of 15. According reference range was completed on 9 documented under Status, 1. Oral problem loss. A review of resident	alue taken at the facility and red a Prealbumin (protein) ing to the laboratory values the s 18-45. inimum data set) assessment 0/16/05. Facility staff section K., Oral/Nutritional plems, no chewing or s or mouth pain. 3. no weight 1's medical record dietary		325		
	assessment address prealburnin had bee Resident 1 had a nu completed 2/15/05. resident 1 received a The RD calculated to 1500-1700 calories protein per day. On 5/24/05, the RD Progress Note" that of 9 pounds. She do "meal intake avera active - up [and] down adequate calorie intadocumented evidence.	no RD (registered dietitian) sing the weight loss and low in completed for resident 1. Itritional assessment The RD documented that a regular mechanical soft diet. That resident 1 required per day and 50-55 grams of documented in a "Nutritional resident 1 had a weight loss occumented that resident 1's ige 50-60% Resident is very in a lot- may not receive ake" There was no be that the RD calculated of determine if resident 1's re being met.				

DEPARTMENT OF HEALTH AND HUMA. REVICES PRINTED: 11/18/2005 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465158 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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 325 Continued From page 84 F 325 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,

DEPARTMENT OF HEALTH AND HUMA **ERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICAT	SUPPLIER/CLIA TON NUMBER:	(X2) MULTIPI A. BUILDING		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER			4:	REET ADDRESS, CITY, STATE, ZIP CODE 33 EAST 2700 SOUTH ALT LAKE CITY, UT 84115	1 11	/03/2005	
(X4) ID SUMMARY STATEMENT OF DEFIC PREFIX (EACH DEFICIENCY MUST BE PRECEE TAG REGULATORY OR LSC IDENTIFYING IN	DED BY FULL	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
assisted dining. Anticipate decline complications assoc (associated) There was no documented eviden 1's intake was calculated to determ 1's nutritional needs were being m A nutritional care plan for resident completed on 1/11/05 and last upor Facility staff identified the following "Alteration in nutritional status [relainadequate caloric intake need for mealsFrequent state of anxiety [vistaying seafed [at]] meals. Declinin Facility staff documented the follow interventions, "Restorative aide to nutritional intakeProvide calm at meals [with] 1:1 and TLC (tender look on 11/2/05 at 1:10 PM, the director interviewed. She stated at this time restorative dining program in place. On 10/14/05, the following physicial obtained, "Finger Foods [every] Meintake." On 10/31/05 resident 1's breakfast For breakfast resident 1 received in house supplement, water, juice, hot and a muffin. Resident 1 was obses 50% of the hi-pro supplement. Resident and a muffin. Resident 1 was obses 50% of the hi-pro supplement. Resident 1 was obses 50% of the hi-pro supplement. Resident 1 materials. On 11/1/05 at 7:30 AM, resident 1 was obses in bed. Facility staff were not go in and wake resident 1 for breakfast 11/10 process.	[with] wt loss." ce that resident nine if resident et. 1 was lated on 7/6/05. I problem, ated to] redirection [at] with] difficulty og status" wing under o improve nosphere [at] oving care)" r of nurses was e there was no n order was al. Monitor was observed. nilk, hi-pro a cereal, eggs rved to drink ident 1 was noe with her vas observed observed to fast.	F 3	25				

	TMENT OF HEALTH	AND HUMA ERVICES MEDICAID SERVICES				FOR	D: 11/18/2005 MAPPROVED
TATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		LTIPLE CONSTRUCTION DING	(X3) DATE COMPI	
		465158	B. Wii	NG		11/	03/2005
NAME OF F	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		00/E000
PINE RI	GE CARE CENTER				433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115		
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F 325	Continued From page	ge 86	F (32!	5		
	resident 1 five days resident 1 "did not e breakfast. Got up a what they provided wastated that he had reprovided to resident. Review of resident 1 revealed she was or indicate that resident foods with her meals. On 11/1/05, resident 1 pudding, fish, rice, sp. Resident 1 ate a few bread. Resident 1 w	fter breakfast, don't know when she got up." He further ot seen any finger foods 1 except for bread and rolls. 's diet card on 11/1/05, a regular diet. It did not t 1 was to receive finger					
	Resident 1 was not o assistance with her n	bserved to receive 1:1					
	interviewed. She sta week. She further st at night and she can she sits with her one that her shift begins a	ted that she works one day a ated that resident 1 wanders get her to eat sandwiches if on one. She further stated at 6:00 PM and that she has bods provided for resident 1.					
	was interviewed. She a poor eater and wan stated that she had no provided to resident 1	M, a facility nursing assistant estated that resident 1 was ders around. She further ot seen any finger foods. The nursing assistant receives the same meal					

trays as every one else.

On 11/2/05, resident 1's breakfast was observed.

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		465158	B. WING	5	11/0	3/2005	
	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIF 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115	PCODE	33,2003	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	Resident 1 received milk, water, juice an Resident 1 was obs hi-pro supplement. to receive 1:1 assist A review of resident Monitor" sheet from resident 1 received meals provided no comeal was consumed the facility document that resident 1 consumeds 77 times. On member documente and Fluid Intake Mol"Aide didn't bring to On 11/3/05 at 1:00 F She stated that resident 1 was r DM stated that the laand protein needs w 2/15/05. She further re-assessed resident the weight loss. The RD did not calculating the resident of the weight loss. The RD did not calculating the resident of the weight loss. The RD did not calculating the resident of the did not the did not the did protein needs for resident 2. Resident 2 was as a second to resident 2 was as a second to resident 2 was as a second to resident 2 was as a second to resident 2 was as a second to resident 2 was as a second to resident 2 was as a second to resident 2 was as a second to resident 2 was as a second to resident 2 was as a second to resident 2 was as a second to resident 2 was as a second to resident 2 was as a second to resident 2 was as a second to resident 2 was as a second to resident 2 was as a second to resident 2 was a second to	d eggs, muffin, corn flakes, and hi-pro house supplement. erved to have a sip of the Resident 1 was not observed trance with her meal. 1's "Food and Fluid Intake 10/1/05 until 11/2/05 revealed 99 meals. Six of the 99 documentation that any of the d. Out of the 93 meals that ted on, the charting revealed umed less than 50% of her 10/23/05, a facility staff at the following on the "Food intor" sheet for breakfast, DR (dining room) to eat." PM, the DM was interviewed. Sent 1 was on a regular diet foods. The DM further stated not on an enriched diet. The last time resident 1's caloric ere calculated was on a stated that the RD has not at 1's nutritional needs since that the resident 1 was receiving and protein for her needs, on, staff would not know et would meet the caloric and ident 1. Idmitted to the facility on es which included diabetes and dementia with	F 32	5			

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

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIPI LDING	LE CONSTRUCTION	(X3) DATE (COMPL	
		465158	B. WI	√ G		11/	03/2005
	PROVIDER OR SUPPLIER DGE CARE CENTER			433	ET ADDRESS, CITY, STATE, ZIP COD BEAST 2700 SOUTH LLT LAKE CITY, UT 84115		
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F 325	Continued From pa	age 88	F 3	325			
	on 5/11/05 resident 10/19/05 resident 2 5/11/05 and 10/19/	t 2's weight log revealed that t 2 weighed 178 lbs and on t weighed 154.9 lbs. Between 05 (161 days) resident 2 lost which is considered a severe					
	showed an albumin per deciliter). The maccording to the lab 3.3-4.8 g/dl. An alb considered a mode (Reference guidant Dietetics, American edition, 2000, page dated 9/21/05 was to	t the facility and dated 9/21/05 (protein) level 2.9 g/dl (grams normal reference range, o used by the facility, was numin level of 2.4-2.9 g/dl is rate visceral protein deficit. See: Manual of Clinical Dietetic Association, 6th 22). The albumin of 2.9 g/dl the most current in resident 2's was not acknowledged by the					
	10/11/05. Facility st K., Oral/Nutritional \$	sessment was completed on taff documented under section Status, 1. Oral problems, noing problems or mouth pain. t loss.					
	notes revealed that	ht loss and low albumin had					
77.	completed 7/6/04. Tresident 2 received : The RD calculated to	tritional assessment The RD documented that a 1800 calories regular diet. hat resident 2 required per day and 55-60 grams of					

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		465158	B. WING			11/03/2005	
	PROVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, ZIP CODE 133 EAST 2700 SOUTH SALT LAKE CITY, UT 84115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	On 5/24/05, the RD Progress Note" that of 6 pounds. She d"Appetite is fair ar supervisor) states in days" There was the RD re-calculated determine if residen being met. On 7/12/05, the RD Progress Note" that from 174 lbs to 164 increased protein sudocumented that reschanged [at] meals [(residents) taking forwas no documented re-calculated resident 2's nutrition. On 8/30/05, the RD Progress Note" that of 11.3 lbs. She documented in the progress Note of 11.3 lbs. She documented re-calculated resident 2's nutrition. On 9/6/05, the RD, D following on their "Sk" Continue enriched fidayChange to dinir better eating environ noted" There was that resident 2's intaktored.	documented in a "Nutritional resident 2 had a weight loss ocumented that resident 2's lid FSS (food service litake is improving past few no documented evidence that diresident 2's intake to the 2's nutritional needs were documented in a "Nutritional resident 2 had a weight loss libs, the RD requested applements with meals. She sident 2's "table was due to] 2 other residence that the RD int 2's intake to determine if all needs were being met. Indocumented in a "Nutritional resident 2 had a weight loss lumented to "add 8 oz pro (protein) supplement at the further weight loss" There evidence that the RD int 2's intake to determine if all needs were being met. In ON and DM documented the sin/Weight Review", loods, propass 3 [times] ing table moved to facilitate ment. gradual decline no documented evidence	F	325			

PRINTED: 11/18/2005 DEPARTMENT OF HEALTH AND HUMA. ERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 325 Continued From page 90 F 325 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

DEPARTMENT OF HEALTH AND HUMA! ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465158		(X2) M A. BU		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED 11/03/2005	
			B. WII	NG _	44-44-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-		
	AME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER			4	REET ADDRESS, CITY, STATE, 2IP CODE 133 EAST 2700 SOUTH SALT LAKE CITY, UT 84115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOTO TAG CROSS-REFERENCED TO THE APPROPRIES OF THE PROPRIES OF T		OULD BE	(X5) COMPLETION DATE	
	documented the fol "Regular LCS (low dietHi Pro supplet mealsencourage [and] offer snacks On 4/26/05, the folk obtained, "Diet: LCS regular." On 11/3/05, the DM diet list. It was note receiving a low condousered. For breamilk, hot chocolate, and a muffin. Resident 2 was of her corrol of 10/3 fish, rice, so the following of her milk and 25% of her corrol of 11/1/05, resident 2 was obswater and 100% of like was or concentrated sweet; resident 2 was to reprotein supplement two meal observation resident 2 was not of a protein supplement.	lowing under interventions, or concentrated sweets) ments [with] variety of foods [and] fluid " Dwing physician order was 6 (low concentrated sweets), provided the surveyors with a d, that resident 2 was centrated sweet regular diet. Int 2's breakfast was kfast resident 2 received water, juice, corn flakes, eggs lent 2 was observed to drink colate, 25% of her water, ind she ate 50% of her eggs of flakes. It 2's dinner was observed. It 2's diet card on 11/1/05, of a regular LCS (low of diet. It did not indicate that believe 8 ounces of increased with her meals. During the ins, it should be noted that beerved to receive 8 ounces of ent. It 3's "Food and Fluid Intake"	F	325			
1	Monitor" sheet from	10/1/05 until 11/2/05 revealed			İ		i i

DEPARTMENT OF HEALTH AND HUMA PRINTED: 11/18/2005 **ERVICES** FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 325 Continued From page 92 F 325 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,

insufficiency.

weight loss.

congestive heart failure, edema, hypothyroidism,

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

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.

constipation, failure to thrive and renal

DEPARTMENT OF HEALTH AND HUMAI ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		465158	B. WII			11/03/2005	
	ROVIDER OR SUPPLIER			4:	REET ADDRESS, CITY, STATE, ZIP CODE 33 EAST 2700 SOUTH SALT LAKE CITY, UT 84115	[372003
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDSHOUND THE APPROVIDENCY)	ULD BE	(X5) COMPLETION DATE
F 325	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			325			
	that resident 7 had I meals, and to increate between meals and documented under "continued weight low. (weight) stable is Hospice care [second Res (resident) is DN no feeding tube Cormeals [and] offer [in (supplements) if [lewall Cont. CP (care plandocumented evident 7's intake to nutritional needs we interventions or after maintain resident 7's	ce that the RD calculated of determine if resident 7's re being met. No new matives were put into place to					

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465158	B. WING			11/03/2005	
	PROVIDER OR SUPPLIER			433	ET ADDRESS, CITY, STATE, ZIP COI EAST 2700 SOUTH LT LAKE CITY, UT 84115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Progress Notes" that 109.5 lbs, "Confisince last review. Reare Resident has thrive needs assis [at]all meals is less plan)". There was the RD calculated resident 7's nutrition Progress I loss to 99.6 [lbs] Recare Appetite is possist [at] meals soften refused Reside [with] failure to thrive adequate hydration: There was no docume calculated resident 7's nutrition. There was no document alternatives, despite supplement. From 5/11/05 until 17 lost 20.8 lbs (18.52 about resident 7's we no evidence that the caloric needs. There the RD implemented.	at resident 7's weight was inued weight loss of 10 [lbs] desident receives Hospice DX (diagnosis) of failure to out [with] all meals. Intake than 50%. Cont CP (care no documented evidence that esident 7's intake to determine onal needs were being met. D documented in the Notes", "Continued weight sident continues on Hospice or [with] 1:1 (one on one) upplements are offered but ent physical status declining e Observe resident for status [and] skin breakdown." nented evidence that the RD r's intake to determine if al needs were being met.	F3	25			
ia.	A review of resident Monitor " sheet from revealed that resider	7's "Food and Fluid Intake 10/01/05 until 11/02/05 at 7 received 99 meals. Out ided, the charting revealed					

DEPARTMENT OF HEALTH AND HUMA. ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) F AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	PROVIDER/SUPPLIER/CLIA (X2) M DENTIFICATION NUMBER: A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	465158		B. WII	NG _		11/03/2005	
	PROVIDER OR SUPPLIER DGE CARE CENTER			4	REET ADDRESS, CITY, STATE, ZIP CODE 33 EAST 2700 SOUTH SALT LAKE CITY, UT 84115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	that resident 7 consimeals 72 times. In that resident 7 consimeals 41 out of the Resident 7 was obson 11/1/05. At 5:30 to be in her wheelch Her son was sitting resident 7 was obsef:03 PM, resident 7 nursing assistant cat asked the resident in At 6:05 PM until 6:10 observed to sit by rethe meal. At 6:26 Pup resident 7 was serviced from 5:50 PM until 6:10 observed to drink 50 and 25% of the juice offered. From 5:50 PM until 6:10 offered. From 5:50 PM until 6:10 offered. From 5:50 PM until 6:10 offered. From 5:50 PM until 6:10 offered. Resident 7 was continuity of the juice offered. Resident 7 was obsefined on 11/2/05. At brought into the dinir assisted table. At 7: served breakfast. At served breakfast.	umed less than 50% of her addition, the charting revealed umed less than 25% of the 72 meals. erved during the dinner meal PM, resident 7 was observed hair sitting at an assisted table. Inext to her. At 5:50 PM, arved to receive her tray. At a son left. At 6:04 PM, a me over to resident 7 and a she was okay and then left. At PM, a nursing assistant was esident 7 and assist her with PM, a nursing assistant picked and the HiPro supplement are bread. Resident 7 was 10% of the HiPro supplement are. No alternatives were 15:26 PM (36 minutes), housely observed by a nurse 7 was observed to receive her meal for a total of 9 arved during the breakfast 7:10 AM, resident 7 was 15:47 AM, resident 7	F	325	DETICIENT!		
	offered a bite of her then started feeding	t 7:47 AM, resident 7 was muffin. The nursing assistant another resident at the table. 7 was offered another bite of					

PRINTED: 11/18/2005 DEPARTMENT OF HEALTH AND HUMA **ERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465158 11/03/2005

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		SALT LAKE CITY, UT 84115			
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F 325 Continued From page 96	F 32	25			
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					

DEPARTMENT OF HEALTH AND HUMA' ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	465158		1	S	-		
	PROVIDER OR SUPPLIER DGE CARE CENTER	400100	<u> </u>	STREET ADDRESS, CITY, STATE, ZIF 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115	CODE	03/2005	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF	CORRECTION TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
SS=E	juice, 25% of the m the chicken parmes supplement. No alt A physician's order be located in reside On 11/3/05 at 1:00 interviewed. She st receive a pureed en manager stated than not doing as well so resident 7 with a liquing manager stated that physician's order for 483.30(b) NURSING NURSE Except when waived this section, the facil registered nurse for a day, 7 days a weel Except when waived this section, the facil registered nurse to sinursing on a full time. The director of nursing nurse only when the occupancy of 60 or for This REQUIREMENT by: Based on interviews	ilk, 25% of the carrots, 25% of san, and 80% Hi-Pro ernatives were offered. for a liquefied diet could not nt 7's medical record. PM the dietary manager was ated that resident 7 was to wriched diet. The dietary to she noticed the resident was they were now providing uefied diet. The dietary to she did not think there was a realiquefied diet. SERVICES - REGISTERED I under paragraph (c) or (d) of lity must use the services of a lat least 8 consecutive hours of the consecutive as the director of lity must designate a leave as the director of leasts. In g may serve as a charge facility has an average daily	to profire sever		iviely g a y newspaper. vices to meet N for ignee dule. ignee n RN ive hours. ick and e nce	12-15-05	

DEPARTMENT OF HEALTH AND HUMA GERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	465158	D. WING		11/03/2005	
	DGE CARE CENTER			REET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 354			F 354			
SS=E	nurse (RN) for at lea 7 days a week, since 7 days a week, since Findings include: Review of the facility October 2005 on 11 did not have 8 hours 9/17/05, 9/24/05, 10 and 10/29/05. On 11/2/05 at approximate 100 by stated that she and at times on Satu. She further stated that there was no RN coverage 483.35(c) MENUS A ADEQUACY Menus must meet the residents in accordar dietary allowances of Board of the National Academy of Sciences and be followed. This REQUIREMENT by: Based on observation determined that the fact approved menus for the dinner meals observed 11/2/05 and 11/3/05. Not served food items		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 provide by Dietician for all dietary employees 1. Proper serving sizes and utensils us 2. Following posted menu 3. All residents will receive meals con 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.	d s. e	

DEPARTMENT OF HEALTH AND HUMA PRINTED: 11/18/2005 **ERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465158 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 363 Continued From page 99 F 363 sized utensils to serve food items which resulted in incorrect amounts of food being provided to the residents. 6.All servings will be measured using appropriate serving tool. Findings include: 7. Purchase of serving tools completed The menu documented the following to be served for breakfast on 10/31/05. 8. Alternative food choices will be available at every meal and is Oatmeal posted in the dining area. Scrambled eggs with onion Glazed cinnamon roll 9. Dietary Manager will conduct random Whole milk audits to insure compliance. Juice 10.A log of audits will be maintained by Observations made during the breakfast meal the Dietary Manager or Designee. served on 10/31/05 revealed that the eggs served had no onions and a muffin was served instead of The Dietary manager will track and a cinnamon roll. trend results of audits and report to the Quality Assessment and Quality The menu documented the following to be served Assurance Committee at least quarterly. for dinner on 11/01/05: The Dietary manager will report to the Administrator the results of the audits. Crunchy fish This plan of correction will be Creamed spinach completed by December 15, 2005 Fruit mix Bread Whole milk **Tarter Sauce** Observations made during the dinner meal on

indicated.

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

Further observation of the tray line revealed random servings of spinach were being served by

	TMENT OF HEALTH RS FOR MEDICARE	AND HUMA ERVICES & MEDICAID SERVICES				FORI	D: 11/18/2005 M APPROVED	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		465158	B. Wi	NG		11/	03/2005	
	PROVIDER OR SUPPLIER DGE CARE CENTER				TREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH			
					SALT LAKE CITY, UT 84115			
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F 363	Continued From pag	je 100	F:	 363	3			
	spread sheets document to be served with a serving the spinach measuring the serving meal trays revealed none that resembled. Observations were not the lunch meal on 10 utensils and menu its Beef Burgundy -8 oz Noodles -serving spone measurement). Rice - serving spoon measurement). Mixed vegetables - 8. Further observation roof the noodles or rice three spoonfuls. The quarter of a ladle to a land a full spoon to a vegetables. It was observed at the serving served serving servin	. ladle oon (no documented (no documented						
9	she likes to over feed give them too much. S out of vegetables. The following are the	erving sizes, she stated that the residents and tends to She also stated that she ran menu's documented serving for the lunch meal on				ı		

Beef Burgundy - 4 oz. Rice - 1/2 cup Broccoli - 1/2 cup

11/3/05:

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

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		465158	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	403138			11/0	3/2005
	OGE CARE CENTER	_	43	EET ADDRESS, CITY, STATE, ZIP CODE 33 EAST 2700 SOUTH ALT LAKE CITY, UT 84115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 363	Continued From pa	ge 101	F 363	F367: Therapeutic Diets		
	11/03/05 she stated changes to the recip	the dietary manager on I that she had made some be for the beef burgundy. She is to add her own touches.		This facility does and will continue to provide therapeutic diets as pr attending physician 1. Resident 1		
F 367 SS=H	483.35(e) THERAPI Therapeutic diets m attending physician.	ust be prescribed by the	F 367	Resident treatment plan has been reviewed and up Comprehensive assessment completed Registered Dictician updated dictary assess Physician order for "Inger foods" is incorp	meni	12-15-05
	by: Based on observation and interview, it was sampled residents a not receive a therape physician or assessed interdisciplinary team 20.) Findings include: 1. Resident 1 was a 10/24/02 with diagnor dementia, depression A review of resident 1 and on 10/19/05 resident and on 10/19/05 resident and on 10/19/05 resident was a 10/26/05 resident 10 and 10/19/05 a	on, medical record review, determined that 4 out of 10 and 2 additional residents did eutic diet as ordered by the ed as being necessary by an an. (Residents 1, 2, 7, 8, 10, dmitted to the facility on eses which included vascular an, anxiety and insomnia. 1's weight log revealed that I weighed 126.1 lbs (pounds) dent 1 weighed 106.7 lbs. I 10/19/05 (176 days)		treatment plan and provided. iv. Three day calorie count v. Alternate food choices or supplements will for all meals. vi. Will be offered nutrient dense foods through between meals. vii. Regular meals will be proved during meal to room or after the meals in the during meal to room or after the meals in the during room, a positive eating environment. viii. Resident will be seated at the assistive dining support with meals b. Employee Education completed specific to resident 2. Resident 2 a. Resident treatment plan has been reviewed and updated. i. Comprehensive assessment completed. ii. Registered Dictician updated dictary assessmit. Three day calorie count. iv. Alternate food choices or supplements will be	mes in the diving of need to promote g table to provide trestment plan. ted.	
,	considered a severe A review of the dietar	y notes revealed an order egular diet with house		for all meals. v. Will be offered high protein supplements at n vi. The apeutic diet provided as ordered by the p vii. Resident will be seated at the assistive dining support with meals	neaks hysician.	

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		(X3) DATE SURVEY COMPLETED	
	465158	B. WING	3	11/0	03/2005	
NAME OF PROVIDER OR SUPPLIEF	•		STREET ADDRESS, CITY, STATE, ZIP CO 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115			
PRÉFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
an order for finger The following obset 10/31/05 Breakfast Resident 1 was set HiPro supplement and a muffin. Resident 1 was set besides the muffin 11/1/05 Dinner: Resident 1 was set water, juice, fish, rand pudding. Resident 1 was set water, juice and take a fet pudding. No altern were no other fing bread observed or 11/2/05 Breakfast: Resident 1 was set HiPro supplement, and a muffin. Resident 1 was set hiPro supplement 1 was set hiPro supple	dated 10/14/05, documented foods every meal. ervations were made: st: erved a regular diet of milk, water, juice, hot cereal, eggs sident 1 was observed to drink ment. No alternatives were were no other finger foods observed on the tray. erved a regular diet of milk, ice, spinach, buttered bread ident 1 was observed to drink 25% of the water, 80% of the w bites of the rice, bread and natives were offered and there er foods besides the fish and on the tray. rves a regular diet of milk, water, juice, eggs, corn flakes ident 1 was observed to drink a pplement. No alternatives here were no other finger foods observed on the tray. ing assistant who provided five days a week was ated that resident 1 received a of the other residents. He rethan breads, there were no	F 36	a. Resident 7 a. Resident treatment plan has been reviewed a i. Registered Dictician updated dictary ii. Three day caloric count iii. Atternate food choices or supplement for all meals. iv. Full liquid diet provided. 1. No bread is offered. v. Will be offered high protein supplement in the assistive support with meals. 4. Resident 8 a. Resident treatment plan has been reviewed in Registered Dictician updated dictary ii. Three day caloric count iii. Alternate food choices or supplement for all meals. iv. Will be offered high protein supplement iii. Alternate food choices or supplement v. Therapeutic diet provided as ordered vi. Resident will be seated at the assistive support with meals. vi. Swallow evaluation completed by Speability and tolerance of meal consister. 1. Bread products offered sturnied diet.	assessment is will be made available ents at meals by the physician. e dining table to provide and updated. assessment is will be made available ents at meals by the physician. e dining table to provide ech Therapist to evaluate cy.		

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

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	On 11/2/05, a facili stated that she wor week. She stated the finger foods provided on 11/3/05 at 1:00 interviewed. She stregular diet but is not further stated that rediet which is enricheraccording to the phromaccording by nurse was interviewed. She ks with resident 1 one day a hat she had not seen any ed on resident 1's tray. PM, the dietary manager was tated that resident 1 was on a low on finger foods. She esident 1 does not receive a ed which is inaccurate ysician order dated 4/26/05. In made during the survey ent 1 did not receive any finger lose on a regular diet. This did cian order of 10/14/05 for ery meal. Indicated to the facility on sees which included diabetes on and dementia with ious features. 2's weight log revealed that 2 weighed 178 lbs and on weighed 154.9 lbs. Between 5 (161 days) resident 2 lost hich is considered a severe notes revealed that she was a diet with 8 ounces of ipplement with each meal. Cation order, dated 10/3/05, er for a low concentrated	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% alternat choices 7. Implementation of Meal Monitoring Tool. Administration St random meals 5-7 days a week. Monitoring tool evaluates the the method of serving, distributing, and assisting with meal, or alternatives, use of adaptive equipment, and other concerns as 8. Dietary Manager will conduct random audits to insure compilia. A log of audits will be maintained by the Dietary Manager will track and trend results of audits and Quality Assessment and Assurance Committee at least quarter. 10. This plan of correction will be completed by December 15, 20	aff will monitor e quality of food, ffering of they arise. ance. ager or Designee report to the		

DEPARTMENT OF HEALTH AND HUMA PRINTED: 11/18/2005 **ERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 367 Continued From page 104 F 367 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

dietician.

on resident 2's tray.

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 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

3. Resident 7 was admitted to the facility on 03/02/01 with diagnosis which included: dementia

with psychosis, osteoarthritis, Parkinsons,

DEPARTMENT OF HEALTH AND HUMA **ERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

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		465158	B. WING		11/0	3/2005
NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER			43	EET ADDRESS, CITY, STATE, ZIP CODE 33 EAST 2700 SOUTH ALT LAKE CITY, UT 84115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	constipation, failure insufficiency. A review of resident on 5/11/05 resident 7 5/11/05 and 10/19/0 17 lbs (15.13%) white weight loss. A review of the dieta order, dated 4/26/05 on tray, and houses [three times a day]. The following observed the following observed the buttern consisted of liquefied spinach, water, milk, buttered bread. Res 50% of the HiPro suppuice. No alternative except for the muffin orange juice, milk, Hipper lique, eggs, and a nobserved that resider alteratives, or to have Resident 7 was observed consisted of the HiProsuppuice, 75% of	lure, edema, hypothyroidism, to thrive and renal 7's weight log revealed that 7 weighed 112.3 lbs and on weighed 95.3 lbs. Between 5 (161 days) resident 7 lost ch is considered a severe ary notes revealed a diet of its considered a diet with no salt supplements, [increase] Provations were made: ed a diet which was liquefied, and bread. The meal of rice, liquefied fish, liquefied juice, HiPro supplement and ident 7 was observed to drink oplement and 25% of the swere offered. ed a diet which was liquefied, and a diet which was liquefi	F 367			

DEPARTMENT OF HEALTH AND HUMA **SERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		465158 B. WING		——————————————————————————————————————	11/03/2005		
NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER			4:	REET ADDRESS, CITY, STATE, ZIP CODE 33 EAST 2700 SOUTH BALT LAKE CITY, UT 84115		30/2000	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	except for the banal consisted of HiPro scarrots, chicken par banana pudding, an observed that reside juice, 25% of the mithe chicken parmess supplement, and 80 alternatives were off A physician's order for be located in resider On 11/3/05 at 1:00 Finterviewed. She stareceive a pureed en manager stated that not doing as well so resident 7 with a liquing manager stated that physician's order for 4. Resident 8 was a 7/25/96 with diagnos with anxious and dephypertension and con A review of the dietard dated 4/26/05 for a protein, high caloric so Nubasics 120 cc (cula day.	ved a diet which was liquefied, ha and garlic roll. The meal supplement, milk, juice, mesan, whole banana, d a garlic roll. It was ent 7 consumed 75% of the lk, 25% of the carrots, 25% of an, 25% of the HiPro % of the milk. No fered. For a liquefied diet could not not 7's medical record. The dietary manager was sated that resident 7 was to riched diet. The dietary she noticed the resident was they were now providing efied diet. The dietary she did not think there was a a liquefied diet. Idmitted to the facility on es which included dementia pressive features, negestive heart failure. The notes revealed a diet order uree honey thick liquids, high supplement with meals one centimeters) three times	F	367			
	documented an order high protein, high cal	r for a honey thick liquids, oric supplement with meals oic centimeters) three times					

DEPARTMENT OF HEALTH AND HUMA **ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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 A. BUILDING			(X3) DATE SURVEY COMPLETED 11/03/2005	
	465158			11/		
NAME OF PROVIDER OR SUPPLIER PINE RIDGE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115					
PRÉFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE SE APPROPRIATE	(X5) COMPLETION DATE	
11/1/05 Dinner: Resident 8 was se water and pureed also served puddir Resident 8 was ob milk and juice, eat of the bread. No a resident 8 was not protein high calorid her meal. 11/2/05 Breakfast: Resident 8 was se HiPro supplement cereal as well as repiece of toast with to drink 100% of the 20% of the HiPro sobserved to eat 50 the toast and 50% was eating the muf swallowed a bite. If and Nubasics was 11/3/05 Breakfast: Resident 8 was ser supplement, water french toast, cereal Nubasics was not so On 11/3/05 at 1:00 interviewed. She salways been a bread didn't get bread she	ervations were made: rved thickened milk, juice and rice, fish and spinach. She was a gas well as buttered bread. served to drink 100% of the 50% of the pudding and 80% alternatives were offered and observed to receive a high supplement or Nubasics with explain and 2 gilly. Resident 8 was observed e juice, 20% of the water and upplement. Resident 8 was 6 of the regular eggs, 75% of of the muffin. While resident 8 fin she would cough after she No alternatives were offered not served with her meal. The dietary manager was tated that resident 8 has deater and "if [resident 8] would starve." The dietary atted that resident 8 was on a	F 367				

PRINTED: 11/18/2005 DEPARTMENT OF HEALTH AND HUMA **ERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 367 Continued From page 108 F 367 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

protein and high caloric supplement was not observed on her tray.

ORM CMS-2567(02-99) Previous Versions Obsolete

11/03/05 Lunch:

her tray.

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

Resident 10 was served a regular diet of beef burgundy, noodles, mixed vegetables and sherbet. No alternatives were offered and a high

Event ID: BZ5911

Facility ID: UT0064

If continuation sheet Page 109 of 124

DEPARTMENT OF HEALTH AND HUMAI ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE COMP	
		465158	B. WI	NG_		11/	03/2005
	PROVIDER OR SUPPLIER DGE CARE CENTER			4	REET ADDRESS, CITY, STATE, ZIP CODE 33 EAST 2700 SOUTH GALT LAKE CITY, UT 84115	1 11	00,2000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 367	Continued From pa	ge 109	F	367			
	he stated that he do food to increase the stated that the only of is the supplemen. On 11/3/05 at 1:00 I interviewed. She st pureed diets receive BeneCal added to the label of the supplem would add 330 calor their cereal if they we cereal. Additionally, teaspoon of ProPassoz. (ounces) of milk review of the protein instructions docume (provided in the can grams of protein to the instructions revealed supplement was an instructions revealed supplement was an instructions.	a dietary cook on 11/01/05, bes not add anything to the e calories or the protein. He "enrichment" that he is aware ts on the resident's trays. PM, the dietary manager was ated that the residents on a powder supplement called heir cereal. A review of the lent documented that this ries and 7 grams of protein to ere to consume 100% of their she stated that she adds 1 is (a protein supplement) to 8 to increase the protein. A supplement revealed the inted that "one scoop" of supplement) would add 6 he milk. Further review of the that one scoop of 8 gram measurement which spoon measurement.					
	11/3/05 revealed tha	s on 11/1/05, 11/2/05 and t residents on a puree diet s which were not pureed or					
	diet signed by the ph their dietary notes. N	had diet orders for a pureed ysician and documented in one of the residents had an to be added to their diets.					
[]	o receive a dinner ro The therapeutic spre	s 7, 8 and 20 were observed If with their evening meal. ad sheets documented that eed diet would have received					

DEPARTMENT OF HEALTH AND HUMAI ERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

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

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE	SURVEY LETED
-		465158	B. WII	V G		11/	03/2005
	PROVIDER OR SUPPLIER DGE CARE CENTER			4:	REET ADDRESS, CITY, STATE, ZIP CODE 33 EAST 2700 SOUTH ALT LAKE CITY, UT 84115	<u> </u>	0.200
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371 SS=E	a pureed bread. On 11/02/05, reside observed to receive meal tray. The thera documented that the would have received. On 11/02/05, reside observed to receive trays. The therapeut that the resident on received a slurried be observed to receive trays. The therapeut that the resident on received a pureed by observed to receive trays. The therapeut that the resident on a received a pureed by on 11/3/05 at 1:00 Finterviewed. She stated on their trays that dietitian was aware to puree trays, but was further stated that the not to put bread on the manager stated that guidance from the dietital that guidance from the dietital services.	anuffin on their breakfast apeutic spread sheets a resident on a pureed diet d a slurried muffin. Ints 7, 8 and 20 were garlic bread on their lunch ic spread sheets documented a pureed diet would have bread. Ints 7, 8 and 20 were a dinner roll on their lunch ic spread sheets documented a pureed diet would have bread. Ints 7, 8 and 20 were a dinner roll on their lunch ic spread sheets documented a pureed diet would have bread. Ints 7, 8 and 20 were a dinner roll on their lunch ic spread sheets documented a pureed diet would have bread. Ints 7, 8 and 20 were a dinner roll on their lunch ic spread sheets documented a pureed diet would have bread. Ints 7, 8 and 20 were a dinner roll on their lunch ic spread sheets documented a pureed that she has always put bread was not sure if the hat bread was put on the pretty sure she was. She is dietitian has never told her he puree trays. The dietary she "does not get much" betitian. INTS CONDITIONS - FOOD	F 37	71			
	The facility must store serve food under san	e, prepare, distribute, and itary conditions.					

	TMENT OF HEALTH RS FOR MEDICARE	AND HUMA ERVICES & MEDICAID SERVICES				FORM	D: 11/18/200 // APPROVE
TATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE S). 0938-039 SURVEY .ETED .
		465158	B. WIN	1G		11/	03/2005
	PROVIDER OR SUPPLIER			43	EET ADDRESS, CITY, STATE, ZIP COE 33 EAST 2700 SOUTH ALT LAKE CITY, UT 84115		03/2005
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	by: Based on observation determined that the distribute and serve conditions. Findings include: During the initial insigno/31/05 the following the service of the service	on and interview, it was facility did not prepare, food under sanitary Dection of the kitchen on ag was observed. pice rack: ted 10/21, an open package ee opened packages of an opened package of d 10/22 and another opened lated 10/23. by storage room: and sour cream with an 1/29/05, an opened pitcher of	Th	The I week contained prefings is necessary to by Door	mitary Conditions- Food Prep and Service lity does and will continue to store, prepare, of conditions Employee education of dietary staff by die a. Proper storage and usage of food pub. Proper labeling and dating i. Beverage preparation for food. c. Use of appropriate storage contained Purchase of approved food storage contained Dietary Manager will conduct random audit a. A log of audits will be maintained be The Dietary manager will track and trend to Quality Assessment and Assurance Commit This plan of correction will be completed by the consure that food is marked and dated. It is plan of correction will be completed by the consure that food is marked and dated. It is plan of correction will be completed by the consure that food is marked and dated. It is plan of correction will be completed by the consure that food is marked and dated. It is plan of containers will be in-serviced on using proper containers will be in-serviced on using proper and the proper time of changing gloves during the proper time of changing gloves during the proper time of changing med pass times ded then the nurse will get more out of the releast. After med pass, the supplement will be proper to more different or assessing the proper from refrigerator. All Licen and time removed from refrigerator. All Licen and time removed from refrigerator. All Licen and time removed from refrigerator. All Licen and time removed from refrigerator. All Licen and time removed from refrigerator. All Licen between the completed of the storage of supplement.	etician roducts flowing day ers ers ers its to insure complian by the Dietary Mana, esults of audits and r ittee at least quarterly by December 15, 200 stored in refrigerators DM will also monitor age room. New use items. All single or utensils for dishing of gloves during mea age meals. pt in a 2 quart, or a. If more supplement frigerator to help fini put back into the will be marked with use Nurses will be in-	nce. ger or Designee report to the y. 15. a bi- r for use of al
t	89 (a) "single-use and oulk food containers once and dis	ticles" means utensils and designed and constructed to carded.					

(b) "single-use articles" includes items such

PRINTED: 11/18/2005 DEPARTMENT OF HEALTH AND HUMAI ERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 371 Continued From page 112 F 371 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 travs 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

Hi-Pro Medication Pass

items were served to the facility residents. The dietary manager was only observed to change her gloves one time during the breakfast tray line.

On 11/2/05 from 6:45 AM until 8:52 AM, a gallon milk jug of Hi-pro medication pass was observed

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION	(X3) D	ATE SURVEY DMPLETED
		465158	B. WI	IG		44/02/2007
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST 433 EAST 2700 SOUTH SALT LAKE CITY, UT		11/03/2005
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S F X (EACH CORREC' CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)	(X5) COMPLETION DATE
F 371	on the medication of residents during the medication pass was refrigerated. At 8:5 the Hi-pro medication 8:53 AM, a nurse suttemperature of the Hound the temp to be 11:45 AM, the facility medication pass out administered it to far a nurse surveyor chell-pro medication pastemperature to be 58 According to the 200 Food Code, "Potenti shall be maintained at Celsius or 41 degrees."	art and administered to facility medication pass. The Hi-pro s not observed to be on ice or 2 AM, a facility nurse placed on pass in the refrigerator. At property of the Hi-pro medication pass and to 62 degrees Farenheit. At y nurse took the same Hi-pro of the refrigerator and cility residents. At 12:10 PM, to be assaud found the degrees Farenheit. If U.S. Public Health Service ally Hazardous Foods (milk) at a temperature of 5 degrees as Fahrenheit."	F3	Rounds will be co	Ompleted on a daily	
SS=E	properly. This REQUIREMENT by: Based on observation facility did not dispose properly. Specifically that the waste recept Findings include: On 10/31/05 at 7:00 A	ARY CONDITIONS - AL cose of garbage and refuse I is not met as evidenced In, it was determined that the e of garbage or refuse the facility did not ensure acle was covered with a lid. AM, the waste dumpster facility was observed to	F 3	ensure that dumps at all times. An ir given to all staff e waste receptacle is will be instructed and why leaving to dumpsters could consider the 15th of 1 Sanitation in respendisposal will be disposal will be disposal will be disposal will keep a often he finds the 1 dumpsters. He will	ensuring that the s covered. They on proper sanitation, he lid open on the ause a health hazard. be completed on or December 2005. Lect to garbage scussed in our first being held. The maintenance a log, on how lids open on the	12-15-05

DEPARTMENT OF HEALTH AND HUMA **ERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES

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

		I .			
IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` '	IULTIPLE CONSTRUCTION	(X3) DATE : COMPL	
	465158	B. WII	NG		03/2005
-			433 EAST 2700 SOUTH		
(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL		(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
'	•	F:	372		
dumpster located in observed to contain closed. On 11/2/05 at 6:20 observed to contain closed.	a front of the facility was garbage and the lid was not AM, the waste dumpster was garbage and the lid was not	TI le: af da 1. Re	nis facility provides physiciar ast once every 30-day for the ter admission and at least once by thereafter. esident 8/10 has been schedul	n visits at first 90-days ce every 60-	-
VISITS The resident must be once every 30 days admission, and at let thereafter. A physician visit is of	pe seen by a physician at least for the first 90 days after east once every 60 days considered timely if it occurs	2. A from the second of the se	2005 or before. Ill resident records have been equency of physician visits. esidents requiring a physician been scheduled and will be exampled as the physician visit tracking too vised to schedule one year of the physician will receive a coearly schedule at least monthly equently as changes arise. The Medical Records Director	audited for n visit has amined by the 05 tol has been Evisits. topy of the ty or more or Designee	12-15-05
by: Based on record revidetermined that 1 of (Resident 8) and 1 stress (resident 10) were not least once every 30 admission and at least required. Findings include: 1. Resident 8 was a	view and interview, it was f 10 sample residents supplemental resident not seen by a physician at days for the first 90 days after ast once every 60 days as	c. Ti w no sc pe d. Ti e. Ti tro	quired visits with dates each the Medical Records Director ill contact the physician of visit completed by the scheduled hedule a visit within the teneriod. The Medical Records Director log of physician visits. The Medical Records Director and physician visits and reportuality Assessment and Assurate mittee at least quarterly.	month. or Designee sits that are d date and day grace will maintain will track and it to the ance	fter.
	PROVIDER OR SUPPLIER DGE CARE CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa contain garbage an On 11/1/05 at 7:20 dumpster located in observed to contain closed. On 11/2/05 at 6:20 observed to contain closed. 483.40(c)(1)-(2) FR VISITS The resident must be once every 30 days admission, and at let thereafter. A physician visit is on to later than 10 day required. This REQUIREMEN by: Based on record rev determined that 1 of (Resident 8) and 1 se (resident 10) were in least once every 30 admission and at let required. Findings include: 1. Resident 8 was a	DENTIFICATION NUMBER: 465158 PROVIDER OR SUPPLIER DGE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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.	PROVIDER OR SUPPLIER DGE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. Till AB3.40(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 2/2/26/66 with diagnoses which included domontics.	PROVIDER OR SUPPLIER DEE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. On 11/2/05 at 6:20 AM, the waste dumpster was observed to contain garbage and the lid was not closed. 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 tetermined that 1 of 10 sample residents (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 by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days are required. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was tetermined that 1 of 10 sample residents (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. The Medical Records Director will contact the physician of vinot completed by the schedule schedule a visit within the tenperiod. The Medical Records Director will contact the physician visits and report Quality Assessment and Assur	A BUILDING RROWDER OR SUPPLIER DOE CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY STATE, ZIP CODE 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY STATE, ZIP CODE 433 EAST 2700 SOUTH SALT LAKE CITY, UT 84115 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. On 11/2/05 at 6:20 AM, the waste dumpster was observed to contain garbage and the lid was not closed. A 83.40(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: This REQUIREMENT is not met as evidenced by: This REQUIREMENT is not met as evidenced by: This REQUIREMENT is not met as evidenced by: This REQUIREMENT is not met as evidenced by: This REQUIREMENT is not met as evidenced by: The Medical Records Director or Designee will provide to the physician of visits that are not completed by the scheduled date and schedule a visit within the ten-day grace will contact the physician of visits that are not completed by the scheduled date and schedule a visit within the ten-day grace period. The Medical Records Director or Designee will provide to the physician or visits and report to the Quality Assessment and Assurance Committee at least quarterly. The Medical Records Director will track and trend physician visits and report to the Quality Assessment and Assurance Committee at least quarterly. The Medical Records Director will reach and trend physician visits and report to the Quality Assessment and Assurance Committee at

December 15, 2005.

DEPARTMENT OF HEALTH AND HUM/ SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

	OF CORRECTION	iDENTIFICATION NUMBER:	A. BUI		TPLE CONSTRUCTION NG	(X3) DATE S COMPLE		
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	with anxious and dhypertension. A review of resider that the resident had 10/10/04 and 1/5/0 Resident 8 should on or around 12/10 There was no docurecord to provide ebeen seen by a phy 2. Resident 10 was diagnoses which in hypothyroidism, hypothyroidism, hypothyroidism, hypothyroidism, hypothyroidism, hypothyroidism, hypothyroidism, hypothyroidism, hypothyroidism, hypothyroidism, hypothyroidism, hypothyroidism, hypothyroidism, hypothyroidism, hypothyroidism, hypothyroidism, hypothyroidism, hypothyroidism on or around 10/19/05. Resident 10 should physician on or around 10/19/05. On 11/2/05, during staff the missing phypothyroidism visits.	epressive features and at 8's medical record revealed ad been seen by a physician on 5. have been seen by a physician //04. mentation in the medical vidence that resident 8 had //sician on or around 12/10/04. s admitted to the facility with cluded depression, dementia, pertension and gastrointestinal at 10's medical record revealed as last seen by a physician on have been seen by her and 8/19/05 and 10/19/05. mentation in the medical //idence that resident 10 had sician on or around 8/19/05 a meeting with administration ysician visits were requested, able to provide any missing			F388: Frequency of Physician V This facility provides all require visits to be made personally by physician. All required visits w performed by the physician. The may alternate required visits with practitioner or clinical nurse spector of the physician on 11/5/05. Resident 1 has been examined be physician on 11/5/05. Resident 2 has been examined be physician on 11/15/05. All resident records have been a frequency of physician visits. Residents requiring a physician been scheduled and will be examphysician by December 15, 2005. All required visits will be complement of the physician. The nurse practitioner will provivisits as need to address lab value psychotropic drug review, and condition that may arise between visits as directed by the physician.	ed physician the ill be e physician h a nurse ocialist. y the udited for visit has nined by the deted by the deted by the deted by the deted in a neguired to the neguired to the detect of the detect		
I .	483.40(c)(3)-(4) FR VISITS	EQUENCY OF PHYSICIAN	F 3	88				

PRINTED: 11/18/2005 DEPARTMENT OF HEALTH AND HUMA **ERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 465158 11/03/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 433 EAST 2700 SOUTH PINE RIDGE CARE CENTER SALT LAKE CITY, UT 84115 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 388 Continued From page 116 F 388 Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be 4. The physician visit tracking tool has been made by the physician personally. revised to schedule one year of visits. The physician will receive a copy of the At the option of the physician, required visits in vearly schedule at least monthly or more SNFs, after the initial visit, may alternate between frequently as changes arise. personal visits by the physician and visits by a The Medical Records Director or Designee physician assistant, nurse practitioner or clinical will provide to the physician a list of nurse specialist in accordance with paragraph (e) required visits with dates each month. of this section. 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 This REQUIREMENT is not met as evidenced period. d. The Medical Records Director will maintain a log of physician visits. Based on record review it was determined that for The Medical Records Director will track and 2 of 10 sample residents (residents 1 and 2), the trend physician visits and report to the physician visits did not alternate between the visits of a nurse practitioner. Quality Assessment and Assurance Committee at least quarterly. Findings include: 5. This plan of correction will be completed by December 15, 2005. F490: Administration 1. Resident 1 was admitted to the facility on 10/24/02 with diagnoses which included vascular dementia, depression, anxiety and insomnia. This facility does and will continue to be

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

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

administered in such a manner that enables it to use its resources effectively and

efficiently to attain or maintain the highest

psychosocial well-being of each resident.

practicable physical, mental and

DEPARTMENT OF HEALTH AND HUMA! ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE S COMPLE	
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	2/16/05 visit.	ave seen resident 2 on the		388			
	A facility must be acenables it to use its efficiently to attain of practicable physical well-being of each of the second of the	dministered in a manner that resources effectively and or maintain the highest I, mental, and psychosocial resident. In the survey with a subsequent anded survey, conducted I/3/05, and resultant finding of y and Substandard Quality of ined that the facility was not in a manner that enabled it to ther efficiently or effectively to be were provided the or maintain their highest, mental, and psychosocial resident in the areas of staff resident to resident abuse and unknown etiology. The facility viding Substandard Quality of ctual harm) in these areas.	F	490	This facility does and will continue be administered in such a manner the enables it to use its resources effect and efficiently to attain or maintain highest practicable physical, mental psychosocial well-being of each result of Correction for all 19 deficies please see pages 1 through 124 of the form CMS 2567. No later than December 15, 2005 the will be in substantial compliance. A will be followed up by the Administrant discussed in our Quality Assurated meetings. Our first meeting will be December 13, 2005.	nat ively the and ident. ncies ne facility All POC's trator nce	12-15-05

DEPARTMENT OF HEALTH AND HUMA! ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER:	- 1	IULTIP ILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	of Immediate Jeopal of Care was based in non-compliance in the and Facility Practice Regulations (CFR) and Facility administrate ach resident was from Cacope and severity 2. Facility administration investigate, and report the abuse, neglect, and report the abuse, neglect, a origin. (Scope and severity) 3. Facility administration investigate, and report the abuse, neglect, and programmed from cacopic and programmed from occurring. Scottage F-226) 4. In addition to the and Substandard Quather facility administration from occurring and substandard Quather facility administrate from cacopic in the follow practice cited during the survey completed 11/4. Facility administration for the survey completed 11/4. Facility administration for the corresponding to the follow practice cited during the survey completed 11/4. Facility administration for the corresponding to the following the facility administration for the corresponding to the following the facility administration for the	ardy and Substandard Quality on the findings of significant he area of Resident Behavior is [42 Code of Federal 183.13 (b) (c), cross reference 25 and Tag F-226]. ation failed to ensure that ree from physical abuse. "K", refer to Tag F-223) ation failed to thoroughly on to appropriate agencies and injuries of unknown reverity "K", refer to Tag ation failed to implement procedures concerning ent abuse, resident to avestigation of injuries of now to prevent the abuse pe and severity "K", refer to areas of Immediate Jeopardy ality of Care stated above, tion failed to effectively and purces to ensure that each maintained their highest mental and psychosocial wing areas of deficient the annual and extended 3/05. Ition failed to ensure that residents deposited with the ded, and managed. (Scope	F	190			

DEPARTMENT OF HEALTH AND HUMA. REVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 490	Continued From pa	ge 119	F4	190			
	most recent survey in a place readily ad (Scope and severity c. Facility administ policies and proced prohibited neglect. to Tag F-224) d. Facility administration in the significant change in completed when a resignificant change. The to Tag F-224) e. Facility failed to expression in the second plans were deviced measurable objectives ident's needs. (Sto Tag F-279). f. Facility administration in the second plans were deviced plans were deviced by the second plans were deviced by the second plans were deviced plans were deviced by the second plans were deviced plans were deviced plans were deviced plans were deviced plans were deviced plans were deviced plans were deviced plans were deviced plans were deviced plans were deviced plans were deviced plans were plans were deviced plans were plans were deviced plans were plans were deviced plans were plans wer	ration failed to ensure that the was available for examination occessible to the residents. y "B", refer to Tag F-167) ration failed to ensure that ures were implemented that (Scope and severity "G", refer ration failed to ensure that ninimum data sets were esident experienced a (Scope and severity "D", refer resource that comprehensive reloped and implemented with res and timetables to meet the scope and severity "E", refer refer ration failed to ensure that were completed as ordered ending physicians. (Scope					
	and severity "E", refe g. Facility administra residents who requir meals received the r	ation failed to ensure that ed assistance with their necessary services to on. (Scope and severity "H",					
6	each resident mainta	nal status. (Scope and					

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\$\$=K	committee meets a issues with respect and assurance action develops and imple action to correct ide. A State or the Secretisclosure of the reexcept insofar as a compliance of such requirements of this Good faith attempts and correct quality a basis for sanction. This REQUIREMENT by: Based on a review meeting minutes, fainterview with the failed to ensure that committee effectives. In During an interview administrator on 11 that they had a qual 2005 and September the meetings consist director of nursing, recreational worker,	ment and assurance at least quarterly to identify to which quality assessment vities are necessary; and ements appropriate plans of entified quality deficiencies. etary may not require cords of such committee uch disclosure is related to the committee with the section. It by the committee to identify deficiencies will not be used as assess. It is not met as evidenced of the facility quality assurance acility administrator, the facility the quality assurance ally identified quality issues.	F	521	The facility does and will continue as a quality assessment and assurate committee at least quarterly to ide issues with respect to which quality Assessment and assurance activities necessary; and develop and imples appropriate plans of action to correidentified quality deficiencies. A new policy and procedure manuwill be in place by December 13, a regarding Quality Assurance/Impromeetings. Quality improvement of meeting will be on a monthly basis the second Tuesday of the month. committee will identify and discuss concerns, and corrective actions the taken to help ensure quality implements from the previous months will be reviewed and discussed by committee members. Issues, concernd follow up will also be discussed see if improvements were made, or other interventions are needed.	nice nitify y es are nent ect al 2005 ovement Committee s on The is issues, at will orovement. ide: meeting erbs, ed to	12-15-05

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BZ5911

Facility ID: UT0064

If continuation sheet Page 122 of 124

PRINTED: 11/18/2005

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES					APPROVED
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F 521	Continued From pa	ge 122	F	52	21		İ
	facility incident repo	dent medical records and orts on 10/26/05 through			}		!
	that resident's had I could not provide do	everal incidents documenting peen injured. The facility pocumentation that the					
		thoroughly investigated to find yor to rule out abuse.					 - -
	not identify, and sub corrective action pla	ulity assurance committee did psequently did not establish ans to ensure that resident's (Refer to Tag F-224)					
	not identify, and sub corrective action pla staff to resident abu and injuries of unkn	ity assurance committee did osequently did not establish ans to ensure that all alleged se, resident to resident abuse own origin were thoroughly reported to the appropriate F-225)					
:	not identify, and sub- corrective action pla implemented written resident abuse, resi- investigation of injur	lity assurance committee did esequently did not establish ins to ensure that the facility policies regarding staff to dent to resident abuse, the es of unknown origin and how m occurring. (Refer to F-226)					
	identified weight loss establish corrective	lity assurance committee s concerns, but failed to plans to ensure interventions o prevent further weight -325)					
	not identify, and sub	ity assurance committee did sequently did not establish nsure that the resident's trust					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 875911

Facility ID: UT0084

If continuation sheet Page 123 of 124

		AND HUMAN SERVICES				FORM	11/18/2005 APPROVED
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Addenden to POC

Fax Cover Sheet

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

Le Sideni Assessment	From: Pine Ridge Care Center
Attention: Leslie B.	Date: W-15-05
Office Location: Program Certification	Office Location: $\mathbb{Z}\mathcal{A}$
Fax Number: 538-6/63	Phone Number: (801) 487-2248
Urgent Reply ASAP Reply ASAP Rease comment Please Review For your Information Total pages, including cover: Comments:	
Addendum 70 250 Survey Nov 3, 20	67
Survey Nov 3, 20	005

Confidential: This facsimile transmission contains confidential information intended for parties identified above. If you receive this transmission in error, please immediately notify by telephone and return the original message to me at address listed above. Distribution, reproduction or any other use of transmission by any party other than the included recipients strictly prohibited as stipulated by HIPPA standards of privacy for the use and disclosure of patient health information.

Addendum to Plan of Correction for Pine Ridge Care Center

- 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
 - 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
- 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.
- Resident will be seated at the assistive dining table to provide support with meals.
- 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
 - 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

13/19/05 e 0800 phone unterview Kare-DON 521 - Montored Monthly 367 - Wong name for resident 10 - Should be Will correct name & PUT actions will correct name &

Frank Kilby. Administrator

Karie Jones, Director of Nursing

PINE RIDGE CARE CENTER POLICY/PROCEDURE

TITLE: Abuse Prevention, Investigation & Rep	porting POLICY# AD-1
FORMULATED: October 30 th 2005 2005	DISTRIBUTION: October 30th
REVIEWED/REVISED: October 30 th 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

- 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.
- 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.

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

I. Investigation

- 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.

- The Administrator will assure immediate notification of Adult Protective Services or 3. 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:
 - 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.
 - State your name and title and that this is a facility "initial" report. b.
 - C. Describe the incident.
 - Inform the RAS nurse as to "how" the resident is being protected from the d. alleged perpetrator, e.g., suspension, termination, etc.
 - 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

- The Director of Social Services / Director of Nursing will assure notification of the 4. responsible party and physician of alleged incident for all residents involved.
- The Administrator, or his/her designee, will complete the investigation within five (5) 5. working days. Document all interviews with the date, time and content of the
- During the investigation process, the facility must prevent further physical abuse, 6. 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
 - 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.
 - 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.
- 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 all 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 30 th 2005
PROPONENT: Administrator	

- 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:

- 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 designce. 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.
- 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

Facili	y Name:	Admi	nistrator Name:
			laint Number:
Date a	lleged abuse reported to Adminis	trator/designee:	
Date al	leged abuse incident occurred:	-	
Emplo	yee Information		
Ethnic I	Background:	Home I	Phone
Address	:		
License/	Certification Number:		
	Victim Information		
Name:		D.O.B	
Diagnosi	s		
Vitness]	Information		
		Phone No	
ame:		Phone No.	
ame:			
		- 4701101	
ne follow	ing measures were implemented	to ensure the refere	of the all
event pos	ss: ble reoccurrence of an inciden	t.	of the affeged victim and to
	Employee assignment changed		Physician interest
) []	Employee suspended Employee not scheduled to work		Physician intervention Staff Education
_	Emplesses and the Work		Resident education
	comproyee terminated/resigned	1 1	
	Employee terminated/resigned Police Notified	D =	Social Services intervention Other:

PINE RIDGE CARE CENTER POLICY/PROCEDURE

Facility Name:	Administrator Name:
	Complaint Number:
Date alleged abuse reported to Admi	inistrator/designee:
Date alleged abuse incident occurred	
Alleged Victim Information	l:
Name:	
Diagnosis:	
Alleged Perpetrator Information	
Name:	
Name:	Phone No.
vame:	
Vame:	Phone No.
	Phone No.
he following measures were implement	
event possible recommend	ed to ensure the safety of the alleged victim and to
possible reoccurrence of an incid-	
possible reoccurrence of an incid	
Room Change	
	Resident Education Staff Education New Care Plant

Policy AD-9, Appendix B

PINE RIDGE CARE CENTER POLICY/PROCEDURE

Facilit	y Name:	Adı	mini	strator Name:
		Con	npla	int Number:
Date a)	leged abuse reported to Administ	rator/designee: _		
Date al	leged abuse incident occurred:			
<u> </u>	nployee Information			
		Phon	a N-	
	ship: Visitor Fam	ily Member		her:
Alleged	Victim Information			
Name:		D O B	ì.	
			·- —	
Witness]	nformation			
		Phone No		
vame:		Phone No		
he follow revent pos	ng measures were implemented to sible reoccurrence of an incident.	o ensure the safe	ety o	f the alleged victim and to
	Physician Intervention Police notified Social Service intervention Other:]	Non-employee education IDT conference Other family intervention

Policy AD-9, Appendix C

Summary of Incident:	
ollow Up:	
investigation completed:	
be completed within 5 days of Administrator/designee notification)	
of the state of th	Administrator/Designee

Policy AD-9, Appendix D

Prohibiting and ... aporting Abuse Focus Round

Date: EMPLOYEES

Facility:

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

ON :	SUPERVISORS	S	~ " "
13:42	(1)		11 C
[TX/	2)		- 1
RX NO 5	3)		
52561	L	Employee able to answer anadion of	P:

- Employee able to answer question accurately/completely.

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

- 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.
- 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.
- Sexual Abuse Includes, but is not limited to, sexual harassment, sexual coercion or sexual assault.
- Physical Abuse Includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.
- 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 pian of care to meet the resident=s needs.

PROCEDURE:

Employee Screening:

- 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 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:

- 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:

- 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.
- 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.
- Ongoing education will be provided to employees with administrative focused round tools and immediate in servicing provided to staff as needed.
- Significant trends identified with focused round tools will be addresses in facility Quality Assurance meetings as applicable.
- 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.
- 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:

- 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:

 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.
- 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.
- 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 Date Signature

Policy AD-9, Appendix E

Summary of Incident:	
Follow Up:	
ate investigation completed	
nust be completed within 5 days of Administrator notification)	Administrator/Designee
•	

MAIN/MYDOCUMENTS/MASTERFORMS/Employee to Resident Alleged Abuse Report

PINE RIDGE CARE CENTER

Facility Name		· · · · · · · · · · · · · · · · · · ·	
Facility Name:			ator Name:
Complaint Number: (from the State)	# UT		
Date alleged abuse reported to Admi-	nistrator/designee:		
Date alleged abuse incident occurred			
Alleged Victim Information	Employee	Resident	Other
Name: Ethnic Background: Diagnosis (resident only):	SS#:		D.O.B#
Alleged Perpetrator Information			
thnic Background:	SS#:Home Phone	(If not a resident	D.O.B# t):
icense/Certification #: Vitness Information			
ame:			
ame:			
ame:			
the following measures were implement ossible reoccurrence of an incident. Room Change Social Service Intervention	□ Res	sident Education	
Physician Intervention Physician Intervention Employee assignment changed Employee suspended Employee not scheduled to work Employee terminated/resigned Police Notified Other	Sta	ff Education n-Employee Edu w Care Plan Inte Conference er Family Interv	ication rvention

Summary of Incident:	
ollow Up:	
	_
e investigation completed	
e investigation completed t be completed within 5 days of Administrator notification)	
ompleted within) days of Administrator notification)	Administrator/Designee

MAIN/MYDOCUMENTS/MASTERFORMS/Resident to Resident Alleged Abuse Report

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	Ε	ate:	
Facility Name:Facility Address:			
Facility Address: City, State, Zip:			
City, State, Zip:			
City, State, Zip: Facility Telephone:			_
Your name and title:			
Name of person who reported to fa witness:	cility or		
Resident #1	DOB	904	
Diagnosis		55#	
Resident #2	DOR	55#	
Diagnosis		55#	
Describe injuries, if any:	nt incident from recu	uring?	

Summary of Incident:	
Market Control of the	
	_
ollow Up:	
	·
	
e investigation completed	
st be completed within 5 days of Administrator notification)	
SLUC COMMISSION & January Cart	Administrator/Designe

MAIN/MYDOCUMENTS/MASTERFORMS/Resident to Resident Alleged Abuse Report

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:

- 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 irvestigated, 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/her 3. 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:

- Report any knowledge of all alleged violations involving mistreatment, neglect or 1. 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.
- The Administrator or his/her designee will promptly ensure safety of alleged 2. 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.
- The Administrator will assure immediate notification of Adult Protective Services 3. 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.
- 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.

- 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.
- 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.
- 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.
- 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
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			-			
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PAGE 02/03

FORM APPROVED

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PRINTED:	01/27/2006	

DEPART	MENT OF HEALTH	I AND HUMAN SERVICES				OMB NO	. 0938-0391
TATEMENT (S FOR MEDICARE OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUIL	DING	CONSTRUCTION 01 - PINE RIDGE CARE CENTE		R
		465158	B, WIN			01/1	9/2006
NAME OF PF	OVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE EAST 2700 SOUTH		
PINE RID	GE CARE CENTER			SAI	LT LAKE CITY, UT 84115	= (0.1)	(X5)
(X4) ID PREFIX TAG	ニュー・ ちこうごうごういん	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTT CROSS-REFERENCED TO THE APPROPRIED CORRECT CO	ULD BE	COMPLETION DATE
{K 000}	INITIAL COMMEN	TS	(KO	00}	CROSS-REFERENCED TO THE APPR DEFICIENCY)		
A fire alarm system with a devices or equipment is in NFPA 72, National Fire A effective warning of fire in Activation of the complete manual fire alarm initiation extinguishing system oper patient sleeping areas mathet manual pull stations nurse's stations. Pull state path of egress. Electronic tests are available. A relipower is provided. Fire a maintained in accordance records of maintenance.	m with approved components, nent is installed according to all Fire Alarm Code, to provide of fire in any part of the building, complete fire alarm system is by initiation, automatic detection or tem operation. Pull stations in treas may be omitted provided stations are within 200 feet of Pull stations are located in the Electronic or written records of e. A reliable second source of d. Fire alarm systems are cordance with NFPA 72 and enance are kept readily available, annunciation of the fire alarm proved central station. 19.3.4,		051				
	Based on observation the administrato was determined control valve, tal	D is not met as evidenced by; vations made in the presence of r during a revisit on 1-19-06, it that the facility's antifreeze loop, mper switch was not hard-wired	l				NA PATE
LABORATO	DRY DIRECTORS OF PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATUR	ΙE	Administration		(X8) DATE 2-6-0

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BZ5922

Facility ID: UT0064

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