STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A049	A. BUILDING _____ B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAYFIELD COMMUNITY CARE CENTER	11 SOUTH MAIN MAYFIELD, UT 84643

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F 221 SS=E	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility did not ensure that 5 of 14 sample residents were free from the use of physical restraints that were not required to treat the resident's medical symptoms.(Resident Identifiers: R5, R9, R10, R12, R13) Findings Included: Resident 5, was admitted to the facility 7/22/96 with diagnoses that included anemia, hypertension and hypothyroidism. An evaluation of need for side rails as fall prevention was done on 6/3/05. A physician's order for siderails day and night was signed on 7/22/96. Random observations were made of resident 5 during the survey. Each time the resident was observed to be out of bed, they were observed to be in a wheelchair with a tied soft crotch restraint in place. There was no evidence in the medical record of an evaluation for physical restraint, no signed approval for restraint by resident or surrogate or a physician's order for a restraint. Resident 9 was admitted to the facility 4/12/05 with diagnoses that included hemangioma,	F 221	On July 26, 2006 DON reviewed the five resident's charts identified by surveyors to have questionable use of side rails or restraints. The report will be presented to the QA Team at the July 31 st meeting. We have decided to change our policy from only getting signatures from family and/or residents and physicians on only residents who are ambulatory with assistance or try to climb out of bed, (where the side rail is actually used as a restraint to prevent fall injuries), to getting signatures on all residents that have side rails for different reasons such as personal choice (patient rights); used to turn them, to aid in positioning with cushion devices, and protection because of seizure disorders. Resident #5 and # 13 identified by surveyors were two such residents that cannot ambulate and are both total lift and must be turned and positioned by staff. The side rails are used as positioning devices for pillows and for the resident to hold on to while turning and changing. We will now get a signature from the family to document that this is acceptable.	8-18-06

8/1/06 DOC acceptable Completion date 8/18/06 Cindy Blackburn RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cindy Peterson	Administration	7-31-06

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

Utah Department of Health
7099-3220-0001-3661-1749

AUG 0 3 2006
8-1-06
Bureau of Health Facility Licensing,
Certification and Resident Assessment

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F 221	Continued From page 1 hypothyroidism and insomnia. Random observations were made during the survey. The resident's bed had full side rails. There was no evidence in the medical record of an evaluation of need for side rails, no signed approval for side rails by resident or surrogate or a physicians' order for side rails. Resident 10 was admitted to the facility 6/7/04 with diagnoses that included non-insulin dependant diabetes, psychosis, anxiety and depression. Random observations were made during the survey. The resident's bed had full side rails. There was no evidence in the medical record of an evaluation of need for side rails, no signed approval for side rails by resident or surrogate or a physicians' order for side rails. Resident 12 was admitted to the facility 10/03/02 with diagnoses that included diabetes mellitus insulin dependent, osteoarthritis and anemia. An evaluation of need for physical restraints was done on 3/3/05. A signed approval for physical restraints was signed by a surrogate on 3/3/05. A physicians' order for a self-release lap belt was signed 3/28/05. Random observations were made during the survey. Each time the resident was observed to be out of bed, they were observed to be in a wheelchair with a tied soft restraint in place rather than a self-release lap belt. Resident 13 was admitted to the facility on	F 221	Resident # 10 has never had a side rail and is fully ambulatory by herself and could put it up or down if there was one on her bed but there is not one. This may have been a mix up by surveyors on whose bed they observed but to avoid any other mix up, all other beds were checked by DON for unused side rails or ones not having permission on July 27 th. Resident # 9 requested a side rail because she has seizures and the rail makes her feel safer. Her 90 year old mother in the room with her also feels safer because she is unable to help her if she should start to fall while having a seizure. We will get proper family and doctor signatures on evaluation for side rail for patient rights and safety from seizure disorder. Neither the resident nor the family sees this rail as a restraint. Nursing staff will be inserviced on Aug. 9 about using the proper type of restraint which has been identified on the release form by family and doctor. We will also evaluate # 12 again for changing the type of restraint used and the risks verses the benefits of one kind over another.	8-18-06

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F 221	Continued From page 2 10/02/03 with diagnoses that included bipolar disorder, dementia and anemia. Random observations were made during the survey. The resident's bed has full side rails. There was an evaluation for need for side rails done on 1/4/05. There was no evidence of a signed approval for side rails by resident or surrogate or a physicians' order for side rails.	F 221	The DON will report to the QA committee quarterly on the implementation of the new form and any areas of concern discovered at IDT meetings. The committee will make recommendations as necessary.	
F 255 SS=C	483.15(h)(4) ENVIRONMENT- CLOSET SPACE The facility must provide private closet space in each resident room, as specified in §483.70(d)(2)(iv) of this part. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility did not provide each resident with individual closet space in his/her bedroom. Findings included: Room 1 with 4 residents in the room had 3 individual closets. Room 4 with 3 residents had 2 individual closets. Room 11 with 2 residents had 1 individual closet. Room 2 with 2 residents had one closet and one wardrobe. The wardrobe was positioned in the room in such a way that the wardrobe door could not be opened to allow sufficient room for the resident to have access to their belongings.	F 255	Three new closet wardrobes were ordered from supplier July 31st. These wardrobes are 36 inches wide and 22 inches deep and will be used to add additional closet space for rooms # 4, 11 and 2. Room #1 has always had 4 closets so it must have been a mistake by surveyors concerning what room they looked at. The one wardrobe in room #2 was turned around by the resident him self because of his suspiciousness about people getting in his closet. The RSC will make routine checks on the closet space available to all residents and report the status to the QA committee at their quarterly meetings.	8-18-06

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F 323 SS=B	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility did not ensure their environment remained as free of accident hazards as possible. Findings included: On 6/28/06 during an observation of the mens' bathroom/shower room a clear plastic spray container.was found in an unsecured cabinet in the shower area. The bottle was .labeled "Lysol" on a typed, plain, white label. There was no additional information on the label . On 6/28/06 during an observation of the womens' bathroom a spray container labeled "methlbenzelhonium chloride of no alkaline soapless cleaner and wetting agent for external use only" was found on a wall shelf.	F 323	The facility will ensure that the environment will be free from chemical hazards by inservicing all employees about storing chemicals in their provided locked cabinets. The QA committee discussed ways to police areas of concern such as residents' bathrooms and supply closets. All department heads are responsible for making rounds on their shifts to observe for chemicals left unlocked. The entire staff was inserviced on July 18th and the nursing staff will be inserviced again at their meeting on Aug. 9th. Housekeeping is responsible for making sure that no chemical is placed in an unlabeled bottle such as the peri wash or other cleaning chemicals. They are also responsible for make sure all cabinets and doors are locked after use in cleaning. The QA committee will discuss their observations as to the handling of chemicals quarterly. Any areas of concern will be addressed and recommendations for better containment will be made.	8-18-06

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F 329 SS=E	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on record review and observation it was determined that the facility did not insure that 3 of 14 sampled residents were not free from unnecessary drugs. (Resident Identifiers R7, R8, R10) Findings Include: Resident 7 was admitted to the facility on 8/5/02 with diagnoses that included anemia, dementia, Alzheimer's Disease and ORIF (open reduction internal fixation) of fractured hip. On 10/31/05 the resident was ordered Valium 5 mg PO(by mouth) Qday (once a day). On 11/04/05 the order was modified to read "change Valium order to 2.5mg PO bid (twice a day) give 1/2 5 mg tablet as muscle relaxant. The resident had not been treated with a shorter-acting benzodiazepine. The resident had been treated previously with Robaxin for stiffness and muscle spasm. There is no documentation to indicate that a gradual dose reduction has been attempted since the drug was initiated, and no indication that a gradual dose reduction was clinically contraindicated. On 1/31/06 a doctor's note	F 329	On Aug. 09, 2006 DON and administrator will inservice nursing staff on better charting on already present behavior symptom sheets in the residents records. The evaluation of their monthly summary charting will be reviewed and suggestions given on how to improve their documentation. The Quality assurance committee will meet on July 31 st to discuss our new charting requirements for all attending physicians. New form implemented to obtain the documentation required to support the use of antipsychotic drugs and what is clinically appropriate. DON will present the new form and instructions first to the QA committee and the Medical Director and then to each individual physician and explain how it applies to their individual resident. Each physician will be given an example of what evidence for a specific drug will be needed to document why it is being used or to say why reduction is contraindicated for his or her resident. On the form the physician shall state the dosage, duration, indication and monitoring which is clinically appropriate. They will also be required to document if drug reduction has been unsuccessful.	8-18-06

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F 329	Continued From page 5 states "tense, maybe pain, Lortab helps. Valium calms." Resident 8 was admitted to the facility on 09/18/04 with diagnoses that included cardiovascular accident, coronary artery disease, hypertension, and hypothyroidism. The resident had the following medications ordered: 09/18/04: Zoloft 50 mg (milligram), 1 po (oral) daily (QD) 07/21/05: Risperdal 0.5 mg, po twice a day (BID) 10/12/05: Remeron 30 mg, po at night (QHS) 05/24/05: Trazodone HCL 100 mg, 1/2-1 tablet (TAB), 50 mg po, every night (QPM) as necessary (PRN) sleep 10/21/04: Klonopin 0.5 mg 1-2 TAB po, three times a day (TID) PRN anxiousness There was no documentation to indicate that a gradual dose reduction has been attempted since the drugs were initiated, and no indication that a gradual dose reduction was clinically contraindicated. Resident 10 was admitted to the facility on 06/07/05 with diagnoses that included anxiety, depression, insomnia, schizophrenia, and glaucoma. The resident had the following medications ordered: 06/07/05: Lexapro 20 mg I tab po (QAM) every morning 09/12/05: Geodon 80 mg. I capsule po BID (twice a day) 06/07/05: Ambien 10 mg I tab po QHS(every evening)	F 329	If the resident has a seriously mentally illness, with a passar level II, as Resident #10 does, the monthly progress notes and drug changes will be requested from their monthly mental health therapy visit, to be placed on our charts here. The drug changes will be coordinated with the primary care physician and mental health to document appropriate information. Our drug reduction sheet will still be maintained in the residents' records. Residents # 7 and #8 will be reviewed again with their physicians and the appropriate documentation and/or reduction actions will be discussed by Aug. 18 th. Documentation showing the resident's subjective and objective improvements or maintenance of function while taking the medication will be provided in nursing charting, physician progress notes, and other consultant reports as they apply. This will be reviewed by DON. The pharmacy consultant's form will be reviewed by not only the individual physicians each month and/or at the time of visits to their residents but by the IDT committee at regular review of that resident.	8-18-06

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F 329	Continued From page 6 06/07/05: Abilify 30 mg I tab po QHS(every evening) 12/19/05: Clonazepan 0.5 mg I tab po TID (three times a day), PRN (as needed) On 6/29/06 the medication tracking sheets, resident monthly summary, and the nursing notes were reviewed. There was no documentation indicating behavioral monitoring to assess the resident's behavioral symptoms. There was no documentation to indicate if there was a need for intervention; if the symptoms were transitory or permanent; if other environmental causes were ruled out; or documentation of medical conditions to support current medications.	F 329	The IDT committee will document on the quarterly MDS form and watch for significant change information for improvement or decline of residents' drug therapy. Information concerning whether a particular drug, dose, or duration may cause symptoms or other resident characteristics such as age, weight, or other factors that may cause the resident to react differently to certain drug doses will be evaluated by the team.	8-18-06
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility did not store prepare, distribute and serve food under sanitary conditions. Findings include: Based on continuous observation on 6/26, 6/27,	F 371	The Dietary Supervisor will report to the QA committee at their quarterly meetings as to the progress of these changes. The dietary consultant and dietary supervisor, along with administrator, conduced inservice with dietary staff on July 27 th. All survey issues were addressed and the staff was trained on solutions to areas of concern. Dietary supervisor presented solutions to Quality Assurance committee on July 31 st. The following resolutions were accepted.	8-18-06

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F 371	Continued From page 7 6/28 and 6/29, disposable hair coverings were not available. The dietary manager stated that they did not have hair coverings and that the dietary staff wear ball caps. Observations throughout the survey were made of multiple staff members of non-dietary staff seen entering and leaving kitchen area without nets or ball caps. On 6/26/ 6/27 and 6/28 continuous observation of the breakfast meal was done. The food server was observed placing peeled bananas on the plates that were to be served to the residents without using a kitchen utensil to handle the food. The food server was also observed to touch the diet tray cards, condiments, milk cartons, and other food preparation items without washing hands. Gloves were not worn by any of the food preparers or servers at any time. Additionally, staff were observed to use the same tray repeatedly to deliver resident meals. Staff were observed to set the tray on dining tables and return the tray to the food server for another resident's meal. The cook was observed removing bread directly from the bread sack and placing it in the toaster without using a kitchen utensil As the cook continued to serve the meals, she was observed to open cupboards, the refrigerator and touch other surfaces in the kitchen. She was not wearing gloves, using tongs and did not wash her hands after touching other surfaces. Late resident diners or those who requested second helpings or substitutions were served cold cereal from large plastic bags poured directly into the cereal bowls.	F 371	New signs were posted on both entrances to kitchen which read "No one may enter the kitchen without appropriate hair cover". On July 27th all employees were inserviced on the requirement and encouraged not to enter the kitchen at all unless kitchen staff is not present. Boxes of hair nets and paper disposable hats will be placed by both kitchen entrances. Kitchen staff can still wear their own hats or a scarf as long as their hair is pulled up under the hat or scarf. To prevent any further possible contamination by using the same tray delivering food to each of the residents, new individual serving trays were purchased and put into use on July 27 th. These trays will be sanitized after each meal service. Change in serving routine was started July 27 th that allows the person dishing up food on individual trays not to touch the drink cartons, cupboards, or other so called dirty objects. The server will wear gloves and change them or use hand sanitizer if the need arises to touch something perceived as dirty. Diet cards are plastic and sanitized before	

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F 371	Continued From page 8 During breakfast preparation on 6/26, 6/27 and 6/28, it was observed that un-pasturized eggs were used to prepare soft cooked eggs for 7 residents. 1 resident had a signed release of liability for the use of un-pasturized eggs. On 6/29, scoops were found in the following locations, in a bucket in the sink, inside the kitchen door, in the ice bucket by the sink next to the hand sanitizer dispenser and in an open container of pancake mix. Two icebuckets under the ice maching were found with ice scoops inside. On 6/26 during the initial kitchen tour, the following was observed: 1. 16 ounces of vanilla low fat yogurt opened but not dated. 2. 2 1 pound containers of unopened cottage cheese with an expiration date of 6/5/06 3. 1 1 pound container of unopened cottage cheese with an expiration date of 6/6/06 4. 1 opened container of Rejuve with an expiration date of 6/8/06 5. 12 1 pound portions of butter found in the vegetable crisper with no date. 6. 1 pitcher of vanilla milk shake dated 6/23/06. 7. 1 pitcher of strawberry milk shake dated 6/24/06. 8. 1 gallon of thousand island dressing - manufacturer's label date, 12/18/05 - not dated by the facility. 9. 1 gallon of ranch dressing - manufacturer's label date, 5/31/06 - facility labeled 6/1/06. 10. 1 gallon of creamy Italian dressing - manufacturer's date - 4/5/06, facility labeled 6/6/6 11. 1 container of unopened heavy whipping	F 371	each meal so they can be touched to be placed on the serving tray by the server's hands. Server uses tongs and spoons for all food placed on plate. On July 28th signed releases were obtained for all residents requesting soft boiled or over easy eggs. Four of the 7 residents' releases were already on their charts. These releases will be placed in the dietary section of the medical record. Dietary staff was inserviced on proper use of scoops, and a reminder sign was hung by the ice machine about not leaving the scoop in empty buckets and getting a new scoop each time ice is passed. All dietary staff checking in food supplies will continue to write dates on products, but as of July 28th will write "RC" before the date so it is easily recognized as the arrival date. The manufactures expiration date will be noted at this time to make sure the product is no already expired. Products coming frozen will be put directly into the freezer with an "RC/F" date. This will allow as to know how long food has been in the freezer and which to use first. When meat/products are taken out to thaw the date taken out and what meal date is to be written on tray or	8-18-06

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F 371	Continued From page 9 cream dated 6/5/06 12. 1 opened container of liquid eggs dated 6/19/06. 13. 4 unopened 6 ounce peach yogurt containers dated 6/6/06 14. 4 unopened 6 ounce vanilla yogurt containers dated 6/25/06. 15. A small container of ranch dressing was not dated. A beef roast located on the bottom rack of the refrigerator was thawing with a label date of 3/4/06 - facility label stated thawing for Thursday. A turkey breast with a date of 6/19/06 was thawing on the bottom shelf of the refrigerator - labled thaw for dinner. Roast beef #2 was also thawing on the bottom shelf with a date of 5/4/06 - tabled Thursday lunch. In an interview Dietary Manager, she stated the date on the meat thawing in the regrigerator is the date we originally placed the meat in the freezer. On 6/28, at 7:30 am, it was noted there was an uncovered lined garbage can under one sink. There was also an uncovered garbage can under the sink next to the dishwasher that was filled with disposed of food.	F 371	product. When other products are opened such as liquid eggs or shakes, the staff will write an "O" before the date. Plastic containers with covered pour spouts were put into use to replace cereal plastic bags to eliminate the plastic touching the bowl or extra handling from closing the bag. To ensure no products such as yogurt, salad dressings, whipping creams, etc. with expired manufactures dates remain in the refrigerator the person assigned to the deep cleaning once a week will discard all produces which will expire before the next deep cleaning date. Each of the refrigerators has a specific day of the week that a certain staff person is assigned to clean. All opened liquid egg products will be discarded after 3 days per manufactures suggestion. If there are no after open instructions the product will be discarded by manufactures date. All liquid shake products will be discarded after 3 days of being opened. Two new motion detector garbage cans were purchased July 31st for the kitchen so the lid to the garbage can is always closed and does not have to be touched by hands when opened.	

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MAYFIELD COMMUNITY CARE CENTER	11 SOUTH MAIN MAYFIELD, UT 84643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 492 SS=B	483.75(b) ADMINISTRATION The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility did not comply with all applicable Federal, Sate and local laws. The facility did not ensure that there was a publicly posted number of nursing staff (licensed and unlicensed) that showed who was on duty to care for the residents on each shift. Findings Included: On 6/26, 6/27, 6/28/and 6/29 the unit was observed by a nurse surveyor. There was an erasable board with movable markers but this was not changed during the survey and no permanent record was kept. On 6/29 the administrator was interviewed and stated that she was aware that this needed to be posted and records kept but that the process had not been instituted.	F 492	A new printed daily census form was developed and approved by the QA committee at their July 31st meeting. These will be used to retain record of daily staff present and the number of residents present on any given day. As of Aug. 1, 2006, it will be publicly posted on the door of the nurses station by the Administrator or an appointee daily to show the number of licensed and unlicensed nursing staff present at any given time during the day. It will be retained by the administrator for a period of not less than 18 months and will be copied for any one requesting it for 25 cents a page.	8-18-06