DEPARTMENT OF HEALTH AND HUMAN JERVICES

PRINTED: 10/09/20 FORM APPROVE

HEALTE	HEALTH CARE FINANCING ADMINISTRATION				10/19/01 H1 2567					
STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE SUF COMPLETF C 09/27/	ED .			
NAME OF PI	ROVIDER OR SUPPLIER	403000		REET ADDRESS, CITY, STATE, ZIP CODE						
SOUTH C	OGDEN REHAB CENT	ΓER	5865 S WA OGDEN, U	ASATCH DR JT 84403						
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FUL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE			
F 224 SS=K	RESIDENTS The facility must developolicies and proceduneglect, and abuse of of resident property. (Use F224 for deficient neglect or misapproperty.) This REQUIREMENT Based on interview a determined the facility services and supervisity from exhibiting "sextowards other facility. The facility had door record that starting 1 continuously monito inappropriate behavior in the facility of the facility is serviced. The facility had door record that starting 1 continuously monito inappropriate behavior in the facility is serviced. The facility had door record that starting 1 continuously monito in the facility is serviced behavior in the facility is serviced. The facility had door record that starting 1 continuously monito in the facility is serviced behavior in the facility is serviced behavior in the facility of the facility is serviced behavior in the facility of the facility is serviced behavior in the facility of the facility of the facility had door record that starting 1 continuously monito in the facility of the facili	relop and implement wares that prohibit mistres fresidents and misapperencies concerning mistroriation of resident properties and record review, it was to resident 1 to provide sion to resident 1 to provide sion to resident 1 to provide y residents. The properties of the provide sion to resident 1 to provide sion to resident 1 to provide sion to resident 1 to provide y residents. The properties of the p	reatment, repriation reatment, perty.) need by: as necessary revent him naviors" medical ren r "sexually facility nvolving facility staff y sexually	F 224 10/23/01	F224 As of 09/26/01 resident 1 is the building and can no long considered a danger to any oresidents. It should also be that no direct observations of interactions between the resimade. The report on 07/23/01 that was not made in the form of report. It was word of moutiperson to another and no activas ever made in written for for written nurses's notes that entry and was not made by the nurse that was on shift that doccurred. Until the report on 09/05/01, no indication that a plan of resexual aggression was neede weren't any reports of sexual aggressive reports made. No	ger be other reminded of any idents were is referred to an incident in from one ual report m except at was a late he actual lay that it there was eduction in d as there lly	0			

The facility's failure to provide necessary services and

abusive behaviors towards cognitively impaired

residents. Three further instances occurred after

inappropriate behavior involving resident 1 and

resident 3. On 9/20/01, there were 2 incidents of sexually inappropriate behavior involving resident 1

7/23/01. On 9/5/01, there was 1 incident of sexually

and resident 4. (In all incidents, there were no direct

observations of the interactions between the residents.)

place necessary services and supervision to adequately intervene in resident 1's facility identified sexually

These incidents indicate the facility's failure to put in

harm, mental anguish or mental illness

reports were made. Resident 1 has been

noted in the nurses' notes to have made

MDS's are being checked for those who

inappropriate sexual remarks daily.

These have also been noted on the

behavior sheets for this resident.

may be sexually inappropriate.

(X6) DATE

VE'S MONATURE LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REJ

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days aft such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

HCFA-2567L

inappropriate behavior.

DEPARTMENT OF HEALTH AND HUMA. SERVICES HEALTH CARE FINANCING ADMINISTRATION

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTI A. BUILDING B. WING	PLE CONSTRUCTION G	(X3) DATE SU COMPLET	ED C	
NAME OF D	DOLUBER OR GURBLIER	465086	STREET ADD	RESS, CITY, ST	ATE ZIP CODE	09/27	/2001	
	ROVIDER OR SUPPLIER OGDEN REHAB CENT	TER		ASATCH DR				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
F 224	Immediate Jeopardy is defined in Append Manual as: "Failure necessary to avoid pl mental illness". The facility removed discharging resident on 9/26/01. (During residents were found emotional threat to refindings include: 1. Resident 1 was adwith diagnoses which On 9/27/01, a review revealed the following as a MDS was compacted from the facility staff assessed long term memory prognitive skills for divas assessed as having being verbally abusing not assessed as being b. A review of reside was done. The care care plan included a status" which was main inappropriateness, de The goals for this ide the reduction or elimbehaviors. The plan include strategies for	nt 1 led to a determinate to residents for neglect ix PP of the State Oper to provide goods and suscical harm, mental and the Immediate Jeopard 1 to an acute psychiatric the survey investigation who posed a physical desidents.) Imitted to the facility of a included chronic schirt of resident 1's medical	i. Neglect rations ervices requish, or ly by ic setting in, no other or ly ly ly ic setting in, no other or ly impaired record ly impaired resident 1 indering, he was ly impaired resident 1 indering. He was ly impaired resident 1 indering, he was ly impaired resident 1 indering in the resident	F 224	The care plans of all the respective being reviewed and are being for inclusion of strategies for inappropriate behaviors. Be sheets have been re-emphasinservices to their important tracking behaviors in reside results of the drugs or strate change these behaviors. Because the county human secaseworker never made his apatients he works with avail facility for review we were this feelings that the facility able to prevent resident 1's simappropriate behavior with residents. The term "opport predator" came to our attents after the most recent reports. No suggestions or questions by him about the manner in resident 1 was monitored, comis findings of "opportunistic were known to him long beffacility considered resident. The TRT has been inserviced other employees of the facility importance of monitoring an all inappropriate behaviors of all inappropriate behaviors of the facility importance of monitoring an all inappropriate behaviors of the facility considered resident.	reducing checked or reducing chavior sized at ce of and the gies used to services notes on any able to the unaware of would not be sexually other unistic ion only were made, were posed which onsidering c predator" fore the so. d with the ty to the d recording		

care plan with target behaviors of sexually

UT0015

DEPARTMENT OF HEALTH AND HUMAL SERVICES HEALTH CARE FINANCING ADMINISTRATION

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 09/27/2001 465086 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5865 S WASATCH DR SOUTH OGDEN REHAB CENTER **OGDEN, UT 84403** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 224 Continued From Page 2 F 224 resident no matter how long they have inappropriateness. This care plan was dated May been at the facility or what their "usual" 2001, and was updated on 9/21/01 to include sexual behaviors are. The SSW was a new hire aggression. in July and would not be aware of any questionable behaviors prior to that Prior to 9/21/01, the goals for the identified problem point. of "Altered mental status" did not address the reduction or elimination of sexually inappropriateness. The DON and SSW meet on a weekly On 9/21/01, a goal was added to this identified problem that the resident would have a reduction in basis to discuss any reports of behaviors sexual aggression. Interventions for this identified that have been made that may have the problem included the administration of medication potential of becoming abusive in nature (Celexa, Seroquel), monitoring of target behaviors The IDT will be informed of these every shift, redirection or reality orientation if target reports and make assessments if they behaviors were exhibited, documentation of target appear to becoming abusive and will behaviors and side effects to medications. On 9/21/01, determine what strategies will be the approaches were updated to include the use of developed to decrease or stop the Ativan and Depo Provera. behavior. If this included hiring additional help to monitor a resident one 2. Facility staff were documenting sexual on one, then that would be presented to inappropriate behaviors of resident 1 on his Celexa the Administrator for approval. medication flow sheet. Totaled monthly, as documented on the flow sheets, resident 1 exhibited At the time Depo Provera was sexually inappropriate behaviors as follows: administered, resident 1 was in a private room on the SNU. With 2 CNA's to January 2001 -15 manage 14 residents the ratio appeared February 2001 - 15 March 2001 -1 appropriate for resident 1's closer April 2001 -25 observations May 2001 -68 June 2001 -58 July 2001 -61 August 2001 -93 14 (For the month of September 9/1 - 9/25 -2001 there were 14 shifts that were left blank.) 3. An interview was held with resident 1's county human services social worker/case worker on 9/26/01 at 12:30 PM. He stated he had been working with

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resident 1 for 13 months. He stated that he believed

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F 224	that resident 1 has knactions. The case worker state of the consequences great lengths the resicaught. The case we facility's staff would sexually inappropriate because resident 1 wopportunity and explementary and explementary tear. The IDT consisted or recreation therapist (supervisor (FSS). a. The SSW stated to resident 1 had sexually other residents prior residents 1 and 2. The stated that resident 1 behaviors were gene comments to staff metallic to sta	poportunistic predator". It was the consequences and the consequences are the consequences a	was aware e of the id being not feel the dent 1's residents sible 2:30 PM. speutic vice are that iors toward involving e IDT te xplicit sidents were was just n the ate	F 224	The nurses have been insinservices that they need assessments of questiona the future. Administrator will monit to ensure Plan of Correct followed at the monthly Completion Date: October	to document a ble situations i or all the abovions are being QA meeting.	n
	discuss resident 1's bafter the incident with	W stated the IDT did rehaviors to other resid th resident 3 on 9/5/01. the 9/5/01 incident, the	ents until The SSW				

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AND DE LAS OF CONDUCTIONS		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		465086		B. WING		09/:	27/2001
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SOUTH	OGDEN REHAB CENT	ER	5865 S WA OGDEN, U	SATCH DR T 84403			
(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 CORI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
F 224	d. The SSW stated shuman services social that the case worker of an opportunistic preduction of the property o	the contacted resident 1's be contacted resident 1 l worker/case worker. old her that he felt resident. The contacted resident 1 lours ator. The contacted resident 1 to december a to resident 1 to december a week or so before any effect on resident and the contact with resident and the medication began to directed the nurse aident at the contact and the contact	ed to crease his knew it fore the dent 1. were put in ent 1 and o work. staff to enurse o not let nursing ing of sary cares stated that e made to it 1 more sessments staff situation.	F 224	DEFICIENCY)		
	assessments that the	stated they were unawa nursing staff may have conduct any assessmen	done, and				: :

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Event I IL2N11

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UT0015

If continuation sheet 5 o

DEPARTMENT OF HEALTH AND HUMA: SERVICES HEALTH CARE FINANCING ADMINISTRATION

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTI A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE S	eted C
		465086	•			09/2	27/2001
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, ST	TATE, ZIP CODE		
SOUTH	OGDEN REHAB CENT	ΓER	5865 S WA OGDEN, U	ASATCH DR JT 84403			
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F 224	BEHAVIOR: Resident 1 was ident incident reports and s in four incidents of s with three other resid to 9/21/01. INCIDENT 1 1. An interview with	XUALLY INAPPROP ified through nursing n staff interviews as bein exually inappropriate b lents during the period the facility's Director	ootes, ag involved behavior of 7/23/01	F 224			
	stated that resident 1 sometime during the stated that resident 1 on the Special Needs incident. She stated staff member entered found semen on the f 2. A review of reside on 9/27/01. The follows	2/26/01 at 9:00 AM. That an incident with remonth of July 2001. That and resident 2 were rost Unit (SNU) at the time that during this July included a residents 1 and 2 root face of one of the resident 1's medical record wowing entry was document.	esident 2 The DON commates e of the cident, a m and ents' face.				
	reported finding resident's [2] nationale resident's [2] national mouth after an apparencement. Unable to because of non-responsabled, evasive repliprobable incident to transfer of [resident 1] from room with all	CNA [certified nurse a dent [1] kneeling over a laked private area, wipinent inappropriate sexual determine extent of ironsiveness from victim, ies from resident [1]. In D.O.N. and SSW, who all to a different room all belongings and cautioniate behaviors and positions.	another ng his al ncident , and Reported authorized Transferred oned about				

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DEPARTMENT OF HEALTH AND HUMAL SERVICES HEALTH CARE FINANCING ADMINISTRATION

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		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WOLG		1 ' '	(X3) DATE SURVEY COMPLETED C	
		465086		B. WING		27/2001		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
SOUTH	OGDEN REHAB CENT	rer	5865 S WAS OGDEN, UT					
(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 CORE (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
F 224	Entry" dated 7/1/01. these late entries was 7/23/01 "late entry" the incident between 3. A telephone inter 10/01/01 at 2:45 PM the CNA referenced note. Employee 1 exresidents 1 and 2 diffinursing note entry. Employee 1 stated or shift, resident 2 walk leading from the SNI were open and that stated the nurse responsive aide assigned t station.	The nursing note entry 8/30/01. This would in 8/30/01. This would in was written at least 37 or residents 1 and 2 occur wiew was held with emptors. She stated she was a in resident 1's 7/23/01 aplained the incident beforently than was described that night, during a great toward the double of the was at the nurse's state on sible for the SNU and the SNU were also at	prior to ndicate the days after rred. cloyee 1 on CNA and nursing tween bed in the aveyard coors le doors ation. She d the other the nurse's	F 224				
	had "semen" on his f substance. She state She stated she escort resident 1 had remain nude and out of his b resident 1 and 2's roo Employee 1 stated sh	ne requested the nurse t	s a white s semen. m where it 1 was r to					
	resident 2's face. Shother nurse aide, refu aide 1 stated she then 4. An interview was at 4:50 PM. Employ	what she knew was seme e stated the nurse, as was ed to assess resident an went to clean resident held with employee 2 was the charge nure stated she was the nur	ell as the 2. Nurse t 2's face. on 10/1/01 rse the					

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documented the "Late Entry" nursing note, dated

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DEPARTMENT OF HEALTH AND HUMAL SERVICES HEALTH CARE FINANCING ADMINISTRATION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NU				E CONSTRUCTION	(X3) DATE S COMPLE			
		465086				09/2	7/2001	
	ROVIDER OR SUPPLIER OGDEN REHAB CENT	TER	5865 S WA	STREET ADDRESS, CITY, STATE, ZIP CODE 5865 S WASATCH DR OGDEN, UT 84403				
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F 224	had a substance on he "ejaculate". She state employee 1 also told the time. She said that she did room because "it was She indicated that she "preposterous" that rejaculate on his face, frequently had food a allow staff to clean. When asked if an income she stated she did not she stated she did not she stated she did not she stated to another room resident 2 on 7/23/01. The SSW stated that with resident 3 as a reliable to the same sexual advances. The facility's Admin SSW made these contresident 1 was placed identified by the SSW 6. On 10/01/01, the investigation of resident in the state of the same she with the same she with the same she with a same she with a same she with a same she with a same she with the same she with a same she wi	oyee 1 informed her that is face that she characted that she believed that her that resident 1 was not go down to resider a supposition; no definite felt that the it was esident 2 might have here. She indicated that resident report had been for the recall filling one out. The SSW stated resident following this incident resident 1 was moved from following this incident resident 3 because resident 3 because resident 3 because resident 3 because resident 3 download in the resident 3 for the word of the state	erized as at a nude at a nude at at and 2's at a nude at at a nude at at a nude at at a nude at a number at a nu	F 224				

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Event I IL2N11

Facility ID:

UT0015

If continuation sheet 8 o

DEPARTMENT OF HEALTH AND HUMAIL SERVICES HEALTH CARE FINANCING ADMINISTRATION

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	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		A. BUILDING B. WING	LE CONSTRUCTION	COMPLI	
	ROVIDER OR SUPPLIER	465086 TER		SATCH DR	STATE, ZIP CODE		
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F 224	"As reported on July by [employee 1]. Sh 2] came to the door were sharing the roo her to be semen on his room. At that tir wandering around the [resident 1]. She led her findings to [employee happened, he replied usual response from was questioned, he shed did have his pants an naked as stated prevaluated [Resident 1] was more because it was close CNAs could keep a as [resident 3] was kanyone approached. 7. On 9/27/01, the sunable to locate an involved the staff in incident report was admit diagnoses that inclusively and seize the following complexity. On 9/27/01, a review revealed the following warms and seize the staff of the set of the s	was sitting in the hall of their room (he and [rom) and he had what applies face. She took him has face and [resident 2] there and loyee 2]. The nurse felt gate and [employee 1] contained to have and [resident 2] has face and [resident 2]. When [rom has face h	I, [resident tesident 1] peared to peared to peared to peared to peared to peared to reported to it was not leaned him what me?' (a resident 1] sident 2] at 1] was room and the re. As well when rey were neident onts 1 and 2. ieved an 17/23/01 1/96 with thic brain all record	F 224			

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

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		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	MBER: A. BUILI		2) MULTIPLE CONSTRUCTION BUILDING		SURVEY ETED C		
		465086		B. WING		09/2	27/2001		
	ROVIDER OR SUPPLIER DGDEN REHAB CEN'	ГER	5865 S WA	STREET ADDRESS, CITY, STATE, ZIP CODE 5865 S WASATCH DR OGDEN, UT 84403					
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F 224	resident 2 had short and that his cognitive were severely impair having unclear speece mumbled words and understood. This assessment dated by the last assessment	dated 6/21/01, docume and long term memory e skills for daily decisioned. Resident 2 was asset which was slurred withat he was not always sessment further docume status had deteriorated	problems on making sessed as ith able to be mented that d since the ealed that incident ras no essed for dent. e section is attending ncident. a resident re was no essment after medical	F 224					
	(DON) was held on stated that resident is sometime at the end September, 2001. T	h the facility's Director 9/26/01 at 9:00 AM. To had an incident with roll of August or first part. The DON stated that resummates on the Special To the incident.	The DON resident 3 of sident 1 and						

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE EDVANCING ADMINISTRATION

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HEALII	H CARE FINANCING	ADMINISTRATION				· · · · · · · · · · · · · · · · · · ·	2567
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NAME OF P	ROVIDER OR SUPPLIER	403000	STREET ADI	DRESS, CITY, STA	TE ZIP CODE		2//2001
	OGDEN REHAB CENT	TER		ASATCH DR	AL, SA CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO ' DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 224	employee 3 had enter found both residents employee 3 observed residents' bedding an staff to have blood in 2. A review of reside on 9/27/01. The follother resident's nursing a. "9/7/01 @ 0840 A for 9/5/01 @ 1540 p [employee 3] came to [and] other peer resident [and] other peer resident [and] was wiping B. In penis - Peer roommat own bed with back to room - Resident [1] we [and] incident was resident was resident was resident [and] was wiping B. In penis - Peer roommat own bed with back to room - Resident [and] was resident [and] incident was resident was r	at the time of this incided residents' 1 and 3 rewith their pants off. Slatecal material on one of that resident 3 was of his underpants. The sent 1's medical record was been gentry was documentes: [8:40 AM] out of order [3:40 PM]. A staff material resident of this lent [resident 3]. Hous on nursing staff member in peer's [resident 3] side. (fecal matter) from the [resident 3] was lying door and facing outside who was standing was reported to another staff.	oom and he stated of the oserved by was done hented in er charting ember resident ekeeper because de of room he end of g on his le wall of edirected employee	F 224			
	service employee [an to a private room @ emonitoring." b. The following nur documented, "1400 [afor 9/5/01. Cont'd [coresident's [1] [increas	yees [3 and 4] went to d] DON - resident [1] wend of hall - with close sing note entry, dated 92:00 PM] out of order on tinued] - Concern [weed] sexual outbursts brity human services sociator behaviors."	0/7/01, charting ith] ought to				
		ry date 9/6/01 docume ending physician] calle					

HCFA-2567L ATC

ATG112000

Event I IL2N11

concern over [increased] sexual outburst - new order for depro provera [Depo Provera] 150 mg [milligrams]

Facility ID:

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	of CORRECTION IDENTIFICATION 465			B. WING	B. WING		C 27/2001
			STREET ADD	DRESS, CITY, ST.	ATE, ZIP CODE		27/2001
SOUTH (OGDEN REHAB CENT	ΓER		5865 S WASATCH DR OGDEN, UT 84403			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 224	IM [intramuscular] A possible]Depro procontinue to monitor be some the incident between report was dated 9/5/ "I [employee 3] was 3] room to deliver the 3] walking away from pants [and] [resident his bed cleaning his between the pants in his [resident 1] told [resident 1] told [resident 1] told [resident 1] can do what he wants the side of [resident 1] can do what he wants the side of [resident 1] that had bowel move [employee 4] and I to 3 documented the incident 1. 4. An interview with at 2:13 PM. Employ working as a nurse aid the laundry department of documented incident 1. At the time of the incresident 1 and 3's roof on the SNU, employed assisting other resident they were not in the 1.	ASAP [as soon as overa IM given as order opehavior." Deleted an incident repor residents 1 and 3. The	t regarding incident Ints 1 and [resident the side of of pants the side of pants th	F 224			

HCFA-2567L ATGI12000

Event I IL2N11

Facility ID:

UT0015

If continuation sheet 12 o

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		SURVEY ETED C			
		465086				09/	27/2001			
	ROVIDER OR SUPPLIER OGDEN REHAB CEN'	TER	5865 S W	STREET ADDRESS, CITY, STATE, ZIP CODE 5865 S WASATCH DR OGDEN, UT 84403						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(XS) COMPLETE DATE			
F 224	stated resident 1 was cleaning a pair of pa She stated she hung delivering and that we resident 1 stated, "Howith us too." She state he made the comment of the made the made the door, with the door of the made	ants and incontinence be standing by his bed, do nts and his bedding with up the clothes that she when she turned to leave ow about we ask her to nted resident 1 was laughter than the she was laughter to sh	was the treatment of the room next to mployee 3 what had one of her with t employee shoulders. the room to arsing and 3	F 224						
	Employee 3 stated that she had entered resident 1's room on several occasions to find him masturbating, but that she had never observed him in a sexually inappropriate situation with another resident. She stated that a few days prior to 9/5/01, resident 1 asked her to come into his room for a "secret kiss".									
	at 1:35 PM. Employ	held with employee 4 yee 4 stated she was a C ed if she was aware of	CNA.							

HCFA-2567L ATG112000 Event I IL2N11 Facility ID: UT0015 If continuation sheet 13 o

between resident 1 and 3 that occurred on 9/5/01.

DEPARTMENT OF HEALTH AND HUMAIN SERVICES HEALTH CARE FINANCING ADMINISTRATION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465086			(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	C 09/27/2001				
	ROVIDER OR SUPPLIER OGDEN REHAB CE		5865 S WA	DDRESS, CITY, STATE, ZIP CODE VASATCH DR , UT 84403					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIE CY MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
F 224	what occurred. Emoccurred was similar employee 3. There Employee 4 stated resident 1 and 3's reand was sitting on a Employee 4 stated her shift and that shale left to inform the had heard from and resident 3 was note the day. 6. An interview what 10:46 AM. Empthat she worked on Employee 5 indicarresident 1 and was him closely because behaviors. Employee 5 stated for the SNU each shall worked, she and the one of them remain monitor resident 1'. Employee 5 stated aides, assigned to the rooms providing and At those times, emunable to monitor resident 1'.	she was and proceeded to ployee 4's description of ar to the events described were a few notable except that when she and employee 5 and the incident occurred at the edid not see resident 1 are social worker. She state of the incident occurred at the social worker. She state of the management of the incident occurred at the social worker. She state of the management of the social worker is the state of the should be should	f what d by eptions. oyee 3 left the room the SNU. the end of or 3 after ated she er that ool, later in on 9/26/01 CNA and ility. with monitor opriate nurse aides er she l ensure that SNU to ooth nurse in resident DL) cares. uld be	F 224					
	nurse, was held on stated that she had	ith employee 10, a facility 9/27/01 at 2:00 PM. En never observed resident tate with another resident	nployee 10 1 being						

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Event I IL2N11 Facility ID:

cility ID: UT0015

If continuation sheet 14 o

DEPARTMENT OF HEALTH AND HUMA.. SERVICES HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 10/09/20 FORM APPROVE 2567

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	C (X3) DATE SURVEY COMPLETED C		
		465086		B. WING		09/	27/2001	
	ROVIDER OR SUPPLIER OGDEN REHAB CEN		5865 S WA	EET ADDRESS, CITY, STATE, ZIP CODE 5 S WASATCH DR DEN, UT 84403				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
F 224	stated she had receive between resident 1 anursing note to describe did document the inthe day of the incide 8. On 9/27/01, a reverse described social servence, dated 9/7/01 described and servence, dated 9/7/01 described and reside been changed and how as unable to contact 1], due to lack of a considered for remost described and inform behaviors continue and inform behaviors continue considered for remost facility. Dr [rest notified and has present 1] in an efficial propriate behaviors discussed in appropriate behaviors discussed in appropriate discussed in a social work programment discussed in a social work	ved report about an inci- and 3 and was asked to ribe the incident. She s cident, but that it was n ent. view of resident 1's med- ice progress notes. A p ocumented the followin] was notified on 9/5/01 iate sexual encounter be lent 1]. [Resident 1]'s r e no longer has a roome ct a family member for current phone number.] [county human server a for resident 1]. Case we esident 1]'s behaviors we him that if the inapprop [resident 1] may need to val to the [state owned ident 1's attending phys scribed a chemical restr fort to curb further sexual	write a stated she of done on dical record rogress ag: of a etween oom has mate. SW [resident However, vices social vorker has ith Pt priate of be psychiatric ician] was raint for fally diffed of the [names of ent 1] and the 1] closely " SSW on lent 1 was 1/5/01. She	F 224				

UT0015

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING B. WING O9/27/2001 NAME OF PROVIDER OR SUPPLIER (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING O9/27/2001								MAFFROVE
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C	HEALTH	H CARE FINANCING	ADMINISTRATION	•				2567
NAME OF PROVIDER OR SUPPLIER 465086 STREET ADDRESS, CITY, STATE, ZIP CODE 09/27/2001					A. BUILDING		, ,	ETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			465086		B. WING		09/:	
	NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SOUTH OGDEN REHAB CENTER 5865 S WASATCH DR OGDEN, UT 84403	SOUTH (OGDEN REHAB CENT	ГER					
PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	PREFIX	(EACH DEFICIENCY	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL			(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
F 224 Continued From Page 15 10. On 10/01/01, the DON faxed a copy of an investigation of [resident 1] to the State Survey Agency. The following information was documented in investigation report: "On September 5, 2001 it was reported by [employee 3] that as she was delivering clean clothing to [resident 3]'s room she saw [resident 3] walking away from [resident 1]'s bed, pulling up his pants. His pants were just below his stomach. [Employee 3] stated in an interview on October 1, 2001 that he 'probably' had a brief on and was pulling at his pants. [Resident 1] was standing up at the side of his own bed. [Resident 1] was standing up at the side of his own bed. [Resident 1] was completely clothed. [Resident 1] was cleaning the bedspread and a pair of pants that were laid out on the bed with a piece of toilet paper. Then he took the pants and hung them in the closet. As she was walking out of the room [resident 1] said to [resident 3], 'Hey how about we ask her to come sit with us?' Then [employee 4] asked [resident 1] what had happened. He said it's none of her business, he can do what he wants to [resident 3]. On the floor on the side of [resident 1]'s bed was a piece of toilet paper that had bowel movement on it. [Employee 4] and [employee 3] reported this to the social worker. The social worker also called [county human services social worker/case worker]. She told him about the report that had been received about [resident 1]'s behavior. She told him that Dr [resident 1's attending physician] had prescribed DepoProvera and asked him to talk to his supervisors about any suggestions on what to do with [resident 1]. [County human services social worker/case worker]'s response was that [resident 1]'s next stop was the State Hospital.	F 224	10. On 10/01/01, the investigation of [resident Agency. The following in investigation reports of the property	e DON faxed a copy of dent 1] to the State Suring information was dont: Oo1 it was reported by [livering clean clothing esident 3] walking away alling up his pants. His ch. [Employee 3] state of 1, 2001 that he 'probating at his pants. [Resident 6] was done of pants that were laid oilet paper. Then he to a fin the closet. As she was dent 1] said to [resident 6] what she sate from the come sit with us? I mployee 4] what she sate fresident 1] what had her business, he can do . On the floor on the sit is a piece of toilet pape it. [Employee 4] and [le social worker. Talso called [county huser/case worker]. She to had been received aboold him that Dr [resident 1] al worker/case worker].	employee to [resident y from pants were d in an ably' had a dent 1] was sident 1] cleaning the out on the ook the was walking at 3], 'Hey Then aw and appened. What he ide of a that had employee man old him ut [resident at 1's rovera and any . [County is response	F 224			

If continuation sheet 16 o ATG112000 Event I IL2N11 Facility ID: UT0015 HCFA-2567L

stated that [resident 1] was an opportunistic predator, however there is no written documentation in [resident

DEPARTMENT OF HEALTH AND HUM. SERVICES HEALTH CARE FINANCING ADMINISTRATION

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NAME OF PROVIDER OR SUPPLIER SOUTH OGDEN REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG F 224 Continued From Page 16 1]'s chart which indicates any such concern. [County human services social worker/case worker] was supposed to get back to the social worker, but never did" SUMMARY STATEMENT OF DEFICIENCIES (EACH DRECTION PROVIDER'S PLAN OF CORRECTION (AND PREFIX) (EACH CORRECTIVA ACTION SHOULD BE COMPLETE DATE TAG F 224 Continued From Page 16 1]'s chart which indicates any such concern. [County human services social worker/case worker] was supposed to get back to the social worker, but never did"		MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTII A. BUILDING	PLE CONSTRUCTION	(X3) DATE COMPL	ETED	
SOUTH OGDEN REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 224 Continued From Page 16 1]'s chart which indicates any such concern. [County human services social worker/case worker] was supposed to get back to the social worker, but never did" STREET ADDRESS, CITY, STATE, ZIP CODE 5865 S WASATCH DR OGDEN, UT 84403 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE) COMPLETE DATE F 224 F 224			465086		B. WING		09/	C 27/2001	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 224 Continued From Page 16 1]'s chart which indicates any such concern. [County human services social worker/case worker] was supposed to get back to the social worker, but never did" X5) PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)	NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST.	ATE, ZIP CODE		,	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 224 Continued From Page 16 1]'s chart which indicates any such concern. [County human services social worker/case worker] was supposed to get back to the social worker, but never did" F 224 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE TAG F 224 F 224 F 224	SOUTH	OGDEN REHAB CENT	ΓER						
1]'s chart which indicates any such concern. [County human services social worker/case worker] was supposed to get back to the social worker, but never did"	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIATE	COMPLETE	
11. Resident 3, the resident involved in incident 2, was admitted to the facility on 5/18/01 with diagnoses that included Alzheimer's disease, hypertension, and diabetes mellitus. On 9/27/01, a review of resident 3's medical record revealed the following: a. A MDS comprehensive resident assessment, dated 8/23/01, documented that resident 3 had short and long term memory problems and that his cognitive skills for daily decision making were moderately impaired. b. A review of the nurse's notes section revealed that there was no documentation of the 9/5/01 incident between resident 1 and resident 3. There was no documentation that resident 3 was assessed for any bleeding problems or injuries following the incident. c. A review of the physician's progress note section revealed no documentation that resident 3 had been seen by his attending physician since 8/28/01. d. A review of the social progress notes revealed a note, dated 9/5/01, that documented, "SW spoke on telephone [with][relative of resident 3], about a suspected incident of inappropriate sexual behavior between [resident 1 and resident 3]. Sw answered [relative of resident 1] as [resident 3]'s roommate. SW was notified by CNA and Laundry aide of this incident. A report was completed and faxed to APS [Adult Protective Services]. SW also spoke [with][county human services social worker/case	F 224	1]'s chart which indice human services social supposed to get back did" 11. Resident 3, the rewas admitted to the fit that included Alzhein diabetes mellitus. On 9/27/01, a review revealed the following a. A MDS comprehe 8/23/01, documented term memory probler daily decision making b. A review of the nuthere was no documented term memory problem and there was no documented term of the eding problems or c. A review of the phrevealed no documented term seen by his attending d. A review of the seen by his attending d. A review of the seen to the phrevealed no documented the phrevealed n	eates any such concern. It worker/case worker] to the social worker, be esident involved in incitacility on 5/18/01 with mer's disease, hypertens of resident 3's medical eg: ensive resident assessment that resident 3 had shown and that his cognitive gwere moderately important assessment to the social progress notes section reventation of the 9/5/01 in and resident 3. There was esident 3 was assessed injuries following the mysician's progress notes reventation that resident 3 had physician since 8/28/0 pocial progress notes reventation that resident 3 had social progress notes reventation that resident 3 had social progress notes reventation of resident 3. SW special progress notes reventation of resident 3. SW and all questions and notification and resident 3. SW and as completed and faxed exices. SW also spoke	was ut never ident 2, diagnoses sion, and I record ent, dated ort and long re skills for aired. ealed that acident as no for any incident. esection ad been 1. realed a poke on about a behavior swered d him of mmate. of this I to APS	F 224				

HCFA-2567L AT

ATG112000 Event I IL2N11

Facility ID:

UT0015

If continuation sheet 17 o

DEPARTMENT OF HEALTH AND HUM. SERVICES HEALTH CARE FINANCING ADMINISTRATION

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	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
		465086		B. WING		09/	27/2001	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE			
SOUTH (OGDEN REHAB CENT	TER		S S WASATCH DR DEN, UT 84403				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
F 224		1] regarding this incide	ent. DON	F 224				
	INCIDENTS 3 and 4							
	(DON) was held on 9	the facility's Director of 1/26/01 at 9:00 AM. The had an incident with re	ne DON					
	The DON stated that resident 1's room was located next to resident 4's room, on the SNU, at the time of the incident, and the residents have remained in the same rooms since the incident. She stated a staff member entered resident 4's room to find resident 1 standing, nude, next to resident 4's bed. Resident 4's pants and under pants were off as well. When the staff member entered the room, resident 1 ran out of the room and into his room.							
	on 9/27/01. The following the resident's nursing [employee 6] reports resident's rm [room] found one of the femal down around her ft [f	ent 1's medical record vowing entry was documnotes, "9/21/01 7A - 7 that pt was found in a [with] [no] pants on anale residents [with] her [eet] - pt. states to [empllo to his 'mother' - will ."	nented in P - CNA female d the CNA brief loyee 6]					
	PM] Dr [resident 1's ordered Depo-Prover	documented, "9/21/01 attending physician] no a 150 mg [times] 1 tomouth] [every four hour	otified He norrow.					
		se aide, completed an i					!	

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Event I IL2N11

Facility ID:

UT0015

If continuation sheet 18 o

DEPARTMENT OF HEALTH AND HUMA TERVICES HEALTH CARE FINANCING ADMINISTRATION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM					(X3) DATE SURVEY COMPLETED C		
		465086		B. WING		09/	27/2001
	ROVIDER OR SUPPLIER OGDEN REHAB CEN	TER	5865 S W	STREET ADDRESS, CITY, STATE, ZIP CODE 5865 S WASATCH DR OGDEN, UT 84403			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 224	documented: "When I got in the rowhich is [resident 4 anaked standing behinded. He said 'I just what name he mention checked [resident 5] with the cover on. [14] was sleeping. I diand went through the took me about 10 miround I came out and 4. Employee 6, a nureport for an incident This incident report charge nurse. The in 10:00 PM and docur [resident 4]'s room of completely naked and of her bed [with] her 5. A telephone internurse aide, on 10/3/stated she was worki incidents occurred by She stated that it was 10:00 PM shift. She building to empty the the SNU, employee (employee 8) that resident and naked. Employee 6 stated the	oom [resident 4 and 5's and 5]'s room, I saw [resident to say hi to' I von - and he ran out of the [resident 4], they just Resident 5] was awake, dn't notice any strange thall to check all the ren [minutes]. After finis	room] esident 1] esident 5]'s vas not sure ne room - I lay there [resident so I got out esidents, it shed the incident and 2. e 9, a d 9/20/01 at into esident 1] at the end s." ployee 6, a yee 6 nen two esident 4. 0 PM to the the urning to arge nurse e 4's room				
	1	oors to the SNU she st					

resident 1 ran out of resident 4's room and into his own!

DEPARTMENT OF HEALTH AND HUMA ERVICES HEALTH CARE FINANCING ADMINISTRATION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUM					(X3) DATE SURVEY COMPLETED C		
		465086	1504			09/2	7/2001
	ROVIDER OR SUPPLIER DGDEN REHAB CENT	TER		ORESS, CITY, STA ASATCH DR JT 84403			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 224	Employee 6 stated sh door to which was of the foot of her bed w She stated resident 4 of her bed. Employer resident 4 for signs on none, then pulled the resident into bed. Employee 6 stated sh and asked him what replied, "I went to sa 6 stated she then report that she was mincidents between resident 1 resident 4's room on She stated she was in about 10 minutes and documentation of the nursing notes or incited that employee 9 stated she complete an incident observed. She stated that employee 6 compreport was dated 9/2 the incident. Employing incidents in resident 8 had not done so.	the entered resident 4's report, to find resident 4 so the principal around he was holding onto the five 6 indicated that she at briefs up and assisted the then entered resident had happened, to which you hello to my mother." orted the incident to entered the incident to entered the incident to entered the incident to entered the incident of sidents 1 and 4. The principal around the incidents of the incidents and could find the signed the incident pleted. She stated the 0/01, because that was yee 9 stated she docum 1's nursing notes since	tanding at er ankles. Foot board assessed and found the at 1's room a resident 1 Employee 8. Ployee 9 on nurse, 7 the two served a served at 1 the fore. Accourred and no at before and no at the date of the employee 6 at report incident the date of the employee	F 224			
	±7 On 10/01/01, the	DON faxed a copy of	an				

Facility ID:

DEPARTMENT OF HEALTH AND HUMA TERVICES HEALTH CARE FINANCING ADMINISTRATION

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C			
		465086		B. WING		09/	27/2001		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	03,7	-,,2001		
SOUTH (OGDEN REHAB CENT	TER		S WASATCH DR EN, UT 84403					
(X4) ID PREFIX TAG			FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THIS DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE		
F 224	Agency. The following in investigation reports in investigation reports. The following in investigation reports. The following in investigation reports. The following and approximately arounds and and and and and and aresident 5]'s bed. He forms and and and are and are arounds and are arounds and arounds and arounds are also and arounds and arounds are arounds and arounds around and around and arounds around and around and around a foot of her bed with a	dent 1] to the State Surng information was dont: 001 a report was received 10 p.m. [employee 7] dent was away [resident ing behind the curtain research to her, 'I just warn to the room. She chant 4] and they were between with blankets. [sident 4] was asleep. Sind went out and told [e. [Employee 8] told [e. [resident 5 and resident of the room, she found and [resident 4] standinger brief around her and esident 4]'s brief to slip with edical record revealed the standinger of the room, she found and [resident 4]'s brief to slip with edical record revealed the standinger of the room and the sident 4]'s brief to slip with edical record revealed the standinger of the standin	red that at stated that of [resident 1] in there next to to say his tecked by the condition of the condition	F 224	DEFICIENCY				
	7/12/01, documented term memory problem	resident assessment, da that resident 4 had sho as and that her cognitive were severely impaire	rt and long e skills for						
	there was no document incident between resident	rse's note section reveal ntation found of the 9/2 dents 1 and 4. There was sident 4 had been assess	20/01 /as no						

any injuries or problems following the incident.

DEPARTMENT OF HEALTH AND HUM/ SERVICES

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HEALTH CARE FINANCING ADMINISTRATION 2567 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDING \mathbf{C} B. WING_ 465086 09/27/2001

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SOUTH OGDEN REHAB CENTER

5865 S WASATCH DR **OGDEN, UT 84403**

(Y4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
F 224	Continued From Page 21	F 224		
	c. A review of the physician's progress note section			
	revealed that resident 4 had not been seen by her			
	attending physician since 8/8/01.	i		
	d. A review of the social progress notes section	Í		
	revealed that there was no documentation of the			
	9/20/01 incident between residents 1 and 4.			
F 226 SS=K	483.13(C)(1)(i) STAFF TREATMENT OF RESIDENTS	F 226		
	The facility must develop and implement written	:		
	policies and procedures that prohibit mistreatment,			
	neglect, and abuse of residents and misappropriation			
	of resident property.			
	(Use F226 for deficiencies concerning the facility's			
	development and implementation of policies and procedures.)			
	This REQUIREMENT is not met as evidenced by:			
	Based on interview and record review, it was			
	determined the facility failed to operationalize and			
	fully implement policies and procedures when			
	allegations of sexual abuse involving residents 1, 2, 3, and 4 were made. The facility failure is as follows:			
	Facility staff failed to identify the incident			
	between residents 1 and 2, which occurred on 7/23/01,			
	and the incidents between residents 1 and 4, which occurred on 9/20/01, as potential sexual abuse;			
	2. Facility staff failed to fully investigate 4 instances			
	of alleged resident to resident sexual abuse which	,		
ĺ	occurred between 7/23/01 and 9/20/01;	· I		

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Event I IL2N11

Facility ID:

UT0015

DEPARTMENT OF HEALTH AND HUMA SERVICES

HEALTH CARE FINANCING ADMINIST. ΓΙΟΝ

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

A. BUILDING B. WING

C

09/27/2001

465086

STREET ADDRESS, CITY, STATE, ZIP CODE

SOUTH OGDEN REHAB CENTER

5865 S WASATCH DR OGDEN, UT 84403

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

PREFIX TAG

F 226

10/23/01

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETE DATE

F 226 - Continued From Page 22

- Facility staff failed to provide immediate protection to potential abuse victims while investigation into the allegations were underway in 3 instances of alleged resident to resident sexual abuse which occurred 7/23/01 and 9/20/01:
- Facility staff failed to assess potential abuse victims for possible injury in 3 instances of alleged resident to resident sexual abuse which occurred 7/23/01 and 9/20/01; and,
- The facility failed to notify the State Survey Agency, and Adult Protective Services or local law enforcement, immediately following the receipt of an allegations of resident to resident sexual abuse which occurred on 7/23/01 and 9/20/01.

On 7/23/01, the facility identified sexually inappropriate behavior involving residents 1 and resident 2. From that date, facility staff were put on notice of resident 1's potentially sexually abusive behaviors towards cognitively impaired residents. Three further instances occurred after 7/23/01. On 9/5/01, there was 1 incident of sexually inappropriate behavior involving resident 1 and resident 3. On 9/20/01, there were 2 incidents of sexually inappropriate behavior involving resident 1 and resident 4. (In all incidents, there were no direct observations of the interactions between the residents.)

The facility's failure to implement policies and procedures to identify potential resident to resident sexual abuse, to fully investigate these allegations of abuse, to provide protection to residents from further risk of abuse, and to report these allegations of abuse to appropriate authorities, led to a determination of Immediate Jeopardy to residents. The facility removed the Immediate Jeopardy by discharging

F226

Inservices have been held the day after the surveyors' exit and on a weekly basis until all employees have attended exit concerning abuse: what it is; when to report it; who to report it to; what to do after reporting it: and then what happens after those reports are made. All employees of the facility have been in attendance to at least one of these inservices including employees 1 through 10. Each new employee, as they are oriented to the facility are inservices as well.

The staff was also inservices on what to do immediately if a suspected abuse has been reported. Late entries were acceptable, but that entries made into the nurses' notes at the time the incident occurred are the best form of reporting. Those notes on the incident report and in the nurses' notes are to include only factual findings and no speculation or guesses. The charge nurse is required to go to the room of the resident and do a thorough exam of the situation including those involved so as to make an accurate report and be able to take appropriate corrections of the situation.

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If continuation sheet 23 o

DEPARTMENT OF HEALTH AND HUMANISERVICES HEALTH CARE FINANCING ADMINIST. ION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER. IDENTIFICATION NUM					(X3) DATE SURVEY COMPLETED C		
		465086				09/2	7/2001
	ROVIDER OR SUPPLIER OGDEN REHAB CEN'	TER	l	ASATCH DR	FATE, ZIP CODE		·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
F 226	(During the survey in were found who pose to residents.) Findings include: Between 7/23/01 and resident 1 on four oc residents to be involved potential to be sexual. Tag F-224.) 1. A telephone interval of 10/1/01 at 2:45 PM. 7/23/01, she observed Special Needs Unit (She stated that when room, his roommate, 1 stated she left reside and went to the nursing the charge nurse (employee 1 stated she the residents' room to on resident 2's face. assess resident 2. Employee 1 stated the other nursing station where the nursing station where the nursing station where the charge nurse on 7 occurred between residents.	e psychiatric setting on hvestigation, no other red a physical or emotion of a physical or employee a p	observed orent at had a Refer to was held on to on way of the is face. to his Employee resident 1 incident to come to was semen refused to ident there was 2 on duty. e 2 were at ed.	F 226	The monitoring that occibasis has continued with making observations ever resident that is on any permedications and/or have are abnormal and need to lift the situation merits, the designates a CNA or other monitor specific resident one basis to ensure the saresidents. All incident restracked for potential abust through the SSW. All incare also being noted in the These reports are being resafety Committee Chairn SSW. The facility has fur implemented those parts and procedures that hadner followed closely concerns. These would include report within one working day of occurrence, and letting the agencies know of the resider both the alleged perpetrate victim are being made. The Administrator has been the need to notify the approagencies in the absence of the SSW.	the CNA's ery shift on each sychotropic behaviors that o be monitored. The charge nurse er individuals to so on a one to afety of all the sports are being se and routed cident reports e nurses' notes outed by the man to the rither of the policies of the eappropriate of the eappropriate of the its involved, or and the en informed of copriate state	

DEPARTMENT OF HEALTH AND HUMANISERVICES HEALTH CARE FINANCING ADMINIST. ITION

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NU		(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION	COMPLET	(X3) DATE SURVEY COMPLETED C	
		465086	company . Da			09/27	//2001	
	ROVIDER OR SUPPLIER OGDEN REHAB CEN'	ΓER	[ASATCH DR	TATE, ZIP CODE			
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F 226	employee 1 also info at the time. Employee 2 stated shand 2's room because proof". Employee 2 that resident 2 might Employee 2 stated thincident report for thinot document the increcord. She stated shisometime after the odlate entry for the inci 8/30/01.) 3. A telephone interior on 10/3/01 at 8:30 Alworking with employ incidents occurred be Employee 6 stated thinot their 2:00 PM to 1 she had left the build while returning to the the charge nurse (empresident 4's room and Employee 6 stated the SNU, as she thought As she entered the doresident 1 ran out of room. Resident 1 was Employee 6 stated she door to which was opthe foot of her bed with the state of the	culate". She stated she remed her that resident her did not go down to re "it was supposition; in stated that it was "prephave had ejaculate on hat she did not complete incident. She also strident in resident 1's more made a late entry nuccurrence. (Per record dent occurred sometime wiew was held with emmade and employee 8 verween resident 1 and res	esident 1 to definite posterous" his face. e an ated she did edical rsing note review, the te after ployee 6, she was when two esident 4. d at the end ated that ge and s informing 1 was in at onto the ccurred. ated nto his own oom, the tanding at er ankles. toot board	F 226	There is training on the treatment of those residents training will include potentially abusive situated manage those residents sexually abusive. This come on one staffing for this suspected of being abusive. There have been request county human services those notes made by the services social worker wany of our residents so the informed as they on the abusive residents before occur. Any suspected abuse that reported to the facility why interviews of the empthe report as well as potentially are able. Actual queused in the reports and the entered, as assumptions and documented.	ents on the SNU le what to do in ations and how to who may be would include the resident who usive in any es made to the to have access to county human who works with that we can be as potentially situations that been allowed alloyee making ential witnesses, interviewed if otes will be the facts wil		
CFA-2567L		ATG112000 Event I	IL2N11	Facility ID:	UT0015	If continuatio	n sheet 25 o	

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	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C	
		465086				09/27	//2001
NAME OF PROVIDER OR SUPPLIER SOUTH OGDEN REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 5865 S WASATCH DR OGDEN, UT 84403							
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
F 226	resident 4 for signs o none, then pulled the resident into bed. En incident to employee Employee 6 stated th facility since May 20 specific training on h behaviors. 4. A telephone interval 10/3/01 at 9:00 AM. stated that she was not incidents between resigned found, nude, in residnight before. She stated incidents occurred at Employee 9 stated shat the incidents and cour incident reports. She to complete an incident observed. Employee incident report was defined the date of the incident documented the incident report was defined at the incident report was defined at the date of the incident report was defined at the incident report was defined at the date of the incident report was defined at the date of the incident report was defined at the incident report.	the 6 indicated that she as a formusing or redness are briefs up and assisted apployee 6 stated she replay to 1, and that she had remove to monitor resident wiew was held with emptower of working the night of sidents 1 and 4. She stated are port that resident 1 lent 4's room on two octed she was informed the cout 10 minutes apart. The lend of the cout 10 minutes apart what ere of stated she instructed event report about what ere 9 stated she signed the 6 completed. She stated ated 9/20/01, because the temployee 9 stated lents in resident 1's nursident 1's	and found the ported the ported the ported the red at the ceived no 1's ployee 9 on nurse, the two ated that on 1 had been casions the he ation of s or mployee 6 mployee 6 mincident ed the hat was she sing notes ployee 10 1 being about an sked to	F 226	During the investigation the their family will be free of fereprisal from the accused. It is important to note that an with employee 5 was held in informed the DON and the Stresident 1 has never been see an erection. He may have be masturbating, but no erection Administrator will monitor at QA meeting to ensure Plan of Correction are followed. Completion Date: October 10	interview which she SW that n to have en was noted.	

Event I IL2N11

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE : COMPL	
			IDEIX.	A. BUILDIN	G		C
		465086		B. WING		00/	27/2001
NAME OF P	ROVIDER OR SUPPLIER	10000	STREET ADI	 DRESS, CITY, ST	ATE, ZIP CODE		27/2001
SOUTH (OGDEN REHAB CENT	ГЕК		ASATCH DR			
Or A. FD							· · · · · · · · · · · · · · · · · · ·
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F 226	stated she did docum not done on the day of 6. An interview was SSW on 9/27/01 at 1. When asked about la occurred following ir DON stated the licenneeded to also docum notes, believing that it documentation neede became aware of the she frequently came a no corroborating nurs. The SSW stated that report for the inciden 2 that occurred on 7/2 was still trying to get who observed the incidents 1 at 7. An interview was interdisciplinary teams The IDT consisted of recreation therapist (Taspervisor (FSS)). a. The SSW stated the resident 1 had sexuall other residents prior to residents 1 and 2. The stated that resident 1's behaviors were generated of the stated that resident 1 had sexuall other residents 1 and 2. The stated that resident 1's behaviors were generated of the stated that resident 1 had sexuall other residents 1 and 2. The stated that resident 1's behaviors were generated of the stated that resident 1's behaviors were generated of the stated that resident 1's behaviors were generated of the stated that resident 1's behaviors were generated of the stated that resident 1's behaviors were generated of the stated that resident 1's behaviors were generated of the stated that resident 1's behaviors were generated of the stated that resident 1's behaviors were generated of the stated that resident 1's behaviors were generated of the stated that resident 1's behaviors were generated of the stated that resident 1's behaviors were generated the stated that resident 1's behaviors were	the incident, but the of the incident. held with the facility's 0:45 AM. te entry documentation incidents involving residents involving residents incidents in the the incident reports were did. The DON stated the incident reports as incident reports from the inciden	that lent 1, the w they e nursing re the only at she because and found ncident d resident that she m the staff 20/01 230 PM. beutic rice re that ors toward involving IDT e plicit	F 226			
		e comment that the inci- nd the other residents v					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	MBER:	(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE : COMPL	eted C
	ROVIDER OR SUPPLIER DGDEN REHAB CEN	465086 WTER	STREET ADI	PRESS, CITY, STA ASATCH DR JT 84403	TE, ZIP CODE		27/2001
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCI CY MUST BE PRECEEDED BY LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
	fresident 1]". She s facility so long and behaviors toward st unusual. c. The DON and St discuss resident 1's after the incident widthe IDT met to discust 1's behaviors. She stated that the county human serving She stated that the cresident 1 was an open of the IDT met to discust 1's behaviors. The DON stated administer Depo Prosexual behaviors. The DON was as place to prevent fur other residents until The DON stated she monitor him closely g. The SSW also stated staff to watch in the IDON and Staff were enabled to the resident 1 and contitute to other residents. In o increase in staffin	lered abuse because, "It tated that he had been in had sexually inappropriated for so long that it discovered the IDT did is behaviors to other resident 3 on 9/5/01 that following the 9/5/0 uses possible solutions to stated she contacted resident as worker/case worker told her that apportunistic predator. That an order was obtain over a to resident 1 to do the DON stated that she is possibly up to a week would have any effect or ked what interventions ther incidents with resident medication began to directed the nurse aid of the directed the nurse aid of the directed that she directed the sident 1 very closely, attend to the directed the sident 1 very closely,	in the riate d not seem not meet to dents until Of incident, or resident rident 1's worker. It he felt to ecrease his exhaust to roso before a resident 1. were put in dent 1 and to work. The estaff to the nurse to not let to not let the nurse ring of essary cares V stated that re made to	F 226			

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Event I IL2N11

Facility ID:

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If continuation sheet 28 o

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINIST ITON

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPLI			
	465086			B. WING C				
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	FATE, ZIP CODE		7/2001	
SOUTH (OGDEN REHAB CENT	ΓER	5865 S WA OGDEN, U	ASATCH DR UT 84403				
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
TAG	i. The SSW and DOO of residents 1, 2, 3, 4 found the residents in The DON and SSW sassessments that the residents. j. The SSW stated the Adult Protective Services, volume to the State Protective Services, volume to the T/23/01, or either of the and 4 on 9/20/01. She was called to the State Protective Services, volume to the T/23/01 sexually in the resident 1 which occur assessments of reside staff investigated a poincident.	N were asked if any ass, or 5 were done when a potentially abusive stated they were unawarursing staff may have conduct any assessment at the State Survey Agrices were not contacted twith residents 1 and 2 the two incidents with restated the only incide e Survey Agency and Awas the incident between at 2 was the resident idea to 9/5/01.	ressments staff situation. re of any done, and so of the ency and decomposition of the ency and decomposition of residents 1 and the ency and evere no dicated ive ency and the		CROSS-REFERENCED TO TI	HE APPROPRIATE		
j	resident 2's room, how	wever there was no other	er					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINIST. ION

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	OF CORRECTION	IDENTIFICATION NUM		A. BUILDING	LE CONSTRUCTION	COMPL	ETED
		465086		B. WING		09/	C 27/2001
	ROVIDER OR SUPPLIER DGDEN REHAB CENT	TER		DRESS, CITY, STA ASATCH DR UT 84403	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 226	9. A review of reside on 9/27/01. (Resident the two 9/20/01 sexual resident 1.) Resident 4's medical documentation of the resident 1 which occur assessments of reside staff investigated the sincidents. There was no docume record that would indicate the resident while contincidents. 10. A review of resident on 9/27/01. (Resident 9/5/01 sexually in 1.) Resident 3's medical progress note, dated 9 the resident's son, Ad county human service notified of the incident occurred on 9/5/01. There were no assessificated staff in abusive incident. 11. A review of resident on 9/27/01. Facility nursing staff.	ent 4's medical record wat 4 was the resident ideally inappropriate behavior of the following properties of the following properties of the following properties of the following investigations of the following investigations of the following investigations of the following investigations of the following investigation of the following investigated a potential of the following investigated in the f	and e were no dicated abusive medical otection to into these was done entified in of resident ial service ted that , and a rorker were and 3 that t would y sexually was done	F 226			
	medical record.	busive incidents in resi	uciit 1 \$				1

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AND PLAN	OF CORRECTION	IDENTIFICATION NUM		A. BUILDING	LE CONSTRUCTION	COMPL	
				B. WING			C
		465086		D: WING		09/	27/2001
	ROVIDER OR SUPPLIER OGDEN REHAB CENT	ren		DRESS, CITY, STA ASATCH DR	TE, ZIP CODE		
5001H	JGDEN REHAB CENT	LK	OGDEN, U	JT 84403			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO ' DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 226	Continued From Page 3	60		F 226			
	residents 1 and 2, was 8/30/01. (The incider note, differed from the of the staff who observed between the incident which residents 1 and 3, was the nursing note that written by a nurse that written by a nurse that c. The two incidents involving residents 1 immediately. The incidents 1 immediately. The incidents 1 immediately. The incidents 1 immediately incidents 1 immediately. The facility's Diracopy of the facility's Residents" on 9/27/01 following direction to	th occurred on 9/5/01, is not documented until was documented on 9/2 t did not observed the which occurred on 9/2 and 4, were not documented to the end of	after nursing interviews nvolving 9/7/01. (7/01, was incident. 0/01, nented ed on not 1) provided or d the				
	Education For All Fac	Employees and Continuciality Employees	ung				
	hire to this facility, tra Developer regarding recognize possible ab abuse by co-workers of family-to-patient abuse	oyee's general orientation ining will be given by the types of abuse, how use, how to report susp or patient-to-patient, or se, and how to protect to	the Staff to pected the				
	residents in this facilitaten against them'	ty from possible abusiv	e actions				
	b. "When Should A	abuse Be Reported?					
		nust be reported to the the incident is noted.		;			

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	OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	MBER:	A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE COMPL	ETED C
NAME OF B	DOWNER OF CURPLIER	465086		DRESS CITY STA	TE ZIR CODE	09/.	27/2001
	ROVIDER OR SUPPLIER OGDEN REHAB CEN	TTER		DRESS, CITY, STA ASATCH DR UT 84403	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCII Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORM.	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 226	resident and they do held accountable for general orientation, instructed to report immediately to their	me form of abuse towa o not report it—they will t their actions. At the t all new employees will any type of abuse noted	l also be ime of l be l	F 226			
	All employees within supervisor when the has a Dept. Head with that particular depart Dept. Head is not or designated to be the person is generally to Supervisor. When a by an employee, the their Depart. Head of	n this facility have an ity are on shift. Each denote is the general supervitment. During the time of duty, a staff member it responsible supervisor the charge nurse or the case of suspected abusy must immediately report the nursing supervisor the nursing supervisor.	mmediate partment risor over e when a is This Nursing se is noted port it to				
	their supervisor, the writing what they sa facility investigation	has reported the suspecty will be requested to pow and/or heard as part a." gencies Must Be Notif	out on of the				
	Suspected Abuse?" All allegations of su within the facility, b State Health Departs investigation must b allegation has been in be complete when the has been notified, he must be shared as so may be made by the	spected abuse must be ut must also be called i ment survey division. Tegin immediately once made. The investigation to DOH [Department of the poor as possible. The not facility Social Worker irector of Nursing or fa	investigated in to the The the in may not if Health] indings of their in or their in				

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ATG112000

Event I IL2N11

Facility ID:

UT0015

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINIST ITON

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NAME OF PROVIDER OR SUPPLIER SOUTH OGDEN REHAB CENTER SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 226 Continued From Page 32 Administrator. This call needs to be made within one working day from receiving the allegation. Other agencies that must also be notified are the area Ombudsman, Adult Protective Services, and the local police if the suspected abuse results in actual physical harm" e. "How Should The Suspected Abuse Be Investigated Within The Facility? Once the suspected abuse has been reported to the immediate supervisor, the facility Director of Nursing, facility Social Worker, and the facility Director of Nursing, facility Social Worker, and the facility provides. The patient must also be interviewed and their		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S COMPLI	ETED
NAME OF PROVIDER OR SUPPLIER SOUTH OGDEN REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES: SUMMARY STATEMENT OF DEFICIENCIES: REGULATORY OR LSC IDENTIFYING INFORMATION) F 226 Continued From Page 32 Administrator. This call needs to be made within one working day from receiving the allegation. Other agencies that must also be notified are the area Ombudsman, Adult Protective Services, and the local police if the suspected abuse results in actual physical harm" e. "How Should The Suspected Abuse Be Investigated Within The Facility? Once the suspected abuse has been reported to the immediate supervisor, the facility Director of Nursing, facility Social Worker, and the facility Administrator must be notified. The employee placing the report must be interviewed and their response written down on the abuse form that the facility provides. The patient must also be interviewed and their			465086		1		00/	C 27/2001
SOUTH OGDEN REHAB CENTER S865 S WASATCH DR OGDEN, UT 84403	NAME OF D	DOVIDED OD CURRIUED	403000	STREET ADD	DESC CITY STA	TE ZIB CODE	<u> </u>	2//2001
CX4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 226 Continued From Page 32 Administrator. This call needs to be made within one working day from receiving the allegation. Other agencies that must also be notified are the area Ombudsman, Adult Protective Services, and the local police if the suspected abuse results in actual physical harm" e. "How Should The Suspected Abuse Be Investigated Within The Facility? Once the suspected abuse has been reported to the immediate supervisor, the facility Director of Nursing, facility Social Worker, and the facility Administrator must be interviewed and their response written down on the abuse form that the facility provides. The patient must also be interviewed and their	NAME OF P.	ROVIDER OR SUPPLIER				TE, ZIF CODE		
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response documented as well. Any bruising or unexplained injury must be noted and documented. If there were any witnesses to the suspected abuse incident, such as a roommate or another employee, they will be interviewed and responses documented. Document actual quotes from the patient and the witnesses regarding the incident. Do not document your own assumptions, only actual facts. Documentation in the patient record must be factual as to the incident and descriptive as to any injuries or bruising. Patient quotes may also be documented" f. "Protection Of The Alleged Abuse Patient During The Investigation During the investigation, the patient and their family must be free of fear of reprisal from the accused. The accused will not be allowed to visit or discuss the abuse charges with the resident unless the patient and	F 226	Administrator. This working day from recomplishing day from the within The Facility? Once the suspected a immediate supervisor facility Social Worker must be notified. The must be interviewed a continuity on the abuse form that the patient must also response documented unexplained injury must there were any witness incident, such as a root they will be interviewed bocument actual quo witnesses regarding theyour own assumption Documentation in the tothe incident and debruising. Patient quo f. "Protection Of The Investigation During the investigation day from the day of the patient quo accused will not be all the day of the patient quo for the investigation days and the patient quo for the investigation days are the patient quo for the patient q	call needs to be made veriving the allegation. Thust also be notified are protective Services, and discussed abuse results in actual suspected Abuse Be In the facility Director of the facility Director of the facility Director of the facility Provides. The employee placing the facility provides as well. Any bruising the facility provides as well. Any bruising the fact and the facility provides as to the suspected about the facility provides from the patient and the incident. Do not does, only actual facts. The patient record must be scriptive as to any injustes may also be document. The patient and their freprisal from the acculous the Alleged Abuse Patient on, the patient and their freprisal from the acculowed to visit or discussion, the patient and their freprisal from the acculowed to visit or discussion.	the area the local liphysical nivestigated to the f Nursing, inistrator report en down eir or nented. If use ployee, mented. I the cument factual as ries or ented"	F 226			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINIST FION

PRINTED: 10/09/20 FORM APPROVE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDR		(X3) DATE SURVEY COMPLETED C		
		465086		B. WING			27/2001
NAME OF P	ROVIDER OR SUPPLIER				TATE, ZIP CODE		
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