STATEMENT OF CORRECTION  AND PLAN OF COMPLAIN  STREET ADDRESS. CITY. STATE. 2P CODE  NUMBER. HENDOLLE GOOD  COMPLAIN  STREET ADDRESS. CITY. STATE. 2P CODE  NUMBER. HENDOLLE GOOD  COMPLAIN  AND PROVIDER PLAN OF CORRECTION  AND PROVIDER PLAN OF CORRECTION  AND PROPERLY THE CONSTRUCTION  REGISTATORY OR LSC IDENTIFYING INFORMATION  FREITY  TAG  PROVIDER PLAN OF CORRECTION  REGISTATORY OR LSC IDENTIFYING INFORMATION  FREITY  A \$3.10(b)(11) NOTIFICATION OF RIGHTS AND  SERVICES  A facility must immediately inform the resident: consult with the resident's physician; and if known, notify the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physician in the resident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physician in the resident involving the resident which results in injury and has the potential for requiring physician in intervention; a significant change in the resident significantly (i.e., a deterioration in health, menual, or psychosocial status in either life  threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of residents undersected family member when there is a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or incommete an endication and the paragraph (b)(1) of this section.  The facility must also promptly motify the resident and i	CENTER	RS FOR MEDICARE &	& MEDICAID SERVI	CES			2567-I
SOUTH OGDEN REHAB CENTER  SOUTH OGDEN REHAB CENTER  SOUTH WASATCH DRIVE  REGULATORY OR ISC EDENTIFYING INFORMATION)  F 157  483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES  A facility must immediately inform the resident: consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is a change in room or roommate assignment as specified in s483.12(a).  The facility must also promptly notify the resident rights and resident's physician, room or roommate assignment as specified in s483.12(a).  The facility must also promptly notify the resident rights under Federal or State law or regulations as specified in paragraph (b(1) of this section.)  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member when there is a change in resident rights under Federal or State law or regulations as specified in paragraph (b(1) of this section.)  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to immediately notify the family of one resident, when a medication error had occurred. (resident 1)			IDENTIFICATION NUM		A. BUILDIN		COMPLETED
SOUTH OGDEN REHAB CENTER  See SOUTH WASATCH DRIVE  OGDEN, UT 84403  PREFIX  GRACH DEPRICIENCY MUST BE PRECEDED BY PIUL.  FREETY  TAG  REGULATORY OR ISC IDENTIFYING INFORMATION)  FIST  483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES  A facility must immediately inform the resident; consult with the residents physician; and if known, notify the resident sphysician; and if known, notify the resident sphysician intervention; a significant change in the resident involving the resident involving the resident involving the resident increased family member when there is an accident involving the resident (i.e., a deterroint in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment) for a decision to transfer or discharge the resident from the facility as specified in s483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(a)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.  This REQUIREMENT is not met as evidenced by:  Based on record review and interview, it was determined that the facility failed to immediately noutly the family of one resident, when a medication error had occurred. (resident 1)			465086	CERTIFIE : D.D.			1/26/2004
PREFIX TAG REACH DEFICIENCY MIST BE PRECEDED BY FULL TAG REGULATORY OR ISC IDENTIFYING INFORMATION)  F 157 483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES  A facility must immediately inform the resident; consult with the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status (i.e., a deterioration); a need to alter treatment significants or clinical complications); a need to alter treatment significants or discharge the resident (i.e. a visition of treatment); or a decision to transfer or discharge the resident (i.e. a need to alter treatment significants or discharge the resident (i.e. a fast) (i.e. a need to discontinue an existing form of treatment); or a decision to transfer or discharge the resident (i.e. a need to discontinue an existing form of treatment); or a decision to transfer or discharge the resident (i.e. a need to discontinue and treatment); or a change in resident is under the resid			rer	5865 SOUT	H WASATO	N!! M. (京 ) (1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/	0001691)
A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.15(e). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.  This REQUIREMENT is not met as evidenced by:  Based on record review and interview, it was determined that the facility failed to immediately notify the family of one resident, when a medication error had occurred. (resident 1)	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI	SHOULD BE COMPLETE
5/26/09		A facility must imme consult with the resident's linterested family mer involving the resident the potential for requisignificant change in psychosocial status (imental, or psychosocial status (imental, or psychosocial status) threatening condition need to alter treatment discontinue an existing adverse consequences treatment); or a decision resident from the facility must also and, if known, the resinterested family men room or roommate as \$483.15(e)(2); or a chief Federal or State law of paragraph (b)(1) of the facility must reconsidered and phone not representative or interested family of or the family of or error had occurred. (in the family of or error had occurred.)	diately inform the resident's physician; and if legal representative or an at which results in injury iring physician interver the resident's physical, .e., a deterioration in heial status in either life sor clinical complication it significantly (i.e., a neg form of treatment does, or to commence a negion to transfer or dischility as specified in s485 promptly notify the resident's legal representant ber when there is a chasignment as specified in ange in resident rights or regulations as specified in section.  For and periodically upon the resident's rested family member.  The is not met as evidence we and interview, it was cility failed to immediance resident, when a mediance resident, when a mediance resident, when a mediance in the resident, when a mediance resident resident resident, when a mediance resident resident resident resident resident resident resident resident resident, when a mediance resident	lent; known, an accident y and has ation; a mental, or ealth, ons); a eed to ae to ew form of arge the 3.12(a). sident tive or ange in n under ed in date the legal	FISO CONTROLLY TO JOHN DOWN PLY	Jamilies, physicisms and administration emonas a substant in the D.O.N will in nursing staff on proceeding such income for detection of such can be enhanced a four way check residents name, the Telephone order, pto any incidents will to accordingly and a daily (5 x weekly D.O.N. and admis all such incident logged and neviewed togged	ident, scen. liciary cident, service proper ting and idente. errors ky using re label, resident reviewed by the instrator to are ed at for further

Any deficiency statement ending with an arterisk (\*) 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. Patients of the patients of the patients. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

UT0015 FEB 1 7 2004 1

If continuation sheet 1 of 30

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPP IDENTIFICATION			A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPLE	
		465086		B. WING _			6/2004
	ROVIDER OR SUPPLIER  OGDEN REHAB CENT	TER		TH WASAT	TATE, ZIP CODE CH <b>DRIVE</b>		
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 157	to the facility on 4/15 artery disease, demer A review of the pharm reporting form dated medication error had facility's pharmacy m Zyprexa 10 mg (milli have been labeled for The facility's consulti on 1/29/04 at 8:00 Al facility contacted him order for Zyprexa was upply was sent to the medication Zyprexa sensident 2 but had been the input technician with the medication, labeled wrong resident name, the following on the incident was discusse assurance) meeting of including [Facility phistated that he thought the patient was fine a The facility's Director interviewed on 1/24/0 medication error occupharmacy mislabeled pills, with resident 1' physician's order for Zyprexa 10 mg in erromedication. The DOI are the patient was fine a the patient of the policy of the physician's order for Zyprexa 10 mg in erromedication. The DOI are the patient was fine at the pati	year old female who was 5/03 with diagnoses of contia, hypertension and in macy's medication incide 1/22/04 documented the occurred with resident itstakenly processed an agrams) for resident 1 the	coronary nsomnia.  Ident at a 1. The order of nat should rviewed ted that the 15/03. The a 30 day he ad for at 1's name. In our end, labeled with the numented with the numented stopped."  Is eded and stopped."  s ed that a ay 10 mg not have a ed whow	F 157			

### DEPARTMENT OF HEALTH AND HUM/ SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

CLITTLE	COT OK MILDICANCE	& MEDICIND BEK 11	<u> </u>				2307-L
AND PLAN OF CORRECTION IDENTIFICATION N		(XI) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULT. A. BUILDIN B. WING		(X3) DATE SURVEY COMPLETED C 1/26/2004	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S'	TATE, ZIP CODE		
	OGDEN REHAB CENT	ГЕК	5865 SOU OGDEN, U	ГН WASAT ЈТ 84403	CH DRIVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
F 157	stated the error could shift nurses had been against the medicatio DON stated that it wa 12/15/03 when employed had found the error. It is thought the Zypre negatively effected renot to any great exter and falling." The sur Fall Prevention progrestated, "It's a work in Employee 1, a license interviewed on 1/22/0 stated that she remem resident 1, but she was error had occurred.  Employee 2, a license interviewed on 1/22/0 stated that she was ad resident 1, and notice card for Zyprexa, and not on the medication to the resident's mediorder, and realized the Employee 2 stated that many pills had been a error.  On 1/22/04, a review summary of resident 1's son we shall shall be and the resident 1's son we summary of resident that resident 1's son we shall shall be a summary of resident that resident 1's son we shall shall be a summary of resident that resident 1's son we shall shall be a summary of resident that resident 1's son we shall shall be a summary of resident that resident 1's son we shall shall be a summary of resident that resident 1's son we shall shall be a summary of resident that resident 1's son we shall shall be a summary of resident that resident 1's son we shall shall be a summary of resident that resident 1's son we shall shall be a summary of resident that resident 1's son we shall shall be a summary of resident that resident 1's son we shall shall be a summary of resident that resident 1's son we shall shall be a summary of resident that resident 1's son we shall shall be a summary of resident that resident 1's son we shall shall be a summary of resident that resident 1's son we shall shall be a summary of resident that resident 1's son we shall shall be a summary of resident that resident 1's son we shall shall be a summary of resident that resident 1's son we shall shal	wasn't sure. The DON have been prevented in checking the physiciar on administration record as brought to her attent oyee 2, a licensed pract. The surveyor asked the exa medication error have been asked in the process of the facility of t	f the night his orders d. The ion on ical nurse DON if id ited, "No, d falling, ity had a the DON  oyee 1 Cyprexa to ication lent was then went ck the d. er how t 1, in lischarge s revealed sible party	F 157			
	and resident 1's grand marked as the emerge	dson and granddaughter ency contacts.	r were				

AND PLAN OF CORRECTION IDENTIFICATION NU		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULT. A. BUILDIN B. WING	IPLE CONSTRUCTION	1	
NAME OF P	ROVIDER OR SUPPLIER	405000	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE	1/20	12004
	OGDEN REHAB CEN	rer	5865 SOU OGDEN, U	TH WASAT UT 84403	CH DRIVE		
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
F 157	contacted and on 2/3 was interviewed. Dur interested family men notified of the drug e  A record review of th for medication errors that when a medicati- individuals must be r	I's son and grandson w /04, resident I's grandd ring their interviews, ea mber stated that they we	laughter uch ere not  procedures It revealed pertinent sician,	F 157			
F 309 SS=G	provide the necessary maintain the highest psychosocial well-be comprehensive asses  Use F309 for quality by s483.25(a)-(m).  This REQUIREMEN Based on interviews determined that the finecessary services to practicable physical, well-being of a reside between 12/5/03 and error, Zyprexa 10 mg	eceive and the facility my care and services to an practicable physical, ming, in accordance with sment and plan of care.  Of care deficiencies no accordance with sment and plan of care are deficiencies and record review it was acility did not provide to attain or maintain the homental and psychosocient. (resident 1) Specifi 12/15/03, resident 1 reg. Following 12/5/03, regased. Resident identifications.	ttain or nental, and othe t covered to the ced by: as the highest all cally, ceived in esident 1's	F 309	The fall nick assessments done quarterly medded. This plan is check (i.e. varifying name, the lobel, order, physiciana reducing the chance errors. It is the policy to them included from the risk assessment with the quarterly and as by the following medical facords we weetly 10T resident as assessment to ensure that a	resident Telepho Telepho Telepho Jackter Jackter Mederica M	toolay icotion ilto

# DEPARTMENT OF HEALTH AND HUM/ SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULT A. BUILDIN B. WING _	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
NAME OF P	ROVIDER OR SUPPLIER	405080	STREET ADD	RESS CITY S	TATE, ZIP CODE	1/26/2004
	OGDEN REHAB CENT	ΓER		TH WASAT		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
F 309	A review of the pharm reporting form dated medication error had facility's pharmacy mand that should have be a superscript of the pharmacy in the should have be a superscript of the should have be a superscript	macy's medication incided 1/22/04, documented the occurred with resident distakenly processed and igrams) every evening freen labeled for resident exchotic medication with ess, orthostatic hypoten endations for Zyprexa and of the dosage range in	hat a  1. The order of for resident 2.  potential sion, and re to start in the o patients sion, hose who has rexa has idance:  rviewed ted that the 15/03. The filled on facility on we been with he error no filled d the me." The e incident I in 12/17/03 ician].	F 309	and the information is reflected upon to II no coneplon exist D.O.N. will then be to covert the situal Resident 1's care found for and fall risk has ne-evaluated and a supplem will be more by medical feconds the D.S.N. Reports on success / failure be done during no a. A. meeting.	he coreflow.  To, the  e notified  this  been  orrected  This  netoned  and

CENTER	S FOR MEDICARE	E MEDICAID SERVI	CINO				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULT A. BUILDIN B. WING _		<b>I</b>	C C
	SOURCE OF OURSE INS	465086	CTDEET ADD	DECC CETY C	FATE 3TO CODE	1/20	6/2004
	ROVIDER OR SUPPLIER DGDEN REHAB CENT	TER		TH WASAT	TATE, ZIP CODE CH DRIVE		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
F 309	admitted to the facility coronary artery diseasinsomnia.  A review of resident on 1/22/04 and reveal.  Facility staff complet data set) assessment of again on 1/5/04. Facility moderately in 10/16/03 and 1/5/04. assessed resident 1's assessments. Facility decline as follows:  a. Resident 1 went frowith set up help only with one person physical assister, toilet use and b. Resident 1 went frow the person physical assist c. Resident 1 went frow the ability to reduce assistance to requiring a facility nurses compliadmission. A fall risk	9 year old female who y on 4/15/03 with diagse, dementia, hypertensel, hypertensel, hypertensel, dementia, hypertensel, which is medical record was led the following:  ed a quarterly MDS (most resident 1 on 10/16/03)  for resident 1 on 10/16/03  fility staff assessed resident assistance for bed if personal hygiene.  for requiring limited assistance for walking in herom having an unsteady alance herself without g physical support while ted a Fall Risk Assessed assessment was also contact the support was also cont	noses of sion and completed ninimum 33 and dent 1 as on y staff ben the two 1's sistance mobility, on with set with one r room. balance physical de standing.	F 309	DEFICIENCY		
	instructions on the facthe total score is 10 or considered a high risk scores a 10 or higher protocol should be in	and a again on 1/5/03. cility Fall Risk Assessmer greater, the resident state for potential falls. If the for total score, a preventiated immediately and replan." Facility staff as follows:	nent, "if hould be he resident ntive				

· · · · · · · · · · · · · · · · · · ·		(XI) PROVIDER/SUPPLIER IDENTIFICATION NUM		A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		465086		B. WING		1/20	6/2004
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	ORESS, CITY, ST	ATE, ZIP CODE		
SOUTH	OGDEN REHAB CENT	TER :	5865 SOU' OGDEN, U	TH WASATO JT 84403	CH DRIVE		
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 309	Continued From page 6	i		F 309			
	b. On 7/22/03 and falls. c. On 1/5/04. "21" A review of resident	"7", a low risk for falls 10/15/03- "9", a low r', a high risk for falls.  1's comprehensive care 1. Resident 1's care plan	isk for e plan was				
	resident 1 experience documentation: a. 5/2/03- Per docum Report Log. b. 9/3/03- Per docum Report Log. c. 10/2/03- Per docum Report Log. d. 10/8/03- Per docum Report Log. d. 10/8/03- Per docum Report Log. e. 12/7/03 at 10:30 P 1's nursing notes, " sitting on her bathroowith walker to bed w steadiness. She almobed" "Resident to paranoid" "Ativated f. 12/7/03- Resident documentation in the g. 12/9/03 at 10:30 P resident 1's nursing naide) reports fall to the knees bent [and] arm bleeding. Pt. [with] cm [centimeters] to fe back with pressure approximation.	o the facility through I d the following falls per the facility the nentation in the facility the nentation that is the nentation that is the nentation that is the nentation to the nentation that is the nentation t	er staff s Incident s Incident 's Incident 's Incident in resident lp. Found bulated or any back to hal, and date per ort Log. in ded nurse [with] ed ] 2 1/2 - 3 tolled to alert [and]				

CMS-2567L

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULT A. BUILDIN B. WING			
	ROVIDER OR SUPPLIER OGDEN REHAB CENT			TH WASAT	TATE, ZIP CODE CH DRIVE		72004
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 309	pt. to ER [emergency h. 12/10/03 at 8:30 F resident I's nursing mappears to have falle bed" "personal ali. 12/10/03 at 12:00 resident I's nursing makesident found sitting her chair. O (no) inj Resident returned to bed alarm" j. 12/11/03 at 6:45 A I's nursing notes, " down. Has skin tear, lateral side of right el k. 12/12/03 at 11:00 documentation in resinot stay in bed" " Her slides to the floor" 1. 12/12/03 at 5:45 AI facility's "Incident/Ac resident face down in toward closets. Apprtear on the lateral side m. 12/13/03 at 1:00 P resident I's nursing max to recliner chair, [small] skin tear rt [max to recliner chair, [small] skin tear rt [max to recliner chair, small]	PM- Per documentation notes, "resident found on forward while sitting larm will now be used AM-Per documentation notes, "Bed alarm we go note her bedroom floor jury found, put onto flowed, staff unable to local. AM-Per documentation Resident found on flow (approximately 3" X 5 lbow"  PM TO 7:00 AM- Per ident 1's nursing notes, cannot comprehend to be legs are weak and she afront of easy chair with roximately a 3 cm X 5 cm	d on floor. g on edge of" n in ent off. r next to oor. cate part of n in resident oor face 5") on , "Will stay in bed sits or in the a found th head cm skin n in d on floor oed. Sm mately 2 in the id vall." in resident f dent	F 309			

CENTER	RS FOR MEDICARE	<u>&amp; MEDICAID SERVI</u>	CES		W-0-1		2567-L
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUN 465086		A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 1/26/2004	
NAME OF D	ROVIDER OR SUPPLIER		STREET ADD	RESS CITY ST	TATE, ZIP CODE		0,2001
NAME OF FI	NOVIDER OR SUFFLIER						
		OGDEN, U	TH WASATO T 84403	CH DRIVE			
(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 ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
F 309	Continued From page 8	3		F 309			
	p. 12/17/03 at 4:00 A	M- Per documentation	in resident		•		
	1 -	Resident found sitting	i				
		low bed" "Re-ope					
		orearm. Steri-stripped					
	and covered with teg	aderm"					
		M- Per documentation					
	_	Resident found on floo	1				
		nd an old looking abra					
	_	sident made to underst					
		that she is not to get o	ut of bed				
	by self and use call li	_					
		M- Per documentation	I				
	_	Resident on floor craw	_				
		mmates bed. O (no) in cal for this resident. Re					1
		sident moved near nurs					
	for close monitoring.		ing station				
		M- Per documentation	of nursing			•	
		und yelling for help. F					·
		o recliner lying on her l					
	side. No new injurie		. [				
		M - Per documentation	ı in				
	resident I's nursing n	otes, "fof [found on f	loor] on				
	her knees by her beds	side. Abrasion on R (ri	ght) knee.				
	Cleansed + (and) anti	ibiotic oint (ointment)	(with)				
	bandaid applied"						
		M - Per documentation	I				
		At 17:30 (5:30 P.M.) R					
		on floor) by cna (certif					
		OC (level of consciou					
		on), injury and bleeding					
	(checked). There we	re no injuries et (and) i	no changes.				
	A mhyminian and and	stad 10/10/02 ==	stad that				
		ated 12/10/03, document					
	, -	onal alarm initiated for	- 1				
		esident 1's nursing notes					
		lent was placed on a lo	w bea with				
	a mattress on the floo	Or.					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIP	LE CONSTRUCTION	COMPL		
		465086		A. BUILDING B. WING		1/2	C 26/2004	
	SOUTH OCDEN DEHAR CENTED 5865 SO			DRESS, CITY, STATE, ZIP CODE  JTH WASATCH DRIVE  UT 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 C (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
F 309	Continued From page	9		F 309				
	resident 1 had a low initiated.	ated 12/16/03, docume bed with a mattress on 1's medication adminis	the floor					
	A review of resident 1's medication administration records was completed on 1/22/04. The following medications were administered to resident 1, which may have increased her risk for falls, sedation and decreased level of consciousness, when given with							
	Zyprexa: a. 12/7/03 - Ativan 2 mg at 11:30 PM, after resident had fallen. b. 12/8/03 - Restoril 30 mg at HS (hour of sleep). c. 12/10/03 - Ativan 1 mg at 1:00 AM.							
	d. 12/12/03 - Ativai 30 mg at 9:00 PM.	n 0.5 mg at 1:00 AM, at n 0.5 mg (2) at 9:00 PM						
	medication administ	amentation on resident ration record, resident 1 mg, every evening sir	l was					
	Interviews:							
	interviewed on 1/24, medication error occupharmacy mislabele pills, with resident physician's order for Zyprexa 10 mg in er medication. The DO many doses resident DON stated that she stated the error coul	or of Nursing (DON) w /04 at 2:40 PM. She state curred because the facil- d resident 2's, Zyprexa, I's name. Resident 1 did Zyprexa and had receiver, that was resident 2' DN was asked if she knew I had received in error wasn't sure. The DON d have been prevented in checking the physician	ted that a ity 10 mg I not have a ved s we how , and the further if the night					

	TEMENT OF DEFICIENCIES  D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  EDENTIFICATION NUMBER:			(X2) MULTIP	LE CONSTRUCTION	COMPLE	(X3) DATE SURVEY COMPLETED C	
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SOUTH OGDEN REHAB CENTER		TER .	5865 SOUT OGDEN, U	TH WASATC T 84403	H DRIVE			
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F 309	DON stated that it w 12/15/03 when employed found the error. she thought the Zyprinegatively effected in not to any great externance and falling." The surfall Prevention progistated, "It's a work in Employee 1, a facilit interviewed on 1/22/stated that she remer resident 1, but she werror had occurred.  Employee 2, a facilit interviewed on 1/22/stated on one day she to resident 1, and no card for Zyprexa. Stresident was not on Employee 2 then we to double check the had occurred. Employee 1, in error.  On 1/21/04, the facility (SSW) was interviewed she had occurred. Employee 2 then we to double check the had occurred. Employee 2 then we to double check the had occurred. Employee 2 then we to double check the had occurred. Employee 2 then we to double check the had occurred. Employee 2 then we to double check the had occurred. Employee 2 then we to double check the had occurred. Employee 2 then we to double check the had occurred. Employee 1 the facility of the	on administration record as brought to her attent oyee 2, a licensed pract The surveyor asked the exa medication error ha esident 1. The DON stant. She kept falling, an recover asked if the facility	ion on tical nurse DON if ad ated, "No, d falling, lity had a the DON rse, was loyee 1 Zyprexa to lication rse was oyee 2 edications medication hat this a. Lical chart an error couldn't stered to rker 1. The la change . The SSW a walker and hy she felt he had	F 309				

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/S			1` '	PLE CONSTRUCTION	COMPLE	TED		
	1	465086		A. BUILDING B. WING		C 1/26/2004		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE			
				5865 SOUTH WASATCH DRIVE OGDEN, UT 84403				
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F 309	She stated the medical The SSW stated the stated the beginning of Decide Resident 1's physicial 1:00 PM. He stated medication, may incomplete the facility nurse was PM. The facility nurse assessed at risk for fawould be included in Two facility nurse ai at 9:30 AM. These to 1 had fallen into the incident was docume on 12/15/03. Facility experienced no injur However, facility stated to the state of the sta	resident's medication i ation given in error was medication error had on	s Zyprexa. ccurred in  1/22/04 at ipsychotic or falling. at 2:30 ent was protocols in.  on 1/22/04 hat resident This ident report ident 1 ill. caused a hole in the	F 309				
	An interview was held with another facility nurse aide on 1/22/04 at 9:00 AM. She stated that resident 1 had been alert and ambulatory, using her walker, going to and from the dining room. The nurse aide stated that in the first part of December 2003, resident 1 began falling all the time and became confused. She stated that one time resident 1 fell in the bathroom, and made a hole in the wall, and that resident 1 had hurt her hip. The nurse aide stated that the change in resident 1 had been sudden.  On 1/22/04, at 2:30 PM, the facility Administrator was interviewed regarding resident 1's Zyprexa medication error and falls. The Administrator stated that resident							

DEPARTMENT OF HEALTH AND HUM/ **BERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES 2567-L STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING\_ 465086 1/26/2004 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5865 SOUTH WASATCH DRIVE SOUTH OGDEN REHAB CENTER **OGDEN, UT 84403** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID. (X4) 1D (X5)(EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 309 Continued From page 12 F 309 1 had received resident 2's Zyprexa medication for "multiple days, 6 or 7 doses.." The surveyor asked the Administrator if he had thought resident 1 had been negatively effected because of the medication error. The Administrator stated, "No, she was drugged." The surveyor asked the Administrator if he thought that resident 1 had been falling because she was "drugged", to which the Administrator stated, "I don't know." for resedent I was an isolated F 431 F 431 483.60(d) PHARMACY SERVICES SS=Dincident which can be corrected Drugs and biologicals used in the facility must be by using current policy and labeled in accordance with currently accepted proceeding which regume the professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. - obtain a m. D. Order - Transmit order to Phormacy This REQUIREMENT is not met as evidenced by: - upon receipt of medication Based on staff interviews and the pharmacy medication incident reporting form it was determined from Pharmacy, verify that the facility used a medication that was not labeled in accordance with current accepted professional correct patient, drug, principles. Specifically, resident 1 received Zyprexa dose time and method. due to an error in medication labeling. The Zyprexa Quality assurance will be label included resident 1's name in place of resident 2's name. (Resident identifiers 1,2) sustained by using a 4 way Findings include: check daily as all new orders are necessed, all A review of the pharmacy's medication incident

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reporting form dated 1/22/04 documented that a medication error had occurred with resident 1. The facility's pharmacy mistakenly processed an order of Zyprexa 10 mg (milligrams) every evening for resident 1 that should have been labeled for resident 2.

> Facility ID: UT0015

If continuation sheet 13 of 30

monthly refell orders well be checked against Physician Order and Pharmacy print

CENTER	STOK MEDICAKE	& MEDICAID SERVI	CEO	·-			4307-L
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES DENTIFICATION NUM 465086		(X2) MULT A. BUILDIN B. WING	·	(X3) DATE SU. COMPLET	ED
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F 431	The facility's consultation 1/29/04 at 8:00 Al facility contacted him order for Zyprexa was supply was sent to the medication Zyprexa seresident 2 but had been the input technician with the medication, labeled wrong resident name, the following on the incident was discusse assurance) meeting or including [facility phystated that he thought the patient was fine at The facility's Director interviewed on 1/24/0 medication error occup harmacy mislabeled pills, with resident 1 physician's order for Zyprexa 10 mg in error medication. The DO many doses resident 1 DON stated that she with the medication of	ant pharmacist was interest of the medication was interested in quarterly QA (quantized in quarterly Q	ted that the 15/03. The a 30 day he a 30 day he ed for it 1's name. In our end, I labeled with the umented it, "This ulity ersonnel, sician] eeded and is stopped."  as ted that a ty 10 mg I not have a wed is whow, and the further of the night ins orders it. The ion on ical nurse DON if addited, "No, it dalling, it is a 15/03. The ion on ical nurse ic	F 431	to reinforce process to licensed staff will do checks up of medication. The or assigned nurse monitor and spot atalf no less the	the bold, of physics will the D.O. reconsider of the chack on reports they a. A	N.

CENTER	CS FUR MEDICARE	& MEDICAID SERVI	CES				2567-L
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F 431	Fall Prevention progrestated, "It's a work in The facility's Admini 1/22/04 at 2:30 PM." resident 1 had receive medication for "multi-Employee 1, a license interviewed on 1/22/0 stated that she remer resident 1, but she wateror had occurred.  Employee 2, a license interviewed on 1/22/0 that she was administ and noticed there was and realized that this medication Zyprexa. resident's medical charterior.	ram in place, to which to process - but yes."  istrator was interviewed. The Administrator state red resident 2's Zyprexactiple days, 6 or 7 doses.  sed practical nurse, was 04 at 10:30 AM. Employered administering Z as not aware that a med red practical nurse, was 104 at 1:40 PM. Employering medications to resident was not on the Employee 2 then went art to double check the had occurred. Employember how many pills had process.	d on ed that it" loyee 1 Zyprexa to dication  yee 2 stated esident 1, it Zyprexa, et to the order, and yee 2 stated	F 431			
F 490 SS=E	A facility must be addenables it to use its reefficiently to attain or physical, mental, and resident.  This REQUIREMEN Based on interviews	RATION  Iministered in a manner esources effectively and maintain the highest place psychosocial well-beir with facility staff and reas determined that the fast determined the fast	d practicable ng of each nced by:	F 490	The administrator only one instance employee I acted on the scope of her That was on Jone when the administrativork, only to find I the only neuse	any 16, 2 a come amploye	1204 Tu

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIERAL IDENTIFICATION NUM			A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
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F 490	not administered in a nursing staff so that emaintain their highes Specifically, the facil to the licensing restrinurse, and allowed faresidents records. (E. An abbreviated surve through 1/26/04. No areas:  1. Compliance with professional standard (CFR) 483.75, Tag F.  2. Clinical Records Findings include:  A review of employed 1/22/04, which reveated in employee 1's filed Division of Occupation of the Department of (DOPL). The document Case number DOPL and restrictions on elicensed practical nursestrictions imposed but were not limited.  a. (2j) "Respondent and surroundings where the restrictions imposed but were not limited."	manner that utilized liceach resident may attain to practicable well-being lity Administrator did notions of one licensed palsification of information of in	n or g. not adhere practical on in  21/04 d in two  al laws and gulation  4  d on  The Licensing e of Utah nd Order, anctions practice as a and included  be to duties excess to, or nces."	F 490	the facility due call of by another deproximately hours, employed worked unsuper a R.N. on the bunce this twe for improper sugar as well as the signing limitiales narcotics record the facility of the facility of the policy that any kind of restriction when the medication when the medication will be audited and checked for	es I vised by P. a. N.  I employee on employment.  persision improper improper improper improper improper income has as real with internal with internal with internal incernal inceres income record inceres incord inceres
	b. (2n) "Respondent	shall practice only und	ler the		initialing, medi	cal facords ->

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F 490	standing with the Div physician shall be pri periodically delegate  A second document i September 29, 2003, Department of Health that the facility had re (background screening granted this variance, specific conditions of with the following rea. (2j) "When [emploise [Licensed Practical Naupervision of a RN I do the narcotic count each shift. [Employed medication cart, but the and all narcotics or opossession at all time.  b. (2n) "[Employed by a RN in good stan will be the primary neworking with."  The Administrator was PM. The Administrate employee 1 had restrict employee 1 was to be The designated regist of Nursing. The Administrate employee 1 had alone, unsupervised.	f a registered nurse in grision. The supervising marily one (1) person to other qualified person to other qualified person to other qualified person employee 1's file, dat from the State of Utah, Bureau of Licensing, equested a variance to be a supervision of the variance that was a strictions:  Description of the variance that was a strictions:  Description of the variance of the variance that was a strictions:  Description of the variance of the variance that was a strictions:  Description of the variance of the variance of the variance that was a strictions:  Description of the variance of the va	anurse or who may onnel."  ded  Utah revealed R432-35 ensing es the approved  LPN or the direct at RN will he end of the routine by to any ces in her  all times his RN be  704, at 2:20 ware that had that ered nurse. The Director is aware in nurse.	F 490	will do the The P.D.N. is to follow-up monitor. a will be reve at Q.A., with anomalies chec immediately P.J.N. and	and report  ewed northly  to any  ked

		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULT. A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE S COMPLE	
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F 490	1/21/04, at 2:45 PM. she was aware that er license, to which the The surveyor asked to specific restrictions to The DON stated that access to narcotics. It allowed employee 1 to narcotic keys, and concout supervision.  Employee 1 was intered. Employee 1 stated she shated the restrict supervised by a regist administer narcotics. Administrator was aware unsupervised by a regist administered narcotic. Two facility nursing at 2:30 PM. The two carry the narcotic key. Five facility aides we five nursing aides state working without being the A review of the facility and agency invoices was completed on 1/2 Employee 1 had worth 11/22/03, 11/28/03, 17 There had not been at those dates to supervisions.	The surveyor asked the mployee I had a restrict DON responded she whe DON if she was away of employee I's nursing employee I's was not to administer narcotics out the controlled substitute of the DON stated that she to administer narcotics out the controlled substitute of the DON stated that she was tered nurse and that she was tered nurse and that she was tered nurse and that ware that she was work gistered nurse and had as to facility residents.  Staff were interviewed nurses stated that employe and was counting the property of the pr	ted nursing as aware. are of the license. To have the had a carry the tances with license. To be the could not to the ting on 1/21/04 loyee 1 did to harcotics. It ime cards, 1/15/04, on 1/2/04. The displayment of the ling on 1/21/04, on 1/2/04. The displayment of the ling on 1/2/04, on 1/2/04.	F 490			

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465086 B. WING	1/26/2004
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
SOUTH OGDEN REHAB CENTER  5865 SOUTH WASATCH DRIVE OGDEN, UT 84403	
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F 490 Continued From page 18 building on 11/27/03, 12/25/03, 12/26/03, 1/11/04, and 1/14/04.  (Refer to F 492) 2. A review of the facility's Controlled Drug Administration Records, between 1/9/04 and 1/22/04 was completed on 1/22/04.  Employee 1 was interviewed on 1/22/04 at 10:30 AM. Employee 1 stated the DON had her initial the DON's initials on the Controlled Drug Administration Records, on individual resident's medication administration records and individual residents' narcotic records.  Employee 1 was asked to identify how may times she had signed the DON's initials on the Controlled Drug Administration Records. Employee 1 identified eight times in January, 2004, that she had signed the DON's initials.  A review of the narcotic records for individual residents, for October 1, 2003 through January 22, 2004 was completed on 1/22/04.  Employee 1 was asked to identify how may times she had signed the DON's initials on the individual residents narcotic records. Employee 1 identified 100 out 114 times she initialed the DON's initials on the narcotic records.  The facility's DON was interviewed on 1/21/04 at 2:45 PM. The DON acknowledged that she had employee 1 initial the Controlled Drug Administration Records and the individual residents' narcotic records with	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMB.			(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 490	Continued From page 1 (Refer to F 514)	9		F 490		
F 492 SS=E	compliance with all a local laws, regulation professional standard professionals providi.  This REQUIREMEN Based on employee r it was determined that with all applicable Stensure that a licensed restriction on her lice restrictions placed or Findings include:  A review of employee completed on 1/22/04. In employee 1's file Division of Occupation of the Department of (DOPL). The document Case number DOPL restrictions on employing licensed practical nurrestrictions imposed but were not limited.	erate and provide service applicable Federal, States, and codes, and with a sand principles that aping services in such a factor is not met as evident ecord review and staff at the facility failed to cate laws. The facility delay practical nurse (LPN) ense was adhering to the her license. (Employe et al., which revealed the forward and Professional I. Commerce of the States ent was a Stipulation and 2003-185, imposing sayee 1's ability to practicate. Specific sanctions a on September 8, 2003;	e, and accepted oply to accility.  aced by: interviews omply id not that had a e e 1)  Collowing:  The Licensing e of Utah and Order, actions and ce as a and included	F 492	The facility will no future prople restricted licenses to a new facility that does not all hering of any new a variance on other upon their licen Before any new are done, the factor licenses or does and will con do background of a current nurse on licenses restrict will be the policy facility to terminate the employment of nurse to sustain	se with restrictions as it already will a it already it places toon, it is of these votes toon, it is a placed toon that compliance
	and surroundings wh	ich do not allow her act to to controlled substar	cess to, or		with this negula	tion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUM			A. BUILDIN	PLE CONSTRUCTION  G	COMPLETED C	
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F 492	b. (2n) "Respondent on-site supervision of standing with the Divident physician shall be properiodically delegated. A second document in September 29, 2003, Department of Health that the facility had represent	shall practice only under a registered nurse in a vision. The supervising imarily one (1) person to other qualified person to other qualified person to other qualified person to other qualified person the State of Utah the Harman of Licensing, equested a variance to ang). The Bureau of Licensing. The document outling the variance that was strictions:  Description of the property of the Working as a striction of the under the person of the tat the beginning and the ell will have a key to the RN will have the keyther controlled substantial	good g nurse or who may onnel."  ted , Utah , revealed R432-35 ensing es the approved  LPN er the direct hat RN will he end of the routine ey to any ices in her  all times this RN be  e	F 492	Monitoring of process is to by the D.O. and the Office Reports will ! in australy	they administration of administration manager- se given a.A. 3/26/ay

Event I AN7811

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING		COMPLETED		
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the restriction on her administering medic was required to be w RN. Employee I state to administer nor under the supervision that she was not allo administer narcotics.  Employee I was ask narcotic medications stated, "Yes."  Employee I was ask administer narcotics that request. Employees that request. Employees asked to administer Nursing), and the All Nursing).  Employee I was ask administer narcotics the DON that she was ask administer narcotics the DON's initials of individual resident series asked to the DON's initials of individual resident series asked to the that the DON had in with her initials (the stated that the DON any problems from the Employee I was ask the DON's asked to the DON any problems from the Employee I was ask the DON any problems from t	r license, in relation to ations. Employee 1 stated that the restriction in-narcotic medications in of an RN. Employee wed to have access to come different at the facility, and who is to residents at the facility in the facility, and who is to residents at the facility in the facility, and who is to residents at the facility in the facility in the facility in the DON (Assistant Directors). Employee 1 stated that is "uncomfortable doin the different facility in the facility in th	vision of a allowed to residents I stated or inistering lity and she ested to a had made had been (Director of or of the door	F 492				
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	CONTIDER OR SUPPLIER  SUMMARY ST (EACH DEFICIENCY REGULATORY OR IT  Continued From page the restriction on her administering medic was required to be warden RN. Employee 1 st. her to administer nor under the supervision that she was not allo administer narcotics  Employee 1 was ask narcotic medications stated, "Yes."  Employee 1 was ask administer narcotics that request. Employate to administer Nursing), and the Al Nursing).  Employee 1 was ask administer narcotics the DON that she was ask administer narcotics that request. Employate to administer narcotics the DON that she was ask the DON's initials or individual resident seriedent MAR's (me Employee 1 stated, documents with the that the DON had in with her initials (the stated that the DON any problems from the Employee 1 was ask ask and the DON any problems from the Employee 1 was ask ask and the DON any problems from the stated that the DON any problems from the Employee 1 was ask ask and the DON any problems from the stated that the DON any problems from the summary of the stated that the DON any problems from the summary of the stated that the DON any problems from the summary of the stated that the DON any problems from the summary of the stated that the DON any problems from the summary of the stated that the DON any problems from the summary of the summa	AGOVIDER OR SUPPLIER  DGDEN REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY REGULATORY OR LSC IDENTIFYING INFORMA)  Continued From page 21  the restriction on her license, in relation to administering medications. 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Employee 1 was asked if she had been requested to administer narcotics in the facility, and who had made that request. Employee 1 stated, "Yes." she had been asked to administer narcotics, by the DON (Director of Nursing), and the ADON (Assistant Director of Nursing).  Employee 1 was asked if she had ever refused to administer narcotics. Employee 1 stated that she told the DON that she was "uncomfortable doing it."  Employee 1 was asked if she had ever signed or put the DON's initials on facility narcotic sign out sheets, individual resident sign out sheets, or on individual resident MAR's (medication administration records). Employee 1 stated, "Yes,", she had signed these documents with the DON's initials. Employee 1 stated that the DON had instructed her to sign the records with her initials (the DON's initials). Employee 1 stated that the DON had stated that she would handle	A BUILDING B. WING —  STREET ADDRESS, CITY, STA 5865 SOUTH WASATCI OGDEN, UT 84403  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 21 the restriction on her license, in relation to administering medications. Employee 1 stated that she was required to be working under the supervision of a RN. Employee 1 stated that the restriction allowed her to administer non-narcotic medications to residents under the supervision of an RN. Employee 1 stated that she was not allowed to have access to or administer narcotics.  Employee 1 was asked if she had been administering narcotic medications to residents at the facility and she stated, "Yes."  Employee 1 was asked if she had been requested to administer narcotics in the facility, and who had made that request. Employee 1 stated, "Yes." she had been asked to administer narcotics, by the DON (Director of Nursing), and the ADON (Assistant Director of Nursing).  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Employee 1 was asked if she ever had possession of	TOURTHEACHTON NUMBER:  465086  STREET ADDRESS, CITY, STATE, ZIP CODE  STREET ADDRESS, CITY, STATE, ZIP CODE  SOUTH WASATCH DRIVE  SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCIES  SUMMARY STATEMENT OF DEFICIENCIES  (EACH CORRECTIVE MUST BE PRECEDED BY PULL REGULATORY OR LAC IDENTIFYING INTORNATION)  Continued From page 21  the restriction on her license, in relation to administering medications. Employee I stated that she was required to be working under the supervision of a RN. Employee I stated that the restriction allowed hat she was not allowed to have access to or administer non-narcotic medications to residents under the supervision of an RN. Employee I stated that she was not allowed to have access to or administer narcotics.  Employee I was asked if she had been requested to administer narcotics in the facility, and who had made that request. Employee I stated, "Yes."  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F 492	Employee 1 was asked if she had ever worked alone, (as the only licensed nurse in the building) and did she ever administer narcotics during those times.  Employee 1 stated, "Yes, but not very often."  Employee 1 stated that the last time she was working alone in the building was Friday, January 16, 2004.  Employee 1 stated that she was working alone in the building until an agency nurse came in to help.  Employee 1 was asked if she had ever worked alone in the building when the DON was on vacation.  Employee 1 stated, "Yes."  Employee 1 was asked if the Administrator was aware that she had been working alone, unsupervised by a RN, and administering narcotics. Employee 1 stated, "Yes, he told me to do what was needed to take care of the residents."  Employee 1 was asked when the facility's Administrator was first made aware of the restriction on her license. Employee 1 stated that she thought it was in September or October of 2003.		F 492					
	The DON was interviewed on 1/21/04 at 2:45 PM. The DON was asked if employee 1 had ever had possession of the facility narcotic keys. The DON stated, "I can't lie, she has."  The DON was asked if employee 1 had been allowed to administer narcotics to the residents. The DON stated that she (employee 1) had administered narcotics to the residents.  The DON was asked if employee 1 had been allowed to sign her (DON's) initials on the resident MAR's (medication administration record) and the facility narcotic counting sheet. The DON stated, "Yes." The							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLI AND PLAN OF CORRECTION IDENTIFICATION N			(X2) MULTIPI	LE CONSTRUCTION	COMPLI			
AND PLAN U	F CORRECTION	IDENTIFICATION NON	(BEK:	A. BUILDING B. WING			C	
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F 492	DON then clarified to been signed by either DON). The DON to been initialing and so narcotic count sheets signatures.  The DON was asked employee 1. The DO employee 1's resider stated that she made their medications, and on time.  The DON was asked the time. The DON supervise her the whole she was in a meeting administer narcotic of the DON was asked employee 1's licensed was my understanding iving the narcotics.  The DON was asked employee Administrator) about stated that employee Administrator) about sure of the exact date or October of 2003.  The DON was asked to administer narcotic stated that employee Administratory about sure of the exact date or October of 2003.	that the signatures, could be one of them, (employ hen stated that both of the igning resident MAR's, so, with the DON's initial how she specifically so ON stated that she madents were taken care of sure that the residents and that the medications of the initial hole time." The DON's go, she would have [employee 1] she is the initial what her understanding erestriction. The DON ing that [employee 1] she is a week a like told them (DON in the restriction, but she is, but thought it was in the initial was initial was in the initial was initial was in the initi	ee 1 or them, had and and and als and upervised e sure. The DON were given were given were given loyee 1 all here to tated that if loyee 1] dents.  In and the ware of the stated, "It wouldn't be ware of the the DON I and the wasn't September employee 1 ON stated	F 492				
	The DON was asked	d what employee 1's rep	oly was					

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F 492	when [employee 1] w The DON stated that "uncomfortable doing." The DON was asked administer narcotics. residents." The DON negative outcome to employee 1 administ. "No."  The DON was asked alone at the facility.' had worked alone, w The date was January employee 1 had only shift.  The facility's Adminity. The Administrator w aware of employee 1 Administrator stated her license restriction The Administrator w asked employee 1 to residents. The Administ employee 1 was adm residents during the a day when employe building. He stated the	was asked to administer employee I said that sig it."  why employee I was a The DON said, "I did was asked if there had any of the residents as ering narcotics. The D if employee I had ever The DON stated that erithout supervision in the y 16, 2004. The DON worked alone for 4 ho istrator was interviewed as asked when he was asked when he was asked if he knew what administer narcotics to inistrator stated that he rator stated that he rator stated that he suspinistering narcotics to week the DON was on e I was the only nurse that he was not aware the administering narcotics to admini	a result of ON said,  r worked in ployee 1 in facility. Stated that turns on that in of the didn't bected the vacation on in the lat	F 492			
-		as asked why this prac	tice had				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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:	On 1/22/04, five facility nurse aides were interviewed about their knowledge of employee 1 working alone, as the only nurse in the building.  On 1/22/04, nurse aide 1 stated that employee 1 worked alone in the building when the DON was on vacation.							

NAME OF PROVIDER OR SUPPLIER  SOUTH OCDEN REHAB CENTER  SOUTH OCDEN REHAB CENTER  B. WING  1/26/2004  1/26/2004	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		COMPLE	(X3) DATE SURVEY COMPLETED C	
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OGDEN, UT 84403	5865 SOU					CH DRIVE			
PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL. PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PREFIX	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL.			PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETE DATE	
F 492  Continued From page 26  On 1/22/04, nurse aide 2 stated that employee 1 was the only nurse working a couple of times. The nurse aide could not remember exact dates.  On 1/22/04, nurse aide 3 stated employee 1 had worked alone.  On 1/22/04, nurse aide 4 stated, employee 1 had worked alone in the building, and "No" the DON did not supervise her.  On 1/22/04, nurse aide 5 stated that employee 1 administered medications to the residents, and "No" the DON did not supervise her.  3. A review of the facility's Controlled Drug Administration Records, (narcotic counting sheets) between 1/9/04 and 1/22/04, was completed on 1/22/04.  Employee 1 was asked to identify how may times she signed the DON's initials on the Controlled Drug Administration Records. Employee 1 identified eight times for the month of January, 2004.  4. A review of the narcotic records for individual residents, for October 1, 2003, through January 22, 2004, was completed on 1/22/04.  Employee 1 was asked to identify how may times she had signed the DON's initials on the narcotic records. Employee 1 identified 100 out 114 times.  5. A review of the facility's mursing schedules, time cards, and agency nurse time sheet invoices from November 1, 2003, through January 15, 2004 was	F 492	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 26  On 1/22/04, nurse aide 2 stated that employee 1 was the only nurse working a couple of times. The nurse aide could not remember exact dates.  On 1/22/04, nurse aide 3 stated employee 1 had worked alone.  On 1/22/04, nurse aide 4 stated, employee 1 had worked alone in the building, and "No" the DON did not supervise her.  On 1/22/04, nurse aide 5 stated that employee 1 administered medications to the residents, and "No" the DON did not supervise her.  3. A review of the facility's Controlled Drug Administration Records, (narcotic counting sheets) between 1/9/04 and 1/22/04, was completed on 1/22/04.  Employee 1 was asked to identify how may times she signed the DON's initials on the Controlled Drug Administration Records. Employee 1 identified eight times for the month of January, 2004.  4. A review of the narcotic records for individual residents, for October 1, 2003, through January 22, 2004, was completed on 1/22/04.  Employee 1 was asked to identify how may times she had signed the DON's initials on the narcotic records. Employee 1 identified 100 out 114 times.		had  I had DON did  ee 1 and "No"  g sheets) I on  times she Drug ified eight  vidual uary 22,  times she ic records.	F 492				

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F 492 F 514 SS=E	Employee 1 had worked with another LPN of 11/22/03, 11/28/03, 12/4/03, 12/6/03, and 1/2 There had not been a registered nurse working those dates to supervise employee 1.  Employee 1 had worked alone and unsupervise building on 11/27/03, 12/25/03, 12/26/03, 1/2 and 1/14/04.  Employee 1 documented on her January, time pay period ending 1/15/04, the following, "we hours by myself, 4 hours double time."  Employee 1 documented on her December's pay period ending 12/15/03, the following, "I alone on Thanksgiving 3-11 and was informed was to get double time, and was only paid for hours. I need the 8 hours extra please."  Employee 1 documented on her December's pay period ending 12/16/03 (sic), the following "worked alone double time."		/2/04. ing on  vised in the /11/04,  ne card, worked 4  stime card, "I worked hed that I for regular 8  stime card, ing,  on each sional	F 492	The Lacility adminis	trator layment and	
	documented; readily organized.  This REQUIREMEN Based on interviews determined that the foresident clinical reco	accessible; and system  IT is not met as evider  and record review, it was acility failed to ensure  rds were maintained in the epted professional stand	atically nced by: vas that		the D.O.N. for all the cited practices ensure no future of this notine, the will systematically the medication od	e incidents Jacility	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		465086	B. WING			1/26/2004	
NAME OF PROVIDER OR SUPPLIER				TATE, ZIP CODE			
SOUTH OGDEN REHAB CENTER			5865 SOUTH WASATCH DRIVE OGDEN, UT 84403				
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	document medication not given by another  2. The facility did no error was made, that the resident's clinical Findings include:  1. A review of the fa Administration Record was completed on 1/2  Employee 1 was interesting the Employee 1 stated the DON's initials on the Records, on individual administration record narcotic records.  Employee 1 was asket had signed the DON's Administration Record times in January, 200 initials.  A review of the narcord residents, for October 2004, was completed  Employee 1 was asket had signed the DON's resident narcotic record out 114 times she initials.	ed a licensed practical mass he had administered nurse in the facility.  It ensure that when a me the incident was docum record.  Cility's Controlled Drug rds, between 1/9/04 and 22/04.  Eviewed on 1/22/04 at 1 to the DON had her initice the DON had her initice the DON had her initice and individual residents medication and individual residered to identify how may to initials on the Controlleds. Employee 1 identify that she had signed that the records for individual 1, 2003 through January and the signed that the records for individual 1, 2003 through January and the signed that the records for individual 1, 2003 through January and the records for individual 1, 2003 through January and the records for individual 1, 2003 through January and the records for individual 1, 2003 through January and the records for individual 1, 2003 through January and the records for individual 1, 2003 through January and the records for individual 1, 2003 through January and the records for individual 1, 2003 through January and the records for individual 1, 2003 through January and the records for individual 1, 2003 through January and the records for individual 1, 2003 through January and the records for individual 1, 2003 through January and the records for individual 1, 2003 through January and the records for individual 1, 2003 through January and the records for individual 1, 2003 through January and the records for individual 1, 2003 through January and 1, 2003 through Janu	edication mented in 1/22/04 0:30 AM. al the mistration mts' imes she led Drug fied eight me DON's all ry 22, imes she all fied 100	F 514	Reard and Nancota weekly, checking against nurse in medical Revords we and will report on monthly a A. The well monitor.  On inservice w be given to all I staff to ensure of documentation for errors will be reported Errors will be reported the "medication Ene report (EXHIBIT A), reviewed upon reco reusing by the T administrator. all error incidents w acted upon immed by the D.D.N. and licaned staff report to ensure the safe	against itials. It audit at the D.D. ~  Ill exercised response medication and ext from and medication ill ke hately the storig	
	narcotic records.				the resident. al		

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING  $\mathbf{C}$ B. WING \_ 465086 1/26/2004 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SOUTH WASATCH DRIVE SOUTH OGDEN REHAB CENTER **OGDEN, UT 84403** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL. PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 514 Continued From page 29 F 514 en be logged in the The facility's DON was interviewed on 1/21/04 at 2:45 adent report log book of reported on in months PM. The DON acknowledged that she had employee 1 initial the Controlled Drug Administration Records and the individual residents narcotic records with initials that were not hers. 2. By interview of facility staff, it was determined that a medication error was made in December, 2003, involving resident 1. A review of resident 1's entire medical record was completed on 1/22/04. Resident 1's medical record did not contain documentation about the incident on the nursing notes or medication administration record. Employee 2, an LPN (Licensed Practical Nurse) was interviewed on 1/22/04 at 1:20 PM. Employee 2 stated that she was administering medications to resident 1. and noticed there was a new medication card for Zyprexa, and realized that this resident was not on the medication Zyprexa. Employee 2 then went to the resident 1's medical chart to double check the order, and realized that an error had occurred. Employee 2 stated that she couldn't remember how many pills had been administered to resident 1, in error. Employee 1, an LPN was interviewed on 1/22/04 at 10:30 AM. Employee 1 stated that she remembered administering Zyprexa to resident 1, but she was not aware that a medication error had occurred.

# MEDICATION ERROR REPORT CONFIDENTIAL

Date of Report:



Resident:	_ Room: Physi	ician:
Date & Time Error Discovered:	Date & Time Error C	Occurred:
Medication Given:	Dosage:	Route of Admin.
Physician Order & Date:		
Description of Error:		
Physician Notified:	Date:	Time:
Orders Received at Time of Notification:		
Correction of Littor:		
Family Notified:	Date:	Time:
Staff Member Filing Report:		
Staff Member Making Error:		
Supervisor Review (apparent cause of error)	:	
Consultation with staff member making erro		-
Staff Member Stagnature		
Administration Review:		Date
Nursing Service Director:		
Administrator:		
Medical Director:		Date: