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

PRINTED: 12/20/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING ______ B. WING ______	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223 SS=G	483.13(b), 483.13(b)(1)(i) ABUSE	F 223		

Summary statement of deficiencies (F 223):

The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and reviews of record, the facility did not ensure residents' rights to be free from physical abuse, for 2 of 11 residents. Specifically, between 8/7/06 and 10/13/06, resident 3 was either documented as having been involved in an altercation with resident 6 or noted to have injuries of a suspicious nature on at least six occasions. Resident identifiers 6 and 3.

Findings included:

1. Resident 6 was originally admitted to the facility on 7/17/06 and readmitted on 11/24/06 with diagnoses which included dementia, type II diabetes mellitus, congestive heart failure, sepsis and agitation. Resident 6 was accommodated on the special needs unit, in a room nearest the unit entrance.

On 11/27/06, several residents on the special needs unit were observed ambulating in the hallway after lunch. One resident approached a surveyor and stated that "I don't go down to that end of the hall." The surveyor asked the resident "why not?" The resident replied "because I'm afraid of that big man down there." The surveyor

1/8/07 POC acceptable completion date 1/13/07 Busenbark RN

Provider's plan of correction (F 223):

F 223
Resident #3 admitted on 7/31/06. Shortly after admission, the facility had intervened and implemented measures designed to reduce or prevent potential incidents between the two Residents mentioned, by removing resident 3 during meals and daily activities off of the special needs unit.

The facility had also increased monitoring of both residents, during all shifts, and both have received revised care plans with appropriate interventions listed.

The two Residents have also been separated because Resident #3 has been physically relocated to a different bedroom off of the Special Needs Unit, because his needs had changed.

Staff will be inserviced on dealing appropriately with residents with behavioral issues, especially if physical altercations are involved.

In order to prevent further problems between Residents, staff will re-assess residents after Resident-to-Resident incidents. To prevent other residents

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 1/5/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 1 asked Nurse Aide 1, who was working in the special needs unit, who the resident was talking about. Nurse Aide 1 indicated the resident was probably referring to resident 6 and stated that resident 6 "is aggressive at times and we try to keep him away from the residents." 2. Resident 3 was originally admitted to the facility on 7/27/03 and readmitted on 7/31/06 with diagnoses which included dementia, coronary artery disease, dehydration, anxiety, hypothyroidism and status/post acute cardiovascular accident. Resident 3 was accommodated in a room near the special needs unit dining room. On 11/27/06 at approximately 10:30 AM, resident 3 was observed while being ambulated in his wheelchair off of the special needs unit to the facility's main dining room. Resident 3 was observed to be striking out with closed fist at facility staff members who were attempting to place his feet onto wheelchair footrests. A member of the survey team who was observing resident 3 was cautioned by the facility staff to maintain a safe distance from resident 3. On 11/27/06 at approximately 1:30 PM, resident 3 was observed lying on his bed, in his room, located near the special needs unit dining room. Resident 3 appeared to be sleeping. Nurse Aide 2, assigned to the special needs unit was interviewed regarding resident 3. Nurse Aide 2 stated that another resident (resident 6), also on the special needs unit, did not like resident 3 to use profanity or display verbal aggression and would physically attack resident 3 when this occurred. Nurse Aide 2 stated that resident 3 was usually taken off the special needs unit when	F 223	being affected by similar circumstances, the facility is implementing the following: The nurse will document on the 24 hour report any cognitive, physical, or behavioral changes. The 24 hour report is a communication and tracking log that is reviewed daily by all department heads at the morning stand up meeting. Incident Reports are also reviewed daily by Director of Nursing and Administrative staff in the morning stand-up meeting. The incident reports are logged and tracked on the Incident Report Tracking Log, and evaluated for trends. Completed by Director of Nursing, monitored monthly by Administrator. Reviewed by Quality Assurance team, next scheduled meeting 1-12-07, then reviewed by Q/A team quarterly thereafter. Completion date January 13, 2007.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 2	F 223		

he was awake and ambulating on the unit in order to keep him separated from resident 6. Nurse Aide 2 stated that "both (resident 3) and (resident 6) are very strong men."

On 11/29/06 at 4:00 AM, resident 3 was observed sitting in his wheelchair near the facility's main nurses station, located off of the special needs unit. Resident 3 appeared to be sleeping. At that time, Nurse Aide 3, assigned to the special needs unit, was interviewed about resident 3. Nurse Aide 3 stated that resident 3 had "a rough night". "He has his days and nights mixed up so he's up a lot at night." Nurse Aide 3 further stated "we have to take him off the unit because it makes other residents mad if he is loud and wakes them up." Nurse Aide 3 was asked what would be done for resident 3 that morning. Nurse Aide 3 stated "he's quiet now, ready to sleep, so we'll bring him back and put him to bed." At approximately 5:00 AM, resident 3 was wheeled back to his room on the special needs unit and transferred to his bed.

At 8:00 AM, resident 3 was observed to be in his bed as other residents were being served breakfast. The surveyor asked Nurse Aide 2 "What about breakfast for (resident 3)?" Nurse Aide 2 stated that resident 3 had been up all night so "we will let him rest this morning."

On 11/27/06, an interview was held with a family member/responsible party of resident 3. During the interview, resident 3's family member stated that the family had concerns for resident 3's safety in the facility. Resident 3's family member stated that resident 3 had several instances of bruising over his arms, hands and face during the past four months and that a facility staff member

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 3 had reported to resident 3's family member that resident 6 had entered resident 3's room and assaulted resident 3 while he was sleeping. NOTE: On 8/7/06 11:00 PM, facility staff documented the following entry on resident 3's Nursing Notes: "(Resident 3) was asleep in the bed in his room and another resident came into the room and proceeded to slap him (resident 3). Staff intervened and removed resident from (resident 3's) room." The other resident was identified as resident 6. Resident 3's family member stated that concerns for resident 3's safety were presented to facility nursing staff and the facility social services worker at resident 3's Interdisciplinary Team (IDT) Meeting on 8/16/06. Resident 3's family member said the facility social worker stated "things were going much better between (resident 3) and (resident 6)." Resident 3's family stated that altercations between resident 3 and resident 6 had continued to occur after that meeting and that resident 3 was taken to his family doctor on 10/11/06 for bruising and injury to resident 3's right eye, including a dislocated intraocular lens implant. On 11/28/06, facility records, including incident reports and medical records for resident 3 and resident 6 were reviewed. A review of resident 3's nursing care plan under "Skin Integrity Care Plan" dated 8/7/06 revealed the following entries: a. "8/7/06 at 2300 (11:00 PM). (Resident 3) was asleep in bed when another resident entered his room and struck him (slapping)" (sic). The CNA (certified nursing assistant) was present in the (special needs) unit and removed the	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 4 attacking resident. No noticeable injuries were obvious." Resident 6 was identified as the other resident. b. "8/9/06 12:05 at mealtime. Another resident hit (resident 3) across the bridge of the nose after (resident 3) said 'oh shit'". Resident 6 was identified as the other resident. A review of resident 3's nursing notes revealed the following, in the order they appear in the record: a. "8/9/06 angry resident hit (resident 3) across bridge of nose. Scuffle of slapping and fist tossing followed. Separated by CNAs." "(Resident 3) to come out to meals and sit at a feeding assisted table (due to) combative behaviors of other residents against (resident 3) on unit." Resident 6 was identified as the other resident. b. "8/16/06 2:00 PM IDT (Interdisciplinary Team Meeting) held. (Family member for resident 3) was present. Overall resident doing well." No reference was found for instances of assault and injury with other residents. c. "8/7/06 at 2300 (11:00 PM) (Resident 3) was asleep in the bed in his room and another resident came into the room and proceeded to slap him (resident 3). Staff intervened and removed resident from (resident 3's) room." Resident 6 was identified as the other resident. d. "On 8/7/06 at (time undecipherable) (Resident 3) was struck on the arm two times from another resident because (resident 3) called the other resident (a profanity)." Resident 6 was identified as the other resident. e. "9/8/06 at 1:30 PM Another resident (resident 6) hitting (resident 3) with open hand to (resident 3)'s right face in dining room. Noted bruising to right hand and multiple (bruises) on	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 5 right arm, abrasions to right cheek." f. "9/26/06 09:30 AM Night nurse found bruise on right eyelid. Unknown origin. (Resident 3)'s Dr. notified." g. "10/5/06 1550 (3:50 PM) altercation between this resident and another resident. (Resident 3) received superficial scrapes over nose. Cleaned with normal saline. Residents were separated without difficulty." Resident 6 was identified as the other resident. This entry was signed by the facility's Director of Nursing (DON). h. "10/8/06 Noted right eye schelera (sic) reddened." A second entry by the facility's DON read: "1615 (4:15 PM) MD (medical doctor) notified of right eye - red and drainage. Request for antibiotic eye drops made". i. "10/13/06 at 1500 (3:00 PM) While resident (3) was receiving a shower, 3 dark purple bruises were found on (resident 3)'s lower right side of his back. They are all about 2 cm in length and 4 cm wide." Resident 3 was seen by his attending physician on 10/11/06, and was seen on 10/12/06 in follow up with an ophthalmologist for an injury to his right eye. A physician's clinical note in resident 3's medical record included the following documentation, "Patient was assaulted by another resident of the extended care facility where he is living. Had some facial and right orbital trauma. . . . It is difficult for the patient opened (sic) his right eye. He definitely has a laterally displaced pupil that is eccentric and the intraocular lens from his previous cataract surgery seems to be extruded into the anterior chamber." On 11/29/06, a review of the facility medical	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 6 record was completed for resident 3. The review showed: a. Nursing Monthly Assessment, dated 9/30/06, noted under the heading "Skin Condition" "bruise - right upper eye lid." b. Nursing Monthly Assessment, dated 10/18/06, noted under heading "Significant Improvement/ Decline..." "on receiving end of alteration with another resident with possible lingering effects to right lens replacement. Plan: Follow up with optometrist." c. Nursing Monthly Assessment, dated 11/27/06, noted under "Care Plan Review: . . . Problem: . . . Abuse by Another Resident. . . . Reason /Changes: No reports of recent abuse ". No evidence of care planning to prevent abuse, assault or injury were noted in the care plan for resident 3. On 11/29/06, the Administrator provided the surveyors a facility report titled "Inservicing" dated 10/7/06. This report included the following entry, "Walkie talkie for CNA assigned to special needs unit as well as charge nurses Recently, a nurse was on the Unit. Two male residents got into a physical altercation. The nurse tried to intervene. She did not have the walkie-talkie and she was essentially alone on the Unit. The ' fight ' between the Residents was starting to turn ugly (the men involved are both quite physically strong). So another male Resident tried to intervene - in order to help the nurse who was struggling to keep the men from hurting each other -and then he [the assisting resident] got punched too. So, imagine it: three strong male Residents, and one lone nurse, trying to break up	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223	Continued From page 7 the fight. She finally sent a Resident to bang on the door, in the hopes that someone would hear, and come to their rescue." On 11/29/06, the DON provided surveyors with an Adult Protective Services Report, dated 10/11/06, which described the altercation between resident 3 and resident 6 on 10/5/06 at 3:50 PM. This report was completed by the DON and included the following documentation: "(Resident 6) seemed (sic) to grab another resident's wheelchair/ ns.(nursing) had difficulty separating (sic) the two residents. (Resident 3) was scraped (sic) over bridge of his nose by (resident 6). Injuries: (Resident 6) 2 skin tears forearm and (resident 3) scrape over nose. What steps have been taken to prevent from recurring? Nsg (nursing) monitored more frequently."	F 223		
F 224 SS=G	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and reviews of records, it was determined that for 2 of 11 sampled residents, the facility neglected to respond with comprehensive and coordinated interventions to ensure that residents with known assaultive/combative behaviors were protected from each other. Resident identifiers 3 and 6. Findings included: 1. During the annual recertification survey on	F 224	F224 Staff will be inserviced upon the necessity of following the steps mentioned in F223, which support the current policy of prevention of Residents abuse—even between Residents themselves. The steps provide for comprehensive and coordinated interventions to ensure that Residents with known assaultive/combative behaviors are protected from each other. Beginning with referral for placement, the facility screens potential residents to determine if there is a prior pattern of abusive behavior.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 8 11/27/06 through 11/30/06, the facility's policy and procedure for prohibiting abuse was reviewed. The review revealed that the facility's policy and procedure included elements to prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. 2. Resident 6 was originally admitted to the facility on 7/17/06 and readmitted on 11/24/06 with diagnoses which included dementia, type II diabetes mellitus, congestive heart failure, lower extremity edema, sepsis and agitation. Resident 6 was accommodated on the special needs unit near the unit entrance. On 11/27/06, at approximately 8:30 AM resident 6 was observed ambulating in the hallway near the special needs unit dining room. Resident 6 approached the surveyor and was engaged in conversation. Resident 6 was asked if he was comfortable in the facility to which he responded "Yes." Resident 6 was observed to pace between the dining room and resident 3's room. He was also observed to be watching resident 3's room closely. At that time, resident 3 was not in his room. The surveyor asked resident 6 if he had any problems in the facility. Resident 6 responded that he had no problems with anyone in the facility and abruptly ambulated to his room. He was observed a few minutes later sitting in his room at the facility. He was further interviewed regarding his stay at the facility and had no complaints about cares. He was observed throughout the day, between 8:30 AM and 11:00 AM and again between 1:00 PM and 3:30 PM. He was observed to be ambulating on the special needs unit and seated in the special needs unit dining	F 224	In the event incidents occur between Residents, the steps to be taken include the following: Physically separate the residents involved from each other. This may include temporarily moving residents to rooms further away from each other, if necessary. Implementation of care plan to address behavioral issues. Reporting of incidents on 24 hour report , incident report generated, and addressed by department heads at daily standup meeting. Care plan team reviews care plan implemented at time of incident, and discusses and revises care plan as necessary. Care plan team discusses approaches used, evaluates if they are working, or comes up with alternatives as necessary. Care plan team re-asses and evaluates clients after any resident-to-resident incident, to prevent further problems. Care plan team monitors and documents successes of interventions used.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 9 room for lunch. Resident 6 was not observed to exhibit assaultive or aggressive behavior during the observations, and he was not observed to spontaneously engage in conversations with staff or residents. On 11/30/06 at 2:00 PM, Nurse Aide 4, who was assigned to the special needs unit, was interviewed. Nurse Aide 4 stated that resident 3 was very combative and that he used foul language. Nurse Aide 4 stated that resident 6 was very offended by resident 3's behavior and "fights him" (resident 3). Nurse Aide 4 stated "we have to keep them separated so they don't get into it with each other." A review of resident 6's facility record indicated the following: Nursing notes for resident 6 noted an incident on 7/17/06 at 7:35 PM, in which resident 6 had been in another resident's room showing verbal aggression by accusing the resident of taking his room and physical aggression by "twisting apart an aluminum beverage can into two ragged pieces". An entry for 7/17/06 at 7:45 PM, showed that resident 6 was demanding staff to open the unit door so he could leave. An entry on 7/17/06 at 8:15 PM, showed that resident 6 was given Ativan to calm his agitation. Resident 6's Skin Integrity Care Plan, dated 7/17/06, included the following documentation, "8/1/06 at 2030 (8:30 PM) Resident 6 was in BR (bathroom) and a resident from another room came in and started to hand fight. The other resident caught resident 6 by the arm and ... caused a skin tear. Right forearm dressed". This incident was also documented in resident 6's	F 224	Staff will also be inserviced upon the importance of following facility protocol concerning staff keeping Residents who reside on the Special Needs Unit, under close supervision. To ensure that solutions are sustained, the Quality Assurance Team will review Incident Reports tracking logs, and compare and contrast the log with the Investigation Log concerning Injuries of unknown Injury. The Administrator will assign a Department Head or Administrative staff , to do a monthly monitoring—including checking on a night shift, that the SNU is always under staff supervision. This will be documented and submitted to Administrator for review, and included in review by quarterly Quality Assurance Committee Meeting. The inservice training completed by Director of Nursing, Reviewed by Quality Assurance team, next scheduled meeting 1-12-07, then reviewed by Q/A team quarterly thereafter. Monitored quarterly by Administrator. Completion date January 13, 2007.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 10 nursing notes. An entry in nursing notes for resident 6 dated 8/5/06 at 2:00 PM showed resident 6 left the unit and went outside the facility. When approached, he refused to go back into the facility and became combative with staff. "2 nurses and 2 CNA's (certified nurse aides) escorted resident back to (special needs unit)". The facility records did not show an incident report for resident 6's behavior on 8/5/06. Resident 6's Psychotropic Medication Care Plan, dated 8/9/06, showed a notation that Seroquel 100 milligrams, twice a day, had been ordered for resident 6. The plan showed a notation of "Problem 8/9/06 3 incidents of slapping, hitting, verbal aggression in last 3 days. Goal Resident 6 will be free of physical aggression with other residents, particularly 1 resident. Plan 1) Other resident will take all med(ications) in main dining room out of unit and out of proximity to resident 6 during meals... and Eval(uation) 8/16/06 no further aggressive incidents noted". Resident 6's plan of care did not include interventions for staff to implement in order to prevent resident 6 from assaulting other residents. Entries in nursing notes for resident 6 revealed the following a. Entry dated 10/18/06, Interdisciplinary Team Meeting (IDT) was held to discuss a physical encounter with another resident which occurred 10/1/06. Note: There was no documentation available in resident 6's medical record nor a facility incident report to describe the physical encounter on 10/1/06.	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 11 b. Entry dated 10/19/06 marked "Late Entry", the facility planned to "maintain on Seroquel 300 milligrams each evening and bedtime and keeping (resident 6) more closely supervised and away from a particular resident who he does not get along with." c. Entry dated 10/29/06 at 1:25 PM, "In hallway in close proximity with other resident whose wheelchair bumped into (resident 6)'s. Angry words exchanged, batted at each other, hitting mostly CNA. Residents separated, (resident 6) to special needs unit." Resident 6's Nursing Monthly Assessments were reviewed for August 2006, September 2006, October 2006, and November 2006 (11/20/06) and revealed monthly entries showing: a. 8/20/06 "Resident (6) can become mean and onery very rapidly" and Psychotropic Med "Seroquel, Ativan" with "Seroquel increased to 100 milligrams twice a day". The summary noted no interventions under Care Plan Review to deal with resident 6's moods and assaultive behaviors. b 9/20/06 "Resident (6) becomes mean and onery at the slightest provocation." Psychotropic medications were noted to "have no effect yet" with no notation of changes to care plan or drug regimen. c. 10/20/06 "argues with other residents quickly slightest provocation". Psychotropic medications were noted to have "minimal change in behavior". Care Plan Review showed "Staff helps keep others away from (resident 6) during this time." d. 11/20/06 "mood is pleasant most of the time but can change very quickly at the slightest provocation". No change or effect was noted for medications. Care Plan Review was left blank. 3. Resident 3 was originally admitted to the	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 12 facility on 7/27/03 and readmitted on 7/31/06 with diagnoses which included dementia, coronary artery disease, dehydration, anxiety, hypothyroidism and status/post acute cardiovascular accident. Resident 3 was accommodated in a room near the special needs unit dining room. On 11/27/06, an interview was held with a family member/responsible party of resident 3. During the interview, resident 3's family member stated that the family has had concerns for resident 3's safety in the facility. Resident 3's family member stated that resident 3 had several instances of bruising over his arms, hands and face during the past four months and that a facility staff member had reported to resident 3's family member that resident 6 had entered into resident 3's room and assaulted him while resident 3 was asleep. Resident 3's family member stated that concerns for resident 3's safety were presented to facility nursing staff and the facility social services worker at resident 3's Interdisciplinary Team Meeting on 8/16/06. Resident 3's family member said the facility social worker stated "things were going much better between (resident 3) and (resident 6)." Resident 3's family member stated that altercations between resident 3 and resident 6 had continued to occur after that meeting and that resident 3 was taken to his family doctor on 10/11/06 for bruising and injury to resident 3's right eye, including a dislocated intraocular lens implant. Resident 3's medical record was reviewed on 11/28/06. The following was noted: a. 8/7/06 at 11:00 PM, a nursing entry documented, "(Resident 3) was asleep in bed when another resident entered his room and	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 13 struck him (slapping)" (sic). The CNA (certified nursing assistant) was present in the (special needs) unit and removed the attacking resident. No noticeable injuries were obvious." Resident 6 was identified as being the other resident. b. 8/8/06 at 6:30 PM, a facility incident report included documentation that, "(Resident 3) was struck in the arm (times) 2 by another resident because (resident 3) said the word SOB." c. 8/9/06 at 12:05 PM, a nursing entry documented, "Another resident hit (resident 3) across the bridge of the nose after (resident 3) said 'Oh shit'". Resident 6 was identified as the other resident. d. 9/8/06 at 1:30 PM, a nursing entry documented, "Another resident (resident 6) hitting (resident 3) with open hand to (resident 3)'s right face in dining room. Noted bruising to right hand and multiple (bruises) on right arm, abrasions to right cheek." e. 9/26/06 at 9:30 AM, a nurse note entry documented, "Night nurse found bruise on right eyelid. Unknown origin. (Resident 3)'s Dr.(doctor) notified." f. 10/5/06 at 3:50 PM, a nursing entry documented, "altercation between this resident and another resident. (Resident 3) received superficial scrapes over nose. Cleaned with normal saline. Residents were separated without difficulty." Resident 6 was identified as the other resident. This entry was signed by the facility's Director of Nursing (DON). g. 10/8/06, a nursing entry documented, "Noted right eye schelera (sic) reddened." h. 10/8/06 at 4:15 PM, a nursing entry documented, "MD (medical doctor) notified of right eye - red and drainage. Request for antibiotic eye drops made". i. 10/13/06 at 3:00 PM, a nursing entry	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 14 documented, "3 dark purple bruises were found on resident 3's lower right side of his back. They are all about 2 cm in length and 4 cm wide." Resident 3's plan of care did not identify resident 3's behaviors that contributed to other residents becoming assaultive toward him. Resident 3's medical record included documentation that the resident had been involved in physical altercations with resident 6 on 8/07/06, 8/08/06, 8/09/06, 9/8/06, and 10/5/06, and had been found to have a bruised right eye from an unknown source on 9/26/06. Additional injuries to the right eye and right side of resident 3's face were noted in the nursing notes for the dates of 8/9/06, 9/8/06, 9/26/06, 10/5/06, 10/8/06, and 10/13/06. Resident 3 was seen by his attending physician on 10/11/06, and on 10/12/06, in follow up with an ophthalmologist for injury to his right eye. A physician's clinical note in resident 3's medical record included documentation that the, "Patient was assaulted by another resident of the extended care facility where he is living. Had some facial and right orbital trauma. .. It is difficult for the patient opened (sic) his right eye. He definitely has a laterally displaced pupil that is eccentric and the intraocular lens from his previous cataract surgery seems to be extruded into the anterior chamber." 4. On 11/28/06 at approximately 2:30 PM, an interview was held with the Administrator to determine how the facility had responded to the physical altercations between resident 3 and resident 6 and to the injuries of unknown origin that resident 3 sustained.	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 15 On 11/29/06, the Administrator provided Incident Reports, dated 8/08/06, 9/8/06 and 10/05/06 for altercations involving resident 3. The Administrator did not provide Incident Reports, or other investigation/intervention(s) for the injury of unknown origin to resident 3's right eye, identified by nursing staff on 9/26/06, for the bruising of unknown origin discovered on 10/13/06, or for the trauma to resident 3's right eye identified in the physician's clinical note on 10/11/06. The Administrator was not able to identify how behavioral approaches to resident 3 or resident 6 evolved as the two residents continued to have physical altercations, some of which resulted in resident injuries. The interventions identified by the Administrator included general interventions such as keeping resident 3 and resident 6 separated and by providing walkie-talkies to staff. 5. On 11/28/06 at approximately 2:30 PM, an interview was held with the DON to determine how the facility had responded to the physical altercations between resident 3 and resident 6 and to the injuries of unknown origin that resident 3 sustained. On 11/29/06, the DON provided the surveyors with an Adult Protective Services Report, dated 10/11/06. Attached to the Adult Protective Services Report, were the facility Incident Reports, dated 10/5/06, which facility staff completed to document an altercation between resident 3 and resident 6 on 10/5/06 at 3:50 PM. The Adult Protective Services Report included the following documentation, "(Resident 6) seemed (sic) to grab another resident ' s wheelchair/ ns. (nursing) had difficulty separating (sic) the two	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 16	F 224		

residents. (Resident 3) was scraped (sic) over bridge of his nose by (resident 6). Injuries: (Resident 6 has) 2 skin tears forearm and (resident 3 has) scrape over nose. What steps have been taken to prevent from recurring ? Nsg (nursing) monitored more frequently."

During an interview, held 11/29/06 with the facility DON, the surveyor asked what steps the facility had put in place to protect resident 3 from further assault and injury. The Director of Nursing stated that, since the altercation on 10/05/06 in which the DON was involved with resident 3, resident 6 and another resident on the special needs unit, "we keep (resident 3) and (resident 6) separated when they are awake and active. We bring (resident 3) off of the unit for meals."

The DON stated that after the October incident, in which she was involved, the facility had started staffing "a continuous aide back on the (special needs) unit. Before, the aide on the unit would do showers, too. Now an aide stays back on the unit and another aide does showers." The DON further stated that "longer separation periods" were the measures taken after the October incident.

The surveyor asked the DON if the facility had implemented other behavioral interventions to ensure resident 3's safety and to investigate his injuries of unknown origin. The DON responded, "we've separated the two residents and had (resident 3) come out at mealtimes. That seemed like that was good enough."

When the DON was asked what had occurred to cause the trauma to resident 3's right eye, she stated that "we don't know what happened. It's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 17 just (resident 3's) family member's statement that (resident 3) was assaulted." The DON was not able to provide any other explanation, based on investigation, as to how the injury to resident 3's eye may have occurred. 6. On 11/29/06, beginning at 4:00 AM, observations of facility staffing were made. It was observed that the facility staff on this shift consisted of one licensed practical nurse (LPN) and two nursing assistants. The nurse was observed to be at the nurses station in the main hub of the facility, off of the special needs unit. The nursing assistants were observed to be working together to provide continence and turning/positioning cares. At various times, for periods up to 20 minutes, it was observed that the special needs unit did not have a facility staff member present. At times, the door to the special needs unit remained closed and locked to the general population of the facility.	F 224		
F 225 SS=G	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225	F225 Staff will be inserviced on the steps and processes to be followed, in order to support the policy and procedure to prevent abuse. Steps include the following. According to facility procedure all injuries of unknown origin are written on an incident report, as well as reported on the 24 hour report, which is given to the Director of Nursing. The D.O.N. reports the incident in the morning stand up meeting. (Administrator is notified.) These reports are reviewed daily at department head stand up meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 18 misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and reviews of records, it was determined that for 1 of 11 residents, the facility did not ensure that all injuries of unknown origin were reported immediately to the Administrator of the facility and to other officials in accordance with State law through established procedures. Additionally, the injuries of unknown origin were not investigated to determine the likely cause, nor was there evidence that the facility put in place measures to ensure the resident's safety while the investigation took place. Resident identifiers 3. Findings included: 1. Resident 3 was originally admitted to the	F 225	Proper State and Advocacy agencies are notified. The incident will be investigated by designated person. Incident Reports are logged, tracked, and reviewed regularly by D.O.N., to evaluate for trends. Care plans implemented and Revised and amended, as needed, by I.D.T. Team at next scheduled Care Plan Review meeting. Documentation completed on either Investigation Report, or in Resident's chart, includes probable reasons for injury (cause.) What was done to fix the problem (measures to ensure Resident's safety while investigation is taking place.) What was done to prevent the problem from happening again. Analyze physical environment. On a quarterly basis, the Quality Assurance Committee will review the Incident Report tracking log and incident report investigation log, to ensure reporting is done properly. Completed by Director of Nursing, monitored monthly by Administrator. Reviewed by Quality Assurance team, next scheduled meeting 1-12-07, then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 19 facility on 7/27/03 and readmitted on 7/31/06 with diagnoses which included dementia, coronary artery disease, dehydration, anxiety, hypothyroidism and status/post acute cardiovascular accident. Resident 3 was accommodated in a room near the special needs unit dining room. On 11/27/06, an interview was held with a family member/responsible party of resident 3. During the interview, resident 3's family member stated that the family has had concerns for resident 3's safety in the facility. Resident 3's family member stated that resident 3 had several instances of bruising over his arms, hands and face during the past four months and that a facility staff member had reported to resident 3's family member that resident 6 had entered into resident 3's room and assaulted him while he was sleeping. Resident 3's family member stated that the family's concerns for resident 3's safety were presented to facility nursing staff and the facility social services worker at resident 3's Interdisciplinary Team Meeting on 8/16/06. Resident 3's family member said the facility social worker stated, "things were going much better between (resident 3) and (resident 6)." Resident 3's family member stated that altercations between resident 3 and resident 6 had continued to occur after that meeting and that resident 3 had been taken to his family doctor on 10/11/06, for bruising and injuries to resident 3's right eye, including a dislocated intraocular lens implant. Resident 3's medical record included documentation that the resident had been involved in physical altercations with resident 6 on 8/07/06, 8/08/06, 8/09/06, 9/8/06, and 10/5/06.	F 225	reviewed by Q/A team quarterly thereafter. Completion date January 13, 2007.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 20 Per nursing documentation, injuries that resident 3 sustained during these physical altercations ranged from no apparent injuries on 8/7/06, 8/8/06, and 8/9/06, to bruising on his right arm and hand and an abrasion to his right cheek on 9/8/05 and scrapes across his nose on 10/5/06. In addition to the injuries with a known probable cause, nursing staff documented that resident 3 had injuries with an unknown cause. A nursing entry, dated 9/26/06 at 9:30 AM, included the following documentation, "Night nurse found bruise on right eyelid. Unknown origin. (Resident 3)'s Dr.(doctor) notified." The nursing documentation did not include evidence that the facility Administrator was immediately notified of the injury of an unknown origin to resident 3, or that additional interventions were put in place to ensure the resident's safety while the facility investigated the likely cause of the resident's injury. Additionally, resident 3's medical record did not include documentation to evidence that an investigation as to the likely cause of his injury had been initiated. Resident 3 was seen by his attending physician on 10/11/06, and 10/12/06 in follow up with an ophthalmologist, for injuries to his right eye. A physician's clinical note in resident 3's medical record included documentation that, "Patient was assaulted by another resident of the extended care facility where he is living. Had some facial and right orbital trauma. .. It is difficult for the patient opened (sic) his right eye. He definitely has a laterally displaced pupil that is eccentric and the intraocular lens from his previous cataract surgery seems to be extruded into the anterior chamber."	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 21 The nursing documentation did not include evidence that the facility Administrator was immediately notified of the injury of an unknown origin to resident 3, or that additional interventions were put in place to ensure the resident's safety while the facility investigated the likely cause of the resident's injury. Additionally, resident 3's medical record did not include documentation to evidence that an investigation as to the likely cause of his injury had been initiated. Resident 3 was identified as sustaining additional injuries of unknown origin. A nursing entry, dated 10/13/06 at 3:00 PM, included documentation that, "3 dark purple bruises were found on (resident 3)'s lower right side of his back. They are all about 2 cm in length and 4 cm wide." The nursing documentation did not include evidence that the facility Administrator was immediately notified of the injury of an unknown origin to resident 3, or that additional interventions were put in place to ensure the resident's safety while the facility investigated the likely cause of the resident's injury. Additionally, resident 3's medical record did not include documentation to evidence that an investigation as to the likely cause of his injury had been initiated. On 11/28/06 at approximately 2:30 PM, an interview was held with the Administrator to determine how the facility had responded to the injuries of unknown origin that resident 3 had sustained. On 11/29/06, the Administrator provided Incident Reports, dated 8/08/06, 9/8/06 and 10/05/06 for altercations involving resident 3 and resident 6.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 22 The Administrator did not provide Incident Reports, or other investigation/intervention(s) for the injury of unknown origin to resident 3's right eye, identified by nursing staff on 9/26/06, for the trauma to resident 3's right eye identified in the physician's clinical note on 10/11/06. or for the bruising of unknown origin, located on his back, discovered on 10/13/06. NOTE: There was not sufficient documentation available in resident 3's medical record to clarify if the laterally displaced pupil that was eccentric and the intraocular lens extruded into the anterior chamber, as noted by an opthalmologist on 10/12/06, were related to the bruised right eye injury, as noted by a facility nurse 9/26/06. The Administrator was not able to provide evidence that the facility had not conducted investigations to determine the likely cause, when resident 3 was identified to have the bruised right eye, the displaced intraocular lens, or the multiple bruises on his back, as identified on 9/26/06, 10/12/06, and 10/13/06 respectively. The Administrator was not able to provide evidence that the facility reported resident 3's injuries of unknown origin to the State Survey and Certification Agency. Additionally, other than general interventions such as keeping resident 3 and resident 6 separated and by providing walkie-talkies to staff, the Administrator was not able to identify comprehensive and coordinated facility interventions to ensure resident 3's safety. On 11/28/06 at approximately 2:30 PM, an interview was held with the DON to determine how the facility had responded to the injuries of unknown origin that resident 3 had sustained. On 11/29/06, the DON provided the surveyors	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 23	F 225		

with an Adult Protective Services Report, dated 10/11/06. Attached to the Adult Protective Services Report, were the facility Incident Reports, dated 10/5/06, which facility staff completed to document an altercation between resident 3 and resident 6 on 10/5/06 at 3:50 PM. The Adult Protective Services Report included the following documentation, "(Resident 6) seemed (sic) to grab another resident ' s wheelchair/ ns. (nursing) had difficulty separating (sic) the two residents. (Resident 3) was scraped (sic) over bridge of his nose by (resident 6). Injuries: (Resident 6) 2 skin tears forearm and (resident 3) scrape over nose. What steps have been taken to prevent from recurring ? Nsg (nursing) monitored more frequently."

During an interview, held 11/29/06 with the facility DON, the surveyor asked what steps the facility had put in place to protect resident 3 from further assault and injury. The Director of Nursing stated that since the altercation on 10/05/06, in which the DON was involved with resident 3, resident 6 and another resident on the special needs unit, "we keep (resident 3) and (resident 6) separated when they are awake and active. We bring (resident 3) off of the unit for meals."

The DON stated that after the 10/5/06 incident, in which she was involved, the facility had started staffing "a continuous aide back on the (special needs) unit. Before, the aide on the unit would do showers, too. Now an aide stays back on the unit and another aide does showers."

The surveyor asked the DON if the facility had implemented behavioral interventions to ensure resident 3's safety and if the facility had investigated the resident's injuries of unknown

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 24 origin. The DON responded, "we've separated the two residents and had (resident 3) come out at mealtimes. That seemed like that was good enough." When the DON was asked what had occurred to cause the trauma to resident 3's right eye, she stated that "we don't know what happened. It's just (resident 3's) family member's statement that (resident 3) was assaulted." The DON was not able to provide any other explanation, based on investigation, as to how the injury to resident 3's eye may have occurred.	F 225		
F 226 SS=G	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and reviews of record, the facility did not operationalize policies and procedures to prohibit abuse and neglect for 2 of 11 sampled residents. Findings included: During the annual recertification survey on 11/27/06, the facility's policy and procedure for prohibiting abuse was reviewed. The review revealed that the facility's policy and procedure included elements to prohibit mistreatment, neglect and abuse of residents, including Under the heading of "Prevention of Abuse" the facility policy stated, "Residents with challenging	F 226	F 226 According to facility procedure all injuries of unknown origin are written on an incident report, as well as reported on the 24 hour report, which is given to the Director of Nursing. The D.O.N. reports the incident in the morning stand up meeting. (Administrator is notified.) These reports are reviewed daily at department head stand up meeting. Proper State and Advocacy agencies are notified. The incident will be investigated by designated person.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 25 behaviors will be reviewed periodically at the interdisciplinary team meetings and the mood/; behavior/psychotropic meeting. Referrals will be made ...."; and "The facility will periodically analyze the physical environment, evaluate staffing to ensure sufficient numbers of ... staff ... and evaluate the careplanning process to ensure adequate monitoring of residents at risk for potential behavioral challenges." A review of resident 3's and resident 6's medical record as well as facility Incident Reports was completed on 11/29/06. Between 8/7/06 and 10/5/06, resident 3 and resident 6 were involved in five physical altercations. Per nursing documentation, injuries that resident 3 sustained during these physical altercations ranged from no apparent injuries on 8/7/06, 8/8/06, and 8/9/06, to bruising on his right arm and hand and an abrasion to his right cheek on 9/8/05, and scrapes across his nose on 10/5/06. Facility records showed evidence that resident 6's care plan was reviewed on 7/17/06, and was updated on 8/1/06 and 8/9/06. Facility records did not show that resident 6's care plan was reviewed by the interdisciplinary team, nor that the the facility periodically analyzed the physical environment, evaluated staffing and ensured adequate monitoring of residents at risk. Facility records showed evidence that resident 3's care plan was reviewed on 8/9/06. Facility records did not show that resident 3's care plan was reviewed by the interdisciplinary team, nor that the facility periodically analyzed the physical environment, evaluated staffing and ensured	F 226	Incident Reports are logged, tracked, and reviewed regularly by D.O.N., to evaluate for trends. Care plans implemented and Revised and amended, as needed, by I.D.T. Team at next scheduled Care Plan Review meeting. Documentation completed on either Investigation Report, or in Resident's chart, includes probable reasons for injury (cause.) What was done to fix the problem (measures to ensure Resident's safety while investigation is taking place.) What was done to prevent the problem from happening again. Analyze physical environment. IDT and psychotropic meetings, referrals will be made. Following an allegation of abuse, immediate implementation of increased monitoring will occur of any residents deemed to be at risk for abuse. In order to ensure that the facility operationalizes the policies and procedures for preventing abuse, the Quality Assurance Team will meet quarterly. The Team will review the Incident Report tracking logs, and evaluate for trends. The Team will review the Incident Investigation Log, and compare it to the Incident Report tracking log, and evaluate if there are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 26 adequate monitoring of residents at risk. Under the heading of "Identification of perpetrators and potential victims", the facility policy stated, "Each new resident will undergo a 'risk assessment' completed by nursing and/or social services in order to determine if the resident is at high risk for mood, behavior or psychosocial problems. If a resident is determined to be at risk, the interdisciplinary team will initiate appropriate monitoring and behavioral approaches using the care plan process." Reviews of the facility medical records showed no evidence that risk assessments, to determine mood, behavior, or psychosocial problems, had been completed for either resident 3 or resident 6. Under the heading of "Protection of high risk residents" the facility policy stated, "Following an allegation of abuse, the facility will immediately implement increased monitoring of any residents deemed to be at risk for further abuse. If the alleged perpetrator is a resident, the interdisciplinary team will convene as soon as feasible to review current plan of care and make any necessary revisions in order to ensure the safety of others." After documented physical altercations began on 7/17/06 between resident 6 and other residents and staff, including resident 3, there was no evidence that the interdisciplinary team initiated monitoring and behavioral approaches, using the care plan process to prevent further incidents. Facility records document physical incidents of aggression and assault involving resident 6 on 7/17/06, 8/1/06, 8/5/06, 8/7/06, 8/8/06, 8/9/06,	F 226	any incidents recurring between specific Residents. The Team will then make recommendations for change, as necessary. Completed by Director of Nursing, monitored monthly by Administrator. Reviewed by Quality Assurance team, next scheduled meeting 1-12-07, then reviewed by Q/A team quarterly thereafter. Completion date January 13, 2007.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 27 9/8/06, 10/1/06, 10/5/06 and 10/29/06. During an interview held 11/29/06, with the facility DON, the surveyor asked what steps the facility had put in place to protect resident 3 from further assault and injury. The Director of Nursing stated that, since the altercation on 10/05/06 in which the DON was involved with resident 3, resident 6 and another resident on the special needs unit, "we keep resident 3 and resident 6 separated when they are awake and active. We bring resident 3 off unit into for meals." The DON stated that after the October incident in which she was involved, the facility had started staffing "a continuous aide back on the (special needs) unit. Before, the aide on the unit would do showers, too. Now an aide stays back on the unit and another aide does showers." The DON further stated that "longer separation periods" were the measures taken after the October incident. When the DON was asked why the facility had not provided interventions to investigate resident 3's injuries and protect resident 3, the DON stated "we've separated the two residents and had (resident 3) come out at mealtimes. That seemed like that was good enough."	F 226		
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: The facility did not promote care for residents in a	F 241	F 241 A General Staff training session was held on 12/08/06. Ways to protect Residents' dignity were discussed and reviewed with staff. Specific	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 28 manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality, for 1 of 11 sampled residents and 1 supplemental resident. Specifically, the facility did not provide dignified and respectful dining assistance to resident 3 and did not provide physical privacy to resident.22. Findings included: 1. On 11/28/06 at 8:00 AM, residents, including resident 3, were observed sitting at the facility's assisted dining table in the main dining room, eating their breakfast with assistance of a facility staff person. At 8:25 AM and again at 8:30 AM, the facility staff person was overheard to tell resident 3 "stop biting me" and "don't bite". At 8:31 AM the facility staff person was overheard to state "That's it. (Resident 3) you're done." Resident 3 replied "I'll tell you when I'm done". The facility staff person stated "No. You're out of here. I've had enough. You're biting and throwing food on the floor." The facility staff person then ambulated resident 3 out of the dining room in his wheelchair. 2. On 11/28/06 at 9:45 AM observations were made of resident 22. Resident 22 was observed being pulled by a nursing assitant, backwards in a shower chair from her bedroom on the 300 hallway to the shower room on the 400 hallway. Resident 22 was partially covered in a bath blanket which left her inner thighs exposed. While resident 22 was being pulled backwards to the shower room she became incontinent of bowel outside the shower room. She was not wearing an incontinence brief.	F 241	behaviors to avoid included the examples of the two Residents listed. Both new staff, and general staff, will receive periodic instruction on ways to preserve residents' dignity. Upon hire, new care staff will receive instruction regarding proper ways to treat Residents in order to preserve dignity; current staff will receive the same instruction during general inservice training scheduled for January 10, 2007. To ensure compliance with this issue, the facility will employ the following: Use of Quality Assurance rounds, done on a weekly basis. Observation—and interventions as necessary—by Professional Nursing Staff and Department Head Managers, who are empowered to intervene as needed. Training Completed by Director of Nursing, monitored monthly by Administrator. Quality Assurance Committee will review quarterly, next scheduled meeting date January 12, 2007. Completion date January 13, 2007.	
F 253	483.15(h)(2) HOUSEKEEPING/MAINTENANCE	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 SS=E	Continued From page 29 The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: 2. The bathroom shared by room 400 and room 401 had a pipe with no shower head protruding above the tub. 3. The bathroom shared by room 403 and room 404 had a shower head at the end of a long shower hose. The shower head rested flat in the bathtub. There was no backflow valve for the shower. 4. The carpet in the common hallway of the special needs unit was observed to have dark stains intermittently spaced over the length of the hallway. The carpet had a loose patch, approximately 6 inches by 6 inches near the outside exit door. 5. Shower room 1 had rusty colored stains in the corner under the sink and at the back of the shower where the floor met the wall. 6. Shower room 2 had brownish stains in the left corner and approximately 1 foot up the wall. Based on observations, the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior; specifically, it was determined the special needs unit in the facility had a pervasive urine like odor present in the hallway which was strongest near the special needs unit resident dining room, the carpet in the	F 253	F 253 The tub and shower in bathroom between room 400 and 401, is not used for bathing purposes, and the showerhead was in the process of being replaced. The shower head was replaced on 12/22/06. A longer shower hose was only temporarily in place in shower in 403, as the shower hoses were back-ordered. The shower hose was received and replaced on 12/22/06. The stains in the Special Needs Unit were treated and cleaned. The 6x6 patch was in fact a covering for a drain clean-out valve; it has been repaired and glued firmly in place. Shower room 1 is currently not used for bathing purposes. The stains under the sink and in the shower stall will be repaired by Maintenance. Shower room 2 stains that did not clean with normal cleaning, will be repaired by Maintenance. The stains in the Special Needs Unit were treated and cleaned. The frayed carpet will be repaired. Shower rooms will be repaired by Maintenance. We have recently identified a resident with specific continence needs that occupied a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 30 special needs unit was torn and soiled, two common showers had dark stains, and two resident bathroom showers required maintenance. Findings include: 1. A strong urine like odor was observed to be present throughout the special needs unit on 11/27/06 during continuous observation from 1:00 PM to 3:00 PM. On 11/28/06 a strong urine like odor was observed to be present on the special needs unit in the hallway near the resident dining room and day room. On 11/29/06, a urine like odor was observed to be present on the special needs unit in resident rooms and the hallway adjacent to the dining room and day room. The urine like odor was observed to be stronger at approximately 8:00 AM through 10:00 AM but was noted to be present throughout the day. An interview was conducted with the facility maintenance man on 11/28/06 regarding air circulation, ventilation, housekeeping and urine odors on the special needs unit. The facility maintenance man stated that the facility was aware there was a problem with urine odors on the special needs unit but had not been able to come up with a solution to the problem.	F 253	carpeted room has been relocated to a linoleum room. And the affected areas have been deep cleaned. Cont - F 253 Department Heads and General Staff will be taught to watch for environmental repairs needed, and to document them in the 'Maintenance Communication Book' located at the Nurses' Station. The training inservice is scheduled for January 10th, 2007. The Maintenance person will check the book regularly—at least weekly, and perform repairs needed, and document such in the Book. The maintenance will do a monthly facility walk through and record on preventative maintenance checklist.. Completed by Maintenance, monitored monthly by Administrator, reviewed by Quality Assurance Team on next scheduled meeting on January 12, 2007, and then reviewed quarterly by Q/A team thereafter. Completion date January 13, 2007.	
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined that the facility did not store, prepare and distribute food under sanitary conditions. Findings included: On 11/28/06 at 9:30 AM, observations were made in the kitchen. The following concerns were observed: 1. The walk in freezer contained a cup of ice cream that was not covered or dated; a cup of fruit that was not dated or labelled, and three boxes of food items that were stored directly on the floor of the freezer. A middle shelf on the south wall of the freezer was observed to have a dried, brownish, crusty substance that was built up across the metal shelf wires. 2. The refrigerator contained 3 and 1/2 bags of shredded cheese dated 5/17/006 and 2 packages of sliced cheese that were opened, uncovered and dated 5/17/06. 3. A fan cover on the air vent in the west wall of the kitchen was dusty. The air vent was observed to be venting air directly from the outside of the building into the kitchen. 4. During a second observation made in the kitchen on 11/28/06, a kitchen staff member was observed putting clean dishes away with ungloved hands.	F 371	F 371 Dietary Manager inventoried walk-in freezer and refrigerator and discarded all expired items, including unlabeled item. Boxed food was placed properly on shelf. All items were properly dated and covered. The shelves were checked in the freezer. The fan cover on the air vent was taken down and cleaned. Dietary staff will be trained on the importance of putting all food items on the proper shelves in the walk-in refrigerator and freezers. The Cooks will be trained on their responsibility to check daily, to ensure that food is both stored and labeled properly. The employee listed, who was putting away clean dishes, had just washed her hands. It is not a requirement that hands be gloved in order to put away clean dishes. Dietary Manager will monitor by also performing a monthly, random observation and inspection, for next quarter, then quarterly after that, to ensure compliance. Completed by Dietary Manager, monitored by Administrator. Reviewed quarterly by Quality Assurance team, next scheduled meeting 1/12/07. Completion date January 13, 2007	
F 426	483.60(a) PHARMACY SERVICES -	F 426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 426 SS=D	Continued From page 32 PROCEDURES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility did not ensure accurate administration of medications for 1 of 7 sampled residents who had not received a physician prescribed medication. (Resident identifier: 4) Findings included: Resident 4 was admitted to the facility 4/25/06 with diagnoses that included acute renal failure, hypertension, benign prostatic hyperplasia, depression and multiple sclerosis. Resident 4's medical record was reviewed on 11/28/06. The physician's orders, signed 9/28/06 for Annusol H.C. suppositories: insert into rectum nightly. Quantity 12 with 3 refills. Resident 4's Medication Administration Records (MARs) dated September 2006, October 2006 and November 2006 were reviewed. The MAR's did not have the physicians order for Annusol H.C. insert into rectum nightly. On 11/28/06 at 2:30 PM, the surveyor asked the Licensed Practical Nurse (LPN), assigned to	F 426	F 426 The revised system to convey changes in orders appropriately to Medical Records, will consist of the following. Nursing staff will copy any physician referrals that contain revised orders, telephone orders and place them in the Medical Records communication box, so that the orders and Medication Administration Records, which are updated monthly, will be accurate. In order to verify that no other patients are affected by same problem, nursing will perform three-way checks/audit of remaining patient charts in facility. The Director of Nursing will train and in-service nursing staff on the importance of following correct procedure of communicating order changes to Medical Records, and the importance of performing monthly three way checks. Director of Nursing will monitor by performing a minimum of 2 random audits of two Resident charts per month , for the next 3 months, then quarterly thereafter, focusing on Physician Orders, to ensure communication is occurring properly with Medical Records.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 426	Continued From page 33 resident 4, to show all available doses of Annusol for resident 4. The LPN searched the medication refrigerator located in the medication room. Within the medication refrigerator there were 12 Annusol suppositories dated 9/30/06 for resident 4. On 11/28/06 at 3:00 PM an interview was held with the Director of Nursing (DON). The DON stated that the medication was not administered because it did not get transcribed to the MAR properly.	F 426	Completed by Director of Nursing, monitored by Administrator. Reviewed by Quality Assurance team, next scheduled meeting January 12, 2007, then reviewed by Q/A team quarterly thereafter. Completion date January 13, 2007.	
F 432 SS=E	483.60(e) STORAGE OF DRUGS AND BIOLOGICALS In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined the facility did not store all drugs and biologicals in locked compartments or prevent potential access by unauthorized persons.	F 432	F 432 The Nursing Director will train and inservice nursing staff on the importance of keeping the medication room door secure at all times. Director of Nursing will do monthly checks on varying shifts to ensure compliance. The refrigerators mentioned in the survey are separate from each other. The medication refrigerator is separate from the one used for specimens. Completed by director of nursing, monitored by Administrator. Reviewed by the Quality Assurance Team, at the next meeting scheduled for January 12, 2007. Reviewed by Q/A team quarterly thereafter. Completion date January 13, 2007.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 432	Continued From page 34 Findings included: On 11/29/06 at 4:00 AM, observation was made of the medication room from the area of the nurses' station. The door to the medication room had been propped open. A stack of bubble packed medications was observed to be on the counter. On 11/29/06 at 4:15 AM, the surveyor entered the medication room. A refrigerator containing two urine samples was accessible and a refrigerator containing insulins and suppositories was accessible. The medication packets on the counter were observed to contain: antipsychotic: Risperdal 1 mg, 15 tablets, Seroquel 300 mg, 30 Tablets, antidepressant: sertraline Hcl 50 mg, 25 tablets, paroxetine Hcl 30 mg, 30 tablets, mirtazapine 15 mg, 30 tablets, anticonvulsant: Depakote 500 mg, 5 tablets, antihypertensive: hydralazine Hcl (hydrochlorothiazide) 50 mg, 80 tablets, labetalol Hcl 200 mg, 120 tablets, Coreg 6.25 mg, 60 tablets, metoprolol tartrate 25 mg, 4 tablets, lisinopril 5 mg, 30 tablets, diuretic: Lasix 80 mg, 30 tablets, Lasix 20 mg, 30 tablets, antidiabetic: Avandia 4 mg, 30 tablets, central nervous system: Aricept 10 mg, 30 tablets	F 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 432	Continued From page 35 The medication room was observed to have been blocked open for 40 minutes. During the time the medication room had been blocked open, from 1 to 3 residents were observed to be near the nurses station and the medication room. The nurse was helping answer call lights and unable to monitor the room continuously	F 432		
F 496 SS=E	483.75(e)(5)-(7) REQUIRED TRAINING OF NURSING AIDES Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.	F 496	F 496 C N A Registry The registry was checked on the employees mentioned, and verifications have been completed. Director of Nursing was trained on how to access the C.N.A. registry online and obtain verification of certification. The registry will be checked and verification printed before the applicant is hired and works the floor. If the applicant is in a certification class at the time of hire, the registry will be checked and printed and the Director of Nursing will verify and document participation in class. Business Manager will not create a time card for new employees until proper documentation has been received. D.O.N. will track and ensure that certification is completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 496	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on staff interviews, review of employee files and a review of the facility's policies and procedures on abuse, it was determined that the facility did not implement procedures that included an investigation for a history of abuse, neglect or mistreating residents prior to allowing nurse aide staff to provide direct care to residents. The facility did not obtain Certified Nurse Aide (CNA) Registry verification for 4 of 4 nurse aides (NA) reviewed. Staff identifiers: NA 3, NA 4, NA 5, and NA 6. Findings include: On 11/27/06, a current list of new employees was obtained from the facility. The files of 5 of the employees were reviewed to determine that the appropriate background information had been obtained. Four of the five employee records reviewed were for nurse aides. The surveyor verified the date the facility obtained CNA Registry verification and also the date in which each nurse aide began providing direct care to residents. NA 3 began providing direct care to residents on 9/4/06. Per documentation, the facility did not obtain CNA Registry verification until 9/17/06. NA 4 began providing direct care to residents on 9/2/06. Per documentation, the facility did not obtain CNA Registry verification until 9/25/06. NA 5 began providing direct care to residents on 8/20/06. Per documentation, the facility did not	F 496	Completed by Director of Nursing, monitored monthly by the Business Personnel Manager , and reported to the Administrator. Reviewed by the Quality Assurance Team, at the next meeting scheduled for January 12, 2007, and reviewed by Q/A team quarterly thereafter. Completion date January 13, 2007. ~~F 502~~	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 496	Continued From page 37 obtain CNA Registry verification until 8/23/06. NA 6 began providing direct care to residents on 6/27/06. Per documentation, the facility did not obtain CNA Registry verification until 11/29/06. An interview was held with the Human Resource Director on 11/29/06 at 2:30 PM. The Human Resource Director stated that she has not been checking the CNA registry verification before employees worked their first scheduled shift.	F 496		
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility did not obtain laboratory services, as ordered by the physician, to meet the needs of its residents for 2 of 11 sample residents. Residents 1 and 4. Findings included: 1. Resident 4 was admitted to the facility 4/25/03. Resident 4 had diagnoses which included deep vein thrombosis. Resident 4 had an anticoagulant medication for his history of deep vein thrombosis. A physician's telephone order, dated 9/13/06, clarified that resident 4 had been prescribed Coumadin 5.5 milligrams to be given daily.	F 502	F 502 Nurses will audit all patient charts to ensure all ordered labs completed properly. Nursing staff will be taught and inserviced on the importance of making sure that Physician-ordered labs are placed immediately into the Lab Book. Nurses working the night shift will have the responsibility to audit Physician Orders in patient charts, looking for labs, and ensuring that they are placed in the lab book. D.O.N. will monitor by performing a random weekly audit of a 'physician orders' section of a patient chart, compared to the lab book, to ensure compliance, and report findings for Q/A Team. Completed by Director of Nursing, monitored by Administrator. Reviewed by Quality Assurance team, next	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 38 The physician ordered blood testing, PT (prothrombin time) / INR (international ratio), to monitor the efficacy of resident 4's anticoagulant medication. When they were received from the laboratory, resident 4's laboratory results were called to the physician and noted by the nurse. Resident 4's PT/INR was checked on 10/30/06 and the results were called to the physician the same day. The nurse received a new telephone order to have the test repeated in one week. The next PT/INR would have been due 11//8/06. On 11/28/06 at 1:50 PM, the Director of Nursing (DON) was notified there was no laboratory report indicating the test for resident 4, that was due 11/8/06, had been completed. The DON was asked to provide any laboratory reports to document resident 4's PT/INR had been tested on or near 11/28/06. The DON then called Schryver Medical Laboratories where the PT/INR was processed. They confirmed that the last PT/INR for resident 4 was completed on 10/30/06. 2. Resident 1 was admitted to the facility 4/5/06 with diagnoses which included hypertension, weight loss and anxiety. Resident 1's record was reviewed on 9/27/06. A physician's telephone order, dated 9/30/06, revealed resident 1 was to have had a urinalysis with culture and sensitivity. The laboratory result was not found in the resident's medical record. On 11/28/06, the Director of Nursing (DON) and	F 502	scheduled meeting 1-12-07, then reviewed by Q/A team quarterly thereafter. Completion date January 13, 2007.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 39 Medical Records staff were asked to locate the laboratory result. The facility did not locate any urinalysis test results.	F 502	F 507 Nurses will audit all patient charts to ensure all ordered labs are completed properly, and that all ordered lab results have been placed into the residents' medical record. Nursing staff will be taught and inserviced on the importance of making sure that Physician-ordered labs are placed immediately on the calendar and the night nurse will create requisition forms. When labs are received they are noted as received on the requisition form and Physician notified and then placed in Physician's box for signature. Once signed, they are placed into the Resident's medical record. Nurses working the night shift will have the responsibility to audit Physician Orders in Resident charts, looking for labs and ensuring that they are placed on calendar, verifying results have been received, and then placed in the appropriate location. D.O.N. will monitor by performing a random weekly audit of 'physician orders' section of a patient chart, compared to the lab book, to ensure compliance, ensure that results are in chart, and report findings to Q/A Team. Completed by Director of Nursing, monitored monthly by Administrator at department head meeting. Reviewed by Quality Assurance team, next scheduled meeting 1-12-07, then reviewed by Q/A team quarterly thereafter. Completion date January 13, 2007.	
F 507 SS=D	483.75(j)(2)(iv) LABORATORY SERVICES The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on interview and medical record review, it was determined that the facility did not obtain timely laboratory results for 1 of 7 sample residents as ordered by the physician. Resident 2 Resident 2 was admitted to the facility on 7/13/05 with diagnoses which included anemia, rheumatoid arthritis, chronic obstructive pulmonary disease, esophageal reflux, hip replacement and type two diabetes. A complete review of resident 2's medical record was completed on 11/28/06. On 11/22/06 at 2:10 PM, a physician's order was obtained for a UA (Urinalysis). There was no documented evidence in the medical record that the UA was completed. On 11/28/06 at 1:40 PM a staff LPN (Licensed Practical Nurse) was interviewed about the ordered UA for resident 2. She stated that the results were not in the medical record. LPN 1 called Schryver Medical Laboratory at 1:45 PM to check on results of resident 2 ' s UA. The UA	F 507		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 40 results were faxed to the facility on 11/28/06 at 1:50 PM.	F 507		
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility did not ensure accurate administration of medications for 3 of 7 sampled residents and 2 additional residents. One resident did not have a physician order transcribed correctly, the medical records for two residents contained information for two different residents. (Resident identifier: 4, 5, 10, 18, 22) Findings included: 1. Resident 4 was admitted to the facility 4/25/06 with diagnoses that included acute renal failure, hypertension, benign prostatic hyperplasia, depression and multiple sclerosis. Resident 4's medical record was reviewed on 11/28/06.	F 514	F 514 The revised system to convey changes in orders appropriately to Medical Records, will consist of the following. Nursing staff will copy any physician referrals that contain revised orders, telephone orders and place them in the Medical Records communication box, so that the orders and Medication Administration Records, which are updated monthly, -will be accurate. In order to verify that no other patients are affected by same problem, nursing will perform three-way checks/audit of remaining patient charts in facility. The Director of Nursing will train and in-service nursing staff on the importance of following correct procedure of communicating order changes to Medical Records, and the importance of performing monthly three way checks. Director of Nursing will monitor by performing a minimum of 2 random, monthly audits of 2 patient charts, for the next 3 months, then quarterly thereafter, focusing on Physician	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 41 The physician's orders, signed 9/28/06, revealed resident 4 was to receive Annusol H.C. suppositories: insert into rectum nightly. Quantity 12 with 3 refills. Resident 4's Medication Administration Records (MARs) dated September 2006, October 2006 and November 2006 were reviewed. The MAR's did not have documentation of the physician's order for Annusol H.C. nightly. On 11/28/06 at 2:30 PM, the surveyor asked the Licensed Practical Nurse (LPN), assigned to resident 4, to show all available doses of Annusol for resident 4. The LPN searched the medication refrigerator located in the medication room. Within the medication refrigerator there were 12 Annusol suppositories for resident 4. On 11/28/06 at 3:00 PM an interview was held with the Assistant Director of Nursing (ADON). The ADON stated that the medication was not administered because it did not get transcribed to the MAR properly. 2. The medical record for resident 5 was reviewed on 11/27/06. The social services progress note for resident 5, dated 6/20/06, began with the name of resident 18 rather than resident 5. 3. Resident 10's medical record was reviewed on 11/29/06. Physician's orders dated 11/3/06, for resident 22, were found in resident 10's medical record.	F 514	Orders, to ensure communication is occurring properly with Medical Records. Completed by Director of Nursing, monitored by Administrator. Reviewed by Quality Assurance Committee; next scheduled meeting 1/12/07, and then quarterly thereafter. Completion date January 13, 2007.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	C 11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: 2. The bathroom shared by room 400 and room 401 had a pipe with no shower head protruding above the tub. 3. The bathroom shared by room 403 and room 404 had a shower head at the end of a long shower hose. The shower head rested flat in the bathtub. There was no backflow valve for the shower. 4. The carpet in the common hallway of the special needs unit was observed to have dark stains intermittently spaced over the length of the hallway. The carpet had a loose patch, approximately 6 inches by 6 inches near the outside exit door. 5. Shower room 1 had rusty colored stains in the corner under the sink and at the back of the shower where the floor met the wall. 6. Shower room 2 had brownish stains in the left corner and approximately 1 foot up the wall. Based on observations, the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior; specifically, it was determined the special needs unit in the facility had a pervasive urine like odor present in the hallway which was strongest near the special needs unit resident dining room, the carpet in the	F 253	F 253 Duplicate - Please refer to POC on Recertification Survey page 30.	

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

Administrator 1/5/07

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	C 11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 1 special needs unit was torn and soiled, two common showers had dark stains, and two resident bathroom showers required maintenance. Findings include: 1. A strong urine like odor was observed to be present throughout the special needs unit on 11/27/06 during continuous observation from 1:00 PM to 3:00 PM. On 11/28/06 a strong urine like odor was observed to be present on the special needs unit in the hallway near the resident dining room and day room. On 11/29/06, a urine like odor was observed to be present on the special needs unit in resident rooms and the hallway adjacent to the dining room and day room. The urine like odor was observed to be stronger at approximately 8:00 AM through 10:00 AM but was noted to be present throughout the day. An interview was conducted with the facility maintenance man on 11/28/06 regarding air circulation, ventilation, housekeeping and urine odors on the special needs unit. The facility maintenance man stated that the facility was aware there was a problem with urine odors on the special needs unit but had not been able to come up with a solution to the problem.	F 253		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	C 11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility did not perform blood glucose checks four times a day as had been ordered by the physician of a diabetic resident. Resident 11. Findings included: Resident 11 was admitted to the facility 8/19/06 with diagnoses that included diabetes mellitus. ischemic ulcers, congestive heart failure, chronic obstructive pulmonary disease and chronic severe foot pain. The admitting physician's orders for resident 11, dated 8/19/06, included an order that the resident was to have her blood glucose level checked four times daily; before each of her three meals and when she went to bed. The blood glucoses monitoring chart for resident 11, dated August 2006, was reviewed. The nurses documented when they checked resident 11's blood glucose levels and the results on the monitoring chart. As ordered, resident 11's blood glucose levels should have been checked 44 times from the time she admitted to the facility at noon on 8/19/06 until she left on 9/30/06 at 1:30 PM. The nurses actually documented resident 11's blood glucose checks 25 times during that period. Nineteen blood glucose checks were not documented as having been completed. In the Brunner and Suddarth's Textbook of Medical Surgical Nursing, eighth edition, Lippencott Raven Publishers, 1996" Suzanne Smeltzer, RN and Brenda Bare, RN, page 1028 and 1029 states, "Blood glucose monitoring is a	F 281	F 281 The Director of Nursing will inservice and train the licensed nursing staff, upon the importance of documentation, specifically regarding blood glucose checking and monitoring. In order to verify that no other Residents are affected, a complete chart audit will be completed by nurses, to verify all Residents who need glucose monitoring are receiving it as ordered. Monthly chart audits will then be implemented, on those Residents who receive glucose monitoring. Chart audits to be performed by Medical Records person, and given to Director of Nursing for Review. Completed by director of Nursing, monitored by Administrator, reviewed by Quarterly Quality Assurance Committee, next scheduled meeting January 12, 2007. Completion date January 13, 2007.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465086	A. BUILDING _____ B. WING _____	C 11/30/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HEALTH SERVICES	5865 SOUTH WASATCH DRIVE OGDEN, UT 84403

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 3 useful procedure for all people with diabetes. . . ."	F 281		