CC NUMBER: Vita 23168

PRINTED: 02/28/2005
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465069	A. BUILDING _____ B. WING _____	C 02/22/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT OGDEN NURSING & REHAB	375 EAST 5350 SOUTH OGDEN, UT 84405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 324 SS=G	483.25(h)(2) QUALITY OF CARE The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff interviews, it was determined that the facility did not provide adequate supervision and implement procedures to prevent accidents. Specifically, a resident (resident 1) was left by a physical therapy aide, unattended and without supervision, in therapy pool for approximately four minutes. Upon the return of the physical therapy aide, resident 1 was found face down in therapy pool. Resident 1 was pulled from pool by facility staff and CPR (Cardiopulmonary Resuscitation) was initiated. Some 50 minutes after being found in the pool, resident one was pronouced dead by the local paramedics. Findings include: 1. In an interview with the facility physical therapist on 2/22/05 at 1:20 PM, the therapist stated that resident 1 had been receiving physical therapy for neck and shoulder pain related to her recent fall on 2/7/05. The therapist stated that he had evaluated resident 1 for pool therapy exercises and whirlpool therapy to help alleviate her pain. The therapist stated that his treatment plan for resident 1 was for resident 1 to do pool exercises for 30 minutes, under the supervision of a therapy aide and then to sit on the bench of the pool, for 10 minutes and have the water jets to "relieve" the pain in the resident's neck and shoulders. The therapist stated that on 2/18/05, resident 1 had been in the pool for her 30 minutes	F 324	F324 On February 22nd the facility swimming pool was drained and closed. A final decision for closing the pool was made on March 1st 2005, based upon the cost effectiveness of operating the pool, as well as the liability risk associated. We will not be offering pool therapy for our patients in the future. Within 48 hours of Admit, or new physical therapy orders given, the Director of Nursing will provide the Director of Physical Therapy a completed Physical Restraint Eval/ Assessment/ Consent form for each of the patients who receives physical therapy, (See attached tool).	April 15, 2005

3/14/05 POC acceptable compliance date 4/15/05 Usenbuth RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3-10-05

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

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F 324	Continued From page 1 of supervised exercise and the therapy aide had the resident sit on the bench for her 10 minutes of water jet therapy. At the end of the ten minutes, the resident requested to sit with the jets on for an additional period of time and that the aide reset the timer and left resident 1 alone in the pool while she took another resident back to their room (approximately 4 to 5 minutes). The therapist stated that when the aide returned to the pool area, resident 1 was found with her head under the water in the pool. 2. Resident 1 was admitted to the facility on 7/03/2004 with the diagnoses of peripheral vascular disease, diabetes mellitus, allergies, anemia, cancer, and renal failure. Resident 1 was discharged from facility and admitted to the hospital on 2/07/2005 for a subdural hematoma she sustained after a fall in the facility bathroom. Upon admission to the hospital, resident 1 stated she had become dizzy while getting up to use the restroom and fell. Resident 1 was readmitted to the facility on 2/10/05 with diagnoses including, weakness, end-stage renal failure, hyperkalemia, diabetes mellitus, hypertension, congestive heart failure and subdural hematoma. Resident 1's admitting orders included orders for physical therapy. 3. On 2/10/2005 a facility nurse documented on the Nursing History and Admission Assessment form that resident 1 had difficulty in new situations, decisions were poor, supervision/cues were needed and resident could ambulate with "supervision only." Resident 1 was also assessed as having dizziness and unsteady gait with a fall in the last 30 days. The safety portion of the assessment form indicated that resident 1 was a	F 324	The Director of Therapy will meet with his therapy staff to discuss the safety enhanced procedures relating to therapy. A member of the therapy staff will always be present in the gym during therapy secessions with patients. A oxygen concentrator will also be available in the Therapy gym if needed, as well as a pulse oxyimeter. The Administrator, and Director of Nursing will complete a tool for each resident who desires to go out of the facility on a leave of absence by themselves. (See attached tool). The Administrator will discuss the new tool with the staff on March 10, 2005. It will be placed in the resident's chart, with a flag	

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F 324	Continued From page 2 Fall Risk. The Activities of Daily Living portion assessed resident 1 as requiring one-person assistance in the following areas, transferring, toileting, and dressing. 4. A Physical Therapy Evaluation was done on 2/11/2005. Findings include: 1) Patient lost balance occasionally, 2) Safety concerns were present during standing, and pivoting to a wheel chair, patient should not be allowed to attempt these activities unassisted, 3) Gross bed mobility was limited by weakness, 4) Transfers were limited by weakness, imbalance, and shoulder pain, and fall risk was mild to moderate. Physical Therapy assessed resident 1 as needing contact guard (A qualified and trained individual to have hands on the patient while patient is performing tasks to assist if needed) for all transfers. On 2/18/2005 a Physical Therapy Discharge Summary was performed. This summary documented that resident 1 had been improving in bed mobility, transfers, and balance. It was also documented in the discharge summary that resident 1 had consistent performance in gait. In a physical therapy note dated 2/14/2005, resident 1 asked physical therapist 1 if she could start ambulating behind her wheel chair like she did prior to going to the hospital and physical therapy recommended that resident 1 wait one week before this activity. In an interview with Physical Therapist 1 on 2/22/05, at 1:20 PM, he stated he had assessed resident 1 as needing pool therapy three times a week. He stated that he had assessed this need on 2/15/05. The physical therapist stated in his interview on 2/22/2005 that he believed per his assessment that resident 1 was safe to be in pool	F 324	sheet in the Resident sign out book. The nurse assisting the Resident who is signing out will then check to see if the Resident qualifies to go out by themselves, or to ensure that safety measures such as oxygen are in place before the Resident goes out. The Administrator will be responsible to ensure compliance, and the completed tools will be shared each month in our Quality Assurance meetings.	

MOUNT OGDEN NURSING & REHAB

PHYSICAL RESTRAINT EVAL/ASSESSMENT/CONSENT

RESIDENT _____ DATE _____

This facility promotes the dignity and independence of our residents. Residents have a right to live without fear of physical restraint. The use of restraints is prohibited for purposes of discipline or staff convenience, and are used solely to treat a resident's medical symptoms. When alternatives to restraints are not effective, the interdisciplinary team evaluates the least restrictive restraint to promote safety and attain/maintain the highest practical, physical, mental and psychosocial function of the resident. The following evaluations have occurred, and the recommendations are as follows.

REFERRAL REASON

ASSESSMENT FOR RESTRAINTS;

I. Cognition/Judgment

Comatose_____ Confused_____ Oriented_____ Times_____

Follows directions **Able to**_____ **Unable to**_____

Awareness of environment/safety

Good_____ Fair_____ Poor_____

II. Ambulation/transferring ability

Sit to stand_____Indopendent_____ Assist required of 1 ___ Assist required of 2 ___

Standing Posture: Erect_____ Leans right_____ Leans Left_____ Leans Back_____Slumps_____

Ambulation: Independent _____**Assist required of 1**_____ **Assist required of 2**_____**Unable**_____

Contracture: _____**Yes** _____**No** **Site**_____

History of falls last 3 months _____**No**_____**Yes**

III. Sitting Posture

Leans to the right_____ **Leans to the left**_____ **Leans front**_____ **Leans back**_____ **Slumps**_____

IV. Symptoms / Diagnosis that indicate need for restraint_____

V. Alternatives recommended

Least restrictive alternatives: _____**footrests on w/c** _____**gait training** _____**geri chair**_____ **non-slip fabric**

_____**increased supervision** _____**pillow/pads** _____**pommel cushion** _____**postural support** _____**tilted w/c**

_____**Low bed** _____**strengthening exercises by PT/RTA/CNA/OTHER**

Staff / family / resident education _____

Environmental changes / staff intervention_____

VI. Restraint type least restrictive to be used if indicated:

_____**Geri chair** _____**Lap buddy** _____ **Mats on floor** _____**Side rails x1 x2** _____**Self release belt**

_____ **Crotch restraint** _____**Other**

VII. Frequency and reasons for alternative/restraints:

_____**Maintain safety**
_____**Enhance increased self mobility and repositioning**
_____**Maintain an upright position despite decreased upper body strength**
_____**Protect from life threatening injury due to falls**
_____**To enable nutritional support of medical treatment to proceed**
_____**Enable to remain seated when not being assisted to transfer/ ambulate**
_____**Enable to interact socially in the environment**
_____**To remind to call for assistance with all transfers**
_____**At all times** _____**While in bed** _____**While in chair** _____**During meals** _____**During activities**
_____**While ambulating** _____**Other**_____

Assessment completed by_____PT / RTA
Date_____
Assessment reviewed by IDT team members:Date_____SSW_____
TRT_____NSG_____
DON_____Dietary_____
PT_____MDS coordinator_____

VIII. Potential benefits;
- Prevention of falls which could result in injury
- Protection from other accidents/.injuries
- Protection of other residents from physical harm
- Aid in maintaining proper positioning and feeding
- Increased feeling of safety/ security by the resident
- Allow medical treatment to proceed with interference

Potential risks;
- Incontinence
- Injury from fall/injury from the restraint
- Functional decline
- Skin breakdown / abrasions
- Circulatory compromise
- Decreased social contact

I understand that we will re-evaluate the continued need and possible options for restraint use on a continual basis with the goal to become restraint- free.
_____I consent to the use of restraints for the reasons stated above and understand the risks involved.
_____I do not consent to the use of restraints and understand the risk involved

_____

Resident / Legal Representative / Guardian **Date**

_____

Facility Representative **Date**

IX. Physician notified_____Yes _____No Orders received _____Yes _____No
X. Care planned _____Yes _____No Consent sent_____Yes _____No
XI. Consent signed and in chart _____Yes _____No

Quarterly review by IDT team / Recommendations
Date/ recommend
1._____
2._____
3._____
4._____

:e _____ Telelphone Consent received by: _____
sponsible person spoken to: _____

Mt. Ogden Nursing
Leave of Absence Form

Resident's Name_____

Date of Evaluation_____

Employee Completing Evaluation_____

Resident's Mental Status_____Alert _____Confused

Resident's Diagnosis_____

Stability of Disease Process_____

Ambulation Status_____Independent _____Walks with Walker _____Wheelchair

Safety Awareness_____Good Judgement _____Poor Judgement

Would resident be able the contact the facility in the case of an emergency_____Yes _____No

Length of time approved_____0-2 hours _____2-4 hours _____Unlimited

Concerns or Limitations:

_____
_____
_____
_____

Notified Resident on_____