STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. BUILDING _____ B. WING _____	06/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAYSON NURSING AND REHAB	2192 WEST STATE ROAD PAYSON, UT 84651

(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 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview with facility staff, it was determined that 1 resident of x reviewed was not free from a physical restraint that was not being used to treat a medical symptom. Resident identifier: 24 Findings: Resident 24 was readmitted to the facility on 12/31/05 with diagnoses of Atrial fibrillation, Ischemic heart disease and type II diabetes. Resident 24's medical record was reviewed on 06/29/06. Resident 24's MDS's were reviewed. The MDS, dated 04/13/06, documented that resident 24 did not have any physical restraints in use. No documentation could be found to show that resident 24 had been care planned for the use of a lap belt, or that he had ever fallen out of his wheelchair. Resident 24 was observed to have a lap belt in place during 3 observed meals, breakfast on 06/28/06 and 06/29/06 and lunch on 06/29/06. Resident 24 was unable to release the lap belt when cued by staff to do so. In an interview with the facility administrator and	F 221	F – 221 Resident 24 has been re-assessed and it has been determined that no physical restraint is necessary due to the decline in condition. Restraint discontinued on June 28, 2006. The facility has revised a Quality Assurance Assessment tool to be used as a monthly review for all residents using physical restraints to track a decline in condition or the need to continue with such devises. The facility will evaluate all new wheel chair bound resident for 3 weeks using a chair alarm to determine if the resident is a fall risk. After 3 weeks if it is determined that the resident is not a fall risk, the chair alarm will be discontinued. The nursing staff will be re-in-serviced on 7/25/2006 on the use of this form and the proper procedure for physical restraint use. The Director of Nursing is responsible for ongoing compliance and monitoring.	Aug 11, 2006

7/27/06 POC acceptable Compliance date 8/11/06 Rosenbaum RN

Utah Department of Health
7004 2890 0002 3886 7608
JUL 25 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joan Lister | TITLE: Administrator | (X6) DATE: July 21, 2006

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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PAYSON NURSING AND REHAB	2192 WEST STATE ROAD PAYSON, UT 84651

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F 221	Continued From page 1 DON, on 06/29/06 at 8:35 AM, both indicated that resident 24 had been able to release the lap belt up until approximately 06/14/06 when he returned to the facility after being in the hospital and his condition had worsened. They also stated that less restrictive measures had not been tried.	F 221	A Quality Assessment and Assurance Plan of Action and Implementation Record has been completed and will be reviewed with the QA committee at the monthly meeting and again reviewed with the QA Team at the Quarterly QA meeting. The monthly assessment tool will also be reviewed at these same meetings	Aug 11, 2006

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F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview with the facility Director of Nursing, DON, it was determined that facility did not maintain Minimum Data Set (MDS) assessments that were complete and accurate for 2 of 10 sampled residents. Resident identifiers: 5 and 24.	F 278	F – 278 MDS's for Residents 5 and 24 will be corrected and re-transmitted by July 28, 2006. All residents have the potential to be affected. One MDS will be audited weekly for 6 weeks for 90 % accuracy. If 90% accuracy it achieved we will consider to be in compliance. Once in compliance, one MDS will be audited monthly by IDT team for accuracy. The Director of Nursing/MDS nurse will be responsible for ongoing compliance. A Quality Assessment and Assurance Plan of Action and Implementation Record has been completed and will be reviewed with the QA committee at the monthly meeting and again reviewed with the QA Team at the Quarterly QA meeting.	Aug 11, 2006

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F 278	Continued From page 3 Findings Include: 1. Resident 5 was admitted to the facility on 2/20/06 with diagnoses including duodenal ulcer, ileostomy and congestive heart failure. Resident 5's medical record was reviewed on 6/27/06. Resident 5's MDS's were reviewed. The MDS's did not document that resident 5 had an ostomy. The facility DON (who completes the MDS's) was interviewed on 6/28/06 and stated that resident 5's MDS's were incorrect. 2. Resident 24 was readmitted to the facility on 12/31/05 with diagnoses of Atrial fibrillation, Ischemic heart disease and type II diabetes. Resident 24's medical record was reviewed on 06/29/06. Resident 24's MDS's were reviewed. The MDS, dated 04/13/06, documented that resident 24 did not have any physical restraints in use. No documentation could be found to show that resident 24 had been care planned for the use of a lap belt, or that he had ever fallen out of his wheelchair. Resident 24 was observed to have a lap belt in place during 3 observed meals, breakfast on 06/28/06 and 06/29/06 and lunch on 06/29/06. Resident 24 was unable to release the lap belt when cued by staff to do so. In an interview with the facility administrator and	F 278		

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F 278	Continued From page 4 DON, on 06/29/06 at 8:35 AM, both indicated that resident 24 had been able to release the lap belt up until approximately 06/14/06 when he returned to the facility after being in the hospital and his condition had worsened. They also stated that less restrictive measures had not been tried.	F 278		
F 432 SS=D	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 medical record review and interview of facility staff during the annual survey conducted on 6/27/06 - 6/29/06, it was determined that the facility did not store medications properly and discard medications when they expired. During the medication pass on 6/28/06, the medication refrigerator was checked for expired	F 432	F – 432 Expired medications have been properly disposed. It is the policy of this facility to monitor for expired medications. A sign off sheet to monitor daily for expired medication will be signed off daily by nurse. The daily sign off sheet was started the week of July 21, 2006. Nursing staff will be in-serviced on July 25, 2006. The Director of Nursing will review and initial weekly that the sign off sheet is being completed. This will be monitored for 6 weeks for 90% accuracy. If 90% accuracy it achieved we will consider to be in compliance. Monthly follow up with the QA committee for ongoing compliance will be done.	Aug 11, 2006

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F 432	Continued From page 5 medications or medications opened and then not dated. Expired medications found were five Phenergan 25 mg suppositories with the expiration date of 4/20/06. The nurse passing medications on 6/28/06 was interviewed about the facilities policy for checking the medication refrigerator for expired medications. She said that there was no policy for checking for expired medications or how to dispose of expired medications when they were found. Interview of the Director of Nursing on 6/28/06, about the facility policy for checking for expired medications and disposal , she said there was no policy for checking for expired medications. She said it was just the nurses job doing medications to check for expired medications and dispose those medications. Found during the medication pass were four different insulins opened and not dated for the day opened. One bottle of Humulin 70/30 was opened but not dated. Two bottles of Humalog insulin were opened but not dated. One bottle of Humulin "R" was opened and dated 9/04/05.	F 432		

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F 502 SS=E	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 record review and interview with facility staff, it was determined the facility did not obtain laboratory services to meet the needs of 5 of 10 sampled residents. Resident identifiers: 5, 10, 14 , 20 and CL1 Findings Include: 1. Resident 5 was admitted to the facility on 2/20/06 with diagnoses including congestive heart failure, duodenal ulcer and factitious illness. Resident 5's medical record was reviewed on 6/27/06 and 6/28/06. On 2/23/06, resident 5 had a phenobarbital level drawn and returned low at 14.7 (normal range by lab 15.0 to 40.0). On 3/1/06, resident 5's physician order a phenobarbital level to be done in 1 month. This lab was not completed until 4/13/06, 12 days later than when it was due. 2. Resident 14 was admitted to the facility on 2/3/77 with diagnoses including epilepsy, dementia and chronic obstructive pulmonary disease. Resident 14's medical record was reviewed on	F 502	F – 502 Lab records have been reviewed for residents 5, 14, 10, 1 and 20 to ensure that lab orders are on current calendar. A new internal tracking form has been revised and will be reviewed weekly by DON for 6 week period for 100% compliance. If 100% compliance is achieved, monthly after that for accuracy and timeliness of labs ordered. A Quality Assessment and Assurance Plan of Action and Implementation Record has been completed and will be reviewed with the QA committee at the monthly meeting and again reviewed with the QA Team at the Quarterly QA meeting. The monthly assessment tool will also be reviewed at these same meetings Aug 11, 2006	

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F 502	Continued From page 7 6/28/06. On 10/26/05, resident 14's primary care physician ordered a sed rate to be done. No documentation was available in resident 14's medical record indicating that the lab had been completed. The facility Director of Nursing (DON) was unable to provide documentation that the lab had been completed as ordered. 3. Resident 10 was admitted to the facility on 11/15/02 with the diagnoses of cerebro vascular accident, Depression, hypertension and Type I diabetes. Resident 10's redical record was reviewed on 06/28/06. On 02/14/02, resident 10's physician ordered laboratory tests for HBAIC, BMP and a urine analysis for albumin/creatinine ratio, to be done every 4 months. No documentation could be found of laboratory test results of any urinalysis for albumin/creatinine ratio, which should have been done on 05/12/05, 09/12/05, 05/04/06, 01/09/06. On 11/15/02, resident 10's physician ordered laboratory tests for TSH, ALT and CBC to be done every 6 months. No documentation could be found of laboratory results for a TSH, CBC and ALT, that should have been done in December 2005 and an ALT that should have been done on 06/09/05. The DON was unable to provide documentation that the tests had been done as ordered.	F 502		

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F 502	Continued From page 8	F 502		

4. Resident CL1 was admitted to the facility on 4/20/05 with diagnoses including ischemic heart disease, hypertension, and cerebral vascular accident.

Resident CL1's medical record was reviewed on 6/29/06.

On 9/11/05, resident CL1's primary care physician ordered a "STAT UA (urinalysis) & (and) CBC (complete blood count)".

No documentation was available in resident CL1's medical record that the STAT labs had been completed.

The facility DON was unable to provide documentation that the labs had been completed as ordered.

Resident 20 was admitted to the facility on 11/30/92 with diagnoses including schizoaffective disorder, dementia, chronic obstructive pulmonary disease and has a pacemaker.

Resident 20's medical record was reviewed on 6/27/06 and 6/28/06.

On 2/22/06, resident 20 had a TSH drawn and returned elevated at 13.0(normal range by lab 0.47 to 4.68).

On 4/15/06, resident 20's physician ordered a TSH now and in 6 months and then 1 time a year. This lab should have been drawn on 4/16/06. This lab draw was missed completely and the order to

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F 502	Continued From page 9 the lab was listed as one time per year.	F 502		

F-221

Monthly Restraint Assessment

Resident: _____ Date of Review: _____

Being Evaluated Due To: _____

Resident Mobility:

Total Care - No voluntary movement _____
Non dependant resident, with voluntary movement _____
Total Care - with voluntary movement _____
Does the resident have the ability to self transfer from standard wheel chair? _____
Non specialized bed? _____

Are Restraints needed for resident at this time? _____ YES _____ NO

The following less restrictive measures have been tried before determining that a physical restraint is needed:

Measure	**Result**

Would a Physical Therapy or Occupational Therapy Evaluation be of benefit or reduce the need for restraint?
_____ YES _____ NO

If Yes, Date of Evaluation: _____ Recommendation from PT or OT: _____

_____

If restraint is indicated, identify type to be used (least restrictive applicable):

Self Release belt	Crotch	Geri Chair	Baroda chair
Bed Rails	Postural Support	Vest for Positioning	Chair Alarm
Lap buddy	Hand Mitts	Tray on chair	

Signatures of Quality Assurance Committee:

_____ _____
_____ _____
_____ _____

PHYSICAL RESTRAINT APPROVAL BY RESIDENT OR SURROGATE

I understand that the use of physical restraints may lead to the following conditions:

loss of self esteem	contractures	incontinence	reduced social contact
constipation	falls	loss of muscle tone	decreased ROM
decreased ability to walk	increased agitation	fractures	loss of balance
loss of independence	increased confusion	symptoms of withdrawal	symptoms of depression

However, I understand that a restraint is being recommended for the following medical reasons: _____

_____

I understand that the restraint will be used when: _____

_____

I understand the time period for use will not exceed this and that the restraint will be checked and released for(10) ten minutes every (2) two hours.

Approval by Resident: _____ Date: _____

Approval by Family Member: _____ Date: _____

Date order received by MD: _____ Restraints on care plan: _____ Restraints listed on MDS _____

Expired Medication Dailiy Checklist

Year: _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Jan																															
Feb																															
Mar																															
April																															
May																															
June																															
July																															
Aug																															
Sept																															
Oct																															
Nov																															
Dec																															

*Please initial each day to ensure that the Med Fridge top drawers in Med cart have been checked and cleared of any expired meds

F-432

F - 502

Patient's Name	Date Ordered	Requisition Done	Type of Lab Stat/Standard/Reg	Lab Ordered	Date Drawn	Date of Results	Nurse's Signature

Payson Nursing and Rehabilitation

"Where Care Exceeds Expectations"

2192 West State Road
Payson, UT 84660

(801)465-9211
Fax (801) 465-1052

July 21, 2006

Ann E. Lee
Utah Department of Health
Long-Term Care Survey Section
P.O. Box 144103
Salt Lake City, UT 84114-4103

Dear Ms. Lee,

On June 29, 2006 a Recertification Survey was conducted at Payson Nursing and Rehabilitation Center. This letter is to assert that the PoC submitted by our facility is our credible allegation of compliance. We believe as of August 11, 2006 we are in compliance with Long Term Care Regulations.

We appreciate the professional manner in which the survey was conducted.

If you have any questions, please feel free to call me.

Respectfully,

Jason Giatras
Administrator
Payson Nursing and Rehab