PRINTED: 09/14/2006 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING B. WING 08/31/2006 465020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 815 SOUTH 200 WEST BRIGHAM CITY, UT 84302 PIONEER CARE CENTER PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) **DEFICIENCY**) TAG F 241 : 483.15(a) DIGNITY F-241 The facility must promote care for residents in a manner and in an environment that maintains or The facility has mountains ola la montain ex enhances each resident's dignity and respect in purchased two way full recognition of his or her individuality. radios for each department head along This REQUIREMENT is not met as evidenced with the nurses and CNA's. They will be Based on individual and group interviews used to monitor and conducted at the facility on 8/29/06 and review of communicate the needs Resident Council minutes, it was determined that of the residents in a the facility did not promote care for residents in a manner and environment that maintained or timely manner. enhanced each resident's dignity and respect, for 4 out of 5 residents interviewed in group. An all-staff in-service was held on September Findings included: 15th, 2006 on the importance of answering During resident group interview held on 8/29/06, 5 call lights in a timely residents attending the meeting were asked if they had any concerns regarding enough staff to manner and to attend to take care of everyone. Several residents related the residents needs prior that the facility needed more Certified Nurse to leaving the Aides (CNA). One resident stated he once was yoom/resetting the call throwing up milk and he had used the call light to get help. He had timed the response to the call light, and it took 30 minutes to be answered.

they had any concerns regarding enough staff to take care of everyone. Several residents related that the facility needed more Certified Nurse Aides (CNA). One resident stated he once was throwing up milk and he had used the call light to get help. He had timed the response to the call light, and it took 30 minutes to be answered. Three other residents related instances of waiting over 20 minutes. One resident stated and the other residents agreed that in many instances staff would call into the room when a call light was put on, promising to send a staff to assist them, turn the call light off, and then it would be 20 to 30 minutes before the CNA would arrive. Another resident related a similar instance when he was cold and asked for a blanket they told him, over the speaker, that they would send one down, and

The Administrator or designee will conduct call light focused rounds three times a week to ensure timely response.

LABORATORY DIRECTOR'S OR PROVIDER SURPLIER BEPRESENTATIVE'S SIGNATURE

they never brought one to him.

Administrator

9-22-06

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 findings stated above 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8Y2J11

Facility ID: UT0065

5 2006 If continuation sheet Page 1 of 15

Bureau of Health Facility Licensing, Certification and Resident Assessment

PRINTED: 03/14/2006 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 08/31/2006 465020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **815 SOUTH 200 WEST** PIONEER CARE CENTER BRIGHAM CITY, UT 84302 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION 1D SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 241 F 241 Continued From page 1 The timely answering of call lights will be Residents stated that 20 minutes wawa too long addressed with the to wait if you have to go to the bathroom and by the time the staff get there it is too late. A Resident Council on a resident stated, and the others agreed, that this is monthly basis and a an ongoing and a recent issue. report made to the **Ouality Assurance** A review of Resident Council minutes was Committee. Identified conducted on 8/29/06. In the minutes for the month of May 2006, under the heading of abuse, trends will be reviewed neglect & exploitation the following was stated, at the Quality Assurance "Call lights have been answered slowly - evening committee monthly and have been worse -concern form filed." For the as needed until a lesser month of July 2006 the statement "Call lights not resolved. Staff continually trying" was in the frequency is deemed minutes under the heading of interventions to be appropriate. implemented. For August 2006, under the heading of abuse, neglect & exploitation the Completion Date: following was stated, "New concern form filed for October 20, 2006 call lights. Afternoon is the bigger problem." Utah Department of Health SEP 25 23 Bureau of Health Facility Licensing. Certification and Resident As resemble

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLI LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465020	B. WII	16	~ · · · · · · · · · · · · · · · · · · ·	08/	31/2006
	ROVIDER OR SUPPLIER			815	ET ADDRESS, CITY, STATE, ZIP COD SOUTH 200 WEST IGHAM CITY, UT 84302	ÞΕ	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 278 SS=B		IDENT ASSESSMENT	F	278	<u>F-278</u>		
	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.				The MDS's in que with resident 3 and were both correcte submitted to the st 8-29-06.	17 d and	
				; ; ;	A complete audit f	pletion	
		o completes a portion of the sign and certify the accuracy of assessment.			of all MDS's will I completed by the I or designee by Oct	DON	
	willfully and knowir false statement in subject to a civil m \$1,000 for each as willfully and knowir to certify a materia resident assessment	nd Medicaid, an individual who ngly certifies a material and a resident assessment is oney penalty of not more than issessment; or an individual who ngly causes another individual all and false statement in a ent is subject to a civil money e than \$5,000 for each			20, 2006. An in-service for accuracy and compthe MDS will be hithe DON or design September 29, 200 all staff involved in MDS process.	eld by nee on 06 for	
	Clinical disagreement does not constitute a material and false statement.			 	All MDS's will be reviewed by the Do designee prior to b	ON or	
	by: Based on record rethe facility did not lassessments that	eview it was determined that have Minimum Data Set (MDS) accurately reflected the or 2 of 12 sample residents.			submitted to the sta This review will in a focused review o weight and skin conditions from the	ate. iclude of	
	Resident identifier				Monthly Weight an		•

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		465020	B. WING	3	08/:	31/2006
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 815 SOUTH 200 WEST BRIGHAM CITY, UT 84302	E.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 278	diagnoses includin nutritional deficient Resident 3's chart. The MDS assessr 3, revealed the residual weight to be 1 assessment dated revealed the residue weight on 2/27/06 correction MDS to height. Resident 7 was as with diagnoses the Retardation, Esop Mellitus, and Chro A review of reside completed beginn A significant chan 7/27/06, document a pressure ulcer. Record revealed documented as no The facility Direct interviewed on 8/3 stated that the pre MDS and that it we resident to the pressure ulcer.	Imitted to the facility with ag: chronic skin ulcer and cy. was reviewed on 8/29/06. ment dated 10/6/05, for resident sident's height to be 63 inches 158 pounds. The MDS 12/27/06, for resident 3, ent's height to be 65 inches and bunds. Resident 3's actual was 157. There was no clarify the correct weight and dmitted to the facility on 1/21/03 at included Mild Mental shagus Reflux, Diabetes onic Anxiety. ent 7 's medical chart was sing on 8/28/06 through 8/31/06. age MDS assessment, dated that resident 7 did not have The Weekly Pressure Sore a Stage II pressure ulcer ew on 7/21/06. or of Nurses (DON) was 29/06 at 2:45 PM. The DON essure ulcer was not on the vas his fault; he knew about the it it had slipped his mind when	F 2	MDS's will be spechecked for accur weekly the DON designee. Identifit trends will be revien the monthly Quant Assurance commit and as needed unt lesser frequency is deemed appropriate. Completion Date: October 20, 2006	acy or ed icwed tality ttee il a s te.	
	The significant ch	nance MDS assessment, dated				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		EFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		465020	B. WING		08/	08/31/2006	
	ROVIDER OR SUPPLIE	R	815	T ADDRESS, CITY, STATE, ZIP SOUTH 200 WEST GHAM CITY, UT 84302	CODE		
(X4) ID PREFIX TAG	FACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 278	Continued From	page 4	F 278				
	loss of 5% or more in the last	ented that resident 7 had a weight ore in the last 30 days; or 10% or 180 days. Resident 7 's 2006 and Vital signs Record included ights:	:				
	1/9 172 2/6 173 3/6 171 4/3 171 5/1 169 6/12 167	;					
	Resident 7 's w 7/27/06 MDS.	eight was listed as 165 on her					
	interviewed on	ector of Nurses (DON) was 8/29/06 at 2:45 PM. The DON dent 7 has not had a weight loss I on the MDS.					
	t						

CENTERS FOR MEDICARE & MEDICALUS STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SU IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		465020	B. WIN	1G		08/31/2006	
	ROVIDER OR SUPPLIER			81	EET ADDRESS, CITY, STATE, ZIP CODE 15 SOUTH 200 WEST RIGHAM CITY, UT 84302		
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F 279 SS=B	483.20(d), 483.20(CARE PLANS	(k)(1) COMPREHENSIVE	F	279	<u>F-279</u>		
	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.				The Care Plans for residents 3, 4, 8, a were reviewed an corrections were	and 11 id	
	plan for each residence objectives and time medical, nursing.	develop a comprehensive care dent that includes measurable netables to meet a resident's and mental and psychosocial entified in the comprehensive			to include specification concernation don 9-15-06.	erning	,
	The care plan mu to be furnished to highest practicabl psychosocial well §483.25; and any be required under	ast describe the services that are attain or maintain the resident's le physical, mental, and l-being as required under services that would otherwise r §483.25 but are not provided ant's exercise of rights under g the right to refuse treatment (4).			A complete audit Resident Care Pla be completed by or designee for ac and completion b October 20, 2006 A nursing in-serv be held by the Do designee on 9-29	ans will DON ccuracy by 6. vice will ON or 0-06 to	
	This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, it was determined that the facility did not develop care plan interventions to address facility assessed needs for 4 of 13 sample residents. Resident identifiers 3, 4, 8 & 11				address with all of givers the MDS application of the paid to communication of the dementia	and care i. n will	
	Findings include	d:			population.		I
	7/07/99 with diag	as admitted to the facility on gnoses including Hypothyroidism, trition Deficiency, Senile Constination.			Care Plans will be reviewed by the		

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LDING		(X3) DATE SURVEY COMPLETED	
	465020	B. WI	1G		08/31/20	
ROVIDER OR SUPPLIER			819	5 SOUTH 200 WEST	E	
(EACH DESIGNENC)	Y MUST BE PRECEEDED BY FULL			(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE
Resident 4's medion 8/28/06 through Nesident 4 had an Set) assessment on the results of the following RAP Protocol) were trig further: 1. Cognitive Loss 2. Communication 3. ADL Function/f4. Urinary incontin 5. Psychosocial V 6. Mood State 7. Behavioral Syn 8. Falls 9. Nutritional State 10. Pressure Ulco	cal record chart was reviewed in 8/31/06. In annual MDS (Minimum Data completed on 12/09/05. Based that assessment for resident 4, 1's (Resident Assessment gered to be investigated) The Rehab Potential mence Vell-being inptoms	F	279	with each annual quarterly, and ch condition MDS tensure Care Plan place to match the RAPS that have completed. Trends identified reviewed month Quality Assuran committee until frequency is dee appropriate.	ange of o s are in he been I will be ly at the ce a lesser med	
On the RAP Sum MDS, the facility Problem Areas to except for Urinar Ulcers. Resident 4 was a 8/29/06 at 2:20 Frearranging the parameter tapped the bed a Several attempts with resident 4. It werbal communications to the Director of I	amary sheet of the 12/09/05 indicated that each of the RAP riggered would be care planned by Incontinence and Pressure observed and interviewed on PM. Resident 4 was in her room billows on her bed. Resident 4 as if to ask me to sit down. It is were made to communicate Resident 4 did not understand cation.			SEP 2	5 2006	dog.
	ROVIDER OR SUPPLIER CARE CENTER SUMMARY ST. (EACH DEFICIENCY REGULATORY OR Continued From p Resident 4's medion 8/28/06 through Resident 4 had an Set) assessment on the results of the following RAP Protocol) were trice further: 1. Cognitive Loss 2. Communication 3. ADL Function/f 4. Urinary incontin 5. Psychosocial V 6. Mood State 7. Behavioral Syn 8. Falls 9. Nutritional Stat 10. Pressure Ulca 11. Psychotropic On the RAP Sum MDS, the facility Problem Areas to except for Urinar Ulcers. Resident 4 was 6 8/29/06 at 2:20 Frearranging the part of the bed as Several attempts with resident 4. It werbal communication of the Director of the Direc	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 Resident 4's medical record chart was reviewed on 8/28/06 through 8/31/06. Resident 4 had an annual MDS (Minimum Data Set) assessment completed on 12/09/05. Based on the results of that assessment for resident 4, the following RAP's (Resident Assessment Protocol) were triggered to be investigated further: 1. Cognitive Loss 2. Communication 3. ADL Function/Rehab Potential 4. Urinary incontinence 5. Psychosocial Well-being 6. Mood State 7. Behavioral Symptoms 8. Falls 9. Nutritional Status 10. Pressure Ulcers 11. Psychotropic Drug Use On the RAP Summary sheet of the 12/09/05 MDS, the facility indicated that each of the RAP Problem Areas triggered would be care planned except for Urinary Incontinence and Pressure	A BUI ACORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A65020 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 Resident 4's medical record chart was reviewed on 8/28/06 through 8/31/06. Resident 4 had an annual MDS (Minimum Data Set) assessment completed on 12/09/05. 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The Director of Nursing (DON) was interviewed	A BUILDING B WING CORRECTION CORRECTION A BUILDING B WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 Resident 4's medical record chart was reviewed on 8/28/06 through 8/31/06. Resident 4 had an annual MDS (Minimum Data Set) assessment completed on 12/09/05. Based on the results of that assessment for resident 4, the following RAP's (Resident Assessment Protocol) were triggered to be investigated further: 1. Cognitive Loss 2. Communication 3. ADL Function/Rehab Potential 4. Urinary incontinence 5. Psychosocial Well-being 6. Mood State 7. Behavioral Symptoms 8. Falls 9. Nutritional Status 10. Pressure Ulcers 11. Psychotropic Drug Use On the RAP Summary sheet of the 12/09/05 MDS, the facility indicated that each of the RAP Problem Areas triggered would be care planned except for Urinary Incontinence and Pressure Ulcers. 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Mood State 7. Behavioral Symptoms 8. Falls 9. Nutritional Status 10. Pressure Ulcers 11. Psychotropic Drug Use On the RAP Summary sheet of the 12/09/05 MDS, the facility indicated that each of the RAP Problem Areas triggered would be care planned except for Urinary Incontinence and Pressure Ulcers. Resident 4 was observed and interviewed on 8/29/06 at 2:20 PM. Resident 4 was in her room rearranging the pillows on her bed. Resident 4 tapped the bed as if to ask me to sit down. Several attempts were made to communicate with resident 4. Resident 4 did not understand verbal communication. The Director of Nursing (DON) was interviewed	OF DEFICIENCIES (CORRECTION NUMBER: ASB020 (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER SUPPLIER (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MUL

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING B. WING 08/31/2006 465020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **815 SOUTH 200 WEST** PIONEER CARE CENTER **BRIGHAM CITY, UT 84302** (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 279 F 279 | Continued From page 7 care plan for resident 4 's communication problem had not been written and was not in the chart. 2. Resident 8 was admitted to the facility on 2/23/06 with diagnoses including Nutrition Deficiency, Dementia with Behaviors, Mental Disorder, Hypertension, and Abnormality of Gait. Resident 8's medical record chart was reviewed on 8/28/06 through 8/31/06. Resident 8 had an admission MDS assessment completed on 3/7/06. Based on the results of that assessment for resident 8, the following RAP's were triggered to be investigated further: 1. Cognitive Loss 2. Communication 3. ADL Function/Rehab Potential 4. Urinary incontinence 5. Mood State 6. Behavioral Symptoms 7. Falls 8. Psychotropic Drug Use On the RAP Summary sheet of the 12/09/05 MDS, the facility indicated that each of the RAP Problem Areas triggered would be care planned. The Director of Nursing (DON) was interviewed on 8/31/06 at 2:20 PM. The DON stated that a care plan for resident 8 's communication

chart.

problem had not been written and was not in the

3. Resident 11 was admitted to the facility on 3/14/05 with diagnoses including Nutrition

PRINTED: 09/14/2006

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 08/31/2006 465020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **815 SOUTH 200 WEST** PIONEER CARE CENTER **BRIGHAM CITY, UT 84302** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL DATE **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 279 F 279 Continued From page 8 Deficiency, Arterial Fibrillation, Hypertension, Edema and Constipation. Resident 11's medical record chart was reviewed on 8/28/06 through 8/31/06. Resident 11 had an admission MDS assessment completed on 03/04/06. Based on the results of that assessment for resident 4, the following RAP's were triggered to be investigated further: 1. Cognitive Loss 2. Communication 3. Urinary incontinence 4. Mood State 5. Behavioral Symptoms 6. Falls 7. Dehydration 8. Pressure Ulcers 9. Psychotropic Drug Use 10. Dental Care 11. ADL Function/Rehab Potential 12. Nutritional Status On the RAP Summary sheet of the 03/04/06 MDS, the facility indicated that each of the RAP Problem Areas triggered would be care planned. The DON was interviewed on 8/31/06 at 10:30 AM. The DON stated that a care plan for resident 11's communication issues had not been written and was not in the chart. The DON also stated that resident 11 's Dental Care had not been specifically addressed with a care plan. 4. Resident 3 was readmitted to the facility on

2/23/2006 with diagnoses including: chronic skin ulcer, mental disorder, cerebral vascular accident, PRINTED: 09/14/2006

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING		0813	1/2006
		465020	STR	EET ADDRESS, CITY, STATE, ZIP C		11/2000
	ROVIDER OR SUPPLIER		81	15 SOUTH 200 WEST RIGHAM CITY, UT 84302		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 279	Continued From p	age 9	F 279	<u>F-286</u>		!
	and insomnia.			The missing M	IDS's for	•
	·			The missing N residents 1 and		
		Record review of resident 3's chart was done on				
	8/29/06.			located and pla active charts o		,
	The comprehensi	ve assessment triggered		8/29/2006. Th		:
	communication fo	r resident 3. The care plan did			•	! ;
	not address comm	nunication.		previously been submitted to the		
					ne state.	
F 286	483,20(d) RESID	ENT ASSESSMENT - USE	F 286	i A building wi	de audit	1
SS=B	d.			was completed		
	A facility must ma	nintain all resident assessments the previous 15 months in the		06 by Medica		
	resident's active	e record.		personnel to e		
	Tesident's active i			15 months of		
	1			in each active		
	This REQUIREM	ENT is not met as evidenced		medical chart		j
	by:		ļ	missing MDS		
ŀ	Based on intervie	w and review of the resident it was determined that for 2 of	İ	been pulled fr		
	i medical records, ii 12 sample reside	ents, the facility did not include all		overflow reco		1
	resident assessn	nents completed within the		added back to		
	previous 15 mon	oths in the resident's active not identifiers: 1 and 7.		charts.		
	Findings included	d·		Medicare Red	cords or	Ì
				designee will		
	Resident 1 was a	admitted to the facility on 4/13/05	1	MDS's forwa		! !
	with diagnoses in	ncluding: pulmonary embolism, , congestive heart failure, and		residents that		
	urine retention.	,	:	our facility.		!
	Record review o	f resident 1's chart was done on	l	Ì		
	8/29/06. The ac	tive record did not contain all		· ;		
	resident assessr	ments completed within the	1			
	previous 15 mor	oths. It was missing a discharge	!			Ì
I	tracking MDS to	r 6/19/06, a re-entry tracking		i		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		465020	B. WING		08/3	1/2006
	ROVIDER OR SUPPLIER		81	EET ADDRESS, CITY, STATE, ZIP CODE 15 SOUTH 200 WEST RIGHAM CITY, UT 84302		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BÉ	(X5) COMPLETION DATE
F 286	for 6/14/06. The r tracking forms we 8/30/06. Resident 7 was ac with diagnoses the Retardation, Esop Mellitus, and Chro Record review of 8/29/06. The acti- resident assessm previous 15 monti	and a significant change MDS missing MDS assessment and re provided to the surveyors on dmitted to the facility on 1/21/03 at included Mild Mental shagus Reflux, Diabetes	F 286	Medical Records or designee will comple an audit monthly to ensure all MDS's as appropriate are in the active charts. Identified trends will reviewed monthly at Quality Assurance committee until a les frequency is deemed appropriate. Completion Date October 20, 2006	e I be the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465020	B. WING		08/31/2006	
NAME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	00/31	72000
	R CARE CENTER		815	SOUTH 200 WEST IGHAM CITY, UT 84302		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
SS=B		ATED DATA PROCESSING	F 287	<u>F-287</u>	:	
		er a facility completes a	į.			
	resident's assess	ment, a facility must encode the ion for each resident in the	:	Medical records will re-in-serviced on September 22, 2006		
	•			the regulations and t	!	
	Admission assess Annual assessme	:	!	frames for the	:	
		e in status assessments.		transmitting of MDS	S's	
	Quarterly review a		:	as defined by CMS.	· ;	
	reentry, discharge	e, and death.	İ	Medical records or		
	•	e-sheet) information, if there is				
	no admission ass	essment.		designee will do a		
	Mithin 7 days afte	er a facility completes a		complete audit of all		
		ment, a facility must be capable	-	MDS's by October 2	20,	
		the State information for each		2006 to ensure all		
		d in the MDS in a format that		MDS's are submitted		
		dard record layouts and data		the state as required	by :	
		that passes standardized edits		CMS. This audit wil	l be	
	defined by CMS a	and the State.	1	shared with the DON	1	
			1	and Administrator.	Anv	
		ectronically transmit, at least		MDS not submitted	•	
		d, accurate, complete MDS data		the state as required		
		I assessments conducted during		•	by	
	the previous mon	th, including the following:		CMS date will be	į	
	Admission asses	sment		submitted immediate	ely.	
	Annual assessme					
		e in status assessment.	ĺ	Medical Records or		
		ction of prior full assessment.	I	designee will submit	r all	
		tion of prior quarterly	:	C		
	assessment.			completed MDS's to		
	Quarterly review.			State on a weekly ba	ISIS.	
		s upon a resident's transfer,			1	
[reentry, discharge	e, and death.				
		e-sheet) information, for an initial MDS data on a resident that does	i			

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	465020	B. WING	···	08/31/2006	
ROVIDER OR SUPPLIER		8	15 SOUTH 200 WEST		
(FACH DEFICIENC)	MUST BE PRECEEDED BY FULL	ID PREFIX TAG	. (EACH CORRECTIVE ACTION S	HOULD BE COMPLETION	
not have an admiss The facility must tr specified by CMS alternate RAI appr specified by the St This REQUIREME by: Based on record r determined that th state in a timely m Set) information for Resident 1 and St Findings included Resident 1 was an Record review of 8/29/06. The acti significant change The missing MDS forms were provid The MDS submis days after the record Resident 12 had	ansmit data in the format or, for a State which has an oved by CMS, in the format rate and approved by CMS. ENT is not met as evidenced eview and interview it was be facility did not transmit to the ranner MDS (Minimum Data or 2 of 12 sample residents. Supplemental resident 12. In the facility on 4/13/05. It is not met as evidenced eview and interview it was be facility did not transmit to the ranner MDS (Minimum Data or 2 of 12 sample residents. In the facility on 4/13/05. It is not met as evidenced eview and interview it was be facility did not transmit to the ranner MDS (Minimum Data or 2 of 12 sample residents. In the facility on 4/13/05. It is not met as evidenced eview and interview it was be facility did not transmit to the ranner MDS (Minimum Data or 2 of 12 sample residents. It is not met as evidenced eview and interview it was be facility did not transmit to the ranner MDS (Minimum Data or 2 of 12 sample residents. It is not met as evidenced eview and interview it was be facility did not transmit to the ranner MDS (Minimum Data or 2 of 12 sample residents. It is not met as evidenced eview and interview it was be facility did not transmit to the ranner MDS (Minimum Data or 2 of 12 sample residents. It is not met as evidenced eview and interview it was be facility did not transmit to the ranner MDS (Minimum Data or 2 of 12 sample residents. It is not met as evidenced eview and interview it was evidenced eview a	F 287	The Administrator designee will log a review all transmit MDS's, bi-monthl ensure compliance defined by CMS. Identified trends w reviewed monthly Quality Assurance committee until le frequency is deem appropriate. Completion Date: October 20, 2006	ent of Health 2006 acjility Licensing.	
	ROVIDER OR SUPPLIER CARE CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR IT Continued From particles and the summary of	ROVIDER OR SUPPLIER R CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 not have an admission assessment. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility did not transmit to the state in a timely manner MDS (Minimum Data Set) information for 2 of 12 sample residents. Resident 1 and Supplemental resident 12. Findings included: Resident 1 was admitted to the facility on 4/13/05. Record review of resident 1's chart was done on 8/29/06. The active record did not contain a significant change MDS that was dated 6/14/06. The missing MDS assessment and tracking forms were provided to the surveyors on 8/30/06. The MDS submission date was more than 31 days after the record completion date. Resident 12 had an annual MDS completed	ROVIDER OR SUPPLIER R CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 not have an admission assessment. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility did not transmit to the state in a timely manner MDS (Minimum Data Set) information for 2 of 12 sample residents. Resident 1 and Supplemental resident 12. Findings included: Resident 1 was admitted to the facility on 4/13/05. Record review of resident 1's chart was done on 8/29/06. The active record did not contain a significant change MDS that was dated 6/14/06. The missing MDS assessment and tracking forms were provided to the surveyors on 8/30/06. The MDS submission date was more than 31 days after the record completion date. Resident 12 had an annual MDS completed	ROVIDER OR SUPPLIER REQUIATORY OR LSC IDENTIFICATION NUMBER: A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 815 SOUTH 200 WEST BRIGHAM CITY, UT 84302 DPROVIDERS PLAN OF CORR (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 not have an admission assessment. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility did not transmit to the state in a timely manner MDS (Minimum Data Set) information for 2 of 12 sample residents. Resident 1 and Supplemental resident 12. Findings included: Resident 1 was admitted to the facility on 4/13/05. Record review of resident 1's chart was done on 8/29/06. The active record did not contain a significant change MDS that was dated 6/14/06. The missing MDS assessment and tracking forms were provided to the surveyors on 8/30/06. The MDS submission date was more than 31 days after the record completion date. Resident 12 had an annual MDS completed	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUI	LDING			
		465020	B. WIN	IG		08	/31/2006
	ROVIDER OR SUPPLIER			81	ET ADDRESS, CITY, STATE, ZIP CO S SOUTH 200 WEST KIGHAM CITY, UT 84302	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	483.65(b)(3) PRE	VENTING SPREAD OF	F	144	<u>F-444</u>		
	after each direct in handwashing is in professional praction. This REQUIREM	require staff to wash their hands resident contact for which indicated by accepted tice. ENT is not met as evidenced			An in-service was conducted on 8-2' with all nursing steducate of proper washing technique cross contaminations. Hand sanions	9-06 taff to hand es and on	
	by: Based on observations, the facility did not ensure that facility staff washed their hands after each instance of direct resident contact for which hand washing was indicated by accepted professional practice, for 3 of 13 sampled residents. (Resider identifier: 3, 4 & 13)				made available to staff members to between surface of as appropriate.	be used contacts	
	Findings included	-			Weekly observati will be completed Administrator or		
	Observations were made in the dining room during meals on 8/28/06 and 8/29/06. Staff that assisted the residents, during each of the meals, were observed to feed residents without washing their hands between potentially contaminated contacts.			distant party in the second	designee to ensur wash and sanitize hands after each of resident contact f which hand wash	their lirect or ing is	
	(CNA) 1 assisted	15 PM Certified Nurses Aide d resident 4 with her food.			indicated by acce professional pract		
	floor. CNA 1 use drink, from reside floor. CNA 1 took the door, threw the table and picked	k was spilled on her lap and the d a cloth to wipe up the spilt ent 4's lap, shoes and then the the cloth to the kitchen, opened ne cloth in a bin, returned to the up resident 4's fork and began out washing or sanitizing his			The Director of Nor designee will to every new staff manager of the regarding cross contamination and proper hand wash	rain nember d ing	
	On 8/29/06 at 8:3	31 AM, CNA 2 entered the dining		i	techniques at gene orientation.	टाचा	

room, sat down at table 13 and began feeding the

		AND HUMAN SERVICES & MEDICAID SERVICES				APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465020	B. WING		08/	31/2006
	ROVIDER OR SUPPLIER		815	ET ADDRESS, CITY, STATE, ZIF SOUTH 200 WEST CIGHAM CITY, UT 84302	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 444	dining room with he 8:40 AM, CNA 2 re to another table. Coucked her hair bet pants and picked whim. CNA 2 reached un resident 3's wheel then picked up resident 3's wheel then picked up resident a door and room. At 8:44 AM, out of the break room CNA 2 tucked her pulled up on her paspoon and began to CNA 2 then picked CNA 2 then picked CNA 2 then picked CNA 2 then picked to another paspoon and began to the state of the picked the pulled up on her paspoon and began to the state of th	ole. At 8:36 AM, CNA 2 left the er hands in her pockets. At turned pushing a wheel chair NA 2 sat down at table 13, and her ears, pulled up her up a resident 13's fork and fed der the table and pulled chair closer to the table. CNA 2 ident 3's fork and fed her 3 CNA 2 left the dining room and I entered the employee break CNA 2 opened the door came om and returned to table 13. hair behind her ears, sat down, ants, picked up resident 3's	F 444	The Administ monitor bi-monitor bi-monitor bi-monitor bi-monitor bi-monitor bi-monitor will be in the Quality committee monitored as needed untifrequency is compropriate. Completion I October 20, 2	onthly for Identified reviewed Assurance onthly and il lesser deemed	

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