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
	465020	A. BUILDING _____ B. WING _____	08/31/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER CARE CENTER	815 SOUTH 200 WEST BRIGHAM CITY, UT 84302

(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 241 SS=E	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: Based on individual and group interviews conducted at the facility on 8/29/06 and review of Resident Council minutes, it was determined that the facility did not promote care for residents in a manner and environment that maintained or enhanced each resident's dignity and respect, for 4 out of 5 residents interviewed in group. Findings included: During resident group interview held on 8/29/06, 5 residents attending the meeting were asked if 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 they never brought one to him.	F 241	***F-241*** The facility has purchased two way radios for each department head along with the nurses and CNA's. They will be used to monitor and communicate the needs of the residents in a timely manner. An all-staff in-service was held on September 15th, 2006 on the importance of answering call lights in a timely manner and to attend to the residents needs prior to leaving the room/resetting the call light The Administrator or designee will conduct call light focused rounds three times a week to ensure timely response.	10/20/06

9/28/06 POC acceptable Completion date 10/20/06 Bwambach RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David D. Barnes — TITLE: Administrator — (X6) DATE: 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.

Utah Department of Health
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SEP 25 2006
PM 9.22.06
Bureau of Health Facility Licensing, Certification and Resident Assessment

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F 241	Continued From page 1 Residents stated that 20 minutes wawa too long to wait if you have to go to the bathroom and by the time the staff get there it is too late. A resident stated, and the others agreed, that this is an ongoing and a recent issue. A review of Resident Council minutes was conducted on 8/29/06. In the minutes for the month of May 2006, under the heading of abuse, neglect & exploitation the following was stated, "Call lights have been answered slowly - evening have been worse -concern form filed." For the month of July 2006 the statement "Call lights - not resolved. Staff continually trying" was in the minutes under the heading of interventions to be implemented. For August 2006, under the heading of abuse, neglect & exploitation the following was stated, "New concern form filed for call lights. Afternoon is the bigger problem."	F 241	The timely answering of call lights will be addressed with the Resident Council on a monthly basis and a report made to the Quality Assurance Committee. Identified trends will be reviewed at the Quality Assurance committee monthly and as needed until a lesser frequency is deemed appropriate. Completion Date: October 20, 2006	

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F 278 SS=B	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 it was determined that the facility did not have Minimum Data Set (MDS) assessments that accurately reflected the residents' status for 2 of 12 sample residents. Resident identifiers: 3 and 7.	F 278	***F-278*** The MDS's in question with resident 3 and 7 were both corrected and submitted to the state on 8-29-06. A complete audit for accuracy and completion of all MDS's will be completed by the DON or designee by October 20, 2006. An in-service for accuracy and completion the MDS will be held by the DON or designee on September 29, 2006 for all staff involved in the MDS process. All MDS's will be reviewed by the DON or designee prior to being submitted to the state. This review will include a focused review of weight and skin conditions from the Monthly Weight and Vital Signs Record.	

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F 278	Continued From page 3 Findings included: Resident 3 was admitted to the facility with diagnoses including: chronic skin ulcer and nutritional deficiency. Resident 3's chart was reviewed on 8/29/06. The MDS assessment dated 10/6/05, for resident 3, revealed the resident's height to be 63 inches and weight to be 158 pounds. The MDS assessment dated 2/27/06, for resident 3, revealed the resident's height to be 65 inches and weight to be 30 pounds. Resident 3's actual weight on 2/27/06 was 157. There was no correction MDS to clarify the correct weight and height. Resident 7 was admitted to the facility on 1/21/03 with diagnoses that included Mild Mental Retardation, Esophagus Reflux, Diabetes Mellitus, and Chronic Anxiety. A review of resident 7 's medical chart was completed beginning on 8/28/06 through 8/31/06. A significant change MDS assessment, dated 7/27/06, documented that resident 7 did not have a pressure ulcer. The Weekly Pressure Sore Record revealed a Stage II pressure ulcer documented as new on 7/21/06. The facility Director of Nurses (DON) was interviewed on 8/29/06 at 2:45 PM. The DON stated that the pressure ulcer was not on the MDS and that it was his fault; he knew about the pressure ulcer but it had slipped his mind when he was completing the MDS. The significant change MDS assessment, dated	F 278	MDS's will be spot checked for accuracy weekly by the DON or designee. Identified trends will be reviewed in the monthly Quality Assurance committee and as needed until a lesser frequency is deemed appropriate. Completion Date: October 20, 2006	

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F 278	Continued From page 4	F 278		

7/27/06, documented that resident 7 had a weight loss of 5% or more in the last 30 days; or 10% or more in the last 180 days. Resident 7 's 2006 Monthly Weight and Vital signs Record included the following weights:

1/9 172
2/6 173
3/6 171
4/3 171
5/1 169
6/12 167

Resident 7 ' s weight was listed as 165 on her 7/27/06 MDS.

The facility Director of Nurses (DON) was interviewed on 8/29/06 at 2:45 PM. The DON stated that resident 7 has not had a weight loss as documented on the MDS.

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F 279 SS=B	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). 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 Findings included: 1. Resident 4 was admitted to the facility on 7/07/99 with diagnoses including Hypothyroidism, Dehydration, Nutrition Deficiency, Senile Dementia, and Constipation.	F 279	***F-279*** The Care Plans for residents 3, 4, 8, and 11 were reviewed and corrections were made to include specific information concerning communication deficits on 9-15-06. A complete audit of all Resident Care Plans will be completed by DON or designee for accuracy and completion by October 20, 2006. A nursing in-service will be held by the DON or designee on 9-29-06 to address with all care givers the MDS and care planning process. Specific attention will be paid to communication deficits in the dementia population. Care Plans will be reviewed by the Director	

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F 279	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. 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 on 8/30/06 at 10:30 AM. The DON stated that a	F 279	of Nursing or designee with each annual, quarterly, and change of condition MDS to ensure Care Plans are in place to match the RAPS that have been completed. Trends identified will be reviewed monthly at the Quality Assurance committee until a lesser frequency is deemed appropriate. October 20, 2006 Utah Department of Health SEP 25 2006 Bureau of Health Facility Licensing, Certification and Resident Assessment	

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F 279	Continued From page 7	F 279		

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 problem had not been written and was not in the chart.

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

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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,

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F 279	Continued From page 9 and insomnia. Record review of resident 3's chart was done on 8/29/06. The comprehensive assessment triggered communication for resident 3. The care plan did not address communication.	F 279	***F-286*** The missing MDS's for residents 1 and 7 were located and placed in the active charts on 8/29/2006. They had previously been submitted to the state.	
F 286 SS=B	483.20(d) RESIDENT ASSESSMENT - USE A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on interview and review of the resident medical records, it was determined that for 2 of 12 sample residents, the facility did not include all resident assessments completed within the previous 15 months in the resident's active record. Resident identifiers: 1 and 7. Findings included: Resident 1 was admitted to the facility on 4/13/05 with diagnoses including: pulmonary embolism, thrombophlebitis, congestive heart failure, and urine retention. Record review of resident 1's chart was done on 8/29/06. The active record did not contain all resident assessments completed within the previous 15 months. It was missing a discharge tracking MDS for 6/19/06, a re-entry tracking	F 286	A building wide audit was completed by 9-22-06 by Medical Records personnel to ensure that 15 months of MDS's are in each active resident's medical chart. All missing MDS's have been pulled from the overflow records and added back to the active charts. Medicare Records or designee will pull all MDS's forward on all residents that re-admit to our facility.	

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F 286	Continued From page 10 MDS for 6/22/06, and a significant change MDS for 6/14/06. The missing MDS assessment and tracking forms were provided to the surveyors on 8/30/06. Resident 7 was admitted to the facility on 1/21/03 with diagnoses that included Mild Mental Retardation, Esophagus Reflux, Diabetes Mellitus, and Chronic Anxiety. Record review of resident 7's chart was done on 8/29/06. The active record did not contain all resident assessments completed within the previous 15 months. It was missing a discharge MDS for 7/10/06 and a re-entry MDS for 7/17/06.	F 286	Medical Records or designee will complete an audit monthly to ensure all MDS's as appropriate are in the active charts. Identified trends will be reviewed monthly at the Quality Assurance committee until a lesser frequency is deemed appropriate. Completion Date October 20, 2006	

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F 287 SS=B	483.20(f) AUTOMATED DATA PROCESSING Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: Admission assessment. Annual assessment updates. Significant change in status assessments. Quarterly review assessments. A subset of items upon a resident's transfer, reentry, discharge, and death. Background (face-sheet) information, if there is no admission assessment. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month, including the following: Admission assessment. Annual assessment. Significant change in status assessment. Significant correction of prior full assessment. Significant correction of prior quarterly assessment. Quarterly review. A subset of items upon a resident's transfer, reentry, discharge, and death. Background (face-sheet) information, for an initial transmission of MDS data on a resident that does	F 287	***F-287*** Medical records will be re-in-serviced on September 22, 2006 on the regulations and time frames for the transmitting of MDS's as defined by CMS. Medical records or designee will do a complete audit of all MDS's by October 20, 2006 to ensure all MDS's are submitted to the state as required by CMS. This audit will be shared with the DON and Administrator. Any MDS not submitted to the state as required by CMS date will be submitted immediately. Medical Records or designee will submit all completed MDS's to the State on a weekly basis.	

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F 287	Continued From page 12	F 287		

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 5/29/06 that was transmitted on 7/10/06. The submission date was more than 31 days after the record completion date.

Interview of the DON on 8/30/06 confirmed that the MDS assessments were transmitted late.

The Administrator or designee will log and review all transmitted MDS's, bi-monthly to ensure compliance as defined by CMS.

Identified trends will be reviewed monthly at Quality Assurance committee until lesser frequency is deemed appropriate.

Completion Date:
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER CARE CENTER	815 SOUTH 200 WEST BRIGHAM CITY, UT 84302

(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 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced 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. (Resident identifier: 3, 4 & 13) Findings included: 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. On 8/28/06 at 6:45 PM Certified Nurses Aide (CNA) 1 assisted resident 4 with her food. Resident 4's drink was spilled on her lap and the floor. CNA 1 used a cloth to wipe up the spilt drink, from resident 4's lap, shoes and then the floor. CNA 1 took the cloth to the kitchen, opened the door, threw the cloth in a bin, returned to the table and picked up resident 4's fork and began feeding her without washing or sanitizing his hands. On 8/29/06 at 8:31 AM, CNA 2 entered the dining room, sat down at table 13 and began feeding the	F 444	***F-444*** An in-service was conducted on 8-29-06 with all nursing staff to educate of proper hand washing techniques and cross contamination issues. Hand sanitizer is made available to all staff members to be used between surface contacts as appropriate. Weekly observations will be completed by the Administrator or designee to ensure staff wash and sanitize their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. The Director of Nursing or designee will train every new staff member regarding cross contamination and proper hand washing techniques at general orientation.	

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

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F 444	Continued From page 14 residents at the table. At 8:36 AM, CNA 2 left the dining room with her hands in her pockets. At 8:40 AM, CNA 2 returned pushing a wheel chair to another table. CNA 2 sat down at table 13, tucked her hair behind her ears, pulled up her pants and picked up a resident 13's fork and fed him. CNA 2 reached under the table and pulled resident 3's wheel chair closer to the table. CNA 2 then picked up resident 3's fork and fed her 3 bites. At 8:43 AM, CNA 2 left the dining room and opened a door and entered the employee break room. At 8:44 AM, CNA 2 opened the door came out of the break room and returned to table 13. CNA 2 tucked her hair behind her ears, sat down, pulled up on her pants, picked up resident 3's spoon and began to feed resident 3. CNA 2 then picked up resident 13's fork and fed him. CNA 2 did not wash or sanitize her hands during this time.	F 444	The Administrator will monitor bi-monthly for compliance. Identified trends will be reviewed in the Quality Assurance committee monthly and as needed until lesser frequency is deemed appropriate. Completion Date: October 20, 2006	