COMPLAINT NUMBER 5255

PRINTED: 4/6/01
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465119	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 3/29/01

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST LAKE CARE CENTER	**1001 N 500 W PROVO, UT 84601**

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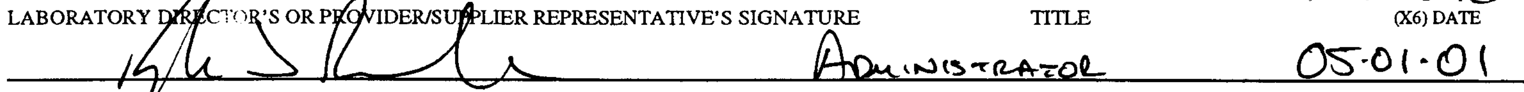
F 223 SS=G	483.13(b)ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on observations, family interview, staff interview and record review, it was determined the facility did not ensure that 1 of 6 sample residents remained free from physical abuse when a resident with identified aggressive behaviors struck resident 1 with a wheelchair foot rest, causing injuries to resident 1's nose, teeth and arm. (Residents 1, 3) Findings include: 1. Resident 1 was an 80-year-old male who admitted to the facility 12/21/00 with diagnoses including diabetes mellitus, Parkinson's, gout, dizzy, anemia, macular degeneration, coronary artery disease and history of stroke. The initial social service evaluation for resident 1 documented the resident, "Demonstrates a flat affect. Nothing appears to stimulate or motivate him," and the resident, "does not socialize much with others. He keeps quietly to himself in his room. He has quit verbalizing with his son completely and minimal speech with his wife." On 3/3/01, resident 1 was transferred into resident 3's room. Review of the nurse's note for resident 1, dated 3/14/01 at 7:00 PM, documented the resident, "had a large [inverted U] shaped laceration to nose with extensive bleeding and swelling and 1 centimeter round wound R [right] forearm, pt states that his	F 223	F223 ABUSE 483.13(b) 1. Plan of Correction is for identified residents, current residents, and for those residents to be admitted. Identified residents #1 and #3 have been discharged since POC written. 2. Indications of aggressive behavior will be thoroughly care planned by the interdisciplinary team. Indications of such shall include but are not limited to: history and physical, previous records from other institutions, facility observations, etc. 3. If it is identified that "aggression" or any other disruptive behavior is present, all care will be taken to ensure proper protection of the individual and protection of the main populace. This will be done through proper monitoring of the resident and monitoring of the identified concerns. Monitoring to be completed by the nursing staff, SSW, and IDT team. Reviews of care plans by nursing staff and IDT will enhance the monitoring and protection aspects. 4. All staff to be inserviced as to facility abuse protocol on 05-10-01. Completed attendance records and inservice notes will be forwarded to resident assessment. 5. All reported incidents of abuse and the abuse policy itself will be thoroughly reviewed and investigated by the QA program to determine if there are existing patterns. Completion Date: May 15, 2001 MAY 7 2001 5-4-01 WB	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 05-01-01

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

(Mailed 05-03-01)

approved 5-14-01

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F 223	Continued From page 1	F 223		

roommate had hit him with wheelchair foot rest." The nurse's note documented resident 1's wife was notified. Resident 1's nurse's note further documented, sent pt to [hospital] via ambulance at 8:30 PM for evaluation of injuries."

Following the incident with resident 3, resident 1 was taken to the hospital emergency room where it was documented, on 3/14/01, "The patient is an 80-year-old male who was assaulted in a nursing home, when he was struck by a metal foot rest by his roommate. He has a broken tooth, right lateral incisor, and a flap avulsion of the nose based distally. Operative repair is recommended."

Review of resident 1's notes, dated 3/19/01, from a hospital emergency room consultation documented, "He got in a fight with another resident of the care center about four days ago, and has had some swelling and tenderness in his right forearm since. He was brought to [hospital emergency room] with the complaint of right forearm pain and swelling." The X-ray results for resident 1, dated 3/19/01, documented, "a displaced fracture of the distal ulna." Resident 1 was admitted to a hospital on 3/21/01 for surgical repair of his fractured right arm. Review of hospital records documented a metallic plate was used to bridge the distal ulnar fracture.

2. Resident 3 was 68-year-old male who was admitted on 11/30/00 with diagnoses including adjustment disorder, situational depression, right cerebral vascular accident, hemiparesis, and contractures of the left elbow and left shoulder. Resident 3 did not speak English.

A review of resident 3's medical record revealed the following:

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F 223	Continued From page 2 Information received from the discharging facility on 11/28/00, prior to resident 3 being admitted to this facility, documented that resident 3 had a history of physical aggression. This information included "Interdisciplinary Progress Notes" that documented acts of physical aggression when resident 3 hit other residents at the facility. These notes documented that resident 3 had hit a resident with a wheelchair foot rest, kicked a resident, slapped a resident, and hit a resident with a cane. The admitting nurse's note for resident 3, dated on 11/30/00, documented, "Dr. [doctor at the previous facility] gave update on pt [patient] status: Difficult to please, isolates self- needs own room, 'mean in other words' - MD[doctor] stated 'pt had 4 bed changes et [and]does not do well with roommate. He better have his own room'." The facility's nurse's note, dated 12/29/00, documented that resident 3, "talks angrily and makes angry expressions on face." On 1/11/01, the nurse's note documented that resident 3 got angry when the nurse attempted to get him to eat. Review of resident 3's comprehensive care plan revealed that resident 3's known history of aggressive physical behaviors and need for a private room were not care planned until after the 3/14/01 incident of resident 3 hitting resident 1 with the wheelchair foot rest. 3. Interviews: In an interview, on 3/28/01 at 2:55 PM, with a nurse aide who had cared for both resident 1 and resident 3, the aide stated that "the only time there was a	F 223		

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F 223	Continued From page 3 problem was when we were giving cares" to resident 1. The aide stated, "[resident 3] didn't like it." The aide stated resident 3 didn't want the light on in the room, so staff would pull the privacy curtain and only use the overbed light while working with resident 1. On 3/28/01 at 9:30 AM, the administrator was interviewed in regards to the facility's previous knowledge of resident 3's behavior. The administrator stated that the facility knew of resident 3's behavior history. The administrator stated that resident 3 "acted out" on the occasions the resident's son was away, and that this facility could manage resident 3's behavior because his son was close by. The administrator further stated that after 3 months without a roommate, resident 3 would benefit from a roommate for socialization. The administrator further stated that resident 1 could also benefit from socialization with a roommate. On 3/29/01 at 2:10 PM, a facility staff nurse was interviewed in regards to resident 3's behavior. The staff nurse stated that she saw no indication that demonstrated resident 3's aggressive behaviors. Since there was no aggressive behavior, the facility did not perceive aggression a problem. If it was a problem the nurse would know by monitoring the resident agitation. On 3/29/01 at 2:40 PM, a the social service worker was interviewed in regards of allowing resident 1 move into resident 3's room. She stated that she wrote the room numbers that were available and that the nurse had given the list to resident 1's wife to choose from. The social service worker stated she was surprised that resident 1 chose resident 3's room but did not question why resident 1's wife had chosen that room. She further stated that she did not notify	F 223		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

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F 223	Continued From page 4 resident 1's wife that resident 3 did not speak any English. The social service worker omitted that that the facility failed to document and monitor resident 3's aggressive behaviors after he was given a roommate. On 3/28/01 at 11:15 AM, the family member of resident 1 was interviewed. The family member of resident 1 stated that she was not notified of resident 3's potential for aggressive behaviors.	F 223		
F 225 SS=D	483.13(c)(1)(ii)STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must	F 225	F225 STAFF TREATMENT OF RESIDENTS 483.13(c)(1)(ii) 1. Plan of Correction is for identified resident, current residents, and for those residents to be admitted. Identified resident has been discharged. 2. All alleged violations of abuse, mistreatment, neglect, and those identified as "unknown origin" will be immediately directed to the Administrator and other officials in accordance with State law. Upon notification, all investigations will be thoroughly conducted by the Administrator or SSW and will be immediately forwarded to the proper agencies. 3. Verified instances of abuse, neglect or mistreatment, will be reviewed with the proper authorities and appropriate action will be taken immediately. 4. All staff will be inserviced on 05-10-01 as to the importance of promptly notifying Administrator when possible abuse (including those of unknown origin), mistreatment, or neglect have been observed or have occurred. Initial training on hire. Training as to proper procedures will occur at least quarterly thereafter. Notes and attendance logs of inservice to be forwarded to Resident Assessment upon completion of inservice. 5. All reported incidents of abuse and the abuse policy itself will be	still says. report immediately to Admin accepted

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	prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews, closed medical record review, review of incident reports, review of facility abuse policy and review of the State survey and certification agency records, it was determined that the facility did not submit notification of an injury of unknown origin to this State agency, nor did the facility submit follow up notification to this state agency, within 5 working days, of the results of the investigation into an injury of unknown origin for 1 of 6 sample residents. (Resident 2) Findings include: Resident 2 was admitted to the facility on 11/5/00 with diagnoses that include seizure disorder, mild bilateral knee contractures, osteopenia, osteoporosis and renal insufficiency. On 3/27/01 a review of resident 2's medical record showed a nurses's note, dated 12/4/00 at 1800, stated "[Right] arm has lg [large] Bruise et [and] swelling Order given for x-rays Dr [doctor] will see in AM". On 3/27/01 a review of resident 2's physician's progress note, dated 12/5/00, stated "Right upper extremity and chest ecchymoses. There is no known trauma and no pain...x-rays are unremarkable for		thoroughly reviewed and investigated for patterns by the QA program. Completion Date: May 15, 2001	

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F 225	Continued From page 6 fracture...Clearly a vessel broke and did not coagulate very quickly. She is hemodynamically stable." On 3/28/01 an interview was conducted with the facility administrator. He stated that the police department was notified and investigated the incident the same day that it was reported to him. The administrator stated that the police investigation found no evidence of abuse. He stated that since abuse was not suspected he did not notify the State agency. On 3/29/01 an interview was conducted with the facility Director of Nursing. She stated that she had not called the State agency to report the incident. On 3/29/01 at 3:30 PM an interview was conducted with the facility social worker. She stated that she was on vacation at the time of the incident, when she returned from vacation the following Monday she notified the Ombudsman and gave the family of resident 2 the phone number for Adult Protective Services. The social worker stated that she conducted an investigation, at the request of resident 2's family, into the incident . She stated that she did not notify the State agency. The social worker was asked if she knew to report all injuries of unknown origin to the state, she stated that she aware that such occurances would need to be reported to the state. On 3/29/01 a review of the facility incident reports showed that an incident report was done on resident 2's injury. The incident report showed the date of the injury to be 12/5/00 at 1300. Documentation on the incident report stated "Nurse for [resident]notified me that resident had bruising noted to [right] arm [and] chest, breast area/also approx [approximately] 3-1/2"X 3" area of hard mass reddened, noted to	F 225		

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F 225	Continued From page 7 [upper] arm." The incident report also documented that on 12/5/00 at 1300 the physician examined the resident and that the resident's daughter was in attendance. On 3/29/01 a review of the facility abuse policy was done. There policy does not specifically state that injuries of unknown origin must be reported immediately to the State agency. Facility abuse policy : "All allegations of suspected abuse must be investigated within the facility, but must also be called to the State Department survey division. The investigation must begin immediately once the allegation has been made. The investigation may not be complete when the DOH (Department of Health) has been notified, however the immediate findings must be shared as soon as possible. The notification may be made by the facility Social Worker, or in their absence, the Director of Nursing or facility Administrator. This call needs to be made within one working day from receiving the allegation."	F 225		
F 323 SS=G	483.25(h)(1)QUALITY OF CARE The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation, interviews with a resident, a family member and staff, and record review, it was determined the facility did not ensure the facility van	F 323	F 323 QUALITY OF CARE 483.25(H)(1) 1. Plan of Correction is for identified residents, current residents, and for those residents to be admitted. Identified resident has since been discharged. 2. As of 03-28-01 all four van straps are present and in working order. Appropriate staff inserviced on stated date as to proper usage of straps.	

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F 323	Continued From page 8 was maintained to prevent injury to resident 1 who was tipped over in his wheelchair while being transported from a doctor's appointment and incurred a separated shoulder. The facility van was not maintained to ensure the safety of resident 4 who slipped from a wheelchair during van transportation, or for the safety of any two residents traveling in wheelchairs at the same time, or to provide the van with working brake lights or turn signals. Findings include: 1. Resident 1 An interview was conducted with a family member of resident 1, on 3/28/01 at 11:15 AM. Resident 1's family member stated that while being transported in a wheelchair via the van on 3/27/01, resident 1 and the wheelchair had tipped over. Resident 1's family member said the resident complained of pain in his shoulders, although he had a very high pain tolerance and had seldom complained of pain. The family member stated the incident caused resident 1 to suffer a separated shoulder. Resident 1's family member stated an x-ray had been taken which verified the injury to the resident's shoulder. Resident 1's family member stated she had ridden in the van with the resident earlier in the day. The resident's family member stated the wheels of resident 1's wheelchair were fastened to the floor of the van with the straps that were there. Resident 1's family member said there were not enough straps for all four wheels to be fastened down. The family member said resident 1's wheelchair "seemed wobbly" in the van. Review of nurse's notes, dated 3/27/01 at 3:00 PM,	F 323	F323 (cont.) 3. Effective Immediately: until proper restraints for the safe transport of two wheelchairs are installed, only one wheelchair will be transported in the proper manner. Proper manner was demonstrated in the inservice provided 03-28-01. All future transportation personnel will receive proper training on placement of one wheelchair during transport. Training procedure that will be utilized is hereto attached as Exhibit 1. 4. The facility van, and maintenance of such, will be thoroughly reviewed in the monthly Safety Committee. Safety Committee is an integral and continuing part of the facility's Q.A. program. Also, facility van inspection will occur on a weekly basis by Plant Operations Manager. Transport staff will also be trained on 05-01-01 as to how to utilize maintenance logs in the event that something should happen to the facility van that might otherwise go unnoticed. 5. Van lights and turn signals repaired prior to writing this Plan of Correction. 6. Completion Date: May 15, 2001 Plant Operations Manager will review maintenance logs daily. When a concern is identified as needing repair, 3 bids will be obtained + repairs made immediately. per Kyle Peacock by telephone on 5-14-01 @ 3:50pm Sharen Jorgensen	Still doesn't say specifically rprs will be made timely. Can't specify which repairs must be done - accepted

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F 323	Continued From page 9 documented resident 1 was being transported from an appointment in the facility van. The nurse's note documented, "the belt that held w/c [wheelchair] in place came loose causing w/c and pt [patient/resident] to tip over." Review of nurse's notes, dated 3/28/01 at 1:00 AM, documented, "X-ray results questionable Rt [right] shoulder AC separation vs [versus] recession of Rt clavicle." 2. Resident 4 Review of the facility's incident report dated 8/31/00, documented resident 4 was transported to an appointment via the facility van. The report was written by a "transportation driver"employed by the facility. The incident report documented, "On the way over I noticed her slumping over so I pulled over and in the process the seat belt had come un-done and she slid out of her wheelchair and I was able to catch her before hitting her head so I tried to put her back into her wheelchair and I couldn't so I drove back to [facility] where I asked aide's to get a restraint and help me put her back into her chair." It was documented that resident 4 was then taken to her appointment. 3. Observations On 3/28/01 at 1:30 PM, two of the employees who drive the facility's van were observed and interviewed as they were inserviced on how to position and strap down wheelchairs in the van for resident safety. The two employees demonstrated the side sitting position they had been using for wheelchairs, which had the resident facing out the right side window. One of the drivers stated she had been inserviced, about a year	F 323		

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ago, by a van driver who taught her the side sitting position. They both stated that was the position they had always used. As observed by the surveyors and as stated by the administrator, the side sitting position did not allow a wheelchair to be positioned firmly even with the additional tie-down strap.

Observation of the facility van was made on 3/28/01 at 1:30 PM. The van was observed to have four tie-down straps and a seat belt. The back of the van was observed to have one tie-down strap and a seat belt where a second wheelchair would go.

Observation of the facility's van as it was being driven to pick up a resident, on 3/28/01 at 1:50 PM, revealed that neither the brake lights nor turn signal were working.

4. Interviews

In an interview with the medical records staff in charge of the facility van, on 3/28/01 at 1:15 PM, the staff member stated a request had been submitted for additional safety straps in the van, but a voucher authorizing the repair work had not been received. In the interview with the medical records staff in charge of the van records, the staff member stated only one resident is scheduled to be transported in the van at any time. The medical records staff stated that, "once or twice a week", two residents are ready to return to the facility at the same time, and have to be transported together.

In an interview with a driver of the van, on 3/28/01, the driver stated that two residents with wheelchairs have been transported together, "once or twice a week".

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F 323	Continued From page 11 In an interview with the medical records staff in charge of the van, on 3/28/01 at 2:00 PM, the staff stated the brake lights and turn signal must have been working in December, 2000, but for the past couple of months there had been weekly verbal requests to have the lights repaired. At the time of the interview, 3/28/01 at 2:00 PM, a voucher authorizing the necessary repairs, to the brake lights and turn signal, had not been received, as stated by the medical records staff. Resident 5 uses a wheelchair for locomotion. In an interview with resident 5, on 3/29/01, the resident stated he has been taken to the hospital in the van every Monday, Wednesday, and Friday. Resident 5 stated that occasionally there are two residents riding in the van in their wheelchairs. In confidential interviews with two of the facility staff on 3/28/01, the staff members stated they had assisted residents into the facility's van on several occasions up to 3/28/01 and there had not been four tie-down straps for either wheelchair spot in the van prior to 3/28/01. 5. Record Review Review of the facility van's maintenance records documented that, on 1/19/01, a request was submitted for, "additional seat belts/wheelchair attachments for secure transport of two residents." The requisition also documented an estimated cost for "4 point tie-down with seat belt and shoulder harness" and for "each additional seat belt (1 needed for present tie-down)." When asked for the work order that documented the repair work had been authorized or completed, the facility did not have one.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465119	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 3/29/01

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F 494 SS=E	483.75(e)(2)-(3)ADMINISTRATION A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of ss483.151-483.154 of this part; that individual has been deemed or determined competent as provided in s483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews with the Director of Nursing, the Nurse Aide Trainer, the Administrator, and the State Registry and on record review, it was determined the facility employed nurse aides who had not completed a State approved certification program and passed a State approved competency evaluation for 12 of 13 sampled nurse aides who had worked at the facility for periods from four months and one week up to fourteen months and three weeks. Findings include: In an interview with the Human Resourses nurse, who provided nurse aide training at the facility, on 3/28/01, the nurse stated that since November, 2000, there had been several turnovers in employees who had worked to train the nurse aides and some of the	F 494	F 494 ADMINISTRATION 483.75(e)(2)-(3) 1. Plan of Correction is for identified nurse aides, current nurse aides that may be effected, and all nurse aides that will be hired. 2. Since the Survey, East Lake is no longer able to complete the CNA training here at this facility as this facility is currently on probationary status. East Lake does, however, employ an approved instructor for the CNA course. The facility administrator will insure that those CNA's currently involved in classroom education will be able to continue with the same instructor at another facility. All future CNA's hired while East Lake's certification of CNA's is on probation, will also be trained at an offsite locale. The Utah Health Technology Center will review East Lake's status in July, 2001. 3. Thus, all new nursing assistants hired without prior certification will be followed by facility's administrator, staff developer and director of nursing to ensure that the four month provision is not jeopardized. 4. To make provision for those that have been identified by Resident Assessment and for those aides that may crossover the four month provision, that do not pass, the facility administrator will contact Resident Assessment and the Utah Health Technology Center on a case by case basis. Appropriate action up to and including dismissal will ensue. ~~This will only occur if resident safety~~ last line deleted by phone with Janet, DON 5-14-01 Shauna Jorgensen & with Kyle Peacock 5/4/01 350pm	

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F 494	Continued From page 13 records were not kept up to date. In an interview with the Director of Nurses (DON) on 3/28/01, the DON stated there have been some changes in the training department and that some of the nurse aides working longer than four months had not yet been certified. In an interview with the Administrator on 3/29/01, he stated he thought there may have been two or three nurse aides working longer than the four months allowed for training. In an interview with the State Registry, the Registry Director stated there was no one certified to provide nurse aide training at the facility as of 4/4/01. Record Review A list of current employees and their dates of hire was provided by the facility. A sample of thirteen employees listed as nurse aides, who had worked longer than four months, was verified with the State Registry. Eleven of the thirteen sampled employees who worked as nurse aides longer than four months were verified by the State Registry as not having been certified. Nurse aide 1 had been working nine months and three weeks. Nurse aide 2 had been working fourteen months. Nurse aide 3 had been working fourteen months and three weeks. Nurse aide 5 had been working six months and two weeks. Nurse aide 6 had been working four months and two weeks. Nurse aide 7 had been working ten months.	F 494	~~will not be jeopardized.~~ Completion Date: ~~July 15, 2001~~ June 13 - 2000 per Kyle Peacock on 5/14/01 @ 350pm Sharon Jorgensen	

PRINTED: 4/6/01
FORM APPROVED
2567-L

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F 494	Continued From page 14 Nurse aide 8 had been working seven months and three weeks. Nurse aide 9 had been working nine months and three weeks. Nurse aide 10 had been working five months and one week when the aide was temporarily terminated. Nurse aide 11 had been working eight months. Nurse aide 13 had been working twelve months and three weeks.	F 494		