UEFAR	3/29/2005 17:21 {{MEN! OF HEALT	8013779747 H AND HUMA>LSERVICES	Ε₽	STLAKECARECENTER		GE 01
CENTE	RS FOR MEDICAR	E & MEDICAIL ERVICES			PRINTE): 03/07/20 MAPPROVE
, ~ , CIVIE/	O OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMBNO). 0938-03
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE:	SURVEY
·		465119	B. WING		}	
AME OF	PROVIDER OR SUPPLIER				02/2	23/2005
	AKE CARE CENTER			REET ADDRESS, CITY, STATE, ZIP COI 1001 NORTH 500 WEST	PE	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVO, UT 84601		
PREFIX TAG	1 (PACE DEFICIENT)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 157 SS=G		TFICATION OF RIGHTS AND	F 157			
	known, notify the resident involving the injury and has the printervention; a signification in heat status in either life the clinical complication significantly (i.e., a rexisting form of treatment); or a decreatment); or a decreatment); or a decreatment); or a decreatment from the 12(a). The facility must also and, if known, the resident from or respective in season or respective in season. The facility must receive the address and phose address and phos	ediately inform the resident; ident's physician; and if esident's legal representative mily member when there is an he resident which results in totential for requiring physician ficant change in the resident's psychosocial status (i.e., a th, mental, or psychosocial hreatening conditions or is); a need to alter treatment heed to discontinue an eatment due to adverse or commence a new form of ision to transfer or discharge is facility as specified in s483. To promptly notify the resident is ident's legal representative member when there is a commate assignment as is (e)(2); or a change in rederal or State law or fied in paragraph (b)(1) of the production of the resident's for interested family member. To is not met as evidenced by and medical record reviews, a facility did not consult with an for 1 of 22 sampled esident exhibited a change of excupplier representative's signal medical record reviews, and medical record reviews, a facility did not consult with an for 1 of 22 sampled esident exhibited a change of excupplier representative's signal representative's signal representative and medical record reviews, and medical record reviews, and medical record reviews, and medical record reviews, as facility and not consult with an for 1 of 22 sampled esident exhibited a change of excupplier representative's signal representative and medical record reviews, and medical record reviews, as facility and not consult with an for 1 of 22 sampled esident exhibited a change of excupplier representative and medical record reviews, as facility and not consult with an for 1 of 22 sampled esident exhibited a change of		Licensed Nurses will be inserved Notification of physician when has a change in condition, pronotification for new or change treatments and proper docume in Nurses Notes. D.O.N will me Thru QA nursing rounds and report weekly to Quality Assuracommittee. Completed by April 8, 2005.	a resident per in entation onitor	DATE

residency statement ending with an esterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that a safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days which date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 gram participation.

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

Event ID; F4WD11

Facility ID: UT0022

If continuation sheet Page 1 of 80

03	/29/2005 17:21	8013779747		EAST	LAKECARECENTER		PAG	GE 02
OFINIE	UO LOR MEDICARE	AND HUMA SERVICES					PRINTED FORM): 03/07/200 0 APPROVED
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIP JILDING	PLE CONSTRUCTION		(X3) DATE S	
		465119	B. WI	ING				
	PROVIDER OR SUPPLIER	,	<u></u>	STRE	EET ADDRESS, CITY, STATE, Z	ID CODE	02/2	3/2005
	KE CARE CENTER			10	01 NORTH 500 WEST ROVO, UT 84601	P CODE		
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F 157	Continued From page	ge 1		4 5 - 2	<u> </u>			
		fleed to commence now	۲	157				
	Findings include:							
	 Resident 9 was a diagnoses which inci depression. 	dmitted to the facility with uded quadriplegia and						
	returned to the facility therapy at another fa [she] and a family mean concern to facility muleft leg seemed to be leg at the upper thigh left thigh had been rember and the nurspe "about 4 inches" leg care facility where [she reated for left intertro Resident 9 stated [she reapy out of the facily when [she] was admitted to 5/3/04 [her] left fen	9 was interviewed in her lated that on 4/30/04 [she] y after receiving physical cility. Resident 9 stated that ember had expressed sing staff that resident 9's much larger than [her] right. Resident 9 stated that [her neasured by a family sing staff and was found to orger than [her] right thigh. It several days later at [her] was examined at an acute e] was diagnosed with and chanter hip fracture. It is physical lity. Resident 9 stated that the to an acute care facility our had been displaced to 5" shorter than her right						
r /t	ecord nurse's notes r 04 at 2100 (11:00 PM "[Resident 9 and a oncemed that resident nan right extremity.	of resident 9's medical evealed an entry dated 4/30 l) which documented: a family member] are nt 9's left extremity is larger eft thigh 28"						
CMS-2567	02-99) Previous Versions Obs	colete Event ID: F4WD11	Facilit	ty ID:	UT0022	If continue	tion sheet Pa	ige 2 of 80

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

PRINTED: 03/07/2005 FORM APPROVED

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SIALLMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL	ULTIPLE CONSTRUCTION	(X3) DATE S	. 0938-039 SURVEY ETED
		465119	B. WING	G	•	
	PROVIDER OR SUPPLIER AKE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP (1001 NORTH 500 WEST PROVO, UT 84601	02/2	3/2005
(X4) ID PREFIX TAG	(CACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C	HOLLID BE COOCC	(X5) COMPLETION DATE
F 157	Continued From paginght calf 15" ankle 9"	ge 2 left calf 15 1/4" left ankle 9"	F 15	57		
ł	in the ER (emergency thigh swelling. Thigh circumference than touch from above the The entry further doctaken to the emerge An entry dated 5/3/0 documents that Resi acute care facility will fracture and that the was notified at 11:45 medical record revea	d 5/3/04 at 1500 (3:00 PM) resident 9) needed to be seen by room) for left increased in about 3 1/2 to 4" larger in mon-affected thigh; tight to be knee to hip on left side". Cuments that resident 9 was not room via ambulance. 4 at 2130 (11:30 PM) indent 9 was admitted to the left intertrochanter hip facility Director of Nursing PM. A review of resident 9's alled no evidence that resident leg.				
F 224 SS=G	483.13(c)(1)(i) STAF RESIDENTS	F TREATMENT OF	F 224	4		
	policies and procedu mistreatment, neglec	elop and implement written ires that prohibit ct, and abuse of residents of residents.				-
	(Use F224 for deficie mistreatment, neglec resident property.)	ncies concerning t or misappropriation of				
1	: Based on interview ar determined that the fa	is not met as evidenced by nd review of records, it was acility did not implement recedures that prohibit	Ġ			

O PLAN	NT OF DEFICIENCIES OF CORRECTION	E & MEDICAL ERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	FORM OMB NO (X3) DATE S COMPL). 0938-03 BURVEY
		465119	B. WING			
ME OF:	PROVIDER OR SUPPLIER				02/2	3/2005
AST LA X4) ID PREFIX TAG	: VERGIN DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL	1	REET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH 500 WEST PROVO, UT 84601 PROVIDER'S PLAN OF CORR	ECTION	(×5)
	- SON ON OR	SCIDEN (IFYING INFORMATION)	TĀG	(EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS- E DEFICIENCY)	COMPLET
of contact actions and distributions are distributions and distributions and distributions are distributions are distributions and distributions are distributions are distributions and distributions are distributions and distributions are distributions and distributions are distributions are distributions and distributions are distributions are distributions are distributions and distributions are distributions and distributions are distrib	mistreatment, negle 2 of 22 sampled restactives; did not provistaff on Issues relatives and treating resider not adequately repostaff abuse for residinvestigate circumstructures and sphysical harm, mentures and eight certagration, preventives and eight certaining during the past year. Facility Director of Nucleopies of both the abatelity during the presonance training. Facility during had taget training had taget they were unable after several requests evidence that training and the Resident 9 was at	ect and abuse of residents for sidents. Specifically, the de ongoing training to facility ted to abuse prohibition revent neglect in assessing at 9 for a hip fracture; and did out or investigate allegations of dent 11 nor report or tances of neglect for resident the failure by the facility to services necessary to avoid tal anguish, or mental illness 9 and 11. 1. 2/14/05, 2/15/05 and 2/16/15 were conducted with three tified nursing assistants ceived at the facility on abuse on and reporting procedures. Itaff interviewed could not being provided at the facility. On 2/15/05 and 2/17/05, the rising was asked to provide suse training given at the vious year and the signed inployees attending the ity administration stated that ken place within the year, to provide documentation (as from the survey team) to had occurred. Idmitted to the facility with ided quadriplegia and	t r r r r r r r r r r r r r r r r r r r	All Nurses and Nursing Assistatinserviced on Abuse Policy, Abwill be incorporated into the fact Hire Orientation. Incident Accident Log Book will logging Individual incident report Investigation and Injury of Unkn Report will be implemented. Nursill be inserviced on proper comflictent Report and reporting mesuspected abuse/neglect or Injuritation Surgected Injury of Unknown Source to Committee weekly for the next 3 hen monthly thereafter. D.O.N. eport daily incidents of suspected appropriate to Junknown source to Admitted by April 8, 2005. Resident 9 was admitted to the hospitor a repair of her hip. She was redmitted to this facility, and per her equest, changed to in house therapy. The inservice was held for all staff tembers. Documentation is in the inservice book.	be set up ts. Fall own Source sing staff pletion of whods of tyof whiter all ts of Fall the QA months will d abuse m.	

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

RINTED:	03/07/2005
FORM /	APPROVED

DEPARTMENT OF HEALTH AND HUMA	ERVICES
CENTERS FOR MEDICARE & MEDICAID 9	

& MEDICAID SERVICES		OMB NO. 0938-0391
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
		<u> </u>

		465119	B. WING		02/2	3/2005
	PROVIDER OR SUPPLIER	·		REET ADDRESS, CITY, STATE, ZIP CODE	OZ/Z	<u> </u>
EAST LA	AKE CARE CENTER	·		001 NORTH 500 WEST POVO, UT 84601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL BC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F 224	Continued From pa	ge 4	F 224		<u> </u>	
	returned to the facilit therapy at another facility in concern to facility in left leg seemed to be leg at the upper thigh had be member and the number "about 4 inches". Resident 9 stated the own insistence, [she care facility where [streated for left intertion Resident 9 stated for left intertion	elated that on 4/30/04 [she] ty after receiving physical acility. Resident 9 stated that nember had expressed ursing staff that resident 9's e much larger than [her] right h. Resident 9 stated that [een measured by a family rsing staff and was found to larger than [her] right thigh, at several days later at [her] e) was examined at an acute she] was diagnosed with and rochanter hip fracture, he] believed [her] left leg had 0/04 during a visit to physical cility. Resident 9 stated that nitted to an acute care facility emur had been displaced "4 or 5" shorter than her right				
	record nurse's notes /04 at 2100 (11:00 P '[Resident 9 an concerned that resid than right extremity. right thigh 24 ½" right calf 15" ankle 9" A further entry dated documented "Pt. (rin the ER (emergence thigh swelling. Thigh circumference than retouch from above the The entry further documented contents of the entry further documented than retouch from above the contents of the entry further documented contents of the entry further docume	of resident 9's medical revealed an entry dated 4/30 M) which documented: d a family member] are lent 9's left extremity is larger left thigh 28" left calf 15 1/4 left ankle 9" left ankle 9" left obe seen by room) for left increased a about 3 1/2 to 4" larger in non-affected thigh; tight to be knee to hip on left side".				

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

Event ID: F4WD11

Facility ID: UT0022

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DEPARTMENT OF HEALTH AND HUMA. SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/07/2005 FORM APPROVED OMB NO 0938-0391

TATEMEN	T OF DEFICIENCE	E & INEDICAID SERVICES				OMB NO). 0938-039 ⁻
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		465119	B. Wir	1G —		02/5	32/2005
	PROVIDER OR SUPPLIER AKE CARE CENTER			10	REET ADDRESS. CITY, STATE, ZIP COI 001 NORTH 500 WEST PROVO, UT 84601		23/2005
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES (MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS.	(X5) COMPLETION DATE
F 224			F2	224			
	An entry dated 5/3/documents that Reacute care facility was recture and that the was notified 11:45 If On 2/16/05, the face Residents" was revided documented that the assure that all residency be free of abus involuntary seclusion property during their documented, under be Monitored During All facility staff must work performance to fine facility care for the following proton and explains the proof facility charge nur Nursing) and ADON Nursing) and ADON Nursing) to monitor ensure that neglect On 2/16/05, facility I examined for the pethrough February 20 document alleged vides dealer 9 was four On 2/17/05, an internal Administrator-In-Tra Services Worker, an regarding the facility	cility "Anti-Abuse Policy for riewed. The policy he facility objective was to." dents residing at the facility se of any sort; neglect; on or misappropriate of their firstay". The policy further the heading "How Staff Will g Delivery of Care & Services: the monitored during their to assure there is no evidence of those residents whom they for. This will be accomplished tocol: "The policy further lists occodures for the responsibility rises, DON (Director of It (Assistant Director of staff work performance and does not occur. Incident Reports were period covering January 2004 2005. No Incident Report to itolations involving neglect for					

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Event ID: F4WD11

Facility ID: UT0022

If continuation sheet Page 6 of 80

DEPARTMENT OF HEALTH AND HUM, SERVICES

PRINTED: 03/07/2005

CENTE	RS FOR MEDICARI	& MEDICAID SERVICES			,	FORM	APPROVE
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<u>. </u>		465119	B. WIN	IG			
NAME OF	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		23/2005
EAST LA	AKE CARE CENTER			100	01 NORTH 500 WEST ROVO, UT 84601	•	
(X4) ID PREFIX TAG	J (\$ACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	LD BE CROSS-	(XJ) COMPLETION DATE
F 224	Continued From pa	ige 6	F2	24			
	and neglect. In res about Resident 9's May 2004, the facil than an incident Refor Resident 9's hip Administrator-In-Tr. Services Worker ar further stated that r been made to the Sagency. Federal recontained within this allegations of negle several agencies, ir certification agency. 3. Resident 11 was	ponse to surveyor questions episode of inpatient care in ity Director of Nursing stated eport had not been completed fracture. The facility's aining, the Certified Social not the Director of Nursing to report of the incident had state survey and certification guilations (please see F 225 is document) require that ct are immediately reported to including the State survey and its admitted to the facility with cluded senile dementia and		24			
	Residents" was revithat the facility objet residents residing at abuse of any sort; nor misappropriate of stay". The policy further do "Who Should Stay". To Within the Facility abuse is noted by an immediately report in nursing supervisor, thas been reported to the facility Director of Worker, and facility.	ewed. The policy documents extive is to "assure that all the facility may be free of eglect, involuntary seclusion their property during their ocuments, under the heading: uspected Abuse Be Reported y? When a case of suspected in employee, they must to their Dept. Head or the conce the suspected abuse of the immediate supervisor, of Nursing, facility Social Administrator must be notified ing the report must be					

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

the abuse form. ..."

Event ID: F4WD11

Facility ID: UT0022

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DEPARTMENT OF HEALTH AND HUM, SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X2) MULTIPLE CONSTRUCTION

PRINTED: 03/07/2005 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

A. BUILDING

(X3) DATE SURVEY COMPLETED

465119

B. WING

02/23/2005

NAME OF PROVIDER OR SUPPLIER

EAST LAKE CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH 500 WEST

			PROVO, UT 84601				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(U PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	Continued From page 7	F 224					
	"What Outside Agencies Must be Notified of the Suspected Abuse? All allegations of suspected abuse must be investigated within the facility, but must also be called in to the State Health Department survey division. The investigation must begin immediately once the allegation has been made. The notification may be made by the facility Social Worker, or their (sic) in their absence, the Director of Nursing or facility Administration. This call needs to be made within one working day from receiving the allegation: On 2/17/05, the facility Administrator-In-Training, the Certified Social Services Worker and the Director of Nursing were interviewed regarding the facility's policy and procedures for reporting and investigating allegations of staff abuse against residents. During the interview, facility staff revealed that representatives of an advocacy agency had visited the facility on 2/17/05 to investigate an anonymous complaint alleging that, on 2/10/05, a facility certified nursing assistant had kicked resident 11 and that this had been reported to the facility by another certified nursing assistant when it happened. During the interview, the Director of Nursing stated that a written "warning note" reporting the alleged abuse incident had been "slipped under [her] door" sometime around 2/10/05 and that [she] had not taken any action on the allegation of abuse. The Administrator-In-Training and the Certified Social Services Worker stated they had not been aware of the alleged abuse incident until 2/17/05 and the facility had not reported the abuse to any						

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

Event ID: F4WD11

Facility ID: UT0022

If continuation sheet Page 8 of 80

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DEPAR	TMENT OF HEALTH	HAND HUMA SERVICES				03/07/200
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				APPROVEI 0938-039
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDEN FIFICATION NUMBER:	(X2) MULTI	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		465119	B. WING_		02/2	3/2005
NAME OF F	PROVIDER OR SUPPLIER		STF	REET ADDRESS: CITY, STATE, ZIF		3/2005
EAST LA	AKE CARE CENTER		1	1001 NORTH 500 WEST PROVO, UT 84601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS-	(X5) COMPLETION DATE
F 224	Continued From pa	age 8	F 224			
	outside agencies, r allegations of abus facility.	nor had any investigation of the e been done by anyone at the				
	a form titled "Warn completed by a fac appeared to allege 2 (CNA 2) had bee	or of Nursing provided a copy of ing Slip" which had been illty charge nurse and which that certified nursing assistant n observed "hitting at least 2 X ked(sic) at least 2 X (times) in ff".				
÷	Social Services Wo stated they would in	otrator-in-Training, Certified orker and Director of Nursing mmediately investigate the abuse and present surveyors t of their findings.				
	Investigation Re: A reviewed. This rec facility had conduct	O AM, two printed pages titled " sliegation of Abuse" were ord documented that the ed interviews with several of 2/17/2005 and 2/18/05. The				
	during this incident, deal with an incider	determine what happened It is especially difficult to it which happened more than let that the incident is				

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unsubstantiated, but will not allow the CNA involved to work on that side of the Unit anymore

The record was signed by the Administrator in Training and the Certified Social Worker.

On 2/23/05 an interview was conducted with Certified Nursing Assistant 1(CNA 1) who had reported the alleged abuse of CNA 2 to resident

Event ID: F4WD11

Facility ID: UT0022

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DEPARTMENT OF HEALTH AND HUMA. JERVICES

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING (X3) DATE SURVEY A. BUILDING	
CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO. 0938	<u>-038</u>

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH 500 WEST

EAST LAKE CARE CENTER			1001 NORTH 500 WEST PROVO, UT 84601				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F 224	Continued From page 9	F 224					
	11. CNA 1 stated that the abuse happened on 2/9/05 or 2/10/05 and that [she] reported the incident immediately to the facility charge nurse. CNA 1 stated that CNA 2 has stated [she] doesn't like resident 11. CNA 1 stated [she] was in resident 11's room administering personal cares. CNA 2 came into the room and asked if CNA 1 if [she] needed any help. CNA 1 told CNA 2 "no" and witnessed CNA 2 kick resident 11 "for no reason" and then slap [him]. CNA 1 stated that [she] did not want CNA 2 to know that [she] had reported the abuse because [she] was fearful that CNA 2 would retallate against [her]. The facility Certified Social Worker was Interviewed on 2/23/05. The Certified Social Worker stated that the facility did not substantiate						
	the allegation of abuse against CNA 2 but that CNA 2 did not report for work at the next scheduled shift after the investigation interview was conducted with [her] on 2/18/05. The Certified Social Worker stated that the facility had decided to terminate CNA 2's employment with the facility. When asked directly, the Certified Social Worker stated that [she] would re-hire CNA 2 if [she] reapplied for work at the facility.						
F 22 5 SS≃H		F 225					

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Event ID: F4WD11 Facility ID: UT0022

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CENTE	RS FOR MEDICAR	F & MEDICAL - FRANCES		₩ # 	PRINTE	03/07/2005
TATEMEN	T OF DEFICIENCIES				OMB NC	MAPPROVED). 0938-0391
ND PLAN (OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	ULTIPLE CONSTRUCTION LDING	(X3) DATE S	BURVEY
		465119	B. WIN	G		
AME OF A	PROVIDER OR SUPPLIER				02/2	23/2005
			1	STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
	KE CARE CENTER	•	- 1	1001 NORTH 500 WEST		
(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCIES		PROVO, UT 84601		
PREFIX TAG	I LEACH DEFICIENCY	Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPR	OULD BE CROSS	COMPLETION DATE
F 225	Continued From pa	age 10	<u> </u>			
į		the State nurse aide registry	F 22	25)		<u> </u>
İ	or licensing authori	ties	F225	All otoff will be		ſ
			F226	All staff will be inserviced of	n reporting	
ļ	The facility must en	sure that all alleged violations		Abuse/Neglect/Injury of uni	known.	Í
	mistreatm	lent, neglect, or abuse		Injury of Unknown Source	Investigation	İ
ļ	including injuries of	Unknown source and		form will be implemented a	nd all reports	ł
	immediately to the	resident property are reported		of injuries of unknown sour	ce will be	
	to other officials in a	administrator of the facility and accordance with State law		investigated by the D.O.N. to the Adm. Daily, continue	and reported	1
	through established	procedures (including to the		by logging on the Incident re	monitoring	
.	State survey and ce	ertification agency)		thru the QA committee wee	Pon Log	
				3 monthly then monthly. At	Kiy tor ine nexi	
	The facility must ha	ve evidence that all alleged		Will be investigated by social	use/Neglect	i
- }	Violations are thorou	Johly investigated and muct.	· ·	Notification will be made to	ii worker	
j	prevent futtner pote investigation is in pr	ntial abuse while the		Agencies. Investigations wil	ан арргордат е с	ļ
	Wite and Barrow Lis III bi	ogress		Completed within 5 days. The	u oc his w ill	
	The results of all inv	restigations must be reported		rollowed up weekly for 3 mo	nths in	
1	to the administrator	or his designated		QA, then monthly.	' '	
	representative and t	o other officials in	-	All resident incidents were inve	estigated	
	accordance with Sta	ate law (including to the State		by the DON and the CSW. The	· -	-
	survey and certificat	ion agency) within 5 working		findings are on file		1
	/erifled appropriate	and if the alleged violation is corrective action must be		Resident 11 had his incident		
	aken.	corrective action must be		investigated by the DON and th	· CON	-
				and results reported to the appro	ECSW,	
	This REQUIREMEN	T is not met as evidenced by		agencies. APS conducted their	follow-	
-	1			up investigation in house.	,	
F	Based on interviews	and record review, the facility		1 477 44	1	Ì
10	ild not ensure that, t	for 6 of 22 sampled residents		All incidents for residents 3,4,	9,12,13,	
1 8	alleged violations inv	Olving neglect, abuse and		were reviewed in a special IDT I	neeting,	į
i	mmediately to the a	Source were reported		and the deficient practice was identified inservice that was given re-	entified	-
ļ t	o other officials in a	dministrator of the facility and coordance with State law		each of those items to assure that	viewen	
t	hrough established	procedures. Specifically, the		correct procedures will be follow	red in	
16	acility aid not report	alleged violations involving		the future.		_
<u> </u>	legiect for Resident	9. did not adequately report			_	• •
0	ir investigatė allegat	ions of staff abuse for		These same inservices will be rep	eated C	
r	esident 11 and resid	lent to resident abuse for		quarterly. Completed by April	8,2005. I	
CMS-2567	(02-99) Previous Versions O	bsolete Event ID: F4WD11	Facility	iD: UT0022 if con	itinuation sheet Pag	

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RINTED: 03/07/2005
FORM APPROVED
MB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORPECTION (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION						OMB NO. 0938-03			38-039		
AND PLAN	OF CORRECTION	DENTIFICATION NUMBER	(X2) / A. BU			STRUCT	TON	•		(X3) DATE SURVEY COMPLETED			EY
			1		·G						COMP	'L≒1ED	ļ
NAME OF I	PROVIDER OR SUPPLIER	465119	B. WI	NG _						02/23/2005			
	AKE CARE CENTER			31	REET ADDR	TH 500	WEST	TATE, ZII	CODE			2012	703
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	T		ROVO, U								
PREFIX TAG	/ VERGIN DEFICIENCY	MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH	CORRE	CTIVE	PLAN OF ACTION E APPRO	SMOUL	O PE OF	ROSS- ENCY	. cor	(X5) MPLETION DATE
F 225	Continued From pa	ge 11		200									
	Resident 12, and did	d not adequately report unknown source for 13. Residents 3, 4, 9, 11, 12,	+ ½	225									
	Sub-Standard Qualit Resident Behavior a 483.13). The detern Quality of Care was identification, investi	181100 and reporting of											
	residents) and injurie	(both by staff and other is of unknown source.			·								
	residents, one of who went untreated for 3 neglect), 2 of whom vabuse and an addition additional and a significant injuries (or oroken finger and lacted, another resident through his lip around with a right eye incidents were investionally and agencies, incompleted agencies, incompleted agencies, incompleted agencies, incompleted agencies, incompleted agencies, incompleted agencies. The facility becember 13, 2004, for a sidence that any of the facility becember 13, 2004, for a sidence that any of the facility becember 13, 2004, for a sidence that any of the facility becember 13, 2004, for a sidence that any of the facility becember 13, 2004, for a sidence that any of the facility becember 13, 2004, for a sidence that any of the facility becember 13, 2004, for a sidence that any of the facility becember 13, 2004, for a sidence that any of the facility becember 13, 2004, for a sidence that any of the facility becember 13, 2004, for a sidence that any of the facility becember 13, 2004, for a sidence that any of the facility becember 13, 2004, for a sidence that any of the facility becember 13, 2004, for a sidence that any of the facility becember 13, 2004, for a sidence that any of the facility becember 13, 2004, for a sidence that any of the facility become that any of the facility become the facility become the facility and the facility become the facility and t	om had a broken leg which days (see F224 regarding were alleged victims of nal 3 who suffered he resident was found with a erations to the back of her not was found with his front and the third resident was injury). None of the gated by the facility. None reported by the facility to cluding the State survey and The facility did not have the incidents were to the administrator, as had evidence that on their quality assurance.											
ir H W	ommittee had identifi nvestigation of injurie: lowever, three days li /as found with two lac ead while lying in bed	ed the lack of reporting and sof unknown source. ater, on 12/16/04, resident 4 cerations on the back of her d. No one knew how the The incident was not											

left leg seemed to be much larger than [her] right leg at the upper thigh. Resident 9 stated that [her] left thigh had been measured by a family member and the nursing staff and was found to be "about 4 inches" larger than [her] right thigh. Resident 9 stated that several days later at [her] own insistence, [she] was examined at an acute care facility where [she] was diagnosed with and treated for left intertrochanter hip fracture. Resident 9 stated [she] believed [her] left leg had been injured on 4/30/04 during a visit to physical therapy out of the facility. Resident 9 stated that when [she] was admitted to an acute care facility on 5/3/04 [her] left femur had been displaced making [her] left leg "4 or 5" shorter than her right leg.

On 2/17/05, a review of resident 9's medical record nurse's notes revealed an entry dated 4/30 /04 at 2100 (11:00 PM) which documented:

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[Resident 9 and a family member] are concerned that resident 9's left extremity is larger than right

Event ID: F4WD11 Facility ID: UT0022

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DEDAG	72372000 17.20 8013779747	E	ASTLAKECARECENTER	PAG	E 04
CENTE	RTMENT OF HEALTH AND HUM/ SERVICES ERS FOR MEDICARE & MEDICAL SERVICES			FORM): 03/07/200 APPROVE
_ _ [[[[i,v](_)	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MI A. BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATE S	
	465119	B. WIN	G	1	
NAME OF	PROVIDER OR SUPPLIER			02/2	3/2005
EAST L	AKE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 1001 NORTH 500 WEST PROVO, UT 84601	ЭE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	III D DE COACA	(X5) COMPLETION DATE
F 225	Continued From page 13			· · · · · · · · · · · · · · · · · · ·	
	extremity. right thigh 24 1/2" left thigh 28" right calf 15" left calf 15 1/4" right ankle 9" left ankle 9"	F 22	25		
	A further entry dated 5/3/04 at 1500 (3:00 PM) documented "Pt. (resident 9) needed to be seen in the ER (emergency room) for left increased thigh swelling. Thigh about 3 1/2 to 4" larger in circumference than non-affected thigh; tight to touch from above the knee to hip on left side". The entry further documents that resident 9 was taken to the emergency room via ambulance.	·			
i	An entry dated 5/3/04 at 2130 (11:30 PM) documents that Resident 9 was admitted to the acute care facility with left intertrochanter hip fracture and that the facility Director of Nursing was notified at 11:45 PM.				
	On 2/16/05, facility Incident Reports were examined for the period covering January 2004, through February 2005. No Incident Report to document alleged violations involving neglect for Resident 9 was found.				
r a a c s c fi	On 2/17/05, an interview was held with the facility Administrator-In-Training, the Certified Social Services Worker and the Director of Nursing regarding the facility's policy and procedures for reporting and investigating allegations of abuse and neglect. In response to surveyor questions about Resident 9's episode of acute inpatient care in May 2004, the facility Director of Nursing stated that an Incident Report had not been completed for Resident 9's hip fracture. The acility Administrator-In-Training, the Certified Social Services Worker and the Director of Jursing further stated that no report of the				

EASTLAKECARECENTER

03/29/2005 17:26 8013779747

8013779747 EASTLAKECARECENTER DEPARTMENT OF HEALTH AND L

CENTE	RS FOR MEDICARE	AND HUM. SERVICES MEDICAID SERVICES				PRINTED): 03/07/2005 APPROVED	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTI	PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED		
		465119	B. WI	NG_				
NAME OF I	PROVIDER OR SUPPLIER					02/2	3/2005	
EAST L	AKE CARE CENTER			10	REET ADDRESS, CITY, STATE, ZIP CODE 101 NORTH 500 WEST ROVO, UT 84601			
(X4) ID PREFIX TAG	I LEAUH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D BE COAse	(X5) COMPLETION DATE	
F 225	oonanded i form ba	nade to the State survey and	F	225				
	2. Resident 11 was	s admitted to the facility with						
	Director of Nursing value the facility's policy are and investigating alle against residents. Distaff revealed that reagency had visited the investigate an anony on 2/10/05, a facility had kicked resident.	ity Administrator-In-Training, Services Worker and the vere interviewed regarding and procedures for reporting egations of staff abuse ruring the interview, facility presentatives of an advocacy are facility on 2/17/05 to mous complaint alleging that, certified nursing assistant 11 and that this had been up by another certified nursing opened.						
	warning note" reporti incident had been "sl sometime around 2/1	ng stated that a written " ng the alleged abuse ipped under [her] door" 0/05 and that [she] had not he allegation of abuse.						

Social Services Worker stated they had not been aware of the alleged abuse incident until 2/17/05 and the facility had not reported the abuse to any outside agencies, nor had any investigation of the allegations of abuse been done by anyone at the facility.

The Administrator-In-Training and the Certified

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The facility Director of Nursing provided a copy of a form titled "Warning Slip" which had been

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Feolity ID: UT0022

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		<u>~</u> .			_		
		AND HUM, SERVICES				PRINTED	: 03/07/20(APPROVE
		& MEDICAID SERVICES				OMB NO	. 0938-039
<i>\$</i> -	ICIENCIES ,RECTION	(X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER:	(X2) M	IULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY	
	•		A. BU	LDING	3	COMPLE	ETED
		465119	6. Wil	NG			
1	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	02/2	3/2005
	AKE CARE CENTER		i	10	101 NORTH 500 WEST ROVO, UT 84601		
.) ID (EFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE I	RC CDOSC	(X5) COMPLETION DATE
F 225	Continued From pa	ge 15	F 2	225			
	appeared to allege to Assistant 2 (CNA 2) least 2 X (times) et (times) in buttocks to The facility Administ Social Services Worstated they would im	rator-In-Training, Certified rker and Director of Nursing					
	On 2/22/05 at 10:00 headed "Investigation were reviewed. This facility had conducted."	buse and present surveyors of their findings. AM, two printed pages in Re: Allegation of Abuse" record documented that the d interviews with several of 17/2005 and 2/18/05. The					
	during this incident deal with an incident a week ago. We fee unsubstantiated, but	etermine what happened . It is especially difficult to which happened more than it that the incident is will not allow the CNA hat side of the Unit anymore					
	The record was signed.	ed by the Administrator-in-					

Training and the Certified Social Worker.

On 2/23/05 an interview was conducted with Certified Nursing Assistant 1 (CNA 1) who had reported the alleged abuse of CNA 2 to resident 11. CNA 1 stated that the abuse happened on 2/ 9/05 or 2/10/05 and that [she] reported the incident immediately to the facility charge nurse. CNA 1 stated that CNA 2 has stated [she] doesn't like resident 11. CNA 1 stated [she] was in resident 11's room administering personal cares.

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occurred.

to see [him] sitting in a chair in [her] room. Resident 12 stated [she] was afraid "it would happen again". Resident 12 was not able to give an exact date and time when these incidents had

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Fedility ID: UT0022

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DEPARTMENT OF HEALTH AND HUM, SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2005 FORM APPROVED

STATEMEN	T OF DEFICIENCIES	TOTAL SEASON OF THE SEASON OF				<u>O</u> MB NO). 0938-03 9	
AND PLAN (OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		465119	B. Wi	NG_				
	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 001 NORTH 500 WEST PROVO, UT 84601	02/2	23/2005	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		F				
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F 225	Continued From pa	age 17	F	225		<u>.</u>		
	that room 108 was the end of the hally station and room 1	he surveyor observed the ns on the 100 hall and noted located in the locked unit at vay away from the nurse's 14 was located immediately from the nurse's station.						
	15/05. The medica resident 12 had init 108 on the locked the sadmission nursindocumented that refall at home and the bruise marks on [her] up Nurse's Notes in redocument that on 1	cal record was reviewed on 2/sl record documented that ially been admitted to room unit on 12/03/04. Resident 12 g note dated 12/3/04 sident 12 was admitted after a at resident 12 had yellowing er] face. Resident 12's wed no documentation of per arms and upper chest.						
,	reported to LPN 1 the been beat up by ar further documents the any documentation reported to the family No documentation y	hat resident 12 said [she] had nother resident". The note hat (LPN 1) "could not find to back this up which was ly". vas noted in resident 12's opposed to be a second to						
	acility nursing staff _PN 1) regarding th amily that [she] had resident. LPN 1 stated and reported the ass _PN 1 did not reme! eport. LPN 1 states	view was conducted with Licensed Practical Nurse 1 (e report by resident 12's been assaulted by another ted that resident 12's family sault by another resident. mber the exact date of this d that resident 12 was ty following a fall at home.					-	

DEPARTMENT OF HEALTH AND HUM SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/07/2005 FORM APPROVED

TATEMEN	IT OF DEFICIENCIES	(X1) PROMINER INTERIOR		—		OMB NO). <mark>0938-</mark> 039
ND PLAN (OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N : A. BU		TIPLE CONSTRUCTION NG	(X3) DATE S COMPL	SURVEY
		465119	B. Wir	NG_		225	
EAST LA	PROVIDER OR SUPPLIER	1 		1	REET ADDRESS, CITY, STATE, ZIP 1001 NORTH 500 WEST PROVO, UT 84601	, CODE	23/2005
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEPICIENCIES CY MUST BE PRECEEDED BY FULL R (.SC IDENTIFYING INFORMATION)	ID PREF TAG	ΞIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS	(X5) COMPLETION DATE
	LPN 1 further state admitted with bruit and upper part of any difference in the examined resident reported. LPN 1 s was necessary to complete an Incide During the intervies surveyor asked if r man" sitting in resino, but I would not reported a man sitt was on that end of unit). The surveyor been moved from a stated [she] did not been moved. On 2/17/05, the fact the Certified Social Director of Nursing the facility's policy and investigating at against residents. Staff were asked at allegation that [she another resident. Finterview stated the incident. Injuries of unknown.	ted that since resident 12 was ises "over the face, upper arms the chest", LPN 1 could not see the bruising when [she] at 12 after the assault was stated that [she] did not feel it report the information or to lent Report. The with LPN 1 on 2/17/05, the resident 12 had ever reported "a ident 12's room. LPN 1 stated " to be surprised if [she] had titing in [her] room because [she] of the hall (referring to the locked for asked why resident 12 had room 108 to room 114. LPN 1 to know why resident 12 had room 108 to room 114. LPN 1 to know why resident 12 had room 108 to room 114. LPN 1 to know why resident 12 had room 108 to room 114. LPN 1 to know why resident 12 had regarding and procedures for reporting allegations of staff abuse. During the interview, facility bout the resident 12's each had been assaulted by Facility staff present at the rey were not aware of the resource: Is admitted to the facility with included Alzheimer's disease.	F 2	225			

03/29/2005 17:29 8013779747 EASTLAKECARECENTER PAGE DEPARTMENT OF HEALTH AND HUMA PRINTED: 03/07/2005 **JERVICES** CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 465119 02/23/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EAST LAKE CARE CENTER 1001 NORTH 500 WEST PROVO, UT 84601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE F 225 Continued From page 19 F 225 completed on 2/17/05. An incident report dated 10/2/04 documented that resident 13 was found in [his] room with "blood going down his cheek". The incident report further stated that "resident (13) put [his] front tooth through [his] upper lip". On 2/17/05, the facility Administrator-In-Training, the Certified Social Services Worker, and the Director of Nursing were interviewed regarding the facility's policy and procedures for reporting and investigating allegations of abuse and injuries of unknown origin. The facility staff present at this interview were asked if the incident involving resident 13 had been reported and investigated. Facility staff present stated that the incident had not been reported to Adult Protective Services (APS) or State survey and certification. The Director of Nursing stated [she] did not know until [she] was told in a facility meeting held in December, 2004 that it was [her] responsibility to investigate incident reports and report them to APS and State survey and certification. 5. Resident 4 was an 81 year old female who was admitted to the facility on 6/19/97 with diagnoses which included Parkinson's Disease алd dementia.

November 2004 nurse's notes documented the

following:

11/8/04 - 12:10 PM - "order from MD for L (left) hand to r/o (rule out) fx (fracture)." 11/8/04 - 4:05 PM - "x-ray results came back.

Possible fx of 5th finger on L hand. See under lab results '

11/9/04 - 9:00 AM - Resident's L hand swollen +2 edema with discoloration and L little finger swollen +1 edema with discoloration..."

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DEPARTMENT OF HEALTH AND HUM. SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/07/2005 FORM APPROVED

STATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES				OMB NO	0938-039	
ND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE S	URVEY	
		465119	B. Wil	بر 10v				
	PROVIDER OR SUPPLIER			10	REET ADDRESS, CITY, STATE, ZIP CODE 001 NORTH 500 WEST PROVO, UT 84601	AN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG	×	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATION	I DIRE CROSS.	(X5) COMPLETION DATE	
	11/9/04 - 9:30 AM - results he suggeste " 11/9/04 - 11:00 AM room)for tx (treatr 11/9/04 - 1:00 PM - dx (diagnosis) Fx (f proximal phalanx, fi wrapped in ace wra An incident report releft hand, dated 11/i injury. The time list circled the left hand indicating that was to narrative was "unkn report was signed by form, the director of was not signed by the Neither the medical facility staff had doctevidence that this significant was immedia administrator or the agency. Facility staff documentation that the documentation t	MD "was notified of x-ray of to see crothopedic [sic] MD - "Sent out to ER (emergency ment) by orthopedic [sic] MD." Pt. (patient) returned from ER racture) L (left) hand 5th inger was splinted and p" egarding resident 4 and her 8/04, does not describe the ed was 7:00 AM. The nurse on the picture on the form the area of concern. The only own origin". The incident by the nurse completing the nurses and the physician. It is administrator. record for resident 4 nor commentation which would guifficant injury of "unknown telly reported to the State survey and certification if were not able to provide any this injury of "unknown origin" and to determine the cause. er, on 12/16/04, this same and by CNA in bed, with 2 small lacerations found on own etiology of wounds.	F2	225				
] -	respectively. Hair st trimmed, steri strips betadine. "	applied after cleaning with					. ;	

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Event IQ; F4WQ11

Facility IQ: UT0022

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DEPARTMENT OF HEALTH AND HUM, SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/07/2005 FORM APPROVED

CLIVIC	NO FOR MEDICARI	E & MEDICAID SERVICES				. 0938-039
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S	URVEY
		465119	B. WING _		-	
NAME OF	PROVIDER OR SUPPLIER					3/2005
EAST LA	AKE CARE CENTER	·	1	REET ADDRESS, CITY, STATE, ZIP 001 NORTH 500 WEST	CODE	
(X4) ID	SUMMARY CT	ATEMENT OF DEFICIENCIES	· · · · · · · · ·	ROVO, UT 84601		
PREFIX TAG	(CAUM DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS.	(X5) COMPLETION DATE
F 225	Continued From pa	1ge 21	F 225			
	The incident report facility's incident re	for this was not found in the port book for 2004.	, 220			
	and the facility staff documentation to e unknown etiology" \	I for resident 4 did not contain (could not provide) vidence that this injury of " was immediately reported to the State survey and				
	documentation agency documentation to e thorough investigati was some speculati 04 and she relayed the resident "possib was no documentation to e	The facility did not have vidence that there had been a on into this incident. There ion by the day nurse on 12/16/ to the resident's family that ly hit head on table." There ion to support this speculation bed side table, etc.)				
	6. Resident 3 was a diagnoses that inclu congestive heart fail	admitted on 9/16/04 with ded hyperthyroidism				
	22/05 and the nurse 2000 (8:00 PM) doc found /c (with) R (rig found in room on flo day. No injury to ey	al record was reviewed on 2/ s notes, dated 11/15/04 at umented "Res (resident) tht) eye bruising. Aides state or /c plllow to face earlier this es assessed". No other ury were found in the nurses				,
ľ	facility staff had doc	record for resident 3 nor umentation which would ury was reported to the		<i>:</i>		

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administrator or the State survey and certification agency. The Incident/Accident Log for November 2004 was reviewed and there was no entry about

the incident that occurred on 11/15/04.

Event ID: F4WD11

Facility ID: UT0022

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DEPARTMENT OF HEALTH AND HUN I SERVICES

PRINTED: 03/07/2005

SIAIEMEN	NT OF DEFICIENCIES	MEDICALD SERVICES			FURN OMB NC	VI APPROVI <u>0. 0938</u> -03:		
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION		(X3) DATE SURVEY		
		1	A. BUILDIN	NG	COMPL	ETED .		
		465119	B. WING_					
	PROVIDER OR SUPPLIER AKE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH 500 WEST					
(X4) ID PREFIX TAG	I GAGO DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVO, UT 84601 PROVIDER'S PLAN OF COMMERCE ACTION SHOWN REFERENCED TO THE APPROPRIES.		(X5) COMPLETION DATE		
F 225	Continued From page	ge 22	F 225			 		
	was reviewed. It was the facility called in cabuse, neglect, misa injuries of unknown reports were 4/13/04 these facility reported information regarding deficiency. The facility required allegations of State surveyors exite shared all the areas of their quality assurance.	g the examples listed in this lity again began to report on 2/24/05, the day after the ed the facility after having of concern. with facility administration on that they had identified in ce (QA) meeting, held 12/13/						
:	Review of their QA m	reported everything that						
t v	"Incident reports were November and there these 3 warranted adwas not completed conduct investigation reports and communication protective services) at warranted. These will	g: e reviewed for the month of were a total of 25 reports of Iditional investigations that We will have the DON of all new unknown origin icate findings to APS (adult						
t/	was found in her bed t wo lacerations on the	n 12/16/04, that resident 4 with blood on her pillow and back of her head. Facility s to have an "unknown						

, , , , , , , , , , , , , , , , , , ,	T OF DEFICIENCIES OF CORRECTION	& MEDICAL SERVICES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(X3) DATE S	0. 0938-039 SURVEY ETED
		465119	B. WING			
EAST LA	PROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 001 NORTH 500 WEST PROVO, UT 84501	02/2	23/2005
(X4) ID PREFIX TAG	「「「「「「「「「「「「「「」」」」 「「「「」」 「「」 「「」 「」 「」	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL GC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D DE ADAAA	(X5) COMPLETION DATE
F 225	etiology", but did not administrator or Stat staff did not pursue a events surrounding t identification of this of facility's quality assu	report this incident to the survey agency. Facility	F 225			
30=G	mistreatment, neglet and misappropriation (Use F226 for deficie	elop and implement written ires that prohibit ot, and abuse of residents of resident property.	F 226			
	Based on interview are determined that the factorial policies and provided and provided accility did not provided accility did not provided accility did not provided accility did not provided accility did not prevent freating resident and treating resident accility and treating resident accility acc	rent neglect in assessing of for a hip fracture; and did or investigate allegations of				

EASTLAKECARECENTER

)RN

03/29/2005 17:32 8013779747

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PAGE 02

DEPARTMENT OF HEALTH AND HUM.

PRINTED: 03/07/2005

CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB <u>NO. 0938-0391</u> (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 465119 NAME OF PROVIDER OR SUPPLIER 02/23/2005 STREET ADDRESS, CITY, STATE, ZIP CODE EAST LAKE CARE CENTER 1001 NORTH 500 WEST PROVO, UT 84601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) F 226 Continued From page 24 F 226 physical harm, mental anguish, or mental illness Resident identifiers 9 and 11. Findings include: 1. During survey on 2/14/05, 2/15/05 and 2/16/ 05, eleven interviews were conducted with three nurses and eight certified nursing assistants regarding training received at the facility on abuse recognition, prevention and reporting procedures. Nine of nine facility staff interviewed could not recall abuse training being provided at the facility during the past year. On 2/15/05 and 2/17/05, the facility Director of Nursing was asked to provide copies of both the abuse training given at the facility during the previous year and the signed rosters evidencing employees attending the abuse training. Facility administration stated that abuse training had taken place within the year. but they were unable to provide documentation (after several requests from the survey team) to evidence that training had occurred. 2. Resident 9 was admitted to the facility with diagnoses which included quadriplegia and depression. On 2/17/05, resident 9 was interviewed in her room. Resident 9 related that on 4/30/04 [she] returned to the facility after receiving physical therapy at another facility. Resident 9 stated that [she] and a family member had expressed concern to facility nursing staff that resident 9's left leg seemed to be much larger than [her] right leg at the upper thigh. Resident 9 stated that [her Heft thigh had been measured by a family member and the nursing staff and was found to

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be "about 4 inches" larger than [her] right thigh. Resident 9 stated that several days later at [her]

Event ID: F4WD11

Pacility ID: UT0022 If continuation sheet Page 25 of 80

0 3,	/29/2005 17:32	8013779747	Е	EASTL	_AKECARECENTER	PAG	E 04
DEPA	RTMENT OF HEALTH	AND HUM I SERVICES	_				
OLIVIE	THO FUR MEDICARE	& MEDICA. SERVICES				FOR*	D: 03/07/200 MAPPROVEI
~ 1 ~ 1 ~ (4) []	AT OF DEEL REVIEWS	(X1) PROVIDER/SUPPLIED/CLIA	CVTL	0.0.		OMB NO	0.0938-039
MO PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE:	SURVEY
			A. BU	ILDING		COMPL	ETEO
		465119	B. WIN	NG			
NAME OF	PROVIDER OR SUPPLIER			T		02/;	23/2005
EAST L	AKE CARE CENTER			10	EET ADDRESS, CITY, STATE, ZIP COI 01 NORTH 500 WEST ROVO, UT 84601	DE	
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	<u> </u>				
TAG	REGULATORY OR LS	MUST BE PRECEEDED BY FULL GC IDENTIFYING INFORMATION)	PREFI; TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 226	Continued From pag	ie 25		-		· · · · · · · · · · · · · · · · · · ·	
·	own insistence, [she care facility where [s treated for left intertr Resident 9 stated [si been injured on 4/30 therapy out of the fac when [she] was adm on 5/3/04 [her] left fe	was examined at an acute he] was diagnosed with and ochanter hip fracture. he] believed [her] left leg had /04 during a visit to physical cility. Resident 9 stated that itted to an acute care facility mur had been displaced "4 or 5" shorter than her right	F 2	226			
	record nurse's notes	of resident 9's medical revealed an entry dated 4/30 M) which documented:	•				
	extremity.	mily member] are concerned extremity is larger than right left thigh 28" left calf 15 ½ left ankle 9"				e si es en e e e	
	cocumented "Pt. (rein the ER (emergency thigh swelling. Thigh circumference than not touch from above the The entry further docutaken to the emergence An entry dated 5/3/04 documents that Residuate care facility with fracture and that the favors	5/3/04 at 1500 (3:00 PM) esident 9) needed to be seen about 3 1/2 to 4" larger in con-affected thigh; tight to knee to hip on left side". Imments that resident 9 was by room via ambulance. at 2130 (11:30 PM) ent 9 was admitted to the left intertrochanter hip acility Director of Nursing					
(notified at 11:45 PM. On 2/16/05, the facility (02-99) Previous Versions Obe	y "Anti-Abuse Policy for Event ID: F4WD11					

DEPARTMENT OF HEALTH AND HUM. SERVICES CENTERS FOR MEDICARE & MEDICA

PRINTED:	03/07	7/2005
FORM.		
OMB NO		

STATEMEN	T OF DEFICIENCIES	X1) BROWNER WITH THE				OMB NO	7 APPROVE 2. 0938-039	
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		PLE CONSTRUCTION	N	(X3) DATE SURVEY COMPLETED		
			A. BUILDI	· · · · · · · · · · · · · · · · · · ·				
		465119	B. WING					
	PROVIDER OR SUPPLIER		1 1	REET ADDRESS, CITY 1001 NORTH 500 WE PROVO, UT 84601	EST		23/2005	
(X4) ID PREFIX TAG	(COOL DELICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FUILL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER (EACH CORRECT	R'S PLAN OF CORR TVE ACTION SHOU THE APPROPRIAT	ID Pt cooce	(X5) COMPLETION DATE	
F 226	Residents" was revi that the facility obje residents residing a abuse of any sort; n	ewed. The policy documents ctive is to "assure that all the facility may be free of eglect, involuntary sectusion.	F 226		*			
	The policy further do "How Staff Will be M Care & Services: All monitored during the assure there is no exthose residents who in This will be accompliprotocol:" The policy procedures for the renurses, DON (Direct Assistant Director of work performance arnot occur.	cuments, under the heading lonitored During Delivery of facility staff must be in work performance to ridence of neglect of care to make the provide daily care for shed by the following further lists and explains the esponsibility of facility charge or of Nursing) and ADON (Nursing) to monitor staff and ensure that neglect does						
	mrough February 200 document alleged vio Resident 9 was found On 2/17/05, an intervadministrator-In-Train Services Worker, and regarding the facility's reporting and investigand neglect. In responsibility to the stated than an Incidence completed for Reside acility's Administrator	od covering January 2004 05. No Incident Report to						

DEPARTMENT OF HEALTH AND HUI **I SERVICES** PRINTED: 03/07/2005 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 465119 NAME OF PROVIDER OR SUPPLIER 02/23/2005 STREET ADDRESS, CITY, STATE. ZIP CODE EAST LAKE CARE CENTER 1001 NORTH 500 WEST PROVO, UT 84601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (X5)REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-TAG COMPLETION TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE F 226 Continued From page 27 F 226 Nursing further stated that no report of the incident had been made to the State survey and certification agency. 3. Resident 11 was admitted to the facility with diagnoses which included senile dementia and insulin dependent diabetes. On 2/16/05, the facility "Anti-Abuse Policy for Residents" was reviewed. The policy documents that the facility objective is to "assure that all residents residing at the facility may be free of abuse of any sort; neglect, involuntary seclusion or misappropriate of their property during their stay". The policy further documents, under the heading Who Should Suspected Abuse Be Reported To Within the Facility? When a case of suspected abuse is noted by an employee, they must immediately report it to their Dept. Head or the nursing supervisor. ... Once the suspected abuse has been reported to the immediate supervisor, the facility Director of Nursing, facility Social Worker, and facility Administrator must be notified . The employee placing the report must be interviewed and their response written down on the abuse form, ... What Outside Agencies Must be Notified of the Suspected Abuse? All allegations of suspected abuse must be investigated within the facility, but must also be called in to the State Health Department survey division. The investigation must begin immediately once the allegation has been made. ...The notification may be made by the facility Social Worker, or their (sic) in their absence, the Director of Nursing or facility Administration. This

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Event ID: F4W011

Facility ID: UT0022

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03/	/29/2005 17:32	8013779747	EΑ	STLAKECARECENTER	PAG	E 07	
DEPAF	RTMENT OF HEALTH	AND HUM/ SERVICES					
CENTE	RS FOR MEDICARE	& MEDICALL SERVICES			PKIN I E	D: 03/07/200 MAPPROVE	
		(X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-00		
WIAD MOVIN	OF CORRECTION	DENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	(X3) DATE:	SURVEY	
			A. BUILE	DING	COMP	ETED	
		465119	B. WING				
NAME OF	PROVIDER OR SUPPLIER				02/2	23/2005	
EAST LA	AKE CARE CENTER		s	TREET ADDRESS, CITY, STATE, ZIP COL	DE		
		•	1	1001 NORTH 500 WEST			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVO, UT 84601			
PREFIX TAG		MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	I S D DC GDGGG	(X5) COMPLETION DATE	
F 226	Continued From pag	ne 28					
			F 226	5			
	from receiving the al	de within one working day llegation.					
	On 2/17/05, the facil	ity Administrator-in-Training,					
	The Columba Social S	DEDVICES Worker and the		'			
	the facility's policy ar	vere interviewed regarding and procedures for reporting					
Į	and myesuozumo and	Mations of staff ob					
	agamst residents. Di	Uring the interview facility					
ŀ	Stall revealed flist te	Dresentatives of an odus	•				
	agency had visited in	le facility on 2/17/05 to					
	on 2/10/05, a facility	mous complaint alleging that, certified nursing assistant					
ı	Had kicked resident 1	1 and that this had been					
	reported to the jacility	/ by another certified nursing i			!		
	assistant when it hap	pened.				1	
	The Director of Manager					, ,	
	warning note" reportir	ng stated that a written "		* * * * * * * * * * * * * * * * * * *		ŀ	
	incident had been "sli	pped under [her] door"	1		1		
	sometime around 2/1	0/05 and that [she] had not				.	
·	taken any action on th	ne allegation of abuse.		•			
f						İ	
	ne Administrator-In-	Training and the Certified		•		-	
	Sware of the alleged	er stated they had not been	ł			1	
	and the facility had no	abuse incident until 2/17/05 t reported the abuse to any					
	outside agencies, nor	had any investigation of the					
je	allegations of abuse b	een done by anyone at the			1		
f	acility.						
	The facility Director of	f Nursing provided a copy of					
ء ا	i iorm titled "Warning	Slip" which had been				1	
10	ompleted by a facility	Charge nurse and which				Ì	
1 6	ippeared to allege tha	it Certified Nursing				ļ	
14	Nasistant 2 (CNA 2) ha	ad been observed "hitting at					
(1	imes) in buttocks by t	nd) klcked (sic) at least 2 X				•	
'		uns stan.		·			
	*				İ	}	

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Event ID: F4WD11 Facility ID: UT0022

If continuation sheet Page 29 of 80

DEPARTMENT OF HEALTH AND HUM/ SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2005 FORM APPROVED

ND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) A	AUI TI	IPLE CONSTRUCTION) <u>. 0938-03</u> 9	
		IDENTIFICATION NUMBER:	A. Bu	,		(X3) DATE S COMPL		
NAME OF S		465119	B. WII	NG _				
	PROVIDER OR SUPPLIER			70	REET ADDRESS, CITY, STATE, ZIP COD 001 NORTH 500 WEST PROVO, UT 84601	02/23/2005 CODE		
(X4) ID PREFIX TAG	(サンシロ ひとと(い)とれば	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI	x	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	II D DE ADAGA	(X5) COMPLETION DATE	
F 226	The facility Administrated Services We stated they would in	strator-In-Training, Certified orker and Director of Nursing mmediately investigate the abuse and present supressore	F2	226		<u> </u>		
	were reviewed. The facility had conduct	O AM, two printed pages on Re: Allegation of Abuse" is record documented that the ed interviews with several of 2/17/2005 and 2/18/05. The						
	dering this incident. deal with an inciden a week ago. We fe unsubstantiated, bu	determine what happened It is especially difficult to t which happened more than al that the incident is t will not allow the CNA that side of the Unit anymore	:					
o c c c c c c c c c c c c c c c c c c c	On 2/23/05 at intervicertified Nursing As eported the alleged 1. CNA 1 stated the MO5 or 2/10/05 and incident immediately CNA 1 stated that Clike resident 11. CNA 2 came into the hell needed any help asson" and then sland witnessed CNA 2 eason" and then sland ell did not want CNA 2 incident 11 communications and the sland witnessed CNA 2 eason" and then sland ell did not want CNA 2 came into the sland witnessed CNA 2 eason" and then sland ell did not want CNA 2 came into the sland ell did not want CNA 2 came into the sland ell did not want CNA 2 came into the sland ell did not want CNA 2 came into the sland ell did not want CNA 2 came into the sland ell did not want CNA 2 came into the sland ell did not want CNA 2 came into the sland ell did not want CNA 2 came into the sland ell did not want CNA 2 came into the sland ell did not want CNA 2 came into the sland ell did not want CNA 2 came into the sland ell did not want CNA 2 came into the sland ell did not want CNA 2 came into the sland ell did not want CNA 2 came into the sland ell did not want CNA 2 came into the sland ell did not want CNA 2 came into the sland ell did not want CNA 2 came into the sland ell did not want CNA 2 came into the sland ell did not want CNA 2 came into the sland ell did not want cNA 2 came into the sland ell did not want cNA 2 came into the sland ell did not want ell	ed by the Administrator in tiffied Social Worker. ew was conducted with sistant 1(CNA 1) who had abuse of CNA 2 to resident at the abuse happened on 2/ that [she] reported the to the facility charge nurse. NA 2 has stated [she] doesn't A 1 stated [she] was in dministering personal cares. room and asked if CNA 1 if [D. CNA 1 told CNA 2 "no" 2 kick resident 11 "for no to [him]. CNA 1 stated that [D. CNA 2 to know that [she] had because [she] was fearful that						

DEPAR	3/29/2005 17:35 TMENT OF HEALTH BS FOR MEDICARE	8013779747 AND HUMAN-SERVICES & MEDICAIL - PRVICES		EASTLAKECARECENTER	PAGE 01 FRINTED: 03/07/200 FORM APPROVE
ATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i	LDING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
·		465119	B. WI	NG	00/00/000
EAST LA	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH 500 WEST PROVO, UT 84601	02/23/2005
(X4) ID PREFIX TAG	REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		DBE CROSS- L COMPLETION
F 241 SS=E	Worker stated that the allegation of abut CNA 2 did not report scheduled shift after was conducted with Certified Social Worker stated the facility. When at Social Worker stated 2 if [she] reapplied for 483.15(a) QUALITY The facility must promanner and in an entendances each residul recognition of his REQUIREMENT. Based on observation care for some of the maintained or enhanced in the south east dinition of 22 sampled residents. (Resident and 27) Findings included: 1. On 2/15/05 at 8:30 in the south east dinition and wheelchair was in a wheelchair was in a wheelchair was in a wheelchair was in a wheelchair was in a wheelchair was in a wheelchair was in a wheelchair was in a wheelchair was in a wheelchair was in a wheelchair was in a wheelchair was in a wheelchair was in a wheelchair was in a wheelchair was in a wheelchair was in a wa	Social Worker was 05. The Certified Social he facility did not substantiate se against CNA 2 but that t for work at the next the investigation interview [her] on 2/18/05. The ker stated that the facility had c CNA-2's employment with sked directly, the Certified t that [she] would re-hire CNA or work at the facility. OF LIFE mote care for residents in a vironment that maintains or lent's dignity and respect in or her individuality. I is not met as evidenced by In the facility did not promote residents in a manner that ced the dignity and respect in or her individuality for 1 out ints and for 5 supplemental identifiers: 13, 23, 24, 25, 26, AM breakfast was observed ag room. Resident 13, who	F 2	Nursing staff will be inserviced dignity of residents during meal Resident 13's lab buddy will be during meals, Resident 24, 25 a properly positioned during meal will not stand), Resident 13, 24 hair will be combed daily by stall residents will be properly positioned during meal time. D.O.N. Will monito During meal time rounds and report to QA committee Completed by April 8, 2005.	s. removed & 13 will be ls. (aides 26, 27 tff. sitioned at
	7(02-99) Previous Versions Of			ity iD- UTopga	i

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

F 253

SS=E

resident 23 lunch.

483.15(h)(2) ENVIRONMENT

The facility must provide housekeeping and

Event IQ: F4WD11

Facility ID: UT0022

F 253

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ENTE	RS FOR MEDICADI	HAND HUMAN SERVICES	— —	STLAKECARECENTER	PAG	J. UO/U//
TEMEN	T OF DEFICIENCIES	E & MEDICA: JERVICES			FORM	APPRO
PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	TIPLE CONSTRUCTION	OMB NO). <u>0938-</u>
		OCH PICATION NUMBER:	A. BUILE		(X3) DATE :	
		}	1			
		465119	B. WING		•	
Æ OF F	PROVIDER OR SUPPLIER		1.	TREET ARREST	02/2	23/2005
ST LA	AKE CARE CENTER		"	TREET ADDRESS, CITY, STATE, ZIP C 1001 NORTH 500 WEST	ODE	
		•		PROVO, UT 84601		
(4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES				
REFIX FAG	I CEAUM DEFICIENCY	MUST BE DESCRETED BY ANY	ID PREFIX	PROVIDER'S PLAN OF CO	PRECTION	(X5
/10	NECOUNTOR! ORL	SC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SH REFERENCED TO THE APPROPE	NOULD BE CROSS	COMPLE
0.00				1	"TIE DES TOTENCY)]
253	Continued From pa	ge 32	F 25			
		es necessary to maintain a	1 25.	21-		
	sanitary, orderly an	d comfortable interior.	F253	Nureino ata ce		į
		s como abic interior.		Nursing staff will be inserv	iced on the prot	рет
ļ	This REQUIREMEN	IT is not met as evidenced by			·	
ŀ						
	Based on observe	on the feether		- WOUTOI GUILLE UNITEDIA	TV37744 1	
	housekeeping and	on, the facility did not provide		TOP AND LANGUAGE TO A COMPANY AND AND AND AND AND AND AND AND AND AND		
	necessary to mainte	naintenance services		- Pouluies in dispersions	li ba ah	
	Comfortable interior	in sanitary, orderly and		away. Restorative Nursing	woe infown	
	housekeeping and r	as evidenced by inadequate		lap buddies weekly assurin	stan will monito	r
1	moducitespiring and i	naintenance.		buddies in good	g only lap	
İ	Findings included:			buddies in good repair are 1	ised for residen	ts .
ļ	midnigo meladed.	Į			OA 1-1- 1 V 4-	
	During an inspection	of the facility on 2/15/05		" " YA VA CUMMIMEE MASSE	l	
	through 2/23/05 the	following itoms		Ann rest padding on all Hoy	er lifts will be	. ,
	were revealed:			TOSTOTATIVE Mires	mine C 4 - 200 - 199	
1		.]			A !.	
	1. On 2/22/05 at 8:5:	AM the south west dining		- ^ P - 4 4 UU C C an 11 (1 N % - 7	1	
1 1	room, across from the	le south nurses' station was 1		to the QA committee month!	V	
- 1 '	observed. Eleven ol	It of 18 chairs had dried food in				
- 1	hai noies ou tile alma	of the chairs. One chair's		Completed by April 8, 2005.		
1	ien arm was lose and	could be raised up	,	F-10, 2005.		
6	approximately 3 inch	es. One out of 5 tables was it	ļ			
1	unstable and wobble	d from side to side.	ļ			
		, i		•		
	2. On 2/15/05 at 7:00	AM the south east dining	1			
11	com was observed.	On the west side of the		•		
	aining room was a co	unter with a television duct	1			
į li	ahed to the conuter.	Just below and in front of		•		
Li	THE REPORTSHOLD THE COL	Diers edge was missing a 2	ľ			
, ,	ov∠ inch by 1 inch sec	tion of laminate. Near tho				
0	ide was a 1 *= 1 4's	s edge on the entry door	ł			
la I	aminate missing.	inch by 1 inch section of			ļ	
"	ammate missing,		į			
2	On 2/15/05 -4 40-0	7.034.1				
3	Crops from 72:3	AM the shower room				
٦	48 inch ha 20 inch	was observed. There was	ļ			٠.
d	hower room The	y 6 inch divider wall in the			ŀ	
		were 2 ceramic tiles missing	1			
	(02-99) Previous Versions Ob				1	

<u> </u>	<u>NO FOR WEDICARE</u>	E & MEDICALL PRIVIOUS			FORM	03/07 APPR
UEMEN	T DE DEBICIEMAIRS	& MEDICAIL ERVICES			OMB NO.	0938
) PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	(XZ) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SI COMPLE	URVEY
		465119	B. WING			
ME OF F	PROVIDER OR SUPPLIER				02/2:	<u>3/2</u> 005
ST LA	AKE CARE CENTER		5	TREET ADDRESS. CITY, STATE, ZIP CODE 1001 NORTH 500 WEST		
(4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVO, UT 84601		
REFIX TAG	REGULATORY OR L	MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD) REFERENCED TO THE APPROPRIATE D	RECDOSS	(X COMPL DA
253	Continued From pa	ge 33	F 25	3		
	from the 6 inch wide	e part of the divider walt is	1	31		
	I mones up itom the	1001. There was a container	F253	All chairs in the disingroom have	been	
	or overrowing ditto.	laundry with a towel that had		Repaired, as have the tables.		
	numerous dark red	SDOIS, not unlike blood, on the		Housekeeping will clean chairs a	fter	
	top. The container of	of laundry was uncovered.		Each meal.	,	
- x - 1	4. On 2/15/05 at 12:	45 PM the north nurses'		779.		
	station was observe	d. The column at the coeth.		This will be monitored by the		
}	and or the unizes 25	ation had tom and beginn		Housekeeping supervisor weekly		
	wall paper near the	floor and the can of the corner	<u>!</u> ; .	776.	1	
	guard was missing,	exposing,bare metal.		The broken laminate will be replace	:ed	
	5 On 2/22/05 of 4.0	0.504.45		On the countertop Housekeepers		
	across from the sour	0 PM the shower room th nurses station was		Have lists on their carts where the	у	
	observed. Upon ente	ering the shower room the		Will note items that need repair. I	he	
	COLOR MAIL MAS ODSEL	ved to have numerous areas		Lists will be turned over to their	.	
	of peeling paint.		•	Supervisor weekly, and she will		
•	The forest of		,	Make sure it is on the main tenance Log, and completed.		
	the first snower stall for storage.	l observed was being used		De, and completed.		
	. o., bioraga.			All missing tile has been replaced in	,	
•	The second shower:	stall on the south wall above		The shower rooms. The shower	Ψ ,	
- 11	ine base board tile w	as a 2 foot by 3 foot area of		Benches have been refinished.	l	
i 8	neemig baint and eld	Oling Wall There was a 49		Painting has been done in the show	/er	
; '	TICH BY 30 INCH BY 6 I	nch divider wall in the		Rooms. All of the shower rooms		
l f	from the 6 inch wide	were 3 ceramic tiles missing		Will be checked on a monthly basis		
'	Shower curtain locate	part of the divider wall. The ed in this stall had a dime		By maintenance,		
5	size area of a brown	raised substance, not unlike		• •		
[eces, located near th	ne edge of the curtain	•	The soiled linenhave lids now,		
1 6	ipproximately 5 feet	from the floor. The wooden		And will be monitored by maintenant	ce.	
5	mower seat had area	IS Of exposed bare wood		monthly		
	ine varnish and woo	d stain were wearing off.		The frayed carpethas been fixed, an	nd .	
Ţ	he third shower stall	at the entry way had 2		Will be monitored by maintenance n	onthly	
L	iaseboard tiles missi	ng on the south side and 3		Completed by Andr 2005		
10	asebbard tiles missi	ng on the north side. On the		Completed by April 8, 2005.		-
	all where the water f	aucet was located grout	į	C.		
; ^\	as missing directly b	elow the faucet and down to		7	,	
	(02-99) Previous Versions Ob			•		

EASTLAKECARECENTER

03/29/2005 17:35 8013779747

PAGE 05

PRINTED: 03/07/2005

FORM APPROVED

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING						(X3) DATE SURVEY COMPLETED			
		465119	B. Wii	NG_				_		00/0		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH 500 WEST PROVO, UT 84601					CODE	02/23/2005)5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG	IX.	(EACH COI REFERENC	RRECTIVE	PLAN OF C E ACTION S HE APPROP	SHOULD	BF CRC	DSS- NCY)	COMP	(X5) PLETION DATE
F 253	exposed bare wood	len shower seat had areas of d. Approximately twenty per and wood stain was worn off	F2	253								
	across from room 3 above the shower fa was a 1 and 1/4th in	20 AM the shower room 301 was observed. One inch aucet in the 12 o'clock position nch by 1 inch by 1 and 1/2 inch e wall. It appeared that a ssing.			·							
	room was a pink bas personal care items combs, a tube of Ba Chopstick, a tube of a pony tail band. Th had numerous white	next to the sink in the shower sin that had the following in it; tube of toothpaste, 2 acitracin ointment, a pencil and felidel ointment, a pencil and ne bottom of the pink basin black, blue, and brown al on it. There was no name	: :									
	number 1 was interv she knew who owne care items in it. She stated, "I don't know	ed nursing assistant (CNA) viewed. CNA 1 was asked if ed the basin with the personal e picked it up, looked at it and v who it belongs to. This is NA then put the basin down										
	across from the north observed. On the sorthere were numerous largest area measure was 3 feet up from the	O AM the shower room th nurses' station was buth wall of the entry hallway is areas of peeling paint. The ed 4 feet by 1 inch long, and the floor. On the north wall of the ere was a 30 1/2 inch by 2 inch paint.								The state of the s		

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:

FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

COMPLETED

02/23/2005

(X6)

COMPLETION DATE

NAME OF PROVIDER OR SUPPLIER

EAST LAK	(E CARE	CENTER
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(X4) IO PREFIX

TAG

STREET ADDRESS, CITY, STATE, ZIP CODE

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

1001 NORTH 500 WEST PROVO, UT 84601

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

PREFIX

TAG

F 253 Continued From page 35 F 253 An open area on the south side of the shower room that had an old dusty unused whirlpool tub was observed. This area was being used for storage of equipment and dirty laundry. There was a container of uncovered dirty laundry emitting stool and urine like odors.

465119

On the back wall at the north shower stall was a 23 inch long by 4 1/2 inch wide hole in the wallboard approximately 6 inch up from the floor. The wooden shower seat located in the north shower stall had areas of exposed bare wood. Approximately twenty per cent of the varnish and wood stain was worn off. The wooden shower seat located in the south shower stall had areas of exposed bare wood. The varnish and wood stain were wearing off.

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

- 8. On 2/23/05 at 9:50 AM the shower room across from room 321 was observed. The towel rack on the north wall was lose and part of the screws securing the rack to the wall were exposed.
- 9. On 2/23/05 at 10:05 AM the tub room across from room 505 was observed. There was a container of uncovered dirty laundry.
- 10. On 2/23/05 at 10:10 AM the second floor dining room was observed. At the entrance of the dining room, where the hall carpeting and the dining room carpeting met there was an eight inch section of frayed carpet.
- 11. On 2/15/05, 2/16/05, 2/17/05, 2/21/05, 2/22/ 05, 2/23/05 and 2/24/05 resident 13 was observed to have a black lap buddy in use while in his wheelchair. The vinyl covering on the black lap buddy was torn and pieces of vinyl were

Facility ID: UT0022

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CENTE TATEMEN NO PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTRUCTION	- OMR NO	APPRO\ .0938-0:
	9 -1	IDENTIFICATION NUMBER:	A. BUILO		(X3) DATE S COMPLE	JRVEY TED
JAME OF	PROVIDER OR SUPPLIER	465119	B. WING			
			s	TREET ADDRESS, CITY, STATE, ZIP CODE	02/2	3/2005
- AG (L)	AKE CARE CENTER			1001 NORTH 500 WEST	-	
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVO, UT 84601	_	
TAG	REGULATORY OR L	MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	I D. D	(X5) COMPLET DATE
F 253	God i Tom pa		F 253			_
	repair. The afternor	orning of 2/23/05 resident 13 n lap buddy that was in good on of 2/23/05 the previous t was in disrepair was again	1 200			
	brown arm rests whillft seat. The arm re padding was torn off the arm rests exposisheepskin sling had in several areas of the appearance of the sl	3:50 AM two Hoyer lifts were hallway. Hoyer lift one had ch attached to a sheepskin sts had padding and the on the outer edges of bothing a layer of foam. The crusted brown material noted he seat and the general neepskin was matted.				
-4-0		DENT ASSESSMENT	F 274			
i si si si si si si si si si si si si si	significant change in mental condition. (Fosignificant change maniprovement in the report of the fosignificant change maniprovement in the report of the compally resolve itself of the polystaff or by implementated clinical interventation more than one are tatus, and requires in evision of the care place.			A new MDS Coordinator has be fulltime. MDS Coordinator will to RAI Manual that determines comprehensive, significant cha assessment/IDT review is required. Residents 4&5 MDS will be revassess if a Significant Change as should be done. MDS Coordinatend daily stand up meeting a communicate with staffnurses significant change in residents of D.O.N. will monitor weekly and the residents of the resi	be oriented when a nge ired riewed to correction a tor will nd for condition.	
B fo ce	ased on record revieor 2 of 22 sample resonduct a comprehen	is not met as evidenced by w, it was determined that idents, the facility did not sive, significant change sciplinary review within 14		QA committee monthly to assure residents with Significant Chang been completed. Completed by April 8, 2005.	e that all	÷

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2005 revealed the following:

A review of resident 5's medical record on 2/15/

Resident 5 was admitted to the facility on 12/14/

Event ID: F4WD1;

Facility ID: UT0022

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03/29/2005 17:38 8013779747 **EASTLAKECARECENTER** DEPARTMENT OF HEALTH AND HUMAN SERVICES PAGE PRINTED: 03/07/2005 CENTERS FOR MEDICARE & MEDICAL ⇒ERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER. (X3) DATE SURVEY A. BUILDING COMPLETED 465119 B. WING NAME OF PROVIDER OR SUPPLIER 02/23/2005 STREET ADDRESS, CITY, STATE, ZIP CODE EAST LAKE CARE CENTER 1001 NORTH 500 WEST PROVO, UT 84601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-JO. REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (X5) COMPLETION REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE F 274 Continued From page 38 F 274 2004 with diagnosis including pneumonia (strep), emphysema, anemia, and renal failure. Admission minimum data set done on 12/27/2004 assessed resident as having intravenous medications, a feeding tube, tracheotomy care and ventilator use. Record review revealed that on 1/12/2005 resident 5 no longer required the use of intravenous medications, a feeding tube, tracheotomy care or ventilator use. Further review of these two medical records revealed that no significant change minimum data set was done to document improvement and or decline of resident 4 and 5. F 278 483.20(g) - (h) RESIDENT ASSESSMENT SS≃D F278 A new MDS Coordinator has been hired and The assessment must accurately reflect the resident's status. oriented on the accuracy of MDS including listing restraints and infections. Residents A registered nurse must conduct or coordinate 13 & 10's MDS has been reviewed and each assessment with the appropriate corrected. All residents most current MDS participation of health professionals. will be reviewed to assure restraints & A registered nurse must sign and certify that the infections are accurate. D.O.N. will monitor accuracy thru MDS audit tool assessment is completed. monthly and report to QA committee. Each individual who completes a portion of the assessment must sign and certify the accuracy of Completed by April 8, 2005. 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 Causes another individual to certify a material and false statement in a resident assessment is RM CMS-2567(02-99) Previous Versions Obsolete Event ID: F4WD11 Facility ID: UT0022 If continuation sheet Page 39 of 80

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

PRINTED: 03/07/2005 FORM APPROVED OMB NO. 0938-0391

ND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCT	TION		(X3) DATE COMP	<u>0. 0938-03</u> Survey Leted
VAME OF	PROVIDEM OF	465119	B, WIN	اھ					
	PROVIDER OR SUPPLIER			10	ET ADDRESS, C	ITY, STATE, Z	IP CODE	02/	23/2005
(X4) ID PREFIX TAG		MEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	- 1	PROVIE (EACH CORRE REFERENCED	ER'S PLAN O	N. CUA:		(X5) COMPLETIC DATE
F1 Fr RR ala Ada Ada Ada	subject to a civil mo \$5,000 for each ass Clinical disagreeme material and false s This REQUIREMEN: Based on observation interview the facility of 22 resident's asset the resident's status 10) Findings included: 1. Resident 13 was 04 with diagnoses the disease and schizop Resident 13's medical 2/17/05. Resident 13's quarter 12/22/04 was reviewed Restraints document esident 13. Resident 13's "Fall Ricestraint Use" quarter 12/22/04 under sap buddy was being uphysician's telephorated 9/30/04 ordered sineeded).	admitted to the facility on 9/9/at included Alzheimer's hrenia. If ecord was reviewed on the facility on 9/9/at included Alzheimer's hrenia. If ecord was reviewed on the facility on 9/9/at included Alzheimer's hrenia. If ecord was reviewed on the facility on 9/9/at included Alzheimer's hrenia. If we was reviewed on the facility on 9/9/at included Alzheimer's hrenia. If we was reviewed on the facility on 9/9/at included Alzheimer's hrenia. If we was reviewed on the facility on 9/9/at included Alzheimer's hrenia. If we was reviewed on the facility on 9/9/at included Alzheimer's hrenia.	F2	78					

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conducted on 2/22/05. An examination of a Minimum Data Set (MDS) dated 9/9/04 revealed that, under Section I1, Diseases; Section d, HIV

Event ID: F4WD11

Facility ID: UT0022

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03/29/2005 17:38 8013779747 EASTLAKECARECENTER DEPARTMENT OF HEALTH AND HUM TO SERVICES PAGE PRINTED: 03/07/2005 CENTERS FOR MEDICARE & MEDICAL SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (XZ) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 465119 B. WING NAME OF PROVIDER OR SUPPLIER 02/23/2005 STREET ADDRESS, CITY, STATE, ZIP CODE EAST LAKE CARE CENTER 1001 NORTH 500 WEST PROVO, UT 84601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-(X3) COMPLETION TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE F 278 Continued From page 41 F 278 Infection, was checked, indicating resident 10's diagnosis of "AIDS", Resident 10's quarterly Minimum Data Set dated 12/17/04 was reviewed. Under Section I1, Diseases; Section d. HIV Infection, was not checked. Section m. None of the above, was checked, indicating that resident 10 had no infections, despite resident 10's diagnosis of " AIDS" on admission. An interview was conducted on 2/22/05 with facility Licensed Practical Nurse 2 (LPN 2) related to care planning and overall functioning of resident 10. LPN 2 stated that resident 10 was scheduled during the coming week to see a medical specialist for ongoing evaluation and treatment of his HIV infection. F 279 483:20(k) RESIDENT ASSESSMENT F 279 SS=D The facility must develop a comprehensive care plan for each resident that includes measurable F279 Resident 13' Plan of Cares will be reviewed objectives and timetables to meet a resident's and updated to reflect residents current medical, nursing, and mental and psychosocial condition including mobility, lab buddy and needs that are identified in the comprehensive Anitpsychotic record/plan of care. assessment. Resident 15's care plan will be reviewed & updated to reflect current condition & The care plan must describe the following: The services that are to be furnished to attain or assure all triggered RAP's addressed

resident's exercise of rights under s483.10, including the right to refuse treatment under s483. 10(b)(4).

PM CMS-2567(02-99) Prévious Versions Obsolete

maintain the resident's highest practicable

required under \$483,25; and

physical, mental, and psychosocial well-being as

Any services that would otherwise be required

under s483.25 but are not provided due to the

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to QA committee

Completed by April 8, 2005

If continuation sheet Page 42 of 80

including Infection. Newly hired

MDS Coordinator will be inserviced on

D.O.N. will monitor monthly and report

Care Plans current on all residents.

addressing all triggered RAPS and keeping

DEPA	RTMENT OF HEALTH	AND HUM, SERVICES		_		<i>"</i>
CENT	ERS FOR MEDICARE	& MEDICAID SERVICES			PRINTER	0: 03/07/200 APPROVED
1 ~ . ~ . ŒIVIC	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION	OMB NO). 0938-039 [.] Survey
		46 5119	B. WING			
NAME OF	PROVIDER OR SUPPLIER		- late		02/2	23/2005
	AKE CARE CENTER		} }	REET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH 500 WEST PROVO, UT 84601	:	· ·
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROPRIATE	D 85 00 44	(X5) COMPLETION DATE
F 279	Continued From page	ge 42	F 279			
	Based on record revinterview, it was determined not maintain accurate	IT is not met as evidenced by riew, observation and ermined that the facility did se care plans for 2 of 22 Resident identifiers: 13, 15)				
	Findings included:		ļ			
	Resident 13 was /04 with diagnoses the disease and schizope	admitted to the facility on 9/9 hat included Alzheimer's hrenia.				
	Resident 13's medica 2/17/05.	al record was reviewed on				
	1 17704 revealed and 1. Current ambul 2. Resident 13 w C (wheelchair) d/t (du	Risk Care Plan" dated documented the following: ation ability: independent as to have "Lap buddy in W/e to) poor sitting balance.				
	Observations:					
	buddy. Since the residuith his meals, and the forced resident 13 to leave the hyper-extend his neck mouth in order to rece	A just prior to breakfast, the a wheelchair with a black lap lent needed total assistance e CNA remained standing, it ean back in his wheelchair, lift his chin and open his ive food. Resident 13 was nupright position during the				

13 was taken to his room. Personal cares were)RM CMS-2567(02-99) Previous Versions Obsolete

On 2/15/05 at approximately 10:15 AM resident

Event ID: F4WD11

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

resident's unsteady gait.

On 12/16/05 at 7:40 AM CNA 2 was interviewed. CNA 2 stated that resident 13 was put into the wheelchair with the lap buddy because of the

On 2/16/05 at 7:30 AM LPN 2 (licensed practical nurse) was interviewed. LPN 2 stated that at times resident 13 is unstable when ambulating.

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DEPARTMENT OF HEALTH AND HUMA SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/07/2005 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	WILDIOAID SETVICES	_,							<u>_OM</u>	B NO	. 0938	3-039
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•	MULTI MLDIN	IPLE CON	ISTRUCT	ION	·	_	(X3) DATE SURVEY COMPLETED			
	465119		B. WI	B. WING									
	PROVIDER OR SUPPLIER AKE CARE CENTER			1	REET ADD	TH 500	WEST	TE, ZIP	CODE	<u></u>	<u>U2/2</u>	3/200	5
(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ix	(EAC)		DER'S PL	CTION 5	SHOULD	BE CR	OSS- ENCY)	COMP	X5) LETION ATE
F 279	Continued From pate LPN 2 stated that in wheelchair with a lad occasional unstead. On 2/17/05 at 9:05 therapist (PT), who different occasions, stated that the imminesident 13 from fall wheelchair with a lab. Resident 13's "So Plan dated 9/22/04 facility staff was review of the Antidated February-05 (every night) for seid A review of the February-05 (alusional behaviors of the February-05) and the	ge 44 esident 13 is put into a ip buddy because of his/her y gait: AM, the facility physical assessed resident 13 on two was interviewed. The PT ediate solution to prevent ling was to put him in a p buddy. eizure Disorder-History" Care and reviewed on 12/22/04 by iewed and documented the ons as ordered Depakote nilligrams) BID&250 mg Q PM zure control. Psychotic Monthly Record documented that the n was being given for " is: "uary 2005 physician's is documented that resident 13 epakote for the diagnosis of "		279	REFER	TENCED	Take 2		**/ATE (ENCY)	DA	ATE
	Nursing) was intervi- she called resident ' that resident 13 was control of delusional stated that the physi	PM the DON (Director of ewed. The DON stated that I3's physician and he stated receiving the Depakote for behaviors. The DON further cian stated that Depakote need to be monitored since											

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seizures.

the Depakote was prescribed for the

management of behaviors, and not for control of

Event ID: F4WD11

Facility ID: UT0022

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DEPARTMENT OF HEALTH AND HUM, SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2005 FORM APPROVED OMB NO. 0938-0391

EAST LA		465119	A. BUILDI B. WING						
EAST LA					İ				
	NAME OF PROVIDER OR SUPPLIER EAST LAKE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH 500 WEST PROVO, UT 846D1					
PREFIX TAG	(ログロロ わらしに)だいび	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIAT	ID BE CROSS COUNTY	ÉTION			
	diagnoses that inci Schizophrenia, Dia Resident 15's med	age 45 s admitted on 10/3/04 with uded chronic hepatitis C, betes mellitis and brain injury. ical record was reviewed on 2/	F 279						
	23/05. Resident 15's Initial dated 11/24/04, Separt 2. infections, during This resulted in the RAProtocol) and a care	I MDS (minimum data set), ection I. Disease Diagnoses id not identify (k) viral hepatitis ne condition not being APS (Resident Assessment e plan was not done.							
	n an interview, on to ON she stated sh	which is an infectious disease 2/23/05 at 3:45 PM, with the e was not aware that Resident ddress hepatitis, and did not t on the MDS or the care plan.							
SS=E E	provide the necessa or maintain the high nental, and psycho	receive and the facility must ary care and services to attain est practicable physical, social well-being, in comprehensive assessment	F 309						
T :	overed by \$483,25	T is not met as evidenced by				-			

DEPAR	3/29/2005 17:41 TMENT OF HEALTH	8013779747 AND HUMAN AFRVICES	E	ASTLAKECARECENTER	רים ואוועג	GE 03 : U3/U//20
ATEMEN	RS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION	& MEDICAID, RVICES	(X2) MU	TIPLE CONSTRUCTION	FORM OMB NO	APPROVE . 0938-03
L PLANT	UP CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	(X3) DATE SI COMPLE	URVEY ETED
MEGE	PROVIDER OR SUPPLIER	465119	D. WING		02/2	3/2005
	AKE CARE CENTER		s	TREET ADDRESS, CITY, STATE, ZIP COC 1001 NORTH 500 WEST PROVO, UT 84601)E	3/2005
(X4) ID PREFIX TAG	I TEMOR DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SHOUREFERENCED TO THE APPROPRIA	JLD BECROSS_	(X5) COMPLETION DATE
	Based on observation medical records, it vil 22 sampled resident the necessary care maintain each resident physical, mental and Resident identifiers: Findings included: 1. Resident 19 was Sclerosis whom the from the physician a culture and sensitiviturine was cloudy with was given by the phy and culture and sensitiviturine was cloudy with was given by the phy and culture and sensitiviturine was cloudy with was given by the phy and culture and sensitiviturine was cloudy with was given by the phy and culture and sensitiviturine was cloudy with a culture and sensitiviturine was cloudy with a culture and sensitiviturine was cloudy with a culture and sensitiviturine was from the catheter and notified on Monday (the from the catheter and course with a 22 free problems. On 11/02/04 there was called to redepressed and crying voices again and ask the last urinalysis report, the office indicate the answer. On 11/04/04 nurse's resident answer. On 11/04/04 nurse's resident answer.	on, interview and review of vas determined that for 5 of its, the facility did not provide and services to attain or ent's highest practicable I psychosocial well-being. 3, 13, 16, 19, 20. a 39 year old with Multiple facility on 10/28/04 requested norder for a urinalysis and a y because the resident's particles noted. An order vaician to obtain a urinalysis sitivity. On 10/29/04 there indicating the results of the to the physician's office. On	F 309	Resident 3, 13, 16, 19, 20 will for appropriate lab orders and Licensed nurses will be insers importance of timely follow-up MDS and/or D.O.N. will review daily and monitor to assure the are on the charts, proper doct has been done as well as propand orders obtained and carriwill report to monthly QA count Resident 13 will be evaluated. The rapy for gain strenghtening Alienment, and for least restrict restraint. All nursing staff will inserviced on use of least restrictive restraint, include Restorative Nursing. Restraint monitored by the D.O.N. thru the Action Committee weekly. Completed by April 8, 2005.	I followup. Viced on the O of lab reports V all lab orders at lab reports 1 mentation per follow-up ed out. D.O.N minitee by Physical /proper body trive be ling PT or ts will be	:
	(02-99) Previous Versions Ob		Facility In	: UT0022 If conti		
			· acmty IL	. 910022 If conti	inu atio n sheet Pag	je 47 ci80

DEPARTMENT OF HEALTH AND HUMA SERVICES
CENTERS FOR MEDICARE & MEDICARE & MEDICARE

PRINTED: 03/07/2005 FORM APPROVED OMB NO. 0938-0391

CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES					APPROVE
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		IPLE CONSTRUCTION	(X3) DATE S COMPLE	
		465119	B. WII	NG _	~~~	200	2/0205
	PROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 001 NORTH 500 WEST PROVO, UT 84601		3/2005
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG	· IX	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	DAF CROSS-	(X5) COMPLETION DATE
	office. On 11/17/04 the nurse suprapublic catheter gravity with clear ye 12/04/04 the nurse catheter was draining suprapublic insertion inflammation. Review of the medic evidence to support culture and sensitivition 2/23/05, the Staff LPN on duty to laboratory services a urinalysis and culturathe urinalysis and culturathe urinalysis and culturathe urinalysis. Catheter nitrites, moderate an protein, moderate an protein, moderate an protein, moderate and culture and sensitivities. Culture and sensitivities aruginosa, 50,000 con terrococcus faecal noted to be sensitive aeruginosa as well anoted with sensitivities faecalis. Review of timedication administroorders showed no ar	rse's notes stated the r was patent and draining by allow urine. It's notes stated the suprapubicing yellow urine, and that the n site showed no drainage or call record showed no results of a urinalysis or the surveyor requested the place a call to the specified and request a copy of the e and sensitivity. A copy of all the surveyor on 2/23/05 with specimen, positive for mount of hemoglobin, 2+ ukocyte esterase. The revealed the following: > nounts of hemoglobin, 2+ ukocyte esterase. The revealed the following: > nounts Pseudomonas Colony forming units is. Several antibiotics were as several antibiotics were set to the Enterococcus.	F	309			

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The facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized

Event ID: F4WD11

Fedility ID: UT0022

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organisms isolated".

culture with result of "no lactose-negative

highest practicable physical well-being in

Hand written on the lab slip was a note "can run the Giardia". These were the only results noted in the medical record. The facility did not provide the necessary care and services to maintain the

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22/04 incontinent of urine.

7/17/04, 7/18/04 then "WNL (within normal limits)" documented on 7/19/04, 7/2004, 7/21/04 and 7/

The medical record revealed a urine culture dated 7/16/04 which showed it to be a "clean catch" specimen with the following findings: > (greater than) 100,000 colony forming units of Escherichia

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Facility ID: UT0022

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DEPARTMENT OF HEALTH AND HUM, SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2005 FORM APPROVED

DATE

	T WILDICAID SERVICES		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
		A. BUILDING	COMPLETED
	465119	B. WING	00/00/0005
NAME OF DECIDED OF SURDIVED			02/23/2005

EAST LAKE CARE CENTER

(X4) ID PREFIX

TAG

F 309

STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH 500 WEST

PROVO, UT 84601 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-

REFERENCED TO THE APPROPRIATE DEFICIENCY)

Continued From page 50
coli and > 100,000 units of Klebsiella pneumoniae. The lab results showed the final report was issued 07/19/04 and a hand written note on the lab reports stated "faxed 7/26/04 to physician". A medication order was written on 7/29/04 for Levaquin 250 mg (milligrams) PO (by mouth) for 7 days. Resident 20 had no orders for the Urinary Tract Infection for 10 days following the assessment for a Urinary Tract Infection. The medical record contained an undated form for Infection on Admission with indication of none (?) and no indication of nosocomial infection. The resident was discharged on 9/21/04 with 3+ bacteria in the urine and was to begin a course of
Cipro 250 milligrams two times a day. 4. Resident 3 was admitted on 9/16/04 with
diagnoses that included hyperthyroidism, congestive heart failure, hypertension.

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

osteoarthritis, dementia, seizure disorder and Schizophrenia,

Resident 3's medical record was reviewed on 2/ 22/05.

Resident 3 had physician's order, dated 10/21/04, for a UA (urinalysis) and Culture (a test to determine if a bacteria is sensitive to specific antibiotics). There was also an order on the same date for the antibiotic Levaquin 250 mg (milligram) PO QD (by mouth once a day) and Rocephin 1 gram IM now.

Laboratory results of resident 3's urine culture documented two organisms present in the urine, Citrobacter freundii (bacteria) and Enterococcus faecalis (bacteria). The bacteria was tested against commonly used antibiotics and the Enterococcus faecalis was documented as being resistant to Levaquin,

F 309

PREFIX

TAG

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

Event to: F4W011

Facility ID: UT0022

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EASTLAKECARECENTER

PAGE 08

DEPARTMENT OF HEALTH AND HUMA ERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2005 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE S		
		465119	B, WIN	(G				
NAME OF PROVIDER OR SUPPLIER EAST LAKE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH 500 WEST PROVO, UT 84601					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	DULD BE CROSS-	(X5) COMPLETION DATE	
F 309	The antibiotic Roc 2005 Drug Handb Wilkins, page 115 susceptible micropenicillinase-and is Staphlococcus au epidermidis, Eschinfluenzae, Neisse gonorrheae, Serre Klebsiella, Proteus Pseudomonas spenterococcus faecus susceptible microc There was no doc record that the physic sulture report. 5. Resident 13 was 04 with diagnoses disease, hypertens Resident 13's med 17/05. An admission nurs dated 9/22/04, rev	cephin is listed in the Nursing ook, Lippincott Williams & documentscaused by such organism as streptococci; non-penicillinase-producing reus, Staphlococcus erichia coli, Haemophilus eria meningitidis, Neisseria atia marcescens, Enterobacter, s, Peptostreptococcus, and ecies. The bacteria calis is not listed as one of the	FS	309				
	falls. A quarterly Minimu	im Data Set (MDS)			·		·	

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revealed that facility staff had documented

Event ID: F4WD11

Facility ID: UT0022

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EASTLAKECARECENTER

PAGE 01

	F 1884
DEPARTMENT OF HEALTH AND HUM,	3ERVICES
CENTERS FOR MEDICARE & MEDICAR) GEDVICES

PRINTED	-03/07/2005
FORM,	APPROVED
OMB NO	0028-0201

STATEMEN' AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE S	
		465119	B. WING		-	
	ROVIDER OR SUPPLIER	400)19	1	REET ADDRESS, CITY, STATE, ZIP (001 NORTH 500 WEST PROVO, UT 84501		23/2005
(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 C (EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP	SHOULD BE CROSS.	(X5) COMPLETION DATE
	had severe difficult The facility staff do assessment that re The facility staff als assessment that r for transfers, amburestraints. Resident 13's "Fall Restraint Use" qua and 12/22/04 unde only a lap buddy ha restraint alternative supervision had be on 9/9/04 9/28/04 Resident 13's "Res Review for Eliminati was reviewed. The documented that "p of occasionally fallia restraints at this tim A physician's telept dated 9/30/04 orde as needed). Interdisciplinary Tea dated 10/4/04 revea Reviewed in chart t it was marked for P documentation). It v Comments" section	ort term memory problems and by for daily decision making. Incumented on the MDS esident 13 had a history of falls. It is documented on the MDS esident 13 required supervision elation and did not use any assessment/Side Rail & reerly assessments for 9/22/04 resection I documented that and been tried and that no es, such as increased en attempted since admission traint Evaluation and Quarterly tion" assessment dated a facility physical therapist (PT) of the patient of	F 309			
	A physician's teleph dated 11/6/04 order	one order for resident 13 ed a "lap buddy while out of				

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

Event ID: F4WD11 Facility ID: UT0022

If continuation sheet Page 53 of 80

03/	29/2005 17: 45	8013779747	E4	4STL	AKECAR	ECENT	ER			PAG	E 02
DEPAR CENTE	TMENT OF HEALTH	AND HUMA' 'ERVICES & MEDICAID SERVICES						PRINTED: 03/07/20 FORM APPROVE OMB NO. 0938-039			
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONST	RUCTION	1		(X3)	DATE S COMPLE	URVEY
		465119	B. WING	·			···	_		00/0	
	PROVIDER OR SUPPLIER		- 6	STREE	T ADDRE	SS, CITY	, STATE,	ZIP CODE		02/2	3/2005
EASILA	AKE CARE CENTER				0 VO , UT						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		P (EACH C REFEREN	ORRECT	R'S PLAN IVE ACTI THE APP	DOHŻ NC	LD BE CI	ROSS- IENCY)	(XS) COMPLETION DATE
F 309	Continued From pa	ge 53	F 30	9							
	revealed and docum 1. Current ambu 2. Resident 13 v C (wheelchair) d/t (d	Risk Care Plan" dated 11/7/04 nented the following; ulation ability; independent was to have "Lap buddy in W/ due to) poor sitting balance, tress on floor d/t frequent falls	·								
	dated 12/22/04 reve Reviewed in chart the it was marked for Pl documentation). It is Comments" section and down the hall.	im (IDT) notes for resident 13 aled under Documentation nat a circle with a line through nysical Restraint Doc. (a documented in the "athat resident 13 "wanders up ays on the groundPt. (aut of bed which resulted in pte floor."									
	without difficulty. At a breakfast, the reside with a black lap bude the wheelchair with I . Since the resident I his meals, and the C forced resident 13 to hyper-extend his necomouth in order to recomouth in order to recomplete the breakfast of the control of	Ilway of the south east unit									
	resident 13 was obsi	9:00 AM and 10:15 AM, erved in the dining room. s in progress, at 9:35 AM, the									

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Event ID: F4WD11

Facility ID: UT0022

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DEPARTMENT OF HEALTH AND HUM, SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/07/2005 FORM APPROVED

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDED TO SERVICES	·			OMB NO	O. 0938-03
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465119	B. WIN	iG			
	PROVIDER OR SUPPLIER			100	ET ADDRESS, CITY, STATE, ZIP CC D1 NORTH 500 WEST IOVO, UT 84601		23/2005
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING (NFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO! (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRI	22090 98 01110	(X5) COMPLETIO DATE
F 309	Continued From pa	ige 54	F3	09			
	buddy with his hand At 10:00 AM the resident 13 was cares were completed. The bed was	Ifully tried to stand up. The g and pushing on the lap de but was unable to remove it. Sident unsuccessfully tried to a row. At approximately 10:15 staken to his room. Personal ted and the resident was put to a regular hospital bed placed. There was no low bed. There the floor.					
•	the south east dininkept in the wheelche lunch. Since the reswith his meals, and forced resident 13 to hyper-extend his ne mouth in order to re	PM lunch was observed in g room. The resident was air with lap buddy on during ident needed total assistance the CNA remained standing, it is lean back in his wheelchair, ck, lift his chin and open his ceive food. Resident 13 was an upright position during the					
	standing in his/her re window in his/her re	PM Resident 13 was observed oom between the bed and the om. Within 1 minute, a CNA of bed and put him into a buddy.					
] '	On 2/17/05 at 8:30 A was observed in his/ buddy in place.	AM and 10:00 AM resident her wheelchair with the lap					
	Interviews:						
	CNA 7 stated that re a wheelchair with a l out of bed. When as	PM CNA 7 was interviewed, sident 13 is suppose to be in ap buddy in place when he is sked why resident 13 was he hallway that morning, the					

EASTLAKECARECENTER

PAGE 04

DEPARTMENT OF HEALTH AN	ID HUM - SERVICES
CENTERS FOR MEDICARE & M	MEDICAL SERVICES

PRINTED:	03/07/2005
FORM	APPROVED
OMB NO	0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION (DENTIFICATION NUMBER:			(X2) MULT	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	4 · · · · ·	465119	B. WING	***************************************				
	PROVIDER OR SUPPLIER		STE		23/2005			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVO, UT 84601 PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHOTH REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE		
F 309	Continued From pa	age 55	F 309					
	CNA replied that w morning he/she is stated that when re resident will lean to	when he/she first gets up in the stable when walking. The CNA esident 13 gets tired the cone side and start walking in resident may fall down or will sit						
	CNA 2 stated that is wheelchair with the resident's unsteady when the resident is he/she is put into the	10 AM CNA 2 was interviewed, resident 13 was put into the lap buddy because of the y gait. The CNA stated that first awakens in the morning, he wheelchair with lap buddy, there is no restorative nursing unit.						
	nurse) was intervientimes resident 13 is LPN 2 stated that rewheelchair with a late occasionally being When asked if residentials restrictive measure nursing restorative	AM LPN 2 (licensed practical awed. LPN 2 stated that at a unstable when ambulating, resident 13 is put into a ap buddy because of unstable when ambulating, ident 13 had received any less as for fall prevention or any care to help with ambulation, nat resident 13 had not.						
	Restorative Nursing supervisor stated the	O AM the Supervisor for g was interviewed. The hat neither he nor any of the d ever received a referral for or sident 13.						
	therapist (PT) was that he filled out the Quarterly Review for 04 and 12/28/04 for	AM, the facility physical interviewed. The PT stated e "Restraint Evaluation and or Elimination" forms on 9/28/ r resident 13. The PT stated niliar with the residents in the						

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Event ID: F4WD11 Facility ID: UT0022

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DEPARTMENT OF HEALTH AND HUM/ BERVICES

PAGE 05

PRINTED:	03/07/2005
FORM /	APPROVED
OMB NO	0028-0201

CENTER	RS FOR MEDICARI	E & MEDICAID SERVICES					. 0938-03 91	
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		465119	A. BUIL B. WIN					
	ROVIDER OR SUPPLIER			100	ET ADDRESS, CITY, STATE, ZIP CODE 01 NORTH 500 WEST ROVO, UT 84601	02/2	23/2005	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	T	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE	DIBE CROSS-	(XE) COMPLETION DATE	
F 309	observed resident PT was made awa falls while ambulat bed. The PT state resident 13 was leading to steady their The PT stated that resident's safety with a lap buddy are that the main thing observations and serident 13 had up and that staff need. The PT stated the had discussed using during meal times be real good", becafeeding resident 13 needed assistance. (The Restraint Evafor Elimination form Every resident upo by the Physical The and possible need side rails. The appand/or use of side by the completion of PT evaluation, and patient/family notifit there is a question being in regards to change in cognitive another evaluation the need for physical property in the physical states.	with the unit manager and 13 for a couple of days. The re of the resident's history of ing to and from the resident's d that during an observation aning to one side, walking in a d. He stated that the CNAs esident so he/she wouldn't fall. The immediate solution for the as to put him in a wheelchair and a low bed. The PT stated he concluded from his staff interviews was that is and downs with coordination ed to periodically walk with him at he and the unit manager and the lap buddy especially because "supervision wouldn't ause the CNAs would be busy and other residents who alluation and Quarterly Review in documented the following: "In admission will be evaluated erapy department for the use of physical restraints and/or oblication of physical restraints rails may only be accomplished of the following assessment, subsequent doctor's order and cation. At any time where of resident safety and well unsteady gait, multiple falls, or and/or physical status, may be done to again assess all restraints and/or side rails.")	F3					
F 323	483.25(h)(1) QUAL 67(02-99) Previous Versions		F 32	 -	UT0022 If contin	nuation sheet	Page 57 of 80	

	8/29/2005 17:45	8013779747	EAS	TLAKECARECENTER	PAGE	0 6	
DETAR	DEPARTMENT OF HEALTH AND HUMA SERVICES			· ····································	PRINTED:	03/07/200	
CENTE	RS FOR MEDICARE	& MEDICAIL JERVICES			FORM	APPROVE	
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTRUCTION	OMB NO.	_0938-039	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	1		(X3) DATE SI COMPLE	JRVEY	
			A. BUILDI	NG	COMITE	משיי	
		465119	B. WING				
NAME OF	PROVIDER OR SUPPLIER				02/2	3/2005	
EASTL	AKE CARE CENTER		ST	REET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH 500 WEST			
End, C	WINE CHAIRM						
~(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	1	PROVO, UT 84601			
PROFIX	1 (ENCH DEFICIENCY	MUST BE PRECEBBED BY FIRE	!D PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD	TION	(X5) COMPLETION	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TÂG	REFERENCED TO THE APPROPRIATE D	BE CROSS-	COMPLETION DATE	
					,,		
F 323	Continued From pa	ge 57	F 323		,		
SS=G		_	1 020	?			
	The facility must en	sure that the resident	F 323	Side Rails will be marked with co	olore d		
	environment remain	is as free of accident hazards		tape to identify up X's 1 Green T			
	as is possible.		1	X's 2 Yellow tape, Do not use si	=		
				Red Tape. All staff will be inser			
4				On color coded SR tape. All	· je e d		
	Inis REQUIREMEN	IT is not met as evidenced by		resident beds will be checked to	an ila a e		
						•	
	Based on interviews	and review of medical		low hed, lower bed, mat on floor			
	records, it was deter	rmined that for 2 of the 22		of care. Aides will monitor daily			
	environment remain	ne facility did not ensure their ed as free of accident	•	to assure low beds, mats, & proper restraint is used for a resident per plan of care.			
	hazards as nossible	Specifically, one resident (4	•				
	Climbed over the si	ide rails on her bed and fell to		D.O.N. will review T.O. orders for			
	the floor. Another re	esident (13) caught his arm in		To assure that the proper docum	***		
	the end of the bed.	Resident identifiers: 4 and 13		is in place, least restrictive used	, α	<u>-,</u>	
·	•			proper restraint applied.			
	Findings include:			Completed by April 8, 2005.			
	1 Pocident 4 was a	m 94	•	A log book is now located at each	. [
	was admitted to the	n 81 year old female who facility on 6/19/97 with	,	nurses station that lists all residents			
į	diagnoses which inc	luded Parkinson's Disease	,	that section with a restraint order. T	t i		
1	and dementia.	arkingul a Disease		oncoming aides will check the book			
				verify it against the residents that the	:y		
	The MDS (minimum	data set), a mandatory		are responsible for	,	ı	
ľ	comprehensive asse	essment of the resident		DON will monitor restraints weekly			
	completed by facility	staff, dated 1/1/05,	J	through the mirsing rounds / quality			
	documented that res	ident 4 had severely	1	assurance check list and report to the			
	impaired decision ma	aking skills, needed		Quality Assurance action committee			
İ	transfore and had on	with bed mobility and	i	meeting.			
	the prior 31-180 days	unsteady gait with falls in	ļ				
	documented the use	of one side rail while the	1	Will be integrated into the Quality			
	resident was in bed.	or one side rail writte (rie	}	Assurance system by March 30, 200	05.		
					1		
	A review of the care i	plan for resident 4, dated 4/3/	1	2	į		
[04, revealed that she	should have side rails up		1	İ	İ	
!	times one. The phys	ician's orders for November	ļ			j	
	57(02-89) Previous Versions C				<u>- </u>		
		======================================	Lacilità iț	o: UT0022 If continua	tion sheet Pag	re 58 of 80	

	29/2005 17:45	8013779747	EAST	LAKECARECENTI	ER	PAGE	E 07
DEPAR	TMENT OF HEALTI	H AND HUM/ SERVICES			-		: 03/07/200
CENTE	RS FOR MEDICARI	E & MEDICAL SERVICES				FORM	APPROVE
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTIO	N	(X3) DATE S	, 0938-039
ANDFLAN	DE COKKECTION	IDENTIFICATION NUMBER;	A. BUILDIN			COMPLE	
	•						
		465119	B. WING _		****	02/2	3/2005
NAME OF F	PROVIDER OR SUPPLIER		STF	REET ADDRESS, CIT	Y. STATE, ZIP CODE		.0/2000
EAST LA	AKE CARE CENTER	•]. T	001 NORTH 500 W	EST		
	· · · · · · · · · · · · · · · · · · ·		P	ROVO, UT 8460	11		
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL	ID	PROVIDE	R'S PLAN OF CORRE	CTION	(X5)
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECT REFERENCED TO	TIVE ACTION SHOULD THE APPROPRIATE	D BE CROSS-	COMPLÉTION
				7121 211211020 10	2 TO CAPE COLUMN	: DEFICIENCY)	DRIE
F 323	Continued From pa	age 58	F 323		-		
	2004 document "si	-	F 323				
		de rais i side up .					
	A nurse's note, dat	ed 11/1/04 at 1:30 AM,					
	documented "Up in	room, Climbed over rails.					
ļ.	Became combative	when attempts made to get			•		
	ner to sit down or li	e down. RN (registered nurse)					
	starving. RN went	Ingry. She said she was to pantry for food. A few				. !	
İ	moments later CNA	(certified nurse aide) found					
	her on floor in hallw	av. No head trauma apparent					
	Has skin tear on l	ateral side left tibla"					
	A						
	A staff nurse was in	iterviewed on 2/23/05. She					
.	climb of the side rai	4 had a history of trying to its of her bed. "That's why					;
	they went to one sid	de rail with the mat on the floor			1.0	The state of	."
	and the bed alarm."	The state of the s					• • •
		. · · · · · · · · · · · · · · · · · · ·				11 [32]	
	A nurse aide was in	terview on 2/17/04. She			•		
·	confirmed that she	had been the primary care				10 10 1	100
	prior three weeks	on "four to five days" during the She stated that on each of	Ì	•		14" A 24"	
	those mornings bott	n side rails were up on the bed					
	for resident 4 when	she went to help her get up.			•	1	
	based on interview	and record review, the facility			•		
	and physician's orde	/ adhering to the care plan ers for resident 4 to use only					
	one side rail while s	he was in bed. Although			·		
	resident 4 should he	ave had one side rail on 11/1/					
	04, it was document	ted that she "climbed over				Ì	
	rails". "A few mome	ents later CNA (certified nurse					
	aide) found her on f	oor in hallway. No head					
	trauma apparent. H	as skin tear on lateral side	1			1	
Ī	TWO SINTENIAL						
	•	į]				
,	2. Resident 13 was	admitted to the facility on 9/9/					
	04 with diagnoses th	nat included Alzheimer's					
ORM CMS.258	37(02-99) Previous Versions (Chapter					
	·· /or.es) : idainas veisibūs (Obsolete Event ID: F4WD11	Facility ID:	UT0022	lf contin	uetion sheet Pa	age 59 of 80

DEPARTMENT OF HEALTH AND HUM. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2005 FORM APPROVED OMB NO. 0938-0391

STATEMEN AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL		CONSTRUCTION		(X3) DATE S	URVEY
		465119	B. WIN	G			02/2	3/2005
	ROVIDER OR SUPPLIER			1001 N	ADDRESS, CITY, S IORTH 500 WEST 'O, UT 84601		1 02/2	3/2005
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	((E	PROVIDER'S ACH CORRECTIVE FERENCED TO TH	PLAN OF CORRE ACTION SHOUL E APPROPRIATE	DIRE CROSS	(X5) COMPLETION DATE
	disease and schizo A review of resident completed on 2/17/ a. An Incident/Accid revealed that reside floor at the side of h b. An Incident/Accid revealed that reside with his/her arm we and mattress spring c. An Incident/Accid revealed that reside floor next to the bed Resident 13's medic 17/05. a. Interdisciplinary T 13 dated 12/22/04 re section that resident which resulted in pt Resident 13's "Restr Review for Eliminatio 04 was reviewed. Th PT) filled out the eva	chrenia. 13's incident reports was 05. Ient report dated 11/3/04 Int 13 was found lying on the is/her bed. Ient report dated 12/2/04 Int 13 was found lying on floor diged between the foot board s. Ient report dated 12/4/04 Int 13 was found lying on the island record was reviewed on 2/Iellia and in the "Comments" In " has fallen out of bed needing a bed on the floor." Iaint Evaluation and Quarterly on assessment dated 12/28/Ielliation. The PT documented reluction by PT" section that	F 3					
	13 was taken to his r completed and the re	kimately 10:15 AM resident com. Personal cares were esident was put to bed. The espital bed placed in the low						

03/29/2005 17:48 8013 JEPAKIMENT OF HEALTH AND H CENTERS FOR MEDICARE & MED	1	i	EASTLAKECARECENTER	PAC	J: U3/07/2004
ATEMENT OF DEFICIENCIES (X1) PRO	ICAID "RVICES VIDER/SUPPLIER/CLIA TIFICATION NUMBER:		JULTIPLE CONSTRUCTION LOING	FORM	M APPROVET 2. 0938-039 SURVEY
	465119	B. WIL	16		
AME OF PROVIDER OR SUPPLIER AST LAKE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COI 1001 NORTH 500 WEST PROVO, UT 84601	02/2	23/2005
(X4) ID SUMMARY STATEMENT O PREFIX (EACH DEFICIENCY MUST BE F TAG REGULATORY OR LSC IDENTIF	DECEMBER 1	ID PREFI TAG	PROVIDER'S PLAN OF COR		(X5) COMPLETION DATE
F 323 Continued From page 60 Interview On 2/17/05 at approximately physical therapist accompanies resident 13's bedroom. Whe what kind of bed the resident the bed and stated that resident ped in the low position bed to be a page 100 per p	ied the surveyor to in the PT was asked had, he looked at	F3			
F 364 SS=B Each resident receives and the food prepared by methods the value, flavor, and appearance palatable, attractive, and at the temperature. This REQUIREMENT is not resident and a confidential group into determined that the facility did was palatable and attractive. Findings include: On 2/14/05 at 1:00 PM, staff we serving the lunch meal. The confidential in the confidential confidential confidential group into the confidential group i	ERVICES The facility provides set conserve nutritive set; and food that is set proper The facility provides set conserve nutritive set proper The facility provides set conserve nutritive set provides and that set proper set proper set proper set proper set provides set provi	F 364	The cooks were inserviced to Dietary manager and the AM Palability of food, apperance Textures to assure food is Prepared correctly. This will be monitored by the Dietary manager and the RD Consultant weekly Completed by April 8, 2005.	on and	
to be cutting cooked chicken be covered in a crunchy coating. square cutting knife, the cook a exerting significant effort into reedges of the chicken which approvercooked. The cook was prefor a resident on a mechanical. The surveyor then asked the communications of the cooked asked the cooked.	reasts which were While using a large appeared to be emoving the outer beared tough and eparing the chicken soft diet.		Monitoring will be done by the Drimanager or the RD through rando trays on various meals and results be reviewed in the weekly quality assurance meeting. Will be integrated into the Quality Assurance system by March 30, 2	m test will	

EASTLAKECARECENTER

PAGE 02

DEPARTMENT OF HEALTH AND HUM/ SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2005 FORM APPROVED

TATEMEN ND PLAN	ATEMENT OF DEFICIENCIES DEPLAY OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465119		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S	
			B. WI	NG_		00/	10 (0 n n =
	PROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP COD 1001 NORTH 500 WEST PROVO, UT 84601		23/2005
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	ULD BE CROSS-	(X5) COMPLETION DATE
F 364	Continued From p	age 61	F:	364			
	The cook stated the When tasting the	nat it was "corn flake chicken". chicken from the test tray, the chicken to be very dry and	•	,			
	group interview con by the facility was ' meat was tough, the were often over-confrequently they were stated that the night was burned stew. staff placed their but vegetables, which is residents stated that supervisor and that accommodate their	ints during the confidential implained that the food served "awful". They stated that the nat the pasta and vegetables loked and "squishy" and that re served burned food. They not of 2/15/05, the dinner meal They stated that the kitchen read on the same plate and the made their bread soggy. The at they liked the food service to she worked hard to reeds, but that the minute the day "all bets are off."					
	revealed the cook to two large cakes wheminutes prior to lun service supervisor of the burned cake, surveyors walking phallway picked up a one of the residents.	ch preparation on 2/16/05 to be cutting all the edges off lich had been burned. (Just lich being served, the food substituted ice cream instead b) The morning of 2/17/05, loast a food cart in the 300 lid from the breakfast tray of lid from the breakfast tray of lid from the breakfast tray of lies and a very dark brown					
F 371 SS=F	483.35(h)(2) DIETA		F 3	71			
	The facility must sto serve food under sa	ore, prepare, distribute, and anitary conditions.					-
	This REQUIREMEN	VT is not met as evidenced by					

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DEPARTMENT OF HEALTH AND HUMA! ERVICES				to a _n	PRINTED	: 03/07/200
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM	APPROVE
ATEMEN	Y OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CONSTRUCTION	OWR NO	0938-039
ID PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	1		(X3) DATE S	URVEY
			A. BUIL	DING	00	- 1 2 1 .
		465119	B. WIN	G		
AME OF F	ROVIDER OR SUPPLIER				02/2	3/2005
			<u>}</u>	STREET ADDRESS, CITY, STATE, ZIP CO 1001 NORTH 500 WEST	IDE	
:AST LA	KE CARE CENTER			PROVO, UT 84601		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES				
PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL] ID ! PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION SHO	RRECTION	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	REFERENCED TO THE APPROPRI	ATE DEFICIENCY)	DATE
F 371	Continued From pa	ge 62	F 3	71		
	Based on observati	ons on 2/14/05 and 2/16/05, it		,		
	was determined tha	at the facility did not store,	F371	The proper rotation of food		
	prepare and distribu	ate food under sanitary		Was reviewed with the dieta	rv staff	
	conditions.	·		And will be monitored by the	:	
		1		Dietary manager weekly		
	Findings include:			The temperature of the water	r	
	Observations in the	kitchen on 2/14/05 at 12:40		Heater was increased to the	level	
	PM revealed three large containers of expired cottage cheese; two dated 2/4/05 and one dated			Necessary to assure safe of		
				Of the dishwasher. The log	will	
ļ	2/7/05			Be maintained by the dishwa	ishers	
ĺ	Section 1997 and the section of the		i i	And will be monitored by the	dietary	
	Observations in the	kitchen on 2/16/05 revealed	: '	Manager. If a temperature is	s low.	•
	that the dish machin	ne was not working properly		The dietary manager will be	notifie d	×.
	using chemical sani	le dishes. The facility was tation to sanitize their dishes.		Immediatley. The logs will b	e reviewed	
. •	When using chemic	al sanitation, the water		In QA meeting weekly.		
	temperature during	the wash cycle must reach at	9		1	
	least 120 degrees F	arenheit and the water		The tile and grout were repair	red by	:
	temperature during	the rinse cycle must reach at	:	Plant operations personnel, a	ind will	
	least 140 degrees Farenheit.			Be monitored by the dietary t	nanager	i
	A kitchen staff norm	on wood at the a state was to		Who will list on the maintena		
	temperatures for the	on recorded the dish machine morning of 2/16/05 to be 128.		Log any repairs necessary in	die tary.	
1	degrees for the was	h cycle and 120 degrees for		—		
}	the rinse cycle. The	rinse water temperature was		Completed by April 8, 2005.		
į	insufficient to achiev	e sanitation of the dishes.		18		
		· ·		1		
	Observation of the o	lishes going through the dish				
	Wasner was perform	ned on 2/16/05 at 11:50 AM.				
	measured 108 door	ure during the wash cycle				
	temperature during t	ees Farenheit and the water the rinse cycle measured 116				
<u> </u>	degrees Farenheit.	Both of these water			1	
	temperatures were i	nsufficient to achieve				Ì
		nes. Multiple loads of dishes		•		<i>-</i> :
		through the dish washer.				-
		re never reached the				
	required temperature	es to achieve sanitation with			i	
4 CM\$-258	37(02-99) Previous Versions (Obsolete Event ID: FAWO11	Facilit	y ID: UT0022 If co	ntinuation sheet Pa	age 63 of 80
				, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		

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FORM APPROVED OMB NO. 0938-0391

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DEPARTMENT OF HEALTH AND HUMA	ERVICES
CENTERS FOR MEDICARE & MEDICAL	SERVICES

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY

465119

B. WING _

COMPLETED

02/23/2005

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

EAST LAKE CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH 500 WEST

DROUG UT ALSO

		Р	ROVO, UT 84601	
X4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 371	Continued From page 63	F 371		
	the chemical sanitizing method.			
	On 2/16/05 at 1:00 PM, the kitchen ran out of clean dish covers. One of the kitchen staff took ten dirty covers and ran them through the dish machine. The water temperature for both the wash and rinse cycle were noted to be 86 degrees Farenheit. This water temperature was insufficient to achieve sanitation. The staff member was then observed to take the ten lids and while still dripping with water, place them over the remaining lunch dishes to be served to residents.			
•	Observation of the dish machine was again observed with the kitchen supervisor. The rinse temperature was initially observed at 140 degrees, but then fell to 118 degrees with subsequent loads.	3		
:	With the dish machine not sanitizing the dishes, it could potentially affect each person who eats food from the facility's kitchen, which would include all the residents and some of the staff.			
	Observation of the physical environment in the kitchen on 2/16/05 revealed multiple areas of missing tile, one place where the wallboard and grout were exposed. The floors had significant dirt built up around the door ways and under the tray line table. The electrical outlet across from the oven was missing a cover plate. The water drains appeared dirty and rusty.			
372 SS=D	483.35(h)(3) DIETARY SERVICES	F 372		
	The facility must dispose of garbage and refuse properly.			

PORM CM5-2567(02-99) Previous Versions Obsolete

Event ID: F4WD11 Facility ID: UT0022

If continuation sheet Page 64 of 80

CENTE	RS FOR MEDICARE	AND HUMAN FRVICES & MEDICAID JERVICES					FORM	1: 03/07/20(APPROVE
ATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		465119	B. WIN	IG			U3/3	3/2005
	ROVIDER OR SUPPLIER			STREET ADDRE		E, ZIP CODE	02/2	3/2005
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH C	ROVIDER'S PLAN ORRECTIVE ACT ICED TO THE AF	TION SHOULD	BE CROSS.	(X5) COMPLETION DATE
F 372	Continued From pa	ige 64	F3	72	,			
	Based on observati	NT is not met as evidenced by ion, it was determined, the use of garbage and refuse lly, the dumpsters at the facility	F372	In genera Were ren Dumpste This will t Dietary m Operation	elstaff meetininded that the same to be monitored tanager and the manager description.	he lids on the kept close by the the plant laily.	je .	
	On 2/15/2005 at 12 was observed to be	:10 PM the facility dumpster		Complete	d by April 8,	2005.		
	On 2/16/2005 at 12 was observed to be	:20 PM the facility dumpster uncovered.		04				
	distance, at the top		,					
	The facility must est program under which prevents infections in procedures, such as to an individual residual incidents and confinections. This REQUIREMEN	ECTION CONTROL cablish an infection control th it investigates, controls, and n the facility; decides what is isolation should be applied dent; and maintains a record rective actions related to	F 44					
	Interviews, it was de not ensure an infecti a safe, sanitary and to help prevent the c	on, record review and termined that the facility did termined that the facility did ton control program to provide comfortable environment and tevelopment and transmission tion. Resident identifier 6, 13,						÷

EASTLAKECARECENTER

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DEPARTMENT OF HEALTH AND HUMA SERVICES

PRINTED: 03/07/2005 91

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM	I APPROVI
IAIEMEN	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII	ULTIPLE CONSTRUCTION LDING	OMB NO (X3) DATE S COMPLE	
		465119	B. WIN	G	-	
NAME OF F	PROVIDER OR SUPPLIER				02/2	3/2005
EAST LA	KE CARE CENTER			SYREET ADDRESS, CITY, STATE, ZI 1001 NORTH 500 WEST PROVO, UT 84601	PCODE	,
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	<u> </u>			
PREFIX TAG	L CACH DEFICIENCY	MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS	(XS) COMPLETIO DATE
F 441.	Continued From pa	ge 65	F 4	41		
	Findings include:	-		*	!	
	must have an active program in place to in their building. The collected and review concerns, etc., and how to correct the part of the infect 1/31/05 revealed the cultures being done when cultures were documentation whet done. The infection documented a cluster infections (UTI) on a UTI's on another half	ion Control Logs for 7/1/04 to at the log was incomplete with and no organism identified done and /or no her a culture was or was not a Control Log for July 2004 ering of four urinary tract.	F441	Resident Infection Control Policy has been put into policy has been put into policy has been put into policy has been put into policy and a surance Infection Monthly Infection Control nurses will be inserviced infections, DON and/or Mill review all T.O. orders infections and assure that taken to correct problem. DON will monitor infection month infection issues an plan to correct any problem follow-up and report to QA monthly Infection Control in the control of the c	place to include nihly Summary, sters on Summary report. Staff by D.O.N to log IDS Coordinator that identify t proper action MDS and/or as throughout the d set up action IDS as well as a committee report.	
	2004 documented a infections and three other halls. A total o identified for the morfacility had no documentey recognized the solustering formations	clustering of six skin more skin infections on two f 9 skin infections were ith of August 2004. The itentation to evidence that scope of the infections or the , nor did they have dence that any action was		All residents personnel item in plastic bags with their na D.O.N. will monitor that too combs (personnel items) a labeled monthly thru QA mand report to the QA common Completed by April 8, 2005	ame on it. oth brushes, are properly arsing rounds mittee monthly.	
	²M, she was asked v charge of the infectio DON replied, "That's	he DON, on 2/23/05 at 3:00 who in the facility was in n control program. The me I guess." When the he infection control log, the				

DON stated that she would gather it for the surveyors, but that it was not all finished. Review of the infection control log confirmed that it was

03/29/2005 17:48 8013779747 EASTLAKECARECENTER PAGE DEPARTMENT OF HEALTH AND HUMA PRINTED: 03/07/2005 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES <u>OMB NO. 0938-0391</u> (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465119 NAME OF PROVIDER OR SUPPLIER 02/23/2005 STREET ADDRESS, CITY, STATE, ZIP CODE EAST LAKE CARE CENTER 1001 NORTH 500 WEST PROVO, UT 84601 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (X5) COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-TAG TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE F 441 Continued From page 66 F 441 not current and the DON said that she would get it finished. Observations within the facility: Resident 6 and resident 24 share a room with a common bathroom. In the bathroom, on 2/22/05 at 10:45 AM, were two unlabeled identical white toothbrushes located on the shelf just below the paper towel rack. The aide for these residents was interviewed at this time. She was shown the toothbrushes sitting next together in the bathroom and was asked how (with both of them unlabeled and both white) she knew which one belonged to which resident. The aide stated, "See that one with the blood on it? That's (resident 24)'s. She always bleeds when we brush her teeth. That's how we tell that that's hers." Resident 13 and resident 25 share a room with a common bathroom. In the bathroom, on 2/22/05 at 10:45 AM, were three unlabeled toothbrushes (two white and a blue) located in the sink with an unlabeled comb. On 2/22/05 at 9:30 AM a blue toothbrush was lying on the floor of the bathroom. In a confidential interview, on 2/22/05 at 10:00 AM, a staff member said that you can not tell who's toothbrush is who's. F 445 483.65(c) INFECTION CONTROL F 445 SS≃B Personnel must handle, store, process, and transport linens so as to prevent the spread of infection This REQUIREMENT is not met as evidenced by Based on observation, it was determined the FORM CMS-2567(02-99) Previous Versions Obsolete

03/29/2005 17:48 8013779747 EASTLAKECARECENTER PAGE _PARTMENT OF HEALTH AND HUMA! TRVICES FRINTED; U3/U/IZUUD FORM APPROVED JENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER COMPLETED A. BUILDING B. WING 465119 02/23/2005 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EAST LAKE CARE CENTER 1001 NORTH 500 WEST PROVO, UT 84601 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CRUSS-TAG TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE F 445 Continued From page 67 F 445 facility did not ensure that soiled linen was stored or transported in a safe and sanitary manner. F445 Aides will be inserviced by the D.O.N. to keep the linen carts covered Findings include: during storage and transport. D.O.N. will monitor thru QA nursing rounds and report On 2/22/05 at 1:20 PM, the shower room across to the QA committee monthly. from the south nurses station was observed. This area was being used for storage of equipment Completed by April 8, 2005. and dirty laundry. There was a container of uncovered dirty laundry emitting stool and urine like odors. On 2/23/05 at 10:05 AM, the tub room across from room 505 was observed. There was a container of uncovered dirty laundry. The facility policy follows the Center for Disease Control guidelines. Soiled linens will be stored and/or transported in a closed container. The facility was not following their own policy. F 490 483.75 ADMINISTRATION F 490 SS=H A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by Based on interviews and review of medical records, incident reports, facility in-services, facility policies and procedures, and part the facility's quality assurance meeting minutes for 12 /13/04, it was determined that the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical,

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mental, and psychosocial well-being for each resident. Specifically, facility administration failed

Event ID: F4WD11

Facility ID: UT0022

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8013779747 DEPARTMENT OF HEALTH AND HUMAN SERVICES EASTLAKECARECENTER PAGE 01 CENTERS FOR MEDICARE & MEDICAL FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 465119 NAME OF PROVIDER OR SUPPLIER 02/23/2005 STREET ADDRESS, CITY, STATE, ZIP CODE EAST LAKE CARE CENTER 1001 NORTH 500 WEST PROVO, UT 84601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X5) COMPLETION TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE F 490 Continued From page 68 F490 to identify and correct the process for identifying, All incident reports will be reviewed reporting and investigating allegations of abuse/ Daily in census meeting by the neglect and injuries of unknown source. The Administrator. All appropriate follow-up facility was cited for deficient practice in a total of Will be completed and logged. This 18 areas, not including this deficiency. Will be reviewed in weekly QA meeting. See also F225 for additional information. Findings include: On 2/23/05, a Standard Extended survey was See F157 completed which resulted in the determination of Sub-Standard Quality of Care in the area of See F309 Resident Behavior and Facility Practices (42 CFR 483.13). The determination of Sub-Standard See F323 Quality of Care was based on the lack of identification, investigation and reporting of See F224 allegations of abuse (both by staff and other residents) and injuries of unknown source. See F241 A pattern of actual harm was identified for 6 residents, one of whom had a broken leg which See P253 went untreated for 3 days (see F224 regarding neglect), 2 of whom were alleged victims of See F371 abuse and an additional 3 who suffered significant injuries (one resident was found with a See F364 broken finger and lacerations to the back of her head, another resident was found with his front tooth through his lip and the third resident was See F372 found with a right eye injury). None of the See F518 incidents were investigated by the facility. None of the incidents were reported by the facility to required agencies, including the State survey and See F514 certification agency. The facility did not have evidence that any of the incidents were See F279 immediately reported to the administrator, as required. The facility had evidence that on See F441 December 13, 2004, their quality assurance committee had identified the lack of reporting and See F445 investigation of injuries of unknown source. However, three days later, on 12/16/04, resident 4 Completed by April 8, 2005. ORM CMS-2567(02-99) Previous Versions Obșolete Event ID: F4WD11 Facility ID: UT0022

29/2005

03/29/2005 17:51 8013779747 EASTLAKECARECENTER PAGE DEPARTMENT OF HEALTH AND HUMA TERVICES PRINTED: 03/07/2005 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 465119 8. WING NAME OF PROVIDER OR SUPPLIER 02/23/2005 STREET ADDRESS, CITY, STATE, ZIP CODE EAST LAKE CARE CENTER 1001 NORTH 500 WEST PROVO, UT 84601 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-(X5) COMPLETION TAG REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE F 490 Continued From page 69 F 490 The administrators performance will be was found with two lacerations on the back of her monitored through the Quality head while lying in bed. No one knew how the Assurance team members, by reviewing injuries had occurred. The incident was not progress made toward compliance. investigated or reported as required. Please also This will be documented in the minutes see tag F-225 for additional information. of the weekly quality assurance meeting. In addition to the area of Sub-Standard Quality of Will be integrated into the Quality Care stated above, the facility's administration Assurance system by March 30, 2005 failed to effectively and efficiently use its resources to ensure that each resident attained or maintained their highest practicable physical, ... mental and psychosocial well-being in the following areas of deficient practice cited during the survey completed 2/23/05. a. Facility administration falled to ensure that the physician was notified when there was a significant change in a resident's physical condition. See F - 157, b. Facility administration failed to ensure that each resident was provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. See F - 309. c. Facility administration failed to ensure that the resident environment remains as free of accident hazards as is possible. See F - 323. d. Facility administration failed to ensure that their residents were not subject to neglect. See F - 224. e. Facility administration failed to ensure that each resident was treated with dignity. See F -241.

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Event ID: F4WQ11

Facility ID: UT0022

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

PRINTED: 03/07/2005 FORM APPROVED OMB NO. 0938-0391

ND PLAN	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A, BUIL	LTIPLE CONSTRUCTION DING	(X3) DATE S	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
	465119		B. WING				
EAST L	PROVIDER OR SUPPLIER AKE CARE CENTER		s	STREET ADDRESS, CITY, STATE, ZIP CO 1001 NORTH 500 WEST PROVO, UT 84601	02/2 DE	23/2005	
(X4) ID PREFIX TAG	THACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SHO REFERENCED TO THE APPROPRIA	UH D DE ODOGG	(X5) COMPLETI DATE	
F 490	f. Facility administration facility's housekeepi provided a sanitary, interior. See F - 253	ation failed to ensure that the ng and maintenance services orderly and comfortable	F 49				
	sanitary conditions.	•					
	h. Facility administration food served to it's resattractive. See F - 36	ation failed to ensure that the sidents was palatable and 64.					
1	 Facility administrat there was a proper di refuse. See F - 372. 	ion failed to ensure that sposal of garbage and	:			it.	
I	j. Facility administrati employees were fami procedures. See F -	ion failed to ensure that it's liar with emergency 518.					
	systematically organiz	i		· .			
1 5	Facility administration in Facility administration in Facility addressed the notes and the facility and the facility and f	on failed to ensure that care leeds of each resident. See					
s p	control program design anitary and comfortal	tion failed to ensure that maintained an infection ned to provide a safe, ple environment and to help ent and transmission of See F - 441.					
n si	. Facility administration	on failed to ensure that perly stored. See F - 445.				-	

03/29/2005 17:51 8013779747 **EASTLAKECARECENTER** DEPARTMENT OF HEALTH AND HUMA" SERVICES PAGE 04 FRINTED: 03/07/2005 CENTERS FOR MEDICARE & MEDICAIL JERVICES FORMAPPROVED STATEMENT OF DEFICIENCIES <u>OMB NO. 0938-039</u>1 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DAYE SURVEY A. BUILDING COMPLETED B. WING 465119 NAME OF PROVIDER OR SUPPLIER 02/23/2005 STREET ADDRESS, CITY, STATE, ZIP CODE EAST LAKE CARE CENTER 1001 NORTH 500 WEST PROVO, UT 84601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX 10 PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-(X5) REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG DATE F 514 Continued From page 71 F 514 F 514 483.75(I)(1) ADMINISTRATION F514 Medical Record for resident 4, 19, 28, 13, SS=E The facility must maintain clinical records on each 18, 32,16 was reviewed to assure the resident in accordance with accepted professional Medical records were filed in the correct standards and practices that are complete; chart. All records will be reviewed for accurately documented; readily accessible; and organization and proper filing by Medical systematically organized. Record Clerk and monitored by Medical This REQUIREMENT is not met as evidenced by Records monthly for correct filing and reported to the QA committee Based on review of medical records, it was Licensed Nurses will be inserviced on the determined that 7 of 22 sampled charts had other importance of charting medications per dr. resident's assessments, laboratory results or other documentation filed in them. One of the order. Medical Records will audit the sampled charts (resident 6) had numerous areas Medication Records for proper charting which had not been signed by the nurse attesting weekly giving results to D.O.N. to evaluate to the fact that medications had been given as thru QA committee monthly. ordered. The same chart (for resident 6) did not contain an accurate or functional representation Completed by April 8, 2005. of the actual experience of the resident during an episode of acute illness. Resident identifiers: 4, 13, 8, 6, 19, 18 and 20. Findings include: 1. The medical record of resident 4 was found to contain an ADL (activities of daily living) sheet for resident 32. 2. The medical record for resident 19 was found to contain a laboratory result for resident 16. 3. On 2/15/2005, a follow up visit note from a physician for Resident 28 was found in the medical record of Resident 13. 4. On 2/15/2005, a monthly summary dated 1/ 2005 for Resident 18 was found in Resident 13's medical record. DRM GMS-2567(02-99) Previous Versions Obsolete Event ID: F4WD11 Facility ID: UT0022 If continuation sheet Page 72 of 80

DRM CMS-2667(02-99) Previous Versions Obsolete

Reminyl 8 mg PO BID (twice a day) ordered 9/9/

Valium 2 mg PO QD (each day) ordered 9/9/04

10/29/04 at 8:00 AM and 8:00 PM

Event ID: F4WD11

Facility ID: UT0022

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CLIVIE	ENS FOR MEDICARE	AND HUMA ERVICES			PRINTED: 03/07 FORM APPR
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	OMB NO. 0938 (X3) DATE SURVEY COMPLETED	
		465119	B. WING		
	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	02/23/2005
	AKE CARE CENTER] 1	1001 NORTH 500 WEST PROVO, UT 84601	
(X4) ID PREFIX TAG) (CACE DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOUL) REFERENCED TO THE APPROPRIATE	DE ADAGA
F 514	Continued From page	ge 7 3	F 514		
	10/16/04 at 8:00 A 10/29/04 at 8:00 AM	М	F 514		
	Synthroid .15 mg QI 10/16/04 at 8:00 AM 10/25/04 at 8:00 AM 10/29/04 at 8:00 AM		, ,		
	Mirapex 0.5 mg PO 10/13/04 at 8:00 PM 10/16/04 at 8:00 PM 10/17/04 at 8:00 PM 10/19 and 10/20 at 10/25/04 at 8:00 PM 10/29/04 at 8:00 AM	1 and 4:00 PM // 8:00 PM			
	Ascorbic Acid 500 mg 10/16/04,10/29/04 e	g PO QD ordered 9/9/04 ach at 8:00 AM			
	Clonazepam 1 mg P0 10/13/04 at 8:00 PM 10/16/04 at 8:00 AM 10/18 and 10/19/04 a 10/29 at 8:00 AM	1			
1	Phenobarbital Sodium mg (20 cc) PO Q12H 9/04 10/13 at 8:00 PM 10/16 at 8:00 AM 10/18 and 10/19 at 8:0	1 (Elixir 20 mg/5ml) give 80 (every 12 hours) ordered 9/			
-	nueled 9/9/04	QHS (each night at bedtime) 0/20 and 10/28 at 8:00 PM		•	
N		2 Day (every day) ordered 9			

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

10/28 Bedtime 10/29-31 10:00 AM

Event ID: F4WD11

Facility ID: UT0022

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

11/11at 8:00 AM

11/13-14 at 8:00 PM 11/26-27 at 8:00 PM

11/12 at 8:00 AM and 4:00 PM

Event ID: F4WD11

Facility ID: UT0022

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DEPARTMENT OF HEALTH AND HUMAI ERVICES

PRINTED: 03/07/2005 FORM APPROVED

CENTERS FOR MEDICARE	& MEDICAID SERVICES		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(NO) NOU THE PLANTS OF THE PARTY OF THE PART	(X3) DATE SURVEY
		A. BUILDING	COMPLETED
	465119	B, WING	02/23/2005

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

EAST LAKE CARE CENTER			1001 NORTH 500 WEST PROVO, UT 84601			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE			
F 514	Continued From page 76	F 51	4			
	Ascorbic Acid 500 mg PO QD ordered 9/9/04 11/11-12 at 8:00 AM					
	Clonazepam 1 mg PO BID ordered 9/9/04 11/11-12 at 8:00 AM 11/13-16 at 8:00 PM 11/27 and 11/29 each at 8:00 PM					
! !	Phenobarbital Sodium (Elixir 20 mg/5ml) give 80 mg (20 cc) PO Q12H (every 12 hours) ordered 9/9/04	,				
	11/11-12 at 8:00 AM 11/13-14 at 8:00 PM 11/21 at 8:00 PM 11/27-28 at 8:00 PM					
	Remeron 15 mg PO QHS (each night at bedtime) ordered 9/9/04 11/2, 11/13, 11/1411/27 each at 8:00 PM					
	Namenda 20 mg PO Q Day (every day) ordered 9 /9/04 11/11-12 @ 8:00 PM					
	Oxycodone 5 mg 1 PO TID ordered 11/11/04 11/15-17 @ 8:00 PM 11/24-26 at 8:00 PM 11/28 at 8:00 PM					
i	December 2004					
	Hydrocodone 5/500 PO (per mouth) TID (three times a day) ordered 9/9/04 12/1-8 all doses for 8:00 AM, 4:00 PM and 8:00 PM 12/9 at 8:00 AM 12/16 at 4:00 PM 12/26 at 8:00 AM and 4:00 PM 12/29 at 4:00 PM 12/30 at 4:PM					

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Event ID: F4WD11

Facility ID: UT0022

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DEPARTMENT OF HEALTH AND HUMAI ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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OERTERIOT OF MEDICARE	A MEDICAID SERVICES		OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	AND ARTHUR DE CONTRACTOR OF TH	(X3) DATE SURVEY
		A, BUILDING	COMPLETED
	465119	B. WING	02/23/2005

NAME OF PROVIDER OR SUPPLIER

EAST LAKE CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH 500 WEST

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	D	PROVIDER'S PLAN OF CORRECTION	(75)
REFIX TAG	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 514	Continued From page 77	F 514		
	12/30 at 4:00 PM 12/31 at 8:00 AM, 4:00 PM and 8:00 PM			
	Reminyl 8 mg PO BID (twice a day) ordered 9/9/			
	12/1-10 at 8:00 AM all doses 12/1-8 at 8:00 PM 12/26 at 8:00 AM			
	12/31 at 8:00 AM and 8:00 PM			
	Valium 2 mg PO QD (each day) ordered 9/9/04 12/26 and 12/31 at 8:00 AM			
	Mirapex 0.5 mg PO TID ordered 9/9/04 12/1-9 at 8 AM all doses 12/1-7 at 4:00 PM all doses			
	12/1-8 at 8:00 PM all doses 12/16 at 4: 00 PM 12/26 at 8:00 AM and 4:00 PM 12/29 and 12/30 at 4:00 PM 12/31 at 8:00 AM, 4:00 PM and 8:00 PM			
	Synthroid .15 mg QD ordered 9/9/04 12/26 at 8:00 AM 12/31 at 8:00 AM			
	Ascorbic Acid 500 mg PO QD ordered 9/9/04 12/26 at 8:00 AM 12/31 at 8:00 AM			
	Clonazepam 1 mg PO BiD ordered 9/9/04 12/26 at 8:00 AM 13/31 at 8:00 AM and 8:00 PM			
	Phenobarbital Sodium (Elixir 20 mg/5ml) give 80 mg (20 cc) PO Q12H (every 12 hours) ordered 9/ 9/04 12/26 and 12/31 at 8:00 AM			. ,

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Facility ID: UT0022

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DEPARTMENT OF HEALTH	AND HUMA	ERVICES
CENTERS FOR MEDICARE	& MEDICAID	SERVICES

(X2) MULTIPLE CONSTRUCTION

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

A. BUILDING

(X3) DATE SURVEY COMPLETED

465119

B. WING

02/23/2005

NAME OF PROVIDER OR SUPPLIER

EAST LAKE CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 1001 NORTH 500 WEST

ZAOT EARL OAKE GERTER			PROVO, UT 84801			
(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 514	Continued From page 78	F 514				
	Remeron 15 mg PO QHS (each night at bedtime) ordered 9/9/04 12/31 at 8:00 AM					
	Namenda 20 mg PO Q Day (every day) ordered 9 /9/04 12/31 at 8:00 AM					
	Phenytoin (Dilantin Suspension) 125 mg/5ml give 100 mg elixer PO TID					
	12/1-8 at 8:00 AM, 4:00 PM and 8:00 PM all doses 12/9 at 8:00 AM 12/16 at 4:00 PM 12/26 at 8:00 AM and 4:00 PM 12/31 at 8:00 AM, 4:00 PM and 8:00 PM					
	Multivitamins with Minerals give one tab PO Q Day ordered 9/9/04 12/21 at 8:00 AM 12/26 at 8:00 AM 12/29-31 at 8:00 AM					
	ZCAL 120 cc PO QID (four times a day) ordered 9/9/04 12/1-17 at 8:00 AM, 12:00 PM, 4:00 PM and HS 1220-23 at HS 12/26 at 8:00 AM, 12:00 PM and 4:00 PM 12/31 at 8:00 AM, 12:00 PM. 4:00 PM and HS					
F 518 SS≖D	483.75(m)(2)-(4) ADMINISTRATION	F 518				
	The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.					
	This REQUIREMENT is not met as evidenced by					
DRM CMS-25	67(02-99) Previous Versions Obsolete Event ID: F4WD11	Facility I	D: UT0022 If continuation sheet F	Page 79 of 80		

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CENTERS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465119		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 02/23/2005		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX (EACH CORRECTIVE ACTION SHOULD	DBECROSS-	COMPLETION DATE
F 518	2 of 3 facility emplemergency procede available. Findings included. On 2/16/05 at 9:19. Assistant (CNA) 8 a daytime team lestated that she was electrical power in some of the electrical power in some of the electrical power of the do in case of a building. CNA 8 stabout what neede and get back with. On 2/23/05 at 10:10 in the facility for a interviewed. CNA no training in fire sknow where the file.	erviews, it was determined that loyees interviewed regarding dures lacked understanding of dures or facility equipment 5 AM, Certifled Nursing was interviewed. CNA 8 was ader of the facility CNAs. CNA 8 as not aware that when the the building was lost, that fical outlets would still work. It that she was not aware of what resident missing from the tated that she would find out at to be done in both instances the surveyor. 20 AM, CNA 9, who had worked pproximately 9 months, was a 9 stated that she had received safety at the facility and did not re alarms were located.	F518	Emergency procedure informated During orientation meeting. Or Emergency drills will be held queen on each shift to ensure staffar Knowledgeable of their response Plant operations manager will be Responsible to complete staffir On these procedures, and turn Report and list of attendees to a Administrator monthly. This report will be reviewed in QA meeting Completed by April 8, 2005. All current employees were inserving on emergency procedures on March 2005. The records are in the inservition.	n going namerly se sibility ne nservice in a the foon	
RM CMS-25	67(02-99) Previous Versio	ns Obsolete Eyent ID: F4WD1	1 Fe	acility ID: UT0022 If conti	nuation sheet !	Page 80 of 80

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