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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 465119 | A. BUILDING _____ B. WING _____ | 02/23/2005 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EAST LAKE CARE CENTER | 1001 NORTH 500 WEST PROVO, UT 84601 |

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| F 157 SS=G | 483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES<br><br>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.<br><br>This REQUIREMENT is not met as evidenced by<br><br>Based on interviews and medical record reviews, it was determined the facility did not consult with the resident's physician for 1 of 22 sampled residents when the resident exhibited a change of | F 157 | F157 Licensed Nurses will be inserviced on Notification of physician when a resident has a change in condition, proper notification for new or change in treatments and proper documentation in Nurses Notes. D.O.N will monitor Thru QA nursing rounds and report weekly to Quality Assurance committee.<br>Completed by April 8, 2005.<br><br>Ok Revised POC acceptable Completion date 4/8/05 Lbuenbank,Ra 3-30-05 | |

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

eficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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| F 157 | Continued From page 1<br>condition indicating need to commence new treatment. Resident identifier 9.<br><br>Findings include:<br><br>1. Resident 9 was admitted to the facility with diagnoses which included quadriplegia and depression.<br><br>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 ] 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.<br><br>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:<br>"[Resident 9 and a family member] are concerned that resident 9's left extremity is larger than right extremity.<br>right thigh 24 1/2" left thigh 28" | F 157 | | |

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| F 157 | Continued From page 2<br>right calf 15" left calf 15 1/4"<br>ankle 9" left ankle 9"<br><br>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.<br><br>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. A review of resident 9's medical record revealed no evidence that resident 9's physician had been notified of change of condition in [her] left leg. | F 157 | | |
| F 224 SS=G | 483.13(c)(1)(i) STAFF TREATMENT OF RESIDENTS<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>(Use F224 for deficiencies concerning mistreatment, neglect or misappropriation of resident property.)<br><br>This REQUIREMENT is not met as evidenced by :<br><br>Based on interview and review of records, it was determined that the facility did not implement written policies and procedures that prohibit | F 224 | | |

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| F 224 | Continued From page 3<br>mistreatment, neglect and abuse of residents for 2 of 22 sampled residents. Specifically, the facility did not provide ongoing training to facility staff on issues related to abuse prohibition practices; did not prevent neglect in assessing and treating resident 9 for a hip fracture; and did not adequately report or investigate allegations of staff abuse for resident 11 nor report or investigate circumstances of neglect for resident 9. Neglect means the failure by the facility to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness Resident identifiers 9 and 11.<br><br>Findings include:<br><br>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.<br><br>2. Resident 9 was admitted to the facility with diagnoses which included quadriplegia and depression.<br><br>On 2/17/05, resident 9 was interviewed in her | F 224 | F224 All Nurses and Nursing Assistants will be inserviced on Abuse Policy, Abuse Policy will be incorporated into the facilities New Hire Orientation.<br><br>Incident Accident Log Book will be set up logging Individual incident reports. Fall Investigation and Injury of Unknown Source Report will be implemnted. Nursing staff will be inserviced on proper completion of Incident Report and reporting methods of suspected abuse/neglect or Injury of unknown source. D.O.N. will monitor all incident reports, and report results of Fall and Injury of Unknown Source to the QA Committee weekly for the next 3 months then monthly thereafter. D.O.N. will report daily incidents of suspected abuse Injury of Unknown source to Admin.<br><br>Completed by April 8, 2005.<br><br>Resident 9 was admitted to the hospital for a repair of her hip. She was re-admitted to this facility, and per her request, changed to in house therapy.<br><br>The inservice was held for all staff members. Documentation is in the inservice book.<br><br>OK | |

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| F 224 | Continued From page 4 | F 224 | | |

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] 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:
"[Resident 9 and a family member] are concerned that resident 9's left extremity is larger than right extremity.
right thigh 24 ½" left thigh 28"
right calf 15" left calf 15 ¼"
ankle 9" left ankle 9"

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

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| F 224 | Continued From page 5<br>taken to the emergency room via ambulance.<br><br>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 11:45 PM.<br><br>On 2/16/05, the facility "Anti-Abuse Policy for Residents" was reviewed. The policy documented that the facility objective was 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 documented, under the heading "How Staff Will be Monitored During Delivery of Care & Services: All facility staff must be monitored during their work performance to assure there is no evidence of neglect of care to those residents whom they provide daily care for. This will be accomplished by the following protocol:" The policy further lists and explains the procedures for the responsibility of facility charge nurses, DON (Director of Nursing) and ADON (Assistant Director of Nursing) to monitor staff work performance and ensure that neglect does not occur.<br><br>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.<br><br>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 | F 224 | | |

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| F 224 | Continued From page 6<br>and neglect. In response to surveyor questions about Resident 9's episode of inpatient care in May 2004, the facility Director of Nursing stated than an Incident Report had not been completed for Resident 9's hip fracture. The facility's Administrator-In-Training, the Certified Social Services Worker and the Director of Nursing further stated that no report of the incident had been made to the State survey and certification agency. Federal regulations (please see F 225 contained within this document) require that allegations of neglect are immediately reported to several agencies, including the State survey and certification agency.<br><br>3. Resident 11 was admitted to the facility with diagnoses which included senile dementia and insulin dependent diabetes.<br><br>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".<br>The policy further documents, under the heading:<br><br>"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. ..." | F 224 | | |

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| F 224 | 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

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| F 224 | Continued From page 8<br>outside agencies, nor had any investigation of the allegations of abuse been done by anyone at the facility.<br><br>The facility Director of Nursing provided a copy of a form titled "Warning Slip" which had been completed by a facility charge nurse and which appeared to allege that certified nursing assistant 2 (CNA 2) had been observed "hitting at least 2 X (times) et (and) kicked(sic) at least 2 X (times) in buttocks by this staff".<br><br>The facility Administrator-In-Training, Certified Social Services Worker and Director of Nursing stated they would immediately investigate the alleged incident of abuse and present surveyors with a written report of their findings.<br><br>On 2/22/05 at 10:00 AM, two printed pages titled " Investigation Re: Allegation of Abuse" were reviewed. This record documented that the facility had conducted interviews with several of the facility staff on 2/17/2005 and 2/18/05. The Summary states:<br><br>"It is difficult to determine what happened during this incident.... It is especially difficult to deal with an incident which happened more than a week ago. We feel that the incident is unsubstantiated, but will not allow the CNA involved to work on that side of the Unit anymore ."<br><br>The record was signed by the Administrator in Training and the Certified Social Worker.<br><br>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 | F 224 | | |

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| F 224 | Continued From page 9<br>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 retaliate against [her].<br><br>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 224 | | |
| F 225 SS=H | 483.13(c)(1)(ii) STAFF TREATMENT OF RESIDENTS<br><br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or | F 225 | | |

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| F 225 | Continued From page 10<br>other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>This REQUIREMENT is not met as evidenced by :<br><br>Based on interviews and record review, the facility did not ensure that, for 6 of 22 sampled residents, alleged violations involving neglect, abuse and injuries of unknown source were reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. Specifically, the facility did not report alleged violations involving neglect for Resident 9, did not adequately report or investigate allegations of staff abuse for resident 11 and resident to resident abuse for | F 225 | F225<br>F226<br>All staff will be inserviced on reporting Abuse/Neglect/Injury of unknown. Injury of Unknown Source Investigation form will be implemented and all reports of injuries of unknown source will be investigated by the D.O.N. and reported to the Adm. Daily, continue monitoring by logging on the Incident report Log thru the QA committee weekly for the next 3 months then monthly. Abuse/Neglect Will be investigated by social worker Notification will be made to all appropriate Agencies. Investigations will be Completed within 5 days. This will Followed up weekly for 3 months in QA, then monthly.<br>All resident incidents were investigated by the DON and the CSW. The findings are on file<br><br>Resident 11 had his incident investigated by the DON and the CSW, and results reported to the appropriate agencies. APS conducted their follow-up investigation in house.<br><br>All incidents for residents 3,4,9,12,13, were reviewed in a special IDT meeting, and the deficient practice was identified. The inservice that was given reviewed each of those items to assure that all correct procedures will be followed in the future.<br><br>These same inservices will be repeated quarterly. Completed by April 8, 2005. | |

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| F 225 | Continued From page 11<br>Resident 12, and did not adequately report incidents of injury of unknown source for Residents 3, 4, and 13. Residents 3, 4, 9, 11, 12, and 13.<br><br>On 2/23/05, a Standard Extended survey was completed which resulted in the determination of Sub-Standard Quality of Care in the area of Resident Behavior and Facility Practices (42 CFR 483.13). The determination of Sub-Standard Quality of Care was based on the lack of identification, investigation and reporting of allegations of abuse (both by staff and other residents) and injuries of unknown source.<br><br>A pattern of actual harm was identified for 6 residents, one of whom had a broken leg which went untreated for 3 days (see F224 regarding neglect), 2 of whom were alleged victims of abuse and an additional 3 who suffered significant injuries (one resident was found with a 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 found with a right eye injury). None of the incidents were investigated by the facility. None of the incidents were reported by the facility to required agencies, including the State survey and certification agency. The facility did not have evidence that any of the incidents were immediately reported to the administrator, as required. The facility had evidence that on December 13, 2004, their quality assurance committee had identified the lack of reporting and investigation of injuries of unknown source. However, three days later, on 12/16/04, resident 4 was found with two lacerations on the back of her head while lying in bed. No one knew how the injuries had occurred. The incident was not | F 225 | | |

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| F 225 | Continued From page 12<br>investigated or reported as required.<br><br>Findings include:<br><br>Allegation of Neglect:<br><br>1. Resident 9 was admitted to the facility with diagnoses which included quadriplegia and depression.<br><br>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 ] 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.<br><br>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:<br><br>[Resident 9 and a family member] are concerned that resident 9's left extremity is larger than right | F 225 | | |

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| F 225 | Continued From page 13 | F 225 | | |

extremity.
right thigh 24 1/2" left thigh 28"
right calf 15" left calf 15 1/4"
right ankle 9" left ankle 9"

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.

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.

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 facility Administrator-In-Training, the Certified Social Services Worker and the Director of Nursing further stated that no report of the

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| F 225 | Continued From page 14<br>incident had been made to the State survey and certification agency.<br><br>Allegations of Abuse:<br><br>2. Resident 11 was admitted to the facility with diagnoses which included senile dementia and insulin dependent diabetes.<br><br>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.<br><br>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.<br><br>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 outside agencies, nor had any investigation of the allegations of abuse been done by anyone at the facility.<br><br>The facility Director of Nursing provided a copy of a form titled "Warning Slip" which had been | F 225 | | |

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| F 225 | Continued From page 15<br>completed by a facility charge nurse and which appeared to allege that Certified Nursing Assistant 2 (CNA 2) had been observed "hitting at least 2 X (times) et (and) kicked (sic) at least 2 X (times) in buttocks by this staff".<br><br>The facility Administrator-In-Training, Certified Social Services Worker and Director of Nursing stated they would immediately investigate the alleged incident of abuse and present surveyors with a written report of their findings.<br><br>On 2/22/05 at 10:00 AM, two printed pages headed "Investigation Re: Allegation of Abuse" were reviewed. This record documented that the facility had conducted interviews with several of the facility staff on 2/17/2005 and 2/18/05. The Summary states:<br><br>"It is difficult to determine what happened during this incident.... It is especially difficult to deal with an incident which happened more than a week ago. We feel that the incident is unsubstantiated, but will not allow the CNA involved to work on that side of the Unit anymore ."<br><br>The record was signed by the Administrator-in-Training and the Certified Social Worker.<br><br>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. | F 225 | | |

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| F 225 | Continued From page 16<br>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 retaliate against [her].<br><br>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]. 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.<br><br>3. Resident 12 was admitted to the facility on 12/ 3/04 with diagnoses which included urinary tract infection, senile dementia with depressive features, chronic bronchitis and alcohol abuse.<br><br>During initial tour of the facility on 2/15/05, resident 12 was observed sitting on the edge of [ her] bed in room 114 eating lunch. Resident 12 stated to the surveyor [she] had been "beat up by another resident" and had to keep [her] door closed all of the time because the individual who beat [her] up had come into [her] room one night while [she] was asleep and [she] had awakened 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 occurred. | F 225 | | |

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| F 225 | Continued From page 17<br><br>During initial tour, the surveyor observed the location of the rooms on the 100 hall and noted that room 108 was located in the locked unit at the end of the hallway away from the nurse's station and room 114 was located immediately across the hallway from the nurse's station.<br><br>Resident 12's medical record was reviewed on 2/15/05. The medical record documented that resident 12 had initially been admitted to room 108 on the locked unit on 12/03/04. Resident 12 's admission nursing note dated 12/3/04 documented that resident 12 was admitted after a fall at home and that resident 12 had yellowing bruise marks on [her] face. Resident 12's medical record showed no documentation of bruising on [her] upper arms and upper chest.<br><br>Nurse's Notes in resident 12's medical record document that on 12/18/04 resident 12's family reported to LPN 1 that resident 12 said [she] had "been beat up by another resident". The note further documents that (LPN 1) "could not find any documentation to back this up which was reported to the family".<br>No documentation was noted in resident 12's medical record to explain why [she] had been moved from room 108 to room 114.<br><br>On 2/17/05 an interview was conducted with facility nursing staff Licensed Practical Nurse 1 ( LPN 1) regarding the report by resident 12's family that [she] had been assaulted by another resident. LPN 1 stated that resident 12's family had reported the assault by another resident. LPN 1 did not remember the exact date of this report. LPN 1 stated that resident 12 was admitted to the facility following a fall at home. | F 225 | | |

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| F 225 | Continued From page 18 | F 225 | | |

LPN 1 further stated that since resident 12 was admitted with bruises "over the face, upper arms and upper part of the chest", LPN 1 could not see any difference in the bruising when [she] examined resident 12 after the assault was reported. LPN 1 stated that [she] did not feel it was necessary to report the information or to complete an Incident Report.

During the interview with LPN 1 on 2/17/05, the surveyor asked if resident 12 had ever reported "a man" sitting in resident 12's room. LPN 1 stated " no, but I would not be surprised if [she] had reported a man sitting in [her] room because [she] was on that end of the hall (referring to the locked unit). The surveyor asked why resident 12 had been moved from room 108 to room 114. LPN 1 stated [she] did not know why resident 12 had been moved.

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 were asked about the resident 12's allegation that [she] had been assaulted by another resident. Facility staff present at the interview stated they were not aware of the incident.

Injuries of unknown source:

4. Resident 13 was admitted to the facility with diagnoses which included Alzheimer's disease, hypertension and Schizophrenia.

A review of Incident Report records was

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| F 225 | Continued From page 19<br>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".<br><br>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.<br><br>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 and dementia.<br><br>November 2004 nurse's notes documented the following:<br><br>11/8/04 - 12:10 PM - "order from MD for L (left) hand to r/o (rule out) fx (fracture)."<br>11/8/04 - 4:05 PM - "x-ray results came back. Possible fx of 5th finger on L hand. See under lab results."<br>11/9/04 - 9:00 AM - Resident's L hand swollen +2 edema with discoloration and L little finger swollen +1 edema with discoloration..." | F 225 | | |

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| F 225 | Continued From page 20<br>11/9/04 - 9:30 AM - MD "was notified of x-ray results he suggested to see orothopedic [sic] MD ."<br>11/9/04 - 11:00 AM - "Sent out to ER (emergency room)...for tx (treatment) by orthopedic [sic] MD."<br>11/9/04 - 1:00 PM - Pt. (patient) returned from ER dx (diagnosis) Fx (fracture) L (left) hand 5th proximal phalanx, finger was splinted and wrapped in ace wrap..."<br><br>An incident report regarding resident 4 and her left hand, dated 11/8/04, does not describe the injury. The time listed was 7:00 AM. The nurse circled the left hand on the picture on the form indicating that was the area of concern. The only narrative was "unknown origin". The incident report was signed by the nurse completing the form, the director of nurses and the physician. It was not signed by the administrator.<br><br>Neither the medical record for resident 4 nor facility staff had documentation which would evidence that this significant injury of "unknown origin" was immediately reported to the administrator or the State survey and certification agency. Facility staff were not able to provide any documentation that this injury of "unknown origin" had been investigated to determine the cause.<br><br>Thirty-eight days later, on 12/16/04, this same resident (#4) was "found by CNA in bed, with blood on pillowcase. 2 small lacerations found on back of scalp...Unknown etiology of wounds. Incident report filled out and faxed to Dr. Lacerations 2 cm (centimeters) and 3 cm, respectively. Hair surrounding scalp wounds trimmed, steri strips applied after cleaning with betadine..." | F 225 | | |

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| F 225 | Continued From page 21<br>The incident report for this was not found in the facility's incident report book for 2004.<br><br>The medical record for resident 4 did not contain ( and the facility staff could not provide) documentation to evidence that this injury of " unknown etiology" was immediately reported to the administrator or the State survey and certification agency. The facility did not have documentation to evidence that there had been a thorough investigation into this incident. There was some speculation by the day nurse on 12/16/ 04 and she relayed to the resident's family that the resident "possibly hit head on table." There was no documentation to support this speculation (i.e. blood and hair on bed side table, etc.)<br><br>6. Resident 3 was admitted on 9/16/04 with diagnoses that included hyperthyroidism, congestive heart failure, hypertension, osteoarthritis, dementia, seizure disorder and Schizophrenia.<br><br>Resident 3's medical record was reviewed on 2/ 22/05 and the nurses notes, dated 11/15/04 at 2000 (8:00 PM) documented "Res (resident) found /c (with) R (right) eye bruising. Aides state found in room on floor /c pillow to face earlier this day. No injury to eyes assessed". No other references to this injury were found in the nurses notes.<br><br>Neither the medical record for resident 3 nor facility staff had documentation which would evidence that this injury was reported to the 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. | F 225 | | |

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| F 225 | Continued From page 22 | F 225 | | |

7. On 2/14/05, the State survey and certification agency's computerized intake log for this facility was reviewed. It was noted that since 4/13/04, the facility called in only two reports of suspected abuse, neglect, misappropriation of property or injuries of unknown source. The dates of these reports were 4/13/04 and 11/30/04. Neither of these facility reported entities included information regarding the examples listed in this deficiency. The facility again began to report required allegations on 2/24/05, the day after the State surveyors exited the facility after having shared all the areas of concern.

8. During interview with facility administration on 2/17/05, they stated that they had identified in their quality assurance (QA) meeting, held 12/13/04, that they had not reported everything that needed to be reported.

Review of their QA meeting minutes for 12/13/04, revealed the following:

"Incident reports were reviewed for the month of November and there were a total of 25 reports of these 3 warranted additional investigations that was not completed...We will have the DON conduct investigation of all new unknown origin reports and communicate findings to APS (adult protective services) and State agency when warranted. These will be reviewed by the administrator and the quarterly quality assurance team."

It was 3 days later, on 12/16/04, that resident 4 was found in her bed with blood on her pillow and two lacerations on the back of her head. Facility staff listed the wounds to have an "unknown

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| F 225 | Continued From page 23<br>etiology", but did not report this incident to the administrator or State survey agency. Facility staff did not pursue an investigation into the events surrounding this incident. The identification of this deficient practice by the facility's quality assurance team on 12/13/04 did not follow with a functional or efficient plan of correction. | F 225 | | |
| F 226 SS=G | 483.13(C)(1)(i) STAFF TREATMENT OF RESIDENTS<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>(Use F226 for deficiencies concerning the facility's development and implementation of policies and procedures.)<br><br>This REQUIREMENT is not met as evidenced by :<br>Based on interview and review of records, it was determined that the facility did not implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents for 2 of 22 sampled residents. Specifically, the facility did not provide ongoing training to facility staff on issues related to abuse prohibition practices; did not prevent neglect in assessing and treating resident 9 for a hip fracture; and did not adequately report or investigate allegations of staff abuse for resident 11 nor report or investigate circumstances of neglect for resident 9. Neglect means the failure by the facility to provide goods and services necessary to avoid | F 226 | | |

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| F 226 | Continued From page 24<br>physical harm, mental anguish, or mental illness Resident identifiers 9 and 11.<br><br>Findings include:<br><br>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.<br><br>2. Resident 9 was admitted to the facility with diagnoses which included quadriplegia and depression.<br><br>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 ] 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] | F 226 | | |

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| F 226 | Continued From page 25 | F 226 | | |

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:

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

| | | | |
|---|---|---|---|
| right thigh | 24 ½" | left thigh | 28" |
| right calf | 15" | left calf | 15 ¼" |
| ankle | 9" | left ankle | 9" |

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.

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, the facility "Anti-Abuse Policy for

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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 "How Staff Will be Monitored During Delivery of Care & Services: All facility staff must be monitored during their work performance to assure there is no evidence of neglect of care to those residents whom they provide daily care for. This will be accomplished by the following protocol:" The policy further lists and explains the procedures for the responsibility of facility charge nurses, DON (Director of Nursing) and ADON ( Assistant Director of Nursing) to monitor staff work performance and ensure that neglect does not occur.

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.

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 inpatient acute care in May 2004, the facility Director of Nursing stated than an Incident Report had not been completed for Resident 9's hip fracture. The facility's Administrator-In-Training, the Certified Social Services Worker and the Director of

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| F 226 | Continued From page 27<br>Nursing further stated that no report of the incident had been made to the State survey and certification agency.<br><br>3. Resident 11 was admitted to the facility with diagnoses which included senile dementia and insulin dependent diabetes.<br><br>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<br><br>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. ...<br><br>What Outside Agencies Must be Notified of the Suspected Abuse?<br>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 | F 226 | | |

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| F 226 | Continued From page 28<br>call needs to be made within one working day from receiving the allegation.<br><br>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.<br><br>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.<br><br>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 outside agencies, nor had any investigation of the allegations of abuse been done by anyone at the facility.<br><br>The facility Director of Nursing provided a copy of a form titled "Warning Slip" which had been completed by a facility charge nurse and which appeared to allege that Certified Nursing Assistant 2 (CNA 2) had been observed "hitting at least 2 X (times) et (and) kicked (sic) at least 2 X (times) in buttocks by this staff". | F 226 | | |

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| F 226 | Continued From page 29<br>The facility Administrator-In-Training, Certified Social Services Worker and Director of Nursing stated they would immediately investigate the alleged incident of abuse and present surveyors with a written report of their findings.<br><br>On 2/22/05 at 10:00 AM, two printed pages headed "Investigation Re: Allegation of Abuse" were reviewed. This record documented that the facility had conducted interviews with several of the facility staff on 2/17/2005 and 2/18/05. The Summary states:<br><br>"It is difficult to determine what happened during this incident.... It is especially difficult to deal with an incident which happened more than a week ago. We feel that the incident is unsubstantiated, but will not allow the CNA involved to work on that side of the Unit anymore ."<br><br>The record was signed by the Administrator in Training and the Certified Social Worker.<br><br>On 2/23/05 at 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. 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 | F 226 | | |

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| F 226 | Continued From page 30<br>CNA 2 would retaliate against [her].<br><br>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 226 | | |
| F 241 SS=E | 483.15(a) QUALITY OF LIFE<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by :<br><br>Based on observation the facility did not promote care for some of the residents in a manner that maintained or enhanced the dignity and respect in full recognition of his or her individuality for 1 out of 22 sampled residents and for 5 supplemental residents. (Resident identifiers: 13, 23, 24, 25, 26, and 27)<br><br>Findings included:<br><br>1. On 2/15/05 at 8:30 AM breakfast was observed in the south east dining room. Resident 13, who was in a wheelchair with a lap buddy, and resident 25, who was sitting in a chair at the same | F 241 | F241 Nursing staff will be inserviced on dignity of residents during meals. Resident 13's lab buddy will be removed during meals, Resident 24, 25 & 13 will be properly positioned during meals, (aides will not stand), Resident 13, 24, 26, 27 hair will be combed daily by staff. All residents will be properly positioned at meal time. D.O.N. Will monitor weekly During meal time rounds and report to QA committee<br><br>Completed by April 8, 2005. CR | |

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| F 241 | Continued From page 31<br>table needed assistance with dining. CNA 4, who was observed standing, fed resident 13 and 25. Resident 13 was not assisted to sit in an upright position during the meal. Since the CNA remained standing it forced resident 13 to lean back in his wheelchair, hyper-extend his neck, lift his chin and open his mouth.<br><br>2. On 2/15/05 at 12:40 PM lunch was observed in the south east dining room. CNA 2, who was observed standing, fed resident 13 and resident 24. Resident 13 was not assisted to sit in an upright position during the meal. Since the CNA remained standing it forced resident 13 to lean back in his wheelchair, hyper-extend his neck, lift his chin and open his mouth.<br>CNA 4, who was observed standing, fed resident 25 lunch.<br><br>3. On 2/16/05 at 8:50 AM resident 13, resident 24 , resident 26 and 27 were observed in the south east dining room with hair looking disheveled and not combed.<br><br>4. On 2/16/05 at 12:45 PM lunch was observed in the southeast dining room. CNA 3, who was observed standing, fed resident 13 lunch. Resident 13 was not assisted to sit in an upright position during the meal. Since the CNA remained standing it forced resident 13 to lean back in his wheelchair, hyper-extend his neck, lift his chin and open his mouth. CNA 4, who was observed standing, fed resident 24 and resident 25 lunch. CNA 5, who was observed standing, fed resident 23 lunch. | F 241 | | |
| F 253 SS=E | 483.15(h)(2) ENVIRONMENT<br><br>The facility must provide housekeeping and | F 253 | | |

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| F 253 | Continued From page 32<br>maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by :<br><br>Based on observation, the facility did not provide housekeeping and maintenance services necessary to maintain sanitary, orderly and comfortable interior as evidenced by inadequate housekeeping and maintenance.<br><br>Findings included:<br><br>During an inspection of the facility on 2/15/05 through 2/23/05 the following items were revealed:<br><br>1. On 2/22/05 at 8:55 AM the south west dining room, across from the south nurses' station was observed. Eleven out of 18 chairs had dried food particles on the arms of the chairs. One chair's left arm was lose and could be raised up approximately 3 inches. One out of 5 tables was unstable and wobbled from side to side.<br><br>2. On 2/15/05 at 7:00 AM the south east dining room was observed. On the west side of the dining room was a counter with a television duct taped to the counter. Just below and in front of the television the counter's edge was missing a 3 1/2 inch by 1 inch section of laminate. Near the corner of the counter's edge on the entry door side was a 1 and 1/8 inch by 1 inch section of laminate missing.<br><br>3. On 2/15/05 at 12:30 AM the shower room across from room 102 was observed. There was a 48 inch by 30 inch by 6 inch divider wall in the shower room. There were 2 ceramic tiles missing | F 253 | F253 Nursing staff will be inserviced on the proper storage of personnal items, ointments, and keeeping laundry barrels covered. D.O.N. will monitor during nursing rounds and report to the QA committee monthly.<br>Lap buddies in disrepair will be thrown away. Restorative Nursing staff will monitor lap buddies weekly assuring only lap buddies in good repair are used for residents. D.O.N. will report condition of lap buddies to the QA committee monthly<br>Arm rest padding on all Hoyer lifts will be replaced. Restorative Nursing Staff will monitor to assure Hoyer lifts are in good repair and clean. D.O.N. will report to the QA committee monthly<br><br>Completed by April 8, 2005. | |

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| F 253 | Continued From page 33<br>from the 6 inch wide part of the divider wall 3 inches up from the floor. There was a container of overflowing dirty laundry with a towel that had numerous dark red spots, not unlike blood, on the top. The container of laundry was uncovered.<br><br>4. On 2/15/05 at 12:45 PM the north nurses' station was observed. The column at the north end of the nurses station had torn and peeling wall paper near the floor and the cap of the corner guard was missing, exposing bare metal.<br><br>5. On 2/22/05 at 1:20 PM the shower room across from the south nurses station was observed. Upon entering the shower room the north wall was observed to have numerous areas of peeling paint.<br><br>The first shower stall observed was being used for storage.<br><br>The second shower stall on the south wall above the base board tile was a 2 foot by 3 foot area of peeling paint and eroding wall. There was a 48 inch by 30 inch by 6 inch divider wall in the shower room. There were 3 ceramic tiles missing from the 6 inch wide part of the divider wall. The shower curtain located in this stall had a dime size area of a brown raised substance, not unlike feces, located near the edge of the curtain approximately 5 feet from the floor. The wooden shower seat had areas of exposed bare wood. The varnish and wood stain were wearing off.<br><br>The third shower stall at the entry way had 2 baseboard tiles missing on the south side and 3 baseboard tiles missing on the north side. On the wall where the water faucet was located grout was missing directly below the faucet and down to | F 253 | F253<br>All chairs in the diningroom have been Repaired, as have the tables. Housekeeping will clean chairs after Each meal.<br><br>This will be monitored by the Housekeeping supervisor weekly<br><br>The broken laminate will be replaced On the countertop. Housekeepers Have lists on their carts where they Will note items that need repair. The Lists will be turned over to their Supervisor weekly, and she will Make sure it is on the maintenance Log, and completed.<br><br>All missing tile has been replaced in The shower rooms. The shower Benches have been refinished. Painting has been done in the shower Rooms. All of the shower rooms Will be checked on a monthly basis By maintenance.<br><br>The soiled linen have lids now, And will be monitored by maintenance. monthly<br>The frayed carpet has been fixed, and Will be monitored by maintenance monthly<br><br>Completed by April 8, 2005.<br><br>CF | |

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| F 253 | Continued From page 34<br>the floor. The wooden shower seat had areas of exposed bare wood. Approximately twenty per cent of the varnish and wood stain was worn off . One long slat was all bare wood.<br><br>6. On 2/23/05 at 9:20 AM the shower room across from room 301 was observed. One inch above the shower faucet in the 12 o'clock position was a 1 and 1/4th inch by 1 inch by 1 and 1/2 inch triangular hole in the wall. It appeared that a piece of tile was missing.<br><br>Located on a chair next to the sink in the shower room was a pink basin that had the following personal care items in it; tube of toothpaste, 2 combs, a tube of Bacitracin ointment, a Chopstick, a tube of Elidel ointment, a pencil and a pony tail band. The bottom of the pink basin had numerous white, black , blue, and brown raised crusty material on it. There was no name on the basin.<br><br>At 9:25 AM a certified nursing assistant (CNA) number 1 was interviewed. CNA 1 was asked if she knew who owned the basin with the personal care items in it. She picked it up, looked at it and stated, "I don't know who it belongs to. This is pretty nasty." The CNA then put the basin down and left the room.<br><br>7. On 2/23/05 at 9:40 AM the shower room across from the north nurses' station was observed. On the south wall of the entry hallway there were numerous areas of peeling paint. The largest area measured 4 feet by 1 inch long, and was 3 feet up from the floor. On the north wall of the entry hallway there was a 30 1/2 inch by 2 inch section of peeling paint. | F 253 | | |

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| F 253 | Continued From page 35<br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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 | F 253 | | |

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| F 253 | Continued From page 36<br>missing. On the morning of 2/23/05 resident 13 was utilizing a green lap buddy that was in good repair. The afternoon of 2/23/05 the previous black lap buddy that was in disrepair was again being utilized.<br><br>12. On 02/22/05 at 8:50 AM two Hoyer lifts were observed in the 200 hallway. Hoyer lift one had brown arm rests which attached to a sheepskin lift seat. The arm rests had padding and the padding was torn off on the outer edges of both the arm rests exposing a layer of foam. The sheepskin sling had crusted brown material noted in several areas of the seat and the general appearance of the sheepskin was matted. | F 253 | | |
| F 274 SS=B | 483.20(b)(2)(ii) RESIDENT ASSESSMENT<br><br>Within 14 days after the facility determines, or should have determined, that there has been a significant change in the residents physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the residents status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the residents health status, and requires interdisciplinary review or revision of the care plan, or both.)<br><br>This REQUIREMENT is not met as evidenced by :<br><br>Based on record review, it was determined that for 2 of 22 sample residents, the facility did not conduct a comprehensive, significant change assessment or interdisciplinary review within 14 | F 274 | F274 A new MDS Coordinator has been hired fulltime. MDS Coordinator will be oriented to RAI Manual that determines when a comprehensive, significant change assessment/IDT review is required Residents 4&5 MDS will be reviewed to assess if a Significant Change correction should be done. MDS Coordinator will attend daily stand up meeting and communicate with staff nurses for significant change in residents condition. D.O.N. will monitor weekly and report to QA committee monthly to assure that all residents with Significant Change MDS has been completed.<br><br>Completed by April 8, 2005. | |

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| F 274 | Continued From page 37<br>calendar days of determining that the resident had a decline or improvement in two or more areas of care.<br>Resident identifiers: 4 & 5<br><br>A review of resident 4's medical record conducted on 2/15/2005 revealed the following:<br><br>Resident 4 was admitted to the facility on 6/19/1997 with diagnosis including Parkinson's , hypertension, post surgical status, history of meningioma, and chronic dementia.<br><br>On 10/5/2004 resident 4 had a quarterly minimum data set done and on 01/01/2005 another quarterly minimum data set was done. Upon comparison of the two assessments it was determined that the resident had a significant change in status in three areas per facility documentation.<br><br>On 10/5/2004 resident 4 was assessed as being moderately impaired in cognitive skills for making daily decisions, on 01/01/2005 resident 4 was assessed as being severely impaired in cognitive skills for making daily decisions. On 10/5/2004 resident 4 was assessed as needing limited assistance with transfers and on 01/01/2005 resident 4 was assessed as needing extensive assistance with transfers. On 10/5/2004 resident 4 was assessed as needing limited assistance with dressing and on 01/01/2005 resident 4 was assessed as needing extensive assistance with dressing.<br><br>A review of resident 5's medical record on 2/15/2005 revealed the following:<br><br>Resident 5 was admitted to the facility on 12/14/ | F 274 | | |

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| F 274 | Continued From page 38<br>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.<br><br>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 274 | | |
| F 278 SS=D | 483.20(g) - (h) RESIDENT ASSESSMENT<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly--<br>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<br>Causes another individual to certify a material and false statement in a resident assessment is | F278 | A new MDS Coordinator has been hired and oriented on the accuracy of MDS including listing restraints and infections. Residents 13 & 10's MDS has been reviewed and corrected. All residents most current MDS will be reviewed to assure restraints & infections are accurate. D.O.N. will monitor accuracy thru MDS audit tool monthly and report to QA committee.<br><br>Completed by April 8, 2005.<br><br>OK | |

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| F 278 | Continued From page 39<br>subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br>This REQUIREMENT is not met as evidenced by :<br><br>Based on observation, record review and interview the facility staff did not assure that 2 out of 22 resident's assessments accurately reflected the resident's status. (Resident identifiers: 13 and 10)<br><br>Findings included:<br><br>1. Resident 13 was admitted to the facility on 9/9/04 with diagnoses that included Alzheimer's disease and schizophrenia.<br><br>Resident 13's medical record was reviewed on 2/17/05.<br><br>Resident 13's quarterly Minimum Data Set dated 12/22/04 was reviewed. Section P 4, Devices and Restraints documents no use of restraints for resident 13.<br><br>Resident 13's "Fall Risk Assessment/Side Rail & Restraint Use" quarterly assessments for 9/22/04 and 12/22/04 under section I documented that a lap buddy was being utilized.<br><br>A physician's telephone order for resident 13 dated 9/30/04 ordered a lap buddy restraint prn ( as needed).<br><br>A physician's telephone order for resident 13 dated 11/6/04 ordered a "lap buddy while out of bed." | F 278 | | |

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| F 278 | Continued From page 40<br><br>Resident 13's "Fall Risk Care Plan" dated 11/7/04 revealed and documented that resident 13 was to have a "Lap buddy in W/C (wheelchair) d/t (due to ) poor sitting balance.<br><br>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 resident's unsteady gait. The CNA stated that when the resident first awakens in the morning, he/she is put into the wheelchair with lap buddy.<br><br>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. LPN 2 stated that resident 13 is put into a wheelchair with a lap buddy because of occasionally being unstable when ambulating.<br><br>Resident 13 was observed in a wheelchair with a lap buddy on, on 2/15/05 from 8:15 AM to 10:15 AM and at 12:40 PM, on 2/16/05 at 2:45 PM and on 2/17/05 at 8:30 & 10:30 AM.<br><br>2. Resident 10 was admitted to the facility with diagnoses which included: Senile dementia, dementia with psychosis, AIDS (HIV) and constipation.<br><br>A review of medical records for Resident 10 was 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 | F 278 | | |

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| F 278 | Continued From page 41<br>Infection, was checked, indicating resident 10's diagnosis of "AIDS".<br><br>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.<br><br>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 278 | | |
| F 279 SS=D | 483.20(k) RESIDENT ASSESSMENT<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the following:<br>The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under s483.25; and<br><br>Any services that would otherwise be required under s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483. 10(b)(4). | F 279 | F279 Resident 13' Plan of Cares will be reviewed and updated to reflect residents current condition including mobility, lab buddy and Antipsychotic record/plan of care. Resident 15's care plan will be reviewed & updated to reflect current condition & assure all triggered RAP's addressed including Infection. Newly hired MDS Coordinator will be inserviced on addressing all triggered RAPS and keeping Care Plans current on all residents. D.O.N. will monitor monthly and report to QA commitee<br><br>OK<br><br>Completed by April 8, 2005. | |

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| F 279 | Continued From page 42<br><br>This REQUIREMENT is not met as evidenced by :<br><br>Based on record review, observation and interview, it was determined that the facility did not maintain accurate care plans for 2 of 22 sampled residents. (Resident identifiers: 13, 15)<br><br>Findings included:<br><br>1. Resident 13 was admitted to the facility on 9/9 /04 with diagnoses that included Alzheimer's disease and schizophrenia.<br><br>Resident 13's medical record was reviewed on 2/17/05.<br><br>a. Resident 13's "Fall Risk Care Plan" dated 11/7/04 revealed and documented the following:<br>1. Current ambulation ability: independent<br>2. Resident 13 was to have "Lap buddy in W/ C (wheelchair) d/t (due to) poor sitting balance.<br>3. 12/04/04 mattress on floor d/t frequent falls<br><br>Observations:<br><br>On 2/15/05 at 8:15 AM just prior to breakfast, the resident was put into a wheelchair with a black lap buddy. Since the resident needed total assistance with his meals, and the CNA remained standing, it forced resident 13 to lean back in his wheelchair, hyper-extend his neck, lift his chin and open his mouth in order to receive food. Resident 13 was not assisted to sit in an upright position during the meal.<br><br>On 2/15/05 at approximately 10:15 AM resident 13 was taken to his room. Personal cares were | F 279 | | |

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| F 279 | Continued From page 43<br>completed and the resident was put to bed. The bed was a regular hospital bed placed in the low position. There was no mattress on the floor next to the bed.<br><br>On 2/15/05 at 12:40 PM lunch was observed in the south east dining room. The resident was kept in the wheelchair with lap buddy on during lunch. Since the resident needed total assistance with his meals, and the CNA remained standing, it forced resident 13 to lean back in his wheelchair, hyper-extend his neck, lift his chin and open his mouth in order to receive food. Resident 13 was not assisted to sit in an upright position during the meal.<br><br>On 2/16/05 at 2:40 PM Resident 13 was observed standing in his/her room between the bed and the window in his/her room. Within 1 minute, a CNA saw resident 13 out of bed and immediately put the resident into a wheelchair with a lap buddy.<br><br>Interviews:<br><br>On 2/15/05 at 12:30 PM CNA 7 was interviewed. CNA 7 stated that resident 13 is suppose to be in a wheelchair with a lap buddy in place when he is out of bed. CNA 7 stated that resident 13 is put into a wheelchair with a lap buddy to prevent him/her from falling.<br><br>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 resident's unsteady gait.<br><br>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. | F 279 | | |

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| F 279 | Continued From page 44<br>LPN 2 stated that resident 13 is put into a wheelchair with a lap buddy because of his/her occasional unsteady gait.<br><br>On 2/17/05 at 9:05 AM, the facility physical therapist (PT), who assessed resident 13 on two different occasions, was interviewed. The PT stated that the immediate solution to prevent resident 13 from falling was to put him in a wheelchair with a lap buddy.<br><br>b. Resident 13's "Seizure Disorder-History" Care Plan dated 9/22/04 and reviewed on 12/22/04 by facility staff was reviewed and documented the following: Medications as ordered Depakote Sprinkles 500 mg (milligrams) BID&250 mg Q PM (every night) for seizure control.<br><br>A review of the Anti-Psychotic Monthly Record dated February-05 documented that the Depakote medication was being given for " delusional behaviors."<br><br>A review of the February 2005 physician's recertification orders documented that resident 13 was receiving the Depakote for the diagnosis of " Alzheimer's Disease."<br><br>On 2/23/05 at 1:00 PM the DON (Director of Nursing) was interviewed. The DON stated that she called resident 13's physician and he stated that resident 13 was receiving the Depakote for control of delusional behaviors. The DON further stated that the physician stated that Depakote blood levels did not need to be monitored since the Depakote was prescribed for the management of behaviors, and not for control of seizures. | F 279 | | |

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| F 279 | Continued From page 45<br>2. Resident 15 was admitted on 10/3/04 with diagnoses that included chronic hepatitis C, Schizophrenia, Diabetes mellitis and brain injury.<br><br>Resident 15's medical record was reviewed on 2/23/05.<br><br>Resident 15's initial MDS (minimum data set), dated 11/24/04, Section I. Disease Diagnoses part 2. infections, did not identify (k) viral hepatitis . This resulted in the condition not being triggered on the RAPS (Resident Assessment Protocol) and a care plan was not done.<br><br>Resident 15's care plan did not address the chronic hepatitis C, which is an infectious disease .<br><br>In an interview, on 2/23/05 at 3:45 PM, with the DON she stated she was not aware that Resident 15's MDS did not address hepatitis, and did not know why it was not on the MDS or the care plan. | F 279 | | |
| F 309 SS=E | 483.25 QUALITY OF CARE<br><br>Each resident must receive and the facility must provide 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.<br><br>Use F309 for quality of care deficiencies not covered by s483.25(a)-(m).<br><br>This REQUIREMENT is not met as evidenced by : | F 309 | | |

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| F 309 | Continued From page 46<br>Based on observation, interview and review of medical records, it was determined that for 5 of 22 sampled residents, the facility did not provide the necessary care and services to attain or maintain each resident's highest practicable physical, mental and psychosocial well-being. Resident identifiers: 3, 13, 16, 19, 20.<br><br>Findings included:<br><br>1. Resident 19 was a 39 year old with Multiple Sclerosis whom the facility on 10/28/04 requested from the physician an order for a urinalysis and a culture and sensitivity because the resident's urine was cloudy with particles noted. An order was given by the physician to obtain a urinalysis and culture and sensitivity. On 10/29/04 there was a nurse's note indicating the results of the urinalysis was faxed to the physician's office. On 10/31/04 in the nurse's notes there was documentation of a lot of sediment in the urine from the catheter and the physician would be notified on Monday (tomorrow) and make sure he had received the faxed results of the urinalysis.<br><br>On 11/02/04 there was a nurse's note which indicated the suprapubic catheter tip was found outside of the bladder and the catheter was changed with a 22 french Foley catheter without problems.<br>On 11/03 the nurse's notes stated the physician's office was called to report the resident was depressed and crying, stating he was hearing voices again and asked if the office had received the last urinalysis report that was faxed on 10/29/04, the office indicated they would call back with the answer.<br>On 11/04/04 nurse's notes stated they had re faxed the urinalysis results to the physician's | F 309 | F309 Resident 3, 13, 16, 19, 20 will be reviewed for appropriate lab orders and followup. Licensed nurses will be inserviced on the importance of timely follow-up of lab reports MDS and/or D.O.N. will review all lab orders daily and monitor to assure that lab reports are on the charts, proper documentation has been done as well as proper follow-up and orders obtained and carried out. D.O.N. will report to monthly QA committee Resident 13 will be evaluated by Physical Therapy for gait strenghtening/proper body Alienment, and for least restrictive restraint. All nursing staff will be Inserviced on use of least restrictive restraint, including PT or Restorative Nursing. Restraints will be monitored by the D.O.N. thru the QA Action Committee weekly<br><br>Completed by April 8, 2005. | |

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| F 309 | Continued From page 47<br>office.<br>On 11/17/04 the nurse's notes stated the suprapubic catheter was patent and draining by gravity with clear yellow urine.<br>12/04/04 the nurse's notes stated the suprapubic catheter was draining yellow urine, and that the suprapubic insertion site showed no drainage or inflammation.<br>Review of the medical record showed no evidence to support results of a urinalysis or culture and sensitivity as ordered on 10/28/04.<br>On 2/23/05, the State Surveyor requested the staff LPN on duty to place a call to the specified laboratory services and request a copy of the urinalysis and culture and sensitivity. A copy of the urinalysis and culture and sensitivity was presented to the State Surveyor on 2/23/05 with the following results:<br><br>Urinalysis: Catheter specimen, positive for nitrites, moderate amount of hemoglobin, 2+ protein, moderate leukocyte esterase.<br>Culture and sensitivity revealed the following: > 100,000 Colony forming units Pseudomonas aeruginosa, 50,000 Colony forming units Enterococcus faecalis. Several antibiotics were noted to be sensitive to the Pseudomonas aeruginosa as well as several antibiotics were noted with sensitivities to the Enterococcus faecalis. Review of the medical record medication administration record and physician orders showed no antibiotics were ordered for this resident from 10/28/04 thru 11/04/04 for a Urinary Tract Infection.<br><br>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 | F 309 | | |

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| F 309 | Continued From page 48<br>pathology and the normal aging process.<br><br>Although the facility recognized and requested the urinalysis, culture and sensitivity and after faxing results to the physician on 10/29/04 and documenting a need to follow up again on 10/31/04, the facility failed to assure the resident received an appropriate antibiotic for two specific colonized strains of bacteria.<br><br>Urinary Tract infections have the potential to lead to sepsis.<br><br>2. Resident 16 was a 69 year old male/female.<br><br>On 02/15/05 at 5:00 PM, the nurse documented that resident 16 experienced two episodes of diarrhea. The records indicate that the nurse called the physician and the physician gave orders for Imodium one to two tablets then one tablet after each loose stool prn (as needed), not to exceed four capsules a day "diagnosis diarrhea ".<br>On 2/16/05 at 6:00 PM a review of the medical record showed an order "If diarrhea returns, perform C-Dif toxin (Clostridium difficile) times 3, culture and sensitivity, Giardia antigen, hemoccult and fecal leukocytes".<br>On 02/21/05 the a note in the resident's medical record indicated diarrhea stools five times. A stool sample was collected on 02/21/05 and sent to the lab. Lab results reported showed stool culture with result of "no lactose-negative organisms isolated".<br>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 highest practicable physical well-being in | F 309 | | |

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| F 309 | Continued From page 49 | F 309 | | |

accordance with the plan of care as they failed to follow up with completing specific ordered labs. A facility LPN was interviewed on 2/23/05. After discussing the ordered labs which could not be found, the LPN called the laboratory. She confirmed that the labs had not been requested or performed.

3. Resident 20 (closed record review-resident discharged) was admitted to the facility on 6/20/04.

Review of the medical record documentation on 07/15/04 revealed an order from the physician to discontinue the Foley catheter if the resident and family were okay with this. The physician directed the family and resident be notified of risks for urinary tract infection if the Foley catheter was left in. On 07/16/04 resident # 20 refused to have the Foley catheter removed because she had concerns about frequency of urination without the catheter. Nursing notes indicated resident was informed about the risk of infection if the catheter was not removed.

On 7/23/04 (Friday) at 9:00 AM it was noted the physician's office was called regarding a urinalysis report. It was noted the office was closed for holiday and the information would be passed on to notify the physician on Monday of the report. Nursing documentation did not reveal if the catheter was removed nor a urine obtained for analysis; however, the physical therapy notes indicated "frequency" in their comments along with "on diuretic" which was documented 7/16/04, 7/17/04, 7/18/04 then "WNL (within normal limits)" documented on 7/19/04, 7/2004, 7/21/04 and 7/22/04 incontinent of urine.

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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| F 309 | Continued From page 50<br>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.<br>The medical record contained an undated form for Infection on Admission with indication of none (?) and no indication of nosocomial infection.<br>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.<br>4. Resident 3 was admitted on 9/16/04 with diagnoses that included hyperthyroidism, congestive heart failure, hypertension, osteoarthritis, dementia, seizure disorder and Schizophrenia.<br><br>Resident 3's medical record was reviewed on 2/22/05.<br><br>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.<br><br>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 | | |

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| F 309 | Continued From page 51<br><br>The antibiotic Rocephin is listed in the Nursing 2005 Drug Handbook, Lippincott Williams & Wilkins, page 115 documents ....caused by such susceptible microorganism as streptococci; penicillinase-and non-penicillinase-producing Staphlococcus aureus, Staphlococcus epidermidis, Escherichia coli, Haemophilus influenzae, Neisseria meningitidis, Neisseria gonorrheae, Serratia marcescens, Enterobacter, Klebsiella, Proteus, Peptostreptococcus, and Pseudomonas species. The bacteria Enterococcus faecalis is not listed as one of the susceptible microorganism.<br><br>There was no documentation in the medical record that the physician was notified of resident 3's culture report.<br><br>5. Resident 13 was admitted to the facility on 9/9/04 with diagnoses that included Alzheimer's disease, hypertension, and schizophrenia.<br><br>Resident 13's medical record was reviewed on 2/17/05.<br><br>An admission nursing assessment for resident 13 dated 9/22/04, revealed that facility staff had documented that resident 13 was a high risk for falls.<br><br>A quarterly Minimum Data Set (MDS) assessment for resident 13 dated 12/22/04, revealed that facility staff had documented | F 309 | | |

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| F 309 | Continued From page 52<br>resident 13 had short term memory problems and had severe difficulty for daily decision making. The facility staff documented on the MDS assessment that resident 13 had a history of falls. The facility staff also documented on the MDS assessment that resident 13 required supervision for transfers, ambulation and did not use any restraints.<br><br>Resident 13's "Fall Risk Assessment/Side Rail & Restraint Use" quarterly assessments for 9/22/04 and 12/22/04 under section I documented that only a lap buddy had been tried and that no restraint alternatives, such as increased supervision had been attempted since admission on 9/9/04.<br>9/28/04<br>Resident 13's "Restraint Evaluation and Quarterly Review for Elimination" assessment dated was reviewed. The facility physical therapist (PT) documented that "pt. (patient) has a hx (history) of occasionally falling, but does not need restraints at this time".<br><br>A physician's telephone order for resident 13 dated 9/30/04 ordered a lap buddy restraint prn ( as needed).<br><br>Interdisciplinary Team (IDT) notes for resident 13 dated 10/4/04 revealed under Documentation Reviewed in chart that a circle with a line through it was marked for Physical Restraint Doc. ( documentation). It was documented in the " Comments" section that resident 13 wanders up & down the hallway, lays on the floor and wanders at mealtime.<br><br>A physician's telephone order for resident 13 dated 11/6/04 ordered a "lap buddy while out of | F 309 | | |

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| F 309 | Continued From page 53<br>bed."<br><br>Resident 13's "Fall Risk Care Plan" dated 11/7/04 revealed and documented the following:<br>1. Current ambulation ability: independent<br>2. Resident 13 was to have "Lap buddy in W/C (wheelchair) d/t (due to) poor sitting balance.<br>3. 12/04/04 mattress on floor d/t frequent falls<br><br>Interdisciplinary Team (IDT) notes for resident 13 dated 12/22/04 revealed under Documentation Reviewed in chart that a circle with a line through it was marked for Physical Restraint Doc. ( documentation). It is documented in the " Comments" section that resident 13 "wanders up and down the hall. Lays on the ground...Pt. ( patient) has fallen out of bed which resulted in pt needing a bed on the floor."<br><br>Observations:<br><br>On 2/15/05 at 7:15 AM resident 13 was ambulating in the hallway of the south east unit without difficulty. At 8:15 AM just prior to breakfast, the resident was put into a wheelchair with a black lap buddy. The resident was kept in the wheelchair with lap buddy on during breakfast . Since the resident needed total assistance with his meals, and the CNA remained standing, it forced resident 13 to lean back in his wheelchair, hyper-extend his neck, lift his chin and open his mouth in order to receive food. Resident 13 was not assisted to sit in an upright position during the meal.<br><br>On 2/15/05 between 9:00 AM and 10:15 AM, resident 13 was observed in the dining room. While an activity was in progress, at 9:35 AM, the | F 309 | | |

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| F 309 | Continued From page 54 | F 309 | | |

resident unsuccessfully tried to stand up. The resident kept pulling and pushing on the lap buddy with his hands but was unable to remove it. At 10:00 AM the resident unsuccessfully tried to stand up 4 times in a row. At approximately 10:15 AM resident 13 was taken to his room. Personal cares were completed and the resident was put to bed. The bed was a regular hospital bed placed in the low position. There was no low bed. There was no mattress on the floor.

On 2/15/05 at 12:40 PM lunch was observed in the south east dining room. The resident was kept in the wheelchair with lap buddy on during lunch. Since the resident needed total assistance with his meals, and the CNA remained standing, it forced resident 13 to lean back in his wheelchair, hyper-extend his neck, lift his chin and open his mouth in order to receive food. Resident 13 was not assisted to sit in an upright position during the meal.

On 2/16/05 at 2:40 PM Resident 13 was observed standing in his/her room between the bed and the window in his/her room. Within 1 minute, a CNA saw resident 13 out of bed and put him into a wheelchair with a lap buddy.

On 2/17/05 at 8:30 AM and 10:00 AM resident was observed in his/her wheelchair with the lap buddy in place.

Interviews:

On 2/15/05 at 12:30 PM CNA 7 was interviewed. CNA 7 stated that resident 13 is suppose to be in a wheelchair with a lap buddy in place when he is out of bed. When asked why resident 13 was seen ambulating in the hallway that morning, the

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| F 309 | Continued From page 55 | F 309 | | |

CNA replied that when he/she first gets up in the morning he/she is stable when walking. The CNA stated that when resident 13 gets tired the resident will lean to one side and start walking in circles. Then, the resident may fall down or will sit on the floor.

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 resident's unsteady gait. The CNA stated that when the resident first awakens in the morning, he/she is put into the wheelchair with lap buddy. CNA 2 stated that there is no restorative nursing done in the closed unit.

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. LPN 2 stated that resident 13 is put into a wheelchair with a lap buddy because of occasionally being unstable when ambulating. When asked if resident 13 had received any less restrictive measures for fall prevention or any nursing restorative care to help with ambulation, LPN 2 confirmed that resident 13 had not.

On 2/17/05 at 8:00 AM the Supervisor for Restorative Nursing was interviewed. The supervisor stated that neither he nor any of the restorative staff had ever received a referral for or had worked with resident 13.

On 2/17/05 at 9:05 AM, the facility physical therapist (PT) was interviewed. The PT stated that he filled out the "Restraint Evaluation and Quarterly Review for Elimination" forms on 9/28/04 and 12/28/04 for resident 13. The PT stated that he was not familiar with the residents in the

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| F 309 | Continued From page 56<br>SNU so he talked with the unit manager and observed resident 13 for a couple of days. The PT was made aware of the resident's history of falls while ambulating to and from the resident's bed. The PT stated that during an observation resident 13 was leaning to one side, walking in a circle and stumbled. He stated that the CNAs had to steady the resident so he/she wouldn't fall. The PT stated that the immediate solution for the resident's safety was to put him in a wheelchair with a lap buddy and a low bed. The PT stated that the main thing he concluded from his observations and staff interviews was that resident 13 had ups and downs with coordination and that staff needed to periodically walk with him . The PT stated that he and the unit manager had discussed using the lap buddy especially during meal times because "supervision wouldn't be real good", because the CNAs would be busy feeding resident 13 and other residents who needed assistance.<br><br>(The Restraint Evaluation and Quarterly Review for Elimination form documented the following: " Every resident upon admission will be evaluated by the Physical Therapy department for the use and possible need of physical restraints and/or side rails. The application of physical restraints and/or use of side rails may only be accomplished by the completion of the following assessment, PT evaluation, and subsequent doctor's order and patient/family notification. At any time where there is a question of resident safety and well being in regards to unsteady gait, multiple falls, or change in cognitive and/or physical status, another evaluation may be done to again assess the need for physical restraints and/or side rails.") | F 309 | | |
| F 323 | 483.25(h)(1) QUALITY OF CARE | F 323 | | |

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| F 323 SS=G | Continued From page 57 | F 323 | | |

The facility must ensure that the resident environment remains as free of accident hazards as is possible.

This REQUIREMENT is not met as evidenced by :

Based on interviews and review of medical records, it was determined that for 2 of the 22 sample residents, the facility did not ensure their environment remained as free of accident hazards as possible. Specifically, one resident (4 ) climbed over the side rails on her bed and fell to the floor. Another resident (13) caught his arm in the end of the bed. Resident identifiers: 4 and 13 .

Findings include:

1. 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 and dementia.

The MDS (minimum data set), a mandatory comprehensive assessment of the resident completed by facility staff, dated 1/1/05, documented that resident 4 had severely impaired decision making skills, needed extensive assistance with bed mobility and transfers and had an unsteady gait with falls in the prior 31-180 days. The MDS also documented the use of one side rail while the resident was in bed.

A review of the care plan for resident 4, dated 4/3/04, revealed that she should have side rails up times one. The physician's orders for November

F 323

Side Rails will be marked with colored tape to identify up X's 1 Green Tape X's 2 Yellow tape, Do not use siderails Red Tape. All staff will be inserviced On color coded SR tape. All resident beds will be checked to reflect low bed, lower bed, mat on floor per plan of care. Aides will monitor daily to assure low beds, mats, & proper restraint is used for a resident per plan of care. D.O.N. will review T.O. orders for restraints To assure that the proper documentation is in place, least restrictive used, & proper restraint applied.

Completed by April 8, 2005.

A log book is now located at each nurses station that lists all residents on that section with a restraint order. The oncoming aides will check the book and verify it against the residents that they are responsible for.

DON will monitor restraints weekly through the nursing rounds / quality assurance check list and report to the Quality Assurance action committee meeting.

Will be integrated into the Quality Assurance system by March 30, 2005.

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| F 323 | Continued From page 58<br>2004 document "side rails 1 side up".<br><br>A nurse's note, dated 11/1/04 at 1:30 AM, documented "Up in room. Climbed over rails. Became combative when attempts made to get her to sit down or lie down. RN (registered nurse) asked if she was hungry. She said she was starving. RN went to pantry for food. A few moments later CNA (certified nurse aide) found her on floor in hallway. No head trauma apparent . Has skin tear on lateral side left tibia..."<br><br>A staff nurse was interviewed on 2/23/05. She stated that resident 4 had a history of trying to climb of the side rails of her bed. "That's why they went to one side rail with the mat on the floor and the bed alarm."<br><br>A nurse aide was interview on 2/17/04. She confirmed that she had been the primary care aide for resident 4 on "four to five days" during the prior three weeks. She stated that on each of those mornings both side rails were up on the bed for resident 4 when she went to help her get up.<br><br>Based on interview and record review, the facility was not consistently adhering to the care plan and physician's orders for resident 4 to use only one side rail while she was in bed. Although resident 4 should have had one side rail on 11/1/04, it was documented that she "climbed over rails". "A few moments later CNA (certified nurse aide) found her on floor in hallway. No head trauma apparent. Has skin tear on lateral side left tibia..."<br><br>2. Resident 13 was admitted to the facility on 9/9/04 with diagnoses that included Alzheimer's | F 323 | | |

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| F 323 | Continued From page 59<br>disease and schizophrenia.<br><br>A review of resident 13's incident reports was completed on 2/17/05.<br><br>a. An Incident/Accident report dated 11/3/04 revealed that resident 13 was found lying on the floor at the side of his/her bed.<br>b. An Incident/Accident report dated 12/2/04 revealed that resident 13 was found lying on floor with his/her arm wedged between the foot board and mattress springs.<br>c. An Incident/Accident report dated 12/4/04 revealed that resident 13 was found lying on the floor next to the bed.<br><br>Resident 13's medical record was reviewed on 2/17/05.<br><br>a. Interdisciplinary Team (IDT) notes for resident 13 dated 12/22/04 revealed in the "Comments" section that resident 13 "... has fallen out of bed which resulted in pt needing a bed on the floor."<br><br>Resident 13's "Restraint Evaluation and Quarterly Review for Elimination" assessment dated 12/28/04 was reviewed. The facility physical therapist (PT) filled out the evaluation. The PT documented in the "Admission Evaluation by PT" section that resident 13 "needs low bed."<br><br>Observations<br><br>On 2/15/05 at approximately 10:15 AM resident 13 was taken to his room. Personal cares were completed and the resident was put to bed. The bed was a regular hospital bed placed in the low position. | F 323 | | |

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| F 323 | Continued From page 60<br>Interview<br><br>On 2/17/05 at approximately 9:30 AM the facility physical therapist accompanied the surveyor to resident 13's bedroom. When the PT was asked what kind of bed the resident had, he looked at the bed and stated that resident 13's bed was a regular bed in the low position, not a "low bed" as he had recommended. | F 323 | | |
| F 364 SS=B | 483.35(d)(1)&(2) DIETARY SERVICES<br><br>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.<br><br>This REQUIREMENT is not met as evidenced by :<br><br>Based on trial of a test tray and comments made during a confidential group interview, it was determined that the facility did not serve food that was palatable and attractive.<br><br>Findings include:<br><br>On 2/14/05 at 1:00 PM, staff were finishing serving the lunch meal. The cook was observed to be cutting cooked chicken breasts which were covered in a crunchy coating. While using a large square cutting knife, the cook appeared to be exerting significant effort into removing the outer edges of the chicken which appeared tough and overcooked. The cook was preparing the chicken for a resident on a mechanical soft diet.<br><br>The surveyor then asked the cook for a test tray. | F 364 | F364 The cooks were inserviced by the Dietary manager and the AIT on Palability of food, apperance and Textures to assure food is Prepared correctly.<br><br>This will be monitored by the Dietary manager and the RD Consultant weekly<br><br>Completed by April 8, 2005.<br><br>Monitoring will be done by the Dietary manager or the RD through random test trays on various meals and results will be reviewed in the weekly quality assurance meeting.<br><br>Will be integrated into the Quality Assurance system by March 30, 2005 | |

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| F 364 | Continued From page 61<br>The cook stated that it was "corn flake chicken". When tasting the chicken from the test tray, the surveyor found the chicken to be very dry and tough to chew.<br><br>On 2/16/05, residents during the confidential group interview complained that the food served by the facility was "awful". They stated that the meat was tough, that the pasta and vegetables were often over-cooked and "squishy" and that frequently they were served burned food. They stated that the night of 2/15/05, the dinner meal was burned stew. They stated that the kitchen staff placed their bread on the same plate and the vegetables, which made their bread soggy. The residents stated that they liked the food service supervisor and that she worked hard to accommodate their needs, but that the minute she goes home for the day "all bets are off."<br><br>Observation of lunch preparation on 2/16/05 revealed the cook to be cutting all the edges off two large cakes which had been burned. (Just minutes prior to lunch being served, the food service supervisor substituted ice cream instead of the burned cake. ) The morning of 2/17/05, surveyors walking past a food cart in the 300 hallway picked up a lid from the breakfast tray of one of the residents. The pancake sitting on the plate had black edges and a very dark brown center. | F 364 | | |
| F 371 SS=F | 483.35(h)(2) DIETARY SERVICES<br><br>The facility must store, prepare, distribute, and serve food under sanitary conditions.<br><br>This REQUIREMENT is not met as evidenced by | F 371 | | |

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| F 371 | Continued From page 62<br><br>Based on observations on 2/14/05 and 2/16/05, it was determined that the facility did not store, prepare and distribute food under sanitary conditions.<br><br>Findings include:<br><br>Observations in the kitchen on 2/14/05 at 12:40 PM revealed three large containers of expired cottage cheese; two dated 2/4/05 and one dated 2/7/05.<br><br>Observations in the kitchen on 2/16/05 revealed that the dish machine was not working properly and not sanitizing the dishes. The facility was using chemical sanitation to sanitize their dishes. When using chemical sanitation, the water temperature during the wash cycle must reach at least 120 degrees Farenheit and the water temperature during the rinse cycle must reach at least 140 degrees Farenheit.<br><br>A kitchen staff person recorded the dish machine temperatures for the morning of 2/16/05 to be 128 degrees for the wash cycle and 120 degrees for the rinse cycle. The rinse water temperature was insufficient to achieve sanitation of the dishes.<br><br>Observation of the dishes going through the dish washer was performed on 2/16/05 at 11:50 AM. The water temperature during the wash cycle measured 108 degrees Farenheit and the water temperature during the rinse cycle measured 116 degrees Farenheit. Both of these water temperatures were insufficient to achieve sanitation of the dishes. Multiple loads of dishes were observed going through the dish washer. The water temperature never reached the required temperatures to achieve sanitation with | F 371 | F371<br><br>The proper rotation of food<br>Was reviewed with the dietary staff<br>And will be monitored by the<br>Dietary manager weekly<br>The temperature of the water<br>Heater was increased to the level<br>Necessary to assure safe operation<br>Of the dishwasher. The logs will<br>Be maintained by the dishwashers<br>And will be monitored by the dietary<br>Manager. If a temperature is low,<br>The dietary manager will be notified<br>Immediatley. The logs will be reviewed<br>In QA meeting weekly.<br><br>The tile and grout were repaired by<br>Plant operations personnel, and will<br>Be monitored by the dietary manager<br>Who will list on the maintenance<br>Log any repairs necessary in dietary.<br><br>Completed by April 8, 2005. | |

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| F 371 | Continued From page 63<br>the chemical sanitizing method.<br><br>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.<br><br>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.<br><br>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.<br><br>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. | F 371 | | |
| F 372 SS=D | 483.35(h)(3) DIETARY SERVICES<br><br>The facility must dispose of garbage and refuse properly. | F 372 | | |

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| F 372 | Continued From page 64<br>This REQUIREMENT is not met as evidenced by :<br><br>Based on observation, it was determined, the facility did not dispose of garbage and refuse properly. Specifically, the dumpsters at the facility were not covered.<br><br>Findings include:<br><br>On 2/15/2005 at 12:10 PM the facility dumpster was observed to be uncovered.<br><br>On 2/16/2005 at 12:20 PM the facility dumpster was observed to be uncovered.<br><br>On both days garbage could be seen, from a distance, at the top of the dumpster. | F 372 | F372 In general staff meeting, employees Were reminded that the lids on the Dumpsters were to be kept closed. This will be monitored by the Dietary manager and the plant Operations manager daily.<br><br>Completed by April 8, 2005. | |
| F 441 SS=E | 483.65(a)(1)-(3) INFECTION CONTROL<br><br>The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.<br><br>This REQUIREMENT is not met as evidenced by :<br><br>Based on observation, record review and interviews, it was determined that the facility did not ensure an infection control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Resident identifier 6, 13, 24, 25. | F 441 | | |

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| EAST LAKE CARE CENTER | 1001 NORTH 500 WEST PROVO, UT 84601 |

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| F 441 | Continued From page 65<br>Findings include:<br><br>The facility had documentation that each facility must have an active infection control monitoring program in place to check on the infection issues in their building. The program consists of data collected and review for problem areas, specific concerns, etc., and the plan of approach as to how to correct the problems.<br><br>Review of the Infection Control Logs for 7/1/04 to 1/31/05 revealed that the log was incomplete with cultures being done and no organism identified when cultures were done and /or no documentation whether a culture was or was not done. The Infection Control Log for July 2004 documented a clustering of four urinary tract infections (UTI) on a hall and a clustering of three UTI's on another hall.<br><br>Review of the Infection Control Logs for August, 2004 documented a clustering of six skin infections and three more skin infections on two other halls. A total of 9 skin infections were identified for the month of August 2004. The facility had no documentation to evidence that they recognized the scope of the infections or the clustering formations, nor did they have documentation to evidence that any action was taken to prevent the spread of infection.<br><br>In an interview with the DON, on 2/23/05 at 3:00 PM, she was asked who in the facility was in charge of the infection control program. The DON replied, "That's me I guess." When the surveyors asked for the 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 | F 441 | F441 Resident Infection Control Surveillance Policy has been put into place to include Nosocomial Infection Monthly Summary, Floor Plan identifying clusters Quality Assurance Infection Summary Monthly Infection Control report. Staff nurses will be inserviced by D.O.N to log infections, DON and/or MDS Coordinator will review all T.O. orders that identify infections and assure that proper action taken to correct problem. MDS and/or DON will monitor infections throughout the month infection issues and set up action plan to correct any problems as well as follow-up and report to QA committee monthly Infection Control report.<br><br>All residents personnel items will be placed in plastic bags with their name on it. D.O.N. will monitor that tooth brushes, combs (personnel items) are properly labeled monthly thru QA nursing rounds and report to the QA committee monthly.<br><br>Completed by April 8, 2005.<br><br>ok | |

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| F 441 | Continued From page 66<br>not current and the DON said that she would get it finished.<br><br>Observations within the facility:<br><br>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."<br><br>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 441 | | |
| F 445 SS=B | 483.65(c) INFECTION CONTROL<br><br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by :<br><br>Based on observation, it was determined the | F 445 | | |

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| F 445 | Continued From page 67<br>facility did not ensure that soiled linen was stored or transported in a safe and sanitary manner.<br><br>Findings include:<br><br>On 2/22/05 at 1:20 PM, the shower room across from the south nurses station 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. 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 445 | F445 Aides will be inserviced by the D.O.N. to keep the linen carts covered during storage and transport. D.O.N. will monitor thru QA nursing rounds and report to the QA committee monthly.<br><br>Completed by April 8, 2005.<br><br>OK | |
| F 490 SS=H | 483.75 ADMINISTRATION<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by :<br><br>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, mental, and psychosocial well-being for each resident. Specifically, facility administration failed | F 490 | | |

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| F 490 | Continued From page 68<br>to identify and correct the process for identifying, reporting and investigating allegations of abuse/ neglect and injuries of unknown source. The facility was cited for deficient practice in a total of 18 areas, not including this deficiency.<br><br>Findings include:<br><br>On 2/23/05, a Standard Extended survey was completed which resulted in the determination of Sub-Standard Quality of Care in the area of Resident Behavior and Facility Practices (42 CFR 483.13). The determination of Sub-Standard Quality of Care was based on the lack of identification, investigation and reporting of allegations of abuse (both by staff and other residents) and injuries of unknown source.<br><br>A pattern of actual harm was identified for 6 residents, one of whom had a broken leg which went untreated for 3 days (see F224 regarding neglect), 2 of whom were alleged victims of abuse and an additional 3 who suffered significant injuries (one resident was found with a 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 found with a right eye injury). None of the incidents were investigated by the facility. None of the incidents were reported by the facility to required agencies, including the State survey and certification agency. The facility did not have evidence that any of the incidents were immediately reported to the administrator, as required. The facility had evidence that on December 13, 2004, their quality assurance committee had identified the lack of reporting and investigation of injuries of unknown source. However, three days later, on 12/16/04, resident 4 | F490 | All incident reports will be reviewed Daily in census meeting by the Administrator. All appropriate follow-up Will be completed and logged. This Will be reviewed in weekly QA meeting. See also F225 for additional information.<br><br>See F157<br><br>See F309<br><br>See F323<br><br>See F224<br><br>See F241<br><br>See F253<br><br>See F371<br><br>See F364<br><br>See F372<br><br>See F518<br><br>See F514<br><br>See F279<br><br>See F441<br><br>See F445<br><br>Completed by April 8, 2005. | |

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| F 490 | Continued From page 69<br>was found with two lacerations on the back of her head while lying in bed. No one knew how the injuries had occurred. The incident was not investigated or reported as required. Please also see tag F-225 for additional information.<br><br>In addition to the area of Sub-Standard Quality of Care stated above, the facility's administration 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.<br><br>a. Facility administration failed to ensure that the physician was notified when there was a significant change in a resident's physical condition. See F - 157.<br><br>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.<br><br>c. Facility administration failed to ensure that the resident environment remains as free of accident hazards as is possible. See F - 323.<br><br>d. Facility administration failed to ensure that their residents were not subject to neglect. See F - 224.<br><br>e. Facility administration failed to ensure that each resident was treated with dignity. See F - 241. | F 490 | The administrators performance will be monitored through the Quality Assurance team members, by reviewing progress made toward compliance. This will be documented in the minutes of the weekly quality assurance meeting.<br><br>Will be integrated into the Quality Assurance system by March 30, 2005<br><br>DK | |

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| F 490 | Continued From page 70<br>f. Facility administration failed to ensure that the facility's housekeeping and maintenance services provided a sanitary, orderly and comfortable interior. See F - 253.<br><br>g. Facility administration failed to ensure that its staff stored, prepared and distributed food under sanitary conditions. See F - 371.<br><br>h. Facility administration failed to ensure that the food served to it's residents was palatable and attractive. See F - 364.<br><br>i. Facility administration failed to ensure that there was a proper disposal of garbage and refuse. See F - 372.<br><br>j. Facility administration failed to ensure that it's employees were familiar with emergency procedures. See F - 518.<br><br>k. Facility administration failed to ensure that medical records were complete, accurate and systematically organized. See F - 514.<br><br>l. Facility administration failed to ensure that care plans addressed the needs of each resident. See F - 279.<br><br>m. Facility administration failed to ensure that staff established and maintained an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. See F - 441.<br><br>n. Facility administration failed to ensure that soiled linens were properly stored. See F - 445. | F 490 | | |

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| F 514 | Continued From page 71 | F 514 | | |
| F 514 SS=E | 483.75(l)(1) ADMINISTRATION<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>This REQUIREMENT is not met as evidenced by<br><br>Based on review of medical records, it was determined that 7 of 22 sampled charts had other resident's assessments, laboratory results or other documentation filed in them. One of the sampled charts (resident 6) had numerous areas which had not been signed by the nurse attesting to the fact that medications had been given as ordered. The same chart (for resident 6) did not contain an accurate or functional representation of the actual experience of the resident during an episode of acute illness. Resident identifiers: 4, 13, 8, 6, 19, 18 and 20.<br><br>Findings include:<br><br>1. The medical record of resident 4 was found to contain an ADL (activities of daily living) sheet for resident 32.<br><br>2. The medical record for resident 19 was found to contain a laboratory result for resident 16.<br>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.<br><br>4. On 2/15/2005, a monthly summary dated 1/ 2005 for Resident 18 was found in Resident 13's medical record. | F514 | Medical Record for resident 4, 19, 28, 13, 18, 32,16 was reviewed to assure the Medical records were filed in the correct chart. All records will be reviewed for organization and proper filing by Medical Record Clerk and monitored by Medical Records monthly for correct filing and reported to the QA committee<br><br>Licensed Nurses will be inserviced on the importance of charting medications per dr. order. Medical Records will audit the Medication Records for proper charting weekly giving results to D.O.N. to evaluate thru QA committee monthly.<br><br>Completed by April 8, 2005.<br><br>OK | |

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| F 514 | Continued From page 72<br>5. On 2/15/05, laboratory results for a comprehensive metabolic panel for Resident 29 were found in the medical record of Resident 6.<br><br>6. Resident 20 was admitted to the facility on 6/20/04 with Hypothyroidism, Congestive Heart Failure, and Hyponatremia, hypertension, osteoporosis, osteoarthritis, vertigo, status post hip fracture, insomnia and edema. Resident 20 had documentation within 2 days of admission for a social history; however, there was no further documentation from Social Services for discharge planning back into the home setting with Home Health services. Resident 20 was discharged 9/21/04.<br><br>7. For Resident 6 the following medications were not documented as given:<br><br>October 2004<br><br>It was not documented that the following medications were not given on the following days and times:<br><br>Hydrocodone 5/500 PO (per mouth) TID (three times a day) ordered 9/9/04<br>10/17 at 8:00 PM<br>10/19 at 8:00 PM<br>10/20 at 8:00 PM<br>10/25 at 8:00 PM<br>10/25 at 8:00 PM<br>10/29 at 8:00 AM and 8:00 PM<br><br>Reminyl 8 mg PO BID (twice a day) ordered 9/9/04<br>10/29/04 at 8:00 AM and 8:00 PM<br><br>Valium 2 mg PO QD (each day) ordered 9/9/04 | F 514 | | |

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| F 514 | Continued From page 73<br>10/16/04 at 8:00 AM<br>10/29/04 at 8:00 AM<br><br>Synthroid .15 mg QD ordered 9/9/04<br>10/16/04 at 8:00 AM<br>10/25/04 at 8:00 AM<br>10/29/04 at 8:00 AM<br><br>Mirapex 0.5 mg PO TID ordered 9/9/04<br>10/13/04 at 8:00 PM<br>10/16/04 at 8:00AM and 4:00 PM<br>10/17/04 at 8:00 PM<br>10/19 and 10/20 at 8:00 PM<br>10/25/04 at 8:00 PM<br>10/29/04 at 8:00 AM and 4:00 PM<br><br>Ascorbic Acid 500 mg PO QD ordered 9/9/04<br>10/16/04,10/29/04 each at 8:00 AM<br><br>Clonazepam 1 mg PO BID ordered 9/9/04<br>10/13/04 at 8:00 PM<br>10/16/04 at 8:00 AM<br>10/18 and 10/19/04 at 8:00 PM<br>10/29 at 8:00 AM<br><br>Phenobarbital Sodium (Elixir 20 mg/5ml) give 80 mg (20 cc) PO Q12H (every 12 hours) ordered 9/9/04<br>10/13 at 8:00 PM<br>10/16 at 8:00 AM<br>10/18 and 10/19 at 8:00 PM<br>10/29 at 8:00 AM<br><br>Remeron 15 mg PO QHS (each night at bedtime) ordered 9/9/04<br>10/13, 10/17, 10/19, 10/20 and 10/28 at 8:00 PM<br><br>Namenda 20 mg PO Q Day (every day) ordered 9/9/04 | F 514 | | |

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| F 514 | Continued From page 74<br>10/16 10/29 each at 8:00 AM<br><br>Phenytoin (Dilantin Suspension) 125 mg/5ml give 100 mg elixer PO TID<br>10/4 at 4:00 PM<br>10/13 at 8:00 PM<br>10/17 at 8:00 PM<br>10/19 and 10/20 at 8:00 PM<br>10/25 at 8:00 PM<br>10/29 at 8:00 AM and 4:00 PM<br><br>Multivitamins with Minerals give one tab PO Q Day ordered 9/9/04<br>10/10, 10/16, 10/23, 10/24, 10/26, 10/29 all at 8:00 AM<br><br>ZCAL 120 cc PO QID (four times a day) ordered 9/9/04<br>10/11 at 4:00 PM<br>10/16 at 8:00 AM, 12:00 PM, 4:00 PM<br>10/17 at 8:00 PM<br>10/19, 10/20, 10/25, at 8:00 PM<br>10/29 at 8:00 AM, 12:00 PM and 4:00 PM<br><br>Plavix 75 mg give 1/2 tab PO QOD (every other day) ordered to start 10/23/04<br>10/29 at 8:00 AM<br><br>Lotrazone to rash BID ordered 10/14/04<br>10/15 10:00 AM and Bedtime<br>10/16 10:00 AM<br>10/17 10:00 AM<br>10/19-22 at 10:00 AM<br>10/19 -20 Bedtime<br>10/23-25 Bedtime<br>10/25-26 10:00 AM<br>10/28 Bedtime<br>10/29-31 10:00 AM | F 514 | | |

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| F 514 | Continued From page 75<br>November 2004<br><br>Phenytoin (Dilantin Suspension) 125 mg/5ml give 100 mg elixer PO TID<br>Beginning 11/1 at 4:00 PM and 8:00 PM the following days were missed 11/2-11/30 all doses at 8:00 AM 4:00 PM and 8:00 PM<br><br>Multivitamins with Minerals give one tab PO Q Day ordered 9/9/04<br>11/13 at 8:00 AM<br>11/23 at 8:00 AM<br><br>ZCAL 120 cc PO QID (four times a day) ordered 9/9/04<br>11/10 at 8:00 PM<br>11/16-18 at 8:00 PM<br>11/24-27 at 8:00 PM<br><br>Rocephin 1GM IM (intramuscular) give now - NO PHYSICIAN ORDER<br><br>Reminyl 8 mg PO BID (twice a day) ordered 9/9/04<br>11/11 at 8:00 PM<br>11/12 at 8:00 AM and 8:00 PM<br><br>Vallum 2 mg PO QD (each day) ordered 9/9/04<br>11/11-12 at 8:00 AM<br><br>Synthroid .15 mg QD ordered 9/9/04<br>11/11-12 at 8:00 AM<br><br>Mirapex 0.5 mg PO TID ordered 9/9/04<br>11/11at 8:00 AM<br>11/12 at 8:00 AM and 4:00 PM<br>11/13-14 at 8:00 PM<br>11/26-27 at 8:00 PM | F 514 | | |

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

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FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 465119 | A. BUILDING _____ 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 |

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|---|---|---|---|---|
| F 514 | Continued From page 76<br>Ascorbic Acid 500 mg PO QD ordered 9/9/04<br>11/11-12 at 8:00 AM<br><br>Clonazepam 1 mg PO BID ordered 9/9/04<br>11/11-12 at 8:00 AM<br>11/13-16 at 8:00 PM<br>11/27 and 11/29 each at 8:00 PM<br><br>Phenobarbital Sodium (Elixir 20 mg/5ml) give 80 mg (20 cc) PO Q12H (every 12 hours) ordered 9/9/04<br>11/11-12 at 8:00 AM<br>11/13-14 at 8:00 PM<br>11/21 at 8:00 PM<br>11/27-28 at 8:00 PM<br><br>Remeron 15 mg PO QHS (each night at bedtime) ordered 9/9/04<br>11/2, 11/13, 11/1411/27 each at 8:00 PM<br><br>Namenda 20 mg PO Q Day (every day) ordered 9/9/04<br>11/11-12 @ 8:00 PM<br><br>Oxycodone 5 mg 1 PO TID ordered 11/11/04<br>11/15-17 @ 8:00 PM<br>11/24-26 at 8:00 PM<br>11/28 at 8:00 PM<br><br>December 2004<br><br>Hydrocodone 5/500 PO (per mouth) TID (three times a day) ordered 9/9/04<br>12/1-8 all doses for 8:00 AM, 4:00 PM and 8:00 PM<br>12/9 at 8:00 AM<br>12/16 at 4:00 PM<br>12/26 at 8:00 AM and 4:00 PM<br>12/29 at 4:00 PM 12/30 at 4:PM | F 514 | | |

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| F 514 | Continued From page 77<br>12/30 at 4:00 PM<br>12/31 at 8:00 AM, 4:00 PM and 8:00 PM<br><br>Reminyl 8 mg PO BID (twice a day) ordered 9/9/04<br>12/1-10 at 8:00 AM all doses<br>12/1-8 at 8:00 PM<br>12/26 at 8:00 AM<br>12/31 at 8:00 AM and 8:00 PM<br><br>Valium 2 mg PO QD (each day) ordered 9/9/04<br>12/26 and 12/31 at 8:00 AM<br><br>Mirapex 0.5 mg PO TID ordered 9/9/04<br>12/1-9 at 8 AM all doses<br>12/1-7 at 4:00 PM all doses<br>12/1-8 at 8:00 PM all doses<br>12/16 at 4: 00 PM<br>12/26 at 8:00 AM and 4:00 PM<br>12/29 and 12/30 at 4:00 PM<br>12/31 at 8:00 AM, 4:00 PM and 8:00 PM<br><br>Synthroid .15 mg QD ordered 9/9/04<br>12/26 at 8:00 AM<br>12/31 at 8:00 AM<br><br>Ascorbic Acid 500 mg PO QD ordered 9/9/04<br>12/26 at 8:00 AM<br>12/31 at 8:00 AM<br><br>Clonazepam 1 mg PO BID ordered 9/9/04<br>12/26 at 8:00 AM<br>13/31 at 8:00 AM and 8:00 PM<br><br>Phenobarbital Sodium (Elixir 20 mg/5ml) give 80 mg (20 cc) PO Q12H (every 12 hours) ordered 9/9/04<br>12/26 and 12/31 at 8:00 AM | F 514 | | |

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| F 514 | Continued From page 78<br>Remeron 15 mg PO QHS (each night at bedtime) ordered 9/9/04<br>12/31 at 8:00 AM<br><br>Namenda 20 mg PO Q Day (every day) ordered 9/9/04<br>12/31 at 8:00 AM<br><br>Phenytoin (Dilantin Suspension) 125 mg/5ml give 100 mg elixer PO TID<br>12/1-8 at 8:00 AM, 4:00 PM and 8:00 PM all doses<br>12/9 at 8:00 AM<br>12/16 at 4:00 PM<br>12/26 at 8:00 AM and 4:00 PM<br>12/31 at 8:00 AM, 4:00 PM and 8:00 PM<br><br>Multivitamins with Minerals give one tab PO Q Day ordered 9/9/04<br>12/21 at 8:00 AM<br>12/26 at 8:00 AM<br>12/29-31 at 8:00 AM<br><br>ZCAL 120 cc PO QID (four times a day) ordered 9/9/04<br>12/1-17 at 8:00 AM, 12:00 PM, 4:00 PM and HS<br>1220-23 at HS<br>12/26 at 8:00 AM, 12:00 PM and 4:00 PM<br>12/31 at 8:00 AM, 12:00 PM. 4:00 PM and HS | F 514 | | |
| F 518 SS=D | 483.75(m)(2)-(4) ADMINISTRATION<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by | F 518 | | |

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|---|---|---|---|---|
| F 518 | Continued From page 79<br><br>Based on staff interviews, it was determined that 2 of 3 facility employees interviewed regarding emergency procedures lacked understanding of emergency procedures or facility equipment available.<br><br>Findings included:<br><br>On 2/16/05 at 9:15 AM, Certified Nursing Assistant (CNA) 8 was interviewed. CNA 8 was a daytime team leader of the facility CNAs. CNA 8 stated that she was not aware that when the electrical power in the building was lost, that some of the electrical outlets would still work. CNA 8 also stated that she was not aware of what to do in case of a resident missing from the building. CNA 8 stated that she would find out about what needed to be done in both instances and get back with the surveyor.<br><br>On 2/23/05 at 10:20 AM, CNA 9, who had worked in the facility for approximately 9 months, was interviewed. CNA 9 stated that she had received no training in fire safety at the facility and did not know where the fire alarms were located. | F518 | All new employees will receive Emergency procedure information During orientation meeting. On going Emergency drills will be held quarterly On each shift to ensure staff are Knowledgeable of their responsibility. Plant operations manager will be Responsible to complete staff inservice On these procedures, and turn in a Report and list of attendees to the Administrator monthly. This report Will be reviewed in QA meeting.<br><br>Completed by April 8, 2005.<br><br>All current employees were inserviced on emergency procedures on March 25, 2005. The records are in the inservice book.<br>OK | |