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

PRINTED: 07/11/2006
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
	465147	A. BUILDING ______ B. WING ______	06/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - HEBER	160 WEST 500 NORTH HEBER CITY, UT 84032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility did not have an effective maintenance system to ensure that the residents environment was maintained in good repair, specifically for window and door screens, leaky faucet in the day room and ceiling paint peeling in day room. Findings Include: 1. Torn screens on resident rooms 13, 22, 23 and both laundry room doors. 2., The hand wash sink in the day room had a continuously leaking faucet and the ceiling above the sink had an area of peeling paint, approximately 5 inches across. 3. A blue couch next to the door leading to the medical records office had large multiple stains and the stuffing in the front corners was coming out from under the padded cover.	F 253 8/30/06 POC acceptable completion date 8/24/06 Busenbark RN	F-253 Administrator will routinely make rounds to identify any environmental issues. F-253 Compliance will be achieved by Facility on This will also be addressed in quarterly QA meeting to ensure progress. (Next QA meeting August 14, 2006) Screens on resident rooms 13, 22, and 23 and both the laundry room doors have been replaced by maintenance and will be monitored during weekly maintenance rounds. Documented in the maintenance log and reviewed at quarterly QA meeting. The faucet in the day room has been replaced and ceiling above the sink has been repainted by maintenance. Maintenance will monitor during weekly rounds. Documentation in maintenance log and reviewed by quarterly QA meeting. The blue couch has been thrown away by maintenance and furniture will be inspected during weekly rounds by maintenance. Documentation in Maintenance log which will be reviewed in QA meeting quarterly.	8-24-2006

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

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

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F 272 SS=E	483.20, 483.20 b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility did not make a comprehensive assessment of resident's needs. Specifically 4 of 8 sample residents did not have	F 272		

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F 272	Continued From page 2 complete comprehensive minimum data set (MDS) assessments. Resident identifier 1, 2, 4, 5. Findings Include: Resident 1 was readmitted on 3/28/06 with diagnoses that included right eye carcinoma, congestive heart failure, schizophrenia, dementia, atrial fibillation, benign prostatic hypertrophy and arthritis. Resident 1's medical record was reviewed on 6/26/06. Section V of the 4/11/06 initial MDS was not completed. The Resident Assessment Protocols (RAP) for 2. Cognitive Loss, 3. Visual Function and 10. Activities, were not marked as to the date of the RAP assessment documentation. Section V of the 12/26/05 annual MDS was not completed. The columns indicating "Location and Date of RAP Assessment Documentation" was incomplete. Under the column for Location and Date of RAP Assessment Documentation for each triggered area it documented "see rap" and no dates were documented on the RAP. Resident 5 was admitted on 1/13/06 with diagnoses that included ceberal vascular accident, hemiparesis, hypertesnion, coromanry artery disease angina pectoris, aphasia, major depression and dementia. Resident 5's medical record was reviewed on 6/26/06.	F 272	Section V on Resident's MDS has been completed by the DON. The sections on Cognitive Loss, Visual Function and Activities have been dated and completed on July 3, 2006. F-272 Compliance will be achieved by Facility on 8-24-2006	

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F 272	Continued From page 3 Section V of the 1/26/06 initial MDS was not completed. The columns indicating "Location and Date of RAP Assessment Documentation" was incomplete. Under the column for Location and Date of RAP Assessment Documentation for each triggered area it documented "see rap" and no dates were documented on the RAP.	F 272	Resident 5- Section V has been completed under Date of RAP assessment documentation by the DON completed on July 27, 2006.	
	Resident 2 was admitted on 3/10/5 with diagnoses of blindness, cerebral palsy, glaucoma, hypertension, myocardial infarction and schizoaffective disorder. Resident 2's medical record was reviewed on 6/26/06. Section V of the 12/1/05 initial MDS was not completed. The Resident Assessment Protocols (RAP) for 1. Delirium, 2. Cognitive Loss, 3. Visual Function, 4. Communication, 5/ ADL Functional//Rehabilitation Potential, 6. Urinary Incontinence and Indwelling Catheter, 7. Psychosocial Well-Being, 8. Mood State, 9. Behavioral Symptoms, 11. Falls, 12. Nutritional Status, 14. Dehydration/Fluid Maintenance, 16, Pressure Ulcers, 17. Psychotropic Drug Use were not marked as to the date of the RAP assessment documentation The column indicating "Location and Date of RAP Assessment Documentation" was		Resident 2- Section V has been completed by the DON. This includes the dates on the RAP. Completed on July 27, 2006.	

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F 272	Continued From page 4 incomplete. Under the column for Location and Date of RAP Assessment Documentation for each triggered area it documented "see rap" and no dates were documented on the RAP. Resident 4 was admitted on 4/1/03 with diagnoses that included brain tumor, seizures and constipation. Resident 4's medical record was reviewed on 6/26/06. Section V of the 4/1/05 initial MDS was not completed. The Resident Assessment Protocols (RAP) for 1. Delirium, 2. Cognitive Loss, 3. Visual Function, 5. ADL Functional/Rehabilitation Potential, 6. Urinary Incontinence and Indwelling Catheter, 7. Psychosocial Well-Being, 8. Mood State, 10. Activities, 11. Falls, 12. Nutritional Status, 16. Pressure Ulcers, and Psychotropic Drug Use were not marked as to the date of the RAP assessment documentation. The column indicating "Location and Date of RAP Assessment Documentation" was incomplete. Under the column for Location and Date of RAP Assessment Documentation for each triggered area it documented "see rap" and no dates were documented on the RAP.	F 272	Resident 4- RAPS have been completed by the DON. This would include the dates mentioned have been completed on July 27, 2006. Medical Records will audit MDS for completion on a regular basis. Reports will be given to the DON and the administrator. Will be reviewed in QA on August 14, 2006 and in every quarterly QA thereafter. F-272 This problem will be followed up on in quarterly QA meetings to ensure progress has been made in this area. Will be reviewed in QA on August 14, 2006.	

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F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement This REQUIREMENT is not met as evidenced by: Based on record reviews and interview, it was determined that the facility did not ensure that the Minimum Data Set (MDS) assessment accurately reflected residents's status. The facility did not ensure that a registered nurse had signed and certified that the assessments were complete for 2 of 8 sample residents. Resident identifiers	F 278		

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F 278	Continued From page 6 3, 4. Findings Include: Resident 3 was admitted on 12/21/04 with diagnoses that included congestive heart failure, hypertension, anemia and insomnia. Resident 3's medical record was reviewed on 6/26/06. On 11/18/05, a quarterly MDS that was completed by the facility staff did not have an RN (registered nurse) signature under section R2a: Signature of Person Coordinating the Assessment, Signature of RN Assessment Coordinator. Resident 4 was admitted on 4/1/04 with diagnoses that included brain tumor, seizures and constipation. Resident 4's medical record was reviewed on 6/26/06. On 6/22/05, a quarterly MDS that was completed by the facility staff, did not have an RN (registered nurse) signature under section R2a: Signature of Person Coordinating the Assessment, Signature of RN Assessment Coordinator.	F 278	Resident 3- RN has signed under section R2A as the person coordinating the assessment. Completed on July 27, 2006. Resident 4- RN has signed under Section R2A as the RN assessment Coordinator. Completed on July 3, 2006. Medical Records will audit all MDS' completed and report to the DON and Administrator. F-278 Compliance will be achieved by Facility on 8-24-2006	

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F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review it was determined that the facility did not develop, review or revise the residents comprehensive plan of care, including measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs. Specifically, 3 of 8 sample resident's did not have care plans based on the assessments, or the plans of care were incomplete. Resident identifiers 1, 3, 5. Findings include: Resident 1 was readmitted on 3/28/06 with	F 279		

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F 279	Continued From page 8 diagnoses that included right eye carcinoma, congestive heart failure, schizophrenia, dementia, atrial fibrillation, benign prostatic hypertrophy and arthritis. Resident 1's medical record was reviewed on 6/26/06. Resident 1's care plans did not address the following areas that were triggered by the RAPS. Cognitive loss Hearing Psychotropic drug use, specifically the signs and symptoms of side effects Oral/dental Activities Resident 1 was placed on hospice on 6/9/06, the care plan was not revised and or updated to include the current hospice care. Resident 3 was admitted on 12/21/04 with diagnoses that included congestive heart failure, hypertension, anemia and insomnia. Resident 3's medical record was reviewed on 6/26/06. Resident 3's care plans did not address the following areas that were triggered by the RAPS. Psychotropic drug use, specifically the signs and symptoms of side effects. Resident 5 was admitted on 1/13/06 with diagnoses that included cerebral vascular accident, hemiparesis, hypertension, coronary artery disease, angina pectoris, major depression, diabetes mellitus and dementia.	F 279	Resident 1- Care Plan has been completed and now includes- Cognitive Loss, Hearing, and Psychotropic Drug use- especially side effects. Oral/Dental Activities. The Care plan was revised to include the present Hospice Care. Completed on July 26, 2006. Resident 3- Care Plan has been revised to include psychotropic medication side effects. Completed on July 27, 2006.	

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F 279	Continued From page 9 Resident 5's medical record was reviewed on 6/27/06. Resident 5's care plans did not address the following areas that were triggered by the RAPS. Psychotropic drug use, specifically the signs and symptoms of side effects.	F 279	Resident 5- Care plan has been revised to include use of psychotropic meds and potential side effects. Completed on July 27, 2006. F-279 Compliance will be achieved by Facility on 8-24-2006	
F 309 SS=D	483.25 QUALITY OF CARE 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. This REQUIREMENT is not met as evidenced by: Based on medical records and interviews, it was determined that the facility did not ensure that residents received the care and services to maintain the highest practicable in accordance with the comprehensive plan of care. Specifically, when 1 resident did not receive medication as ordered, and when both resident's oxygen saturation decreased, there was no documentation in the medical record that any interventions had been implemented. Resident identifiers 1, 3. Findings include: Resident 3 was admitted on 12/21/04 with	F 309	Medical Records will audit care plans at least monthly to ensure all issues are addressed. The audit results will be given to the Director of Nursing and the Administrator. Audit will be reviewed in QA on August 14, 2006 and then every quarterly QA thereafter. The Director of Nursing will monitor all care plans to make sure that all necessary care and services are attained thru completion of comprehensive assessment.	

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F 309	Continued From page 10 diagnoses that included congestive heart failure, hypertension, anemia and insomnia. Resident 3's medical record was reviewed on 6/26/06. Physician's order, dated 2/22/05 documented that Trazodone 50 mg (milligrams) po (per mouth) daily except Sunday was to be given. Review of resident 3's MAR's (medication administration record) documented in April and May of 2006 that Trazodone 50 mg. was given Monday through Sunday (7 days a week). In an interview with the DON (Director of Nursing), on 6/27/06 at 10:30 AM, she said that the nurses were to give the medication Monday through Saturday only. The DON said that the MAR was not done correctly for April and May. Resident 3 had a physician order, dated 6/06, for resident 3 to wear TED hose or ace wraps when out of bed. Resident 3 was observed on 6/26/06 to 6/27/06, during this time frame the resident was not wearing TED hose or ace wraps. In an interview with a staff member, on 6/27/06 at 11:00 AM, she said that the night shift places the TED hose on resident 3, but that she should have check the resident to make sure the TED hose were in place. Resident 3 had physician's recertification orders for April, May and June 2006, that documented O2 (oxygen) to keep SATS (saturation levels) above 90%. Review of resident 3's Treatment Record	F 309	Medication record has been changed so that the resident will not receive Trazadone on Sunday. This completed by the DON on July 27, 2006. Treatment sheet will be clarified that resident is to wear TED Hose when out of bed, on August 1, 2006. Certified Nurses Assistants and Nurses will be in serviced by the DON on reasons and importance of following Doctors Orders on August 25, 2006. The Director of Nursing will monitor all treatment records once a week to make sure that all residents will receive optimum care and services in accordance with the comprehensive plan of care.	

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F 309	Continued From page 11 revealed that for the following days, resident 3's oxygen saturation was below 90%. 4/02/06 was not documented as being done 4/16/06 was 84% room air 4/30/06 was 80% room air 5/07/06 was 89% room air (only one documented for May) 6/04/06 was 83% room air 6/11/06 was not documented as being done 6/18/06 was 85% room air 6/25/06 was 83% room air No documentation could be found that any interventions had taken place to increase resident 3's oxygen level for any of the days which resident 3's oxygen level fell below 90%. On 6/27/06 at 11:00 AM, resident 3 was observed to have a slight discoloration around her lips by a surveyor. A facility staff member was asked to get an O2 SATS, which revealed resident 3's O2 SATS was 87%. Oxygen per nasal cannula was placed on resident 3. In an interview with the DON (Director of Nursing), on 6/27/06 at 10:30 AM, she said O2 SATS are charted on the nurses notes and the back of the treatment record. The DON confirmed that no documentation could be found. Resident 1 was readmitted on 3/28/06 with diagnoses that included right eye carcinoma, congestive heart failure, schizophrenia, dementia, atrial fibrillation, benign prostatic hypertrophy and arthritis. Resident 1's medical record was reviewed on	F 309	Resident 3- Treatment Order on Treatment Sheet has been revised to include charting on O2 sats and Oxygen given- time, date and initials. This was completed by the Director of Nursing on July 27, 2006. Director of Nursing will monitor all treatment orders on treatment sheets once a week to ensure that residents will receive and maintain the highest practicable treatment in accordance with the comprehensive plan of care.	

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F 309	Continued From page 12 6/26/06. Resident 1's admission orders, dated 4/11/06, documented an order for O2 to keep SATS above 90% Dx (diagnoses) CHF (congestive heart failure). Review of resident 1's Treatment Record revealed that for the following days, resident 1's oxygen saturation was below 90%. 4/06 had no documentation of O2 SATS 5/14/06 was 88% room air, there was no other O2 SATS for May 6/04/06 was 86% room air 6/12/06 had no documentation of O2 SATS 6/17/06 was 85% room air No documentation could be found that any interventions had taken place to increase resident 1's oxygen level for any of the days which resident 1's oxygen level fell below 90%. On 6/28/06 at 9:30 AM resident was observed to have a slight discoloration around his lips by a surveyor, a facility staff member was asked to get an O2 SATS, which revealed resident 1's O2 SATS was 87%. In an interview with the DON on 6/28/06 at 9:30 AM, she said that the admission order for O2 SATS got missed.	F 309	Director of Nursing will monitor charting on Oxygen Sats and Oxygen given. If signs and symptoms indicate more frequent monitoring otherwise, once a week. F-309 Compliance will be achieved by Facility on 8-24-2006	

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
	465147	A. BUILDING _____ B. WING _____	06/28/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - HEBER	160 WEST 500 NORTH HEBER CITY, UT 84032

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F 368 SS=B	483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal meal times in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on Resident's confidential interviews, interviews with the Director of Nursing (DON), Administrator and group meeting, it was determined that the facility was not offering daily bedtime snacks to the residents. Findings Include: 1. During the group meeting 4 out of 4 residents reported that night time snacks were not offered on a daily basis. One resident stated that even if you asked for a snack you might not get it. 2. Confidential interviews held with 5 additional residents resulted with 3 of the 5 residents stating that snacks were not being offered at bedtime.	F 368	Each resident will be offered an HS snack every night. Aides will chart on percentage taken or if the resident refuses charge nurse will monitor this Q HS by checking the form used to chart P.M. snack. Administrator will also ask residents weekly to determine if the residents are receiving P.M. snacks nightly and discussed during quarterly QA meeting in August. F-368 Compliance will be achieved by Facility on 8-24-2006	

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	465147	A. BUILDING _____ B. WING _____	06/28/2006

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F 368	Continued From page 14 3. In an interview with the DON and Administrator, on 6/27/06 at 4:30 PM, they both stated that bedtime snacks were placed on the Nurse's Station and resident's could help themselves. Snacks were not verbally offered or passed to individual resident rooms.	F 368		
F 495 SS=D	483.75(e)(4) REQUIRED TRAINING OF NURSING AIDES A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual is a full-time employee in a State-approved training and competency evaluation program; has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or has been deemed or determined competent as provided in §§483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility did not follow federal and state regulations when they hired a person to work as a nurse aide who was neither certified; nor, enrolled in a State-approved training and competency evaluation program. One nurse aide had failed the State-approved training and competency evaluation program and the facility continued to let the nurse aide work at the facility. Findings include:	F 495		

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	465147	A. BUILDING _____ B. WING _____	06/23/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - HEBER	160 WEST 500 NORTH HEBER CITY, UT 84032

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F 495	Continued From page 15 1. E1 was hired on 5/23/06. The personnel file of E1 was reviewed on 6/28/06. The personnel file did not contain any documentation that the new employee had received the required 16 hours of training prior to doing the resident care. In an interview, on 6/28/06 at 9:15 AM, with the CNA (certified nurse aide) Coordinator, she said that E1 would be starting a State-approved training and competency evaluation program next month. E1 had been working the floor as a CNA for over a month. 2. E2 was hired on 4/1/05. The personnel file of E2 was reviewed on 6/28/06. The personnel file did not contain any documentation that the new employee had received the required 16 hours of training prior to doing the resident care. E2 continued to work at the facility as a CNA until 2/3/06, a total of ten months without being certified. In an interview, on 6/28/06 at 9:15 AM, with the CNA (certified nurse aide) Coordinator, said that E2 had taken the State-approved training and competency evaluation program, but had failed the exam.	F 495	All nurses' aides uncertified will receive 16 hours of training prior to working on the floor. This will be done by the C.N.A. coordinator and monitored monthly by the Director of Nursing and Administrator. Any aide who does not complete the training and certifications within 4 months of hire will be terminated. Personnel file will be audited by the C.N.A. coordinator and monitored monthly by the Director of Nursing and Administrator. Employee Training will be addressed and reviewed during QA meeting on August 14, 2006 and during quarterly QA meeting thereafter. F-495 Compliance will be achieved by Facility on 8-24-2006	