PRINTED: 10/18/2005
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465062	A. BUILDING _____ B. WING _____	10/06/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH DAVIS COMMUNITY CARE CTR	401 SOUTH 400 EAST BOUNTIFUL, UT 84010

(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 161 SS=B	483.10(c)(7) ASSURANCE OF FINANCIAL SECURITY The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on record review of the surety bond and resident funds, it was determined that the surety bond's maximum coverage amount was not enough to reimburse all resident funds held by the facility. Findings include: During record review of the resident funds held by the facility, it was noted that the total amount of resident funds for August 2005, was $21,000 and for September 2005, the total amount was $23,000. The surety bond held by the facility had a maximum coverage amount of $15,000 to cover all resident funds.	F 161	The surety bond was increased in maximum coverage to $30,000 in order to exceed the necessary amount to insure all funds held in the resident fund amount. This will be monitored and kept current by the Executive Director of Finance. He will review the bond on a quarterly basis and report his findings to Administration.	10/06/05
F 279 SS=B	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279	All cited care plans have been updated and are consistant with physician orders and actual useage. The Patient Care Coordinator over each unit will be responsible to ensure that care plans are current,	12/02/05

11/7/05 PBC acceptable completion date 12/2/05 UBusenbark

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rosemary Thackeray — TITLE: Assistant Administrator — (X6) DATE: 10/28/05

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 279	Continued From page 1 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 o483.25; and any services that would otherwise be required under o483.25 but are not provided due to the resident's exercise of rights under o483.10, including the right to refuse treatment under o483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews it was determined that the care plans for 3 of 24 residents did not include measurable objectives and timeables to meet the residents' nursing and medical needs that were identified in the comprehensive assessments and resident 2's care plan indicated the use of two different trunk restraints. Residents included are 1, 2, and 3. Findings include: 1. Resident 2 was an 87 year old female who was observed in her wheelchair with a lapbuddy in place on her wheelchair during all days of the survey. A physician telephone order dated 9/9/05	F 279	continued: consistent with physician orders, and updated as changes are made. The Assistant Director of Nursing will ensure, through a monthly physical restraint team meeting, that physical restraints are reviewed for less restrictive measures, and that all documentation is current, appropriate and consistent with facility policies and procedures. The Assistant Director of Nursing will inservice all Patient Care Coordinators on care plan development, review and revision, including the necessary components of measurable objectives and timetables to meet each resident's medical, nursing and mental and psychosocial needs. The Patient Care Coordinator over each unit will be responsible to ensure that all care plans are complete and correct within 21 days of admission, and ongoing that they are current, consistent with physician orders, and updated with	12/02/05 12/02/05 12/02/05

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F 279	Continued From page 2 stated "Lap buddy in wc (wheelchair) for safety..." Resident 2's care plan stated, "Soft waist restraint in place while in w/c . Evaluate use of restraints quarterly prn (as needed) for less restrictive measures. Lapbuddy on while pt (patient) is in wheelchair." 2. Resident 1 was an 81 year old female who was observed in her wheelchair with a softwaist restraint in place on her wheelchair during all days of the survey. Resident 1's care plan did not have a goal that addressed the soft waist restraint or any trunk restraint. A review of resident 1's Minimum Data Set (MDS) assessed the resident as using a trunk restraint daily. This was evidenced on all MDS' reviewed back to 11/13/04. 3. Resident 3 was an 84 year old female who was observed in her wheelchair with a softwaist restraint in place on her wheelchair during all days of the survey. Resident 3's care plan did not have a goal that addressed the soft waist restraint or any trunk restraint. A review of resident 3's MDS assessed the resident as using a trunk restraint daily. This was evidenced on all MDS' reviewed back to 7/7/05.	F 279	continued: changes, a minimum of quarterly, through the weekly IDT process. The Assistant Director of Nursing will ensure complince to the process through random audits on 20% of the facility care plans every month for 3 months. The results of this QA process will be reported and documented in the monthly facility QI meeting.	
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	F 309	Nursing staff will be in-serviced before 12/02/05 on appropriate uses of psychoactive medication and all staff will be inserviced on the importance for each resident to have acess to the nurse call system. The call system will be addressed by the recommendations of Tag F463 response.	12/02/05

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F 309	Continued From page 3 by: Based on observations, staff interviews and record review, it was determined that for 1 of 24 sampled residents the facility staff did not 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. Specifically, Resident 6 was given an anxiolytic medication for "shaking his siderail", when staff report this is Resident 6's way of communicating. Findings include: Medical Record Review was completed on 10/4/05. Resident 6 was admitted to the facility on 11/11/04 with diagnoses including, macular degeneration, aspiration pneumonia, chronic obstructive pulmonary disease, ventilator dependency, and a tracheostomy. Review of Resident 6's medical record revealed that Resident 6 received 0.5 milligrams of Ativan, an anxiolytic, on the following days for "shaking his siderails". a. 6/15/05 at 5:49 AM b. 8/19/05 at 10:22 AM c. 9/12/05 at 3:22 PM d. 10/5/05 at 3:06 PM Interviews with seven different facility staff were conducted on 10/3/05-10/6/05. All staff interviewed confirmed that Resident 6 communicated with staff or got the staff's attention by "shaking the siderails".	F 309	continued: Under the communication deficit problem of Resident #6 care plan, we have specifically addressed his shaking of the side rails as a form of communication. A psychotropic drug meeting will continue to be held monthly. As in the past, each resident on psychotropic medication will be reviewed on a quarterly basis and P.R.N. on what their psychotropic medications are and how they are being used, making sure that resident's needs are being met and that psychotropic medication is not interfering with those needs. A monthly random sampling of 25% of all residents on psychotropic medications will be audited by the Assistant Director of Nursing for the next 3 months. The psychotropic meds will be reviewed for appropriate, diagnosis, behavior tracking and accurate careplans. Results will be reported to the QI Committee on a monthly basis.	12/02/05 12/02/05

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F 309	Continued From page 4 Observations on 10/3/05-10/6/05 showed that Resident 6's call light remained on the shelf of the west wall above Resident 6's bed. The call light was not accessible to Resident 6 throughout the recertification survey.	F 309		
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews it was determined that for one of 24 sampled residents, the facility staff did not ensure that Resident 6 received the proper treatment and care for respiratory care including written procedures for ventilators, e.g. functioning alarms, frequency of staff monitoring, and monitoring of the resident response. Specifically, Resident 6's ventilator alarm and red call light, (mechanism used to let staff know that something is amiss with the ventilator), were allowed to signal without staff intervention. Findings included:	F 328	A staff meeting will be conducted by the Nursing Management Team to review the policy and procedures of the ventilator alarm system before 12/02/05. Weekly audits will be conducted by the Nursing QI Coordinator for resident # 6 to evaluate and assess the number of high and low pressure alarms and the associated response times of each, for four weeks. Results will be reported in the quality assurance committee meeting.	12/02/05 12/02/05

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F 328	Continued From page 5 Resident 6 was admitted to the facility on 11/11/04 with diagnosis including, aspiration pneumonia, chronic obstructive pulmonary disease, macular degeneration, tracheostomy, and ventilator dependency. On 10/5/05 at 9:01 AM two nurse surveyors observed the red call light above Resident 6's room to be flashing off and on. Upon entering Resident 6's room, both nurse surveyors observed the ventilator of Resident 6 to be beeping. Resident 6 was observed to be turning red in the face and coughing. The ventilator and red call light continued to alarm and signal until 9:03 AM. At 9:03 AM the ventilator quit beeping and the red call light outside of Resident 6's room quit signaling. Resident 6 was observed for an additional seven minutes after the call light stopped flashing and the ventilator quit alarming. No staff were observed to come into the room and check Resident 6 while the call light signaled or the ventilator beeped. Nurse Surveyors observed Resident 6 until 9:10 AM. No staff were observed to come into Resident 6's room and check Resident 6 or the equipment during the additional seven minutes of observation. On 10/6/05 at 8:10 AM, a facility staff Registered Nurse was interviewed. Registered Nurse (RN) 1 stated that the red call light means the ventilator is going off or a bed alarm is going off. RN 1 further stated that when the light goes off the staff have an immediate response, "under a minute", to check the resident and the equipment. RN 1 stated that all staff are trained as to what the red call light means and how to respond. On 10/6/05 at 8:15 AM, three different licensed	F 328		

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F 328	Continued From page 6 facility staff members were interviewed regarding the red call light. All three staff members confirmed that the red call light means something is wrong with the ventilator and staff should come right away, "30 seconds to a minute". All three staff members acknowledged that all staff have had training on the red call light and how the staff were to respond. On 10/6/05 at 11:10 AM the Director of Nursing was interviewed regarding the red call light. The Director of Nursing stated that the red call light will signal if something is wrong with the ventilator or if the ventilator is alarming. The Director of Nursing further stated that the alarm should not signal for a minute and that two minutes to answer the alarm is "Pushing it."	F 328		
F 371 SS=E	483.35(h)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to store, prepare, and distribute food under sanitary conditions. Findings included: 1. On 10/3/05 at 9:55 AM, observations were made in the main kitchen. The large Hobart mixer and the Kitchen Aid mixer had dried food particles on and around the neck. These particles have the possibility of flaking of	F 371	Mixers were cleaned thoroughly and staff in-serviced on daily cleaning requirements. Food/ Nutrition Services Manager will review at next staff meeting held November 7, 2005. Food/Nutrition Services Manager will also experiment with steam cleaning and implement consistent deep cleaning cycle with both mixers. Quat sanitizer buckers will be prepared q 2 hours or after raw meat contamination. Food/Nutrition Services Manager will continue to	12/02/05 12/02/05

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F 371	Continued From page 7 and falling in a new batch of food causing contamination. There was a red sanitizer bucket near the range on top of wire shelves. The Quat (Quaternary) test strip measured 100 ppm (parts per million) when dipped in the sanitizing solution. The sanitizing solution must measure 200 ppm. There was another red sanitizer bucket under the preparation counter across from the ovens. The Quat test strip measured 100 ppm when dipped in the sanitizing solution. The walk-in refrigerator had fresh shell eggs stored on a shelf above ready to eat spinach salad. The following spice lids were open: garlic powder and sesame seeds. Lids must be closed when not using spices to prevent possible contamination. 2. On 10/3/05 at 10:25 AM, observations were made in the Orchard Cove kitchen. A cup scoop was lying in a box of bread crumbs. Other scoops were stored in bins of flour and sugar. A bottle of food color, egg shade, was missing the lid and a hole was punched in the top. The garlic powder and baking soda had the lids up. 3. On 10/4/05 at 6:30 AM, observations were made again in the main kitchen. The large Hobart mixer and the Kitchen Aid mixer had dried food particles on the neck of the mixer.	F 371	continued: check strength to ensure it measures 200 ppm. Staff have been in-serviced on preparation and strength and Food/Nutrition Services Manager will review again at staff meeting held on November 7, 2005. Shell eggs will be stored in shipping box on bottom shelf at all times. Staff have been in-serviced and Food/Nutrition Services Manager will review at staff meeting held November 7, 2005. Spice lids will be closed when not in use to prevent contamination. Damaged lids will be replaced. Food/ Nutrition Services Manager will review at staff meeting held November 7, 2005. Scoops will not be stored inside bins or boxes with bulk foods. They will be stored outside bag of food inside bin, or in clean, dry place between uses. Food/Nutrition Services staff were in-serviced on 10/05/05. Food & Nutrition Services Manager will do monthly	12/02/05 12/02/05 12/02/05 12/02/05

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F 371	Continued From page 8 The following spice lids were open: garlic powder and sesame seeds.	F 371	inspections X 3 months on all of the above items and record compliance and any further action needed as part of QI process.	
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined that the facility staff did not have a communication system for all the residents to directly contact the nurses' station from their room. Residents 6, 12, 13, 14, 22, and 23. Findings included: 1. Resident 6 was observed during the survey from 10/3/05 through 10/6/05. Resident 6 was admitted to the facility on 11/11/04 with diagnosis including, aspiration pneumonia, chronic obstructive pulmonary disease, ventilator dependency, tracheostomy, and macular degeneration. During the coarse of the survey, from 10/3/05 through 10/6/05, Resident 6's call light was observed to be hanging over the shelf of the west wall above Resident 6's bed. Resident 6 was not able to access his call light. The call light was never observed to be within reach during the recertification survey. On 10/3/05 at 3:40 PM Resident 6 was observed	F 463	Resident #6 call light was placed on his bed within his reach on 10/06/05. Resident # 12's call light button and cord was replaced on 10/05/05. Resident # 13 had an adaptor placed into the call system to accommodate both a bed alarm and a newly placed call button on 10/05/05. Resident # 14's call light was plugged in and placed within reach on 10/05/05. Resident #22 received easy pressure flat call light on 10/06/05. Resident # 23's flat call light was placed within reach on 10/06/05.	12/02/05

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F 463	Continued From page 9 to be sitting in a chair with no call light accessible to him. Resident 6 was observed to motion with his hands for a nurse surveyor to come closer. Resident 6 was observed to try and grab the nurse entering the room to get her attention. Resident 6 was observed to motion with his hands at the certified nurses aide entering the room. On 10/6/05 at 8:10 AM an interview was conducted with Registered Nurse 1. Registered Nurse 1 stated that Resident 6 knew how to use the call light and she was unsure as to why it was hanging over the shelf above Resident 6's bed. Interviews were conducted with seven different facility staff members from 10/3/05-10/6/05 regarding Resident 6's ability to communicate with staff or get the staff's attention when Resident 6 is in need of assistance. All seven individuals confirmed that Resident 6 will "rattle the side rails" to get their attention or let the staff know he is in need of assistance. 2. On 10/5/05 at 8:15 AM, resident 12's call light was observed to be broken. The red button to press to activate the call light was missing. 3. On 10/5/05 at 8:16 AM, resident 13's bed area was checked in her room. There was no call light for resident 13. On 10/5/05 at 8:40 AM, a patient care coordinator was interviewed. He observed that resident 13 did not have a call light. He stated, "This bed should have a bed alarm and a call light. It should have both. I will look into that." 4. On 10/5/05 at 8:17 AM, resident 14's call light was observed to have the cord wrapped and	F 463	continued: All patient care providers will be in-serviced by 12/02/05 regarding call light policy. Providers will be in-serviced on the use of adapters when bed alarm and call lights are in use. The QI Coordinator will perform bi-monthly audits for 3 months, sampling 25% residents to monitor proper call light placement and function. These results will be reported to the QI Committee.	12/02/05

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F 463	Continued From page 10 tangled around the bed rail. The plug of the call light was laying on the floor, rather than being plugged into the system. 5. On 10/5/05 at 8:18 AM, resident 22's bed area was checked. There was no call light for resident 22. On 10/5/05 at 8:20 AM, the nurse was interviewed. She stated that resident 22 needed an easy pressure flat call light. She said that central supply was out of flat call light remotes; it was on order. 6. On 10/6/05 at 8:15 AM, resident 23 was observed laying in bed. Resident 23's flat call light remote was hanging down under the bed. It was not accessible to resident 23.	F 463		