STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIES

(X1) PROVIDER/SUPPLIAR/CUA DUNTHICATION NUMBER.

XE VATE SURVEY (XZ) MILL HPLH CONSTRUCTION 8349 7761 74 8 COMPLETED A RUIT DING HAR 6 2003 B WING 1/31/2003

465082

CRESTVIEW CARE CENTER

1053 WEST 1020 SOUTH PROVO, UT 84601

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(X4) ID PREFIX TAGE

STIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEIDED BY FULL). REGULATORY OR LSC IDENTIFYING INFORMATION) STREETS TAG

STREET ADDRESS, CITY, STATE, ZIP CODE (

PROVIDER'S PLAN OF CORRECTION CEACH COMPRICTIVE ACTION SHOULD BE CROSS REPORTENCED TO THE APPROPRIATE DEFICIENCY

COMPLETE DATE

F 224 483.13(c)(1)(i) STAFF TREATMENT OF SS=J : RESIDENTS

> The facility must develop and implement written policies and procedures that prohibit mistreatment neglect, and abuse of residents and misappropriation of resident property.

(Use F224 for deficiencies concerning mistreatment, neglect or misappropriation of resident property.)

This REQUIREMENT is not met as evidenced by: Based on interviews and medical record review, it was determined that the facility neglected to assess. monitor, report and intervene with a significant change in a residents' mental status. Subsequently, the resident died of a polydrug overdose that was "certified as suicide" by the medical examiner.

Resident 1 was admitted to the facility on 1/8/02. Resident 1 had a verifiable serious mental illness of Major Depression, recurrent, moderate. On 11/8/02, nurses notes documented that resident I was crying and yelling in the hallway. At that time, resident 1 yelied "I'm going to hoard my pain pills and take them all at once!" On 11/23/02, resident 1 expired in the hospital. Interviews with facility stall during this investigation from 1/27/03 through 1/31/03 revealed that prior to and after resident 1 made this suicidal threat, she was experiencing a major life change and extreme mental distress

There was no evidence that the facility assessed her mental status after she declared her intention on 11/8/02. There was no evidence that facility staff who had knowledge of the suicidal threat, notified the attending physician, the facility's social service worker (SSW), the licensed clinical social worker (LCSW) consultant or other administrative statt.

This letter is to serve as our letter of credible allegation of compliance for our immediate jeopardy tags. We have addressed the issues that you shared with us during your exit conference. The decision point of asking if the same circumstances presented today would the facility respond in the same way is the case we are using to judge ourselves and we feel as of noon today the answer to that question is no. We feel like no resident was in immediate jeopardy as of Saturday February 1, 2003 but our mandatory in servicing was not completed until noon on Monday

The narricular aspects of our actions taken to date are as follows:

February 3, 2003.

- 1. The facility contracted with a consultant MSW to do in servicing to the entire staff on signs and symptoms of emotional trauma and suicide precautions.
- 2. The consultant MSW reviewed our current policy and procedure to ensure proper coverage.
- 3. The consultant MSW reviewed the charts of residents with a diagnosis of depression.
- 4. The consultant MSW has committed to increased time in the facility to ensure ongoing compliance, and is following those residents needing a level two-passar screen.
- 5. The consultant MSW is co signing the facility social worker's notes to help identify training needs.

Any deficiency enterment ending with an anciral 17 soldiers a deliciency which may be exceed from corrections providing the detectable of that other safeguards provide sufficient procession to the patients. The findings stated above the disclosulate whether or not up has of correction is provided. This findings are disclosulate within 14 days after such information is made available to the facility. It deficiencies are cited, an approved plan of correction is requisite to continued program participation.

(89) DATE

89/18/2003 17:01 NUL3732660

CRESTVIEW CARE CENTE

FAGE 82 PRINTED: 2/1/2003

TATEMENT	S POR MEDICARE. TOWNSPICENCIES TO CONSECUTORS	(KI) PROVENSOPPLES ENSEMBLESCHON FUR	CLIA	A RULLING	OUNSTRUCTION		E E E E E E E E E E E E E E E E E E E
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AME OF ST	KOVIDER OR SUPPLIER			USS, CITY, STATE	LZIP CODE		
RESTY	IEW CARE CENTER		PROVO, U	1020 SOUTH F 84601			
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F221 SS⊷I	RESIDENT'S The facility must de policies and procedingleci, and abuse of of resident property. (Use F224 for deficie legical and abuse of of resident property.) The REQUIREME! Based on interviews was determined. The same of the control of the c	nce that the facility ass the declared her intenti- no evidence that facili	invitors realisment, registation realisment, registation realisment, pacty) and by: Actor a saces, continued as a saces, continued as a saces, continued as a saces, continued as a saces, and a 17,8702, as a raylog sadent 1 of take expired in their gets in revealed saces, and a saces are a saces and a saces are a saces and a saces and a saces are a saces and a saces and a saces a	F724	consultant's servering to signs and si emotions i procautions. The consultant procedure is covering. The consultant procedure is covering. The consultant disposits of the charts of disposits of the facility compliance those projections.	if compliance for ; continues to the beautiful to the beautiful to the same man and the same man and the same may be to judge outselves to the same way is to judge outselves to the same same same same same same same sam	
	attending physician worker (SSW), the	s of the solutidal threat, , the facility's social so Hoensed clinical social	vice wake:		signing the worker's n	turit MSW is co theility social otes to help identify	
	(LCSW) consultant	is other editioniscentive Dendeller	stall.	ministr	unining per unus	2/28/0	: ; ; ; ; ;

PRINTED: 2/7/2003 DEPARTMENT OF HEALTH AND HUMA. . SERVICES FORM APPROVED 2567-L CENTERS FOR MEDICARE & MEDICALD SERVICES (XX: DATESURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NO MULTIPLE DONSTRUCTION NIN PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A BUILDING B. WING 1/31/2003 465082 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1053 WEST 1020 SOUTH CRESTVIEW CARE CENTER PROVO, UT 84603 SUMMARY STATEMENT OF DURINGENCIES PROVIDEL'S PLAN OF CORRECTION (X3) COMPLETE (X4: II) (EACH DEFICIENCY MUST BLERD CEEDED BY FULL TRACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS REFERENCED TO THE APPROFRIATE. RUGULATORY OR LISC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY 6. The facility has taped and held F 224 F 224 Continued From page 1 in-services from the county mental health services. The in-There was no evidence that the one staff member who identified resident 1 with severe depression the night services were to help with prior to the suicide had notified anyone or intervened. access and to identify needs for referrals. There was no documentation to evidence that facility 7. The county mental health staff were monitoring the mental status of resident 1. services reviewed the policy There was no documentation to evidence that facility and procedure to ensure that staff attempted to intervene when resident I was their proper numbers were in identified with extreme mental distress and voiced a specific suicidal threat. In addition, once the facility 8. The county has in serviced the became aware that resident 1 committed suicide, they entire staff. failed to investigate the events sarrounding her death. . 9. The facility has reviewed three months of charting to ensure The facility's failure to assess, monitor, report and that no other notations of intervene with resident 1 led to a determination of suicide ideation. None was Immediate Jeopardy for neglect. 10. The facility reviewed the plans The facility was found to have removed the of care for residents with a immediate enpardy on 2/3/03. Also, during the diagnosis of depression; to survey, no other residents were found to have ensure proper care plan psychological problems of an immediate nature which annroaches were included. were not being addressed by the facility 11. The results of the chart audit and in-services have been Findings include: reviewed by the facility practices committee for 1. Resident 1 was a 59 year old female who was development of further action admitted to the facility on 1/8/02 with the diagnoses. of engumonia, choudrodystrophy, fibromyalgia, 12. The facility staff has been octoearthrosis, arthropathy and diabetes. Resident 1 given competency testing over also had a verifiable serious mental diness of Major protocols for suicide

The medical record of resident 1 was reviewed during all days of survey, 1/27/03 through 1/31/03.

The admission psychosocial assessment, dated 1/20/02, documented that prior to hor admission to

94 year old mother "for many years." It also

Depression, recurrent, moderate,

Event ID 1.X1K11

prevention. 13. The facility has posted important numbers and

> standard protocols for emotional distress recognition and intervention.

PRINTED: 2/7/2003

FORM APPROVED DEPARTMENT OF HEALTH AND HUMA. SERVICES 2567-L CUNTERS FOR MEDICARE & MEDICAID SERVICES K3) DATE SURVEY STATEMENT OF DEDUCENCESS STO DRECOGNISH AST TRRETTED AT TA (AD) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION JUSNITHICATION NUMBER: A. BUILDING B. WONG 465082 1/31/2003 STRUCT ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1053 WEST 1020 SOUTH CRESTVIEW CARE CENTER PROVO, UT 84601 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION œ (X4) ID COMPLETE (EACH DRIGGENCY MUST BE PRECEEDED BY FULL PRINTS (FACH CORRECTIVE ACTION SECULD BY PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION: CROSS-REPARENCED VID THE APPROPRIATE 10000 TAG DEDICIENCIÓ The administrator and social F 224 F 224 Continued Francisce 2 services have been given inservices by the MSW on documented that the siblings of resident 1 were recognition of emulional "concerned with the effort her mother has had to expend, which has been detrimental to her own distress. 15. The standard in-service health, to care for [resident 1]. According to her calendar has been adapted to family, [resident 1] has not moved from the couch for include quarterly training on over a year. They reported that her mother slep: at emotional distress and suicide the end of the couch so besiden; 11 could awaken her precautions. to meet her needs or reposition herself by pushing 16. The facility medical director against ber body." It should be noted that resident 1 has consulted with us to ensure and her mother were admitted to this same nursing proper medical interventions home on the same day (1/8/02) and shared the same for residents with emotional room until 11/7/02. distress or suicide ideation. The preadmission screening resident review for We feel the above actions have adverted serious mental illness (PASRR), level 2, was any negative affect on our residents. completed on 1/23/02 and documented that resident 1; The resident complaint under your was "very dependent on 94 year old mother...appears investigation is continuing to ensure preoccupied with parent to exclusion of others". that this resident can continue to help us Another part of this report documented "She understand how systems would heln to describes sad feelings, withdrawl behaviors, lack of avoid this circumstance. A consultant sleep, poor interaction with others, increased physician with expertise in mental anger...Tends to only want to interact with her health has been contacted to review this mother. Relationship appears to be symbiotic." chart, due to the questionable death certificate A social service note, dated 13/5/02, documented "Undate - several stall members expressed concerns re: [resident 1's] increasing demands on her mother/sm mate - felt 'resident 2'l was becomine increasingly tired and upset by [resident 1's] continual 'instructions'. Social services will contact guardian (son of resident 2), to pass on concerns and room. options for her mother." A social service pote, dated 11/6/02, documented an "update" regarding the son of resident 2 and his wife which noted that "both stated they had become

increasingly frustrated with fresident I'sl

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STATEMENT OF DEPICIENCUS AND PLAN OF CORRECTION

ALLXXII PROVIDER/SUPPL/SEATUA IDEN DIFIGATION NUMBER. ASSESSMENT OF THE PROPERTY OF A BITTLDING

(X3) DATE SURVEY COMPLETED 1/31/2003

465082 NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CLIV, STATE, ZIP CODE

1053 WEST 1020 SOUTH ODESTVIEW CARRIESTED

CICLOSTIA	ST CALL. VAS. CILIK	PROVO, UT	84601		
(X4) ID PREEX TAG	SUMMARY STATEMENT OF DEPICIENCIES (FACH DEPICIENCY MUST BE PRECIADAD BY RECLUSIVEY OR USE IDENTIFYING INFORMA-	PULL	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OPPURIENCY)	(NS) COMPLETE DATE

F 224 Continued From page 3

fresident 11 if she continued to 'truset mem' or give her commands they would move [resident 2] to either another room or another facility... Other DEPT. (department) heads who had experienced the frequent demanding/assetting interaction between fresident 11 and [resident 2] also felt it would be in [resident 2's] best interest."

On 11/7/02, resident 2, the 95 year old mother of reschent 1, was moved to a different room in the facility.

A social service note, dated 11/7/02, documented "Social services explained to [resident 1] that it was her own behavior with the tx (treatment) of her morn that resulted in the move rather that everyone being 'hateful' as she had accused - [Resident 1] requested a visit with her mother that instantly had both (resident 1) and (resident 2) sobbing and (resident 1) making suggestions to [resident 2] about death and killing people ."

A note in the medical record of resident, written by murse A, dated 11/8/02 documented "...Pt. (patient) requesting to est Junch in DR (dirang room). SSW instructed rise (nursing) to discourage of d/t (due to). directives to separate Tresident 11 and Iresident 21. When nurse approached fresident 11, by began crying. yelling in hallway. Assisted back to room, lips et (and) mouth eyanotic. Refused 02 (oxygen). Trusoing to heard my pain pills and take them all at once! One way or another I'm going to get my mama back. Witnessed taking all meds."

A nurse's note, dated 11/23/02 at 7:00 AM, documented "Pt was found at 0645 (6:45 AM) unconscious. Not breathing et no pulse...EMS (emergency medical services) left the care center with

F 224

Resident number 1 was no longer in the facility at the time of this complaint investigation.

Residents with a change in psychosocial well-being have the potential to be affected.

A complete chart audit was done for the previous three months to determine if any other residents were in need of acute intervention, none was found. The policy and procedure for assessing. monitoring, and reporting changes in mental well-being was reviewed and rein serviced to the entire staff. Competency testing on the policy was done on a random basis to ensure education was effective. The contracted LCSW held in-services on the emotional distress and interventions and the local mental health organization in serviced employees on how to access and recognize the need for interventions.

The last month of 24-hour reports were reviewed to ensure that residents were being identified with emotional distress and interventions taken. The DON. ADM, and Social Worker were re in serviced on the emotional needs and identification of distress in the nursing home client.

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 2567-L STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED (XI) PROVIDERSTEPLIERCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUZ DING C B. WING 465082 1/31/2003 STREET ADDRESS, CITY STATE, ZIP COOL. NAME OF PROVIDER OR SUPPLIER

DAN TO STOMARY STATEMENT OF DIRECTIONS THEORY TAG TO STATEMENT OF LINE TO PROJECTION OF REGORDATORY OR LINE IDEAS PROJECTION OF REGORDATORY OR LINE IDEAS PROJECTION OF THE PR	dated croffee and law resident	ID PREFIX TAG	PROVIDERS IF AN OF CORRECTION TAGGE CORRECTION ACTIONS SHOULD BE CROSS-REPERBINGED TO THE APPROPRIATE DEBOGRAPHY. The orientation and in service calendars have been adapted to have specific times to address this issue.	(X5) CUMFLET DATE
the pt at 0720 (7:20 AM)." A letter from the medical examiner's office, 12/20/02, addressed to resident 2 (the mothe resident 1) stated "luwestigation by our office enforcement personnel has determined the [i	er of e and law resident	F 224	have been adapted to have specific times to address this issue.	
manner has been certified as suicide." During review of the autres's actes from 118 day resident 1 (fied or 11/23/02, there was in documentation to evidence that facility staff the arending physician, the facility's social is worker (SSW), the itensed citrical social w (LCSW) consultant or other administratives the smootal threat. There was no evidence the staff ussessed the montal status after resident dealers their intention on 11/8/02 to hoard al pain pills and take them all at urce. There we documentation to evidence that facility staff any type of mental health consultation for reto address the aucidal threat. Based on review of the facility's November 2 missing schedule, there were ten nurses who with resident 1 from 11/8/02 through 11/25/0 During interviews with all ten nurses (beginn 1/27/03 and ending 23/03), it was discovere of the nurses decided any knowledge of the suthers at vaced by resident 1. Daring the nore was determined dust nene of the three remainurses, who stafed they were aware of the situated activities of the situation physician, the fixed also service worker. the J.CSW consultant administrative staff. Norses A. G. and C. were aware of the specific	8/02 to the to the to the total service warker staff of the feedbay for the total staff of the feedbay for the total staff of the feedbay for the feedbay feedbay for the feedbay feedbay for the feedbay feed		The results of the audits will be reported to the Cuality of Life committee for review and to determine action plans as needed. This will be on an ungoing issue to be addressed monthly. The ADM is responsible for ongoing compliance.	

PRINTED: 2/7/2003 DEPARTMENT OF HEALTH AND HUN. SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 2567-1 STATEMENT OF DEFICIENCES AB) DATE SURVEY CX:: PROVIDENSUPPLIERGUA PROTECTION REPORTS OF THE PARTY OF THE AND IS AN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A DOMESTING CB. WING 465082 1/31/2003 NAME OF PROVIDER OR STORY HAS STREET ADDRESS, CTD: STATE, ZIP CODE 1053 WEST 1020 SOLTH CRESTVIEW CARE CENTER PROVO. UT 84601 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (NA) COMPLETE 0345 05 (L'ACH DEFICIENCY MUST BE PRECBEDED BY FULL PREFEX (LACIL CORRECTIVE ACTION SHOULD BE PRIDAX CROSS-REFERENCED TO THE APPROPRIATE LATE REGULATORY OF LSC IDENTIFYING INFORMATION) TAG TAG DEFECTIONS: F 224 Continued From page 5 F 224 it to the attending physician, the facility's social service worker, the LCSW consultant or other administrative staff In continuing the interviews with the other seven nurses, it was clear that they were not aware of what procedures to follow had they become aware of the suicidal threat. Each of the seven nurses were asked what they would have done if they had been told of the suicidal threat. Their responses are as follows: Nurse B would have talked to her about it. Nurse D would have checked her every half hour throughout the night and first thing in the morning would have reported the suicidal threat to the attending physician and the social worker. Nurse E would have called the doctor. Nurse F would have talked to resident 1 about it and then called the physician Nurse H would have checked resident 1's mouth to make sure she was swallowing her pills and then would have looked in her room and drawers for pills. Nurse K would have made sure resident I had taken her pills and then made the director of nurses aware. Nurse J would have talked with resident 1, held her pills and notified the social worker and director of Eurses (DON). Although surses E and H were not aware of the specific suicida! threat, they both documented evidence of resident 1's extreme mental distress and then failed to document that any follow-up had been done The DON was interviewed on 1/27/03 at

taks them all at opos.

approximately 4:30 PM. She denied being aware that

PRINTED: 2/7/2003

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 2567-1 SECTION OF STREET STATEMENT OF DEFICIENCIES COLUMB OF THE PROPERTY OF THE OVER MILE TOPLE CONSTRUCTION. AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER A BUILDING B. WING_ 465082 1/31/2003 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1053 WEST 1020 SOUTH CRESTVIEW CARE CENTER PROVO, UT 84601 SUBMARY STATEMENT OF DELICIENCIES PROVEDER'S FLAN OF CORRECTION (You ID (EACH DIRECTENCY MUST BE PRECEDED BY \$170.) PRESTA (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR ESCHIENTIFYING INFORMATION: CROSS-REFERENCED TO THE APPROPRIATE. TAG TAG DEFICIENCY F 224 Continued From page 6 F 224 The social service worker (SSW) and administrator were interviewed on 1/27/03. Both the SSW and administrator stated that resident I could be manipulative, demanding and dramatic. They stated that resident 1 would make many demands of her elderly mother and that her other siblings were concerned about their mother's health. The SSW stated that after resident 1 and 2 were placed in different rooms, by request of the guardian (who was also the son of resident 2), resident 1 became very unset and contacted a lawver. During interview with the SSW on 1/31/03, she stated that resident's 1 and 2 were being kept apart, again by request of resident 2's guardian. The SSW also stated that resident 1 called her mother (resident 2) on the telephone and would say "Mother, I'm somewhere here in the facility. You have to find me. You have to find me." Both the Administrator and SSW denied being aware of any specific suicidal threat from resident 1. Resident 1's attending physician was interviewed by telephone on 1/30/03 at 9:45 AM. During this interview, the physician was "shocked" to hear that the medical examiner had certified resident 1's death to be a suicide. He stated that he did not remember any calls saying she (resident 1) was suicidal and denied being aware of the specific suicidal threat. He stated that if he had been aware, he would have taken it seriously and involved a psychiatrist and a social worker. "I would have acted more aggressively." The facility's medical director was interviewed by phone on 1/30/03 at approximately 9:55 AM. He stated that he had not been made aware of the spicific

and was not aware that resident 1 had made a specific

FORM APPROVED 2567-1 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) DATE SURVEY STATEMENT OF DEFICIENCIES CXE: PROVIDER/SOPPLIER/CLIA DAZLIMIC CIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WING ... 1/31/2003 465082 STREET ADDRESS CITY, STATE ZIP CODE NAME OF PROVIDER OR SUPPLIES 1053 WEST 1020 SOUTH CRESTYIEW CARE CENTER PROVO, UT 84601 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (32) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (RACH DEFICIENCY MUST BE PRECESSION) BY FULL PRHEIN PREFEX REGULATORY OF LSCHOOLSTRYING INFORMATION) CROSS REFERENCED TO THE APPROPRIATE TAIR TAG DEFICIENCY: F 224 F 224 : Continued From page 7 On 1/27/02 at 3:15 PM marse H was interviewed. Norse II took care of resident I on numerous occassions and the night before she died, Nurse H was not aware that on 11/8/02 resident 1 had threatened to hoard her pills and take them all at one time. Nurse H. stated that sometime before the involuntary separation, the nurse recalled a telephone conversation involving resident 1 and 2 and a family member. Nurse H stated that resident 2 told the family member, as instructed by resident 1, that resident 2 would kill herself if they were separated. Nurse H stated that after resident 1 was involuntarily separated from her mother, at first resident 1 was angry and ornery. Resident 1 complained, why did they have to move her? Then resident 1 would cry and scream. Nurse H stated that then resident 1 got actively involved in trying to get her mother's power of artomey. Nurse H stated that on the evening of 11/22/02 resident 1 was very down and wouldn't eat her dinner. Nurse H explained that resident 1 decided ke so to the Ballroom Dance Activity held that evening in hopes of sesing and talking with her mother. Resident 1 came back from the activity even more depressed, "the worst I'd ever seen," because

ter pills.

On 1/29/07 at 2:50 PM name E was interviewed

according to resident 1 her brother would not let resident I sit near her mother. Nitrse H statual that if she had known about resident 1's comment reguarding hoarding her pills she would have looked in her mouth, after administering her medications and would have cheezed in resident 1's drawers/room

CENTERS FOR MEDICARE & MEDICALD SERVICES

(X1. PROVIDER/SUPER/ROCLIA (X2) MU JOPLE CONSTRUCTION DENTIFICATION NUMBER: A BUILDING 3. WING

465082

(X2) DATE SURVEY COMPUSION C: 1/31/2003

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF SHPICIENCES

AND PLAN OF CORRUCTION

STREET ADDRESS, CITY, STATE, ZIP CODE

CRESTVIEW CARE CENTER

1053 WEST 1020 SOUTH PROVO, UT 84601

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PREITX TAG	(EACH DESCRIPTION OF MUST BE PRECEDED BY FULL.	FRILIX J.N.1	(RACH CORRECTIVE ACTION SHORED BY CROSS-REFERENCE) TO THE APPROPRIATE	COMPRETE
	There was no documentation in the medical record to englence that facility stall were addressing, monitoring, reporting or intervalng with the extreme mental discress was evidenced by: - rise comment of 11/8/02 when she was crying and yelling and threatening to show all the pain pills and take them all at once, - the observation by aurise A when resident 1 was expanded and refusing the plan of the oxygen constanting several lawyses contacting several lawyses calling her mother on the phase and saying "You have to find the." You have to find me.", - the observation made by the SSW of resident 1 solving a making supervisions about death and			

CENTERS FOR MEDICARE & MEDICAID SERVICES

(XII) PROVIDERSUPPLIERALLA OCA MULTIPLE CONSTRUCTION DENTIFICATION NUMBER:

465082

COS DIAGO SURVEX COMPLETED A. BUILDING B WING 1/31/2003

STATEMENT OF DERIGENOUS

NAME OF PROVIDING OR SUPPLIES

AND PLAN OF CORRECTION

STREET ADDRESS, CITY STAIR, ZIF CODI. INC. MEET 1820 COUTH

CRESTV	CRESTVIEW CARE CENTER		1053 WEST 1020 SOUTH PROVO, UT 84601				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DESCRIPTION OF GRACH OWN CLICK WAS BE PRECEDED BY REGULATORY OR LSC INVESTIGATION OF OWNER	FUZ.	ID PRAFIX TAG	PROVIDERS PLAN OF CORRECTION GENCH CORRECTIVE ACTION SHOULD HE CROSS-REFERENCED TO THE APPROPRIATE DEFICULACY.	COMPLETE DATE		
F 224	Continued From page 9 killing people. - the observations made by nurse H where it would not eat her dinner, and would cry a - the observation made by nurse H the night resident I died stynig. "Sel president I] was I'd ever seen." I'd ever seen." - the comment heard by nurse H in which r was heard to tell her mother to tell the guas seen that the mother would kill herself if he from resident I, - the statement by nurse E in which she stated the statement by nurse E in which she stated after being separated from her mother, rost became more depressed and was observed to ricer.	nd acream t before fine worst estdent 1 chan (the parated ted that dent 1	F 224				
	483.13(c)(L)(c) STAFF TREATMENT OF RESIDENTS The facility must not employ includuals wibers found guilty of abusing, reglecting, or marrarang residents by a court of law, or a finding entered into the State nurse using recomming abuse, neglect, mistreatment of or missipprogration of their property, and knowledge it has of actions by a court of lat an employee, which would indicate unfilted.	no have have hac egistry residents eport any	Tas of land	:			

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

service as a norse aide or other facility staff to the State nurse aide registry or licensing authorities.

PRINTED: 2/7/2003 DEPARTMENT OF HEALTH AND HUMA. SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 7567-1 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA :X2: MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER. A RITTENSO B. WING ... 465082 1/31/2003 STREET ADDRESS CITY, STATE, 21P CODE NAME OF PROVIDER OF SUPPLIER 1053 WEST 1020 SOUTH CRESTVIEW CARE CENTER PROVO, UT 84601 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION CKS: (X4) ID (EACH DEFICEINCY MUST BE PRECEPTED BY FULL. PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREHX TAO REGULATORY OF LISCIDENTIFYING INFORMATION TAG CROSS-REPERSIONED TO THE APPROPRIATE DESCRIPTION certification agency) The facility must have evidence that all alleged F 225 violations are thoroughly investigated, and must Resident number 1 was no longer in the prevent further potential abuse while the facility at the time of this complaint investigation is in progress. investigation. · The results of all investigations must be reported to Residents with a change in psychosocial the administrator or his designated representative well-being have the potential to be and to other officials in accordance with State law affected. (including to the State survey and certification The facility contracted with a consultant agency) within 5 working days of the incident, and if MSW to do in servicing to the entire the alleged violation is verified appropriate corrective staff on signs and symptoms of action must be taken.

This REQUIREMENT is not me! as evidenced by: Based on interviews and medical record recylew, it was determined that the facility did not have evidence that an allegation of neplect had been investigated. Resident 1 died on 13/23/02. On the morning of 11/23/02, nurse C suggested to the paramedics who responded to the 911 call that the situation with resident 1 could be a "nossible overdose". The medical examiner's office sent a letter to the facility. dated 12/20/02, which stated that resident 1 died of a polydrug overdose that was "certified as suicide" The facility had no documentation to evidence that events surrounding the death of resident 1 had been investigated. The resident's attending physicial; and the facility's licensed clinical social worker (LCSW) were not aware that the resident had committed suicide.

Findings include:

Resident 1 was admitted to the facility on 1/8/02. Resident 1 bad a verificible serious mental illness of Major Depression, recurrent, moderate On 1/8/02, nurses notes documented their resident 1 was drying affected.

The facility contracted with a consultant MSW to do in servicing to the entire saff on signs and symptoms of emotional trauma and suicide procautions. The facility has taped and held in-services from the county mental health services. The in-services method to the lep with access and to identify needs for referrals. The county mental health services reviewed the policy and procedure to ensure that their proper numbers were in place.

The county has in serviced the entire staff.

The lacility has posted important numbers and standard protocols for emotional distress recognition and intervention. The administrator and social services have been given inservices by the MSW on recognition of emotional distress. The standard inservice calendar has been adapted to include quarterly training on emotional distress and sticked procasuloidarses and sticked procasuloidarses and sticked procasuloidarses.

The Administrator is responsible for ungoing compliance.

CENTERS FOR MEDICARE & MEDICATO SERVICES

(XI) PROVIDER/SUPFLÆRCLIA (X2) MTC JUPILE CONSTRUCTION IDENTIFICATION NUMBER A BUILDING B. WINC_

(X5) DATE SURVEY COMPLETED C 1/31/2003

NAME OF FROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

STREET ADDRESS, CITY STATE, ZIP CODE

1053 WEST 1020 SOUTH CRESTVIEW CARE CENTER PROVO, UT 84601

465082

(X4) ID PRESEX TAG	SUMMARY STATEMENT OF DEPICTENCES (RACH DEPICENCY MUST BE PRUCLEDUD BY RULL REGULATORY OR LIST DIENTILY FOR INFORMATION,	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REJERINGED TO THE APPROPRIATE DEPICTENCY)	(XY) (XX)MELETH (X4TE
F 225	Continued From page 11	F 225		
	and yelling in the hallway. At that time, resident I yelled "I'm going to board any pain pills and take them all at note?" On 11/23/02, resident I expired in the hospital. Interviews with facility slaff during this investigation from 12/1/03 through 1/31/03 revealed that prior to and after resident I made this suicidal threat, she was experiencing a major life change and extreme mental distress. There was no evidence that the facility addressed the extreme mental distress.			
	being exhibited by resident 1. Please also refer to tag P-224.			
	On 11/23/02 at 6.45 AM, when nurse C found resident f, she was "uncursoiens. Not breathing et (and) no pulse" Facility staff called 911. One of the parametics who responded was told by nurse C that resident f "had we believe threatened suicide previously" and that an "overdose of medication might have occurred."			
	On 11/23/02, resident I died. Later that same day, the statck medical examiner performed an autopsy The official "report of exemination" was obtained from the medical examiner's office by state survey on 1/30/03. The opinion of the medical examiner was that resident I "died as the consequence of an intentional acure amiripplyline and transatist exercises."			
	The medical examiner's office sent a letter to the facility, dated 12/20/02, which states that resident 1 died of a polydrug overdose that was "certified as suicide".			
	Based on review of the feelility's November 2002 mirsing schedule, there were ten nurses who worked with resident 1 from 11/8/02 (the day of the specific suicidal threat) through 11/23/02 (the day resident 1			

PRINTED: 2/7/2003 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES 2567-1 STATEMENT OF DISPLIENCIES NB) DATE SURVEY X1: PROVIDER/SUPPLIER/CLIA 2022 MILITIPLE CONSTRUCTION COMPLETED) AND PLAN OF CORRECTION IDENTIFICATION NUMBER. A PIIII.DING B WING 465082 1/31/2003 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIES 1053 WEST 1020 SOUTH CRESTVIEW CARE CENTER PROVO, UT 84601 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 7845 90 (X5) COMPLIENT DATE (RACH DEFICIENCY MUST BE PRECEDED BY FULL (CACH CORRECTIVE ACTION SHOULD BE PRIMA PRINCE REGIT ATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS REFERENCED TO THE APPROPRIATE TAG DEFICIENCY: F 225 F 225 Continued From page 12 died). During interviews with all ten nurses (beginning on 1/27/03 and ending 2/3/03), it was discovered that 7 of the turses denied any knowledge of the suicidal threat voiced by resident 1. During the interviews, it was determined that none of the three remaining nurses, who stated they were aware of the suicidal threat, notified the attending physician, the facility's social service worker (SSW), the LCSW consultant or other administrative staff. In continuing the interviews with the other seven nurses. it was clear that they were not aware of what procedures to follow had they become aware of the suicidal threat. During interviews with the Administrator, the director or nurses (DON), and the SSW on 1/27/03, they stated that they were aware that resident 1's death was a studide. All three denied being made aware of the comment resident 1 made on 11/8/02, when she threatened to hoard her pain pills and take them all at once. During interview with the LCSW consultant on 1/29/03 at 3:45 PM, he stated that he had not been told that resident 1 had committed suicide Resident 1's attending physician was interviewed by telephone on 1/30/03 at 9:45 AM. During this interview, the physician was "shocked" to hear that the medical examiner had certified resident 1's death to be a suicide Facility staff could not provide any evulence that the events sumpanding the splatde death of resident I had been investigated by them and that measures had been put true place to provide staff with clear directions on

mental/emotional distress

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES							2567-L
STATEMENT AND PLAN O	CONTROTTON	(X1, PROVIDER/SUPPLIER IDENTIFICATION NO. 465082	ACLIA MDUR.	(K2) MULTI A BUILDIN B. WING_	IPLE CONSTRUCTION		
2012 FT (2012 201	ROVIDER OR SUPPLIER	403002	STREET ADD	RESS, CITY, ST	TATE, ZIP CODI:		
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	the facility's quality a most recent quarter to committee had inves the spicide death of re stated that those deta	inistrator was asked to assurance (QA) minute o determine whether it tigated the events surre- resident 1. The admin- tils would not be in the se events had not been	es for the oe QA ounding estator				
F 250 SS=J	services to attain or a	SERVICES wide medically-related maintain the highest pi d psychosocial well-bed	acticable	F250			
	Tais REQUIREMEN	∛I' is not met as evider	read by:				
	Based on medical re- was determined that medically related sox mental distress and r resident 1 as a result was found that there concerning the ment resident 1 between n personnel and/or add committed to the fir	and review and staff it the faculty failed to prid july services for the ext- major depression exper- of a significant title to was a fack of commun- al health/social service ursing staff, social ser- ministrative staft. This stading by the Medical E as the result of a self-in-	nterview it ovide reme ienced by ange. It ication needs of vices failure xaminer				
	Fastings included:						
	Resident I was with diagnoses that:	adranted to the facility included pneumonia, ibromyalgia, osteoarthi					

2567-L

CENTERS FOR MEDICARE & MEDICAID SERVICES

XI; PROVIDEE/SUPFLIER/CLIA EDENTIFICATION NUMBER:

465082

OZ2: MULTIPLE CONSTRUCTION A PURI DING

X3) DATE SURVEY COMPLETED Γ 1/31/2003

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DESCRIPCIES

AND PLAN OF CORRECTION

B. WINC STREET ADDRESS, CITY, STATE, 20° CODE

1053 WEST 1020 SOUTH

CRESTYDOW CARE CENTER PROVO, UT 84601 SUMMARY STATEMENT OF DIFFICIENCILS (X4) (D) TRACH DIRFROFN CY MUST BE PRECIDED LID BY PULL). PREFIX PRESIX REGULATORY OR LISC IDENTIFYING INJORMATION) TAG TAG

PROVIDER'S PLAN OF CORRECTION (MACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REPERINCED TO THE APPROPRIATE DATE DEFICIENCY

P 250 | Continued From page 14

arthropathy, diabetes and major depression. In addition resident 1's mother, resident 2, was admitted to the facility on 1/8/02. Residents I and 2 were placed in the same room with no other recommate.

The social services worker (55W) was interviewed on 1/27/03. The SSW stated that resident 1 and resident 2 shared the same room in the facility from 1/8/02 until 11/6/02. Upon admission to the facility resident 1 requested to share the same bed with resident 2. This request was denied. Resident 1. had always lived with resident 2. Resident 1 had never been married or had any children. During an interview with the SSW on 1/27/03, it was stated that a Wasalch Mental Health worker had told fee SSW that the relationship between the residents was "symbiotic". Symbiotic is defined as a relationship which is mutually reinforcing between two persons who are dependent on each other.

The SSW stated that resident 2 was moved to another room in the facility on 11/6/02 per a family member request. This family member had obtained full guardianship and power of attorney over resident 2 because the family member felt that the demands of resident 1 on resident 2 were unhealthy for resident 2.

Though the facility had attempted to prepare resident I for the separation from resident 2, the room change resulted in extreme mental distress for resident 1 The SSW stated that after the room change, every time resident 1 was allowed to talk to or visit with resident 2, it would result in both residents "just solbing." The SSW also stated that resident I had called residen: 2 on the telephone and would say "Mother, I'm somewhere here in the facility. You have to find me. You have to find me."

F 250

Resident number I was no longer in the facility at the time of this complaint investigation.

Residents with a change in psychosocial well-being have the potential to be affected.

The facility contracted with a consultant MSW to do in servicing to the entire stall on signs and symptoms of emotional trauma and suicide precautions. The consultant MSW reviewed our current policy and procedure to ensure proper coverage. The consultant MSW reviewed the charts of residents with a diagnosis of depression. The consultant MSW has committed to increased time in the facility to ensure ongoing compliance. and is following those residents needing a level two-passar screen. The consultant MSW is co signing the facility social worker's notes to help identify training needs.

The quality of life committee is reviewing the chart audits and will develop action plans as needed as well as doing a Quality of Life audit monthly indefinitely.

The Administrator is responsible for ongoing compliance.

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CENTER	S FOR MEDICARE	& MEDICAID SERVI	CES .	_		····	2567-1
	OF CORRECTION	(XI) PROVIDERSUPPLIES IDENTIFICATION NO		(XZ) MUJUTIŘ A. BUYLDING	LE CONSTRUCTION	(NS) DATE COMPL	
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NAME OF B	ROVIDLER OR SCIPPLIER	403002	STREET ADD	RESS, CITY STA	TL, ZIF CODE		T DAY
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7 230	3. A review of reside 1.22//03. The 11/08/c resident I was observed the hallway. At that resident I yelled. "Iz and take them all at the going to get my Man 4. The nursing nor "Patient was found a breathing et (and) ac	ent I's marsing notes w 12 nursing notes docum sed to be crying and ye time, it was documente in going to hoard my p once! One way or anot	mented that lling in ad that sin pills her I'm mented				
	examiner. On 1/27/0 from the medical exa- was done. The letter it documented that re- a result of a polydrug cortified as suicide."	performed by the med 35, a review of the lette miner's office (dated 1 was addressed to resi sident 1 "died on 11/2 overdoss. The mann	er report 2/29/02) dent 2 and 3/02" as or has been				į
	completed on 1/30/03 documented: u. A review of res (Preadmission Strawe Mental Illusies)-level dated 1/25/02, was didocuments a diagram resourcent, moderate. PASRR-11 documents dependent on 94 year procoupied with per	siden: 1's PASRR-I/II ting Resident Review I time discel 1/21/03 and on 1/28/05. The P is of "Might Depress". The comments section that "resident I is "verified motherappears ent to exclusion of other	ler Serious . level two . ASRR-II . m, . of the . ry .				
		mendations documente encouragement" and I					

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F250	needed." The "Ment of documents that resid mother for all care in stroke. Tends to out mother. Resident payshosocial evaluation resident I resided in prior to living in the married." Resident I and support." 7. A review of the completed on 1/5000. The licensed threads in successful a substitute of the licensed chinical aware of resident I's out in the SSW was me suited on 1/8/02. The licensed chinical aware of resident I's on 11/1/02, one day were separated, it was that "everyone, was be had requested a visual both residents." Sobb suggestions to resident people." On 11/1/02 it was decontact with an attornessed with the mother documented that residents people."	allow-up psychiatric of all Status Examanation on L "were depender util her mother suffere y want to interact with appears to be symitate appears to be symitate increasing the appears to be symitate appears to be symitate and appears to be symitate for the sufficient North Status (North Status). The sufficient North Status (North Status) and the suf	Summary at the country of the countr	F 250			
	visit they would like r distance from residen	esident 2 to maintain a : 1."	sonie			i i	I

CENTERS FOR MEDICARE & MEDICAID SERVICES 2567-I STATEMENT OF DEFICIENCIES OBCIONIE SURVEY (X1) PROVIDER/SUPPLIER/CLIA COMPLETIBLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUTE DONG B. WING ._ 465082 1/31/2003 STREET ADDRESS, CITY, STATE, ZIP CODE. NAME OF PROVIDER OR SUPPLIES 1053 WEST 1020 SOUTH CRESTVIEW CARE CENTER PROVO, UT 84601 SUMMARY STATEMENT OF DEBOTESORS PROVIDER'S PLAN OF CORRECTION (X4) ID (BACH DERICENCY MUST BY PRECEDUD BY U.S.) PDETAN (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREDEX REGULATORY OR LSC IDENTIFYING INFORMATION: TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY F 250 | Continued From page 17 E 250 8. A review of all physician progress notes and telephone orders from 11/8/02 to 11/23/02 was done on 1/30/03. There was no documentation that the physician was made aware of resident 1's talk of suirade on 11/8/02. 9. A review of the nursing schedule was done on 1/30/03. It documented that between 11/08/02 (when resident 1 made her spicidal threat) and 11/23/02 (when resident 1 expired), ten purses had cared for resident 1. Based on interviews conducted with all 10 of these nurses, only three of the ten nurses were

a. On 1/27/03 at 4:58 PM, intrae A was interviewed. Nurse A was the nurse that documented resident I's suicidal threat on 11/8/02. When asked if she had notified the physician about this specific suicida, threat, she answered "probably not." When asked if she notified the SSW she replied, "I can"

aware that resident I had made the suicidal threat on

11/8/02.

recali 1

Nurse A stated that she reported the suicidal threat to the nurse on the following shift. When asked why she had documented this specific behavioral episodo, the nurse replied that resident 1 was "cyanotic" and " wast,'t interested in her O2 (oxygen) and would not but it on." Nurse A also stated that resident 1 was valling very loudly and while resident 1 had seen very dramatic in the past, this time she voiced a specific quicidal threat.

b. On 2/3/03 at 10:40 AM, nurse G was interviewed via telephone. Nurse G stated that she was aware that resident 1 had died but was not aware. how resident I had died. Nurse G worked the migh. shift on 11/8/02 to the morning of 11/9/02. Noise G

CENTERS FOR MEDICARE & MEDICALD SERVICES

(X2: MRETIPLE CONSTRUCTION (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A BUILDING

COMPLETED C B. WING_____ 1/31/2003

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICENCIES

AND ICAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE

465082

CRESTV	EW CARE CENTER	1053 WES PROVO, U	T 1020 SOL13 .T 84601	Ŧ	
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F 250	was asked if she remembered being told alx resident 1's suicidal threat.		F 250		
	Name G stated that she remembers knowin, threat because nurse Gromembered checkin 1's menth for failing to swallow the pills. I make G couldn't remember the exact date obscarne aware of resident 1's threat.	ng resident Kowever,			
	Nurse G also remembered talking with resistance about her threat to board all her pills and is all at once. Nurse G when asked if she had the physician, the SSW, or the Director of I she replied "Not." When saked if she report resident I's suicidal threat to the nurse on that, the reglied that she remembers werbal on her concerns.	ke inem notified Nursing, ed ne next			
	c. On 1/28/05 at 11:00 AM and 1/30/05 AM nurse C was raterviewed. Nurse C was raterviewed. Nurse C was ratest shift after nurse 6 had worked. (Nurse C, the curse on shift, about resident 1's sheet.) He when Nurse C was asked how whe learned threat, she maked that she might have recent information either in report or from a CNA weeks before the satisfie. When nurse C was the reported resident 1's talk of sucide to it strending physician. SSW or any other facilishe stated that she couldn't recall because it long ago."	iked the e G had ne next owever of the red this a few s asked if he DON, ity staff,			
	Nurse C further stated that the nurses had it could other not to leave any pills with reside Nurse C said that the always helped reside her pills and never left the room until all he were swallowed.	nt 1. 1 1 take	:		

PRINTED: 2/7/2003

	PMENT OF HEALTH RS FOR MEDICARE						M APPROVE 2567-
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		465082		B. WING		1/3	1/2003
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	Nurse C was the nurs	se who found resident	l in her	:			
	room, unresponsive,	on the morning of 11.	/23/02.	i			
	According to nurse C	, she requested that 9	11 be				
		ent I's blood sugar ag:					
		that when the parame					1
		nurse what she thoug					
		nt 1. Nurse C indicate		i			
		a possible overdose an amedica administer N					!
		used medically as an					i
	for an overdose of na		on one	!			
			!				
	d. On 1/30/03 at :	10:45 AM, norse B wa	ıδ .				
		stated that they were					ı
	how resident I had d	lied, nor that resident	l had				
		r pills and taking then					
		that if she had known		. !			!
		ig of suicide, she woul	ld have				
	talked to her about it.			i			
	e. On 1/30/03 at 1	10:10 AM, nurse D wa	is !				
	interviewed. Norse I	stated that she was n	o: aware				
		ed. Nurse D stated ha					
		was depressed but not					
		reatened to hoard her j	pills and				İ
	take them all at one to	me.					
	Nicora Danas datas	f she had known that r		ĺ			
		i sae nac known mai r feations nurse D woul					
		ervital) hour through					
		g in the morning nurs		1			
		idal threat to the atter					
	physician and the SS		٠	100			
		:50 PM, nurse E was					į
		stated that she was or					
	how resident 1 had di	ed. When nurse E was	informed -				

	IMENT OF HEALTH						M APPROVE 2567-
	T OF DEFICIENCIES OF CORRECTION	(XI) PROVEDERS PELIE IDENTIFICATION NO		A BUILDING	LL CONSTRUCTION	OX3: DATE COMP	SURVEY LETED C
		465082		B. WING		1/.	31/2003
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		ie "was surprised - but	toa	1			
	having difficulties be Nurse E stated that never been away from "I (nurse E) had hear (nwygen) of I didn'! to have made a diffor shared that she was as it was all about her tr Nurse E related that in wanted her morning, live I don't know if hocases the was hed and as far as med for control her mark, so stated that since resid stated that since resid	ident I had been depre- ing separated from res- ine knew that resident in resident 2. Nurse B 3 of the she had taken in drink she was Ill enou ance. In report, it had ad. My personal thought estimated in the she was Ill enou estimated in the she didn't want to live sucade came to my an didner and couldn't had estimated came to my an didner and couldn't had estimated in sucade came to my an didner and estimated in sucade same of same of sucade same of ident 2. I had stated that z O2 gh for that bean ght - that i." , she - well not ind ng herself acility) vurse E ceration					
	figreatened to hoard h time. Nurse E further aware that residen() she would have "done think she had the me:	ie was not aware resider pills and take thomstated that if she had inverballed had inverballed had inverballed had inverballed had inverballed had inverballed have called what then so I would have called what they said and to do it."	all at one been about, I didn't ad the				<u> </u>
		k 45 PM næse F, was ione. Nurse P stated th i: 1 had threatened to a					

pills and take them all at one time. Norse P stated

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STATEMENT OF DEFICIENCES (XI) PROVIDERSUPPLE AND PLAN OF INDRESCRICTS DENTITIONED N		RÆLIA	02; MULTIPLE CONSTRUCTION A BUTCHISC			CXE DATE SURVEY COMPLETED C	
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F 250	Continued From page	2.1		F 250			
, 200		e notified the attending	physician.				
	interviewed. Nurse in mamerous occassion Nurse H was not aw threaters it to hoard time. Nurse H stated that separation of resides recalled a lelegione involving resident i member. Nurse H six member, as instructive would kill herself if Nurse H stated that separated from her and ouncy? Reside six didn't understan more to another roos outber roos	ted that resident 2 told ad by resident 1, that re	1 on she died, ident 1 had a all at one woluntary as H woverheard. the lamily skident 2 cohuntarily the "angry se H that forced to you the				
	night before resident resident I was very a dinner. Nurse H exp a facility activity atti Nurse H stated that to activity depressed at Resident I, m resp, she returned to her it	on the evening of 11/22 (1 expired, nurse Hilds beginning and wouldn't lained that resident 1 bette properties to contact resident 1 came back frid was fishe worst Fellew and that a commence to make the worst Fellew and that a fell resident [1 st] near resident	served that eat her had gone to den; 2, orn the er seen about why amily				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES 2567-STATEMENT OF DESIGNATIONS CARLITATION OF A VIEW (X.I): PROVIDER/SUPPLIER/CLIA OCCUMENTARY RECONSTRUCTION AND PLAN OF CORRECTION COMPLETED. EDENTEFICATION NUMBER A. BUILDING B. WING 465082 1/31/2003 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE ZIP CODE 1053 WEST 1020 SOUTH CRESTVIEW CARE CENTER PROVO, UT 84601 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (BACH DERICHNOY MUST BE PRECEDED BY 15.11 PRIJEX SEASTLY CORRECTIVE ACTION SHOULD BE COMPLETE PREIX REGULATORY OR ENCIONATION OF THE WASHINGTON OF THE PROPERTY OF THE STREET, THE WASHINGTON OF THE PROPERTY OF T CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DREICHNOY F 250 Continued From page 22 E 250 mouth after administering her medications and would have checked in resident 1's room and drawers for pills. During the morning of 1/30/03, nurse K was interviewed via telephone. Nurse K stated that she was not aware of any specific suicidal threats reguarding resident 1. Nurse K stated that she was not aware that on 11/8/02, resident 1 had threatened to hoard her pills and take them all at one time. Norse K indicated that she she could not remember hearing from other nursing staff about resident 1's suicidal threa: Norse K stated that if she had known that resident 1 was thinking of suicide, she would have made sire that resident I took her medications and would have informed the DON. Or. 1/30/03 at 11:30 AM, purse I was interviewed. Nerse I stated that she was not aware of any specific sarcida, throats regarding resident 1. Nurse I stated she was not aware that on 11/8/02, resident 1 had threatened to heard her pulls and take them all at one time. Nurse I stated that if she had known that resident 1 was thinking of suicide, she would have talked with resident 1, not given her any pills and reported the suicidal threat to the SSW and the DON 7. Or. 1/29/03 at 3:45 PML a telephone interview was conducted with the facility's Ecensed chinical social worker (LCSW) consultant. In response to questions about his knowledge of the facts surrounding resident

I's death, he indicated that he knew that resident 1

2567-J. CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATESHRYSY STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION (XI) PROVIDERAUPPLERACIA N2: MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER. A. BUILDING C B. WING ______ 1/31/2003 465082 STREET ADDRESS, CITY STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER

1053 WEST 1020 SOUTH CRESTVIEW CARE CENTER PROVO, UT 84601

TUESS T F	E O CORE CHOTER	PROVO, C	/) 84601		
(X4) ID PREPIX TAGE	SUMMARY STATEMENT OF DEFICIENCES JIACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR USE IDENTIFYING DIFORMA	FULL	II: PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE (DEFICIENCY)	COMPLETE DATE
F 250	Continued From page 23. I's death. He stated that he had not been more resident. I's threat to heard all her pills at them at 1 time.	ed take	F 250	7	
	The LCSW stated that the last time he had- with resident I was on 11/30/3. He stated contact was when resident I called him into and indicated that she wanted Power of Atte resident Z. The LCSW response was to offs her in finding legal coursel, to which reside refused his sestiance and anginy asker him The LCSW indicated that resident I's deme during this intenchange was "agitated" but of show any depression.	that the other room orney over er to assist ent 1 to leave.			
	The LCSW was cuestioned concerning wha he would have given had he been aware of a suicidal threats. He indicated that he would the DON seases readont 1 and determine if resident was in immediate danger or not. I indicated that the LCSW. SSW and the DO work together to determine the appropriate mental health intervention needed.	resident T : have had the then he N would		·	:
	8. On 1/27/03 at 4:00 PM, an interview we conducted with the facility's administrator, response to questions about her knowledge-faces surrounding resident 1% death, she in that she had no knowledge that the death we suicide. She learned the cause of death wherether showed her a feater from the Medic Examiner indicating that resident 1% death caused by a poly-drug overdose that was self the date on the Medical Examiner's letter's 12/20/02.	In of the dicated as a en a family bal was F-inflicted			
	The administrator was asked what investigs had conducted and/or steps she had taken is				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICATO SERVICES :XS; DATE SURVEY STATIMEN LOF DEBICIENCIES A 1: PROVIDER/SUPPLIPRATE/A X2: MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER A BUILDING B WING 465082 1/31/2003 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1053 WEST 1020 SOUTH CRESTVIEW CARE CENTER PROVO, UT 84601 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) CONCLETE (X4) ID ŒACIL DIJECTUNCY MUST STUDBECHEDED BY FULL BACH CORRECTIVE ACTION SHOULD BE PREFIX PERFO DATE REGULATORY OR LISC IDENTIFYING INFORMATION; T'A/3 CROSS-REFERENCED TO THE APPROPRIATE DIFICIENCY F 250 F 250 Continued From page 24 that other resident weren't at risk when she had found out about resident 1's spicide. She indicated that she had not investigated the death nor taken any steps to ensure the safety of other residents. F 490 F 490 | 483 75 ADMINISTRATION SS=G A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or regintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: This is a repeat deficiency from the annual recertification survey ending 11/5/02 Based on the findings of this complaint survey which was performed from 1/27/03 through 1/31/03, it was determined that the facility was not being administered in a manner that enabled it to use its resources effectively and officiently. Immediate Jeonardy and Substandard Quality of Cars were identified for the facility neglecting to assess, monitor, report and intervene with a resident who was exhibiting extreme mental distress and who told staff of her exact suicide plan. (F224). The resident died of a polydrug overdose on 11/23/02. The facility failed to investigate the events surrounding the smosde death of this resident. (F 225) The facility failed to provide sufficient and appropriate social services to meet the mental and psychosocial well-being of the resident. (F 250). The facility failed

to consult with the quality assurance committee regarding the events surrounding the suicide death of CENTERS FOR MEDICARE & MEDICALD SERVICES

(X1) PROVIDER/STEPLIER/CLIA IDENTIFICATION NUMBER:

465082

(XI) MIE TIPLE CONSTRUCTION A RIM DING B. WING

2567-L (X3) DATÉ SUKVEY COMPLETED 1/31/2003

NAME OF PROVIDER OF SUPPLIER

STATEMENT OF DENCIENCIES

AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE

1053 WEST 1020 SOUTH CRESTVIEW CARE CENTER PROVO. UT 84691 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CURRECTION (X4) ID CONVERTE CLACH DESTORORY MUST BE PRECISIONAL BY FULL PREPEX (LACIA CORRECTIVE ACTION SHOULD BE PREETX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS RUBBRESCUD FORTHU APPROPRIATE DATE TAG TAG THERICIENCY F 490 F 490 | Continued From page 25

man. Resident identifier: L.

Findings include:

Resident 1 was admitted to the faculty on 1/8/02. Resident 1 had a verifiable serious mental illness of Major Depression, recurrent, moderate. On 11/8/02. nurses notes documented that resident 1 was crying and velling in the ballway. At that time, resident 1 velled "I'm going to hoard my pain pills and take them all at once." On 11/23/02, resident 1 expired in the hospital after being transported from the facility. Interviews with facility staff during this investigation, from 1/27/03 through 1/31/02, revealed that prior to and after resident 1 made this suicidal threat, she was experiencing a major life change and extreme mental distress

There was no evidence first the facility assessed her mental status after she declared her intention or. 11/8/02. There was no evidence that facility staff who had knowledge of the suicidal threat, notified the attending physician, the facility's social service worker (SSW), the licensed clinical social worker (LCSW) consultant or other administrative staff. There was no evidence that the one staff member who identified resident 1 with severe depression the night prior to the suicide had notified anyone or intervened. There was no documentation to evidence that facility staff were monitoring the mental status of resident 1. There was no documentation to evidence that facility staff attempted to intervene when resident 1 was identified with extreme mental distress and voiced a specific spicidal threat. In addition, once the facility became aware that resident 1 committed saicide, they failed to investigate the events surrounding her death.

F 490 (see 224, 225, 250)

Resident number | was no longer in the facility at the time of this complaint investigation.

Residents with a change in psychosocial well-being have the potential to be affected.

The administrator and social services have been given in-services by the MSW on recognition of emotional distress. The standard in-service calendar has been adapted to include quarterly training on emotional distress and spicide precautions. The facility medical director has consulted with us to ensure proper medical interventions for residents with emotional distress or spicide ideation.

The facility OA team will review the Quality of Life committee review at least monthly and develop action plans as indicated. The General Partner on a monthly basis is reviewing the OA for three months to ensure ongoing compliance with the OA process.

The Administrator is responsible for ongoing compliance.

	IMENI OF HEALTH IS FOR MEDICARE	AND HUM SERVI & MEDICAID SERVI				FORI	M APPROVEI -2567
FALEMENT OF DEFICIENCIES (X1) PROVIDENCIPAL IN THE CATION NO DESCRIPTION SET 1465062		OCILIA MBERO	(X2) MULTIPLE CONSTRUCTION A BUEDING B WENG		(X3) DATE SURVEY COMPLETED C 1/31/2003		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RBSS, CT. Y. ST	ATE, 7IP CODE		22000
CRESTV	EW CARE CENTER		1053 WES PROVO, U	[1020 SOU] T 84601	ш		
(XA) ID PREFIX TAG	(EACH DUISCIENCY	ACTEMENT OF DERICIENCES MUST BE PRECISEDED BY SCIDENTIFYING INFORMA	FJILL	(I) PRESTN TAG	PROVIDERS PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCE) TO THE DEFICIENCY)	N SHOULD DE RAPPROPRIA EL	(X5) COXPLETS DATE
F 490	intervene with reside Immediate Jeopardy Facility administration assessed, monitored, resident who was ext and who told staff of Facility administration assertion of the summer of the	m1 I led to a determina	then of that staff and with a distress (F224) the events icient and s of tal.	F 490;			
F521 SS=G	(F 250) Facility administrative consult with the qual- regarding the events the resident and fatle plan. (F521) 483.75(o)(2)&(3) AE The quality assessment mests at least quarter to which quality assessment are necessary, and de appropriate plans of quality deficiencies. A State or the Secretic	m failed to ensure that ity assurance committe surrounding the suicid d to establish a correct	failed to be edeath of ive action intree in respect activities in the description of the control	F 5271			

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(XI: PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER. 2K2: MULTIPLE CONSTRUCTION

465082

(A3) DATE SURVEY COMPLETED 5. BUILDING C 1/31/2003

NAME OF PROVIDER OR SUPPLIER

STRUCT ADDRESS, CITY, STATE, ZIP CODE.

NAME OF TROVIDER OR SUPPLIES		1053 WEST 1020 SOUTH				
CRESTVIE	W CARE CENTER	PROVO, U				
(X4) ID : PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECIBINED BY BEGULATORY OR USE IDENTIFYING ENCOMMA	PDD.	ID PREFIX TAGE	FROVIDERS PLAN OF CORRECTION (HACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	CONTLETE DATE	
=	committee with the requirements of this sec	tien.				
Ties and dispersion of the second of the sec	committee with the requirements of this seed. This REQUEREMENT is not met as evider. Based on interview, it was determined that assurance (QA) cornstitute dit not identify; respect to which quality assessment and assactivities are necessary. The QA committee develop or implement plans of action to considerable along the properties are present and swarf of the training equality deficiences. Specifically, frimediate Jeopardy and Substandard Quality were identified for the facility neglecting to monitor, report and interview with a resident was exhibiting extrume mental distress and staff of her exact suicide plan. (P224) The righted of a polyring overdose on 11/23/02. Tabled to investigate the events surrounding suicide death of this resident. (P225) The failed to provide sufficient and appropriate services to meet the mental and psychosocia well-being of the resident. (P250) The facility occurred to consult with the quality assurance commit regarding the events surrounding the strictly than a contraction of the resident and failed to establish a cornectiplen. Resident identifier. I. Findings include:			Resident number 1 was no longer in the facility at the time of this complaint investigation. Residents with a change in paychosocial well-being have the potential to be affected. The administrator and social services have been given in-services by the MSW on recognition of crunotional distress. The standard in-service calendar has been adapted to include quarterly training on emotional distress and suicide precautions. The facility medical director has consulted with us to ensure proper medical interventions for residents with emotional distress or suicide ideation. The facility QA team will review the Quality of Life committee review at least monthly and develop action plans as indicated. The General Partner on a monthly basis is reviewing the QA for		
M n a y t t	tesident I had a certifiable scrious mental if Agior Depression, recurrent moderate. On urses notes documented that resident I wan in yelling in the hallway. At that time, re- elled "I'm going to heard my pain pills and even all at once!" On 11/23/02, resident I no bospital. Interviews with facility stoff of twestigation from 1/23/03 through 1/31/03 and prior to and after resident I made this s- test, she was experiencing a major life chi where mental distress.	11/8/02, crying ident 1 take expired in gring this revealed nicidal		three months to ensure ongoing compliance with the QA process. The Administrator is responsible for ongoing compliance		

CENTERS FOR MEDICARE & MEDICAID SURVICES STATEMENT OF DEPICIENCIES.

(N1) PROVIDER/SUPPLIAR/CLIA IDENTIFICATION NUMBER:

465082

(XX) MULTIPLE CONSTRUCTION AL BUILDING H. WING

(X2) DATE SURVEY COMPLETIO $^{\circ}$ 1/31/2003

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE: ZIP CODE

CRESTVIEW CARE CHAPTED

1053 WEST 1020 SOUTH

(X4) ID SUMMARY STATEMENT OF DIFFCIENCIES PRICIES TAG REGULATORY OR ESC IDENTIFYING DIFFCIENTION)	ID FRIGIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(%S- COMPLETE
		CROSS REPSRENCED TO THE APPROPRIATE DEFICIENCY)	DATE
F 521 Continued From page 28	F 52:		
There was no evidence that the facility assessed her mental status ofter she declered her intention on 117802. There was no evidence that facility staff who had knowledge of the swicidal threat notified the attenting physician, the facility's social service worker (SSW), the hoeased clinical social worker (LCSW) consultrant or other administrative staff. There was no evidence that the one staff member who felentified resident I with severe depression the high prior to the saucide had notified anyone or intervieed. There was no documentation to evidence that facility staff were monitoring the mental status of resident I. There was no documentation to evidence that facility staff attempted to interview when resident I was identified wife extreme mental disress and voiced a specific wife that resident I committed suicide, they failed to investogate the events surrounding the death. The facility also failed to consult with the quality assurance committee regarding the events surrounding the ruled death of the resident and failed to establish a corrective action plan. During interview with the facility is semimistrator or 1/31/03 at 2:30 PM, she was asked for the foultivis quality assurance times for the most recent quarter to determine weather the facility but investigated the succidal death of resident I and then established a plan of action to ensure that similar creammatiness would be avended. The administrator stated that those details would not be in the QA fainteness because those events had not been investigated.			