STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465003	A. BUILDING _____ B. WING _____	C 06/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2700 WEST 5600 SOUTH ROY, UT 84067

(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 324 SS=G	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews and clinical record review, it was determined that the facility did not provide adequate supervision to prevent accidents for 2 of 3 sampled residents. Specifically, facility staff left residents 1 and 2, who were at risk for falling, unattended while in the shower or bathroom resulting in resident 1 falling and fracturing her femur, and resident 2 sustaining a laceration to her forehead. The facility implement corrective action, including multiple staff inservices, policy reviews, and have incorporated the corrective measures into their quality assessment program. Therefore, this requirement was corrected as of 6/6/06. Findings include: Resident 1 was admitted to the facility on 4/25/05 with diagnoses that include abnormal gait, muscle disuse atrophy, Alzheimer's, and hemiplegia. Resident 1's record was reviewed on 6/13/06. A Significant Change MDS (Minimum Date Set) dated 2/22/06 documents the following for resident 1: 1. Moderately impaired cognition (decisions poor, cues/supervision required). 2. Extensive assistance including 2 person assist during transfers.	F 324	Past noncompliance: no plan of correction required.	

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

Administrator 8/8/06

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 324	Continued From page 1 3. Partial physical support needed to maintain balance while sitting. 4. Resident 1 had fallen in the past 30 days, as well as the past 31-180 days. 5. Resident had been taking multiple psychotropic medications. On 3/21/06 the Nurses Notes for resident 1 documented the following: " 1145 resident fell on floor in shower room, fell on [left] side, arm looked to be very twisted on [left] side, resident [complains of] pain to [left] hip area, slight cut on [left] side of forehead [with] little blood, stopped bleeding right away, family [and] doctor notified, sent out to [local] hospital. " . An Incident Report dated 3/21/06 documented that resident had an unobserved fall, and that she was found on the shower room floor. Resident 1's Initial Nursing Assessment on 2/17/06 documented that she had a score of 48, signifying that she was at a moderate risk for falling. The facility protocol for residents at a moderate risk for falling is to implement the following interventions: 1. Provide for safe clutter free environment 2. Encourage in wellness activities of self care and self initiated exercises. 3. Maintain the lift-free environment 4. Review clothing items to ensure that footwear is slip resistant 5. Review for restorative programs for ambulation/transfers 6. Address specific causes of risk to eliminate cause 7. Lower risk of injury by considering low beds, alarms.	F 324		

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F 324	Continued From page 2 8. Place in active programs designed to improve or maintain function to reduce risk 9. Make caregivers aware of risk (Falling Star program) Resident 1's record included a care plan to address her history of falling and risk for future falls. Many interventions were documented including: 1. Provide supervision with self performance of cares daily. 2. Provide physical assistance as needed for safety and completion of cares daily. 3. Therapy as ordered for transfers and ambulation 5x/week. 4. Supervise and assist with transfers and ambulation everyday as needed for safety. 5. Walker/wheelchair as needed for support 6. W/C (wheelchair) with seatbelt for fall prevention as ordered. 7. Body alarms as ordered everyday when in bed and in W/C. 8. Call light at bedside and respond promptly to calls for assistance daily. 9. Document and report falls or injury PRN (as needed). 10. Assist with toileting as needed everyday. On 6/13/06, an interview was conducted with the facility Administrator and DON (Director of Nursing) regarding residents at risk for falls. They stated that all residents are assessed for falls upon admission, and that a fall risk care plan is then designed, per protocol, based on the fall assessment score. They further stated that all employees are trained at hire, that if a resident is a fall risk, they are not to be left unattended while in the shower or bathroom.	F 324		

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F 324	Continued From page 3 A phone interview was conducted on 6/13/06 with the CNA (Certified Nursing Assistant) who assisted resident 1 to the shower room the day of her fall. The CNA stated that she had assisted resident 1 to the shower room, and that she left resident 1 unattended while she waited outside the shower room door. When asked if resident 1 was at risk for falls, the CNA stated that as far as she knew resident 1 was not a fall risk. She further explained that if she did not know a resident she would ask if the resident was a fall risk, or look in their chart. The CNA also stated that the facility has a falling star program which identifies which residents are at risk for falls, and those residents would have a star sticker on the door frame. On 6/13/06, interviews were conducted with multiple CNA 's on each of the facilities' four units regarding how residents at risk for falls are identified, and what is done differently when providing cares for those residents. 12 of 12 CNA 's stated that they would never leave any resident at risk for falls unattended in the shower or bathroom. Resident 2 was admitted to the facility with diagnoses that include Parkinsons, muscle disuse atrophy, Bipolar disorder, General Anxiety Disorder and Personality Disorder. Resident 2's clinical record was reviewed on 6/13/06. A Significant Change MDS (Minimum Date Set) dated 2/22/06 documents the following for resident 1:	F 324		

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F 324	Continued From page 4 1. Moderately impaired cognition (decisions poor, cues/supervision required). 2. Limited assistance including 2 person assist during transfers. 3. Partial physical support needed to maintain balance while sitting. 4. Resident 1 had fallen in the past 30 days, as well as the past 31-180 days. 5. Resident had been taking multiple psychotropic medications. On 5/10/06 the Nurses Notes for resident 2 documented the following "[12:55 AM] CNA assisted [resident] into the [bathroom and] was waiting outside per [patient] request for privacy. Resident states that she was wiping off toilet seat [and] slipped in some water and fell - found sitting on floor in front of sink...[no] apparent injuries noted...". An.Incident Report dated 5/10/06 documented that resident 2 had an unobserved fall, and that she was found on the bathroom floor. On 5/23/06 the Nurses Notes for resident 2 documented the following "[9:20 PM] summons to [resident room] by CNA, [resident] sitting on [bathroom] floor stated she slipped off toilet, [range of motion within normal limits][no] redness or swelling to bottom, [resident] denies pain [related to] fall...". An Incident Report dated 5/23/06 documented that resident 2 had an unobserved fall, and that she was found on the bathroom floor. On 5/29/06 the Nurses Notes for resident 2 documented the following " [5:00 AM] Resident	F 324		

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F 324	Continued From page 5 was taken to [bathroom]. Refused to let male CNA assist her. He went next door to get female staff member after cautioning resident about safety and letting her know help would be there. He was at the door about two feet from [resident] when she sat down on the floor...". An Incident Report dated 5/29/06 documented that resident 2 had an unobserved fall, and that she was found on the bathroom floor. On 6/13/06 an interview was conducted with the facility Administrator and DON. When asked to provide documentation of employee training/inservices on fall prevention, documentation of an inservice training on 3/23/06 was provided. The summary of that inservice documented the following: "Residents at risk for falls. Do not leave residents left unattended while on toilet/shower chair/bedside. All residents who are at risk for falls should not be left unattended. This includes those [with] following: 1. Dementia diagnosis 2. Stroke / CVA (Cerebral Vascular Accident) 3. Body alarms/ restraints 4. Fall risk residents 5. New admit until assessed by nurse [and] ok'd to toilet self...". Although the facility provided documentation of employees being trained not to leave residents at risk for falls unattended when on the toilet/shower chair; resident 1, who was assessed as a fall risk, fell while left alone in the shower room, resulting in a femoral fracture. Resident 2, also at risk for falls, sustained a cut on her forehead as a result of one of her many falls while left unattended in the bathroom.	F 324		

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