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 04/24/2006

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HERITAGE PARK	2700 WEST 5600 SOUTH ROY, UT 84067

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F 157 SS=G	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in o483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in o483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview it was determined that for one of five sample resident's the facility did not immediately notify the resident's physician when there was:	F 157	5/23/06 POC acceptable Compliance date 6/16/06 UBuenbaum RN **DISCLAIMER CLAUSE** This plan of correction is being submitted in accordance with specific regulatory requirement and should not be construed as an admission of guilt or agreement with any of the deficiencies cited on the HFCA 2567; nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. This Plan of Correction also Serves as our credible allegation of compliance. **F 157 NOTIFICATION OF CHANGES** Corrective Action for residents found to have been affected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 5/5/06

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F 157	Continued From page 1 a.) A significant change in the resident's physical, mental or psychosocial status requiring physician interventions; and, b.) A need to alter treatment significantly. Specifically, the physician was not notified for resident CL1 when he had a fall which caused a head injury requiring medical interventions until after the resident died, 5 hours and 25 minutes after the change in condition was first noted by facility staff. Findings Included: 1. Resident CL1 was admitted to the facility on 3/25/06 with diagnoses which included hypothyroidism, hypertension, anxiety, dementia and rib fractures. Resident CL1's medical record was reviewed on 4/24/06. On 4/24/06 at 1:10 PM, CNA 2 was interviewed. She stated on 3/29/06 she was feeding resident CL1 in the restorative dining room. She stated during the meal resident CL1 was answering yes/no questions. CNA 2 stated while she was bringing him out of the dining room he slumped forward and she lifted him back into the wheelchair, she stated when she let go resident CL1 fell right out of the chair head first. She stated she stayed with the resident and hollered and within 2 minutes facility nurse 3 arrived. She stated during that time the resident did not respond but when the nurse arrived he let out a moan. CNA 2 stated resident CL1 had a bump	F 157	Since all residents could be affected who have a significant change in physical, mental or psychosocial status. The facility has taken the following steps to make sure each resident's physician is notified appropriately. Our physician notification policy was reviewed with our Medical Director on 4/25/06 in our Quality Assurance meeting. Protocols for immediate versus non-immediate notification of physician were clarified One-on-one in-service training was conducted on 4/25 and 4/26/06 to review our physician notification policy with our licensed nurses. On 4/28/06,our nurses were again in-serviced with our Medical Director to make sure they understood immediate versus non-immediate physician notification. The two nurses mentioned with Resident CL1 were counseled and in serviced concerning the incident on 3/29/06	

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F 157	Continued From page 2 on his head about the "size of a fifty cent piece" that was starting to bruise. CNA 2 documented the following statement which was not dated, "...I was stopped and was right behind [resident CL1], when I heard a loud moan from [resident CL1]. I went to reach for him but it was to late, he fell head first out of his wheelchair. I hollier [sic] for help, I didn't want to leave him, I tried [sic] to talk to him but I didn't get a response..." On 3/29/06 on the 6:00 AM to 2:00 PM shift, facility nurse 1 documented the following in a daily progress note, "...This AM res (resident) was alert [with] some confusion. [Up] w/c (wheelchair) for breakfast, body alarm in place. Approx (approximately) [9:05 AM] res fell from w/c, hit his head, small hematoma on [right] side of his head...Res has been sleeping in bed, [no] react to stimuli, his eyes are closed..." On 3/29/06, facility nurse 1 documented the following on an "Incident Report", "...Fall...Bruise [right] side head...Alert this AM, but [after] breakfast sleepy...Notification...Physician...wrote a note on Dr's board...Vital signs: Temp 97.3 Pulse 79 Resp 10 BP (blood pressure) 136/57..." On 4/25/06 at 2:24 PM, facility nurse 1 was interviewed over the phone. Facility nurse 1 stated she recalled resident CL1's fall. She stated she first saw resident CL1 when he was in his room. She stated she could not recall if he was awake when she first went into his room but she checked on him two to three more times during her shift and he was asleep and unresponsive. Facility nurse 1 stated she called	F 157	Measures that will be taken to make sure the deficient practice will not occur again. Compliance with our physician notification policy will be monitored by random audits conducted by our Director of Nurses, Assistant Director of Nurses, Staff Development Nurse, Unit Coordinators and the Administrator. Physician notification will be monitored in our morning standup meeting as the 24 hour report is reviewed and incidents examined. Resident change of condition will be monitored in our Persons At Risk (PAR) meeting each morning/week to make sure the resident's physical, mental or psychosocial needs are being addressed. Another in-service has been scheduled for 5/15/06 with our nursing staff and Medical Director to review compliance with our physician notification policy to ensure compliance. Results of our training and compliance will be given to our Quality Assurance Committee for review.	

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F 157	Continued From page 3 resident CL1's name and he did not respond. When asked if she contacted resident CL1's physician, facility nurse 1 stated "I didn't contact doctor, wrote a note for a referral on the doctor board." On 4/24/06 at 3:40 PM, facility nurse 3 was interviewed. She stated she did not see resident CL1 fall but was the nurse who first assessed resident CL1. She stated that his eyes were opened, he was not moaning and his pupils were equal. Facility nurse 3 stated that resident CL1 had a small hematoma to his forehead that was "quarter size". Facility nurse 3 stated she checked on resident CL1 several times and he did not respond "but that was normal for him" she stated she completed neurological checks every 30 minutes. She stated she did not complete any charting of the neurological checks, that she would tell facility nurse 1 what she was seeing. When asked if she contacted resident CL1's physician, facility nurse 3 stated facility nurse 1 notified resident CL1's physician. On 3/29/05 at 1:50 PM, facility nurse 2 documented the following in a nurses note, "Went into resident's rm (room) to see him [after] fall this AM. Found him in bed laying partley [sic] on [left] side [with] HOB (head of bed) slightly elevated [and] O2 (oxygen) on. Color pale [without] cyanosis. Resp (respirations) non labored but noted pause of 3-5 sec (seconds) between inhalations. Resident responded by briefly opening his eyes when his name was spoken. Noted slight restlessness m/b (manifested by) movement of arms [and] head..." On 3/29/06 at 2:30 PM, facility nurse 3	F 157	Monitoring Performance. Audits will be performed by our Director of Nurses, Assistant Director of Nurses, Staff Development Coordinator, Unit Coordinators, and Administrator over the next 4 weeks and on a as needed basis thereafter as determined by the QA Committee. Additional training and/or disciplinary action will be given to our nurses to ensure compliance.	6/6/06

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F 157	Continued From page 4 documented the following in a daily progress note, "CNA (certified nursing assistant) hollered down hall for this nurse to come to pts (patients) rm (room). Upon arrival, this nurse saw pt [without] breathing. Heart sounds not evident..."	F 157		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview it was determined that the facility did not provide the necessary care and services to attain or maintain the highest practicable physical well being for 1 of 5 sample residents (resident CL1). Specifically, resident CL1 did not receive prompt assessment and services when he presented with a change in condition in his mental status prior to dying. Findings Included: Resident CL1 was admitted to the facility on 3/25/06 with diagnoses which included hypothyroidism, hypertension, anxiety, dementia and rib fractures. Resident CL1's medical record was reviewed on	F 309	**F309 QUALITY OF CARE** Corrective Action for residents Found to have been affected. While one resident (CL1) of five was reported, we feel any resident could be affected who has a change in condition with their physical, mental, or psychosocial status. On 4/25/06, our Change of Condition Policy was reviewed with our Medical Director in our Quality Assurance meeting. Our Neurological Assessment, Physician Notification, and Vital Sign monitoring protocols were reviewed. One-on-one in-services were conducted with our nursing staff on 4/25/06 and 4/27/06. A second in-service was conducted on 4/28/06 by our Medical Director to discuss the reasoning behind these	

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F 309	Continued From page 5 4/24/06. On 3/29/06 on the 6:00 AM to 2:00 PM shift, facility nurse 1 documented the following in a daily progress note, "...This AM res (resident) was alert [with] some confusion. [Up] w/c (wheelchair) for breakfast, body alarm in place. Approx (approximately) [9:05 AM} res fell from w/c, hit his head, small hematoma on [right] side of his head...Res has been sleeping in bed, [no] react to stimuli, his eyes are closed..." On 3/29/06, facility nurse 1 documented the following on an "Incident Report", "...Fall...Bruise [right] side head...Alert this AM, but [after] breakfast sleepy...Notification...Physician...wrote a note on Dr's board...Vital signs: Temp 97.3 Pulse 79 Resp 10 BP (blood pressure) 136/57..." On 3/29/05 at 1:50 PM, facility nurse 2 documented the following in a nurses note, "Went into resident's rm (room) to see him [after] fall this AM. Found him in bed laying partley [sic] on [left] side [with] HOB (head of bed) slightly elevated [and] O2 (oxygen) on. Color pale [without] cyanosis. Resp (respirations) non labored but noted pause of 3-5 sec (seconds) between inhalations. Resident responded by briefly opening his eyes when his name was spoken. Noted slight restlessness m/b (manifested by) movement of arms [and] head..." On 3/29/06 at 2:30 PM, facility nurse 3 documented the following in a daily progress note, "CNA (certified nursing assistant) hollered down hall for this nurse to come to pts (patients) rm (room). Upon arrival, this nurse saw pt [without] breathing. Heart sounds not evident..."	F 309	Neurological Assessment protocols. Nursing Administration was in-serviced on 4/26/06 concerning these policies and the importance of monitoring each resident with a change of condition. The two nurses, mentioned with resident CL1 were given specific training and counseling for not following facility procedures. <u>Measures that will be taken to make sure the deficient practice will not occur again.</u> Each emergent change of condition will be reported to the attending physician immediately. If our nurse has not been able to reach the attending physician, our Medical Director will be notified for appropriate orders. Vital signs will be noted and documented on the neurological assessment form. Each incident will be reviewed in our morning stand up meeting as reported on the 24 hour report. A PAR (Person At Risk) meeting will be conducted to monitor and track each change of condition to ensure follow up has been completed.	

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F 309	Continued From page 6 On 3/29/06, facility nurse 3 documented the following on an "Incident Witness Account", "...I saw pt (patient) lying on [right] side face down on flr (floor) inside C DR (c hall dining room) doorway...Has bruise [with] swelling starting to appear to [right] forehead...PERRL- didn't lose consciousness- was alert but confused which was normal for pt...Visual checks by this nurse q15mins (every 15 minutes) revealed pt asleep, but arousable [with] breathing even [and] unlabored..." Documentation regarding the every 15 minute visual checks completed by facility nurse 3 could not be located in resident CL1's medical record. On 3/20/06 at 7:30 AM, facility nurse 2 documented the following in a nurse note, "From observation of the resident prior to releasing his body to the mortuary- I noticed that he did have an area of superficial bruising on his [right] forehead, which did not catch my attention the afternoon [after] his fall 3-29-06. the tissue had a pale brownish discoloration about the size of a small apricot." On 3/30/06 at 12:20 PM, facility nurse 4 documented the following in a nurses note, "Late entry for 3/29/06 [at] approximately 11:30-12:30 (11:30 AM to 12:30 PM) ...I glanced [at] resident over in his bed. He was asleep in a semi-fowlers position...I did not interact or awaken him. I did not notice a bruise to his forehead in my casual and brief observation of him..." On 4/1/06, CNA 1 documented the following on an "Incident Witness Account", "...After he fell I	F 309	Monitoring Performance. The facility will completed an ongoing review on each reported incident that occurs in our facility. Staff members will be given additional training or education to maintain compliance. A report of our monitoring activities will be given to our Quality Assurance Committee each month for review.	6/6/06

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help put him to bed. he wasn't responding. and we would go in [and] check on him he was just sleeping. At 12:30 (12:30 PM) me and [another CNA] went in to get him up for lunch. they told us to just leave him down. and at 2:00 (2:00 PM) he was sleeping when I left."

CNA 2 documented the following statement which was not dated, "...I was stopped and was right behind [resident CL1], when I heard a loud moan from [resident CL1]. I went to reach for him but it was to late, he fell head first out of his wheelchair. I hollier [sic] for help, I didn't want to leave him, I tried [sic] to talk to him but I didn't get a response..."

Based on the documentation it was noted that resident CL1 sustained a fall at approximately 9:05 AM. Facility staff completed an assessment and obtained vital signs at the time of the fall. There was no documentation in the medical record to provide evidence that facility staff continued ongoing assessment of resident CL1's vital signs, oxygen saturations or level of consciousness. Resident CL1 was found dead by a CNA at 2:30 PM, 5 hours and 25 minutes after resident CL1 fell causing an injury to his head.

On 4/24/06 at 1:10 PM, CNA 2 was interviewed. She stated on 3/29/06 she was feeding resident CL1 in the restorative dining room. She stated during the meal resident CL1 was answering yes/no questions. CNA 2 stated while she was bringing him out of the dining room he slumped forward and she lifted him back into the wheelchair, she stated when she let go resident CL1 fell right out of the chair head first. She stated she stayed with the resident and hollered

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and within 2 minutes facility nurse 3 arrived. She stated during that time the resident did not respond but when the nurse arrived he let out a moan. CNA 2 stated resident CL1 had a bump on his head about the "size of a fifty cent piece" that was starting to bruise.

On 4/24/06 at 1:15 PM, facility nurse 4 was interviewed. He stated on 3/29/06 he was informed that resident CL1 had a fall and he started the process of finding an appropriate restraint for resident CL1. He stated he went into resident CL1's room with a lap buddy and found resident CL1 asleep and did not disturb resident CL1. He stated he did not see any injuries on resident CL1.

On 4/24/06 at 1:20 PM, facility nurse 2 was interviewed. She stated on 3/29/05 at 1:50 PM she went in and did an overall assessment of resident CL1. She stated he was not in distress, his respiration were some what slowed, not labored, but there was a pause for a few seconds. She further stated that resident CL1 was restless moving his arms and legs and it was possible he was in pain. Facility nurse 2 stated when she called his name he opened his eyes, but did not make eye contact. She further stated she did not notice any injuries, but the next day the mortuary had not picked up resident CL1's body and she went in because she was told he had an injury to his head. Resident CL1's stated that resident CL1 had a "discolored bruise [right] side of forehead size of a small apricot." Facility nurse 2 stated whenever a resident has a head injury neurological checks should be completed. She stated on 3/30/06 she reviewed resident CL1's medical record and did not find any neurological

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F 309	Continued From page 9 checks which were completed by facility staff. On 4/24/06 at 3:40 PM, facility nurse 3 was interviewed. She stated she did not see resident CL1 fall but was the nurse who first assessed resident CL1. She stated that his eyes were opened, he was not moaning and his pupils were equal. Facility nurse 3 stated that resident CL1 had a small hematoma to his forehead that was "quarter size". Facility nurse 3 stated she checked on resident CL1 several times and he did not respond "but that was normal for him" she stated she completed neurological checks every 30 minutes. She stated she did not complete any charting of the neurological checks, that she would tell facility nurse 1 what she was seeing. Facility nurse 3 stated that the CNA's and facility nurse 1 should have been charting and completing vital signs on resident CL1. On 4/24/06 at 1:40 PM and 4:00 PM the DON (director of nurses) was interviewed. She she was out of town when resident CL1 had the fall. She stated that facility nurse 4 was acting DON during that time. The DON stated whenever a resident has fallen and clearly hit their head, nursing staff should start neurological checks and if there is a change of condition they should send the resident to the hospital for further evaluation. The DON further stated that she would expect her nursing staff to complete their own charting. On 4/25/06 at 2:24 PM, facility nurse 1 was interviewed over the phone. Facility nurse 1 stated she recalled resident CL1's fall. She stated she first saw resident CL1 when he was in his room. She stated she could not recall if he was awake when she first went into his room but	F 309		

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F 309	Continued From page 10 she checked on him two to three more times during her shift and he was asleep and unresponsive. facility nurse 1 stated she called resident CL1's name and he did not respond. She stated she recalled charting in resident CL1's medical record one time during the shift. When asked if she contacted resident CL1's physician, facility nurse 1 stated "I didn't contact doctor, wrote a note for a referral on the doctor board."	F 309		