STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465084	A. BUILDING _____ B. WING _____	C 2/4/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTS CARE AND REHAB.	187 WEST LAGOON STREET ROOSEVELT, UT 84066

COMPLAINT NUMBER. UT00000323

(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) COMPLETE DATE
F 155 SS=G	483.10(b)(4) NOTICE OF RIGHTS AND SERVICES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews with the resident, the resident's family member and facility staff, and on medical record review, it was determined the facility did not accept the verbal refusal of specific treatment made by one cognitive but physically dependent resident in the facility who suffered a fractured leg when staff put him on a commode chair in spite of his statement to them that he had not been out of bed for five years and his request not to be transferred out of his bed to the commode chair. Resident 13. Findings include: Resident 13 was admitted to the facility on 12/27/02 with diagnoses which included Parkinson's disease and osteoarthritis. Resident 13's medical record was reviewed on 2/4/03. The admitting nurse's assessment of resident 13, documented on 12/27/02, revealed the resident was assessed to have total body paralysis and to require total assistance of staff for all cares. The assessment revealed that resident 13 was on bedrest and was non-weight bearing. The Minimum Data Set (MDS) assessment for resident 13 revealed the resident was responsible for himself (Section A9,F) and had the cognitive skills for making his own decisions daily (Section B4).	F 155 NK 3/10/03 dy	The staff (Entire) was inserviced on 2-5-03 regarding Residents Rights per local ombudsman (copy enclosed) Nursing staff will continue to receive education regarding resident's rights on a minimum of annually. All new nursing staff will receive training upon hire (during orientation) Resident #13 was counseled with, regarding his choice to stay in bed at all times. On 2-18-03, he was informed of complications of immobility and physicians recommendations to be out of bed 3 x 's per week. Resident signed document stating wishes. Counseling and residents request was documented. (Copy enclosed) QA committee was informed on 2-20-03 , the above resolutions were discussed. QA committee will continue to monitor monthly x 6 months. Completion Date: 03-01-03	

pm 3/4/03
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Tammy Jensen — Administrator — 3-4-03

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days aft such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Resident 13 was interviewed on 2/4/03 at 8:35 AM. Resident 13 was asked if he remembered the day the staff got him out of bed to use the commode on 12/29/02. Resident 13 stated that he remembered it well, "because it was the worst pain I have ever experienced." Resident 13 stated that the nurse aides wanted to get him up to the commode early in the morning. Resident 13 stated that he told the nurse aides he had been in bed for five years and he could not sit on a commode. When asked what the nurse aides said to him, resident 13 stated, "They just ignored me and strapped me to the commode anyway." Resident 13 stated, "The pain was so horrible, I can't remember how long they made me stay there or when they got me off" the commode. "I just remember screaming while I was strapped on." Resident 13 stated that the hard pain occurred when the aides tried to bend his legs to make him sit. Resident 13 stated, "My legs don't bend like that."

Resident 13's family member was with him during the interview. The family member stated, ""He has been in bed over five years and he can't bend. They should all have known that, but these girls said they weren't told."

On 2/4/03 at 9:20 AM, an interview was conducted with the nurse who provided care to resident 13 on 12/29/02. The nurse stated that she told the nurse aides to put him on a commode so that gravity could help him have a bowel movement. The nurse stated that the nurse aides told her resident 13 did not want to get up but that she told them he needed to sit on the commode.

Nurse aide 1, who had worked with resident 13 on 12/29/02, was interviewed at the facility on 2/4/03 at 9:50 AM. Nurse aide 1 stated that she remembered

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F 155	Continued From page 2 putting resident 13 on the commode. Nurse aide 1 stated the nurse instructed the aides to put resident 13 on a commode. Nurse aide 1 stated she told the nurse that resident 13 did not want to get up, but the nurse said he needed to be on the commode anyway. Nurse aide 2, who had worked with resident 13 on 12/29/02, was interviewed by telephone on 2/5/03 at 1:00 PM. Nurse aide 2 wasn't certain how long resident 13 had been in the facility, but 12/29/02 was the first time she had worked with the resident. Nurse aide 2 stated that resident 13 told her he had never been out of bed and that he used a bed pan. Nurse aide 2 stated that resident 13 told her and nurse aide 1 to put him on a bed pan because he couldn't sit on a commode. Nurse aide 2 stated the nurse wanted resident 1 to be on the commode, so they followed the nurse's instructions.	F 155		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES 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 s483.12(a).	F 157 OK 3/10/03 DD		

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	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 s483.15(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 interviews with the resident's family members and medical record review, it was determined the facility did not immediately inform one resident's family when one resident in the facility voiced that his leg was broken and that he was in severe pain. Resident 13. Findings include: Resident 13 was admitted to the facility on 12/27/02 with diagnoses that included Parkinson's disease and osteoarthritis. Resident 13's medical record was reviewed on 2/4/03 and it revealed the following documentation: The nurse's notes on 12/29/02, documented resident 13 had complained of pain, the resident complained that his leg was broken, and the nurses had assessed a change in appearance of resident 13's right leg. There was no documentation in the nurses' notes that an attempt had been made to notify resident 13's family of his new condition. A nurse's report, dated 12/29/02 at 7:00 AM, documented an incident for resident 13. The report		The Licensed Nursing Staff was inserviced on 2-20-03 per D.O.N. and Administrator regarding revised policy and procedure for Family Notification. (Copy enclosed of minutes from meeting and Policy and Procedure) A copy of Policy and Procedure will be given to each new licensed nurse at time of orientation. Signature page will be given to place in file for documentation that policy and procedure was received. QA committee addressed problem on 2-20-03 and above resolutions discussed. QA committee will continue to monitor monthly x 6 months. Completion Date: 3-1-03	

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documented that resident 13 had been transferred from his bed to a commode with "two person assist, C/O (complaint of) pain to ® (right) leg transferred back to bed." It was documented that the nurse had observed slight swelling of resident 13's right knee and calf. The report documented that it was necessary to notify resident 13's physician and that the physician had been notified at 12:30 PM on 12/29/02. It was documented that resident 13's family was notified on 12/30/02 at 1:40 PM.

Resident 13's usual care giver, a family member, was interviewed on 2/4/02 at 8:35 AM. The care giver stated that she had been in the hospital when the incident occurred and that she had not been notified of the incident or the change in resident 13's condition.

On 2/4/03 at 10:20 AM, a telephone interview was conducted with the member of resident 13's family who was the resident's first emergency contact. The family member stated she had assisted with admitting the resident to the facility, on 12/27/02, because resident 13's usual care giver was in the hospital.

The family member stated that the first time she was told resident 13 had any problem with his leg was on 12/30/02, when she went to the facility to visit the resident and she was told he had been sent to the emergency room. The family member stated that she had an answering machine on her telephone and that she carried a cell phone. Resident 13's family member stated that she had received no telephone call and no message had been left at either of her telephone numbers.

Review of resident 13's admission and discharge summary sheet in the resident's medical record revealed two telephone numbers for the family

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F 157	Continued From page 5 member were documented under "emergency contact".	F 157	The staff was inserviced on 2-5-03 regarding residents rights per local ombudsman. The QA committee met on 2-20-03 to discuss the problem and the following resolutions. 1. Continue education to all new nursing staff regarding residents rights. 2. Continue education to all staff annually regarding residents rights. 3. Policy and Procedure revised regarding notification of family members with change of condition. 4. Resident #13 was addressed and counseling documentation (2-18-03) was reviewed. Resident currently being in bed at all times per his request. 5. Meeting to be held with key personnel on 2-21-03. To discuss the importance of following the chain of command to ensure critical information is communicated to all staff. Continue next page...	
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. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on interviews with one resident, the resident's family, facility staff, home healthcare nurse, physical therapist, and on medical record review, it was determined the facility did not provided necessary care and services to maintain the highest practicable physical and psychosocial well-being for one resident at the facility who experienced a fractured tibia during staff assisted activities of daily living. Resident 13. Findings include: Resident 13 was admitted to the facility, from his home and at his request, on 12/27/02 with diagnoses that included Parkinson's disease and osteoarthritis. 1. An interview was conducted on 2/4/03 at 1:30 PM with the home health nurse who had been working with resident 13 while he was at home. The home health nurse stated that resident 13 had been in bed for several years and that he was totally dependent upon others for eating, positioning and all of his activities of	F 309 OK 3/10/03 DH		

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F 309	Continued From page 6 daily living. The home health nurse stated she had contacted the facility on 12/23/02 to begin arrangements for resident 13 to be admitted to the facility. The home health nurse stated she had spoken to the facility five times, to the Assistant Administrator and the Minimum Data Set nurse, on 12/27/03 to assist with resident 13's transition from home to the facility. The home health nurse had made arrangements for the facility to transport resident 13 from his home in the facility's van and for the use of a gurney to transport the resident. The home health nurse stated that she had explained several times that resident 13 must be transported on a gurney because he could not sit. The home health nurse did an assessment of resident 13 before he left his home. The home health nurse stated that the resident's right leg had no edema. 2. On 2/4/03 at 2:30, an interview was conducted with the social services worker (SSW), who transported resident 13 from his home to the facility. The SSW stated that he had been instructed to transport resident 13 on a gurney. The SSW stated that resident 13 was lifted from his bed to the gurney with a sheet and the support of six people from both home health and nursing facility staff. 3. On 2/5/03 at 4:20 PM, a telephone interview was conducted with the nurse who admitted resident 13 to the facility on 12/27/02. The admitting nurse stated that she did a physical assessment of resident 13. The admitting nurse stated that resident 13's right leg was not edematous when he arrived at the facility. The admitting nurse stated that resident 13's left leg was visibly smaller than his right leg as a result of an accident that had removed a portion of the resident's left calf when he was much younger.	F 309	Continued #5.... Key personnel; Administrator, Nursing Administration, S.S., Dietary, Rehab. Services, Activities. Implementation of a Staff Communication Record was discussed. The Communication Record will be located in the Skilled Nursing Notes for the first week after admission. This record will be an informal record for staff to document any information that would be beneficial for other disciplines to know. This would improve the quality of care the resident would receive. The Communication record will be implemented for all future admits. 6. QA committee will continue to monitor q month X 6 months. Completion Date: 3-15-03	

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F 309	Continued From page 7 The admitting nurse stated that resident 13 was transferred with a mechanical lift, which was facility practice for any resident whose ability to transfer was not known. The admitting nurse stated that it was facility practice for physical therapy to assess all new resident's who had a physical impairment in an effort to determine if the resident might benefit from therapy. The admitting nurse stated that she did not see which physical therapist assessed resident 13 because the resident was admitted at 1:40 PM and the admitting nurse left at 3:00 PM. 4. The physical therapist who evaluated resident 13 for the facility, was interviewed by telephone on 2/4/03 at 10:30 AM and again at 11:10 AM. The Physical Therapist (PT) stated that he assessed resident 13 when the resident first arrived. The PT stated that resident 13 had been bed bound for quite a while and that the resident's range-of-motion (ROM) was pretty limited. The PT stated that resident 13's hands and upper extremities were much more limited, but that the resident's knees were probably limited about 50 percent. The PT stated that he had concerns regarding providing ROM for resident 13 because the resident was at high risk for fracture and/or increased pain, with no expectations of improvement. The physical therapist stated he told the facility, "Here's the plan, no physical therapy, no rehab nursing. Use caution with extra people for transfers due to risk of fracture due to having been bed ridden so long." 5. Resident 13 was interviewed on 2/4/03 at 8:35 AM. Resident 13 was asked if he remembered the day the staff got him out of bed to use the commode on 12/29/02. Resident 13 stated that he remembered it well, "because it was the worst pain I have ever experienced." Resident 13 stated that the nurse aides	F 309		

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wanted to get him up to the commode early in the morning. Resident 13 stated that he told the nurse aides he had been in bed for five years and he could not sit on a commode. When asked what the nurse aides said to him, resident 13 stated, "They just ignored me and strapped me to the commode anyway." Resident 13 stated, "The pain was so horrible, I can't remember how long they made me stay there or when they got me off" the commode. "I just remember screaming while I was strapped on." Resident 13 stated that the hard pain occurred when the aides tried to bend his legs to make him sit. Resident 13 stated, "My legs don't bend like that."

Resident 13's family member was with him during the interview. The family member stated, ""He has been in bed over five years and he can't bend. They should all have known that, but these girls said they weren't told."

6. On 2/4/03 at 9:20 AM, an interview was conducted at the facility with the nurse who provided care to resident 13 on 12/29/02. The nurse stated that resident 13 had not been able to have a bowel movement. The nurse stated that she told the nurse aides to put him on a commode so that gravity could help him get relief. The nurse stated that the nurse aides told her resident 13 did not want to get up but that she told them he needed to sit on the commode. The nurse stated that resident 13 was only on the commode for about 5 minutes. The nurse stated that she did not check resident 13 for stool until he was back in bed because he was too uncomfortable on the commode. The nurse stated that she notified resident 13's physician when the resident continued to complain of pain in his leg.

The nurse stated that she didn't know for sure whether or not resident 13 had been out of his bed in his geri

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chair before she had him put on the commode, but he had an order for a geri chair. The nurse stated that she thought if he was allowed to get up in a geri chair, the resident would be able to sit on a commode for a while.

7. Nurse aide 1, who had worked with resident 13 on 12/29/02, was interviewed at the facility on 2/4/03 at 9:50 AM. Nurse aide 1 stated that she remembered putting resident 13 on the commode. Nurse aide 1 stated that it happened in the morning when they were getting everyone up. Nurse aide 1 stated resident 13 had received a suppository and the nurse instructed the aides to put the resident on a commode. Nurse aide 1 stated she told the nurse that resident 13 did not want to get up, but the nurse said he needed to be on the commode. Nurse aide 1 stated that she and nurse aide 2 stood the resident at his bedside with a transfer belt and pivoted him to transfer him to a commode. Nurse aide 1 stated that resident 13 complained of hurting after he was on the commode and that he was only on it about 2 or 3 minutes. Nurse aide 1 stated that resident 13 "wasn't sitting on there very good because he can't bend." Nurse aide 1 stated the resident complained that "his leg hurt, then his whole body, but especially his one leg."

Nurse aide 1 stated that, if she had questions about how to care for a new resident, she would ask the Director of Nursing (DON) or the Administrator and then the nurse and other aides. Nurse aide 1 stated she remembered getting report that resident 13 had been in bed for six or seven years, but that she couldn't remember if she had heard whether or not resident 13 had ever gotten up in that time.

8. Nurse aide 2, who had worked with resident 13 on 12/29/02, was interviewed by telephone on 2/5/03 at

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1:00 PM. Nurse aide 2 stated that she worked at the facility in an "on-call" position. Nurse aide 2 wasn't certain how long resident 13 had been in the facility, but 12/29/02 was the first time she had worked with the resident. Nurse aide 2 stated that resident 13 told her he had never been out of bed and that he used a bed pan. Nurse aide 2 stated that resident 13 told her and nurse aide 1 to put him on a bed pan and that he couldn't sit on a commode. Nurse aide 2 stated that she stayed with the resident while nurse aide 1 went to tell the nurse. Nurse aide 2 stated the nurse wanted resident 1 to be on the commode, so they followed the nurse's instructions. Nurse aide 2 stated that resident 13 complained that his back or leg hurt so the nurse said to put the resident back in his bed. Nurse aide 2 stated that the nurse then came to look at the resident and the nurse stated the resident's knee was swollen. Nurse aide 2 stated that the resident's knee had not been bumped during the procedure.

9. The Assistant Director of Nursing (ADON) stated that she talked with resident 13's physician on 12/27/02, when the resident came into the facility. The ADON stated that the physician had told her resident 13 had put himself to bed with Parkinson's five year ago and he hadn't been up. The ADON stated that the physician did not say the facility should not get the resident up.

10. Resident 13's medical record was reviewed on 2/4/03 and it revealed the following documentation:

The nurse's admit assessment documented that the admitting nurse had assessed resident 13 to have total body paralysis and to require total assistance of staff for all cares. It was further documented that resident 13 was on bedrest and the resident was non-weight

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bearing.

The nurse's note, dated 12/29/02 at 7:00 AM, documented that resident 13 had been assisted to the commode and then back to bed. It was documented that resident 13 complained of pain in his right knee and his knee was noted to be swollen. The nurse documented that resident 13 had stated, "Its broke I know it." The resident was medicated for pain and the nurse was going to continue to monitor him.

The nurse's note, dated 12/29/02 at 11:45 AM, documented resident 13 was complaining of both legs hurting and was refusing to get out of bed. The resident was medicated for pain and the nurse was going to continue to monitor him.

The nurse's note, dated 12/29/02 at 9:10 PM, documented resident 13 complained of pain and he had edema in his right leg.

The nurses's note, dated 12/19/02 at 10:00 PM, documented resident 13 had been medicated for pain and was resting quietly.

On 12/30/02 at noon, the nurse's note documented that resident 13's right leg was swollen with bruising under his knee and lower leg that extended to almost mid calf. The resident was medicated for pain and the nurse was going to continue to monitor him.

The nurse's note, dated 12/30/02 at 3:00 PM, documented resident 13 was transported to be evaluated by his physician. At 4:30 PM on 12/30/02, resident 13 returned with a new diagnosis of fractured right tibia.

Review of an emergency room report regarding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465084	A. BUILDING _____ B. WING _____	C 2/4/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTS CARE AND REHAB.	187 WEST LAGOON STREET ROOSEVELT, UT 84066

(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) COMPLETE DATE
F 309	Continued From page 12 resident 13, dated 12/30/02, revealed the resident's X-ray showed that he had a non-displaced, right tibia fracture. The emergency room report documented: "This is a 77-year-old male with a history of Parkinson's disease who has been bedridden for five years. He was recently placed in (facility). He was having constipation. Apparently he started having pain after and the nurses lifted him and placed him on a bedside commode. He'd not been out of bed and onto a commode for greater than five years. The nurses noted some swelling in his right leg with bruising." The physician's assessment documented, "1. Fracture, right tibia." The physician's plan documented, "1. I spoke with (physician) who suggested we place him in a hinged brace with the leg fixed a (sic) comfortable flexion. This was done."	F 309		