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

PRINTED: 09/19/2005
FORM APPROVED
OMB NO. 0938-0391

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 09/14/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BASIN CARE AND REHABILITATION CENTER	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) COMPLETION DATE
F 223 SS=G	483.13(b), 483.13(b)(1)(i) ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on interview and medical record review, it was determined that the facility did not ensure that a resident was free from verbal, sexual, physical and mental abuse, corporal punishment and involuntary seclusion. Specifically, a facility certified nursing assistant verbally abused resident 1 and continued to provide care to facility resident after the incident was reported to a facility nurse. Findings include: Resident 1 was a 90 year old female admitted to the facility on 2/12/01 and then readmitted on 9/15/03 with diagnoses which included Alzheimer, late effect CVA (cerebral vascular accident), hypertension, hypothyroidism and degenerative joint disease. The nursing facility telephoned the State Agency on 8/25/05 to report a facility CNA (certified nursing assistant) was rough while transferring resident 1 from her bed to a wheelchair and that CNA was verbally abusive towards resident 1.	F 223	All residents are free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. The individual discovering the incident will report all allegations of abuse immediately to the skilled nurse on-duty. The skilled nurse will contact the Director of Nursing and/or Administrator immediately. The skilled nurse will give the completed documentation of the incident in a timely manner (at the end of the shift). The employee that has been accused of allegations of abuse will be suspended and removed from the facility immediately until an investigation of charges has been completed. The Director of Nursing will report the incident to the State Health Department, Adult Protective Services, Ombudsman, Physician and family member of the resident. The Director of Nursing will then continue an investigation to determine if the incident was a result of abuse, who was involved, predisposing factors, etc. and file a completed report of the investigation. Records of the investigation, all phone calls, and to whom the phone calls are made will be kept in the social services department. The on-going investigation will be completed within 5 working days and a completed report filed of the findings.	

10/18/05 POC acceptable Completion date 11/11/05 VBusenbark RN

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

Ronald Kap — Administrator — 9/30/05

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	Continued From page 1 Guideline $483.13 (b) and (c) "Abuse" means the willful infliction, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. "Verbal abuse" is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability. On 9/14/05 at 9:05 AM, resident 1 was observed in the activity room. Resident 1 was not alert and oriented. On 9/14/05, resident 1's medical record was reviewed. Facility nurses documented in progress noted that resident 1 was not verbal. There was no documentation to provide evidence that resident 1 was a combative resident. On 9/13/05 at 9:15 PM, CNA 1 was interviewed over the phone. The CNA 1 stated that on 8/22/05, herself and CNA 2 were walking down the west hall at about 4:30 PM and they heard raised voices coming from resident 1's room. CNA 1 further stated that herself and CNA 2 went into resident 1's room and CNA 3 was in the room bent over trying to dress resident 1. CNA 1 stated that they asked CNA 3 if she needed any help and CNA 3 refused. She further stated that CNA 3 was "grouchy and heavy handed" with resident 1. CNA 1 stated that "heavy handed" meant that CNA 3 was "pulling and dragging" resident 1. CNA 1 stated that resident 1 was agitated and striking at CNA 3. CNA 1 stated that CNA 2 replied to CNA 3 that resident 1 does not	F 223	All staff will be in-serviced regarding identifying and reporting abuse: Certified NA Tuesday, September 27, Skilled Nursing Thursday, September 29, 2005, and the General Staff on October 6, 2005. All new employees prior to working will review the facility policy for abuse and reporting abuse. A copy of the in-service and abuse policy will be signed and placed in their personnel files. All personnel files will be monitored by the Director of Nursing compliance. Reports of incidents of abuse will be reviewed during the scheduled Quality Assurance meeting. The Director of Nursing and the Administrator will monitor for compliance. Each month Social Services will check new hire files to assure that new hire orientation on abuse was completed for all new hires. Results will be reported to our monthly Quality Assurance (QA) committee team by Social services.	11/11/05

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F 223	Continued From page 2 usually act like that and CNA 3 stated that resident 1 was "a fu.....[expletive deleted] brat." CNA 1 stated that she and CNA 2 left the room and resident 1 was still being cared for by CNA 3. CNA 1 stated that a few hours later she went to facility nurse 1 and told her about the incident. She stated that facility nurse 1 told her to write up the incident and give it to her and then she will give it to the DON (director of nurses). CNA 1 stated that she wrote up the incident and gave in to facility nurse 1 on 8/24/05 (2 days after the incident occurred). On 9/14/05 at 8:50 AM, CNA 2 was interviewed. CNA 2 stated that on 8/22/05 at approximately 4:30 PM, she was walking down the west wing hall and heard raised voices and resident 1 grunting. CNA 2 stated that her and CNA 1 went into the room to see if they could help. Can 2 stated that CNA 3 refused help. She stated that CNA 3 was by the head of the bed and resident 1 was laying in bed. CNA 2 stated that CNA 3 jerked resident 1's pants up and spun her around on the bed so that her feet were on the ground and she had no back support. CNA 2 stated it appeared that resident 1 was going to fall off the bed and when CNA 1 went to help CNA 3 grabbed resident 1 by her pants and spun her around and "threw her into the chair." CNA 2 stated that resident 1's head and arms flew back and resident 1 tried to hit CNA 3 when she recovered. CNA 2 stated that she stated to CNA 3 that resident 1 does not usually act like that. CNA 2 stated that resident 3 stated " She's being a fu.....[expletive deleted] brat, just a brat." CNA 2 stated that resident 1 had her fist up. CNA 2 stated that she informed facility nurse 1 of the incident shortly after it occurred. She stated that facility nurse 1 told her to write the	F 223	The Director of Nursing/Social Service will conduct 5 random audits of facility staff as to what is abuse and how it should be reported. This audit will be 5 per week until a 90% accurate response is reached; at which time the audit will move to 5 per month. Once a level of 80% accuracy is maintained for two months it will be deemed that abuse training is effective. The results will be maintained on an abuse-tracking log and reported by Social Services to our monthly Quality Assurance meeting. All allegations of abuse will be recorded on an abuse-tracking log by social services. The abuse-tracking log will be filled out after the appropriate agencies have been contacted. The form will be kept in the abuse incident report book, located in the social services office. The potential resident abuse report book will be brought into facility Quality Assurance Meeting (QA) for review by the QA team members. The Abuse Incident tracking log will be reviewed in the next QA meeting, which will be held November 10, 2005. This meeting takes place on a monthly basis.	11/10/05

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F 223	Continued From page 3 incident up and turn the report over to her. CNA 2 stated that she gave the write up to facility nurse 1 on 8/24/05 (2 days after the incident occurred). On 9/14/05 at 7:55 AM, facility nurse 1 was interviewed. Facility nurse 1 stated that the incident involving resident 1 and CNA 3 occurred on 8/22/05. She further stated that she did not witness the incident. Facility nurse 1 stated that CNA 1 and 2 came and told her that evening that they witnessed CNA 3 "tossing" resident 1 around and being verbally abusive. Facility nurse 1 stated that she told the CNA's to write the incidents up and give the write ups to her. Facility nurse 1 stated that she received the write up's from the CNA's on 8/24/05 and she wrote up her report and provided the information to the DON. On 9/14/05 at 7:30 AM, the DON was interviewed. The DON stated that she was not informed of the incident involving CNA 3 and resident 1 until 8/24/05 (2 days after the incident occurred). The DON stated that on 8/24/05, resident 1 was suspended until the investigation was completed. A review of CNA 3's time report provided documented evidence that CNA 3 continued to work at the facility on 8/22/05 until 7:37 PM and worked on 8/24/05 from 12:55 PM until 5:02 PM.	F 223		
F 225 SS=D	483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment	F 225		

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F 225	Continued From page 4 of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. 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 certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility staff did not timely report an allegation of staff to resident abuse to	F 225	The investigation regarding the abuse incident of resident 2 & 3 has been concluded and reported to the administrator and to the State Agency. To protect residents from abuse: • New hire orientation will continue to include abuse prevention and reporting • All staff were in-serviced on facility policy, re: abuse, on October 6, 2005 by Social Services. • In-service on facility policy, re: abuse , will occur at least every six (6) months. • Abuse policy will be posted on bulletin board. • Residents will be educated at resident's council, re: their right to be free from abuse. Following an allegation of abuse by staff, that staff member will be immediately suspended until investigation is concluded. All reports will be reviewed at Quality Assurance meeting. Each month Social Services will check new hire files to assure that new hire orientation on abuse was completed for all new hires. Results will be reported to our monthly Quality Assurance (QA) committee team by Social services.	11/11/05

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F 225	Continued From page 5 the facility administrator or to the State Agency involving resident 1. In addition, facility staff failed to report and investigate an allegation of staff to resident abuse to the facility administrator and the State Agency involving resident 2 and resident 3. Findings include: 1. On 9/13/05 at 9:15 PM, CNA 1 (certified nursing assistant) was interviewed over the phone. The CNA 1 stated that on 8/22/05, herself and CNA 2 were walking down the west hall at about 4:30 PM and they heard raised voices coming from resident 1's room. CNA 1 further stated that herself and CNA 2 went into resident 1's room and CNA 3 was in the room bent over trying to dress resident 1. CNA 1 stated that they asked CNA 3 if she needed any help and CNA 3 refused. She further stated that CNA 3 was "grouchy and heavy handed" with resident 1. CNA 1 stated that "heavy handed" meant that CNA 3 was "pulling and dragging" resident 1. CNA 1 stated that resident 1 was agitated and striking at CNA 3. CNA 1 stated that CNA 2 replied to CNA 3 that resident 1 does not usually act like that and CNA 3 stated that resident 1 was "a fu.....[expletive deleted] brat." CNA 1 stated that she and CNA 2 left the room and resident 1 was still being cared for by CNA 3. CNA 1 stated that a few hours later she went to facility nurse 1 and told her about the incident. She stated that facility nurse 1 told her to write up the incident and give it to her and then she will give it to the DON (director of nurses). CNA 1 stated that she wrote up the incident and gave in to facility nurse 1 on 8/24/05 (2 days after the incident occurred). CNA 1 further stated that approximately 10 days before 8/22/05 (8/12/05) she had seen CNA 3 raise her fists towards resident 2 and knock her	F 225	The Director of Nursing/Social Service will conduct 5 random audits of facility staff as to what is abuse and how it should be reported. This audit will be 5 per week until a 90% accurate response is reached; at which time the audit will move to 5 per month. Once a level of 80% accuracy is maintained for two months it will be deemed that abuse training is effective. The results will be maintained on an abuse-tracking log and reported by Social Services to our monthly Quality Assurance meeting. All allegations of abuse will be recorded on an abuse-tracking log by social services. The abuse-tracking log will be filled out after the appropriate agencies have been contacted. The form will be kept in the abuse incident report book, located in the social services office. The potential resident abuse report book will be brought into facility Quality Assurance Meeting (QA) for review by the QA team members. The Abuse Incident tracking log will be reviewed in the next QA meeting, which will be held November 10, 2005. This meeting takes place on a monthly basis.	11/11/05

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F 225	Continued From page 6 away. CNA 1 stated that she reported this to the SSW (social service worker) on 8/25/05 (13 days after the incident occurred) when she was interviewed regarding the incident involving resident 1. A review of the facility investigation concerning CNA 3 and resident 1 provided documented evidence that CNA 1 informed the facility SSW of the incident involving resident 2 and CNA 3 on 8/25/05. There was no documentation to provided evidence that the allegation of staff to resident abuse involving resident 2 was appropriately investigated and reported to the State Survey Agency. 2. On 9/14/05 at 8:50 AM, CNA 2 was interviewed. CNA 2 stated that on 8/22/05 at approximately 4:30 PM she was in the resident 1's room when the incident involving CNA 3 occurred. CNA 2 stated that she informed facility nurse 1 of the incident shortly after it occurred. She stated that facility nurse 1 told her to write the incident up and turn the report over to her. CNA 2 stated that she gave the write up to facility nurse 1 on 8/24/05 (2 days after the incident occurred). 3. On 9/14/05 at 7:55 AM, facility nurse 1 was interviewed. Facility nurse 1 stated that the incident involving resident 1 and CNA 3 occurred on 8/22/05. She stated that CNA 1 and 2 came and told her that evening that they witnessed CNA 3 "tossing" resident 1 around and being verbally abusive. Facility nurse 1 stated that she told the CNA's to write the incidents up and give the write ups to her. Facility nurse 1 stated that	F 225		

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F 225	Continued From page 7 she received the write up's from the CNA's on 8/24/05 and she wrote up her report and provided the information to the DON. 4. On 9/14/05 at 7:30 AM, the DON was interviewed. The DON stated that she was not informed of the incident involving CNA 3 and resident 1 until 8/24/05 (2 days after the incident occurred). The DON stated that she was not aware of any other staff to resident issues involving CNA 3. 5. On 9/14/05 at 9:45 AM, facility nurse 2 was interviewed. Facility nurse 2 stated that around 8/23/05, resident 3 stated that he asked CNA 3 to get him a drink and CNA 3 stated to him "Oh [resident 3] your such a pain in the a..[expletive deleted]." Facility nurse 2 stated that she confronted CNA 3 about the incident and CNA 3 went and apologized to resident 3. A review of the facility investigation concerning CNA 3 and resident 1 revealed a statement dated 8/23/05 written by facility nurse 2. Facility nurse 2 documented on the statement the incident involving resident 3 and CNA 3. There was no documentation to provide evidence that the allegation of staff to resident abuse involving resident 3 was appropriately investigated and reported to the State Survey Agency.	F 225		