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	465084	A. BUILDING _____ B. WING _____	04/26/2007

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F 240 SS=D	483.15 QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. This REQUIREMENT is not met as evidenced by: Based on interviews, observations and reviews of record, the facility did not care for residents in a manner and in an environment that promoted maintenance or enhancement of each resident's quality of life, for 1 of 13 sampled residents. Resident identifiers 9. Findings included: Resident 9 was admitted to the facility on 12/19/06 with diagnoses which included congestive heart failure, edema, and coronary artery disease. During initial survey tour of the facility on 4/23/07 at approximately 1:00 PM, resident 9 was reported to be accommodated in a room at the end of Wing 4. On 4/24/07 at approximately 9:30 AM, a resident group interview was held during the annual recertification survey of the facility. During the interview, an attending resident stated that she was very concerned about another resident in the facility, identified as resident 9, who had been moved from a room on Wing 2 of the facility on the morning of 4/23/07 while resident 9 was attending an activity elsewhere in the facility. The resident attending group stated that resident 9's belongings had been moved in resident 9's absence and that resident 9 was not aware that	F 240		6/9/07

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

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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her belongings had been moved until she wanted to return to her room on Wing 2 after the activity. The resident attending group stated that she was very upset because resident 9 had been moved to another room without any notice. The resident attending group stated that "she (resident 9) is upset and thinks she did something wrong so that they moved her."

On 4/24/07 at approximately 10:30 AM, resident 9 was observed sitting in the facility day room with a family member present with her. Resident 9's family member was observed to be discussing room accommodations with the facility administrator. Resident 9 and resident 9's family member were observed to be visibly emotionally upset and crying. When resident 9's family member and the facility administrator had finished their discussion, the surveyor asked resident 9's family member for an interview. Resident 9's family member stated "I'm too upset right now. I'll talk to you later." Resident 9's family member then exited the facility. At approximately 1:00 PM on 4/24/07, resident 9 was observed to be moved into a room on Wing 4 that was closer to the nurse's station and her former room on Wing 2.

On 4/25/07 at approximately 12:30 PM, resident 9 was observed to be eating lunch in room 401 on Wing 4, attended by two of her family members. Resident 9's family members stated that they did not know that the facility planned to move resident 9 to a new room on 4/23/07 and that the move had upset resident 9 because "she thinks she did something wrong and that is why they moved her." Resident 9's family members stated that that it was hard to explain events to resident 9 because she was "confused and forgetful." Resident 9's family members stated that they

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hoped the latest move would allow resident 9 to see and visit with her former roommate and "help her feel better" about being in the facility. Resident 9's family members expressed concerns about the negative effect of the move on resident 9's emotional well being. One of resident 9's family members stated that "it's like we don't have any say at all about her room and her care." Both of resident 9's family members stated that they wanted to try the new room assignment to see if resident 9 could be comfortable with the new room.

A review of resident 9's facility record was completed on 4/25/07. Resident 9's facility record showed a partially completed Notice of Room Change form. The form showed that resident 9 was moved from room 204 to room 406 on 4/23/07. The form indicated that resident 9's attending physician had been notified of the room change on 4/24/07. In the space completed as "Reason for the room change:" the form showed "moved (resident 9) off medicare floor." In the space titled "Notified by:" the form showed no information.

On 4/25/07, an interview was held with the facility administrator and the director of nursing. The surveyor asked the facility administrator about notification of resident 9's room change on 4/23/07. The facility administrator stated that resident 9 was moved from Wing 2 to Wing 4 because she was not scheduled for short stay, rehabilitative therapy. The facility administrator stated that the move had been discussed with resident 9 at several times for weeks prior to the move and that facility staff had notified a family member of resident 9 prior to the move. The facility administrator and director of nursing stated

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F 240	Continued From page 3 that resident 9 had been moved on the morning of 4/23/07 because "a new admit had been scheduled for the room on Wing 2."	F 240		
F 247 SS=D	483.15(e)(2) NOTICE BEFORE ROOM CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interviews, reviews of record and observations, the facility did not provide notice before changing a resident's room and changing a resident's roommate, for 1 of 13 sampled residents. Resident identifier 10. Findings included: Resident 10 was admitted to the facility on 3/23/07 with diagnoses which included ankle fracture, diabetes, pain, hypertension, deep venous thrombosis and asthma. Resident 10 was interviewed on 4/25/07 at approximately 10:30 AM. Resident 10 reported that her roommate had been moved to another wing of the facility on 4/23/07 and that she had received a new roommate on the afternoon of 4/23/07. Resident 10 stated that she had not been notified prior to her former roommate's move to another room on 4/23/07. Resident 10 stated that she had not been told that a newly admitted resident would be assigned to room with her on 4/23/07.	F 247		6/9/07
F 279 SS=B	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS	F 279		6/9/07

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F 279	Continued From page 4 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review it was determined that the facility did not use the results of the assessment to develop a plan of care for 1 of 13 sampled residents. Resident identifier: 8. Findings include: Resident 8 was admitted to the facility on 2/6/07 with diagnoses that included Down's syndrome, weakness, morbid obesity, mental retardation, pulmonary embolism, heart failure, hypothyroidism, decubitus ulcer, reflux, gout, and constipation. A review of resident 8's clinical record was	F 279		

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F 279	Continued From page 5 completed on 4/26/07. Based on the initial Minimum Data Set (MDS) assessment, with an assessment reference date of 2/16/07, resident 8 triggered in the following areas of Section V, the Resident Assessment Protocol Summary (RAPS): cognitive loss, communication, activities of daily living (ADL) functional/rehabilitation potential, urinary incontinence, nutritional status, dehydration/fluid maintenance, oral/dental care and pressure ulcers. Resident 8's care plan was reviewed. A care plan for the following areas triggered in the RAPS could not be located: cognitive loss, communication, urinary incontinence, and oral/dental care. Also, a document entitled "Therapeutic Recreation Quarterly Notes" dated 2/13/07 for resident 8 was reviewed. The Therapeutic Recreation Therapist (TRT) wrote, "Assessment and care plan in progress." However, no care plan could be located in resident 8's chart which addressed activities for resident 8.	F 279		
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 observations, staff interviews and record review, if was determined that facility staff failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents. This occurred for 2 of 13 residents in the survey sample. Resident	F 324		6/9/07

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identifiers #5 and 11.

Findings include:

1. Resident 5 was an 84 year old admitted to the facility on 2/29/02, and had the diagnoses which included dementia, hypoxia, anorexia, arthritis, osteoporosis and hypothyroidism.

Resident 5 was observed supine in her bed on 4/23/07 at 2:50, 3:20 and 4:20 PM. Resident 5 did not have mats on the floor near her bed and her bed was approximately 18 inches from the floor to the top of the mattress. Resident 5 was again observed supine in her bed on 4/24/07 at 10:10 AM, 1:55 and 2:20 PM without mats on the floor. A bed alarm was not observed during any of these times and there was not any safety mats observable in the bedroom.

During a review of resident 5's clinical record and the incident reports for the prior 7 months, the following falls were recorded.

During August 2006, the incident report log recorded that on the 18th resident 5 fell and received a skin tear and bruise. On the 20th and 24th, resident 5 fell without apparent injury. On the 25th, she fell and received a lump on her forehead.

During September 2006, the incident report log recorded that on the 1st of the month resident 5 fell without apparent injury. On the 2nd, she fell and received an abrasion to her left elbow and on the 26th, resident 5 fell and received an abrasion to her knee and a right head bump.

An incident report dated 10/15/06 documented

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that kitchen staff "found resident and dining room chair tipped over." Resident 5 was treated for skin tears and sent to the emergency department (ED) and the diagnosis of a fractured cervical (collar bone) was determined.

A nurse's note dated 10/21/06 documented, "tried to place (resident 5) in w/c (wheelchair) but refused to stay, continues to be at risk for falls, monitor closely."

An incident report dated 10/24/06 documented that resident 5 was attempting a transfer from her wheelchair (w/c) to a lobby chair. This resulted in an injury that was documented as "1.2 cm long (and) 0.7 cm long" skin tears to the right elbow.

A nurse's note dated 10/26/06 documented, "...check on resident often throughout the day d/t (due to) her high fall risk status."

An incident report dated 11/1/06 documented that resident 5 was "found outside on ground..." The injuries documented on the incident report were laceration, abrasion, hematoma and bruising.

A nurse's note dated 11/1/06 documented that a nurse, "Assessed hematoma (left) side of forehead laceration on 3X4 (left) shoulder (and) (right) ring finger abrasion to (left) hand bruise (left) elbow (and) (right) thumb." (sic)

An undated incident report signed 11/13/06 by an LPN documented that resident 5 ambulated to her bathroom and "lost her balance (and) sat on floor near toilet received s/t (skin tear) (approximately) 2cm in size to inner (right) elbow."

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A nurse's note dated 11/1406 documented, "At risk for injury (and) pain d/t hx (history) of falls."

An incident report dated 11/20/06 with a time of 6:00 AM documented that a Certified Nurse Assistant (CNA) placed the resident on the toilet and left the area, when the CNA returned resident 5 was on the floor. The injury was documented as "reddness" (sic).

An incident report dated 11/20/06 with a time of 1:30 PM documented "...LPN observed resident trying to sit in lobby chair missed (and) sat on floor reopened s/t from a previous fall this AM..."

An incident report dated 11/29/06 with a time of 8:30 AM documented that resident 5 fell when another resident grabbed at her. The report documented, "S/T (skin tear) cleaned, steri stripped (and) wrapped (lower right) forearm 6cm long 1cm wide."

An incident report dated 11/29/06 with a time of 5:00 PM documents that staff "Heard a loud thud" and determined that resident 5 fell near the front door. The report documents, "Sent to the ER unable to bear wt (weight) R (right) leg c/o (complaint of) pain." The ED determined that resident 5 had fractured her hip.

A nurse's note dated 12/2/06 documented, "resident returned from (hospital) post surgical repair of fx (fractured) hip...(no) change in orders other than a (dressing change every day)"

An incident report dated 12/14/06 documented that "(Resident 5) found on floor in front lobby. PT (patient) sent to (hospital) for evaluation."

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An incident report dated 2/2/07 documented resident 5 was found on the floor next to her bed. No apparent injury.

An incident report dated 2/5/07 documented, "Resident attempting to ambulate/transfer out of W/C, fell to floor." It was documented that the resident had a complaint of pain to her right breast and was "upset, crying."

On 3/15/07 and 4/18/07, incident reports documented that resident 5 fell without any apparent injuries.

A Fall Risk Assessment was completed for resident 5. A score of 10 or above represents a high risk for falls. On 10/5/06 she was assessed as a 17. On 10/15/06 she was assessed as a 20. On 12/14/06 she was assessed as a 19 and on 3/5/07 she was assessed as a 19.

During an interview with the director of nursing (DON) on 4/24/07 at 3:05 PM, she stated that the facility did not try a bed or chair alarm for resident 5 since an alarm device was discontinued on 1/5/06. It was also stated that during the transition of DONs in August 2006, the Falls Committee was inactive at time of transition and had begun actively again, evaluating residents' falls, during 11/07. The DON also stated was that the physician did not order floor mats for resident 5 and that they (the facility) "could have done more" for resident 5.

The Fall Committee recommended on 2/9/07 that resident 5 should have "mat at both sides of bed"

After the 12/14/06 fall and ED visit, resident 5's physician ordered a soft belt restraint at all times

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and a V-roll restraint while in bed as needed. The V-roll restraint was discontinued on 12/22/06 and the soft belt was replaced with a lap buddy w/c restraint at this time.

An 8/31/06 note from the physician documented that resident 5 "...has been falling quite a bit...She has had agitation and gotten up and falling." The note documented as the "Plan: We will continue what we are doing with her."

On 12/22/06, the Care Plan was revised to include "(1) 12/22/06 Lap Buddy when up in chair/wheelchair...(4) Bed in low position with mats on floor to prevent falls from bed." It also documents "At risk for falls/injury..." and the approach is to "Monitor safety and fall risks...(2) Assist with transfers and (ambulation) via wheelchair d/t (due to) non weight bearing."

2. Resident 11 was an 85 year old admitted to the facility on 12/10/02 with diagnoses which included Parkinsonism, dementia, vertigo, hypertension, insomnia and hypothyroidism.

Resident 11 was observed on 4/25/07 at 9:10 AM, in the lobby involved in a ball toss activity sitting in her w/c. The w/c did not have a chair alarm on it. On 4/25/07 at 10:00 AM, resident 11 was observed supine in her bed. The bed did not have a bed alarm. At 12:20 PM, resident 11 was observed sitting in her w/c near the DON's office. A w/c chair alarm was not attached to the w/c. Resident 11 was observed on 4/26/07 at 8:50 AM near the DON's office in her w/c; an alarm was not in place on the w/c.

During an interview with the assistant director of nursing (ADON) on 4/25/07 at 12:25 PM, the

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ADON stated that resident 11 had bed and chair alarms but they were discontinued because resident 11 was turning them off. During another interview with the ADON at 1:05 PM, she stated that the alarm order did not get on the treatment sheets and therefore it did not get discontinued and there was not a physician's order to discontinue it. The DON also stated that there are not any nurses notes documenting that resident 11 disables the alarms.

The physician's recertification orders for 4/07 and signed by the physician regarding resident 11 documents as an initial order on 4/19/05 for "Bed/Chair Alert All" In the right top corner of this document it states, "Cancel All Previous Orders". Also, the recertification orders for 3/07 and signed by the physician on 3/13/07 were the same as April 2007.

A physician's progress not dated 3/21/07 documents that resident 11 "fell this past weekend. She was evaluated in the emergency room and was found to have a fractured finger." The physician assessment was, "Digital fracture in a patient with high risk for falling."

A review of the incident report log documented that on the following dates resident 11 either fell or was found on the floor without apparent injury: December 11, 15 and 26th 2006, January 24, 2007, February 8, 13, 25, and 27th 2007; and March 11 2007 recorded two incidents. An incident report for 3/7/07 documents an unobserved fall and the injury as "skin tears x3 (three times)." Under the section safety devices on this form, it was left blank.

A Fall Risk Assessment was completed for

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F 324	Continued From page 12 resident 11. A score of 10 or above represents a high risk for falls. On 10/4/06 she was assessed as a 10. On 1/23/07 she was assessed as a 12 and on 4/21/07 she was assessed as a 14. The Care Plan for resident 11 showed a notation deleting "(6) Bed/Chair Alarm to be used."	F 324		
F 514 SS=B	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility did not maintain accurate clinical records for 2 of 13 sampled residents. Resident identifiers: 8 and 13. Findings include: 1. Resident 8 was admitted to the facility on 2/6/07 with diagnoses that included Down's syndrome, weakness, morbid obesity, mental retardation, pulmonary embolism, heart failure, hypothyroidism, decubitus ulcer, reflux, gout, and constipation.	F 514		6/9/07

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 _____	04/26/2007

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 PRECEDED 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 514	Continued From page 13	F 514		

A review of resident 8's clinical record was completed on 4/26/07. A nurses note dated 4/25/07 read, "pt (patient) has been refusing antibiotic and at times all his medications." A review of resident 8's April medication sheet indicated that facility staff had initialed indicating that all of resident 8's medications were administered to resident 8 during the month of April with one exception (Spironolactone was not initialed as having been given on the 11th, 14th or 15th at the nighttime dose).

An interview was held with RN 1 on 4/26/07 at 8:45 AM. When RN 1 was asked how the facility documents if a resident refuses their medications, RN 1 stated "I circle my initials" on the medication sheet. When asked if it is a facility practice to circle initials on the medication sheet if a resident refuses medications, RN 1 said yes. No initials were circled on the medication sheet indicating that resident 8 had refused his medications.

Resident 8 left the facility before 12:30 PM on 4/25/07 for a doctor appointment and was subsequently admitted to the hospital. However, on the medication sheet, one of resident 8's medications was initialed as having been given at 2:00 PM on 4/25/07. Resident 8 was not in the facility at 2:00 PM on 4/25/07.

2. Resident 13 was admitted to the facility on 8/3/06 with diagnoses that included hyponatremia, degenerative joint disease, hypertension, anxiety, edema, reflux, constipation, depression, and heart failure.

A review of resident 13's clinical record was completed on 4/25/07. Another resident's physician orders were located in resident 13's

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F 514	Continued From page 14 clinical record.	F 514		