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	465094	A. BUILDING _____ B. WING _____	C 08/09/2007

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WOODLAND PARK CARE CENTER	3855 SOUTH 700 EAST SALT LAKE CITY, UT 84106

(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 000	INITIAL COMMENTS An abbreviated complaint survey was conducted 8/2/07 through 8/10/07. The complaint was substantiated. See HCFA 2567. Deficiencies were cited. See F tag 323, F tag 324 and F tag 166.	F 000		
F 166 SS=D	483.10(f)(2) GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interviews and documentation review, it was determined that the facility did not ensure that 1 of 3 sampled residents had the right to prompt efforts by the facility to resolve grievances the resident may have. Specifically, the facility did not respond timely and did not reach satisfactory resolution to a family member's specific grievance. Resident identifier: 2. Findings include: Resident 2 was admitted to the facility on 3/6/07 with diagnoses which included, CVA with left sided weakness, hypertension, cardiac dysrhythmia, and hyperlipidemia. On 8/2/07 the Facility policy on filing grievances/complaints staff responsibilities was reviewed. The policy states: "All staff members shall assist and encourage residents to file a grievance and or complaint when they believe that their rights have been violated.". Procedure: "Should a staff member overhear or be the	F 166		9/26/07

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

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recipient of a complaint - voice by a resident, his or her representative (sponsor), or other interested family member - concerning the resident's medical care, treatment, food, clothing, behavior of other residents, etc., the staff member should encourage and assist the resident, or person acting on the resident's behalf, to file a written complaint with the facility. Staff members should inform the resident, or other person acting on the resident's behalf, that he or she may file a grievance or complaint with the administrator, or government agencies as noted on the residents' bulletin board, without fear of threat or any other form or reprisal. Staff members should inform he resident, or person acting on the resident's behalf, that an ample supply of Grievance/Complaint Report forms are available at each nurses' station and the procedures for filing a grievance or complaint are posted on the residents' bulletin board.

Resident 2's daughter was interviewed on 7/27/07. She reported that she had multiple grievances that had not been fully addressed by facility staff members or Administration. Some of grievances mentioned in this interview were, lack of CNA care to resident 2, including unanswered call lights. Swelling of resident 2's legs and her inability to wear AFO (ankle foot orthotic), not informing medical providers at Dr's appointments of resident 2's insurance, missing clothing, other missing belongings, not being informed of new room assignments, unable to reach staff members when she had called in to obtain information, and parking issues. Resident 2's daughter provided State Surveyor with a written letter dated July 16, 2007, that she had delivered to facility Administration on July 16, 2007. Resident 2's daughter also stated that because of

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her concerns not previously addressed, she decided to put her concerns down in writing and deliver the letter to facility Administration. She stated that some of these concerns had occurred prior to July 16, 2007.

Resident 2's daughter stated that she had a big concern with a staff member parking in the facility driveway, loading and unloading zone. She stated that because of this, it was difficult for her to assist her mother into and out of the facility. Resident 2 stated that she had spoken to SAU (Sub Acute Unit) Manager about this concern, in early July, and that there was minimal efforts to have the parking issue resolved. Resident 2's daughter stated that she did not put her parking concerns in writing, but that she had specifically talked to SAU Manager, as well as facility Administrator in early July, 2007. She was unable to state exact date/time she reported her parking concerns.

On 7/27/07 the facility's Grievance Log was reviewed. May, 2007, there were no grievances documented regarding resident 2. June, 2007, there were no grievances documented regarding resident 2. July, 2007 there was one grievance logged on 7/24/07 regarding resident 2. There were two documents found. The description of the grievance was documented as follows: "Dtr (daughter) concerned braces not being put on as well as the leg on the wheelchair not being put on. Resident reports difficulty getting her food heated up. Resident reports a nurse gave her beer to another resident. Resident reports she cannot reach her call light in the bathroom. Missing items: clothing and socks.". Description of the grievance: "At times resident 2 refuses to put her braces on with CNA and Nursing staff. Resident

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has difficulty reaching her call light in her bathroom." Recommendation: "Inservice with the aides. Maintenance notified of bathroom concerns. Housekeeping and Administrator notified of missing items. Family meeting held with resident, dtr (daughter) Administrator, unit Manager, director of CNA's and Social Services.". Was grievance/complaint resolved to the satisfaction of all concerned? "Trial period to satisfy and address resident and family concerns.". The form was signed by the facility staff member, with a notation that the patient could not stay awake to sign the second page. There was documentation that the resident signed the second page, and it was dated 7/27/07.

There was no documentation that this grievance form addressed all of the concerns mentioned in the letter submitted by resident 2's daughter on 7/16/07. The grievance form did not address the parking concerns of resident 2's daughter.

On 7/27/07, the facility SAU Manager was interviewed regarding resident 2's parking grievance. She stated that resident 2's daughter had told me about a parking problem, "in passing". SAU Manager stated that "It didn't appear to me, a grievance.". SAU Manager stated that she was not aware a grievance form was needed, and thought the issue had been resolved.

On 7/27/07 at 1:10 PM, facility SSW (Social Services Worker) was interviewed regarding the parking grievance. She stated that Administration follows up on grievances, and that this grievance was documented in the abuse log, and that she did not write up any grievance regarding the

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parking concerns or follow up with resident 2's daughter. She stated that it was all documented in the abuse log, because resident 2 had reported that a facility staff Nurse had come into her room and made a comment about the parking issue that was of concern..

On 8/2/07 a telephone interview was conducted with facility staff Nurse who had been parking in the patient loading and unloading zone area. She stated that resident 2's daughter had never "said anything to me.". I didn't know that she had complained. My Manager told me in the parking lot that resident 2's daughter informed her that if a silver jeep was parked there anymore she was going to call the police. During the interview State Surveyor asked what color her jeep was, and did she continue to park there after being notified of a concern. Staff Nurse stated that her jeep was Silver, and that she did continue to park there, but not all the time. She stated that she was never told not to park there by staff or her Administrator. She stated that all kinds of people park there, and that she felt "singled out." Since the incident on July 7, 2007, when resident 2's daughter contacted the Sheriff's department, she has not parked there. Staff Nurse stated that she still frequently parked there up until July 7, 2007, because there was no other place to park. Staff Nurse stated that she never spoke to the Sheriff, and that she was never told by the Sheriff that she could not park there.

On 7/27/07, during an interview with resident 2's daughter, she stated that she reported multiple times, her concerns of not being able to load and unload her mother, because a staff member's jeep was in the way. She stated that no one ever followed up with her regarding her grievance, and

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that on July 7, 2007, again there was unattended vehicle, a silver jeep, parked in the loading and unloading zone. She stated at that time, she contacted the Sheriff 's Department, and they came out, and could not enforce parking at the facility because it was private property.

On 8/2/07 at 2:00 PM Facility Administrator was interviewed regarding resident 2's daughter's grievances. Facility Administrator stated that Grievances are compiled by his SSW. Facility Administrator stated that his DON (Director of Nursing), talked to the facility Nurse who had been parking there, and said that the Nurse was verbally asked not to park there anymore. The date of this conversation was unknown. Facility Administrator stated that the staff Nurse parked away from the driveway, and that cars could come and go and that the facility driveway was not obstructed. Facility Administrator stated that his DON talked to the nurse after the Sheriff was called, and that his DON did not know that resident 2's daughter had talked to this particular staff nurse about about the parking issue. He stated that his SAU Manager also spoke to the Staff nurse, and that another nurse working on July 7, 2007, had told his DON, that resident 2's daughter came in that night and asked for a phone book to call the police. Resident 2's daughter did not mention to Staff Member working July 7 , 2007, that there was a car blocking the driveway. It was reported to Administrator that resident 2's daughter did not voice a concern about parking that night, that she simply called the police. Facility Administrator stated that resident 2's clothes are still missing. He stated that they are investigating and that it takes a few days to follow up on missing clothes, to look for them. The Administrator stated that he

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F 166	Continued From page 6 did have a family meeting with resident 2 and her daughter after receiving the letter from the daughter about the "care issues". The Administrator stated that resident 2's daughter is worried that resident 2 is trying to get kicked out of here. The Administrator stated that the toilet paper was moved to resident 2's right side to accommodate her and that the call light has been moved so that it was more accessible.	F 166		
F 323 SS=G	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and documentation review, it was determined that the facility did not ensure that 1 of 3 sampled residents environment remains as free of accident hazards as is possible, specifically one resident sustained a broken left arm when she fell from her wheelchair, while propelling herself back into the facility after smoking. The surface outside in the smoking area was uneven. Resident identifier: 2 Findings include: Resident 2 was admitted to the facility, on 3/6/07, with diagnoses which included, CVA with left sided weakness, hypertension, cardiac dysrhythmia, and hyperlipidemia. On 7/27/07 at 3:30 PM, resident 2 was interviewed regarding the circumstances of her fall in the w/c, when she broke her arm. Resident	F 323		9/26/07

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2 stated the following: "The Nurse saw me and lifted me up off the ground, this occurred in the early evening. I was in my wheelchair, and it came off the cement. ".

Resident 2 's medical record was reviewed on 7/27/07. Documentation in the medical record shows that resident 2 sustained a fall from her wheelchair, and suffered a broken left arm on 6/18/07.

On 6/19/07 X ray results of Left shoulder for resident 2: "Humeral Fracture".

On 6/18/07 at 16:00 the following was documented in the Nurses notes: "Resident 2 was out in the smoking area behind DR (dining room) when she says she fell trying to wheel herself back inside. States w/c went off curb and she fell onto L (left) side. No apparent injury but c/o (complains of) increase pain to left shoulder Medicated per order with good results. Reminded resident 2 that staff must take her out to smoke so we can know to help her back in and requested that she go out where staff can see her smoke.

On 6/18/07 PM Late Entry the following was documented in the Nurses notes: "A X O X 3. (Alert and oriented X 3), to self time and place. c/o pain and discomfort left arm. Analgesia given for pain relief as charted on MAR (medication administration record). Will cont (continue) to monitor.".

On 6/18/07, facility staff scored resident 2 as being a "19" and that a score of 10 or more indicates high risk for falls, on the facility health care fall risk assessment.

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The facility Unusual Occurrence report dated 6/18/07 documents the following: "Resident 2 was out in the smoking section behind the DR (dining room) when she says she fell trying to wheel herself back inside. States w/c (wheelchair) went off curb and she fell onto L (left) side. No apparent injury but c/o (complains of) increase pain to left shoulder. Medicated per order with good resulted. Reminded resident 2 that staff must take her out to smoke so we can know to her her back inside.". Final disposition or outcome: "Fracture noted L humerus, MD notified. 6/19 X ray 6/19 No other tx (treatment) required keep in sling.".

On 7/27/07, an observation of the facility smoking courtyard, where resident 2 fell, was conducted. Observation showed that there was a cement pathway surrounded by dirt and earth, along with decorative rocks. It was noted that at multiple areas there was uneven surfaces, and there was a gap of up to 5 inches in certain areas. The specific place where resident 2 fell there was a 2 inch gap.

On 8/2/07 at 11:30 AM, facility CNA 2 was interviewed. CNA 2 assisted resident 2 when she fell on 6/18/07. CNA 2 stated that he was feeding a resident just outside the courtyard, when he heard resident 2. CNA 2 stated that he "Thinks" resident 2 was backing up and attempting to return inside the building. He stated that resident 2 was still in her w/c and she was tipped over and lodged inbetween two rocks. He stated he got the nurse to check the resident, and when the Nurse said it was OK, we lifted her up. CNA 2 stated that resident 2 had been stuck there in that particular spot on more than one occasion.

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F 323	Continued From page 9 On 8/3/07 at 09:30 AM, CNA 2 was reinterviewed. He stated that he did inform a facility nurse that resident 2 had been stuck in her w/c out in the smoking patio. He stated that he informed a nurse that no longer works here, that resident 2 had been "stuck" on the uneven surface prior to the fall that had occurred on 6/18/07. CNA 2 stated that resident 2 had been "stuck" in that particular spot on more than one occasion, but could not recall exactly how many times. On 9/8/07 at 07:30 AM, FN 1 (Facility Nurse) was interviewed. She stated that CNA 2 had not reported the incident of resident 2 being "stuck" out on the smoking patio to her.	F 323		
F 324 SS=D	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 record review and interview, it was determined that the facility not not ensure that 1 of 3 sampled residents received adequate supervision and assistance devices to prevent accidents. Specifically, a facility resident with diminished mental capacities did not receive adequate supervision and monitoring and was found outside of the facility, in a wheelchair, on a busy street. Resident identifier: 1. Finding included: Resident 1 was admitted to the facility on 9/2/05 with diagnoses which included, schizophrenia,	F 324		9/26/07

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paralysis and insomnia.

On 7/13/07, a report was received from a local citizen that a resident from the facility was seen out on the busy street in her wheelchair. The citizen reported that a man was observed to run out from the bus stop and retrieve the resident who was in the middle lane of traffic and take the resident back into the facility.

On 7/25/07, The facility was contacted to inquire about this incident. The facility had no documentation or knowledge of this incident. On 7/25/07, this incident was reported to the Utah Department of Health.

On 7/27/07, an investigation was conducted by the State Agency.

An interview was held with the Director of Nursing (DON) on 7/27/07. The DON stated that they believed it was resident 1, but they were not sure. The DON found out about the incident on 7/25/07.

An interview was next held with the CNA who was caring for resident 1, on 7/13/07. The CNA stated that two males citizens brought resident 1 to the nurse's station and said, "We found her outside on 700 East." The CNA stated that she believed one of the males worked in the facility's physical therapy department. The CNA was then asked if she had reported this incident to resident 1's nurse. The CNA said, No, the Nurse was right there and saw resident 1 being brought back in by the two male citizens. The CNA stated that the Nurse saw and heard the entire conversation.

The Director of Therapy Department was interviewed and an inquiry was made regarding

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information as to any male therapists that had been working on 7/13/07, and did any of them know anything about resident 1 being in the street on 700 East. The Director stated that she did not know if any of her male staff were aware of it. She questioned her male staff working that day, and called the other male staff members at home. The Director stated that none of her male staff members had knowledge about the incident.

The Nurse who was on duty on 7/13/07, was questioned about the incident. She stated that she did not see or hear anything regarding the incident with resident 1.

Resident 1's annual MDS (minimum data set) assessment completed 9/14/06 and quarterly MDS completed 6/11/07 were reviewed. Both of them revealed that resident 1 was identified as a wanderer, and a wandering care plan was in place.

Resident 1's care plan for wandering was reviewed. It revealed a date of 3/9/07 as the last time the care plan was updated and/or reviewed.

Nurse's note revealed that resident 1 often wandered from room to room and made statements like, "I'm getting out of here." Resident 1's care plan indicated that resident was to be redirected to an activity when found wandering.

The facility's Unusual Occurrence Record that was completed on 7/25/07, the day the facility was notified about the incident. There was documentation on the Unusual Occurrence Record that resident 1 was now wearing a wanderguard.

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F 324	Continued From page 12 On 7/27/07 a review of resident 1's medical record was conducted; no elopement risk assessment could be found for resident 1.	F 324		