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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINIA AT ALTA	4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107

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F 155 SS=D	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 interview and record review, it was determined that for 1 of 10 sample residents (Resident 1) that the facility staff failed to allow the resident the right to refuse a shower. Findings included: Resident 1 was admitted to the facility on 10/20/98 with diagnoses including mental retardation. Interviews on 11/14/07, during the dayshift, with Certified Nursing Assistant (CNA) 13 and CNA 14 revealed that on 10/29/07 resident 1 was not allowed the right to refuse a shower. CNA 13 and CNA 14 stated that the Director of Nursing (DON) told them resident 1 had to have a shower that afternoon, and if they had trouble persuading her to shower that they should come to the DON for help. CNA 13 and CNA 14 stated that on 10/29/07, resident 1 refused to shower and that they went to the DON to communicate that resident 1 refused a shower. CNA 13 and CNA 14 stated that the DON told them he would help them. CNA 13 and CNA 14 stated that the DON went to resident 1 and guided resident 1 by holding resident 1's	F 155		1/11/08

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

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arms and assisted resident 1 into the shower room. CNA 13 and CNBA 14 stated that resident 1 was screaming, "No, No." CNA 13 and CNA 14 stated that at that time Nurse 1, CNA 13 and CNA 14 began removing resident 1's clothing while the DON held resident 1's arms to prevent resident 1 from hitting the staff. CNA 13 and CNA 14 stated that resident 1 was screaming, striking out, and kicking.

On 11/19/07 at 10:30 AM, the facility DON was interviewed. The surveyor asked the DON about residents' rights and if a resident had the right to refuse a shower. The DON replied, "It depends on the cognitive abilities of the resident." The DON further stated that if a resident had dementia or can not make wise decisions for themselves, I would try to give them a bath or shower in the most comfortable way. The DON stated that everybody has the right to refuse a shower, however, if a resident were to have body odor that was too offensive to others, it would infringe on other residents' rights. The DON continued that others had the right to enjoy their meal, in the dining room, and enjoy their environment. The DON stated there was a point where body odor infringes on other residents' rights. On10/29/07, the DON stated that two CNAs came to his office, and said resident 1 was resistant to getting into the shower, and that he thought the resident said she did not want to shower. The DON stated the two CNAs asked the DON for his assistance and he told the two CNA s, "Let's go give her a shower." The DON stated that as he approached resident 1 the resident walked past him. He stated that as he got closer to resident 1, he guided her from behind into the shower room. The surveyor asked the DON if resident 1 made any

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F 155	Continued From page 2 comments. The DON replied that resident 1 was resisting, agitated, and yelling. The DON stated they (CNA 13, CNA 14, Nurse 1 and himself) tried to remove resident 1's clothing. The DON stated resident 1 tried to hit the CNAs, so he held the resident's wrists. Review of written reports and written statements, from staff involved in the incident, was done on 11/19/07. This review of these written report and statements revealed that there was no evidence that resident 1 was allowed to refuse treatment (shower). Cross Reference F-223.	F 155		
F 166 SS=E	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, record review, and review of facility grievance log, it was determined that for 3 of 11 sample resident and one supplemental resident for facility did not promptly respond to resolve the resident's grievances. Resident identifiers 2, 3, 19, 32 Findings included: 1. Resident 2 was a 56 year old female admitted to the facility, on 8/11/06, with diagnoses that included infantile cerebral palsy, hypertension, pain, anxiety, dementia with depressive features, and mental retardation.	F 166		1/11/08

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F 166	Continued From page 3 On 11/27/07 at 11:45 AM, resident 2 was interviewed regarding her allegation of stolen/missing money. Resident 2 stated that she did not recall the exact date of when the alleged theft occurred. Resident 2 stated that she first reported it to a facility staff member, who then reported the theft to the facility SSW (Social Services Worker). Resident 2 stated that approximately $ 215.00 was stolen from her husband's locked dresser drawer. Resident 2 reported that she didn't know when or how it happened, the money was just gone. Resident 2 reported that the police never came out to speak to her about it. Resident 2 stated that no one from the facility had done anything to investgate or resolve the alleged stollen/missing money. On 11/21/07, the surveyor was provided a written copy, by the facility social service worker (SSW), of resident 2's alleged theft investigation. The written report indicated that the alleged theft was reported on Saturday, 10/27/07. The investigation reopt indicated that one facility CNAs was aware of where resident 2 had hidden the money in the locked drawer, and even assisted in looking for and reporting the missing money. The report documented that this CNA was never interviewed during the investigation. The report documented that the alleged theft had been reported to the local police department on 10/29/07, but that no one from the police department came to the facility or called the facility about the alleged theft. The report indicated that the facility SSW did not call the police department again until 11/21/07, when the State Agency surveyor was in the facility and asking about the resident's missing money.	F 166		

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On 11/21/07, the State Agency Entity Report intake log was reviewed. There was no evidence that the facility reported this allegation of misappropriation of resident property until 11/29/07, one month after the resident had reported it.

2. Resident 3 was a 70 year old male resident admitted to the facility on 12/2/04, with diagnoses that included obesity, hypertension, infection, ulcers, dermatitis, and urinary obstruction.

On 11/15/07, during the dayshift, resident 3 was interviewed. Resident 3 stated that while he was at a doctor's appointment at a local clinic, his power wheelchair was stolen or given away. Resident 3 stated that the facility staff has done nothing to help him get it back or call the local police to report the missing wheelchair. Resident 3 stated that he bought an electric wheel chair from his former roommate, and that he purchased the wheelchair and was given a receipt for the wheelchair. Resident 3 stated that he currently could not find the receipt. Resident 3 stated that the former facility social service worker (SSW) knew about the purchase of the wheelchair. Resident 3 stated that his roommate was discharged quite a few months ago, and that shortly after his roommate had been discharged, his wheelchair just disappeared one day while he was at the doctor appointment. Resident 3 stated that office staff and former facility administrator knew about his purchase of wheelchair. Resident 3 stated that he asked the office staff and former administrator to call the police and was told that they would not call the police.

On 11/19/07, at 3:40 PM, a telephone interview was conducted with the former facility SSW. The

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former SSW stated that she was aware of the purchase of a power wheelchair by resident 3 from his former roommate. The former SSW stated that she would be willing to come into the facility and provide a summary of what she could recall regarding the sale of the wheel chair from the room mate to resident 3.

On 11/26/07, the current facility SSW provided a written investigation of resident 3's missing/stolen wheelchair. The report documented that resident 3's roommate (seller of the wheelchair) was discharged on 4/19/07 and that resident 3 reported that his wheelchair was stolen/missing a couple of weeks after that the roommate's discharge, most likely in May 2007. Resident 3 stated that the Maintenance Supervisor might know something about the missing wheelchair.

On 11/19/07 at 3:15 PM, the facility Maintenance Supervisor was interviewed to see if he knew anything about the missing wheelchair. The Maintenance Supervisor stated that approximately two weeks after resident's 3 roommate was discharge, the facility staff called the room mate and asked him to come to the facility and pick up the power wheelchair. The Maintenance Supervisor stated that the former room mate came to the facility and picked up the wheelchair.

On 11/21/07 the current facility SSW provided the surveyor with a written "Formal" investigation regarding Resident 3's stolen wheelchair. The report documented that Resident 3 had called the facility Administrator and Maintenance Supervisor to his room to report that he had bought a wheelchair from his past roommate and that it was now stolen/missing. The report documented

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that Maintenance Supervisor stated that Resident 3's wheelchair had not been in Resident 3's room for a few months. The report documented that Resident 3's roommate had been discharged since 4/19/07. The report documented that the SSW called a local Police Department to have an officer come out and take a report. The report documented that an electric wheelchair showed up in resident 3's room and the SSW assumed that this was the chair in question. The report documented that the SSW later questioning resident 3 about the electric wheelchair currently in his room and he stated that this was a new chair provided by the hospital. The report documented that the resident was told that the police had been called and asked to come out to take a report and resident 3 stated that no one from the police department has been out to speak with him. The SSW documented that she called the police department again and was transferred to a different police agency that had the authority to investigate the alleged theft. the report documented that a policeofficer came to the facility with an hour of the SSW's call. The report documented that the facility was told by the police office that reason for delay in responding most likely probably occurred when the other police department did not relay to their department to send out an officer. The report documented that the police officer took a report and the police department is now investigating the alleged theft.

On 12/3/07, the local police department was contacted reagrding Resident 3's missing wheelchair. The police department staff stated that the facility reported stolen/missing wheelchair on 11/20/07.

On 12/10/07 at 3:30, a telephone interview was

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conducted with the investigating officer from the police department. The office stated that Resident 3's former roommate is suspected of the theft of Resident 3's wheelchair, but that the police department has been unable to locate the former roommate to question him. The officer stated that it was unfortunate that this theft occurred so long ago and if the alleged theft had it been reported at the time the wheelchair was missing, perhaps the alleged perpetrator would have been easier to locate, as it is now, they are unable to locate him for questioning.

On 12/3/07, the State Agency Entity Report intake log was reviewed. The review revealed that indicated that the facility did not report this allegation of alleged misappropriation of Resident 3's wheelchair to the State Agency until 11/29/07.

Resident 3's electric wheelchair was reported stolen/missing in May 2007, but was not investigated as being stolen/missing by the facility staff until 11/20/2007. It was noted that the facility Maintenance Supervisor had direct knowledge that resident 3's former roommate picked up the wheelchair at the request of facility staff. Additionally, the Maintenance Supervisor, the former facility SSW, the former facility Administrator, and were all aware of what happened to Resident 3's wheelchair. There was no documentation as to what the facility had done or was currently doing to assist Resident 3 in obtaining his wheelchair back. There was no documentation that any facility staff member had communicated what happened to the wheelchair to Resident 3.

3. Resident 19 was a 71 year old female resident admitted to the facility on 8/1/07 with diagnoses

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that included diabetes mellitus, Parkinson, depression, and asthma.

On 11/14/07, the facility SSW informed the surveyor that resident 19 had reported some money stolen and that she was doing an investigation. The SSW stated that she thought that resident 19 might be confused because resident 19 had reported theft of money from her purse at a previous facility.

On 11/15/07 in the afternoon, resident 19 was interviewed. Resident 19 stated that she dicovered that she was missing money around the middle of October 2007. Resident 19 stated that she reported the theft to Nursing assistant (NA) 1. Resident 19 reported that money and personal items are stolen all the time, and nothing has been done by facility staff to prevent it. Resident 19 stated that she saw CNA 16 take the money from her purse.

On 11/15/07 the facility SSW provided SA Survey Staff member with the written results of a facility investigation into the allegation by Resident 19. The report documented that Rsident 19 asked the facility SSW to come down to her room and at that time, Resident 19 reported that a CNA took 7 dollars out of her purse. The report documented that Resident 19 identified the CNA as CNA 16. The report documented at the SSW asked CNA 16 come to her office. The report documented at the facility SSW asked CNA 16 about the Resident 19's missing money and that CNA 16 denied taking any money from resident 19. The report documented that CNA 16 was taken off the schedule and asked to provide a written statement. The report documented that Resident 19 stated that she told NA 1 that CNA

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16 has stolen money afrom her and that NA 1 had done nothing about it. The report documented that the SSW called in NA 1 and she stated that she had been working a Sunday night graveyard shift when Resident 19 hold her about the stolen/missing money . The report documented that NA 1 had the next day off and that when she returned to work, she had forgotten to tell the facility SSW about the allegation. The report documented that the facility reported the allegation of alleged misappropriation to the State Agency on 11/14/2007. The report documented that Resident 19's story has been consistent and to "err" on the side of caution CNA 16 was not asked to come back to work at the facility. The report documented that the facility had been unable to substantiate the claim of the misappropriation as no one had witnessed the alleged theft to support the claim.

Upon review of facility written investigation it was noted that the police department or APS (Adult Protective Services) had not been notified of this allegation of misappropriation of resident property. Additionally, review of State Agency Entity Report intake log indicated that the facility reported this allegation of misappropriation of resident property on 11/14/07, when the allegation of the theft had been reported to facility staff in the middle of October, 2007.

On 11/15/07 at 3:15 PM, the facility SSW was interviewed regarding the investigation of resident 19's allegation of theft. The facility SSW stated that she reported the allegation to State Agency on Tuesday 11/13/07 at 4:40 PM, and that the State cAgency staff called her back on Wednesday, 11/14/07. The SSW was asked how and when she was notified about this alleged

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theft. The SSW stated that on 11/13/07, resident 19 had informed a staff nurse who then informed her. The SSW stated that at that time she met with resident 19 and began the facility's investigation into the allegation. The SSW stated that she had no knowledge that NA 1 was aware of the missing money since mid October, 2007. The SSW stated that once she was informed she immediately began an investigation.

4. Resident 32 was admitted to the facility on 7/19/07 with diagnoses that included chronic obstructive pulmonary disease, joint and pelvis pain, hypothyroidism, diabetes, hypertension, and irritable bowel syndrome.

On 11/14/07 resident 32 was interviewed. Resident 32 stated that she had multiple complaints that had not been addressed by facility Administration. Resident 32 stated that she wasn't receiving her medications on time, the food was too spicy, and her mattress was old, call lights were not being answered, she wasn't receiving ice water, and her room was not routinely cleaned by housekeeping.

On 11/26/07, a resident group interview was conducted. The residents in the group meeting stated that they had brought up multiple concerns that were not being addressed by facility staff and Administration. The major complaint was that "smokers" at the facility were smoking in non-designated smoking areas, specifically that the second hand smoke comes into the building as residents enter and exit the facility.

On 11/26/07, the facility Administrator was interviewed about this concern, and she stated that she was aware of the concerns and was

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F 166	Continued From page 11 formulating a corrective action plan for the problem. On 12/4/07, a resident approached SA Surveyor and mentioned that the "smoke" was still a problem. On 11/27/07, the current copy of the facility Grievance log was reviewed. The log was four sheets of paper. The log documented some of the above concerns, but not all of the concerns. The facility grievance log did not address the date of the complaint, just the month of the complaint. There was no documentation as to prompt efforts offered by the facility to correct the complaint (s), there was no documentation of follow up with the residents to make sure they were satisfied with the outcomes.	F 166		
F 223 SS=J	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 facility direct care staff, as well as administrative staff interviews, resident interviews, facility documentation review, and medical record review, it was determined that for 1 of 10 sampled residents, the facility failed to protect a resident from physical and mental abuse and failed to identify when such abuse had occurred. Resident Identifier: Resident 1.	F 223		1/11/08

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On 10/29/07, four staff members, including an administrative nurse, used physical force and coersion to shower resident 1 against her will. In addition to the four staff members who participated in this incident, two other administrative personnel were witness to the incident and failed to intervene.

The facility's failure to protect its residents from abuse was determined to constitute an serious risk to the health and welfare of the residents, and therefore determined to be Immediate Jeopardy.

Findings include:

Resident 1 was a 67 year old female admitted to to the facility on 10/20/98, with diagnoses of moderate mental retardation, seizure disorder, and cardio vascular accident.

Resident 1's quarterly MDS (minimum data set) assessment, dated 9/12/07, and signed by a facility RN (Registered Nurse) on 9/13/07, indicated that resident 1 required supervision, with set-up assistance, for ambulation and dressing.

On 11/14/07 at 2:30 PM, certified nurse aide (CNA) 13 was interviewed. The surveyor asked CNA 13 about residents' rights to refuse treatment, including the right to refuse a shower. CNA 13 stated, on the Monday before Halloween, on 10/29/07, she was involved in an incident in which resident 1 was not allowed to refuse a shower. CNA 13 stated the incident occurred between 2:00 and 4:00 PM. On that day, CNA 13 stated she went to the Director of Nursing (DON) and informed him that resident 1 did not

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want to shower. CNA 13 stated she had taken resident 1 into the DON's office in order for the resident to choose which CNA, either CNA 13 or CNA 14, would provide the resident a shower. CNA 13 stated the resident was not afforded the opportunity to refuse the shower, only which staff member would complete the task. CNA 13 stated resident 1 responded that she did not want a shower. The resident left the DON's office and went to the dining room. CNA 13 stated the DON instructed me to get the shower room ready. CNA 13 stated the Administrator was present as the DON was providing these instructions. CNA 13 stated, at some time during the afternoon, the facility Social Service Worker also asked resident 1 to shower, to which resident 1 said, "No." CNA 13 stated she was in the hallway, near the shower room when she observed the DON behind resident 1, holding the resident's arms down, and pushing the resident into the shower room. CNA 13 stated resident 1 was screaming, "No! No!" CNA 13 stated she observed Nurse 1 following behind the DON. CNA 13 stated resident 1 was taken into the shower room by the DON, with Nurse 1, CNA 14 and herself (CNA 13) following. CNA 13 stated the DON was holding resident 1's arms while the three of us undressed resident 1. CNA 13 stated resident 1 was fighting, biting, hitting, kicking and screaming., "will you please let me go?" CNA 13 stated the DON responded by stating, "NO, you're going to shower." CNA 13 stated resident 1 asked CNA 13, "Please tell him to let me go." CNA 13 responded to resident 1, "Will you cooperate?" CNA 13 stated resident 1 replied, "No!" CNA 13 stated the DON held on to resident 1 and would not let go. CNA 13 stated she told the DON, "She's not going to shower." CNA 13 stated the DON responded, "She is, no matter what." CNA 13 stated that while the DON

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was holding resident 1 down, resident 1 was saying, "I can't breathe, I can't breathe". CNA 13 stated that she knew what they were doing was wrong and wanted to leave. CNA 13 stated that when resident 1 was undressed, resident 1 stopped yelling and striking out. CNA 13 stated that because she knew resident 1 was fearful of water, she held a towel over the resident's face and that the resident seemed okay. CNA 13 stated the DON remained in the shower room the entire time. CNA 13 stated that she was upset that they had forced resident 1, against her will, to shower and that she (CNA 13) had no choice, but to participate.

On 11/26/07 at 1:30 PM, CNA 13 was re-interviewed. The surveyor asked CNA 13 if she had reported the showering incident, which occurred on 10/29/07, to any one. CNA 13 stated that she had reported the incident and her concerns to NA 1, the facility CNA Coordinator. At that time, the surveyor clarified with CNA 13, the details of the incident involving resident 1 on 10/29/07, as reported during the interview on 11/14/07.

A review of a written statement, provided by CNA 13, dated 11/15/07, and given to surveyors on 11/19/07, was completed. CNA 13 documented, "I was told [resident 1] needed to take a shower today. I asked her several times, She said NO NO shower. Asked her to come with me to tell D.O.N. She went in there with me She told him no shower and he said yes you need shower today is the day. so you can pick do you want [CNA 13] or [CNA 14] She said neither dont want one. Went to Dr (dining room). I was told to get bathroom ready. Came out of [resident 1] room from getting her cloths [sic] and [resident 1] was

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brought into bathroom by DON he was behind her holding her arms told us [CNA 13, CNA 14, Nurse 1] to take off her clothes She was screaming let me go. please I have to go to the bathroom. tring [sic] to bite scratch kick When she was undressed she was fine She was very apologetic saying to everyone I am sory [sic] honney [sic]. She was fine" This written document was signed by CNA 13.

On 11/1407 at 2:00 PM, CNA 14 was interviewed. The surveyor asked CNA 14 about residents' rights to refuse treatment, including the right to refuse a shower. CNA 14 stated she was involved in an incident in which resident 1 was not allowed to refuse a shower. CNA 14 stated the incident occurred the Monday prior to Halloween, between 2:00 and 4:00 PM. CNA 14 stated the DON, Administrator, and SSW all told her that resident 1 had to shower. CNA 14 stated the DON approached resident 1, in the dining room, and forcibly took her to the shower room. CNA 14 stated the DON walked behind resident 1, not providing the resident the option of not showering. CNA 14 stated that as resident 1 was being taken to the shower room, she was yelling, "No! No! Leave me alone!" CNA 14 stated resident 1 was attempting to bite, scratch, and was kicking. CNA 14 stated that, in the shower room, the DON held resident 1's wrists as CNA 13, Nurse 1, and CNA 14 undressed the resident. CNA 14 stated resident 1 continued to kick, scream "No! No! Leave me alone!", strike out, and attempted to bite, as the staff undressed her. CNA 14 stated that she, as well as CNA 13 and Nurse 1 told the DON that they did not want to force resident 1 to shower. CNA 14 stated the DON insisted resident 1 had to get into the shower. CNA 14 stated, "We did it because he [DON] said we had

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to." CNA 14 stated she was not able to quote exactly what Nurse 1 said, but she did not want to shower resident 1 either. CNA 14 stated the DON remained in the shower room until resident 1's shower was complete. CNA 14 stated once resident 1 was undressed, the resident stopped being combative. CNA 14 stated the Administrator and Social Worker were in the area near the shower room as resident 1 was being forcibly taken to shower. CNA 14 stated neither the Administrator or Social Worker intervened, leading CNA 14 to believe they were, "Okay with it". CNA 14 stated that resident 1 had been forced to shower on more than one occasion, and that on a previous occasion a CNA had been reprimanded for refusing to shower resident 1 when the resident had refused. CNA 14 stated she was not comfortable as they forced resident 1 to shower, but felt she had to participate because the DON told her she had to.

On 11/26/07 at 1:30 PM, CNA 14 was re-interviewed. The surveyor asked CNA 14 if she had reported the showering incident, which occurred on 10/29/07, to any one. CNA 14 stated that she had reported the incident and her concerns to NA 1, the facility CNA Coordinator. At that time, the surveyor clarified with CNA 14, the details of the incident involving resident 1 on 10/29/07, as reported during the interview on 11/14/07.

A review of a written statement, provided by CNA 14, dated 11/15/07, and given to surveyors on 11/19/07, was completed. CNA 14 documented that she and CNA 13 were told, by the DON, that we had to shower resident 1. CNA 14 documented that after resident 1 refused to shower, CNA 13 brought resident 1 to the DON,

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at which time the DON told resident 1 she had to have a shower. CNA 14 documented the DON instructed CNA 13 to get the shower ready, and he grabbed resident 1 from behind and took her to the shower room. CNA 14 documented the DON held resident 1 while the nurse (Nurse 1), CNA 13 and CNA 14 undressed the resident. CNA 14 documented that resident 1 was hitting, screaming, yelling, biting, and saying she did not want a shower. CNA 14 documented that they were able to get resident 1 in the water while she was still fighting and that the.DON stayed in the shower room the whole time. This written statement was signed by CNA 14.

On 11/15/07, following the morning medication pass, Nurse 1 was interviewed. The surveyor asked Nurse 1 about residents' rights to refuse treatment, including the right to refuse a shower. Nurse 1 stated that resident 1 has had a problem with showering, and that staff wanted the resident to shower once a week. Nurse 1 stated, "we got her in there." Nurse 1 stated that on one occasion resident 1 had refused to take a shower for the Social Service Worker (SSW), and that she (Nurse 1) could get on the resident's good side sometimes. Nurse 1 stated she administered a PRN (as needed) dose of Ativan to resident 1. Nurse 1 recalled that resident 1 said "No! No! I don't want to shower." but that the resident seemed to walk into the shower room on her own will. Nurse 1 stated that, once in the shower room, resident 1 started batting her arms as she was being undressed of her three layers of clothing. Nurse 1 stated the DON stood behind resident 1, with his arms around her in a loose hold. Nurse 1 stated resident 1 would have been able to break free and that staff tried not to gang up on her. Nurse 1 stated she sustained

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scratches to her arm, during the incident. Nurse 1 stated that as staff removed the last bit of resident 1's clothing, the resident calmed down. Nurse 1 stated the DON held resident 1's arms so that staff would not be injured by the resident. The surveyor asked Nurse 1 if resident 1 was capable of showering herself., to which Nurse 1 responded that the resident could. Nurse 1 went on to say that resident 1 has not made wise decisions and also that she did not think resident 1 had a legal guardian. Nurse 1 stated she felt it was appropriate to insist resident 1 shower because of the resident's health issues.

The SSW was interviewed on 11/14/07 and again on 11/26/07, at 10:10 AM and 2:35 PM, respectively. The surveyor asked the SSW about residents' rights to refuse treatment, including the right to refuse a shower. The SSW stated that approximately two to three weeks prior, CNA 13 and CNA 14 came to her because resident 1 had been refusing to shower. The SSW stated she went to resident 1 and attempted, unsuccessfully, to get the resident to agree to shower. The SSW stated resident 1 began screaming and said, "No!" The SSW stated the maintenance supervisor tried, also unsuccessfully, to encourage resident 1 to shower. The SSW stated that because the resident had refused to shower, the DON, a facility nurse, CNA 13, and CNA 14 took the resident into the shower. The SSW stated the DON walked behind and directed resident 1 toward the shower, without touching her, while CNA 13 and CNA 14 walked beside the resident. The SSW stated the DON was not physically assisting the resident. The SSW stated resident 1 was resistive and screaming, "I hate you!" as well as obscenities as she was being taken to the shower room. The SSW stated she

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"popped" her head into the shower room to check on the resident and heard resident 1 screaming, "No! No!" The SSW stated she reassured resident 1 verbally, as the resident was being undressed by staff. The SSW stated that once resident was in the shower she was fine and that ever since, showering has not been a problem. The SSW stated, "The CNA's are lazy here", and that staff had a meeting about the need to ensure showers get completed as scheduled. The SSW stated that CNAs needed to go back to the residents more than one or two times to offer a shower when the residents had refused to shower. The SSW stated that when she began her employment at the facility, the facility smelled bad and that resident showers were not being done.

A written statement, documented by the SSW, dated 11/15/07, was provided to the surveyors on 11/19/07. The SSW documented that she was asked to help with resident 1 and her refusal of her shower. She documented that she witnessed CNA 13 and CNA 14 escort resident 1 into the shower as the DON walked behind them. The SSW documented that Nurse 1 went in (the shower room) shortly after. The SSW documented that she stood outside the door (of the shower room) to monitor and that she heard resident 1 swearing and screaming. The SSW documented that she "popped" her head in twice to see if they needed any help. The SSW documented she observed the DON trying to untangle all the necklaces and that Nurse 1, CNA13 and CNA 14 were taking resident 1's clothes off. The SSW documented that the second time she "popped" her head in she observed the resident was sitting on a shower chair and had stopped screaming. The SSW

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documented the DON came out (of the shower room) shortly after and reported that resident 1 was being showered now and seemed to be more calm. This written statement was signed by the SSW.

On 11/19/07, the SSW provided the surveyors with the facility's investigative report relative to resident 1. The SSW documented the facility's investigation findings as, ". . . After reviewing all the statements and the inconsistency in the statements of the people involved it was decided that no abuse had occurred. There was no intent to hurt [resident 1]. As the definition of abuse being a willful infliction of injury, unreasonable confinement, intimidation or punishment which resulted in harm, pain or mental anguish none of these apply to [resident 1]' s situation. Her screaming was not an unusual occurrence for [resident 1] in her regular behavior patterns. As witnessed by the social worker and the Administrator after the staff and [resident 1] left the bathroom all parties looked pleased. Staff were very pleased with how well the shower went. [Resident 1] was happy and smiling. She went around showing everyone her new dress and her hairstyle. This was not reported to the state per our policy due to the fact that no one involved perceived the event to be abusive." This document was signed by the SSW.

On 11/27/07 the facility Maintenance Supervisor was interviewed. Based on previous interviews with the SSW, the surveyor asked the Maintenance Supervisor if he was aware of an instance when staff required resident 1 to shower, when the resident had refused. The Maintenance Supervisor stated the SSW had asked him to speak to resident 1 to see if he could get the

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resident to agree to shower, which he did. The Maintenance Supervisor stated that resident 1 said, "No". The Maintenance Supervisor stated he notified the Administrator that resident 1 did not want to take a shower. The Maintenance Supervisor stated that he returned to cleaning carpets, while listening to an iPod (music listening device). The Maintenance Supervisor stated that he was able to hear resident 1 screaming in the shower room that she did not want to shower.

A written statement, documented by the Maintenance Supervisor, and dated 11/15/07, was provided to the surveyors on 11/19/07. The Maintenance Supervisor documented, on an unknown date, he was cleaning the carpets on the West side and observed staff asking resident 1 if she would like a shower, which she declined. He documented that he was able to hear resident 1 scream, "no no I'm not going to shower". This document was signed by the Maintenance Supervisor.

On 11/27/07 at 11:25 AM, resident 43 was interviewed at the resident's request. Resident 43 began discussing, with the surveyor, an incident in which resident 1 was made to shower against her will. Resident 43 stated, "It's true, [resident 1 being forced to shower] I was laying in bed and I heard [resident 1] screaming bloody murder, and I got up to see if she was okay."

On 11/19/07 at 10:30 AM, the facility DON was interviewed. The surveyor asked the DON about residents' rights and if a resident had the right to refuse a shower. The DON replied, "It depends on the cognitive abilities of the resident." The DON further stated that if a resident had dementia or can not make wise decisions for

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themselves, I would try to give them a bath or shower in the most comfortable way. The DON stated that everybody has the right to refuse a shower, however, if a resident were to have body odor that was too offensive to others, it would infringe on other residents' rights. The DON continued that others had the right to enjoy their meal, in the dining room, and enjoy their environment. The DON stated there was a point where body odor infringes on other residents' rights. The DON stated that he had asked the staff to shower resident 1 on 10/27/07, and on 10/29/07, he noticed that the resident had not been showered. The DON stated, as of 10/29/07, there was no documentation that resident 1 had received a shower for a month. The DON stated two CNAs came to his office, and said resident 1 was resistant to getting into the shower, and that he thought the resident said she did not want to shower. The DON stated the two CNAs asked the DON for his assistance and he told the two CNA s, "Let's go give her a shower." The DON stated that as he approached resident 1 the resident walked past him. He stated that as he got closer to resident 1, he guided her from behind into the shower room. The surveyor asked the DON if resident 1 made any comments. The DON replied that resident 1 was resisting, agitated, and yelling. The DON stated resident1 had an apron tied in a knot, several necklaces, jewelry and a watch, with multiple layers of clothing. The DON stated they (CNA 13, CNA 14, Nurse 1 and himself) tried to remove resident 1's clothing. The DON stated resident 1 tried to hit the CNAs, so he held the resident's wrists. The DON stated resident 1 calmed down and the CNAs were able to shower the resident. The surveyor asked if any one was injured during the incident, to which the DON responded that

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Nurse 1 was scratched or something while resident 1 was being resistive. The surveyor asked the DON if a resident were resistive, with their body language, being combative and striking out at staff, would it be a good time to give the resident a shower? The DON explained that for the three days prior, resident 1's behavior had not been any different, and that the CNAs had gotten used to not having to do showers. The DON stated that it was the CNAs' approach toward the residents that led to not getting showers done on a consistent basis. The DON stated that when residents were clean they were happy; better. NOTE: The DON completed a written statement, dated 11/16/07, regarding the incident involving resident 1 in which the DON indicated he did not believe the manner in which resident 1 was showered constituted abuse.

On 11/14/07 and 11/26/07, at 3:05 PM and 4:15 PM, the facility Administrator was interviewed. The surveyor asked the Administrator if she was aware of an incident in which resident 1 may have been showered against her will. The Administrator reported an incident in which she observed the DON walk behind resident 1 and guide her into the shower. The Administrator stated resident 1 was "swearing" but the Administrator could not recall exactly what was said. The Administrator stated the SSW "popped" into help. The Administrator stated she did hear resident 1 screaming, while the resident was in the shower room. The Administrator stated the DON was in the shower room to help, but did not shower the resident. The Adminstrator stated at that time, she left the area.

The Administrator stated that things, such as resident showers, were not being done. She

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stated that the facility CNA's had developed bad habits, and that recently staff were being held to different standards, and that staff do not like it.

On 11/14/07, during the day shift, CNA 4 was interviewed regarding residents' rights to refuse treatment, including the right to refuse a shower. CNA 4 replied, that in a meeting in the recent past, staff were instructed by the DON that nurse aides have not been showering residents and that they were expected to ensure residents were showered. CNA 4 stated that resident 1 was specifically mentioned by the DON as needing to be showered and ". . . with her [resident 1's] condition the way it was, that we have to do whatever necessary to get her showered." The surveyor asked CNA 4 if she had any knowledge of resident 1 being forced into the shower. CNA 4 stated she had not witnessed any such incident, but that she had heard, "through the grapevine" that resident 1 had been forced to shower.

On 11/14/07 at 10:15 AM, CNA 2 was interviewed. The surveyor asked CNA 2 if she was familiar with resident 1's care needs. CNA 2 stated resident 1 resisted showers, and fought with staff when they attempted to shower her. CNA 2 stated that a couple of weeks ago in a meeting, the facility Administrator and DON said resident 1 had to take a shower, no refusals and no excuses. CNA 2 stated that the CNA's were instructed to inform the DON if resident 1 or any other resident refused to shower..

On 11/15/07, during the day shift, CNA 7 was interviewed regarding residents' rights to refuse treatment, including the right to refuse a shower. CNA 7 stated the CNA staff had a meeting the previous Thursday. She stated the DON,

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Administrator, and SSW instructed that resident showers had to be done. CNA 7 stated most of us were quiet. She stated that we agreed we would not force the residents to shower. CNA 7 stated, during that meeting, she told her (Administrator) that resident 1 was terrified of water. CNA 7 stated the DON said that resident 1's shower had to be done on a schedule, and the resident would get over it. CNA 7 stated the Administrator responded by commenting resident 1 smelled so bad that others were getting sick. CNA 7 stated, "Forcing is a problem. I don't agree with it." She continued that the DON, ". . . started it (forcing residents to shower). He doesn't understand about twisting arms and forcing. The resident you are asking about is independent and can make her own bed, and she feeds herself and dresses herself."

On 11/15/07 at 10:45 AM, nurse aide (NA) 1, the facility's CNA Coordinator, was interviewed. The surveyor asked NA 1 about residents' rights to refuse treatment, including the right to refuse a shower. NA 1 stated she had heard that a former facility CNA had refused to shower resident 1 and that CNA had been written up. NA 1 continued that the following day, a CNA meeting was held and showers, and refusal of showers had been discussed. NA 1 stated she did not attend that meeting. The surveyor asked NA 1 if any facility CNA's had come to her with concerns about residents being forced to shower. NA 1 responded that three facility CNA's had come to her with such concerns. She could not recall when these CNAs had brought their concerns to her. NA 1 stated her supervisor was the DON, and that she discussed the concerns of forcing residents to shower. NA 1 stated, "I told the [name of DON] I wasn't comfortable forcing

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people to take a shower." NA 1 stated the DON replied to her that resident 1 had to shower. NA 1 stated she answered back that resident 1 had "rights". NA 1 stated the DON replied that we have an obligation, and that resident 1 smelled, and that it was affecting other residents. NA 1 stated that while she was not present, she had heard through the "grapevine" that resident 1 had been forced into the shower. NA 1 stated in morning meetings the Administrator talked about resident 1 and the fact that the facility staff had to keep her on a shower schedule. The surveyor asked NA 1 who attended the morning meetings, to which NA 1 replied all department heads.

On 11/14/07 at 3:30 PM, CNA 16 was interviewed. The surveyor asked CNA 16 about residents' rights to refuse treatment, including the right to refuse a shower. CNA 16 stated the DON told me I had to shower resident 1 because the resident had not been showered in two weeks. CNA 16 stated that she responded to the DON, "Okay, I will." CNA 16 stated she informed the DON that resident 1 was tough to get into the shower and that the resident would scream, yell, hit, and kick, but that she would try. CNA 16 stated the DON instructed that the shower needed to be done and that staff have done it before and that it should not be a problem. CNA 16 stated she told the DON that she would ask another CNA to help her with resident 1's shower. CNA 16 stated she had made arrangements with another CNA to shower resident 1 that evening, following dinner. CNA 16 stated that since there had been an agency nurse working that evening shift, she and the other CNA decided they would not "drag" resident 1 in the shower in front of the agency nurse, for fear of being reported. CNA 16 stated resident 1's shower was not done. CNA 16

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F 223	Continued From page 27 stated the next day, there was a meeting, and that the DON talked about showers. CNA 16 stated the DON explained, when he instructed someone to do a shower, he expected it to be done. CNA 16 stated she felt the DON, "put me down" in front of her peers. CNA 16 stated that in that meeting I explained that we could not force residents to shower. Resident 1 was interviewed on 11/14/07 and 11/19/07. Resident 1's stated that one time staff dragged her to the shower. Referring to being dragged to the shower, resident 3 stated, "I didn't like that."	F 223		
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) 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 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	F 225		1/11/08

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F 225	Continued From page 28 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 interviews of current and former, direct care staff and administrative staff, an interview with a respresentative of a local law enforcement agency, reviews of facility records, and review of the State Survey and Certification Agency intake records, it was determined that for 3 of 10 sampled residents plus 1 supplemental resident, the facility did not ensure that all alleged violations involving abuse or misappropriation of resident property were reported immediately to the Administrator, the State Survey and Certification Agency, either local law enforcement or Adult Protective Services, and that all alleged violations were thoroughly investigated. Resident identifiers: 1, 2, 3, 19 Findings included: 1. Resident 1 was a 67 year old female admitted to the facility on 10/20/98 with diagnoses of moderate mental retardation, seizure disorder, and cardio-vascular accident.	F 225		

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F 225	Continued From page 29 On 10/29/07, facility staff physically and mentally abused resident 1 when they forced her to shower against her will. Cross-Refer F-223. On 11/14/07, 11/15/07, 11/19/07, 11/26/07 and 11/27/07, surveyors conducted interviews with nurse aide (NA) 1, certified nursing assistants (CNA)s 2, 4, 7, 13, 14, and 16, Nurse 1, the Director of Nursing (DON), the Administrator, the Social Service Worker (SSW), and the Maintenance Supervisor. These staff members were interviewed to determine the circumstances in which resident 1 was showered on 10/29/07. The following information was gathered: NA 1, the facility's Certified Nurse Aide Coordinator- (interviewed on 11/15/07 at 10:45 AM) - NA 1 stated that three facility CNAs had reported to her, concerns about residents being forced to shower. In addition, NA 1 stated she had heard through the "grapevine" that resident 1 had been forced to shower. NA 1 stated she reported this information to the DON along with her own concern that residents should not be forced to shower. NA 1 stated the DON replied it was the facility's obligation to ensure resident 1, and other residents, were showered. CNA 2 - (interviewed on 11/14/07 at 10:15 AM) - CNA 2 stated that the nurse aide staff were instructed by the Administrator and DON that resident 1 had to shower, that the resident could not refuse and that there were no excuses not to shower her. CNA 4 - (interviewed on 11/14/07, during the day shift) - CNA 4 stated that the nurse aide staff were instructed by the DON that all residents, naming resident 1 in particular, had to be showered. CNA 4 stated she had heard, through the "grapevine" that resident 1 had been forced to shower.	F 225		

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CNA 7 - (interviewed on 11/15/07, during the day shift) - CNA 7 stated that the nurse aide staff had been instructed by the Administrator, DON, and SSW that resident showers had to be done. CNA 7 stated she reported to the DON that resident 1 was terrified of water, to which the DON replied resident 1's shower had to be done on a schedule and that the resident will get over it. CNA 7 stated the DON, "Started it (meaning forcing residents to shower). He doesn't understand about twisting arms and forcing. . . "

CNA 13 - (interviewed on 11/14/07 and 11/26/07 at 2:30 PM and 1:30 PM, respectively) - CNA 13 stated that on 10/29/07, she participated with the DON, Nurse 1, and CNA 14, in forcing resident 1 to shower, after the resident had clearly expressed that she did not want to shower. CNA 13 stated that as resident 1 was forced, she screamed "No! No!" CNA 13 stated that the DON held resident 1's arms as the three others removed the resident's clothing. CNA 13 stated that resident 1 was fighting, trying to bite, striking out, kicking, and screaming "Will you please let me go?" CNA 13 stated the DON responded to resident 1 by saying, "No, you're going to shower." CNA 13 stated she reported this incident to NA 1, her supervisor, the Certified Nurse Aide Coordinator.

CNA 14 - (interviewed on 11/14/07 and 11/26/07 at 2:00 PM and 1:30 PM, respectively.) - CNA 14 stated that on 10/29/07, she participated with the DON, Nurse 1, and CNA 13, in forcing resident 1 to shower, after the resident had clearly expressed that she did not want to shower. CNA 14 stated that as resident 1 was being forced, the resident was yelling "No! No! Leave me alone!", attempting to bite, scratch, and was kicking. CNA 14 stated the DON held resident 1's wrists as the other three staff undressed the resident. CNA 14

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stated resident 1 continued to yell out "No! No! Leave me alone!", strike out, and attempted to bite as staff undressed the resident. CNA 14 stated the Administrator and SSW were aware of what was occuring to resident 1, but did nothing to intervene.

Nurse 1 - (interviewed on 11/15/07, following the morning medication pass) - Nurse 1 stated that resident 1 has had a problem with allowing staff to shower her and that staff wanted the resident to shower once a week. Referring to resident 1's shower, which occurred on 10/29/07, Nurse 1 stated, "We got her in there." Nurse 1 recalled, leading to resident 1's shower on 10/29/07, the resident 1 was saying "No! No! I don't want to shower!" but that the resident seemed to walk into the shower room on her own will. Nurse 1 stated that, once in the shower room, resident 1 started batting her arms as three of the staff undressed of her three layers of clothing and the DON stood behind the resident with his arms around hers, in a loose hold. Nurse 1 stated she felt it was appropriate to insist resident 1 shower because of the resident's health issues.

The SSW - (interviewed on 11/14/07 and again on 11/26/07, at 10:10 AM and 2:35 PM, respectively) - The SSW stated that approximately two to three weeks prior, because resident 1 had refused to shower, the DON, a facility nurse, CNA 13, and CNA 14 took the resident into the shower. The SSW stated resident 1 was resistive and screaming, "I hate you!" as well as obscenities as she was being taken to the shower room. The SSW stated she "popped" her head into the shower room to check on the resident and heard resident 1 screaming, "No! No!" The SSW stated she reassured resident 1 verbally, as the resident was being undressed by staff.

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The DON - (interviewed on 11/19/07 at 10:30 AM) - In reference to resident 1's shower on 10/29/07, The DON stated that he had previously asked staff to shower the resident on 10/27/07, and that on 10/29/07, he noticed that the resident had not been showered. The DON stated he guided resident 1 from behind, leading her into the shower room. The DON stated that resident 1 was resisting, agitated, and yelling. The DON stated they (CNA 13, CNA 14, Nurse 1 and himself) tried to remove resident 1's clothing. The DON stated resident 1 tried to hit the CNAs, so he held the resident's wrists. The DON stated that when residents were clean they were happy; better. NOTE: The DON completed a written statement, dated 11/16/07, regarding the incident involving resident 1 in which the DON indicated he did not believe the manner in which resident 1 was showered constituted abuse.

The Maintenance Supervisor - (interviewed on 11/27/07) - Referring to resident 1's shower on 10/29/07, the Maintenance Supervisor stated that while he was cleaning carpets, while listening to his iPod (a music listening device, he was able to hear resident 1 screaming in the shower room that she did not want to shower.

Administrator - (interviewed on 11/14/07 and 11/26/07, at 3:05 PM and 4:15 PM) - Referring to resident 1's shower on 10/29/07, the Administrator stated she observed the DON walk behind resident 1 and led her into the shower. The Administrator stated resident 1 was "swearing" but the Administrator could not recall exactly what was said. The Administrator stated, at one point, the SSW "popped" into help. The Adminstrator stated she left the area in which resident 1 was being showered. The Administrator did not discuss any intervention to alter the manner in which facility staff were

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showering resident 1.

On 11/19/07, the SSW provided surveyors with the facility's investigative report relative to resident 1. In addition to the results of the investigative report, the SSW provided surveyors with the written statements of CNA 13, CNA 14, Nurse 1, the Maintenance Supervisor, the DON, the SSW, and Administrator. Each of the these statements were dated 11/15/07 or later (17 days after the incident.) and after surveyors entered the facility, on 11/14/07, to begin an investigation into allegations that resident 1 had been abused. The SSW documented the facility's investigation findings as, ". . . After reviewing all the statements and the inconsistency in the statements of the people involved it was decided that no abuse had occurred. There was no intent to hurt [resident 1]. As the definition of abuse being a willful infliction of injury, unreasonable confinement, intimidation or punishment which resulted in harm, pain or mental anguish none of these apply to [resident 1]' s situation. Her screaming was not an unusual occurrence for [resident 1] in her regular behavior patterns. As witnessed by the social worker and the Administrator after the staff and [resident 1] left the bathroom all parties looked pleased. Staff were very pleased with how well the shower went. [Resident 1] was happy and smiling. She went around showing everyone her new dress and her hairstyle. This was not reported to the state per our policy due to the fact that no one involved perceived the event to be abusive." This investigative report was not dated and was signed by the SSW.

On 11/29/07, the facility submitted, to the State Survey and Certification Agency, an initial report of an allegation that resident 1 was abused

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sometime near the end of October. The facility reported that two nurse aides, the DON, and a floor nurse (Nurse 1) forced resident 1 to shower.

Although the Administrator and SSW were present to observe and hear the manner in which resident 1 was being forcibly made to shower on 10/29/07, they did not intervene to protect the resident. Additionally, following the incident, NA 1 reportedly brought to the Administrator, the concerns of multiple CNA staff that residents should not be forced to shower. The Administrator did not report the allegation of abuse of resident 1 to the State Survey and Certification Agency and Adult Protective Services and/or local law enforcement. The allegation that resident 1 had been abused on 10/29/07 was not reported to the State Survey and Certification Agency and local law enforcement until 11/29/07; after the State Survey and Certification Agency had initiated it's own investigation in to the allegation, and 30 days after the incident had occurred.

2. Resident 19 was a 71 year old female resident admitted to the facility on 8/1/07 with diagnoses that included diabetes mellitus, Parkinson's disease, depression, and asthma.

An interview was held with resident 19 on 11/15/07. Resident 19 stated that, on or around 10/15/07, she had $7.00 stolen from her purse. Resident 19 stated she reported this to NA 1 approximately two to three days later. Resident 19 stated that she also reported the missing money to the SSW on 11/13/07 and that the SSW was upset because the resident should have reported it sooner. Resident 19 stated she thought she had reported the missing money

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when she informed NA 1.

An interview was held with the SSW on 11/15/07 at 3:17 PM. The SSW stated that she became aware of the allegation that resident 19's money was stolen on 11/13/07, when resident 19 reported it to Nurse 7. The SSW stated Nurse 7 reported the allegation to her on 11/13/07. The SSW stated she had not received resident 19's allegation of stolen money from NA 1. The SSW stated she reported the allegation of stolen money to the State Survey and Certification Agency and Adult Protective Services on 11/16/07.

On 12/3/07, the facility submitted, to the State Survey and Certification Agency, a final investigative report regarding the the allegation that resident 19's money was stolen. Included in the investigative report was a written statement from NA 1. NA 1 documented that resident 19 had reported, to her, that the resident had money stolen. NA 1 documented that she forgot to report, to the SSW, the resident's allegation of stolen money. Per documentation, the facility was unable to substantiate that the resident's money was stolen.

3. Resident 2 was a 56 year old female admitted to the facility on 8/11/06 with diagnoses that include infantile cerebral palsy, hypertension, pain, anxiety, dementia with depressive features, and mental retardation.

An interview was held with resident 2 on 11/27/07. Resident 2 stated that, on or around 10/28/07, she noticed that $215.00 had been stolen from her locked dresser drawer. Resident 2 stated she informed the SSW about the stolen

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money on 10/28/07.

An interview with the SSW was held on 11/27/07. The SSW stated resident 2 reported stolen money, more than $200, on 10/28/07. The SSW stated, on 10/29/07 she contacted who she believed was the appropriate local law enforcement agency. The SSW stated that it was not for another three weeks that she learned the law enforcement agency she contacted on 10/29/07, was not the correct agency. The SSW stated there were no law enforcement investigation during that three week period. The SSW stated on 11/21/07, she contacted the correct law enforcement agency, at which time she was given a case number and an officer's name to contact.

On 11/29/07, the facility reported both an initial allegation of misappropriation of resident property, as well as the facility's final investigative report, to the State Survey and Certification Agency. The facility reported that on 10/28/07, resident 2 and her husband alleged $75 was missing. The facility reported that local law enforcement had been contacted on 10/30/07. Per documentation in the facility's final report, which was undated, the amount of money missing was either $75.00, or over $200.00. The report also included documentation that the SSW had contacted the incorrect law enforcement agency on 10/29/07, and then the correct law enforcement agency on 11/21/07.

Resident 2 had reported to the SSW that she had some money stolen from a locked dresser drawer on or around 10/27/07. Although the SSW contacted a local law enforcement agency, she did not follow-up when there was a lack of law

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enforcement investigation into the allegation. Additionally, the facility did not report the allegation of misappropriation of resident property, to the State Survey and Certification Agency, until 11/29/07, more than 30 days after the money was allegedly missing.

4. Resident 3 was 70 year old male resident, admitted to the facility on 12/2/04, with diagnoses that included obesity, hypertension, infection, ulcers, dermatitis, and urinary obstruction.

Beginning 11/15/07, resident 3 was interviewed on several occasions. Resident 3 stated his electric wheelchair had been stolen, or given away by staff, while he was at a doctor's appointment. Resident 3 stated he did not believe facility staff had done anything to get the wheelchair back. Resident 3 reported that he purchased, with his own money, the electric wheelchair from his former roommate. Resident 3 stated he was provided a receipt for the wheelchair, but that he was not able to locate it. Resident 3 stated that his former roommate had been discharged from the facility quite a few months prior, and that shortly after his roommate's discharge, the electric wheelchair disappeared while he was at a doctor's appointment. Resident 3 stated he had asked facility staff to call the police, but that they refused to do so. Resident 3 stated the facility's former SSW would be able to verify the transaction, to purchase the electric wheelchair, that resident 3 had with his former roommate.

An telephone interview was held with the facility's former SSW on 11/19/07 at 3:40 PM. The former SSW confirmed resident 3's assertion that he purchased the electric wheelchair from a former

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resident of the facility. The former SSW stated she would be willing to come into the facility and provide a summary of what she could recall regarding the sale of the wheel chair from the room mate to resident 3.

On 11/19/07 at 3:15 PM, the facility Maintenance Supervisor was interviewed regarding resident 3's allegation that his electric wheelchair was missing. The Maintenance Supervisor stated that resident 3's former roommate had been called and informed that he would have to remove his electric wheelchair from the facility and that the former roommate picked up the wheelchair approximately two weeks after his discharge.

On 11/21/07, the facility's current SSW provided a written "Formal Investigation" of resident 3's stolen wheelchair. This document was neither signed nor dated. This report documented that resident 3's roommate (seller) had been discharged on 4/19/07. Per this document, "I [SSW] called the [name of city] Police department to have an Officer come out and take a report. An electric wheelchair showed up in [resident 3]'s room. I [SSW] assumed that this was the chair in question. After questioning [resident 3] about the chair he said that this was a new chair provided by the [payor of services for resident 3]. I [SSW] asked if an officer had come out to take a report. He said no that had not been out. I called the [name of city] Police department again. I [SSW] had explained the situation and that no one had come out. The receptionist transferred me to the County Dispatch. An officer came out within the hour. The officer explained that the reason for delay probably occurred when [name of city] didn't relay that the County needed to send out an officer. . . ."

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F 225	Continued From page 39 On 11/26/07, a telephone interview was held with a representative of the local (County) sheriff's department. Per this representative, the facility made an initial report of resident 3's missing electric wheelchair on 11/20/07. A review of State Survey and Certification Agency, Entity Intake reports was completed on 11/29/07. The facility did not report, to the State Survey and Certification Agency, an allegation of misappropriation of resident property, relating to resident 3's missing electric wheelchair until 11/29/07. Current and former facility staff had been aware resident 3 had purchased, or claimed to have purchased, an electric wheelchair of his former roommate and that the wheelchair was no longer at the facility. However, until an investigation by the State Survey and Certification Agency into this issue was initiated on 11/13/07, the facility had not treated the resident's claim as an allegation of misappropriation of resident property and did not thoroughly investigate and report the allegations to required agencies. There was no information that facility staff were working working with resident 3 to have the wheelchair returned. The wheelchair was allegedly stolen in September, 2007.	F 225		
F 226 SS=J	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced	F 226		1/11/08

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F 226	Continued From page 40 by: Based direct care and administrative staff interviews and review of facility policy and procedures, as well as employee files, it was determined the facility failed to implement written policies and procedures that prohibit abuse of residents and misappropriation of resident property. The facility failed to prevent the physical and mental abuse of 1 of 10 sampled residents. Resident identifier: 1. The facility failed to investigate and report allegations of abuse and misappropriation of resident property for 3 of 10 sampled residents, plus 1 supplemental residents. Resident identifiers: 1, 2, 3, and 19. The facility failed to screen 9 of 14 sampled employees in accordance with their written policies and procedures. Employee identifiers: CNA 9, CNA 16, CNA 17, CNA 20, CNA 21, CNA 23, CNA 24, NA 1, and Nurse 7. Findings included: On 11/26/07, the Administrator provided two versions of the Facility Abuse Policies; first version titled "[Shared name of facility and managment corporation] Health Care Policy and Procedure for Prohibiting Abuse" and second version titled "[Shared name of facility and managment corporation] Inc. Policy and Procedure". The identified topic of the second version was, "Prohibiting Abuse". An interview was held with the Administrator on	F 226		

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F 226	Continued From page 41 11/27/07. The Administrator was asked to clarify which version of abuse policy the facility was currently being implemented. The Administrator reviewed the policies and stated the first version, "[Shared name of facility and managment corporation] Health Care Policy and Procedure for Prohibiting Abuse" were the policies and procedures currently being implemented. A review of facility employee files was completed on 11/28/07. Copies of policies and procedures, titled "[Shared name of facility and managment corporation] Health Care Policy and Procedure for Prohibiting Abuse" were noted to be in the employee files with the employees' signature to indicate they had read the facility abuse policy. 1. A review of the policies and procedures, titled "[Shared name of facility and managment corporation] Health Care Policy and Procedure for Prohibiting Abuse" was completed on 11/28/07. The following information was obtained from this review: "It is the policy of [name of facility] to prohibit any abuse of its residents regardless of source. This company seeks to promote the well-being of its residents by providing a safe and supportive environment. Every resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion." "Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being."	F 226		

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F 226	Continued From page 42 On 10/29/07, facility staff physically and mentally abused resident 1 when they forced her to shower against her will. Cross-Refer F-223. 2. Further review of the facility's policies and procedures, titled "[Shared name of facility and managment corporation] Health Care Policy and Procedure for Prohibiting Abuse" revealed a section titled, "Investigation and Reporting Procedures". These procedures included the following instructions to staff: "Any person who suspects that abuse, neglect, or misappropriation of property may have occurred, will immediately report the alleged violation to the facility administrator and/or advocacy agencies." "The administration will immediately notify Adult Protective Services or local law enforcement authority (and if staff abuse is alleged, also notify the [former name of the State Survey and Certification Agency]) and the local long-term care ombudsman." "The administration will initiate the investigation process by interviewing all staff and residents having any knowledge of the allegation immediately." "The Director of Nursing will ensure notification of responsible parties and physician of the alleged incident." "If the complaint alleges abuse by staff, the facility will take steps to protect residents from any further abuse. This may include suspension of the staff member until the investigation has been completed." "After the investigation is complete, the administration will document a summary of its findings as to whether the alleged abuse was verified and report its findings to the agencies, which were notified at the beginning of the	F 226		

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F 226	Continued From page 43 investigation." In accordance with their own policies and consistent with federal requirements, facility staff, including the Administrator, Director of Nursing, Social Service Worker, Maintenance Supervisor, and Nurse 1 failed to recognize that the manner in which resident 1 was forcibly taken to shower against her will on 10/29/07 was abusive and caused the resident mental distress. Additionally, although CNA 13 and CNA 14 expressed their concerns to their supervisor, NA 1, relating to the manner in which resident 1 was forcibly taken to the shower, this information did not bring about a thorough investigation by facility administration and was therefore not reported as required. Cross-refer F-225. 3. Further review of the facility's policies and procedures, titled "[Shared name of facility and managment corporation] Health Care Policy and Procedure for Prohibiting Abuse" revealed a section titled, "Screening of Staff". These procedures included the following instructions to staff: "All potential employees will be screened as part of the application process to determine if there is a history of abuse, neglect, or mistreatment of individuals. . . . " "Screening will include contact with known current and known past employers." "Screening will also include contact with the appropriate licensing board at [name of professional licensing agency] or the Nursing Assistant Registry." On 11/19/07 and 11/20/07, 14 facility employee files were reviewed: 9 of the 14 employees files were missing elements of the screening	F 226		

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F 226	Continued From page 44 procedures. CNA 21's DOH (date of hire) was 10/24/07. CNA 21 was currently working at the facility. There was no documentation in her employee file that her references had been checked. NA 1, the CNA coordinator, was interviewed regarding reference checks being done. NA 1 stated she had called on CNA 21's reference, and that she had documented it on a notepad but that the documentation was not in the employee's file. NA 1's DOH was 8/20/07. NA 1 was currently working at the facility. There was no documentation in her employee file that her references had been verified. CNA 16's DOH was 8/15/07. CNA 16 terminated 11/20/07. There was no documentation in her employee file that her references had been verified. CNA 17's DOH was 8/21/07. CNA 17 was currently working at the facility. There was no documentation in his employee file that his references had been verified. CNA 9's DOH was 7/6/07. CNA 9 terminated on 12/2/07. There was no documentation in her employee file that her references had been verified. CNA 23's DOH was 8/10/07. CNA 23 has terminated. There was no documentation in her employee file that her references had been verified. CNA 24's DOH was 8/14/07. CNA 24 has terminated. There was no documentation in her employee file that her references had been verified. CNA 20's DOH was 8/10/07. CNA 20 terminated on 12/1/07. There was no documentation in his employee file that his references had been verified. Nurse 7's employee file was reviewed on	F 226		

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F 226	Continued From page 45 11/29/07. There was no documentation in the employee file that indicated her license was verified as active through the the professional licensing agency. On 11/29/07, the Business Office Manager was interviewed as to who was responsible for checking references and verifying licenses. She stated that this responsibility was to be completed by the Department Manager for which the employee was hired. She stated that the CNA Coordinator was responsible for checking the CNA references and licenses, and that the DON was responsible for checking nursing references and licenses. On 11/29/07, the facility CNA coordinator was interviewed. She stated that when she was initially hired, she was asked to check references, and that once the new DON came on board, he started doing the reference checks. On 11/29/07, the facility DON was interviewed about the documentation of reference checks. The facility DON stated that this was his responsibility, but because he was "new" (as a new employee), someone in the business office was doing the reference checks. The facility DON stated that he had not been doing them until recently. The facility Administrator was interviewed on 11/29/07 at 3:00 PM, regarding reference checks being completed. The facility Administrator stated that she thought the Business Office Manager had been doing the reference checks. Surveyors provided the CNA employee files to the Administrator and asked specifically if reference checks had been conducted. The Administrator stated, "I doubt it."	F 226		
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	F 240		1/11/08

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F 240	Continued From page 46 maintenance or enhancement of each resident's quality of life. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility did not care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life for 1 supplemental resident at the facility. Resident identifier 20 Findings included: Resident 20 was a 56 year old admitted to the facility on 11/15/07 with diagnoses including four limb amputations. Resident 20's medical chart was reviewed on 12/03/07. Resident 20's evaluation indicated that Resident 20 was cognitive with good short term and long term memory, and was oriented, and mentally independent with consistent, reasonable decisions. Her mode of locomotion was other person wheeled in wheelchair. She was dependent on staff for transfer and ADL(Activities of Daily Living)'s and for toileting. Comments in chart: " Resident [Resident 5] showed good awareness of safety issues." There was no bowel or bladder assessment in the medical record. There was no admission MDS (minimum data set) assessment in the record. The complete assessment was due to be in the medical record on 11/28/07. The resident care plan documented continent of bowel and bladder. Toileting care plan indicated resident needed	F 240		

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F 240	Continued From page 47	F 240		

level 3 extensive assist with two CNA's (certified nursing assistants). The schedule for toileting indicated per resident request. No care plan for pain was found in the temporary admission care plan.

On 12/03/07 at 9:00 AM, an interview with Resident 20 was initiated. Resident 20 stated she was in the facility for rehabilitation. Resident 20 stated that when she arrived at the facility she was continent. Resident 20 stated that after being at the facility for a week, she was unable to get assistance with toileting and was soiling her bed and clothing several times a day. Resident 20 stated that the aides offered for her to wear a brief to prevent soiling her clothing and bedding. Resident 20 stated that after "holding it" (urine and bowel) for 20 minutes, without assistance from facility staff to get to the restroom, she would just release due to the pain of holding it. Resident 20 stated that she had fear of having urinary accidents due to not getting timely assistance from aides to get to the toilet, and was laying in a urine soaked bed. Resident 20 stated she used the incontinence brief to protect herself from wetting her bed. Resident 20 stated that to wear a brief was horrible and disgusting and she felt humiliated.

On 12/03/07 at 3:15 PM, an interview with CNA 12 was initiated in room 5 with Resident 20 present. CNA 12 stated that they have been short staffed. CNA 12 stated that usually they have two CNA's on the east hall during the day, however, have had only one CNA recently, and one CNA that floats from west to east halls to assist. He stated that two days ago he had responded to Resident 20's call light, and had

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asked her to wait while he finished showering two residents. He stated that he forgot about Resident 20's request for assistance to the restroom, and didn't return.

On 12/03/07 at 9:13 AM, an interview was initiated with resident 20. Resident 20 stated that she had received a prescription for Lortab (a narcotic pain medication in combination with 500 milligrams of acetaminophen) 1-2 tabs every 4 hours for pain. Resident 20 stated that the facility had told her that she could not exceed 4 grams of acetaminophen in a 24-hour period and needed to spread out her pain medications. Resident 20 stated that she was not able to take enough medication in a 24-hour period to keep her pain under control and keep the acetaminophen under four grams.. Resident 20 stated that on a scale from 1 to 10 her pain level was at 9 or 10.

A review of the nursing notes, dated 11/16/07, documented that Resident 20 was complaining of pain in both upper extremities. It documented that Resident 20 stated that while she was at the hospital she was receiving 2 Lortab instead of 1 every 4 hours. It documented Resident 20 was upset, and the nurse had called the doctor to make a clarification to the medication order. There was no documentation was found indicating changes to the medication were made to provide Resident 20 with the appropriate pain control without exceeding the 4 grams of acetaminophen in a 24-hour period.

On 11/16/07, the physician telephone orders for Resident 20 were reviewed. There was an physician order that documented an order clarification for Lortab 10/500 milligrams tablets one or two by mouth every four hours as needed

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for pain. The order also documented that the acetaminophen was not to exceed for grams in 24 hour period.

Review of the nursing note, dated 11/17/07, documented that Resident 20 was still complaining of pain on the left upper stump.

Review of the nursing note, dated 11/28/07, documented that Resident 20 was still complaining of pain in the left extremity, and rated the pain as a 9 out of 10. The note documented that pain medications were being administered per the physician's orders.

On 12/03/07 at approximately 1:15 PM, an interview with the MDS coordinator was initiated. The MDS coordinator stated that the nursing staff have been encouraging resident 20 to spread the pain medication out and wait more than four hours so as not to exceed the 4 gram acetaminophen in a 24-hour period. The MDS coordinator stated that today was the first day Resident 20 had complained, and so the MDS coordinator called in for a new order. The MDS coordinator stated that the new order had the same pain relieving strength, but will not exceed the 4 grams acetaminophen in a 24-hour period.

On 12/3/07, the physician telephone orders for Resident 20 were reviewed. A telephone order, dated 12/3/07, documented that the medication, Lortab 10/500 had been discontinued and a new order for Lortab 10/325 milligrams one to two tablets every four hours as needed for pain had been ordered.

On 12/03/07 at 9:13 AM, an interview was initiated with Resident 20. Resident 20 stated

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F 240	Continued From page 50 that she was admitted to the facility on 11/15/07 in room 5. Resident 5 stated that for the previous 2 weeks she has had ants crawling through her room. Resident 5 stated that since she has no arms or legs she was unable to pick up food that may drop on the floor, and when the room is not swept frequently the ants spread through the room. Resident 5 stated that one of the graveyard nurses had to change her bedding one evening because the ants had migrated to her bed. On 12/03/07 from 9:13 AM to 3:30 PM, it was observed that Resident 20's in room [Room 5] had ants in the room. The ants were observed to be located on the floor under and around Resident 20's bed. The ants were observed to be eating the food particles on the floor. It was observed that there was a brown powdery substance along one of the baseboards. On 12/03/07 at 1:00 PM, an interview with the Maintenance Supervisor was initiated. The Maintenance Supervisor stated that the pest control company had come out the previous week and sprayed the perimeter of the building for ants. The Maintenance Supervisor provided a bill that documented that the pest control company had sprayed the building on 11/28/07. When asked about room 5, the Maintenance Supervisor stated that room 5 was not sprayed, and he was unaware there were ants in room 5. On 12/03/07 at approximately 2:30 PM, the Maintenance Supervisor stated that the brown powdery substance was cinnamon that one of his staff had placed in the room to deter the ants.	F 240		
F 241 SS=E	483.15(a) DIGNITY	F 241		1/11/08

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(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 241	Continued From page 51 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for 1 of 11 sample residents and 4 supplemental sample residents the facility did not promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality. Residents: 2, 8, 12, 19, 20. Findings included: Resident 20 was a 56 year old admitted to the facility on 11/15/07 with diagnoses including four limb amputation. Resident 20's medical chart was reviewed on 12/03/07. Resident 20's evaluation indicated that Resident 20 was cognitive with good short term and long term memory, and was oriented, and mentally independent with consistent, reasonable decisions. Resident 20's mode of locomotion was other person wheeled in wheelchair. Resident 20 was dependent on staff for transfer and for toileting. Comments in chart: " Resident showed good awareness of safety issues." There was no bowel or bladder assessment in the medical record. There was no admission MDS (minimum data set) assessment in the record. The complete assessment was due to be in the medical record. The resident care plan documented that Resident 20 was continent of	F 241		

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bowel and bladder. Toileting care plan indicated that Resident 20 required ex tensive assistance by two CNA's (certified nursing assistants). The schedule for toileting indicated per resident request.

On 12/03/07 at 9:00 AM, an interview with resident 20 was initiated. Resident 20 said she was in the facility for rehabilitation. Resident She said that the aides told her two weeks ago to wear incontinence briefs. Resident 20 stated she had never worn briefs before because she is continent. Resident 20 stateed she had a fear of having urinary accidents due to not getting timely assistance from aides to get to toilet. Resident 20 stated she had waited 20 minutes, and no one came to answer her call light and after 20 minutes, she could not hold it any longer. Resident 20 stated she used the brief to protect herself from wetting her bed. Resident 20 stated that to wear a brief was horrible, disgusting and she felt humiliated.
Resident 8 was admitted to the facility on 12/11/07 with diagnoses which included, schizophrenia, hypothyroidism, congestive heart failure, hypertension, and alzheimer's disease.

On 11/15/07, Nurse 1 was interviewed about the residents' right to be treated with dignity and respect. Nurse 1 stated that the Director of Nursing (DON) had made a comment to resident 8 about her teeth and breath. Nurse 1 stated that the tone of voice the DON used was not a friendly tone. Nurse 1 stated that the DON made the comment had been made at the nurses station in front of other staff members and residents. Nurse 1 stated that Resident appearred very upset by the comment.

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On 11/19/07, Resident 8 was interviewed. Resident 8 stated that approximately two weeks ago, the DON stated, "You need to brush your teeth.". She indicated that the comment was made in a tone that made her feel "degraded". Resident 8 also stated that facility staff members made her feel bad when she orders pizza. Resident 8 stated, "They make me feel like I shouldn't be able to order pizza.". Resident 8 also stated that her room had been searched without her permission, and that her woolite (laundry soap) had been taken from her without her permission.

On 11/27/07 at 12:10 PM, Resident 19 was interviewed. Resident 19 stated that the facility Administrator, Social Service Worker (SSW) and DON had come to her room and said they were searching rooms to "Make sure nothing's here that doesn't belong.". Resident 19 stated that she didn't know what was meant by that. Resident 19 stated that when the DON searched the top drawer of Resident 19's her dresser, Resident 19 stated, "That's my underwear drawer," and the DON did not acknowledge her and continued to search through the drawer without permission. Resident 19 stated that her roommate had a "pee jar" (a jar to urinate in, because a urinal had not been provided) and that facility staff took this "pee jar" with out the roommate's permission. Resident 19 stated that on another occasion, when she had a female roommate, that the Administrator, DON and SSW, had searched her roommate's dresser, closets, and went through things, but did not take anything. Resident 19 stated that this search was conducted while the roommate was at an activity. The roommate was resident 12.

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F 241	Continued From page 54 On 11/27/07, Resident 12 was interviewed and asked if she was aware of a room search, and she stated that she was not aware that her room and belongings had been searched. On 11/20/07 a resident group interview was conducted. Residents in general were asked how they were treated by staff members. The majority of residents present complained that staff members treat them disrespectfully. One resident stated that some of the aides use bad language in from of them. The surveyor asked what was meant by "bad language" and the residents reported, "swear words". On 11/20/07, during the resident group interview, Resident 2 stated that she was "forced" to take a shower. The surveyors met with Resident 2, in private, to discuss the events of the incident. Resident 2 stated that ever since the new DON had been here, the CNA's made you take a shower when you didn't want to. Resident 2 stated that the other day she didn't feel well, and she was supposed to take a shower that day, and that she told the CNA she didn't want to. Resident 2 reported that she was "pestered" and told over and over again, that she had to take a shower, even though she didn't want to. Resident 2 stated, I told her "no", and the CNA made me take a shower anyway, and I just didn't feel good.	F 241		
F 252 SS=D	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced	F 252		1/11/08

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F 252	Continued From page 55 by: Based on observation and interview it was determined that the facility did not provide a safe, clean, comfortable and homelike environment. Specifically, repairing blinds for privacy and functionality, and repairing a dripping faucet in a resident room. Room 5. Findings included: Resident 20 was a 56 year old female admitted to the facility on 11/15/07 with diagnoses that included traumatic amputation of both arms and both legs, hypertension, breast cancer, and migraines. On 12/03/07 at 9:13 AM, an interview was initiated with resident 20. Resident 20 stated that she was admitted to the facility on 11/15/07 in room 5. She stated that when she was admitted the faucet in room 5 continuously dripped, and the blinds would fall off of the window when anyone would try to adjust them. She stated that she had mentioned the concerns to various facility staff, and had the Maintenance Supervisor work on the faucet, however, the faucet was still dripping and keeping her awake at night. On 12/03/07 from 9:13 AM to 3:30 PM, it was observed that the faucet in room 5 continued to drip. The frames of the blinds were observed to be balancing on the frame 3 inches short of the supporting brackets on each side of the window. On 12/03/07 at 1:00 PM, an interview was held the Maintenance Supervisor. The Maintenance Supervisor stated that he had tried to repair the dripping faucet, but that he needed to order parts to repair it. The Maintenance Supervisor stated	F 252		

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F 252	Continued From page 56 that he had faxed a copy of the bill for replacement parts to the corporate office and was waiting for approval on the purchase order. . The Maintenance Supervisor was asked about the broken blinds in room 5, the Maintenance Supervisor stated that he was unaware that they were broken. The Maintenance Supervisor stated that staff in the facility are instructed to write environmental concerns in the maintenance logs located at each nursing station when a repair is identified. The facility was asked for a copy of the estimated bill for replacement parts to repair the faucet in room 5, that was submitted to the corporate office. The facility was unable to provide a copy of the bill. On 12/03/07 at 1:15 PM, a check of the maintenance log located at the east nursing station revealed that no repairs were identified as needed for room 5's window blinds.	F 252		
F 272 SS=B	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision;	F 272		1/11/08

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F 272	Continued From page 57 Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility did not have complete, comprehensive, accurate assessments of each resident's functional capacity for 3 of 11 sample residents. Residents: 2, 4, 11, Findings included: 1. Resident 2's medical record was reviewed on 11/26/07. Resident 2 was admitted to the facility on 8/11/06 with diagnoses including: infantile cerebral palsy, hypertension, pain, anxiety, dementia with depressive features, and mental retardation. Based on an annual MDS (Minimum Data Set) assessment with a reference date of 8/7/07, resident 2 triggered in the following areas of Section V, the Resident Assessment Protocol Summary (RAPS): cognitive loss,	F 272		

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communication, ADL Functional/Rehabilitation potential, Urinary incontinence, mood state, behavioral symptoms, nutritional status, dehydration/fluid maintenance, dental care, pressure ulcers, and psychotropic drug use. For each triggered area there was no specific date and location of the assessment documentation.

2. Resident 4's medical record was reviewed on 11/27/07. Resident 4 was admitted to the facility on 7/13/06 with diagnoses including: spinal stenosis, cerebral vascular accident, recurrent UTI's (urinary tract infections), and lumbago.

An annual MDS (Minimum Data Set) was done 5/31/07. No RAPS were included with the annual MDS which meant that the MDS was not complete.

3. Resident 11's medical record was reviewed on 11/29/07. Resident 11 was admitted to the facility on 8/1/99 with diagnoses including: mental retardation, obesity and hypothyroidism.

Based on an annual MDS assessment, with an assessment reference date of 9/12/07, resident 11 triggered in the following areas of Section V, the Resident Assessment Protocol Summary (RAPS): delirium, cognitive loss/dementia, communication, ADL (activities of daily living) functional/rehabilitation potential, mood state, behavioral symptoms, falls, dehydration/fluid maintenance, pressure ulcers and psychotropic drug use. For each triggered area facility staff documented the location of the RAP assessment as: "s/s (social services) notes, Mo. (monthly) summary, RAP documentation, nurse assess., ADL's (activities of daily living) records, intake-dietetics, skin risk Braden, and MAR

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F 272	Continued From page 59 (medication administration record)." There was no date indicated for any of these. Therefore, the specific entries in which the assessment data could be located for each of these items was not identified. On 11/29/07 at 2:25 PM, an interview with the MDS coordinator nurse was initiated. She was asked about missing RAPS, and missing location and dates of the RAP assessment documentation. She stated that the nurse that filled out those assessments no longer worked at the facility.	F 272		
F 273 SS=D	483.20(b)(2)(i) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility did not conduct a comprehensive assessment of a resident in a timely manner. Resident 20 Findings included: Resident 20 was admitted from the hospital to the facility, on 11/15/07, with diagnoses including	F 273		1/11/08

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F 273	Continued From page 60 recent quadrilateral amputation. Review of resident 20's medical record was done on 11/29/07. There was no Initial Admission Minimum Data Set (MDS) completed or found in the medical record as required. Within 14 calendar days after admission the facility must conduct a comprehensive assessment including RAPS (Resident Assessment Protocol Summary). An interview was initiated with the nurse MDS Coordinator on 12/3/07. She confirmed that a comprehensive MDS assessment had not been completed for resident 20.	F 273		
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 interview and record review it was determined that the facility did not 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 carefor one supplemental sample resident. Resident identifier: 20 Findings included:	F 309		1/11/08

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Resident 20 was a 56 year old admitted to the facility on 11/15/07 with diagnoses including four limb amputations.

On 12/03/07 at 9:13 AM, an interview was initiated with resident 20. Resident 20 stated that she had received a prescription for Lortab (pain medication with acetaminophen) 1-2 tabs every 4 hours for pain. She stated that the facility had told her that she could not exceed 4 grams of acetaminophen in a 24-hour period, and needed to spread out her pain medications. Resident 20 stated that it was not able to take enough medication in a 24-hour period to keep her pain under control. She stated that on a scale from 1 to 10 her pain level was at 9 or 10.

Resident 20's medical chart was reviewed on 12/03/07. Resident 20's evaluation indicated that Resident 20 was cognitive with good short term and long term memory, and was oriented, and mentally independent with consistent, reasonable decisions. Her mode of locomotion was other person wheeled in wheelchair. Comments in chart: " Resident showed good awareness of safety issues." There was no pain assessment in the medical record. There was no admission MDS (minimum data set/comprehensive resident assessment) assessment in the record. The complete assessment was due to be in the medical record on 11/28/07. No care plan for pain was found in the temporary admission care plan.

A review of the nursing note, dated 11/16/07, documented that Resident 20 was complaining of pain in both upper extremities. The note documented that Resident 20 stated that while she was at the hospital she was receiving two

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Lortab instead of one every 4 hours. The note documented that Resident 20 was upset, and the nurse had called the doctor to make a clarification to the medication order. The note documented that the order was clarified, however, no documentation was found indicating what changes to the medication were made to provide the patient with the appropriate pain control without exceeding the 4 grams acetaminophen in a 24-hour period.

A review of the physician telephone orders revealed that, on 11/16/07, a telephone order clarifying the pain medication was written. The order documented that the resident could receive Lortab 10/500 milligrams, one or two tablets, by mouth every four hours as needed. The order dcoumented the acetaminophen was not to exceed 4 grams in 24 hour period.

The nursing note, dated 11/17/07, documented that Resident 20 was still complaining of pain in the left upper extremity.

The nursing note, dated 11/28/07, documented that Resident 20 was still complaining of pain in the left extremity and rated the pain as a 9 out of 10. Pain medications were administered per doctor's orders.

On 12/03/07 at approximately 1:15 PM, an interview with the MDS coordinator nurse was initiated. The MDS coordinator stated that the nursing staff have been encouraging Resident 20 to spread the pain medication out so as not to exceed the 4 grams of acetaminophen in a 24-hour period. The MDS coordinator stated that today was the first day Resident 20 had complained, and so the MDS coordinator called in

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F 309	Continued From page 63 to the doctor for a new order. The MDS coordinator stated that the new order had the same pain relieving strength, but would not exceed the 4 grams of acetaminophen in a 24-hour period. A review of the physician telephone orders revealed a physician order dated, 12/03/07, for Lortab 10/500 to be discontinued and a new order for Lortab 10/325 milligrams, one or two tablets every 4 hours as needed for pain. The facility staff did not properly assess the residents pain and see apppropriate interventions to manage Resident 20's pain successfully for two weeks, during which time the resident continued to be in pain.	F 309		
F 315 SS=G	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the faclilty did not ensure that a resident who entered the facility continent without a clinical urinary condition was put in briefs, and did not receive appropriate services to maintain her dignity and her	F 315		1/11/08

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continence and maintain normal bladder function on a toileting program for one supplemental sample resident. Resident identifier: 20.

Findings included:

Resident 20 was a 56 year old admitted to the facility on 11/15/07 with diagnoses including four limb amputations.

Resident 20's medical chart was reviewed on 12/03/07. Resident 20's evaluation indicated that resident 20 was cognitive with good short term and long term memory. Resident 20 was oriented, and mentally independent with consistent, reasonable decisions. Resident 20's mode of locomotion was in a wheelchair with one person assistance. Resident 20 was dependent on staff for transfers and toileting. The notes documented that Resident 20 showed good awareness of safety issues. There was no bowel or bladder assessment found in Resident 20's medical record. There was no admission MDS (minimum data set/comprehensive resident assessment) assessment in the record. The complete assessment was due to be in the medical record on 11/28/07. The resident care plan documented continent of bowel and bladder. Toileting care plan indicated resident needed extensive assist by two persons. The schedule for toileting indicated per resident request.

On 12/03/07 at 9:00 AM, an interview with Resident 20 was initiated. Resident 20 stated she was in the facility for rehabilitation. Resident 20 stated that when she arrived at the facility she was continent of bowel and bladder. Resident 20 stated that after being at the facility for a week, she was unable to get assistance with toileting

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(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 315	Continued From page 65 and was soiling her bed and clothing several times a day. Resident 20 stated that the nursing assistants offered incontinent briefs for the resident to wear to prevent soiling her clothing and bedding. Resident 20 stated that after "holding it" (urine and bowel) for 20 minutes, without assistance from facility staff to get to the restroom, she would just release due to the pain of holding it. Resident 20 had a fear of having urinary accidents due to not receiving timely assistance from aides to get to toilet and laying in urine soaked bed. Resident 20 stated she used the brief to protect herself from wetting her bed. Resident 20 stated that to wear a brief was horrible, disgusting and she felt humiliated. On 12/03/07 at 3:15 PM, an interview with CNA 12 was initiated in room 5 with Resident 20 present. CNA 12 stated that they have been short staffed. CNA 12 stated that usually they have two CNAs on the east hall during the day, however, they have recently had only one CNA, on the east hall and one CNA that floats from west to east halls. CNA 12 stated that two days ago he had responded to Resident 20's call light, and had asked her to wait while he finished showering two other residents. CNA 12 stated that he forgot about Resident 20's request for assistance to the restroom and didn't return.	F 315		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;	F 334		1/11/08

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F 334	Continued From page 66 (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding	F 334		

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F 334	Continued From page 67 the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility did not ensure that the resident's medical record included documentation that indicated the resident was offered a pneumococcal immunization, unless the immunization was medically contraindicated or the resident had already been immunized. Additionally, the facility did not ensure that resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization, and whether the resident received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. for 5 of 11 sample residents. Residents: 1, 2, 3, 4, 29. Findings included:	F 334		

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F 334	Continued From page 68 On 11/29/07, medical records of residents 1, 2, 3, 4, and 29 were reviewed. There was no documentation of pneumococcal immunization for these residents in their medical records or in other notebooks offered by facility staff for review that included the date the pneumococcal immunization was offered, given, or refused. There was no documentation that these residents or their legal representatives had been educated regarding the benefits and potential side effects of pneumococcal immunization. An interview of the DON on 11/29/07 at 4:00 PM was held. The DON stated that he did not know where the pneumococcal information was. The medical records staff member was interviewed on 12/3/07 at approximately 9:00 AM. She was asked for help in locating these residents' pneumococcal immunization documentation. She was unable to provide documentation regarding pneumococcal immunization.	F 334		
F 367 SS=E	483.35(e) THERAPEUTIC DIETS Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview and resident medical record review, it was determined that the facility did not provide a therapeutic diet as prescribed by the attending physician for 3 of 11 sample resident and 1 supplemental sample resident. Residents: 2, 4, 18, and 32. 1. Resident 18 was a 47 year old male resident	F 367		1/11/08

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admitted to the facility on 10/24/07, with diagnoses that included diabetes mellitus, cerebral vascular accident, cardiac dysrhythmia, hypertension, aphasia, hemiparesis, anxiety, and depression.

On 11/14/07 resident 18's physician's orders were reviewed. Resident 18's November recertification orders indicated that resident 18 was on a NAS, LCS (no added salt, low concentrated sweets) mechanical soft diet.

On 11/14/07 at 12:15 PM, an observation and interview was conducted with Resident 18. Resident 18 was observed attempting to be eating a soft shell flour taco. Resident 18 was interviewed about his noon meal, he shook his head and pushed his tray away, untouched. The surveyor asked Resident 18 if they were able to chew the food. Resident 18 indicated that the food was difficult to chew.

2. Resident 4 was a 69 year old female admitted to the facility on 7/13/06 with diagnoses that included spinal stenosis, cerebral vascular accident, recurrent urinary tract infections, hypokalemia, dehydration and lumbago.

On 11/14/07, Resident 4's physicians orders were reviewed. Resident 4's November recertification orders indicated that Resident 4 was on a Regular SNP (super nutrition program), mechanical soft diet.

On 11/14/07 at 12:20 PM, an observation was made of Resident 4 eating her lunch meal. Resident 4 was served a soft shell flour taco, with lettuce. Resident 4 was observed to be having difficulty eating the lettuce and chewing the flour

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shell.

3. Resident 2 was a 56 year old female resident admitted to the facility on 8/11/06, with diagnoses that include infantile cerebral palsy, hypertension, pain anxiety, dementia with depression and obesity.

On 11/15/07, Resident 2's physician's orders were reviewed. Resident 2's November, recertification orders indicated that Resident 2 was on a regular mechanical soft diet.

On 11/14/07, at 12:45 PM, an observation and interview was conducted with Resident 2. Resident 2 was observed to be eating a regular hamburger sandwich on a bun. Resident 2 was not wearing her dentures. Resident 2 was observed to not receive taco meat on a bun. Resident 2 stated that although she could eat the hamburger, it was difficult.

4. Resident 32 was a 65 year old female resident admitted to the facility on 7/19/07, with diagnoses that included chronic obstructive pulmonary disease, joint pain, hypothyroidism, diabetes, hypertension, and irritable bowel syndrome.

On 11/15/07, Resident 32's physician's orders were reviewed. Resident 32's November, recertification orders indicated that Resident 32 was on a LCS (low concentrated sweets), mechanical soft diet.

On 11/14/07, at 12:30 PM, an observation and interview was conducted with Resident 32. Resident 32 was observed to be eating a soft shell flour taco. Resident 32 stated that the lettuce was difficult to eat, and that the flour shell

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F 367	Continued From page 71 had not been steamed, and was hard and difficult to eat as well. On 11/14/07, was provided the breakdown menu's for therapeutic diets. The menu for November 14th indicated that those residents who had mechanical soft diets, should have received taco meat on a bun. Three residents received a soft shell flour taco, with lettuce, and the outer shell that was difficult to chew, one resident received a regular hamburger patty on a bun. On 11/1407, in the afternoon, a facility staff kitchen workerwas interviewed regarding mechanical soft diets. The kitchen worker acknowledged that for the lunch meal, on 11/14/07, the menu for mechanical soft diets had not been followed.	F 367		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations the facility did not store, prepare, and serve food under sanitary conditions. Findings included: On 11/26/07, at approximately 11:40 AM, the handle of a scoop was observed lying in an	F 371		1/11/08

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F 371	Continued From page 72 orange and white food substance in a container covered with clear wrap in the fridge . On 11/26/07 at 1:40 PM, the walk-in refrigerator had the following items: A one pound carton of Cream O' Weber cottage cheese with expiration date of 11/5/07. Two containers of leftover vanilla pudding, dated 11/26, in single use containers covered with clear wrap. Jalapeno peppers in brine in a single use yogurt container. Ketchup in a single use sour cream container. The walk in freezer contained two pie crusts with no date. In the kitchen, the microwave had pink/red drops of liquid in the bottom and the interior door was greasy. The following spices had the lids open and up: ground oregano, ground ginger, onion powder, and salt. Open lids allowed for possible contamination of the product. There were two light covers under the range hood, over the grill and range that had greasy dust hanging from them.	F 371		
F 406 SS=E	483.45(a) SPECIALIZED REHABILITATIVE SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental	F 406		1/11/08

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health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review it was determined that the facility did not provide the SRS (specialized rehabilitation services) as identified and care planned for by the IDT (inter-disciplinary team). Specifically, not tracking and evaluating the services being implemented for habilitative care. For 3 out of 11sample residents on the sample receiving SRS in the facility. (Resident identifiers: 1, 2, and 11)

Findings included:

1. Resident 1 was a 67 year old female admitted to the facility on 10/20/98 with diagnoses that included moderate mental retardation, seizure disorder, cardio vascular accident.

A review of resident 1's medical record was completed on 11/28/07. No SRS data tracking or progress notes related to SRS were found in resident 1's SRS binder since September 2007.

2. Resident 2 was a 57 year old female admitted to the facility on 8/11/06 with diagnoses that included mental retardation, infantile cerebral palsy, hypertension, dementia, and depression.

A review of resident 2's medical record was

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F 406	Continued From page 74 completed on 11/28/07. No SRS data tracking or progress notes related to SRS were found in resident 2's SRS binder since July 2007. 3. Resident 11 was a 82 year old female admitted to the facility on 8/101/99 with diagnoses that included mental retardation, obesity, and hypothyroidism. A review of resident 11's medical record was completed on 11/28/07. No SRS data tracking or progress notes related to SRS were found in resident 11's SRS binder since July 2007. On 11/27/07 at 4:30 PM, an interview was initiated with the facility social worker. When asked about SRS services, the social worker stated that residents receiving SRS services in the facility had not been tracked or notes summarized since July 2007.	F 406		
F 469 SS=D	483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility did not maintain an effective pest control program so that the facility was free of pests and rodents. Specifically, an ant infestation in resident room 5. Findings included:	F 469		1/11/08

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Resident 20 was a 56 year old female admitted to the facility on 11/15/07 with diagnoses that included traumatic amputation of both arms and both legs, hypertension, breast cancer, and migraines.

On 12/03/07 at 9:13 AM, an interview was initiated with resident 20. Resident 20 stated that she was admitted to the facility on 11/15/07 in room 5. She stated that for the previous 2 weeks she has had ants crawling through her room. She stated that since she has no arms or legs she was unable to pick up food that may drop on the floor and when the room is not swept frequently the ants spread through the room. She stated that one of the graveyard nurses had to change her bedding one evening because the ants had migrated to her bed.

On 12/03/07 from 9:13 AM to 3:30 PM, it was observed that there were ants in Resident 20's room (room 5). The ants were observed to be located on the floor under and around resident 20's bed. The ants were observed to be eating the food particles on the floor. It was observed that there was a brown powdery substance along one of the baseboards.

On 12/03/07 at 1:00 PM, an interview with the Maintenance Supervisor was initiated. The Maintenance Supervisor stated that the pest control company had come out the previous week and sprayed the perimeter of the building for ants. The Maintenance Supervisor provided a bill that documented that the pest control company had sprayed the building on 11/28/07. When asked about room 5, the Maintenance Supervisor stated that room 5 was not sprayed and he was unaware there were ants in room 5.

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F 469	Continued From page 76 On 12/03/07 at approximately 2:30 PM, the Maintenance Supervisor stated that the brown powdery substance was cinnamon that one of his staff had placed in the room to deter the ants.	F 469		
F 490 SS=J	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on resident interviews, direct care and administrative staff interviews as well as former staff interviews, and facility record review, it was determined that the facility was not administered in a manner that ensured residents were free of abuse, and that allegations of abuse and misappropriation of resident property were immediately reported, thoroughly investigated, and that employee screening occurred as required by federal requirements and facility policies and procedures. The failure to prevent and respond to the abuse of 1 of 10 sampled residents, was determined to present an immediate threat to residents' health and safety. Resident identifiers: 1, 2, 3, and 19. Employee identifiers: CNA 9, CNA 16, CNA 17, CNA 20, CNA 21, CNA 22, CNA 23, CNA 24, NA 1, and Nurse 7. Findings included: 1. Interviews were held with the Administrator, Director of Nursing (DON), Social Service Worker	F 490		1/11/08

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(SSW), Maintenance Supervisor, Certified Nurse Aide (CNA)13, and CNA 14 between 11/14/07 and 11/27/07. Consistent from these interviews was that resident 1 clearly expressed that she did not want to shower on 10/29/07; that four facility staff were utilized to ensure resident 1 was showered on 10/29/07, after she clearly expressed that she did not want to shower; that resident fought with the four facility staff members as they prepared the resident for her shower; that resident 1 continued to yell out that she did not want to shower as the four staff members removed her clothing and jewelry; and that the Administrator and SSW were within line of sight as the four staff members forcibly took resident 1 to the shower and were able to hear resident 1's cries for staff to stop, while in the shower room. Also consistent from these interviews was that, once undressed, resident 1 ceased fighting the four facility staff members and stopped yelling. Cross-refer F-223.

2. Interviews were held with resident 1, resident 2, resident 3, resident 19, the Administrator, DON, current SSW, former SSW, Maintenance Supervisor, Nurse Aide (NA)1, CNA 13, and CNA 14, and the Business Office Manager were interviewed between 11/14/07 and 11/27/07. Although facility staff had received allegations of abuse to resident 1, and misappropriation of property of residents 2, 3, and 19, the Administrator did not ensure the allegations were investigated thoroughly, reported timely and in accordance with federal requirements and the facility's own policies and procedures, and to ensure that screening of employees was conducted in accordance with the facility's policies and procedures. Cross-refer F-225 and F-226.

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F 514 SS=E	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 it was determined that the facility did not maintain clinical records on each resident in accordance with accepted professional standards for 4 of 11 sample residents. (Residents 4, 2, 13, 32) Resident 4 Findings included: 1. Resident 4 was admitted to the facility on 7/13/06 with diagnoses including: spinal stenosis, cerebral accident, recurrent urinary tract infections and lumbago. Resident 4's medical record was reviewed on 11/27/07. The August 2007 quarterly MDS (Minimum Data Set) was not dated as completed by the nurse coordinator. 2. Resident 2 was admitted to the facility on 8/11/06 with diagnoses of cerebral palsy,	F 514		1/11/08

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hypertension, pain, anxiety, dementia with depression, and mental retardation.

On 11/26/07, resident 2 ' s medical record was reviewed. Resident 2 ' s Weekly skin evaluation progress notes for the month of October, 2007 were reviewed. The form had no nursing documentation on it, regarding resident 2 ' s skin, for the entire month.

3. Resident 13 was admitted to the facility on 10/5/07, with diagnoses of diabetes mellitus seizure disorder, renal failure, hypertension, hyperlipidemia and esophageal reflux.

On 11/26/07 resident 13 ' s MAR (medication administration record) was reviewed. The following medications were not documented as being given.

Renagel, was not documented as being administered on 11/2/07.

Renaplex, was not documented as being administered on 11/3/07, 11/5/07, 11/6/07, 11/10/07, 11/12/07, and 11/24/07.

Sodium Bicarbonate,was not documented as being administered on 11/2/07 and 11/23/07.

Prilosec, was not documented as being administered on 11/1/07, 11/2/07 and 11/24/07.

Minoxidil, was not documented as being administered on 11/2/07.

Enalapril Maleate, was not documented as being administered on 11/2/07.

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	465100	A. BUILDING _____ B. WING _____	C 12/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINIA AT ALTA	4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107

(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 80	F 514		

Norvasc, was not documented as being administered on 11/2/07.

Metoprolol, was not documented as being administered on 11/2/07.

Lipitor, was not documented as being administered on 11/1/07, 11/2/07, 11/3/07, 11/4/07, 11/7/07, 11/8/07, and 11/28/07.

Relagel, was not documented as being administered on11/23/07 and 11/25/07.

Humalog Insulin, was not documented as being administered on 11/13/07 at 5:00 PM, 11/23/07 at 12:00 PM, and on 11/24/07 at 12:00 PM and 5:00 PM.

Regular Insulin was not documented as being administered on 11/12/07 at 5:00 PM and 8:00 PM and on 11/13/07 at 5:00 PM and 8:00 PM.

Lantus Insulin, was not documented as being administered on 11/13/07 at 8:00 PM.

Resident 13's physician's orders dated 10/5/07 indicated that resident 13 was to have his blood glucose checked AC and HS (before meals and bedtime). The following dates times there was no documentation to indicated that resident 13's blood glucose was taken and documented on 11/2/07 at 07:00 AM and 5:00 PM. 11/2/07 at 5:00 PM. 11/10/05 at 5:00 PM. 11/14/07 at 11:00 AM. 11/23/07 at 11:00 AM. 11/24/07 at 11:00 AM, and 5:00 PM. 11/29/07 at 5:00 PM.

4. Resident 32 was admitted to the facility on 7/19/07 with diagnoses of chronic obstructive pulmonary disease, joint and pelvis pain,

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F 514	Continued From page 81 hypothyroidism, diabetes mellitus, hypertension, and irritable bowel syndrome. On 11/14/07 resident 32's medical record was reviewed, including her August, 2007, MAR (medication administration record). The following medications were not documented as being administered. Ex Lax 25, was not documented as being adiministered on 11/13/07, 11/20/07, 11/21/07, 11/22/07, 11/23/07, 11/24/07, 11/25/07, 11/27/07, 11/28/07, and 11/29/07. Premarin, was not documented as being administered on 11/21/07, 11/22/07, 11/23/07, 11/24/07, 11/25/07, 11/27/07, 11/28/07, and 11/29/07. Prilosec, was not documented as being administered on 11/13/07, 11/14/07, 11/27/07 and 11/28/07. Levothyroxine, was not documented as being administered on 11/20/07, 11/27/07 and 11/28/07. KCL (Potassium), was not documented as being administered on 11/20/07, 11/21/07, 11/22/07, 11/23/07, 11/24/07, 11/25/07, 11/27/07, 11/28/07, and 11/29/07. Provera, was not documented as being administered on 11/20/07, 11/21/07, 11/22/07, 11/23/07, 11/24/07, 11/25/07, 11/27/07, 11/28/07, and 11/29/07.	F 514		
F 520 SS=J	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE	F 520		1/11/08

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F 520	Continued From page 82 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interviews and review of facility records, it was determined that the facility did not ensure that the Quality Assessment and Assurance identified quality problems and developed corrective action plans in the areas of: identification of abuse and misappropriation of resident property; reporting and investigating allegations of abuse and misappropriation of resident property; screening of employees; provision of pain management; and provision of incontinence cares. Resident identifiers: 1, 2, 3, 19, and 20. Employee identifiers: CNA 9, CNA 16, CNA 17,	F 520		

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F 520	Continued From page 83 CNA 20, CNA 21, CNA 23, CNA 24, NA 1, and Nurse 7. Findings included: 1. The facility's Quality Assessment and Assurance Committee did not ensure facility staff intervened with residents in a manner that promotes resident choice and prohibits abuse. On 10/29/07, facility staff physically and mentally abused resident 1 when they forced her to shower against her will. Cross-refer: F-223. 2. The facility's Quality Assessment and Assurance Committee did not ensure facility staff were able to identify abuse and misappropriation of resident property; that facility staff reported allegations of abuse and misappropriation of resident property to agencies in accordance with federal requirements and facility policy and procedures; and that employees were screened to determine appropriateness of employment in accordance with facility policies and procedures. The facility failed to investigate and report allegations of abuse and misappropriation of resident property for 3 of 10 sampled residents, plus 1 supplemental residents. Resident identifiers: 1, 2, 3, and 19. The facility failed to screen 9 of 14 sampled employees in accordance with their written policies and procedures. Employee identifiers: CNA 9, CNA 16, CNA 17, CNA 20, CNA 21, CNA 23, CNA 24, NA 1, and Nurse 7.	F 520		

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F 520	Continued From page 84 Cross-refer: F-225 and F-226. 3. The facility's Quality Assessment and Assurance Committee did not ensure that, for 1 of 10 sampled residents, facility staff provided the necessary cares and services for the resident to achieve pain relief. Resident identifier 20. Cross-refer: F-309. 4. The facility's Quality Assessment and Assurance Committee did not ensure that, for 1 of 10 sampled residents, facility staff provided the necessary cares and services for the resident attain or maintain normal bladder function. Resident identifier 20. Cross-refer: F-315.	F 520		